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The Long Way Home: The Integration of Traditional Medicine Into the Peruvian Healthcare System

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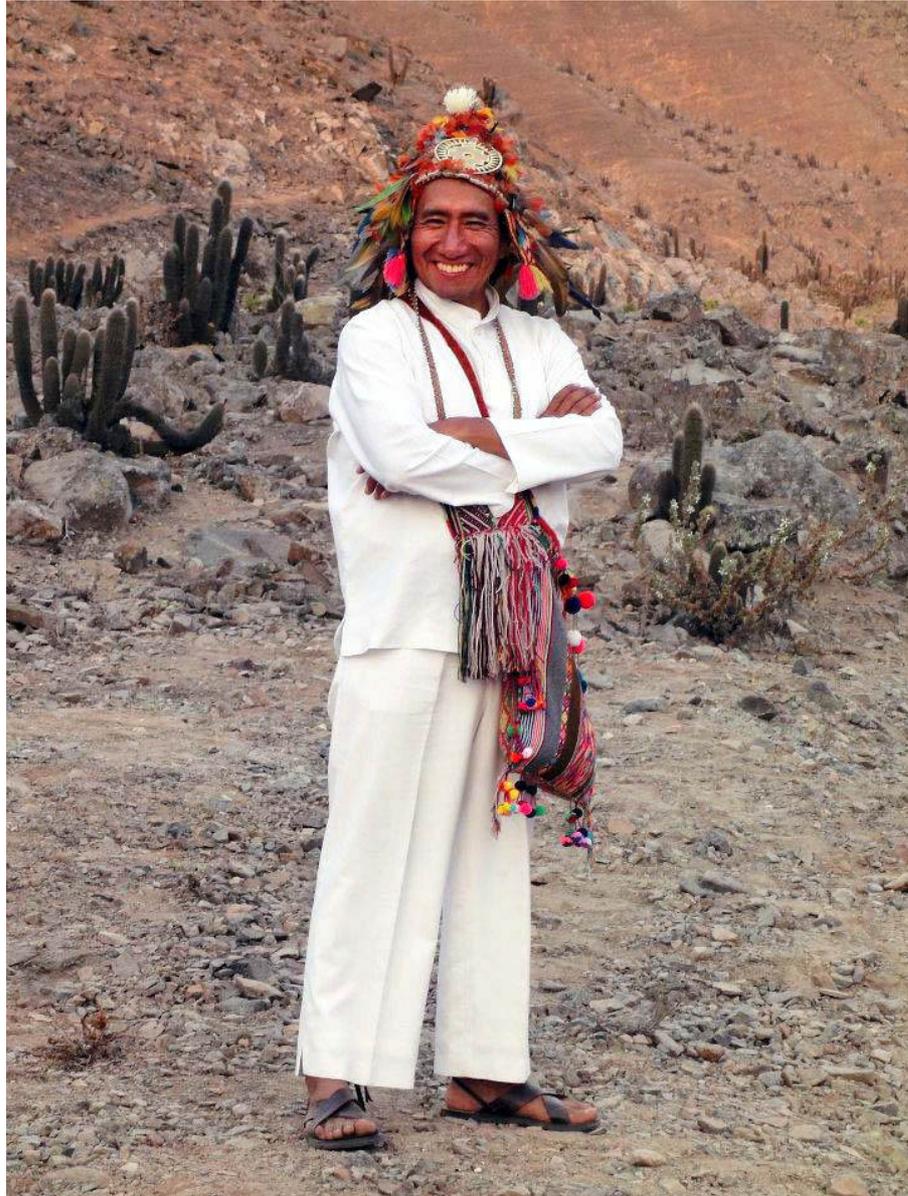
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This work is dedicated to a large part of the Peruvian people
without healthcare attention

And

To all the devoted people working to improve this



(Photo courtesy of Grisel Salazar-Lewis 2011)

Im memoriam

Amauta Tahuiro Wamankanki Collque

(14 March 1951 – 03 December 2011)

“I come from the purest lineage of the Incas... I follow an Inca prophecy, which says, when the sacred stone of the Incas will be hurt, the “pachacuti of light” will be reborn. But it didn’t recount the appearance of a political Inca, rather than the return of our ancestral spirituality... I come from the Andes to the city to spread the doctrine of my masters which I learnt since I was seven years old...The word “priest” means eternity: Someone is born for that, he was chosen for this; there is no other path he could take... My name is Tahuiro Wamankanqui Collque and I bring the knowledge of my ancestors with pride, and too much love. And I can say, I can shout it out to the four winds, that this country is the richest of the world. The world of abundance”(Wamankanki iw/2009)

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Abstracts

Summary

This study deals with the exploration, systematisation and analysis of existing discourses in relation to the articulation of traditional medicine in the official healthcare system in Peru. The focus is on the identification of fundamental thematic guidelines and socio-cultural and anthropological factors on the topic with particular importance for anthropological theory construction and policy making. The work is inspired by approaches of medical anthropology and ethnomedicine, as well as post-colonial and alternative development studies. The starting point is based on empirical data collection on the basis of theme-centred interviews, ethnographies and participant observation with traditional healers, scholars and research experts on traditional medicine, academic and health authorities, physicians and health workers, alternative health practitioners and social activists in the regions of Lima, La Libertad, Ica, and Lambayeque. The collected data was complemented with document research, the achievement, systematisation and analysis of policy documents; scientific literature and archive search; according to the strategies of the grounded theory and other methods of qualitative research, in particular the content analysis. The investigation reveals a number of anthropological factors that are relevant in terms of the feasibility of an official formulation of traditional medicine in Peru. The analysis and systematisation of these results leads to the identification of five models that provide important theoretical positions for the healthcare system's integration: 1. the harmonisation or standardisation model, 2. the inter-cultural approach revisited, or the "intercambio de saberes", 3. the community-based approach, 4. the educational approach, and 5. the cultural heritage approach. The differences in the concepts underlying these five models reflect the different views and content deemed essential related to the integration of indigenous medicines in official care systems. They describe processes and structures that are of outstanding importance for understanding the development and representation of cultural and historical identities in Peru.

Zusammenfassung

Die vorliegende Dissertation befasst sich mit der Aufarbeitung und Analyse der Diskurse um die Integration traditioneller Heilverfahren in das offizielle peruanische Gesundheitssystem. Hierbei liegt der Fokus auf den grundlegenden Vorstellungen, dem Interesse und den Konzepten der handelnden Institutionen und Personen gegenüber einem integrativen Versorgungssystem im öffentlichen Gesundheitswesen. Die Arbeit basiert auf Theorien aus der Medizinanthropologie und Ethnomedizin sowie aus der Anthropologie der internationalen Entwicklung und der Medizinkritik. Als Ausgangspunkt dient eine empirische Datenerhebung anhand von themenzentrierten, meist narrativen Interviews, Ethnographien und teilnehmender Beobachtung in den Regionen Lima, La Libertad, Ica und Lambayeque. In der Erhebungsarbeit wurden sowohl traditionelle HeilerInnen und alternative HeilpraktikerInnen als auch AkademikerInnen und andere ExpertInnen, ÄrztInnen und MitarbeiterInnen des Gesundheitswesens und der zuständigen Behörden interviewt. Die so gewonnenen Daten wurden mithilfe von Literatur- und Internetrecherche ergänzt und nach Strategien aus der *grounded theory* und anderen Methoden der qualitativen Forschung, insbesondere der Inhaltsanalyse, ausgewertet und analysiert. Die Analyse ergibt einerseits eine Reihe von kulturanthropologischen Faktoren, die in Bezug auf die Umsetzbarkeit einer offiziellen Formulierung traditioneller Heilkunde in Peru relevant sind. Andererseits scheinen wichtige Anhaltspunkte auf, die sowohl Möglichkeiten als auch Grenzen der Integration traditioneller und alternativer Versorgungsmodelle in Peru aufzeigen. Eine Analyse und Systematisierung dieser Resultate führt schließlich zur Identifizierung von fünf Modellen, die wesentliche theoretische Positionen zur medizinischen Integration liefern: 1. das Harmonisierungs- oder Standardisierungsmodell; 2. ein erneuerter interkultureller Ansatz beziehungsweise das Modell des Wissenstransfers; 3. das alltags- und gemeinschaftszentrierte Modell; 4. das bildungszentrierte Modell; und 5. die Konstruktion von Artikulationen des Kulturerbes. Die zugrundeliegenden Konzepten reflektieren die verschiedenen Auffassungen und als wesentlich erachteten Inhalte in Bezug auf die medizinische Integrationsarbeit. Sie bezeichnen Prozesse und Konstruktionen, die für das Verständnis der Entwicklung und Repräsentation kultureller und historischer Identitäten in Peru von herausragender Wichtigkeit sind.

Resumen

El presente estudio se ocupa con la exploración, sistematización y análisis de los discursos existentes en relación a la articulación de las medicinas tradicionales en el sistema de salud oficial en el Perú. El principal foco de atención se dirige a la identificación de líneas temáticas y factores antropológicos y socioculturales que contribuyan a la construcción de teorías y modelos antropológicos explicativos al tema. La investigación se inspira en modelos y aportes teóricos y metodológicos de la antropología médica y la etnomedicina; la crítica de la medicina; así como también de los estudios postcoloniales y el desarrollo de modelos alternativos en salud pública. El punto de partida lo constituyen la recolección de datos empíricos basados en estudios de campo. Para ello se realizaron entrevistas de corte narrativo centradas en un tema, etnografías y observación participante con curanderos tradicionales, académicos e investigadores expertos en medicina tradicional, autoridades de las áreas de salud y educación, médicos y personal de salud, practicantes de la medicina alternativa y activistas sociales, en las regiones de Lima, La Libertad, Ica y Lambayeque. Estos datos se complementan con el estudio de documentación bibliográfica pertinente, documentación oficial sobre políticas y programas de salud a nivel nacional, regional e internacional e investigaciones al respecto; así como literatura científica y material de archivos. Estos fueron analizados de acuerdo a las estrategias de la grounded theory y otros métodos de análisis cualitativo, en particular el análisis de contenido. Los resultados revelan un grupo de factores antropológicos relevantes para la formulación oficial de la medicina tradicional en el Perú. El análisis y la sistematización respectiva conduce a la identificación de cinco modelos específicos de integración, que proporcionan enfoques teóricos importantes a ser considerados: 1. El Modelo de Armonización o Estandarización; 2. El Enfoque Intercultural o del Intercambio de Saberes; 3. El Modelo Comunitario o Regional; 4. El Enfoque Educativo y 5. El Modelo del Patrimonio Cultural. Las diferencias conceptuales y de enfoque que se encuentran en estos cinco modelos reflejan perspectivas distintas en relación a una medicina integrativa en los sistemas de atención oficial. El análisis realizado describe procesos y estructuras que son de particular importancia para la comprensión del desarrollo y representaciones de las identidades culturales e históricas en el Perú.

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List of Abbreviations

Nouns and concepts

AHP	Alternative Health Practitioner
CAM	Complementary and Alternative Medicine
CH	Cultural Heritage
HCS	Healthcare System
HMM	Hegemonic Medical Model
MD	Medical Doctor/ Physician
PH	Public Health
PHC	Primary Healthcare
TCAM	Traditional, Complementary, and Alternative Medicine
TCM	Traditional Chinese Medicine
THS	Traditional Health Systems
TK	Traditional Knowledge
TM	Traditional Medicine
THP	Traditional Health Practitioner

Institutions and Organisations

AMARES	<i>Programa de Apoyo a la Modernización del Sector Salud y Aplicación en una Región del Perú</i> ; Support Program for the Modernisation of the Health Sector and Application in a Region of Peru
CENSI	<i>Centro Nacional de Salud Intercultural</i> ; National Centre for Intercultural Health
CMP	<i>Colegio Médico del Perú</i> ; Peruvian Association for Medical Doctors
CMTAC	<i>Comité de Medicina Tradicional, Alternativa y Complementaria del Colegio Médico del Perú</i> ; Committee of Traditional, Alternative and Complementary Medicine of the CMP
CONHU	<i>Convenio Hipólito Unánue</i> ; Hipolito Unanue Convention

ESSALUD	<i>Seguro Social de Salud</i> ; Peruvian Health Social Insurance
FOROSALUD	Forum of the Civil Society for Health
INC	<i>Instituto Nacional de Cultura</i> ; National Institute of Culture
INDECOPI	<i>Instituto Nacional de Defensa de la Competencia y de la Protección de la Propiedad Intelectual</i> ; Peruvian National Institute for the Defence of Competition and Intellectual Property
INMETRA	<i>Instituto Nacional de Medicina Tradicional</i> ; National Institute of Traditional Medicine
INS	<i>Instituto Nacional de Salud</i> ; National Institute of Health
MINSA	<i>Ministerio de Salud</i> ; Ministry of Health of Peru
ORAS	<i>Organismo Andino de Salud</i> ; Andean Health Organisation
PAHO	Pan American Health Organisation
UN	United Nations
WHO	World Health Organisation

Abbreviations

art.	Article
cf.	Compare, confer
ec/	Electronic writing communication
ei/	Electronic virtual interview
e.g.	Exempli gratia (lat. for Example)
et al.	And collaborators
f/	Folio, page number
fr.	French language
gi/	Group Interview
g.	German language
hs.	Healing session
I	Interviewed person
i	Interviewer
inc.	Clause
ic/	Informal conversation
i.e.	Id est (lat. that is)

iq/	Internet quotation
iw/	Interview
pc/	Personal communication
fq/	Field research quotation/notes
l/	Lecture
lat.	Latin language
nr.	Number
par.	Paragraph
qe.	Quechua language
sp.	Spanish language
t.	Translation
t/	Talk
w/	Workshop
X	Hidden name

Quotations

Technical or colloquial expressions, special concepts, stressed ideas, neologisms, and constructs or names in foreign languages, are italicised; e.g.: *medical pluralism*; *deritualisation*; *Huancavelica*.

Commands (“...”) are used to refer to textual quotations from interviews and texts and to stress expressions, words or concepts.

While recognising the important value of linguistic gender distinction, for reasons of better legibility and fluency, in the following text only the masculine form will be used in Spanish, when applicable; e.g. *curanderos*.

Introduction

In the year 1997 I began to work for people with cancer, tuberculosis and HIV, applying mind-body intervention techniques. These procedures are designed to enhance the mind's capacity to positively affect bodily functions and symptoms. I attended to these patients also in the suburbs of Lima, in a health centre of the Ministry of Health. They were mostly Andean migrants and refugees, who had fled from their hometowns in the Andes to the capital, trying to escape terrorism and political violence during the 1990s. While working at this Health Centre in Lima, I encountered a thousand different conceptions about health, disease, healing and outcomes, which made me question my own biomedical-oriented training. I had no answers for patients who claimed they were sick because of a “susto” or “daño”¹. I had no cultural competencies for such situations.

Two years later, one of my clients, a young HIV patient who had made remarkable progress in defeating his depression through psychotherapy, told me that he was exhausted from the antiretroviral therapy² and its negative side effects. He had decided to abandon this treatment and go to a traditional healer in the Amazon Rainforest. Approximately six months later, he returned to Lima with a negative ELISA test report³. He was no longer infected with HIV. For the next ten years we stayed in touch. During these years, he took several different tests and physician exams to verify this –in my eyes– inexplicable outcome.

Until now I have no scientific explanation for this patient's experience. In those days some questions arose in my mind: What did this healer do to my patient? What had happened between this patient and the healer? If this healer was successful with such a

¹ Two of the most common culture-bound syndromes in Peru. The *susto* or *espanto* (qe. *Mancharisqa*) is related to supernatural forces that remove or steal the soul of the patient, characterized by a general state of anxiety and diffuse fear, loss of appetite, insomnia, nightmares and apathy (cf. Delgado Súmar 1999e:4). The *daño* has several symptoms, mostly considered a disease without a clear medical diagnosis, provoked through sorcery and intentional maledictions (cf. Chiappe 1993:191-198).

² Antiretroviral therapy consists in the use of at least three antiretroviral drugs to maximally suppress the HIV virus and stop the progression of the HIV disease.

³ The enzyme-linked immunosorbent assay (ELISA), or enzyme immunoassay (EIA), was the first screening test commonly employed to detect HIV antibodies. Although it has a high sensitivity, the most controversial aspect of this test is determining the cut-off point between a positive and negative result (Branson 2007: 3).

difficult disease –and apparently there were many like him– why don't we health professionals in Peru receive any information about traditional medicine (TM), alternative health methods or even healers during our studies?

I had heard nothing about traditional medicine or *curanderos* (traditional healers) while studying and working at Peruvian universities. They were for me only diffuse concepts related to psychedelics and expanded states of consciousness; curanderos were part of folklore, strongly associated with “superstition” and “ignorance”. TM was not part of the “serious” academic education for health professionals, trained in the Western biomedical paradigm of health, disease, and outcomes. The academic institutions and health professionals in Peru consider biomedicine the only factual way of addressing health problems. Indigenous views of health are consequently discarded and are even perceived as hurdles to biomedicine, despite the fact that traditional health practitioners (THPs)⁴ presently care for millions of people in Peru.

My first attempts to establish scientific approximations of these questions were in terms of the study of rituals and biographies of THPs. I thought that in the study of their life stories and the exact analysis of their techniques it would be possible to find explanations about their efficacy and also about their difficulties in being recognized by the state and health and academic institutions. However, in further researching the topic, I found that some crucial questions had not yet been answered. Why aren't curanderos part of the official healthcare system (HCS)? Why isn't their work recognized? Why isn't indigenous medical knowledge part of the curriculum for health professionals in Peru, a country in which more of 40% of the people are indigenous? What do policy makers, health professionals and the curanderos themselves think about it? Have the discourses around this topic already been studied? Are there scientific scholarships on this specific issue?

During the last eleven years, I have occupied myself with these and related questions as I perform consultation activities as a non-staff researcher for institutional and non-

⁴ The use of the term “traditional healer” or “traditional health practitioner” is strongly misapplied –above all due the dynamic reworking healers constantly do. Anyway, I will use the term because of the extended use of it among healers, policy makers and scientists.

institutional alternative healthcare initiatives in Peru. Many people, scholars, health professionals, and THPs are committed to improving an intercultural healthcare approach in an integrative healthcare system in the country. In order to obtain this goal, some of them propose the social recognition and integration of THPs in the general health system as a *conditio sine qua non*, others, however, believe strongly that this articulation means the ultimate settlement of traditional health systems (THSs), and that this will not resolve the existing structural inequality in the country –on the contrary, it would reinforce it. However, these experts’ opinions, based on years of field-based research, are not accepted by the Peruvian government’s health administration and stakeholders, which view these proposals as undermining their authority. Accordingly, I decided to make a first approximation in the need to systematize the development of prior and existing attempts to articulate the traditional health practitioners in the official health care system in Peru and to analyze these initiatives from the perspective of the discourses about.

Accordingly, this research explores the discourses surrounding the articulation⁵ of THPs in Peruvian HCS by analysing the several ways in which this cultural process is perceived and negotiated by stakeholders and those directly involved. In addressing this main research interest, the study accomplishes three specific inquiry procedures:

- (1) Research, identification and analysis of specific norms, policy regulations and current proposals regarding the integration of TM and THPs in Peruvian HCS: Which historical and social characteristics does the development of this specific health policy in Peru show? How have public health policies in relation to this topic been conceived? Which social and cultural factors are important to explain and understand this development?

⁵ In my view, the term “integration” or “articulation” implies the incorporation of only some aspects of TM that suit the interests of biomedicine (i.e. only herbal medicine products). The focus of the study is on the analysis of policy-making cultural aspects involved in such a process; therefore, I subsequently use these terms as they have been used in policy statements. According to Correa (2002:xi), many indigenous and civil associations prefer the term “partnership” as suggesting a more equal relationship. Although enlightened, such and other terms addressing more fairly political decisions do not reflect the real situation in relation to policy making (see analysis on chapter 5).

- (2) Exploration, analysis and description of the discourses, concepts, and perspectives on the different aspects involved in these policies: What are the current concepts and perceptions of THPs, physicians (MDs), health professionals, scholars, alternative health practitioners, activists, health and academic authorities, policy makers, and other relevant actors in terms of the integration of THSs into the HCS in Peru?

- (3) Categorisation, description, and examination of the identified models proposed for the inclusion of TM and THPs in the Peruvian HCS. Which are the principal perspectives, theories, and procedures addressed by such models? How acquirable are these in terms of their application?

This dissertation research can be theoretically and methodologically located in the field of medical anthropology, but its findings and purposes should be understood among the wide spectrum of topics constituting the anthropology of health and public health research. The study explores and analyzes conceptions and narratives underlying and informing health policymaking structures in the country. The purpose of drawing on the attention of discourses around the implementation of local resources in healthcare reveals the open question about the different forms in which population and communities in Peru make use of different medical and non-medical systems. The use of TM and other popular health methods among the population are not questioned, because these practices do not need to become formalised in order to be continually in use.

I can here only give a testimonial of my intentions and not of the effects they will produce. I have tried to establish a dialogue between the social and the political level, in which I examine their narratives, transporting and interpreting them, but at the same time letting them talk –a reason why there are so many literal quotations in the study. The study is not only about the analysis of abstract contents that have no place into political decisions, and it should not be understood as a merely conventional analysis of a controversial public health affair. It will be an approach that grasps and makes visible the cultural and social processes involved on it. Moreover, I am convinced that an anthropological exploration of policy making aspects on this topic shows different

creative strategies and proposals to extreme dynamic socio-cultural conditions. Additionally, the qualitative analysis of discourses surrounding health policies helps to define key issues and generate knowledge and paradigms that broaden conceptual frameworks and that should be considered in public health administration. In light of this, the research aims to contribute to the identification of relevant local discourses in Peru among the globalised tendency to incorporate indigenous knowledge into formal medical institutions, and to indicate further directions of specific research about the pertinence and feasibility of such models for the country.

I begin Chapter 1 by addressing considerations of the relevance of this research for the scientific community. I introduce the selected methodology and theoretical framework within the disciplines of cultural and social anthropology and health anthropology⁶, and offer a description of the selected methodology and research contexts. I address the selection of the empirical data, analysis of the explored situation, data processing, inductive category development, and the description of the process in code-assignment and category building. By using the grounded theory model throughout my fieldwork, I continually re-evaluated and updated my findings and results. I end Chapter 1 with the principal outlines of my field explorations by topic, and the analytical configuration of the fieldwork in categories.

In Chapter 2, I present a conceptual discussion about the most relevant definitions of TM and THPs, and an analysis of the development of scholarship in this respect. Furthermore, I situate the development of international health policies and PHC to this effect, situating Peru in a regional and international context.

Chapter 3 describes the country and the Peruvian population focussing on the data available and its actual socioeconomic conditions. I provide an introduction about the general health situation of the Peruvian population and, ultimately, a description of the structure and functions of the Peruvian HCS at the present. To this respect, a brief overview is given on its general coverage, physical, material and financial sources in the

⁶ Health anthropology is considered here an applied form of medical anthropology. It stresses the practical implementation of research findings and the incorporation of the perspectives of patients, communal health givers, and minorities into the scientific discourse.

context of the last big reform of the 1990s. I then discuss in detail prior and current health policies that include the work of THPs in Peru and analyse key peculiarities and applications about these policies. I end this part by presenting and analysing selected institutional and academic projects that focus on intercultural health issues, including the work of THPs. An analysis of the work of the two institutions responsible for TM, INMETRA and CENSI, is also provided, as well as the implementation of CAM in specific health centres at the Peruvian Health Social Insurance (ESSALUD) and MINSA, followed by the description of the principal strategies and programmes addressing intercultural healthcare including THPs.

In Chapter 4, I review historical and scientific documents about the persecution of healers, their practice prohibition, and present a framework about their present legal status. I briefly touch upon present transnational socio-medical phenomena and emphasise the possible relation between negative features of secure health outcomes and predictable risks that are strongly related to the non-regularisation of the practice of THPs. Subsequently, I present two ethnographic accounts of THPs that illustrate different working styles and practice contexts.

In Chapter 5, I present the empirical results of the study and the principal conclusions as a research summary. An outgoing proposal is to relocate the scientific discussions within the conversation of a healthcare policy that includes cultural and human rights perspectives and civil and social participation at the local and regional level.

In Chapter 6, I present the principal results of the study. Chapter 7 provides a bibliography, as well as available electronic documents and databases consulted; and a list of informants. In Chapter 8, particularly important documents used during the research are included.

.....

In many developing countries, TM is the most accessible and affordable treatment available. However, only a few of these countries recognise and protect the work of their THPs.

Millions of people throughout the world use TM to help meet their primary healthcare needs (WHO 2002c:1). A national survey conducted by Eisenberg in the USA in 1990 found that 33.8% of 1,539 adults, which can be extrapolated to approximately 60 million Americans (Padilla et al. 2001:1336), had tried at least 1 of 16 alternative procedures or therapies, including practices such as acupuncture, chiropractic, spiritual healing, herbal medicine, or folk remedies (Eisenberg et al. 1993). According to a WHO study, 80% of people in developing countries use traditional, complementary, and alternative medicine (TCAM) (2002a:610). TM accounts for about 40% of all healthcare delivered in China. In Hong Kong, approximately 60% of the population has consulted THPs at least once (WHO 2002a:13). However, other reports state that this percentage is far higher. A recent study asserts that 95% of the population in Asia, Africa, Latin America, and the Middle East use some form of TM (Robinson and Zhang 2011:2). While TCAM usage is less common in the Global North, its popularity is increasing. 42% of the population of the United States uses TM, and the number increases to 48% of the population of Australia, 49% of the population of France, and 70% of the population of Canada (Bodeker and Kronenberg 2002: 1582).

In Latin America, the WHO Regional Office for the Americas reports that 71% of the population of Chile and 40% of the population of Colombia uses TM (WHO 2002a:11). In 1998, a statistical survey about the perception of TM in urban areas in Peru found that at least 8 out of 100 people have used TM (INEI 1998:5). More recent information for this region is not yet available.

Traditional and Western medical systems have coexisted in Peru for centuries in a practice called *medical pluralism*. Most of the early research on medical pluralism consisted of the formulation of different typologies that regarded the existence of this phenomenon in complex societies. Medical systems could be classified due to their geographical and cultural settings. Following Dunn, there are three types of medical

systems: (1) local medical systems, (2) regional medical systems, and (3) the cosmopolitan medical system (1976:135). Local medical systems are “folk” or “indigenous” medical systems of agricultural or pastoral societies and peasant communities that are represented on a small scale. Regional medical systems are distributed over a comparatively large area. Examples of regional medical systems are the different Traditional Chinese Medicines (TCM), the system of Ayurveda, and the Unani Medicine in South Asia. Both local and regional medical systems are usually traditional and indigenous and are, as Dunn points out, normally “intra-cultural”, although by no means insulated from exchange with other systems (1976:136). In addition, cosmopolitan or Western medicine refers to the global medical system, legitimated worldwide through governmental implementation in healthcare, or what commonly has been called “scientific medicine”, “modern medicine”, or “Western medicine”. Complex societies, like India, China, Japan, and Peru, generally contain all three of these medical systems. Despite the dominant character of biomedicine as the state-embedded structure of globalised and emergent countries, it is certainly clear that THPs and their traditional health systems (THSs) remain strong and present, due to their perceived efficacy or their commitment to cultural identity, or both. In fact, the spread of biomedicine did not result in the complete integration of THSs into a dominant modern system based on the principles of biomedicine, but instead, in plurality.

In Peru, medical pluralism is the result of multiple social and historical phenomena that have been developed throughout the history of the country and external and permanent global cultural influences. In addition to Western medicine, Peruvians use treatments from a broad spectrum of health medical systems originating in indigenous knowledge from the coastal, Andean, and Amazon regions. Researchers have often deal with several aspects of the topic, for example, with specific studies on shamanism⁷ in a culture or region (Luna 1986; Giese 1989; Illius 1991; Joralemon and Sharon 1993; Chaumeil 1998). The wide range of matters included the study of the worldview, rituals and symbolism of these practices (Joralemon 1984; Giese 1991; Langdon and Baer 1992; Reichel-Dolmatoff 1996); myths, visions and chants (Luna and Ameringo 1999;

⁷ Due its great number, ethnographies and anthropological analysis on shamanism, ritual performances and healing systems in Peru will be not presented to its full extent in this study. For specific topics see suggested bibliography in each chapter.

Mader 1999; Brabec de Mori 2002, 2009a, 2011a); and gender perspectives (Silverblatt 1987; Glass-Coffin 1998, 1999, 2004). Some studies have focussed also on the social and political fields of action of healers in different periods of history (Rostworowski 1983; Dobkin de Rios 1989; Wörrle 2003); in healing and sickness process (Sal y Rosas 1964; Andritzky 1989, 1999); and biographical studies about “shamans” and healers (Sharon 1978, 2009a; Skillman 1990; Dobkin de Rios 1992).

The herbal medicine (*herbalismo*) is one of the principal native methods used by Peruvians (e.g. Schupp 1991; Bussmann and Sharon 2006). Examples of applied traditional intervention techniques include diagnosis and healing with the guinea pig (Reyna 2002) and the medicinal use of coca leaves (Cabieses 1992; Llosa 2010). But while the cactus *Wachuma* (lat. *Tricocereus pachanoi*) also known as *San Pedro* (Sharon 1978; Polia 1988, 1994, 1994a; Joralemon and Sharon 1993; Glass-Coffin 1998, 2010), and the liana *Ayawaska* (lat. *Banisteriopsis Caapi*, *Banisteriopsi inebrians*) (Dobkin de Rios 1970, 1992; Reichel-Dolmatoff 1972; Luna 1986, etc.), have been studied extensively, common THPs like midwives, widely used in the Andean region (Valdizán 1944:50-63; Cosminsky 1986), and traditional trauma-surgeons⁸ or bone-setters (Oths and Hinojosa 2004), have not been sufficiently researched.

On the one hand, the histories of medicine in Peru (Valdizán 1944; Mariátegui 1980; Pfliegerer 1993; Cabieses 1993, 1993a; Delgado and Salaverry 2000), medical anthropology (Morley and Wallis 1978; Leslie 1980; Kleinman 1980), and ethnomedicine (Chiappe and Millones 1985; Prinz 1993) have consistently shown that biomedicine⁹ has always made use of TM practices, and that the identification of therapeutic benefits of plants was made possible by the botanical knowledge of indigenous communities. While this knowledge has generated immeasurable profits for international pharmaceutical companies, there has been no recognition of indigenous peoples’ contributions in the form of patents or monetary royalties (Eddowes and Sixto

⁸ Denomination proposed by Prinz (1996:6).

⁹ Biomedicine refers to the knowledge, practices, and theories generated through the development of scientific medicine. Since the 18th century, biomedicine has monopolized medical health attention and established an enduring subordinated and opposed relationship to medical practices of earlier periods (Menéndez 1985:596). In this work, I use “biomedicine” and “hegemonic medical model” (HMM) to refer to the same paradigm.

2006:22; Defensoría del Pueblo 2008:176). On the other hand, in Latin America as well as in Africa, THPs integrated antibiotic injections into ritual curing and herbal medicine (Leslie 2001:431). Thus, medical pluralism and syncretism were finally commonly accepted –if not always formally integrated– and medical pluralism became a central concept in medical anthropology.

During Peru's colonial period (1535-1715), medical practice in hospices, asylums, and hospitals exclusively followed the standards of the European medicine in the Renaissance and systematically ignored native medical knowledge (Fernández de Oviedo y Valdés 1851-5; Valdizán 1944; Guerra 1969; Guibovich 1989; Cabieses 1993b; Gareis 1999). Overarching colonial medicine was organised into three sectors: health services for Spaniards, research of tropical diseases, and medical services by missionaries, who expected indigenous peoples to convert to Catholicism before receiving treatment. This practice added to the persecution of TM and THPs (Larco 2008:17).

The *Real Tribunal del Protomedicato* (Royal Tribunal of the Protomedical) was created in Spain in 1442 to regulate the provision of licenses for medicine and pharmacy (cf. Pribyl 2010:132). The *Protomedicato* was established in Lima in 1570¹⁰ and controlled medical practice, regulated apothecaries' shops, fought against empiricism, coordinated the classification of plants and herbal remedies, studied the natural history of Peru, and settled disputes about weather, existing diseases, public hygiene and health issues (Zavala 2010:153). At the time, there were five recognised health professions: physician or doctor in medicine, Latin surgeon, Romanist surgeon, phlebotomist¹¹, and apothecary or pharmacist. Texts used in the physicians' examinations in Peru were the *Corpus Hippocraticum*, the *Galenic Corpus*, and teachings from Christian theology (cf. Pamo-Reyna 2006a:48). The third edition of Galen's works (of 1556) were not only spread in the 16th century in Spain for medical education, but were brought directly to Lima, and were used extensively in the court of the *Protomedicato* and in the first lectures for students (García Cáceres 1999). Anyway, only Spaniards or *criollos*¹² with a certificate

¹⁰ However, in 1537 Peru became the first proto-Medico, Dr. Hernando de Sepúlveda (Bustios 2004:127).

¹¹ Phlebotomists practice the bloodletting or venesection.

¹² Descendants of Spaniards in Peru.

of “racial purity” could study medicine at university. The extension of the first medical faculty in the country during the protectorate of the Marquis José Fernando de Abascal y Sousa (1804-1816) and the work of the Proto-medical-in-chief of that time, Dr. Hipólito Unanue y Pavón (Lastres 1951:36-56), enforced the hegemony of the colonial medical and social structures. As the Tribunal of the Holy Inquisition initiated its activities in Peru the same year as the Protomedicato (Medina 2000 [1956]:13), at the beginning of the Republic in 1821, the situation of THPs in the country was not of public or institutional interest.

As a consequence of philanthropic expeditions in the Amazonian and Andean regions to research and vaccinate against tropical diseases, modern physicians of the early twentieth century came into direct contact with indigenous medical procedures and the health standards of rural populations. As the first medical doctor (MD) working closely with regional curanderos, Manuel Núñez Butrón (1900-1950) grounded the social-sanitary doctrine of *rijcharismo*¹³ in the southwest highlands of Peru (Pamo-Reyna 2006:65). The *rijcharis*, a type of *promotores de salud* (community health workers) were trained in hygiene methods and vaccinations and attended the community within the *brigadas de salud* (health brigades). Dr. Núñez’s innovative work in community health, including the edition of a periodic publication about rural sanity¹⁴, was an unprecedented global innovation (Frisancho 2001). Although in the beginning, the *rijcharismo* was perceived as an altruistic social movement to support the health of the rural poor population, and counted with support from this sector at the national and regional level, its mobilisation and expansion, and above all its promotion of the creation of evangelical schools evoked suspicion among the authorities, who ordered the relocation and exile of its leader to another province (Nino and Vargas 2012:33). Cueto argues that one of the reasons the brigades discontinued was due to the paternalistic attitude of Núñez Butrón, who also used authoritative methods, and the weak articulation of his programme with the national sanitary system (2000:124). However, his work –other than the dominant trend in medicine at that time, which

¹³ Qe. Rijchar: Awakening.

¹⁴ *Runa Sonocco*, a newsletter about rural sanity, was first published on April 28th 1935. The MINSA was founded on the same day.

emphasised technology and the construction of hospitals– stressed the importance of hygiene, intercultural dialogue, health education, and changing habits and life styles, just like the primary healthcare (PHC) promoters years later. His pioneering work with THPs preceded the appearance of the international PHC attention model by over 50 years (Nino and Vargas 2012:33).

In the Declaration of Alma Ata (WHO 1978b) by the First International Conference on PHC, held in 1978 in Alma Ata (Kazakhstan), member states were encouraged to conceive of health as “a fundamental human right”, and it was stated that the attainment of the highest possible level of health “is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (p.1). The Declaration endorsed community PHC by health teams including MDs, nurses, midwives, health workers, auxiliaries, community workers, and THPs (WHO 1978b:2). To understand this recommendation, it is important to analyse the context in which the Conference took place. At that time, the major rivalry in the socialist bloc was between the Soviet Union and China; the conference was held in the USSR, therefore China did not attend (Tejada de Rivero 2003:4). Additionally, due to the economic effects of the Cold War, developing countries in the late 1970s were trying to tackle health problems with minimal financial and infrastructural resources. Anyway, the impact of this global political and economic conflict affected the development of health policies in Latin America as well.

Rather than concentrate efforts using local resources in healthcare issues, Latin America’s governments adapted their policies according to the economic interests of developed countries. The assumptions of Alma Ata were principle-oriented to the recognition of TM and broadly celebrated in official circles¹⁵. As Fernando Cabieses points out, in Latin America governments merely paid the Declaration lip service: “Nested in the entries of the medical bureaucracy in our continent, the roots remained in the scientism and the hegemonic interests of what has been called THE MEDICINE, the only one existent, the modern medicine, academic, the only medical truth. All the rest

¹⁵ Some polemic arose after this first statements, but still in terms of biomedicine. So denounced Velimirovic WHO’s integration’s policy, but in terms of a critique of TM, criticizing it as been not able to “to carry out a permanent revision and critical assessment”, and calling for a “change in beliefs on disease causation and treatments” (1984:65-66).

was considered superstition and was a part of a distorted group of obsolete and incoherent concepts” (1994:25, t. sp.).

After Alma Ata, the WHO and its Regional Office for Latin America (PAHO) released several documents that suggested country members follow the recommendations of the Declaration. During the next 32 years, document meetings and technical reports series asserted specific strategies for incorporating indigenous perspectives, medicines, and therapies into PHC (WHO 1999, 1999a, 2002a, 2002b, 2002c, 2002d, 2003, 2005, 2008). At first, the reasons for this interest were attributable to operational factors: “The most cogent reason for the radical development and promotion of traditional medicine is that it is one of the surest means to achieve total health coverage of the world population by the year 2000” (WHO 1978:13).

During the 1990s, neoliberal politicians and structural changes in Latin America reinforced social inequalities of gender, territory, social class, and ethnicity. Health reforms during this period caused an intensification of the marketing of medicine through the implementation of state structural adjustments, inspired by a market-oriented model (Feo 2008:5). The neoliberal mindset underlying these reforms proposed that public deficit and state regulation of the labour market are intrinsically undesirable, that social protections guaranteed by the welfare state¹⁶ and its redistributive policies hinder economic growth, and that the state should not intervene in the regulation of international financial markets and foreign trade (Armada, Muntaner and Navarro 2001:730). Thus, Latin American health policies in the 1990s were inspired by attention models that regarded healthcare and social security as commodities¹⁷ and not as basic human rights. The negative effects of these health reforms are widely documented¹⁸, with the most serious being the growth of socioeconomic, geographic, gender, and cultural disparities in health service attention, incomplete healthcare coverage with a tendency towards stagnation, dilapidated services with low capacity to solve health problems, and the absence of drug policies (Espinosa 2008:3). The neoliberal reforms

¹⁶ The welfare state comprises benefits in cash and kind. It embraces a wide range of services including education, medical care, and more general forms of care of the infirm (Barr 1993:7).

¹⁷ In the health sector, commodities are physician care and health-related services, including hospital services, pharmaceuticals, dental care, home care, preventive measures, nutritional services, nursing care, and the services of other health professionals (Jacobs and Rapoport 2004:56).

¹⁸ See e.g. Pesantes (2005).

affected a considerable portion of the population in Latin America, especially women and children from indigenous communities.

The amount of scientific literature on social inequalities in health has increased exponentially during the last two decades. In PAHO's review of indigenous health in Latin America in the late 1990s, the organisation noted major inequalities in health outcomes within indigenous communities as compared to majority populations (Montenegro and Stephens 2006:1863). However, current studies addressing the effects of politics on health and social inequalities (Borrell et al. 2007) are still few and not clearly defined (Dressler, Oths and Gravlee 2005:234). In public health research it is accepted that social determinants of health (e.g. cultural, socioeconomic and ethnic ascriptions) are particularly influential in the health outcomes of disadvantaged groups. However, current trends in the field aim at lowering the risk for disease in the general population rather than just in high-risk populations (Scutchfield and Howard 2011:80).

Around the same time as PAHO's study, discussions about the prevalent medical practices rose in global importance. In the hegemonic medical model (HMM), the biological dimension of health is the only important factor in diagnosis and therapy, and biomedicine is characterised by strong individualism, de-historicity, de-sociability, mercantilism, pragmatic efficacy, asymmetry, authoritarianism, subordinated and passive patient's participation, and the inductive tendencies of medical consumption (Menéndez 1988:453). International organisations and experts called for a restructuring of medical practice due to the effects of globalisation on health, i.e., the increase of chronic illnesses, the rapid dissemination of epidemic diseases, expensive medical treatments, and inefficient medical systems. The catastrophic consequences of neoliberal health reforms led to a resurgence of interest in WHO mandates of the previous three decades, and in TM and complementary and alternative medicine (CAM). Healthcare providers, policy makers, and stakeholders began to consider the implementation of culturally sensitive practices in national health programmes and the inclusion of intercultural competence training programmes for health professionals in

the health sector. Peru also implemented initiatives following the intercultural health approach¹⁹.

Accordingly, the incorporation of indigenous perspectives into healthcare systems (HCS) requires the creation and implementation of a legal framework that supports and encourages “culturally appropriate” healthcare programmes. It also demands an understanding of the components and capacity of response of the diverse HCS that includes the knowledge, attitudes, practices, connotations, and perceptions of healthcare providers, social and academic actors, and users. Given that such discourse mediates between public and private domains (e.g., policymakers, physicians, THPs, and the public), such incorporation warrants more attention by scholars than it presently receives. Additionally, and although the uneasy relationship between Western medicine and TM and its resulting social and health implications in Latin America are well-documented (Press 1980; Sharon 1993; Knipper 2001; Armus 2002; Schweitzer and Wörrle 2003; Wörrle 2004), there is a lack of systematic anthropological research addressing national health policies and related socio-cultural factors in the regulation of TM in HCS. Existing contributions approach TM as an essentially local and private phenomenon without establishing connections between it and related policy making structures in a country.

¹⁹ See chapter 3.3.3.

1 Methodology

1.1 Relevance of the Study

Most ethnographers [...] simply ignored medicine or studied exotic folk healers and healing rituals for their symbolic and religious, rather than their medical interest. The legacy of this type of cross-cultural work frustrated the development of a holistic perspective on disease and healthcare in society (Kleinmann 1980:29)

Anthropological interest in medicine and indigenous techniques of healing dates back to the beginnings of the discipline itself. For a long time, the study of traditional medical systems focussed mainly on the role of religion, ritual, and magic. The participation of anthropologists and other social scientists as consultants in international healthcare programmes during the 1950s and 1960s encouraged the emergence of medical anthropology as a special field of research (Leslie 2001:430). However, these health programmes intended to bring the benefits of Western medicine to the Third World, a goal not necessarily expected by its target populations.

During the 1960s, the so-called “Andean ethnography” moved away from an ecological orientation towards theories that sought the incorporation of political concerns, post-colonial structures, and new linear dimensions of analysis and reflection. Through research practice, these new approaches validated new understandings of body, health, sickness, and healing. Although ethnographers tended to turn away from the classic perspectives of the past decades, their work was still deeply connected to rigid conceptualizations about rural Andean peoples and peasant communities. As a result, the studied populations were frequently portrayed in a static way that emphasised tradition over change. Researchers’ perceptions of indigenous people rested firmly on the tendency of communities to resist change by isolating themselves from the cultural influences of outsiders rather than focussing on their interactions with political, economic, and national processes.

Andean anthropology was characterised by the Peruvian sociologist Aníbal Quijano as “the coloniality of power” a historical geo-political condition that de-legitimises non-

Western forms of making sense of the world. “One of the principal axis of this pattern is the social classification of the population according to the concept of race, a mental construction expressing the basic experience of colonial domination...this has embedded the most important dimensions of world power including its specific rationality, namely the Euro-centrism” (2000:201, t. sp.). This conception locates indigenous communities as pre-modern, setting them up for non co-equivalent representations (cf. De La Cadena 2005:14). Many of medical anthropology’s research studies at the time shared this perspective, which also influenced the field of applied anthropology.

In practice, anthropologists’ attention tended to be along similar lines to the dominant modernisation paradigm followed by MDs and public health experts in their management of health projects. Accordingly, consultant anthropologists saw the problem of non-compliance of patients as representing conflicts between modernity and tradition, superstition and science, and rational and irrational cultures (Körling 2005:9). Whereas many consultant anthropologists accepted this view, their examination of local and cultural understandings of health and illness did promote a cultural relativism that was absent from the programme plans (Leslie 2001:430). In other words, they centred on cultural disparities rather than finding solutions.

The anthropology of health and sickness is a subspecialisation of social anthropology, which has demonstrated the capacity to propose interpretations and actions, not only different but strategic, to problems associated with health attention –precisely those issues for which the perspective of classic biomedicine could not successfully find any answers, and showed limitations. In Latin America the ethical dimensions of research redirected anthropological work and caused major shifts in new theoretical frameworks used by scholars. They promoted change from a classical anthropology with colonialist references to a practice that took political dimensions into account. The discovery of knowledge as power and the institution as control are the basis of this research model (Menéndez 1991:27). This work paradigm was accordingly entitled *investigación-acción* (investigation-action) and formally initiated the development of applied health anthropology in the region. The 1970s and 1980s were crucial years for the development of the so-called *medicina social crítica latinoamericana* (Latin American

Movement of Social Medicine Critique) whose studies provided important inputs for the discussion about theories and implementation of programme frames in PHC (Menéndez 1993:67). During this time, ethnographic and theoretical areas of work in medical anthropology flourished under the influence of new perspectives. Medical anthropologists started to challenge the hegemonic claims of Western biomedicine and former research methodologies; they addressed the influence of political interests on medicine for the poor and included the voice of minorities in research work. The cultural critique of biomedicine emerged as one of its principal interests.

In other latitudes during the 1980s and 1990s, attention was also paid to the dangers of an all too narrow and uncritical analysis of medical pluralism. By analysing the revival of TM in Japan, Lock set a number of assumptions that have restricted the anthropological analysis of medical pluralism. These assertions include a romanticised and conservative view of TM, a negative and hostile view of biomedicine and a generalisation of both indigenous and Western medicine (1990:42). Lock's analysis points out the ways in which the HMM might be used to justify unequal social and political relations and turn medical into socially produced health problems. It illustrates the importance of attending the political and ideological aspects of medical systems and the need to examine the competing interests of various groups, for instance patients, families, healers, and the government, in issues of health and illness (Lock 1990:45).

Theories of the anthropology of health began to emerge in peripheral disciplines as a reaction to previous work on illness and therapy in the American and European research tradition. This tradition was grounded in an analytical interest in religion and concentrated on the analysis of rituals, representations of illness and disease as symbolic objects, and on TM itself. Little attention was paid to superstructures like academic medicine, health systems, and their hegemonic cultures of practice. In contrast, the anthropology of health focused attention on conventional medicine, public healthcare services, health attention models, and other therapeutic alternatives, such as herbal remedies, traditional healer's networks, and increasing social and popular participation in public health issues. The perspective also moved beyond the idea of illness as an object of interest to incorporate new understandings of social and political relations, interactions between methods of healthcare delivery, and conceptions of the body and

disease itself (Hadolt 2004:12-13). More attention was paid to the extended social, relational, and institutional contexts in which health outcomes occur.

In the mid-1990s, anthropologists called for a microanalytic approach to complement the macroanalysis of public health and economics. This shift had far-reaching and divergent effects such as the reorientation of research interests in Europe and the training and work of local specialists in their own contexts and countries (Peirano 1998:107). In this period, the impact of international consortiums on the health and survival of indigenous communities became an important research issue and the principal focus of interest of anthropological consultants' work in Latin America. Nevertheless, such research addresses problems that have repercussions on the performance of health systems as a whole, such as power, resource allocation, pharmaceutical concerns, indigenous rights, biological resources, human rights, and patents (Remme et al. 2010:4). International, national, and local agencies seek out anthropology consultants to evaluate the ecological impacts of mining, oil extraction, international industry, and bio-piracy on indigenous communities. To extend their research thematically and methodologically, consultants observe and document the compliance of governments or the participation of corrupt politicians in social problems.

The re-emergence of indigenous identity discussions in the form of neo-indigenous movements has resulted in the participation of indigenous peoples in the academic, social, and political life in the region and has increased the direct participation of the people themselves in decision-making. In the early 2000s, health anthropology promoted the inclusion of new research paradigms in anthropological research and the development of locally-appropriate health programmes.

1.2 Methodology and Research Contexts

This dissertation uses conceptual and methodological frameworks from the disciplines of health anthropology, medical anthropology, ethnomedicine and public health. In addition to a comprehensive bibliographic investigation, the empirical portion of the study is based on documentary health system research and grounded theory-based ethnographic field methods. The principal goal of this study is to explore, analyse, and identify perceptions and conceptions of as well as discourses on the inclusion of TM in a biomedicine-based national health system. I conceive of this inclusion not only as a political or technical matter but as part of a greater cultural process with specific and identifiable factors. An additional goal of this research is to strengthen the role of anthropology in public health research through the analysis of socio-cultural aspects specifically related to policy making.

This dissertation is based on two periods of field research carried out in Peru in 2009 and 2010. Geographically, the study focuses on the coastal zone of Peru, primarily the capital Lima. Short side trips to Chincha (department of Ica) in south-eastern Peru and Trujillo (department of La Libertad) and Chiclayo (department of Lambayeque) in north-eastern Peru contributed additional information, and the extended regional context brought interesting comparative insights to the survey. I selected Lima as my principal field research site due to three factors. The first is its positive responses to my principal research inquiries. The leading national health policy institutions are situated in Lima, as well as 69.4% of all Peruvian physicians, health institutions, professional organisations, scholars, and universities (Carrasco, Lozano and Velásquez 2008:25). The second factor is the importance of its representative demographic. About one third of the Peruvian population (30.9% projected for the year 2010) lives in Lima, which has about 9,113,684 inhabitants, most of them third-generation migrants from the countryside (INEI 2010:24).

Fig. 1: Field Research Cities



Adapted from: Peru Map UNO United Nations Cartographic Section

Lying close to the valleys of the Lurin, Rimac, and Chillón rivers, the metropolis of Lima²⁰ covers a total area of 2,672 kilometres. The city overlooks the Pacific Ocean and is famous for its subtropical climate and chaotic traffic. Hunter-gatherer nomads arrived in Lima 14,000 years ago and began to build villages around 5,000 BCE (López Lenci 2010:7). Archaeological evidence confirms the existence of a territory with extended pan-Peruvian states. The city's strategic location between coast and mountains made it a point of encounter between many nations. The Waris conquered the central coast of Peru in 700 CE, developing settlements like *Cajamarquilla* and routes between the current port of *Callao* in Lima and *Ayacucho* in the Western Andes. The Incas, who conquered the area in the 15th century, converted the land around Lima, then known as *Ichma*, to a central religious and political state. Even before the arrival of the Spaniards and the city's foundation in 1535 as the capital of the viceroyalty of Peru, Lima was a multicultural city.

Anthropologically, the population of Lima is a complex socio-cultural synthesis of different ethnic groups. In addition to the Aymara, Quechua, and Afro-Peruvian communities, the largest group are the *mestizos*, descendants with blended Spanish, Italian, and indigenous heritage. Chinese (Cantonese) and Japanese immigrants came to Peru in the mid-19th and early 20th centuries. Although there are also Peruvian descendants of Spanish, Italian, German, French, British, and Croatian heritage, Asians make up the largest percentage of the metropolitan population with roots overseas. Lima has the largest Chinese community in Latin America²¹, including *tusangs*, descendants of Chinese immigrants (Laurent Herrera 2009:139-141).

²⁰ Qe. *Limaq*, which means “talker” in coastal Quechua, was used before the arrival of the Spaniards referring also to the Rímac Valley. It was later pronounced as Lima (Cerrón Palomino 2000:155-157). Also Garcilaso writes: “Por que no sea menester repetirlo muchas veces, diremos aquí lo que en particular hay que decir del valle de Pachacámac y de otro valle llamado Rímac, al cual los españoles, corrompiendo el nombre, llaman Lima” (Garcilaso de la Vega 1976 [1609]:319).

²¹ Some ingredients and meals in Peru are referred to in Chinese, such as soybean sauce (ch. 酱油 jiàngyóu, per. *sillau*) and ginger (ch. 姜 jiāng, per. *kion*). When asking in a street market for sp. *jengibre* (ginger) instead of for *kion*, it could prove difficult to find anyone who would understand what you are looking for.

Similar to other Latin American cities, *Lima la horrible*²² grew rapidly due to rural-urban migration during the 1940s. The *desplazados*, Andean migrants escaping wars between the government and the Maoist paramilitary group *Sendero Luminoso*²³, arrived in the city in the mid-1980s. According to official statistics, by 2009 15.3% of Lima's population lived in poverty (INEI 2009). However, many experts in social sciences regard the official methods employed in determining poverty rates as controversial. In their opinion, the percentage is actually far higher (Reyna iw/2009). Regardless, Lima is less able to provide housing, employment, and services like water, drainage, and electricity to its inhabitants than other cities in the region.

Migrants have sought social representation and basic services through informal ways. The first wave of migrants established *barriadas* or *zonas urbano-marginales*. These *pueblos jóvenes*, or slums, are poor semi-urban areas in the periphery of the city. Later, the *desplazados* settled in *asentamientos humanos* on the hillsides of Lima. The *desplazados* have no legal right to the land and receive no basic services. *Barriadas* and *asentamientos humanos* are both expressions of spatial segregation that give their inhabitants a place in the city, making possible their incorporation as important social and political actors (Fernández-Maldonado 2008:1885). Many of the former *barriadas* are presently popular districts for an emergent bourgeoisie and a “new middle class” in the city, with competent infrastructure and health services (Takano and Tokeshi 2007:14).

In addition to aiding social integration, the development of the *barriadas* has also offered traditional healing practices a place in the city. Although there are no official statistics about the amount, type, and frequency of use of the service of THPs in Lima, according to my field research findings, the presence of *curanderos* and healers' markets in those areas of the city demonstrate the importance of traditional healing practices.

²² Sp. Lima the horrible, a novel written by Sebastian Salazar Bondy in 1964, depicted the socio-historical origin of the idiosyncrasy of the “limeño”. Through analysis of characters in the colonial arcadia, the novel focused on the Peruvian oligarchy, its political power and aristocratic reluctance, and its repudiation of the country's indigenous legacy.

²³ Peru was submerged between 1980 and 1992 in a civil war initiated by the terrorist group *Sendero luminoso* (Shining Path). About 70,000 people died or disappeared (Sandoval 2004:4), and a million-plus were displaced into crowded cities, with traumas often leading to mental or behavioural disorders (Pedersen ec/2010). See chapter 3.2.1, CVR (2003b) and Roncagliolo (2007).

Accordingly, the final factor in my selection of Lima is its historical importance as an “epicentre of the Peruvian *curanderismo*” (Giese 1989:2). Lima contains not only the largest variety of Peruvian health traditions, with their particular adaptations to a modern city, but also the greatest number of official and alternative health services and a high number of practitioners of biomedical, traditional, and new syncretistic methods.

1.2.1 Methods

The methodological strategies and qualitative data analysis in this study are based on the classical and modern principles and applicative methodologies of the grounded theory (GT). As Glaser and Holton (2004) state: “Classic GT is simply a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area. Classic GT is a highly structured but eminently flexible methodology. Its data collection and analysis procedures are explicit and the pacing of these procedures is, at once, simultaneous, sequential, subsequent, scheduled and serendipitous, forming an integrated methodological “whole” that enables the emergence of conceptual theory”.

GT uses inductive analysis as the principal technique in qualitative research par excellence. But as Glaser and Strauss point out, simply researching and verifying facts is not enough to generate theories about systematically obtained data (Glaser and Strauss: 2008:4-6). Proper scientific research must explain the facts in a suitable and ethical way that makes sense of the perspective of the informants and contexts explored, and should be consistent in its findings.

As is common in anthropological research, I have used several research methods and techniques to collect information (Beer 2003:11-12). GT proposes that a researcher can use more than one data, called the *all is data principle* (Glaser and Holton 2004). Consequently, the following techniques and methods were used in the study:

1.2.1.1 Bibliographic Research

According to Glaser (Glaser and Holton 2004), undertaking an extensive review of literature before the emergence of a core category violates the basic premise of GT. The theory emerges from the data itself and not from extant theory. In my study, the main theoretical interest regarding project design lay in existing scientific literature on the status of TM and THPs in a country's policy, as well as in related socio-anthropological and historical scientific discourse. In this case, a cursory review of scientific sources allowed for the structuring of basic information for later exploration and research. Policy documents and existing related research were considered other sources of data, and were analysed and integrated into the comparative analysis process once the core categories were identified. At this stage, the selective search for a suitable bibliography according to the core categories was done continuously, and its results were integrated into the constant comparative method.

1.2.1.2 Problem-Centred Interviews

I carried out problem-centred interviews (PCIs) with my informants to obtain a more nuanced understanding of the discourses surrounding the topic of my research and to gather in-depth information about the processes explored.

The PCI is a half-structured and open interview technique coined by psychologist Andreas Witzel (Witzel 1982). It is also known as the “discursive dialogue procedure” (Mey 1999:145 cit. by Witzel 2000). In this method, the interviewee discloses information related to a specific theme while at the same time engaging in an open dialogue (Mayring 1999:50). Regarding the characteristics of my informants, the respondents are considered here as experts of their orientations and actions –which have already been made clear at the time of establishing contact. “They should become more confident in the course of the conversation to take at all times the liberty to correct their own statements or those of their interviewers. In order to optimize progress in gaining insight, the interviewer combines listening and repeated questioning” (Witzel 2000). The recurring questioning in the interview encourages the narration of the interviewee

and reinforces trust between both interview partners²⁴. Schlehe (2003:78) considers this interview technique “very vivid, effective and honest.”

PCI requires the application of at least four techniques: a short questionnaire (see Appendix 1), interviewing guidelines, tape recordings, and a postscript (Witzel 2000). Following Spradley’s recommendations for ethnographic interviews, I used an Interview Guideline Form (see Appendix 2) with descriptive, structural, and contrast questions (Spradley 1979: 60-66).

My questioning techniques during the interview were based on PCI. The original recorded audio and film cassettes were deposited in the Phonogram Archive of the Austrian Academy of Sciences, with highly restricted access to ensure the anonymity of the informants. The postscript, or Protocol Form, was taken from the Phonogram Archive of the Austrian Academy of Sciences (see Appendix 3).

1.2.1.3 Participant Observation and Ethnographic Accounts

Participant observation is the largest and most commonly used field-based research strategy in anthropological and ethnological research. In participant observation, the researcher is “to a greater or lesser extent, immersed in the day-to-day activities of the people being studied” (Smith et al. 2005:1). The observed activities were conducted in academic/professional meetings and activities, hospitals, conventional and alternative health centres, professional institutions, universities, academic societies, healing federations, museums, archaeological sites, drugstores, nutraceutical and herbal supplements shops, promotional bazaars, trade markets, and ritual and healing sessions.

According to the guidelines proposed by Smith et al. (2005), and due to the profound interaction with which most participant observation takes place, the informed consent of the participants was handled in a dynamic and continuous process. Consent was established after first contact in oral or written form, and included an ethical statement and description of researcher’s conduct to be maintained throughout the study (see Appendix 4). Throughout my attendance in most of the studied contexts, I applied an

²⁴ For specific questioning techniques and communication strategies used in PCI, see: Schlehe (2003:78-81); Mayring (1999:48-54) and Witzel (2000).

observational strategy with predominant use of open observations (i.e. clearly identifying myself to participants in the situation as a researcher) (Beer 2003a:121). Consent was maintained through constant dialogue with the participants and collaboration agreements.

1.2.1.4 Electronic Interviews and Questionnaires

The questionnaire was used specifically for those key informants not directly accessible at the time of the field research. It was identical to the one used during PCIs (see Appendix 1) and was constructed to identify principal topics of relevance to the study. It was initially conceived as a tool to establish principal thematic fields, interests, attitudes, concepts, and other important information. It is divided into three thematic sections:

- (1) Personal information and occupational background: This section records socio-demographic information, training, or educational background, and past and present occupation, and identifies the discourse of the informant in either the public or private domain of inquiries.
- (2) Public health system: This section explores the opinions of the informants about healthcare, health research, and health methods in Peru.
- (3) Traditional Medicine: This section inquires about TMS, THPs, and related policies in the country.

The surveys were submitted by electronic mail. For cases in which completion by e-mail was not possible, I carried out electronic interviews through the internet services Messenger (MSN) or Skype. In only one case I carried out an interview by telephone.

1.2.1.5 Informal Conversations

The informal conversations with patients, students, trainees, customers, and participants in the explored contexts were, in most cases, unplanned but expected. The content and

principal highlights of these conversations were registered in the field diary and considered as sensitising concepts²⁵.

1.2.1.6 Documentary Research

Documentary research, more commonly associated with history and library science, is an underused research method in the social sciences (Mogalakwe 2006:222). Although Glaser and Strauss (1967:163) argue that documents ought to be regarded as akin “to the anthropologist’s informant or a sociologist’s interviewee”, surveys and in-depth interviews dominate the field. In order to overcome inattention to documentary research by grounded theorists, Prior states that documents should be brought into the research framework solely as informants (Prior 2008:822). This method is advantageous when the researcher wants to study public documents such as government publications, acts of Parliament, policy statements, census reports and statistical bulletins, reports of commissions of inquiry, ministerial or departmental annual reports, and consultancy reports (Mogalakwe 2006:222). The documentary research of texts, documents, and other visual and electronic sources was an appropriate and cost-effective secondary method for me to access specific information.

1.2.1.7 Photographic Register

A photographic register of studied contexts was made during both fieldwork periods. John and Malcolm Collier describe the use of photography in field research as mapping or charting the field (Lederbogen 2003:232). By observing, identifying, and placing-in-relation-to, the researcher can illustrate the cultural organisation of a given group or topic. Comparison with historical photos of the same places and contexts can uniquely demonstrate changes or development that words cannot capture. The camera shows details that may slip past the researcher’s eye, and pictures enable the inclusion and visibility of complex relations (Lederbogen 2003:232).

²⁵ Sensitising concepts suggest directions, draw attention to important features of social interaction, and provide guidelines for research (cf. Bowen 2006).

1.2.2 Research Contexts

The first stage in the selection of cases and contexts for this thesis (persons, documents, and situations) had an exploratory character (Truschkat, Kaiser and Reinartz 2005).

The qualitative paradigm suggests that the researcher seeks data ascertainment in the field in its natural form by taking part in the environment to be studied (Mayring 1999:39). For this reason, while still in Austria several months before my field work, I diligently communicated through the internet with potential collaborative partners for projects in TM and intercultural health in Peru.

In both field research periods, I worked with a selective group of people and contexts to obtain specific information. The target groups principally addressed were physicians and THPs, and my first contacts were mainly psychologists, physicians, scholars, and healers from my former professional network in Peru from the time I worked as a psychologist, psychotherapist, researcher, and lecturer. I contacted them through electronic mail, presented my project, and invited them to join the study as informants. I also offered assistance in any of their projects. Later, I decided to include other informants in the original target group due to the increasing importance to consider other non-expected comparison topics in the exploration, as the integration status of CAM in the country. During this period, I identified my informants' meaningful positions as related to my research inquiries²⁶.

As Bowen asserts, “qualitative research, including grounded theory research, does not start with hypotheses or preconceived notions. Instead, in accordance with its inductive nature, it involves the researcher's attempts to discover, understand, and interpret what is happening in the research context” (Bowen 2006). Since I worked with no presumptive ideas, the additional inclusion of scholars, alternative health practitioners,

²⁶ In my research project, I planned focus groups with MDs and THPs. This idea was vehemently discouraged by some scholars. They argued that this would not be possible, considering MDs' reluctance to work with THPs. As these scholars were part of my expert group, I decided to respect this position and work with them separately. However, I remained attentive to this claim and its possible significances for my inquiries.

trainees, and social activists in the course of my research was an inductive consequence of my explorations. Their participation brought internal consistency to my findings.

In this exploration I focussed on two principal settings: the public and private domains. The public domain includes the official mainstream, meaning the health, academic, and policy making institutional structures in Peru. Accordingly, this domain is represented by official settlements, health policy documents, universities, professional federations, national programmes, institutions and activities related to the topic. Primary informants²⁷ in the public domain are MDs, policy makers, academic authorities, and PH experts, and their contexts are official and academic institutions and professional associations. Primary informants in the private domain include scholars and consultants, independent academic experts on TM, THPs, AHPs, and social and political activists. Their contexts are home or work addresses and the locations of various health-related events.

Table 1: Primary Informants

Domain	Family	Total	Categories	Number
Public	PH Specialists	14	Physicians	14
			Policy makers	3
			Public health experts	10
			Academic authorities	3
Private	Scholars and Experts on TM	17	Historians	2
			Psychologists	5
			Sociologist	1
			Anthropologists	7
			Environment specialist	1
			Archaeologist	1
	Social and Political Activists	9	Activists	4
			Coca specialists	7
	Apprentices and Trainees	8	Apprentices	4
			Alternative health practitioners	4
	THPs	12	Ayawaskeros	4
			Bone setter	1
			Egg and chilli specialists	4
			Guinea pig specialist	1
Naturopaths			3	
Wachumeros			3	

²⁷ Primary informants are all my interviewees. The list does not include occasional (secondary) informants.

As is often the case for qualitative sampling, some of the interviewees belong to more than one category, i.e. most of the PH Specialists are MDs, except for two academic authorities and two PH experts. One of the MDs was also considered in all four categories. Furthermore, two naturopaths are also egg- and coca specialists and one of the *wachumeros* is also a social activist and coca specialist. Within the “coca specialists” category, two psychologists are considered as well. This category-assignment was selected to identify the interviewees’ discourse in each domain and to illustrate the informants’ occupational background. Indeed, such distribution shows the social mobility of the people between categories in the private domain, which is discussed in the qualitative analysis part.

1.2.2.1 First Field Research

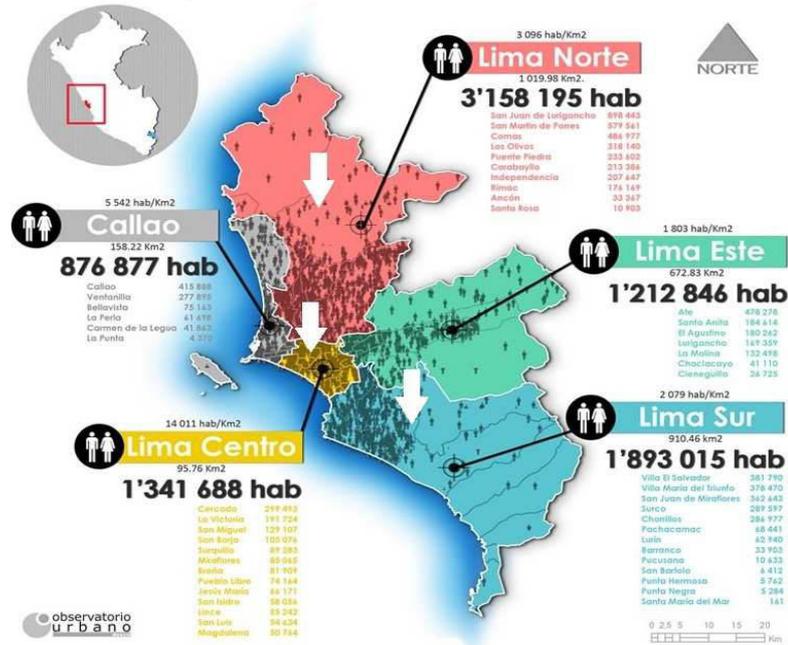
Applying the “back and forth” model (repeated short visits), I carried out two fieldwork research periods within two years. Colleagues and friends helped me by registering and making photos and videos as well as with the transport of materials. They also improved my contact list, gave me interesting information related to my research topic and assisted me in several healing sessions, interviews, and meetings.

The first fieldwork research took place between February and May 2009²⁸. The aims were to recover the most diverse discourses and information on the integration of THPs in HS and to identify the principal contexts to work in. In this period, I used participant observations, ethnographic approaches, interviews, documentary research, informal conversations, and field notes, including a permanent register of daily activities and recollecting the data. Besides the official documents, the updated investigation on TM and archival research on the topic, the documentary research itself was oriented fundamentally by the thematical development of the interviews, participant observation and professional and technical meetings. These three months of field research consisted of intensive work and brought up first-hand information that builds the principal basis of the study.

²⁸ This research period was in part granted by the International Federation of University Women (IFUW). The technical support for video and audio material came from the Phonogram Archive of the Austrian Academy of Sciences (ÖAW).

I visited several academic institutions, universities, and alternative health centres in different districts in Lima²⁹, where I carried out interviews, participant observations, video and photographic registers.

Fig. 2: Lima Metropolitana: Researched zones 2009 and 2010 (white pens)



adapted from Observatorio Urbano (2010)

My original list of interview partners and informants grew exponentially during the first weeks. Many of the interviewees gave me contacts to other people who were “probably also interested in the topic” or had “more information”, so that the number of the original list of interviewers increased in an unexpected way. Although I could not interview all of these new contacts, this *snowball reaction* was, for me, the first indicator of the position on and interest in this topic by this group. I conducted several interviews and ethnographies with academic experts and researchers on traditional medicine, academic authorities, MDs, health professionals, social activists, THPs, alternative health practitioners, apprentices on TM, trainees in alternative medicine, and scholars. I also conducted several informal conversations with occasional informants and made

²⁹ Lima is administrative divided in two provinces: Región Callao (6 districts) and Región Lima Metropolitana (43 districts). During fieldwork I covered 24 districts.

ethnographic registers of alternative health practitioners' work. I also visited and registered market places and esoteric stores, health centres, universities, official institutions, and social and academic activities. In this period I also travelled to cities north (Trujillo) and south of Lima (Chincha)³⁰ to take part in observations of traditional healing rituals and to achieve comparative information about the healers' work in different contexts, including visits to archaeological sites³¹.

I found two close fieldwork partners in the person of two healers, who wanted to be additionally coached for their professional projects³². The Peruvian Association for Medical Doctors (CMP) was the first institution to accept my research proposal and let me actively participate in their work meetings. This was enabled through the interest and support of Dr. Martha Villar, Head of the Committee CMTAC-CM and Dr. Hugo Rengifo, responsible for the Subcommittee for TM. This agreement was both for interest and mutual benefit. The observational and participatory setting by the CMP allowed me to observe in situ the way in which health policies addenda would be discussed, how documents and proposals went to be analysed, academic and research activities were planned and to know firsthand the position and perceptions of MDs and PH experts about TM and THPs. I participated in the work meetings, collaborated with the organisation of academic activities and was even invited as an expositor for conferences. The collaboration is ongoing in form of a continuous assessment of their activities. Among this, I create and coordinate an internet source in a social network to promote the public discussion and updated activities of the Subcommittee of TM of the CMTAC-CM³³.

1.2.2.2 Second Field Research

Between January and April 2010, I made a second data evaluation of the field material accrued in the first research period. Due to its extent, I twice carried out a sorting process and an intensive data analysis, and compiled a data bank with the principal discourses' categories. The ongoing thematical guidelines and the established

³⁰ See Fig. 1.

³¹ Archaeological sites as preferred pilgrimage or retreat places for healers are well documented. See e.g.: Polia (1988); Joralemon and Sharon (1993); Glass-Coffin (1998, 2010).

³² See chapter 4.

³³ See chapter 3.3.3.4.1.

collaboration to persons, organisations and initiatives brought me to a second research-stay carried out in July and August 2010³⁴. Besides conducting new interviews, the objective of my second stay was to deepen my understanding of the discourses I had identified, to evaluate some initiatives' development that I had registered during the first fieldwork and to examine the relevance of preliminary observations and selective documents' achievement through peer review. These activities refined the methodological, theoretical, and empirical basis of the study. Furthermore, they enabled the entrenchment of scientific and academic collaboration with different partners and the consolidation of my specialists' network in Peru.

A specific task during this period was my participation in an academic activity in Lima. I was commissioned for the organisation of a symposium about intercultural health³⁵ with scholars and activists from Latin America participating. In this working group we discussed and analysed the role of health administration and public policies in the development of different health programmes in intercultural settings, including the specific situation of THPs (cf. Pribyl 2010a).

During the first fieldwork, many of my informants told me that CAM practitioners and centres are experiencing more acceptances among health policy makers and subsequently receiving more support from health administrators for projects or centres including THPs. Consequently, in the second period of the fieldwork, I also made an ethnographical documentation of two alternative health centres in Lima and Trujillo to explore and verify these assertions in two different regional and institutional contexts. The first account refers to the oldest CAM centre of MINSA existing in Peru, located in Lima. I chose this setting to explore to which extent there actually are differences in terms of policies and attitudes (acceptance and support) on the part of health administrators in CAM centres. This ethnographic description is in chapter 3. The second centre I explored is a private initiative conducted by an AHP, located in the countryside of the Moche Valley, nearby the city of Trujillo, 567 km north of Lima, and which is briefly described in chapter 4.

³⁴ This fieldwork was possible due to the Fieldwork Doctoral Scholarship of the University of Vienna.

³⁵ Supported by the International Communication Program of the Austrian Society Research Fund (ÖFG).

Fourteen months after my first fieldwork, I observed the development of renewed interest among institutions and organisations in making tentative approaches and organising activities about TM for the public from other academic and social fields. This is reflected, for instance, by the repositioning of the topic in public and academic discussions. Nevertheless, this tendency is not reflected in a specific amount of scientific production and financial investment of the government in the field. The numerous initiatives from MDs, THPs and AHPs and civil society to promote discussions, services or special programmes that integrate both medical systems continue to survive either without direct support of the central government and related institutions, or with very few. The qualitative analysis of the data achieved during both fieldwork periods is presented and discussed in the following chapter.

1.3 Qualitative Content Analysis

For the systematical data analysis, procedures and techniques from the qualitative content analysis provided by Philipp Mayring were applied (Mayring 2007). Qualitative content analysis defines an approach of “empirical, methodological controlled analysis of texts within their context of communication, following content analytical rules and step by step models, without rash quantification” (Mayring 2000:2). Mayring emphasises four principal characteristics for a qualitative content analysis research:

- (1) The material should be included into a model of communication: “It should be determined on what part of the communication inferences shall be made, to aspects of the communicator (his experiences, opinions, feelings), to the situation of text production, to the socio-cultural background, to the text itself or to the effect of the message.
- (2) Rules of analysis: The material is to be analysed step by step, following rules of procedure, devising the material into content analytical units.
- (3) Categories in the centre of analysis: The aspects of text interpretation, following the research questions, are put into categories, which were carefully founded and revised within the process of analysis (feedback loops).

- (4) Criteria of reliability and validity: The procedure has the pretension to be intersubjectively comprehensible, to compare the results with other studies in the sense of triangulation and to carry out checks for reliability” (Mayring 2000:3).

I specifically used content analysis techniques as they were applied along the interpretative paradigm (Mayring 2007:29). According to this model, the interpretation of emerging contents during the data achievement (e.g. through participant observations, interviews, document research and surveys) is oriented towards describing underlying bodies of knowledge and disclosing rules of interaction between them (Mayring 2007:29). At the hedge of the evaluation process, and most important for this study, it shows how better interpretations of people’s and institutions’ discourses and initiatives to integrate THPs in HCS can yield valuable lessons about what works when, under what conditions and how this could be achieved.

1.3.1 Choosing the Empirical Data

During and after both fieldwork periods, and additionally to the primary data, I achieved numerous secondary data. In most of the cases, they were obtained from the informants themselves, but also through my own research on documents and in archives, interviews’ contents, participant observations records and current scholarship on the topic. This secondary material, like books, articles, papers, archive data, communications, e-mails, symposia, conference transcriptions, websites, statements, writings, projects, audiovisual material, etc. was very important in giving an extended context surrounding specific aspects (e.g. intercultural issues, proposals and activities, programmes, initiatives, etc.). Therefore, the principal data sources selected for the qualitative analysis were thematically and methodologically divided into three Hermeneutic Units³⁶ following the conceptual inquiries presented in the principal research questions and objectives of the study. At the core stand two types of materials to be analysed: Grounded data (achieved in the field) and documents (document search

³⁶ A Hermeneutic Unit (HU) is a dense web of primary data considered relevant to a particular research topic. It includes primary documents (PDs) representing the data sources and all the quotations, codes used for developing concepts, conceptual linkages (families, networks), memos, etc. (Muhr and Friese 2004:28).

resources). Both were selected as representative of private and public discourses, respectively, and thematically assigned to each Hermeneutic Unit.

Table 2: Empirical Data

HERMENEUTIC UNIT	SOURCES	NUMBER
Grounded Data	Interviews	40
	Communications	7
	Protocols	10
	Field Notes	4
	Questionnaires	10
	Media	8
		79
Health Policy	Declarations and Mandates	2
	Guidelines and Strategies	7
	Executive Board Resolutions	6
	Consultation Reports	3
	Fact Sheets	1
	Research Articles and Papers	8
	Working Group Meeting Reports	8
	Newsletters	3
	Summaries	2
		40
Public Health	Communications	5
	Congress, Symposia and Academic Reports	12
	Declarations and Statements	2
	Research and Working Papers	10
	Pictures	4
	Projects	1
	Programmes and Departments	9
	News	5
	Sheets and Writings	3
	Resolutions, Laws	7
		58

(1) The *Grounded Data Hermeneutic Unit* contains 79 primary documents (PD) in its final form. It includes problem-centred interviews and informal conversations, observational protocols, field work notes, questionnaires, electronic communications and textual and media sources achieved during the fieldwork (conferences, presentations, project and programmes' reports and TV broadcasts).

The selection of the informants' data for this unit considered the following criteria: Informants should have at least twenty years of experience in the inquired field (in order to obtain firsthand information); and are currently professionally involved in intercultural health issues (have related practice at the academic, consultant, research or activist level).

- (2) The *Health Policy Hermeneutic Unit* was based on 40 PD selected from relevant international and regional health policy documents crucially related to TM and HS. The documents were obtained from updated database resources, libraries, documentation centres and archives of representative organisations and programmes such as WHO, PAHO, UN, UNESCO, UNICEF, and WIPO, among others. The documents are declarations and mandates, guidelines and strategies, executive board resolutions, consultation reports, fact sheets, research articles and papers, working group meeting reports, newsletters and summaries. The selected documents were considered principally due to their relevance to Peruvian policy making regarding PHC, TM and THPs; in the collection I considered their impact on the development of specific national health programmes, to identify a chronology of such interests in HCS and for the national research addenda.
- (3) The *Public Health Hermeneutic Unit* contents 58 PDs, which includes public health documents from Peru with special importance for the current practice of THPs and intercultural health. For this unit, I considered activities such as encounters, congresses and meetings carried out by official institutions such as PAHO-PERU, ORAS-CONHU, CENSI, ESSALUD, MINSA, INS, the Peruvian Parliament, CM; and civil and private organisations such as FORO SALUD, indigenous peoples associations, and traditional and alternative healers' initiatives. These documents display communications, congress, symposia and academic reports, declarations and statements, research and working papers, pictures, projects, programmes and departments, news, sheets and writings, resolutions, decrees and laws. The sources were provided by informants, institutions' databases and archives, and through the exploration and contact of community and social networks.

For the content analysis and results included in chapter 5, and in concordance with the research goals, I present the results of the Grounded Data Hermeneutic Unit. The qualitative results of the analysis of the Health Policy Hermeneutic Unit are also included in chapter 2 (Integrating Traditional Medicine into Healthcare Systems) as part of the whole bibliographical and first data research about policy making. Likewise, the findings on the Public Health Hermeneutic Unit are incorporated in chapter 3 (Peruvian Healthcare System) and 4 (Traditional Health Practitioners in Peru).

1.3.2 Analysis of the Interview Situation

An important aspect and benefit of the content analysis' methodology is the need to embed the material data in the communications' context in which they have arisen (Mayring 2007:42). This provides, for instance, a dynamic analysis framework through the exploration of processes and discourses, also including the researcher or interviewer's role.

In interviews, factors like social hierarchies, cultural identity, gender, age, social class, formation and financial resources play an important role in the reciprocal perception and the positioning of each other in field research (Schlehe 2008:138). As is commonly known in social research, these factors do not affect the course of an interview in a clear, predictable way, but rather in an arbitrary form, depending on how the interviewer proposes the interview situation and also adopts a personal position in relation to the research topic. In current methodological scientific discussion, there are more voices that promote the investment in a research-relationship, in which the interviewee should present the own personality in an open, reflected and conscious way (Schlehe 2008:138). As I gathered directly from colleagues' testimonials, research reports and professional networking, there are some researchers that come to Peru, get information, and leave afterwards without returning research findings to the informants. There is neither feedback about the results, nor even a short excerpt in Spanish they can read. I found this practice almost suspect, from an ethical and scientific standpoint³⁷.

³⁷ My original purpose to write this dissertation in Spanish was not possible due to the available languages (German, English or French). I chose English considering the amount of people in Peru reading English in comparison with German. A Spanish version of this manuscript is planned.

I have a paper series classification of X, who has wrote pretty much about Peru. Unfortunately I can't read them! It's all in German, and there're no translations, anywhere. The same is with the work of X. Do you have something about their works in English or Spanish?... I don't understand how could be consent that these people come to Peru to make research or a thesis, and they didn't care to give a copy to the national library and also a translation in our language –though there are legal dispositions about. And that occurs in anthropology, archaeology, history, social sciences, etc... it must be edited an Analects of foreigner Peruvianists in Spanish, in order to obtain access to publications about Peru that are not accessible for the majority of Peruvian scientists, because of the subscriptions' costs, language or –the most important- the unavailability of the publication (MD, Expert on TM ec/2011)

As I was many years absent from my country, living, studying, and working overseas, I was aware that my starting position in relation to my informants would arouse -in a legitimate way- some suspicions that I could do the same with my research findings. At this point of the research planning an important question for me was: Why will/should the interviewers share information with me? Indeed, I have presented my research project to all the institutions and informants I selected in terms of a collaborative research setting. I established a compromise with them for a permanent assessment from my side; in doing this, I adopted supplementary addenda constructed to organise and promote academic symposiums, network activities, and research on the topic at national and international level. Particularly, I suggested instructive advisory in research or academic projects, programmes and activities that will be carried out by associations, universities, MDs, scholars, experts, THPs and/or AHPs. It is important to say that my compromise with my informants was clearly defined in terms of academic cooperation and professional assessment; since the beginning of the research I strengthened my role as consultant and advisor. Although in such arrangements the risk to get too involved is certainly high, these potential contingencies could be instead perceived “as minor in comparison with the situation of a researcher that does not succeed in going deeper in field and establishes significant relationships with his/her informants there” (Breuer 2009:32).

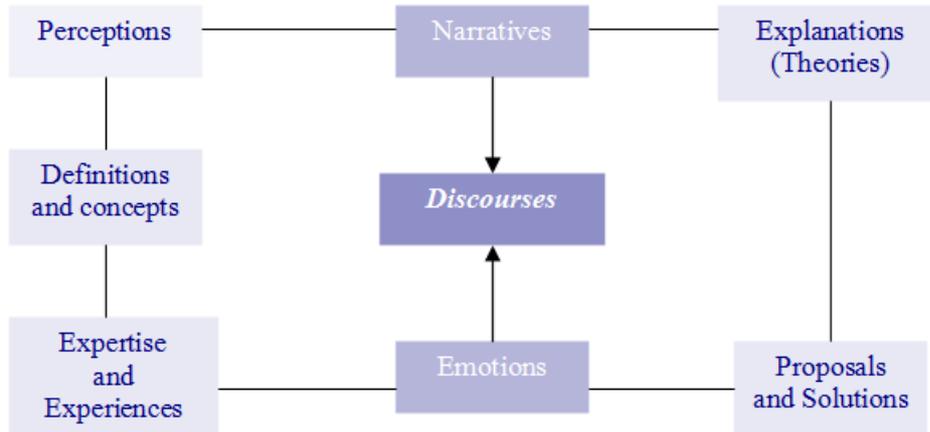
Nevertheless, my research strategy was not always welcome and understood on the part of my informants. Considering the historical and political drawback of including indigenous perspectives in healthcare attention in the country, these groups became both ideologically and socially ambivalent. They are, therefore, attached with many prejudices, doubt and apprehensive attitudes to each other, in a social configuration

combining mutual dependence and rejection at the same time. Thus, due to the argumentative nature of my selected research topic, this procedure may have connoted for someone a researcher's endeavour in trying to be complaisant with two parallel worlds –on the one hand the medical community and healthcare mainstream and on the other the community of TM scholars, activists, THPs and AHPs. Choosing a research strategy like this implies certain risks with internal and external consequences. A direct external consequence was the extension in time of the research, because of the time demanded by the interviewees and organisations in assessing their projects in the post-field-research phase. An internal consequence was the fact that my public address to collaborate in the planning and development of activities at the CMTAC-CM triggered suspicions among some of my collaborators. Subsequently, a part of my interviewees felt “betrayed” and did not want to receive more information about the research or ignored invitations to academic activities in which MDs were also involved. One interview's passage illustrates this attitude as an admonition for me, when I said that I was invited to organise academic activities with the CM: “There is too much rejection in the CM...They want to win you *for their side*; it's a matter of power”. Interestingly, the addresser of this explicit warning is also a MD. However, it was my conviction that this kind of work was necessary in order to move the assumptions of both groups forward. At this respect and among other strategical considerations, I above all thought of the importance of positioning TM and its social researchers and practitioners within an institutionalised and academic network. In my view, their attendance in activities of a professional association with relative gremial political stability in the country like the CM was crucial and necessary. Moreover, its influence in public health issues, curricula formation, and academic activities was another relevant aspect that I considered in doing so.

Within an ethno-methodological tradition, the contents' and discourses' significance is determined principally through human interaction and not as simple action-reaction sequences. Moreover, “the meanings and significances [that emerged e.g. during the interviews and participant observations] are mutually developed and negotiated” (Wilson 1973, cit. by Mayring 2007:30, t. g.). However, in the encounter-situation of an interview, mistrust and resistance, or sympathy and comprehension are not only

determined by the individuals themselves, but also depend on the large context around an interview situation -i.e. the social and political conditions (Schlehe 2008:137).

Fig. 3: Dimensions explored in the Interview Situation



Psychologists in Peru are considered as experts with specific competences to improve mental health conditions for people, the family, and the community. This role perception of me marked my position in the early stages of the interview situation, when I was principally seen as a “counsellor” rather than as a researcher or interview partner. This influenced the attitudes of the informants to the interview situation, to the inquired topic and to sharing information to some degree. Likewise, and although I am also a health professional, I was not directly associated with the health system or policies’ mainstream –“conflict areas” for many of my informants. Additionally, I was not considered as an expert on TM –like most of my principal informants were– so that this allowed for a fluency of discourses, notions and conceptions with a principally “instructive” character. Thus, they were in the disposition to share not only their professional, but also their personal experiences in the field with me. This context created an opportunity for them to speak freely, and to teach and adduce me on the basics about TM and the problems and challenges of these practices in the country. I guess that my informants felt comfortable and genuine in this spontaneous role-disposition in the interview setting, and I did, too.

In contrast to initial warnings by some scholars and experts, my informants were essentially receptive to the questioning process and accessible throughout in sharing information. Interestingly, I found this openness more present among MDs and THPs during fieldwork, and less with other scholars and social researchers, which brought me to repeatedly ponder the possible significance of this situation.

1.3.3 Processing the Data

All the data obtained in the field were archived in a Data Register File. The data recorded in audio or video formats were labelled immediately afterwards by date, situation, and subject. Then, I filled out the protocol for each recorded unit. According to the research situation, one of three different types of protocols was also completed: (1) Interview-protocols, (2) meeting-protocols or (3) observational-protocols³⁸. Information achievement, personal reflections, and interesting quotations were written down in a field diary, which was daily updated in the field. For the analysis I used this material and incorporated it as memos into my research database. A special data register file, both in copy-hard and electronic form, was created for the policy documents, publications, and research reports. Afterwards I made a comprehensive word-to-word transcription of all materials, including field notes and comments made by me during fieldwork, which was the basis for the qualitative analysis. All these registries were written either in Spanish or German and, for the analysis process and for the composition of this dissertation finally translated into English.

The selection and analysis of the whole data unfolded three general phases which were scheduled in accordance to the research plan, the fieldwork preparation and stay in Peru as well as the scholarship and academic reporting work in Austria. In the first period (June-August 2009), the first collected data was analysed and selected and the first major process of transcription was done. Between January and March 2010, the first Hermeneutic Unit for the empirical analysis (Grounded Data) was set up including the unfolding coding assignment process and the creation of the first grounded categories for the analysis. According to these results, and during the last data processing phase

³⁸ Interview and meeting protocols were used as in Protocol Form (appendix 8.3). Observational Protocol format is in appendix 8.5.

between September and December 2010, the creations of two Hermeneutic Units (Health Policy and Public Health, see Table 2) were done in order to obtain categories that guided the interpretation process in each domain.

1.3.4 Inductive Category Development

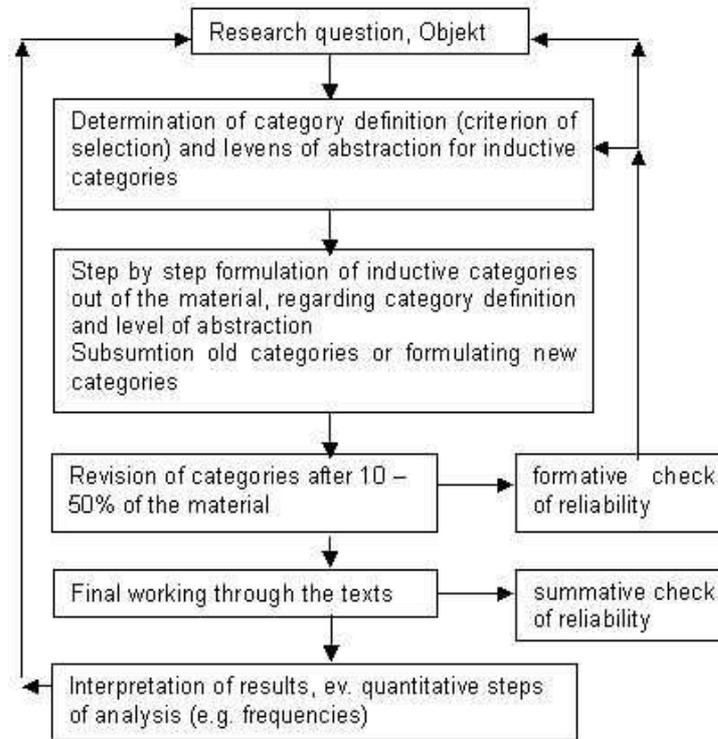
For the category development I applied the inductive approach (Mayring 2000:3-4). Mayring says to this respect, that within the framework of qualitative approaches it would be of central interest to develop the aspects of interpretation, the categories, as closely as possible in terms of the material itself (Mayring 2000:3). The categories' system also represents one of the principal instruments for the qualitative analysis (Mayring 2007:43). It is therefore important to explain how the construction of categories was done.

1.3.4.1 Coding Process

In a general view, the code assignment enhances a descriptive and attributive process of allocating significances in quotations that are relevant for the producer of the text. Despite the fact that by coding we link certain quotations together and form thematic groups of data-pieces (Konopásek 2008:11), the appearance or frequency of terms, words and expressions in the text are not necessarily the only secure criterion in qualitative coding process. By coding, I followed the conceptual attribution that is given during the discourse, identifying the thematic sense of the paragraphs or quotations and labelled them with a conceptual relevant and clearly identifiable name. In doing this, I identified a pattern of request (e.g. a conceptual relevant discourse-drift) and a relationship between this with other parts of the text.

Similarly, Lewins and Silver point out that qualitative coding is the “process by which segments of data are identified as relating to, or being an example of, a more general idea, instance, theme or category“ (2008:81). After this process, the remaining codes are names for such groups that indicate what kind of quotations can be found in each particular bundle (Konopásek 2008:11). The importance of the coding process lays in its conceptual capacity to provide categories of the explored discourses.

Fig. 4: Step Model of Inductive Category Development (Mayring 2000)



1.3.4.2 Determination of Category Definitions

The schematic category in this procedure covers the principal aspects on reporting conceptual development matters that are essentially relevant to the research questions. In contrast with quantitative analysis, the principal interest lies not in obtaining the frequency of appearance of a certain aspect or concept in the research report, but in exploring how it will be accounted within these aspects, e.g. which arguments, discourses or characteristics appear to be important for the interviewees.

1.3.4.3 Formulation of Inductive Categories

The compiled systems of categories contribute to the classification of the texts in demand of these emerging aspects, which should be identified and subsumed in order to make visible the differences and commonalities in the discourses and conceptualizations explored. Here appears the evaluation phase for the development of theoretical knowledge.

1.3.4.4 Theoretical Knowledge

This was generated in the evaluation phase through the application of “sensitising concepts” (Blumer 1954:7) which were further developed through continuous analysis and reinforced with empirically grounded inputs emerged from the data material itself. Therefore, the categories emerging from the first analysis of the data in the field gave indicators about the next steps in the analysis process. This flexible procedure insured that the interviewer’s view of the problems being addressed did not simply overlap that of the respondent’s, and that the theory is not simply superimposed upon the collected data (Winzel 2000). Additionally, and as Mayring asserts, the analysis should also be clear in providing scientific arguments upholding specific explanations regarding the research questions (Mayring 2007:45).

1.3.5 List of Codes

According to Breuer (2009:74-79), the process of coding enhances a bridge between the data and the theoretical level. A code is an abstraction from descriptions of phenomena founded in the transcriptions. From a wide number of code-ideas, the codes finally “emerge” through selection, summarization, sorting, and focussing during the whole coding-process. The categories are an ulterior abstraction of the principal codes, and enable the construction of theories and categorical answers to my research questions. During the coding process, an inductive approach (bottom-up) was organised in 3 sequential stages –i.e. open, axial, and selective coding. This was used to code the Grounded Data Unit. The original coding process resulted in 603 codes in the first stage of analysis of the data. The final amount of 70 codes remained after several processes of recoding, renaming, and deleting codes and after a theoretical iteration of the whole code composition in the next two phases of analysis.

Table 3: List of Codes - Grounded Data

Academic Activities	Alternative Health Practitioners
Authorities' Attitudes	Attitudes to People
Attitudes Policy makers	Attitudes to Linking
Access to Official Healthcare	Benefits Integration
CAM	CAM Centres ESSALUD
CENSI	Commercialisation
Committee TCAM	Economic and Social Situation
Ethic	Explanation
Family Situation	Healers' Attitudes
Healers Education and Training	Healer's Definitions
Healers Classifications	Healers' Initiation
Healers' Intercultural Expertise	Health Condition
Hopeless	Hospitals and Health Centres
INMETRA	International Interests
Intercultural Health Policy	Intercultural Health Programmes
Lack Funding	Legal Situation
Loneliness-Isolation	Media Influence
Medical Association Peru	Medical Doctors and TM
Mystical Tourism	Medical Studies
MINSA and INS	Network Specialists
New Healers	Patients
Peru Health Situation	Peru Health System
Peru Identity Nation	Peruvian Politic
Pharmaceutical Industry	Physicians
Plants and Phitotherapy	Popular Medicine
Praxis and Fees	Projects
Psychologists	Publications
Public Health	Research
Scholars	Social and Political Activism
Socio-cultural Clues	Solutions
Sorcery	Implementation TM
State and Government	Status Quo
TM Characteristics	TM Instruments
TM Techniques	TM vs. CAM
Training Intercultural Competences	WHO and PAHO
<i>Total</i>	<i>70</i>

This networked selection and analysis of the codes in assorted periods at all stages of the study were essential in order to development a theoretical map, composed on an integrated map of codes, memos, comments and quotations. The selection of the items was carefully carried out, follow-up of the bibliographical investigation and the analysis of the other two hermeneutic units, which gave at the same time the necessary basis of content comparison of the findings.

1.3.6 Application of the Computer Program Atlas.ti

The Atlas.ti - *Archiv für Technik, Lebenswelt und Alltagsprache und Text-Interpretation* (archive for technique, environment, speech and text-interpretation) is a software tool for qualitative analysis developed by Thomas Muhr at the Technical University of Berlin, Germany, between 1989 and 1992 (Muhr 2004:6). The software has become a decisive influence on phenomenology, hermeneutic and grounded theory and it is mainly used in qualitative research. The programme means to help the researcher through the identification of complex processes underlying data (Muñoz 2005:2-4) which is located and analysed through a systematical process of segmenting texts in quotations, allocating groups of them into codes, and making visible the complex relations between them through a more or less sophisticated electronic workbench with several functions. Like many other software tools for research analysis, it offers a set of different assistance tools and features to help researchers by the analysis of different electronic documents and multimedia data. However, the process of analysis using options and functions like coding, memos, comments and network view diagrams lays totally on the researcher's analytical work itself. Although it is a very useful instrument that extends the researcher's possibilities to organise, remember and systemise data, "the software only provides more or less useful assistance and support to the thinking subject" (Konópasek 2008) and does not make the analysis process automatic. For this survey I employed the version 6.0 of Atlas.ti.

Fig. 5: Software Atlas.ti 6.0



2 Integrating Traditional Medicine into Healthcare

Systems

It may be enlightening to look at social science and medicine as two different cultures, into which people gradually are enculturated and taught to view and explain the world in a particular way. The often difficult relationship between social and biomedical scientists can then be viewed as a form of mutual ethnocentrism. (Sjaak van der Geest 1995:869)

2.1 Concepts about Traditional Medicine and Traditional Health Practitioners

De facto, defining TM is a complex task that only few researchers have explicitly attempted. Although the ethnographies and studies about traditional medical practices are widely present, it is atypical throughout the academic discourse to find comprehensive definitions of what actually constitutes TM.

Given the diverse ways in which this assignment has been approached, it is nearly impossible to attempt a serious examination here of the different approaches in which these have been addressed over time. Due to the breadth of the task, and giving approval to my research goals, I will confine myself here to examining the institutional and scholarly theoretical frames that were applied the most within the policies regarding TM, and the cooperational work of THPs in HCS at the regional and local levels. In particular, I concentrate the analysis on those concepts with historical, scientific and political importance, and consider their leading position over further academic contributions and PH policies in the country.

In relation to TM, it is certainly necessary to discuss its conceptual space, its aesthetics, symbolism and cosmology, without neglecting its particular geographical, historical and sociological aspects. These have been covered, in part, through the ethnographies existing about specific local indigenous practices. However, these are not necessarily linked to the required search of socio-economical and political constructions for a comprehensive theory (Menéndez 1994). Although the task assigned to medical

anthropology involves the attempt to find similarities and universalities among the great diversity of THS on the planet (Hadolt 2004), the trend of knowledge dissemination in medical anthropology since the 1990s embraced the biomedical and non-biomedical discursive practices encouraging the portability of discontented knowledge. In this way, “take-away messages” or “quick reads” began to appear for the benefit of medical professionals, but they provided little food for thought (Gaines 2011:83). This tendency seems to be concordant for TM practices and its contours among academia in the last decades. Some classical definitions proposed by Andean researchers, however, brought fundamental insights into this development.

Lastres (1945:70) provides a definition approaching the instrumental and ethnic criteria at the front. For this author, the Inca medicine “was a set of practices: fast, penitence, purification, massages, suction and external magic to extract the quid malignum”. Lastres notes that the confession –which was extensively practised among the Incas– represents a sort of “empirical psychoanalysis” the efficacy of which lays principally in the healer’s appraisal of the religious and cultural values of the Andean people³⁹: “with their faith and enthusiasm, their full identification with the worldview of these patients and their deep knowledge, they were able to heal” (1945:34, t. sp.). Lastres asserts that the effectiveness of THPs relays in a genetic born condition and social skills: “they are born empirical psychotherapists with a great social sympathy, and great curative abilities” (1945:35, t. sp.). The influence of such essentialist definitions can be seen in the scholarship developed hereafter. Some of Lastres’ eminent pupils, as Federico Sal y Rosas, reaffirm these conceptions: “The ancient Peruvian culture survives in the backward character on the rural space, and belongs to a medicine that is essentially theurgic and only subsidiary with an empiric-rational character...the autochthonous Peruvian culture has, through its ineluctable variations, a firm structure, and that is why its extinction is so difficult. But this could occur, theoretically said, very

³⁹ The *Capac Raimy* and the *Camay Quilla* constituted a group of collective rituals based on practices of fasts and confessions with a special protective character taking place in Cuzco, in January (cf. Guaman Poma [1613]1956:416-418). Van Kessel notes that these symbolic preventive techniques aim to expulse – ritually and symbolically– the noxious elements disseminated by the disease generator spirits, relegating them to the corresponding space: hills, the sea, the desert or whatever place outside the ayllu’s space: “it is about ritual baths in the river (which should take away all the evil to the sea), cremations with dispersal of ash through the wind or the river...this should protect the life and health of the community, putting enemies and sickening elements out of the ayllu-cosmos” (Van Kessel 1983:169, t. sp.).

slowly in the next centuries, transporting the myths and ceremonies into a Creole medicine less anarchical as the actual one” (Sal y Rosas 1972:93, t. sp.).

Referring to traditional Andean medicine, Carlos Alberto Seguín asserts it as the ensemble of beliefs and practices related to the conception and treatment of diseases; such illnesses, thinking and proceedings emanate from the popular tradition of the most dissimilar and different cultures (Seguín 1979:22). Van der Hoogte and Roersch are more specific and define Andean medicine as an “autochthonous medicine of this region, founded in pre-Columbian medicine and the influence of the medieval European medicine brought by the conquistadores” (1985:101, t. sp.).

A distinctive definition is proposed by Caprara, Chiesa and De Tomaso (1985, cit. by Eddowes 1985:12) who situate the Andean medicine on the “supportive fundamental basis of the Andean rationality, reciprocity and balance” that corresponds to physical and spiritual dimensions. In the same vein, Van Kessel defines the Andean medicine in terms of a “biology”, which conceives the world as a whole living organism (1985:13). Reciprocity refers to two opposite but complementary devices that should stay in alternate contact: sun-earth, heat-cold, male-female, top-down, dry-wet. One part alone does not make sense within this worldview, but together they constitute a dynamic equilibrium, which is “a fertile, never static, always mobile and adjustable” one (1985:15, t. sp.). Thus, there is a dynamic relationship between *pachamama* (earth), *acapacha* (world), and the *ayllu* (domestic space). So the *acapacha* or *kaypacha* (the world here and now) appears stretched between the *arajpacha* or *allaypacha* (world above) and *manqhapacha* or *ukhupacha* (world below) (1980:275-348). This correspondence is represented under the concept of *Tinku*, which has several meanings, such as trying to live in balance, the limit of two ayllus, to balance the load of a section that requires two parts with the same weight, the confluence of rivers, and/or the encounter of two or more persons (1985:13). In a prior publication Van Kessel considers THPs as *administradores de salud* (health providers) with the principal function to realign things in their original disposition and to reaffirm the protective frontiers of the ayllu in defense of the prosperity and the life in which these arise (1983:171).

Concerning TM, Pedersen writes that the “Indo-American⁴⁰ medical traditions” were blended with other medicines taken along from the Conquista and the European colonial expansion, in a process of high hybridization complexity of medical knowledge, the roots of which can be found in Greece, Iberia and Africa, and with a religious syncretism of pre-Hispanic divinities and Christian saints (Pedersen 1988:57-58). For Delgado, the concept of TM distinguishes a set of knowledge, beliefs, and care procedures practised, to a low or high degree, “in all the cultures in the world before the arrival of the so-called “modern”, “Western”, “scientific”, “official” or “allopathic” medicine, whose history dates no longer as two centuries back” (2009:15, t. sp.). This TM, Delgado continues, constitutes the summation of two different levels of attention, always considered by THPs as indivisible: A real or “natural” level –which includes the use of animals, plants and minerals– and a “cultural” one, a magic-religious medicine, including all its ritualistic practices (2009:16). For this author, the coexistence of multiple medical traditions in the country can be explained in terms of an intrinsic survival ability of the autochthonous population: “this coexistence is the confirmation of the survival of a group of practices, procedures, rituals and specialists –deformed or enriched to a greater or lesser extent– that is still the basis of a medical practice sustained in a transmitted knowledge, product of hundreds and thousands of years of observation and experimentation” (2009:18-19, t. sp.). As in the case of many scholars, Delgado situates the birthdate of Peruvian TM before the arrival of the Spaniards. Contradictory or not, he argues that this asseveration does not necessarily mean the exclusion of medical traditions of other regions –including the European ones– as part of “authentic” traditional healing practices: “it is important here to anticipate that, within the Andean system there is not only one, but rather many “traditional medicines” corresponding to different spaces; anyway, they are profoundly related to each other, and the fundamental differences are an expression of the worldview in which they are located, the diagnose and therapeutic procedures employed, and the degree of influence

⁴⁰ Sp. Indoamérica. The term has been proposed among anthropologists and linguists instead of “Latin America”, and has been more successful than other terms between the 1920s and 1940s. In Peru, the first signs can be found in the second half of the 1920s in the left-oriented thought of Víctor Raúl Haya de la Torre and José Carlos Mariátegui who stressed the indigenous essentia of America: “indigenous people are still the economic social and ethnic base of America, both those living within civilization in the present, as well as those huge groups still living in tribal organisations” (Haya De La Torre 1961:27, t. sp.).

of the Western religiosity and symbiotic manifestations –such the Asiatic and African magic-religious beliefs” (2009:20-21, t. sp.). Further, Delgado proposes the distinction of seven basic areas of the TM in Peru: (1) from the Coast and North-Andean Region of Peru (Lambayeque, La Libertad, Piura, Ancash and Lima); (2) the Amazonia Basin (Loreto, Madre de Dios, San Martín, Ucayali, Amazonas, Ayacucho, Cajamarca, Cusco, Huánuco, Junín, Pasco and Puno); (3) the South-Coastal zone (Ica and Arequipa); (4) Quechuas (Cusco, Apurímac, Ayacucho, Huancavelica, Junín, Ancash, Cajamarca); (5) Aymara (Puno); (6) a “mixed” TM with several combinations of the last two ones, and the (7) urban TM, which is practised in big urban cities in the country, product of the integration and interaction among the different medical traditions, and from these with Western medicine (2009:21).

The antagonism between “traditional” and “modern” since the 19th century is built into our imaginary as an essential opposition between the present and the past. Being contemporary cultures in historical sense –also their knowledge– the implied meaning of hierarchy of cultures and knowledge in the nineteenth century was based on the attempts to justify the colonialism of nations and states (cf. Golte 2009:316). Anyway, an analytical contribution should not only be based on good intentions to provide opportunities for relegated cultures, but also on the methodological way in thinking about TM, its definitions and practices.

The pertinence of the use of the adjective “traditional” referring to health practices based principally on indigenous knowledge constitutes a construction process that could be pertinently compared with the concept of “symbolic efficiency” based upon its historical and sociological basis. Social groups, according to their needs, tend to build up new symbolic competences on the basis of economic, ideological and political conjectural processes, which simultaneously disintegrate and eliminate “traditional” forms of curative symbolic performances that –whatever the reasons– do not fit any more. Nevertheless, this does not automatically suppose that these prior competences disappear at all. Moreover, they remain as inveterate repertoire that only could be enhanced and enriched with new techniques and additional information.

Accordingly, some authors have reviewed the adequacy of the term “traditional” in referring to theoretic constructions regarding TM and popular health practices. Menéndez instead prefers the expression “popular knowledge” to refer to TM, and to this respect notes: “For several reasons, we prefer to talk about “popular knowledge” or “popular medical knowledge” instead of traditional medicine. When we use this term [traditional medicine])... it is only due to the need to communicate with each other. Furthermore, the term “traditional” evokes several types of knowledge that a specific analysis puts into question, not only because of its supposed uniqueness, but also due to its conceptual pertinence” (1994:81, t. sp.). Anyway, what this concept of TM questioned by Menéndez exactly is, remains withheld in his works.

Van der Geest, writing about the suitability of using the term “TM” in the context of Africa, brings the previous reflections to the point: “The term is misleading, embarrassing and naive. It is misleading because it suggests that there is a more or less homogenous body of medical thought and practice which can be put together under one name. Such a body does not exist, however. If one examines the type of medical practitioners who are designed *traditional*, one will find an extreme diversity both in theories and practices. The only thing these practitioners have in common –like *alternative* practitioners in Europe and North America– is that they are not biomedical...Lumping together everything which is not “ours” and treating it as if it were one type is a school example of ethnocentric ignorance....the term is naive because it suggests that “our” medical system is not traditional, meaning *handed over*, from generation to generation. Clearly, biomedicine is being handed over all the time, in medical schools, in hospitals, in books and articles, through conferences and the media” (1997:904). Biomedicine therefore is as traditional as any other medical tradition.

For Eyzaguirre, the term TM was created among scholars to counteract modern medicine, and excludes on this the fact that TM is based on a “religious worldview” (2005:36). For this author, the definition of TM should go across the analysis of the terms “traditional” and “modern” within a thinned continuum that should be appraised: “traditional would be consider all that is not modern. This bring us to an abstracted homogenization of the contexts ignoring the particularities; to accumulate and

synthesize practices that are differentiated, expounding them as belonging exclusively to one of these poles; and to not considering these practices as part of when they take place in the opposite system. There is a tendency to consider these poles as historical realities, and not as what they are, namely, only methodological constructions” (2005:5, t. sp.). Pedersen also outlines reflexions to this respect, agreeing that medical systems are “conventional forms” to simplify the complex relations taking place between the dynamic of the social and individual behaviour regarding sickness, and that this “systematic conception means the materialization of an artefact, created by our social organisation, which exists only in our Western mentality” (Pedersen 1988:56, t. sp.).

In the same vein, Campos argued for an attempted definition, in which the indigenous traditional medicines constitute a set of conceptions, knowledge, practices and resources managed by indigenous medicine men from different ethnic groups: “I do not mean only the resources and practices but also the worldview. When somebody does not apprehend the cosmology of the indigenous peoples, cannot understand popular sickness. If I want to understand the *susto* or *espanto* but I don’t know what the indigenous conception about body and illness is, I would say that these are only superstitions” (Campos 2006:3, t. sp.). For this author, traditional and popular medicines are the same regarding the conceptions, knowledge, practices and resources. The only difference is based upon the ethnical characterisation of the group making use of it: TM then turns into popular medicine, when it is practised by mestizos.

Some definitions outlined by organisations in Peru like FORO SALUD define TM as “open, non-exclusive systems of knowledge”. Wherever the knowledge or components are coming from, these elements will be incorporated into the system, and become part of a healer’s repertoire of practices. Thus, they constitute different meanings and forms from contrasting “disciplines”, currently present in the most THSs of Peru. The prevalent use of TM in some regions in Peru is not only due to the existence or not of healthcare centres in specific communities, but rather an evidence of the predominance of TM in places where cultural structures allow this use, and, above all, the attention by a THP (Aliaga t/2009).

According to Sánchez Garrafa (2011), from the perspective of the Andean cosmogony, TM has some relevant characteristics, such as the knowledge transfer through oral tradition; the physical proximity between the specialist and the user; the close bound between magic and remedy, which implies confidence in a certain order of nature and in a number of procedures that are likely to act on this; the potential use of the resources of the environment; and the relationship between disease, curative procedures and world cosmology.

The classic theoretical differentiations between magic and religion as opposite constructs can illustrate, in a crucial point, the different perspectives about what will be considered as “ethnically traditional” (i.e. “magical practices”) and what not (e.g. catholic healing) and its policy regulative consequences. In a work original published in 1924, Rivers writes about the essential differentiation between magic and religion; a theoretical distinctiveness with political consequences that had influenced the discourses about up to that time. He notes: “When I speak of magic, I shall mean a group of processes in which man uses rites which depend for their efficacy on his own power, or on powers believed to be inherent in, or the attributes of, certain objects and processes which are used in these rites. Religion, on the other hand, will comprise a group of processes, the efficacy of which depends on the will of some higher power, some power whose intervention is sought by rites of supplication and propitiation. Religion differs from magic in that it involves the belief in some power in the universe greater than that of man himself” (2005:3).

In Peru, like in other Latin American countries, some spiritual-healing procedures conducted by Catholic or evangelical priests in mass or specific séances (e.g. healing prayer, imposition of hands) are not persecuted or condemned by health authorities in the country. The case of the “Healing Mass” was studied by Hernán Cornejo (1995) as a therapeutic spiritual rite initiated in 1989 in Peru, and disseminated as a religious programme in various departments of the country. He presented it as a curative ritual proceeding with “efficacy in psychosomatic illness with physical-organics nature, and to resolve moral problems”, and quantifies the sociological profile of the attendants of these rituals in his study (1995:28). A particular case studied by Cornejo is the Spanish

priest Manuel Rodríguez, one of the most famous and forceful personalities among the Catholic healers in Peru. Padre Rodríguez employs a technique, the imposition of hands, which consists of a “touch of the head of the patients with prayers, and invocations”, with previous testimonies of cured patients in the centre, who report that their prior ailments were healed through Rodríguez intervention, with posterior exclamations, ovations (“Padre Manuel cures!”) and effervescent applause by all participants (Arroyo 2006:267). Padre Rodríguez conducts his own TV canal in Peru⁴¹ and fervently disapproves of all THS, considering them as “idolatry and superstition” that must be eradicated from the population: “It is a permanent temptation of the people of Israel in recognising God...We say that we love him, but we continue with some cults and the idolatry, with the curanderos, with the witches, we put slots, *ruda*, *wayruros*, all kinds of amulets, as if they were the salvation. Alternatively, we put a candle to God and another to the Devil. Oh, Praise the Lord!” (cit. by Arroyo 2006:265, t. sp.). Although the affluence of terminal patients and persons with advanced serious somatic and mental health conditions that attend these sessions, and undergo these spiritual and physical proceedings without any medical supervision, these practices have been never discussed or put into question among health policy experts. Far different from “traditional” indigenous practices, they are largely not considered as a PH concern that should be examined, regulated or advised.

In addition to considering the practical consequences of such differentiations between magic and religions, the immanent limits proposed in such definitions, such as the clear boundaries allegedly surrounding person, cosmos and nature, “spiritual” or “physical”, between the self and the others, were all not constituent concerns of Andean cosmology. Following an attempt to describe the basis of the sophisticated constructions of the Andean cosmology, Lajo explains this structure using interpretations based on the *Puquina* language⁴². The *qhapaq* (content of wisdom) cannot exist plentifully in the “reality” unless the right, correct or fair deed has been done. Together, the flawless flow

⁴¹ Also at: <http://www.jn19tv.com/>

⁴² Missionaries and civil functionaries in the early 16th century recognise three general languages spoken in the Andean region at the time. In an official report dated from 1582 (Brinton 1890:242), these were the Quechua, Aymara and Pukina. It has been also suggested that, in contrast to Quechua, the language of the Inca Empire, the Puquina or Uru was spoken by the Tiwanaku folk, whose cultural and political prestige was dominant in the central Andes in a time before the Incas (Browman 1994:235).

of human being and nature (*yanantinkuy*) is bonded: they become real only within an environmental community cosmos consciousness with different levels, in which concepts like moral, religion or ethic did not exist (cf. Lajo 2005:98-105). In the Andean cosmology, nothing what exists, including the human being, could be apart from the rest, because the animated elements in nature are intimately related, performing with this a rigorous balance. The human being is the nature.

Delgado Súmar explains that this balance was sustained in a triple relationship in terms of reciprocity, with regard to their geographical environment, their social group and their deities, making it possible with this to achieve a high degree of rationality⁴³, both in the occupation of the territory as in their social organisation (1999f:4). This rationality is explained by Delgado in a very poetic form. The author argues that for the Andean man everything should be kept well (*Allilla kay*), be perfect (*Allilla kakuy*) and be conducted without disruption and alteration (*Allinlla*) so that each thing or each product could be good, helpful, and pleasant and could be used (*Alli*) to ensure the quality of welfare (*Alli kay*) of the people. “To reach this, it was necessary that all people of the community were in good condition and observed good behaviour (*Allin Kama*); they should be good parents (*Allin Tayta*) or good mothers (*Allin mama*); also good eaters (*Allin mikkukk*), make good work (*Allin llankay*), with good hearts (*Allin sonkko*); be honest and kind (*Allin runa*); people of good nature (*Allin sonkko*)” (1999f:4, t. sp.). Being people of good nature means to be people of “good physical presence and moral (*Allin rihch'ay*), capable to do everything in a proper way (*Allinllapi* or *allinllanpi*), so that everything is good in all means, or at least outstanding under all points of view (*Allumpuni*)”. In achieving this, “the person should need to learn perfectly or very well (*Alli allinta yachay*) their art or their craft, and apprehend the real science (*Chekkay yachayta yachay*)” (1999f:4). To reach this ideal, a specific group of rules to be followed were defined, which were highly ritualized, and that promote the maintenance of the arranged relationships between their members.

To the contrary of many idealized discourses, which introduce this behavioural model and stricter prescriptions as basically gentle and self-evident for the population, the

⁴³ For a comprehensive analysis of the Andean rationality see e.g. Golte, Jürgen 1980. *La Racionalidad de la Organización Andina*. Lima, Peru: Instituto de Estudios Peruanos.

concept of disease, defined as a transgression of the rules derived from the temporal breaking down of the moral axioms pertained to those expected rules, suggests that this health model was probably not so easy in being fulfilled or to be maintained for all the citizens –at least not necessarily in the way in which it has been presented by Andean specialists. However, the medical Andean technology evidences a strong symbolic and organic nature, which is otherwise not always clearly understood. Both dimensions – physical and spiritual– must be considered to understand the use of a plant or technique by an Andean specialist. For example, the use of a plant could be perceived as effective not only because of its intrinsically pharmacological properties in restabilising the asymmetry between cold and warm, but also because this plant comes from the *Pachamama* (qe. mother earth) and holds, consequently, a specific virtue and conveys an indubitable blessing. The procurement of health is a constant search for balance and harmony between systems, whenever these are ecological, social, religious or cosmic nature. The Andean sign for good health, good harvest and happiness resides in how to maintain this balance or to establish it after a temporary failure within a never-ending process of failure and reestablishment.

An attempt to define TM on my side seems to be necessary at this point. Peruvian TM embodies a relatively established and identifiable complex corpus of knowledge and practices of religious, spiritual and medical traditions basically developed around, but not exclusive to, concepts and techniques produced by the encounter between ancient cultures in the Andes and those introduced by the Europeans at the time of the Conquista. These knowledge systems are highly dynamic in their configuration, structure and applications, and are in a constant process of change, exchange and assimilation of other conceptual elements and therapeutic traditions since their beginning. In a first period, these customary components included the early interchangeable assimilation of pre-Inca, Inca, and American medical traditions; the Christian-Catholic religion; the European scholastic medical knowledge; the popular medical practices of the renaissance; the spiritism of the last century; and the African and Asian traditions since the 16th and 19th century, respectively. All the practices considered as part of different THS in Peru have in common the principal intention to restore the disrupted balance between the individuals, the social group, the spirits and

the nature –all of these self-conceived of as components of nature– which are said to be the principal ground for ailments and problems in all their forms, multiplicity and character. The reinstallation of balance is a *conditio sine-qua-non* to obtain health and welfare, and to succeed in social, economic, familiar and sentimental aspects of life, which are all entrances that are conducive to health, and that are basically conceived as components. THSs admit concepts and specific local explanations on the origin of disease, the course of it and the different forms of healing quiescent, as well as adapted elements from biomedicine that provide particular accounts and understandings about the physical, biological, social and spiritual aspects underpinning it. The acquisition of these practices is a process that has a socio-cultural, but at the same time, an individual and also occupational character. The apprentice begins to learn about the medical traditions of a giving group (or more), preferably via oral tradition, mostly in the extended intra- and intergenerational family network, but also transmitted from a distinguished curandero beyond the familiar network. The will to accomplish this knowledge follows a personal decision and is defined, in most of the cases, as an inborn ability that has been appealed to through his/her repeated experiences of dreams or visions announcing the apprenticeship, or showing future aspects of his/her life as a curandero; a selection made by the community; or due to his/her social situation in a given time among the group. During a long period of time his/her healing and divinatory skills are confirmed and improved through the efficient performance of rituals, and the experiences of healing and problem-solving that are recognised as such within his social space and clients. A curandero can be indigenous or mestizo; could work in a specific peasant community, big city, or move through all of these; charge little or a lot of money, or still receive commodities, goods or services instead. TM compounds several different levels of permeation with these descriptions, but construes in its basis a reaffirmation of identity and alternative solutions for health, coming from the population itself.

2.1.1 From the Andean Medicine to the Popular Medical Practices

Regarding popular medicine, Sal y Rosas considers it as a “Creole medicine” with no traditional or historical roots. “The content is mixed, fluid and erratic, with elements borrowed from the most diverse therapeutic origins. It is not a properly medical system, rather a merely curative practice without principles, or randomly tacked from everywhere. It is used in the peripheral neighbourhoods of the city and in the rural coast, and it is the only form of curanderismo with the exclusive goal of personal profit. It is the only one that interferes with the scientific medicine; this is why it is located on the field of the illegal practice of the medicine” (1972:93). For Seguín, popular medicine consists of a collection of beliefs and practices about diseases, its prevention and treatment, which are maintained through the popular tradition in all spaces, far away from what is proposed in scientific medicine: “It is exercised by the folk, without major theoretic preparation. It is the recipe of the grandmother, or the prescription of the old aunt; such kind of manoeuvres used in the familiar context” (1998:1).

Other definitions of popular medicine outline the rationality, which includes non-lineal parameters and the inherent potential to incorporate other values, whatever their antithetical origins. Lastra asserts, for example, that popular medicine is the body of health solutions integrated to a set of actions among popular urban-marginal sectors of the society, and in which it is possible to find an “indistinctive mixture on the use of proceedings from the traditional medicine as *santiguamientos* (to make the sign of the cross over oneself), bone-adjustment, *quebradura de empacho*⁴⁴, etc.; with others from the official medicine, as well as self-medication, consultancy of professionals, etc. (1993:111). Frisancho defines Andean medicine as synonym of folkloric medicine, because he considers that the popular and traditional are both part of a country’s folklore (1999:4). Cárdenas emphasises the weak frontiers existing between traditional and popular medicine, establishing a differentiation criterion upon the identification of populations sector making use. She argues that popular medicine is an overlapping

⁴⁴ Empacho is a (culture-bounded) digestive syndrome widely present in Latin America. It is associated with excessive food intake, which causes gastroenteritis and symptoms such as colic, diarrhoea, fever, and vomiting. More commonly found among children, treatments range from the use of medicinal plants to manual procedures and even religious rituals. The “quebradura de empacho” (to break the empacho) consists on a hand-operative technique, in which the patient is cured with massages, frictions and cataplasms (Campos and Coronado 2009:249-250).

group of practices, knowledge and ideologies regarding health originating both in indigenous and modern medicine and the Catholic religion. In her view, “the social groups located in urban, rural and urban-marginal sectors manage this knowledge, which do not emphasise in the preventive and ecological aspects, but in the context of a mestizo national dominant culture, and the market economy” (1990:195).

Instead of THPs, an equivalent category for popular practitioners is the *curioso*. The notion of a *curioso* varies between regions in Peru. A person responsible to offer advice and first aid, whether man or woman, commonly older people, are considered *curiosos*. They constitute a sort of intermediate operators, responsible to solve, or provide information about, in low levels of complains that are not attended by THPs. Principal activities of a *curioso* are to preserve traditional knowledge and to recommend the best treatment or the suitable *curandero* for a specific given case (Delgado 1999:21). They also act as counsellors by resolving interpersonal or familiar problems in the community. Among the *Achuar* from the Huasaga River (Delgado 1999:20), the *curiosos* are healers that use herbal remedies but that do not undergo any initiation process. They acquired the ability to cure while helping the work of other *curanderos*, not necessarily from the own community.

Self-attention and social participation constitute the basis of the social life in the traditional and contemporary local communities in Latin America. They have existed before the appearance of the first concepts and theories about the development of PHC attention models for developing countries. Its presence and importance is extended besides all aspects comprehended among the health-disease-recovery process, and are indeed important social determinants for health attention.

According to Menéndez, the *autoatención* (self-care) makes reference to a structural strategy of the social groups, that includes all its daily activities (nutrition, hygiene, “informal” education, etc.) applied in order to find a provisory or definite solution to the afflictions or problems affecting health conditions of the members of the community (1993:72). The activities employed tend to become appropriated by the group, establishing through this process a dynamic relationship between the individuals,

institutions and products outside (Menéndez 1993:73). Among these activities are the detection of a health problem, the production of a provisory diagnose, the use of a repertoire of diagnose indicators, observation of the development of the disease, the use of criterions on severity or mildness of the disease, etc. These different actions bring the group members to important decisions and actions' course conducting from "doing nothing" through self-medication, self-prescription of substances or therapeutic mechanisms, the inter-familiar or trans-neighbourhood consultation up to the consultation of biomedicine professionals or "curadores populares". Popular medicine is identified by Menéndez as self-care and constitutes a sociological and anthropological strategic adaptation of different traditional medicine techniques that are in use among citizens that are non-specialists of TM (1993:72-80). Menéndez lends the technique of the rubbing with the egg as an example of one of the most practised expressions of popular medicine. Besides, the author does not make any distinction between domestic and popular medicine, and considers both as part of the first level of attention in population self-care in Latin America.

Biomedicine knows that it has efficacy, at least in relation to some ailments, and it does not need to implement traditional practices on that. Similarly, TM responds in an effective way to the mitigation of multiple syndromes, for which biomedicine has shown no effectiveness. Nevertheless, the attention to popular medicine and its practices has emerged as a response of civilian associations, community based movements and other social mass media phenomenon (i.e. cyber cultures) that reflect the wish for direct participation of the population in health decisions concerned national programmes, and due to the progressive discredit of both traditional and biomedical practices.

Due to its expansion and importance for PH, some authors consider that popular medicine should be also acknowledged as a medical system and be constituent of health research like other medical systems, such as the conventional and traditional medicine (Eyzaguirre 2005:22). Pedersen considers that popular medicine has arisen principally as consequence of the social expansion of biomedicine into the popular and mass cultures, and the increasingly high-tech implementation of TM, and constitutes per se a "mosaic of models, remnants and resultants of the historical relationship between Indo-

American medical cultures and the medical traditions from other latitudes” (1988:53). Evidently, popular medicine reproduces an interchangeable process through the daily practice of self-care among the population, and its reproduction’s mechanisms are not necessarily based on oral, community or inter-generational transmission, but rather on several written, visual or mass media resources. It owns an objective value, ratified on the perceptions and direct experiences of the subjects involved, and counts with a varied network of specialists managing different therapies with the most dissimilar origins. A special characteristic is its presence in widely different social, economic and cultural milieus, but always with a popular character, i.e. it is both used among subaltern groups and the hegemonic ones in specific contexts. It is also important here to differentiate between domestic and popular medicine. I consider the first one as part of the first level of care attention, based on the use of mechanisms of self-care, which includes self-medication; well-being practices such as exercise and physical training, nutritional discipline, etc. and that has an essentially preventive focus. On the other hand, popular medicine makes additional use of health resources that exist outside the domestic and private sphere of the groups, but that are characterised by their non-preventive focus. These resources have either clearly abdicated a knowing biomedical, alternative or traditional approach or make mixed use of some techniques, elements or resources of all them.

In contrast with the mainstream definitions of TM, the studies about popular healthcare practices gain increasingly in interest upon policy research, providing new categories to be considered. Most of the reports outlined concepts and practices earmarked through four principal elements:

- (1) Subaltern or subordinate status of popular healthcare practices in relation to TM and conventional medicine;
- (2) Prior informal mechanisms of transmission and preservation of knowledge (extra-mural, writing, from mass-media, and non traditional);
- (3) Linked to a rapidly changing dynamic in order to respond to socio-economic living conditions of communities and popular sectors; and
- (4) Increasingly socio-cultural adherence among the population and progressively epidemiological contextualization

With a statement, Eddowes (1985) illustrates the conformation of perspectives of Peruvian modern social scientists and the definitions provided by international health agencies regarding TM and popular medical practices: “It is a widespread belief that where the magic is, the science must come and replace it. Still, one does not replace the other. The difference between both medicines is sometimes more a desire of the Western scientist as a really change on the part of the customers. That is to say, if the problem was solved, it does not matter how the phenomenon can be explained. Finally, what difference does it make to name a pathogen agent “microscopic bacilli” or “evil spirit”, if in both cases there is harm and the goal is to expulse it?” (1985:6).

2.2 International Health Policies and Primary Healthcare

Traditional medicine does not count, unless we count traditional medicine. (WHO 2010:1)

In the opinion of some specialists, since TM was first mentioned in the WHO’s programmes in 1976 (Djukanovic and Mach 1975, WHO 1976), there is a growing interest of MDs to know more about traditional health practices, and the number of THPs and THS seem to have been incorporated into the health mainstream discourse of the Western world (Zuluaga 2009:257).

In discussing the political consequences of the different discourses that emerged during the 1940s and 1950s surrounding the concept of “development”, Escobar defines a discourse as “a process through which social reality comes into being... the articulation of knowledge and power, of the visible and the expressible” (1995:39). The “visibility” and “expressivity” among the biomedical discourse and its systemic reciprocal relations permit the creation of objects, concepts and strategies –a “perceptual structural space”– in which the different forms of observation, interrogation and registers, as well as interventions on public health, have generated a conglomerate of mainstream relationships. In these affiliations, the role of experts, from whom certain criteria of knowledge and competence were asked, are located at some institutions, like the UN, which have the technical and political authority to name subjects and define strategies that should be done.

The hegemonic medical model (HMM) prioritizes the biological dimension in the consideration of economic, cultural, and political processes related to health. Although it does not eliminate the social aspects in the explanations about health, disease, and recovery, it subordinates and restructures its priorities according to theoretical-operational criteria, reducing it to a supplementary factor. Biomedicine is structured in this way according to the requirements of the positivist science in the natural sciences. Its subject is the disease considered as a biological phenomenon of individual character, identifiable and measurable. Classical studies on this matter (Kleinman 1980, Illich 2007) have characterised the relation between patient care and healthcare providers among this model as asymmetric, paternalistic, and authoritarian. Recent research has demonstrated the permanence of some of these characteristics in healthcare attention in the region, such as paternalism and discrimination (Valdivia 2010), and the presence of antagonistic models of care (Fernández Juárez 2008:189-200), among others. Throughout the development of the HMM, dominated by dichotomy and opposition, the scientific or modern medicine (officially) is always put in contrast to the traditional or indigenous (illegitimate/non-regulated) practice. This remark allows us to state that the expansion of hegemonic medical practices in indigenous or rural communities has led to the transformation, displacement, or even in some cases, elimination of these practices (cf. Prinz 1996a). It would threaten not only the ethnic and specifically cultural aspects, but also the significance and cultural integration functions that these practices have.

According to Stolkiner (1998, cited by Bejarano 2004:17) the HMM is based on a liberal conception of health inspired by a model of individual freedom. This freedom includes the possibility to choose, designing health as an individual responsibility, and not the state's. This model is inspired by the values explored in the French Revolution, in which health became sectorized, as a private obligation, and essentially opposite to the public. As a result, the state should assume the costs and organise HC for the poor only in case of extreme poverty, reducing the social aspects involved in the process of healing and disease to a branch of medicine; first in the social hygiene, and later on in PHC (Bejarano 2004:18). According to Lachenmann, PHC can be seen as one of the earliest concepts of global governance introduced by common international consent. In her view, it brings together a commitment of the international community for global

support, and of the respective countries regarding national implementation. “Its very central meaning implied (1) localisation of a global concept, (2) starting from the local primary level taking into account the referral and support relationships as interaction/interface between different levels of the health system, and (3) bringing “health for all” to the (poor majority) population” (2002:456-457). The last point implies, however, a paradoxical situation, because the “poor population” should often remain poor in order to achieve health attention, or must demonstrate its poverty in order to access the government’s health attention programmes created for it. Furthermore, academic medicine arouses concerns about preserving the traditions and knowledge of popular cultures, but at the same time delegitimises popular medical practice, alleging its unscientific basis, and recommends health attendance at institutionalized HC centres instead.

2.2.1 Policy Development

During the 1970s, the WHO was especially proactive in advocating the integration of TM into PH programmes. Since the WHO globally launched the promotion of TM in public healthcare in 1977 (WHO 1977), members of governments were called on to give importance to THS existing in their countries. The first regulation documents submitted by the WHO on this regard (WHO 1975, 1978, 1978b) opened a large series of meetings, conferences, and working groups, and prompted the establishment of offices and specialized research and policy institutions in member countries to promote the inclusion of TM in HCS. Special focus of these resolutions was put on the design and implementation of policies for development countries with local populations’ participation at PHC level, also considering the inclusion of THPs as community health workers (WHO 1975). In 1976, a resolution board which emphasised the inclusion of health workers for PHC was formed, taking into account “where appropriate, the man power reserve constituted by those practising traditional medicine” (WHO 1976a).

The WHO created the Department of TM on 1972 (Gao and Watanabe 2011:1162). At that time, it had still not provided an official definition or specific policy framework for TM. The term TM was first defined at the Brazzaville meeting (in the Republic of Congo), organised by the WHO Regional Office for Africa, in 1976. It was defined as

“the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing” (WHO 1976:3). TM might also be considered a solid amalgamation of dynamic medical know-how and ancestral experience, also considering in this respect the “practices, measures, ingredients and procedures of all kinds, whether material or not, which from time immemorial had enabled the African to guard against disease, to alleviate his sufferings and to cure himself” (WHO 1976:3-4). A THP was defined as a person “who is recognised by the community in which he lives as competent to provide healthcare by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental, and social well-being and the causation of disease and disability” (WHO 1976:4).

Over the years, this prior definition provided by the WHO remained the same with meagre additional considerations in further documents, drafts, and board reports. The introduction of the terms “culture” and “heritage”, to reflect its “variability, community relevance and dynamism”, have been included in following resolutions (WHO 1977). A meeting report of 1978 focused on the “modern character” of TM (WHO 1978:9-10). In other reports, however, extensive considerations on the “intrinsic quality” of TM, its “extraordinary role on a population’s healthcare”, and the consideration of THPs as “valuable and considerable resources” were addressed constantly (WHO 1995:3).

In this line of documents, the Alma Ata Declaration of 1978 is considered a milestone. It proclaimed PHC as essential healthcare due to the gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, something that is “politically, socially, and economically unacceptable”. The social accent and the concerns about socioeconomic inequalities among people gained prevalence among the discussions on PH policies at governmental level. Consequently, a theoretical model was proposed, in which “suitable and reachable” PHC for communities was promoted. According to this model, and although

the role and responsibilities of states' governments to overcome these disparities were not specifically described at Alma Ata, healthcare should rely on local and referral levels, health workers, and THPs "as needed, suitably trained socially and technically to work as a health team to respond to the expressed health needs of the community" (WHO 1978b). The guidelines to achieve "health for all" expressed in Alma Ata find redoubled political and financial support for PHC from governments and health agencies, and are considered a leading pathway in reaching the Millennium Development Goals⁴⁵. Although many countries' programmes inspired by the recommendations of Alma Ata have shown relative success in providing financing, better healthcare, access, and coverage for health services for the poor (cf. Kruk et al. 2010:907-909; Rincón and Rodríguez 2010:519-523), some critics of the recommendations of the Alma Ata Conference argue that as TM was incorporated into PH, it was evaluated not on its own terms, but on those of biomedicine (Van Wolputte et al. 2002:18-20).

The term "holistic" referring to healthcare practices of indigenous communities was decided on at the Work Meeting on Indigenous Peoples and Health in 1993 (PAHO/WHO/CSIH 1993). This was the first time that indigenous organisations met with representatives of PAHO, governments, and NGOs in hopes of launching a dialogue on the health status of indigenous peoples. The recommendations made in this meeting were grouped together in an initiative entitled "Health of the Indigenous Peoples of the Americas" (PAHO 1993a; PAHO 1997; PAHO 2003; MINSA/INS/CENSI 2010:18). That initiative was subsequently presented to the Governing Bodies of the Organisation and adopted by the 37th Directing Council through resolution CD37.R5 (PAHO 1993b). The recommendations from the Winnipeg meeting and resolution CD37.R5 established five principles to be considered in working with indigenous communities and to facilitate monitoring, and served as groundwork for the evaluation of the processes at the end of the decade, forecast for the year 2004 (cf. PAHO 1997). At first, the symposium emphasised the need to preserve the holistic

⁴⁵ The eight Millennium Development Goals (MDGs) were accorded among all 193 United Nations member states and international organisations to be achieved by the year 2015. Reducing child mortality rates, improving maternal health, combating HIV/AIDS, malaria, and other diseases are referred directly to improve health conditions. See: <http://www.un.org/millenniumgoals/bkgd.shtml>

approach inherent in the different health concepts of the indigenous peoples of the Americas: “A holistic approach to health must be respected and promoted, based on the Indigenous understanding that there are four aspects to health: spiritual, physical, emotional and mental” (PAHO/WHO/CSIH 1993:1-2). Across the most widely varying perspectives presented at the meeting, the common denominator for the term “holistic” is the belief that health expresses dynamic relationships between inseparable components. These include the relationship between “individual aspects (physical, mental, spiritual, and emotional) and group aspects (political, economic, cultural, and social), and between what is natural and what is social” (PAHO 1993a:6). The other four principals submitted by the conference enacted the right to self-determination of indigenous peoples, the right to systematic participation, the respect and revitalization of indigenous cultures, and the reciprocity in relationships with health agencies (PAHO/WHO/CSIH 1993:1-2).

Regarding TM and THPs, the report considered that “ultimately, good health will depend on indigenous control of indigenous health services: any other model will run into political and administrative barriers, created by officials whose prime interest is in organising programmes, spending or saving money, not in improving the health status and ensuring the well-being of indigenous communities” (PAHO/WHO/CSIH 1993:1-2). Moreover, “TM must not be subordinated to the Western health system; it must be placed on a par with it and with popular medicine” (PAHO/WHO/CSIH 1993:2). The declaration recommends, accordingly, that member states immediately recognise indigenous medicine through its legalization, provide appropriate support for indigenous healers and their organisations, and take measures to put an end to the repression of native healers (PAHO/WHO/CSIH 1993:1-3). The position of the Winnipeg attendants was clear: To avoid any utilisation of their traditional healing practices by health agencies. In fact, the declaration does not consider any statement about the integration of TM or THPs into HCS.

Seventeen years ago, the WHO Regional Office for the Americas (PAHO) began to use the expression “traditional health systems” (WHO 1995), which further locates the medical indigenous practices within the concept of TK. This body of knowledge,

defined in prior documents, explain the “aetiology, the nosology and procedures of diagnosis, prognosis, healing and prevention of diseases”, and are transmitted by tradition and orally, from generation to generation, within the villages. This medicine is circumscribed, local, collective, and anonymous and carries a universal message (Valdivia 1986, cit. by WHO 1977:13). According to this view, local health systems are joint complex processes, which constitute the totality of social actions in health at the local level, including but not restricted to the provision of services of health (PAHO/WHO 1993a; WHO 1995). In this sense, THSs are a type of local health systems approaching integrity and holism as concepts that have always been present among indigenous people (WHO 1977:13).

In a workshop on development of national policy on TM organised by the WHO Regional Office for the Western Pacific in October 1999, the expressions “culture” and “ancient tradition” were introduced to define what is TM, but this time in direct opposition to academic medicine, and addressing a relativistic perspective among these practices. Here TM is defined as an “ancient and culture-bound medical practice which existed before the application of modern science to health. The practice of traditional medicine varies widely, in keeping with the societal and cultural heritage of different countries. Every human community has responded to the challenge of maintaining health and treating diseases by developing a medical system. Thus, traditional medicine has been practised to some degree in all cultures” (WHO 2000:11). In this document the term “holistic” is also mentioned, but principally in order to stress its importance for healthcare and the treatment of diseases, and not its intrinsic value in terms of social cohesion and its essentially preventive approach among indigenous peoples: “traditional medicine is the sum total of knowledge, skills and practices of holistic healthcare, which is recognised and accepted by the community for its role in the maintenance of health and the treatment of diseases” (WHO 2000:12).

According to this document, there are many different traditional systems of medicine; however, traditional systems of medicine have some common characteristics:

- (1) Traditional medicine is based on a belief that health is a state of balance between several opposing aspects in the human body. Illness occurs when an individual

falls out of balance, physically or mentally. The causes of imbalance could be a change of weather, intake of certain food; external factors, such as magical or supernatural powers; mental stimulation and societal reasons. Anyhow, TM tries to restore the balance using different therapies.

- (2) Traditional medicine is based on the needs of individuals. Different people may receive different treatments even if they suffer from the same disease. TM is thus based on a belief that each individual has his or her own constitution and social circumstances which result in different reactions to “causes of disease” and treatment.
- (3) Traditional medicine applies a holistic approach. It considers a person in his or her totality within an ecological context and usually will not only look after the sick part of the body. Besides giving treatment, traditional practitioners usually provide advice on lifestyles and healthy behaviour.
- (4) Traditional medicine precedes modern medicine. Most traditional remedies have not been evaluated by scientific methods. This means that, at this stage, TM is not easily understood by modern medicine. However, traditional remedies have been “field-tested” by tens of thousands of people for hundreds of years.
- (5) Traditional medicine covers a wide scope and its practices vary widely from country to country (WHO 2000:12-13).

The first global WHO strategy for TM, submitted in 2002, established the prevailing official definition of TM among member states and stakeholders (WHO 2003b:1-2) and approaches TM as a “comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies –if they involve use of herbal medicines, animal parts and/or minerals and non medication therapies– if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies, and spiritual therapies” (WHO 2002a:1). The role of TM in maintaining well-being and to “treat, diagnose or prevent illness” is also emphasised in successive documents (WHO 2004:1).

A common sentiment in the official discourse among health agencies referring to THPs is the statement that indigenous communities depend on THPs and spiritual leaders to promote health and to prevent and treat common illnesses (WHO 1991a; 1991b; 2003a; 2003b; 2009a); and that these resources often tend to be the only permanent resources available to them (PAHO 2002:4; WHO 2005:9,70; WHO 2008a). Another connected asseveration is that where physical access to healthcare centres is not an issue, there are often financial, geographical, or cultural barriers preventing indigenous people in accessing health services (PAHO 1998:23-24, 1997). “Illiteracy, unemployment, lack of access to land, high rates of morbidity and mortality from avoidable causes, and serious limitations in access to and utilisation of services owing to geographical, economic, and cultural barriers are problems affecting the majority of indigenous communities” (WHO 2003:3-4).

Specifically in two reports, general categories of traditional healers were proposed: the traditional birth attendants, herbalists, bonesetters, and spiritualists (WHO 1995:9; PAHO 1997). Reasonably, some basic rules were also established to identify THPs: “... a traditional medicine practitioner is a person who is recognised by the community where he or she lives as someone competent to provide healthcare by using plant, animal and mineral substances and other methods based on social, cultural and religious practices” (WHO 2000:11). Although THPs are recognised as experts on community *attitudes* and *beliefs* related to physical, mental, and social well-being and the causes of disease and disability, in this list there are specifically recognised as THPs, “traditional healers, traditional birth attendants, herbalists and bonesetters” (WHO 2000:12). In further documents, the PAHO promotes an interchangeable conceptualization of THPs, locating them as equivalent to health professionals, and recognising them as healthcare providers: “While the term “healthcare provider” in conventional health systems includes physicians, nurses, laboratory technicians, dentists, health promoters, etc., in indigenous health systems, the yachas, sukias, pajuyucs (healers from Andean, Afro-Caribbean, and Amazonian cultures), machis spiritual healers from the Mapuche culture, midwives, bonesetters, shadow callers, herbalists, etc., appear in the list of healthcare providers” (PAHO 2002:22). However, in calling for specific integration approaches, the list of mentioned practitioners of TM is reduced significantly,

preferably considering those not performing “non-rational” treatments, such as bonesetters and parteras, who are indigenous medicine specialists who do not necessarily work with the performance of culture-specific or religious rituals. These selection matches, evidently, one of the four goals of the global WHO strategy for TM, established few years later, namely, the promotion of the “rational use” of TM (WHO 2002a:5).

The last programme establishes four main objectives, in line with those of the WHO’s medicine strategy: (1) to integrate relevant aspects of traditional medicine within national healthcare systems by framing national traditional medicine policies and implementing programmes; (b) to promote the safety, efficacy and quality of traditional medicine practices by providing guidance on regulatory and quality assurance standards; (c) to increase access to, and affordability of, traditional medicine; and (d) to promote *rational use* of traditional medicine (WHO 2003:3). As a rule, this “rational use of TM” assures that the knowledge, qualifications and training of TM/CAM providers are “adequate” by means of “using training to ensure that TM/CAM providers and allopathic practitioners understand and appreciate the complementarity of the types of healthcare they offer“ (WHO 2002a:4). This means, for instance, that the practices shall become, in some way, equivalent or objective, and be translated in terms of Western practitioners.

In his analysis of the integration approaches in Africa, Prinz (1996a) postulates, for example, that the integration experiences attempted have shown a tendency to the colonisation of traditional healing practices, and that these arrangements have the potential to produce its breakdown. Following, the integration projects developed from the perspective of the international cooperation community seek the incorporation of THPs as health workers, something which is “unrewarding”, because “it is inappropriate to reduce traditional healers as assistants or fulfilment organs of the modern medicine” (p.146, t. g.). After mentioning the communication strains between THPs and health professionals due to the cultural and educational distance between them as an additional hindering factor, Prinz also situates the problematic in terms of an ambivalent attitude towards THPs in some African countries. This triggers, for instance, an adequate

cooperation between modern and traditional practices in which the “good” herbalist is praised and promoted, the superstitious practices of “witch evil doctors” will be fought consequently, “from whom is feared that they own the destabilising power to affect a whole state or community” (1996a:146-147, t. g.).

According to the programme mentioned above, in countries where the dominant HCS is based on allopathic medicine, or where TM has not been incorporated into the national HCS, TM is often categorically described as “complementary”, “alternative” or “non-conventional” medicine (WHO 2002a:1). Posterior policy recommendations encouraged member countries and civil organisations to disseminate information and cover standards to guarantee the “safe and secure” use of TM, and for instance, associating TM with the embracing concept of CAM (WHO 2002a; 2003; 2004; 2005; 2005a). In a first moment it might be impressive that the number of studies published in the area of TM and CAM processed by Medline⁴⁶ between 1993 and 2003 reached fifty thousand (Cañedo et al. 2003). Nevertheless, according to this study, the number of clinical trials in the area of TM does not exceed 10% of the total, whereas proper CAM studies, on the other hand, show a wealth of research, in which two-thirds of the items processed are indexed as clinical trials⁴⁷. Anyway, the overwhelming publications on CAM in comparison to TM are not difficult to understand, because CAM does not substitute, but share the same perspective on health and illness, and is conceived as a relief for conventional medicine (cf. Johnson 2009:704-705).

The National Centre for Complementary and Alternative Medicine (NCCAM), the federal government’s leading agency in the USA for scientific research on HCS and principal collaborating centre for the WHO (WHO 2002a:49), defines CAM as a group of diverse medical and healthcare systems, practices, and products that are not generally

⁴⁶ Medline is the largest component of PubMed, an online database created by the U.S. National Library of Medicine (NLM). It includes references to articles published in approximately 5,600 current biomedical journals. See: <http://www.nlm.nih.gov/pubs/factsheets/medline.html>. Two Peruvian journals have been indexed, the *Revista Peruana de Medicina Experimental y Salud Pública* (<http://www.ins.gob.pe/rpmesp/>) and *Revista de Gastroenterología del Perú* (<http://www.socgastro.org.pe/revista/acerca.asp>).

⁴⁷ Although the aim is to prove the effectiveness for security use, on a nine-years-period review (2000-2009) of a single journal of TCM (Chinese Medical Journal), the most common research activity was the development of treatments and therapeutic interventions (88%), whereas proper human clinical trials involving natural products accounted only 5.31% of the reported studies (Collins 2011).

considered part of conventional medicine. Western or allopathic medicine is defined as the medicine as practiced by holders of M.D. (medical doctor) and D.O. (doctor of osteopathic medicine) degrees and by allied health professionals, such as physical therapists, psychologists, and registered nurses. In the other hand, “complementary medicine” refers to the use of CAM “together with conventional medicine, such as using acupuncture in addition to usual care to help lessen pain”; and “alternative medicine” adduces to use CAM “in place of” conventional medicine (NCCAM 2011:1). The NCCAM does not provide a definition of TM, but states that the practices of traditional healers can also be considered a form of CAM because THPs “use methods based on indigenous theories, beliefs, and experiences handed down from generation to generation” (NCCAM 2011:4). To this respect the NCCAM quoted the 2007 National Health Interview Survey (NHIS), in which the category „traditional healer“, i.e. *curandero*, *espiritista*, *hierbero/yerbera*, shaman, *botanica*, native American healer or medicine man, and *sobador* (Barnes, Bloom and Nahin 2008:11) were included as a modality of alternative therapy. Listed among acupuncture, ayurveda, biofeedback, chelation therapy, hypnosis, etc. (HHS 2008:55), THPs were not defined categorically as healthcare providers, but as techniques itself. It is interesting to note that whereas conventional medicine is defined as a practice accomplished by recognised practitioners such as MDs and health professionals, THPs become impersonalized, and methodologically considered as equivalent to alternative, non-traditional techniques.

The WHO assumed the NCCAM’s definition about CAM: “complementary and alternative medicine often refers to traditional medicine that is practised in a country but is not part of the country’s own traditions” (WHO 2001:1). They specifically located the expression “traditional medicine” when referring to Africa, Latin America, South-East Asia, and/or the Western Pacific, whereas “complementary and alternative medicine” – used also to refer to healthcare that is considered supplementary to allopathic medicine– refers to Europe and/or North America, including Australia (WHO 2001:1; WHO 2002a:1). However, the WHO notes also that this expression should not be taken for granted, and can become “misleading”: “In some countries, the legal standing of complementary/alternative medicine is equivalent to that of allopathic medicine, many practitioners are certified in both complementary/alternative medicine and allopathic

medicine, and the primary care provider for many patients is a complementary/alternative practitioner” (2001:1). Thus, when the practice is being accomplished in a country where there is no tradition of use, TM turns out to be alternative or complementary. When referring in a general sense to all these regions, the comprehensive TM/CAM is used throughout WHO policies.

Examining the correspondence of TM with CAM posited by the WHO, Correa has added that the expansion of use to other countries, and the possession of written documents of specific THS –defined by him as “codified traditional systems”– constitutes a distinctive criterion that legitimates the use of CAM to refer to these practices (Correa 2002:6-7). Similarly, in the Declaration of Beijing (WHO 2008) it is argued that “noting that the term “traditional medicine” covers a wide variety of therapies and practices which may vary greatly from country to country and from region to region, and that traditional medicine may also be referred to as alternative or complementary medicine”.

Knipper asserts that the development of the new collective category CAM is nothing more than a new stage in the “long and tortuous history of medical pluralism at the global level”, and finds a principal explanation on the heterogeneity of the knowledge, practices and social institutions related to health and illness in indigenous communities, which is much broader than the preconceived corset of CAM’s framework. Accurately, he asks to this respect: “Where is the space for cultural diversity, beyond the surface, in regard to conceptions of life, health and sickness that are so far different? What is then common knowledge and practices of a *yachak*⁴⁸ from the Amazon basin with homeopathy (an elaborate system of healing from Germany at the end of the 18th century/beginning of the 20th century) or with the traditional medicine of China?” (2006:421, t. sp.).

⁴⁸ Qe. “The person who knows”. THPs from the northern area of Ecuador (Imbabura). The formation of a *yachak* consists of long learning processes with different teachers, who very often belong to different ethnic groups and healing traditions which include, among others, the *ayawaska*, the guinea pig healing and herbalism (cf. Knipper 2006:416).

Probably in trying to avoid conflicting priorities and threatening privileges of health professionals and policy makers, conceptual frontiers were introduced that should be established according to the criteria of proximity-distance between traditional and scientific or academic medicine (WHO 2008b). In order to assure and facilitate the applicative access to traditional knowledge (TK) by MDs –not including the contrary way– the incorporation of training courses on TM and specific “intercultural” programmes in universities have entailed. The basic argument was that the integration of TM into HCS at country level requires a better understanding of the specific role of TM by health professionals. Thus, health science institutions should incorporate aspects of TM into the training curricula of health professionals, and embark on continuing education and skills development programmes related to these issues (WHO 2000a:4). This coincides with the fact that HCSs worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers.

Through the increase of communicable diseases due to global and regional migration there is a global call for attention to specific reforms in the structures of human resources education in health (Frenk 2010, AAMC 2011⁴⁹). Although human resources are the most important assets of any health system, problems associated to health professionals training in Latin America have for decades limited the efficiency and quality of healthcare attention. Some countries have proposed the implementation of special medical educational programmes to surpass the lack of intercultural skills; such is the case for Cuba and Mexico, and by focusing on the rural healthcare attention and the implementation of community medicine at the front (cf. Picaroni 2008). In addition to teaching about tropical diseases and providing cross-cultural training, medical schools could also offer courses on international public health, medical anthropology, and global health economics (Drain et al. 2007:229). Although research evidence based principally on ethnographic examinations of cultural competence training highlights recent efforts to develop more nuanced approaches to teaching “culture” among health

⁴⁹ In the medical college admission test to be launched in 2015, the Association of American Medical Colleges considers in chapter 7 a Critical Analysis and Reasoning Skills section, which address topics from disciplines in the social sciences and humanities such as ethics, philosophy, cross-cultural studies, and population health (AAMC 2011:129-146).

professionals (Jenks 2011:209), there are still enough problems when translating such competences into the practice.

Among international policies, a proper scenario to achieve this is provided by the development and advancement of what I call the “botanical approach of TM”. According to this, the study of traditional healing practices should be primarily focused on the evidence-based application of botanical knowledge (WHO 1989); the prescription and use of herbal products, derivatives, and compositions shall be a standard set of techniques that could be managed by conventional medicine specialists (cf. WHO 2006). Emphasis is placed on safety, efficacy, and security in the use of herbal medicines in terms of the allopathic medicine (WHO 2002a:45-46), proscribing cultural aspects: “Generally, cultural rootedness and the widespread use of TMS may indicate safety, but not the efficacy of the treatments especially in herbal medicine where tradition is almost completely based on remedies containing active principles at very low and ultra low concentrations, or relying on magical-energetic properties of the sun, moon, etc.” (Firenzuoli and Gori 2007:37-38). So it is called to attention that for policy makers and health managers, TM signifies only the knowledge and management of herbal medicines, which has been privileged over other social, symbolic, and cultural aspects of healing.

The permanent interest of the WHO on the pharmaceutical benefits of the production and commercialisation of herbal medicines confirmed this assumption. A resolution submitted at the end of the 1960s highlighted the importance of medicinal plants in the policies of medical systems in developing countries (WHO 1969). As long ago as 1975, the Program for Collaborative Research in the Pharmaceutical Sciences (PCRPS) of the University of Illinois in Chicago (USA) created a database called NAPRALERT (Natural Products Alert) which contains information from more than 75,000 scientific papers and books on chemical, pharmacological, and ethnopharmacological studies on herbal medicines⁵⁰, and which provides information on these topics to researchers around the world. The most requested items include ethnobotanicals (Latin names of plants, ethnomedical uses, etc.), the results of tests with extracts of plants,

⁵⁰ See: <http://www.napralert.org/>

microorganisms and animals, and secondary chemical constituents extracted from these sources. Afterwards, in 1988, the First International Consultative Meeting on the Conservation of Medicinal Plants was carried out in the city of Chiang Mai, Thailand, under the sponsorship of the WHO, the International Union for the Conservation of Nature and Natural Resources (IUCN) and the World Wide Fund for Nature (WWF). The declaration calls for international cooperation to establish programmes of conservation of medicinal plants, and highlights the efforts to avoid the continuing alteration and loss of crops of indigenous peoples, who often have the key to find new medicinal plants with the capacity to benefit the world community and future generations (cf. Akerele, Heywood and Synge 1991).

Although a clear distinction between “herbal medicine” and “traditional medicine” was proposed by the WHO in some reports (cf. WHO 2002a), herbal medicines are considered by the WHO at the present as a common medication therapy, i.e., a shared territory, both of TM and CAM (WHO 2004:7). And, although herbal medicines are considered by the WHO principally as based on plants⁵¹, however, “in some countries animal, mineral, or other materials may also be used”. In these cases, “regulations should be specifically tailored to address each country’s unique situation” (WHO 2004:7).

An evaluation plan of work for the years 2000-2001 and 2002-2003 launched in 2003 evaluates policies on the regulation of medicinal plants based on several workshops with governmental ministries of health, NGOs, health agencies, academic institutions, and policy makers of America and the Caribbean, carried out between 1999 and 2001 (WHO 2003:2-3). The document entrenched the recognition and contributions of indigenous medicine, and established partnerships and collaborations with “institutions with prestige and expertise in indigenous medicines”⁵² (WHO 2003:15). The guidelines suggested a plan with priority actions that should have been implemented in 2001-2005

⁵¹ Herbal medicines include “herbs, herbal materials, herbal preparations and finished herbal products that contain as active ingredients parts of plants, or other plant materials, or combinations thereof” (WHO 2002a:1).

⁵² The report does not establish directed collaborations with indigenous organisations. These are mentioned as “experiences” that “will be an asset” (WHO 2003:15).

and demands from states members the establishment of frameworks to promote the integration of TM/CAM into the national HCS (WHO 2003:10-11).

Although the attempt to incorporate indigenous perspectives, medicines, and therapies into PHC was conceived of as one of the strategies for harmonizing indigenous health systems with the conventional health system, the priorities are settled on the creation of policies and programmes to promote the use of TM/CAM, the accuracy of mechanisms on regulatory and quality standards of use (evidence-based, herbal medicine and products), the dissemination of information, and the implementation and affordability of TM/CAM for poor populations (WHO 2003:10-11). The programme asserts a distinction between the terms *incorporation* used as a synonym for association, inclusion, or access, and *harmonisation* as conciliation, interrelation, consensus building, or mediation (WHO 2003:1). The programme aims to achieve the harmonisation of laws, concepts, and practices. In the first case, the legal framework-policies, laws and regulations should be adapted to the socio-cultural characteristics of the indigenous peoples; moreover, it is necessary for the official recognition of the contributions of indigenous THS to the maintenance and restoration of a population's health. The harmonization of concepts aims at the recognition of indigenous knowledge, practices, and health resources as health systems. The harmonisation of practices is considered a process that promotes the formulation and implementation of models of care taking into account the social and cultural characteristics of the beneficiary population, their community resources, and their specific epidemiological profiles (WHO 2003:2).

The importance of protecting indigenous rights among the intellectual property system approached by the WHO in 2008 situated this problematic as a priority directly connected to PH issues: "International negotiations on issues related to intellectual property rights and health should be coherent in their approaches to the promotion of public health... Intellectual property rights are an important incentive in the development of new healthcare products. However, this incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain" (WHO 2008:8). This alignment is specifically

contained in the “Global strategy and plan of action on public health, innovation and intellectual property” (WHO 2008) which is based, in turn, on prior studies, plans, and meetings reports (WHO & WPRO 2000; WHO 2000a; Correa 2002; WHO 2002a; WHO 2003; WHO 2005a) and that has been reinforced in further declarations and instruments (cf. WHO 2008a; WHO 2009; WHO 2010:16-23; WHO 2011) approaching this “universal appeal”. Summarized, the disposal asserts that TM should be further developed based principally on research and innovation. In regard of research, the global strategy foresees an implementation platform for the period 2008-2015 in which stakeholders, such as governments, WHO state members, international organisations, national and regional regulatory agencies, research institutions, academia, etc., should collaborate to this plan of action (cf. WHO 2008:23-47). The plan must succeed basically in terms of: “(a) setting research priorities in traditional medicine; (b) supporting developing countries to build their capacity in research and development in traditional medicine; (c) promoting international cooperation and a ethical conduct of research; (d) supporting South-South cooperation in information exchange and research activities; and (e) supporting early-stage drug research and development in traditional medicine systems in developing countries” (WHO 2008:24).

The focussed priority on research agendas linked to the innovation of traditional medical knowledge in relation to intellectual property rights promotes the feasibility access to TK information “as prior art in examination of patents, including, where appropriate, the inclusion of traditional medicinal knowledge information in digital libraries” (WHO 2008:15). The principal purpose is to avoid the appropriation of indigenous heritage, which is affirmed in the document to be relevant to PH care in developing countries. In relation to regulatory policies, the plan specifies encouraging research and development in TM in accordance with national priorities and legislation, but also “taking into account the relevant international instruments, including, as appropriate, those concerning traditional knowledge and the rights of indigenous peoples” (WHO 2008:24-25).

It is an usual assertion that modern medical professionals are reluctant to accept the integration of TM and THPs on HCS and in the daily practice of medicine. The WHO

explains this rejection in terms of technical handicaps: “rejection is even more intense when it is added to the absence of a rational and widespread use of the procedures of traditional medicine...the training of professionals who practice traditional medicine is not yet strong enough” (PAHO 1990:78). A World Health Assembly resolution passed in May 2009 by the WHO member states urges national governments to respect, preserve, and widely communicate traditional medicine knowledge while formulating national policies and regulations to promote appropriate, safe, and effective use, to further develop traditional medicine based on research and innovation, and to consider the inclusion of traditional medicine into their national health systems (WHO 2009a). It also urges member states to cooperate with each other and to share knowledge while working to strengthen communication between conventional and traditional practitioners (Robinson and Zhang 2011:1).

The emphasis on strengthening harmonised PHC policies among member states considering the protection of TK, and the eradication of health inequalities and the social determinants of health in the policies approached, was set forth and enhanced by the WHO during the last five years. The perspectives for the next ten years is based on finding creative solutions that will have to build on alliances with local authorities, civil society and consumer organisations with the use of growing funds, social security contributions, funds from municipal authorities and tax-sourced funding in order to create a PHC offer that acts as a public safety net, as an “alternative to unregulated commercial care, and as a signal of what trustworthy, people centred healthcare can look like” (WHO 2008b:108). Nevertheless, a study on health system inequalities and poverty carried out in collaboration with the World Bank’s EquiLAC Project and the United Nations Development Fund (PAHO 2011) asserted that a more technocratic PH policy approach may be a better way to decide on policies and make healthcare services more conducive to breaking the cycle of disease and poverty, based mainly on cultural prejudices about indigenous peoples. The report asserts that low-income groups may not perceive symptoms of illness as poor health status, and suggests that “demand-oriented policies relying on peoples’ perception of illness or health risks may not be the best way to decide on the type of services a community needs to address actual health problems” (Suárez-Berenguela 2000:3). Anyway, in the meeting of the WHO’s Board (WHO

2012a) regarding the compromises adopted by governments and ministries of health at the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil, in October 2011 (WHO 2011) the resolution advocated the WHO to adopt the social determinants approach on health in the ongoing reform process of the WHO concerning reducing health inequalities (WHO 2012a:11). In the mentioned document, only one point refers to the strengthening of healthcare access for indigenous peoples and the implementation of according policies (WHO 2012a:8), which clearly demonstrates a growing focus on the social determinants instead of the cultural ones.

Essentially, the discourse on TM submitted by the WHO during the last thirty years has been established on the basis of some core common factors. Always in view of the shortage of health professionals working in rural areas, it has stressed:

- (1) The recognition of the importance for governments in the appointment of existing local resources (THPs) for healthcare attention;
- (2) The circumscription of use of TM at the first level of healthcare attention (PHC); and
- (3) The identification of its applicative techniques, in comparative basis, as chronologically older and qualitatively different as the ones used by scientific medicine.

With this brief analysis of the WHO submissions regarding botanicals and TM regulations, I do not want to deny the important contribution of the WHO concerning the protection of medicinal species of indigenous peoples. However, the need to rescue information about medicinal plants shows that it has been accepted that cultures cannot be easily rescued from the fierce development of the market economy (WHO 1987). In the WHO's efforts, an authentic concern for the imminent loss of the information that many cultures and communities still own can be observed (cf. WHO 1988), and urgently commends member states since the beginning of policies statements on herbal regulations for the creation of classifications, nomenclatures and inventories of herbal medicines (cf. WHO 1978c). All that confirms a sustained and committed interest that, anyway, could also have been done due to pragmatically reasons: "a common denominator among many healers is their use of medicinal plants in their treatments. This common factor can be used as a base for improving their skills in identifying

herbal plants, collecting and preserving specimens in sanitary ways, and prescribing and utilising medicines in safe and consistent ways” (WHO 1995:9). Notwithstanding, this development constitutes, indeed, a declaration of defeat by the Western economic system, from which the governmental Westernized HCS worldwide is organised. Besides local economic and political reasons, this system is not only insufficient to provide well-being and contribute to human development, but also tend to blight botanical traditional knowledge. This approach also confirms that it is almost imperative to rescue what it is not able to be rescued, before it, both culturally and physically, dies (Roersch 1993:4). By any means, the superposition and over-attention given to this model by the principal international health agency in the world has direct consequences on the elaboration of national health policies in member states. Recent reports show that over the last 20 years, the requirement on the establishment of laws and regulations on herbal medicines has found major acceptance within member states as the comprehensive creation of national policies on TM and CAM (WHO 2005a:25).

An interesting emerging concept within the analysis of the official documents is the tendency to underline the opposition between cult and popular practices in defining TM. Accordingly, the institutionalization comes across necessarily through the differentiation between what is academic and the other forms of acquiring knowledge on health, i.e., traditional or non-academic. Golte highlights the fact that there is a close connection between academic medicine and the pharmaceutical industry. He argues that the first thing that would be necessary to discuss is whether some qualitative difference between academic and non-academic knowledge really exists, when in some societies the appropriation of non-academic knowledge is then declared as academic, and goes over to the Western property rights system. “Curiously”, Golte says, “in those states in which these knowledge keepers live, the governments do not defend the intellectual property rights of the creators of this knowledge, but create, instead, institutions to protect the intellectual property of those who have turned this traditional knowledge into an academic one...It would be difficult to find a difference between two forms of knowledge if we remain in the ambivalence of the curative properties of a plant on the one hand, and its extract, on the other” (2009:312, t. sp.).

In a similar way, the postulate asserting that the condition of authentication or legitimisation of a healer should be done principally in terms of his/her community identification as such among the own local population, could be also revisited in its applicability in modern times. When we make a consultation by a MD for the treatment of complains, we know mostly nothing about his or her person, or wherever he/she is reputed and worthy among his/her own community of origin. We *assume* that the MD is competent and reliable, because he/she holds a university degree, and universities and medical centres are social legitimated spaces for training and medical practices among Western –and Westernized– healthcare structures. Thus, the conferred “community-authority” criteria in case of THPs could be applied to healers who are not moving from their own communities, but it could be difficult to use the same criteria for THPs who work along several communities or, inclusive, throughout regions. In the last case, acknowledging their expertise by binding their abilities to specific geographical spaces could not necessarily match the range of their knowledge process and itineraries as experts in population’s health. To this respect, the scientific and historical literature is full of data, including chronicles, ethnographies and reports, attesting to the constant exchange and transit of healers along other communities in the Andean region, also at the time of their initiation process⁵³ (cf. Arriaga 1920 [1621]; Valdizán and Maldonado 1922; Dobkin de Rios 1970, 1992; Garcilaso de la Vega 1976 [1609]; Gushiken 1979; Pedersen and Coloma 1983; Giese 1989; Cárdenas 1990; Gow 1994; Frisancho 1999; Millones 2002, 2008; Baumann 2003; etc.). This invariable transmigration and high mobility has its best representatives in the Kallawayas from Bolivia. The cronista Guamán Poma de Ayala (1980 [1615]) and the Bolivian researcher Oblitas Poblete (1963) found references to the important medical and ritual functions that the Kallawayas⁵⁴ had in the court of the Incas in Cuzco⁵⁵. According to Van Kessel, the Kallawayas were appreciated as healers also outside the limits of the region where they lived (1993:21-22). Furthermore, research has shown that the expectancies and trust of a

⁵³ THPs who have participated in this research informed of a transcultural learning process and regularly exchange with curanderos of other THS and other regions, in and outside of Peru (fq/2009, 2010).

⁵⁴ Itinerant group of Bolivian THPs who travel through Latin America offering their services. According to Oblitas, the right expression is *Kollawayas*, a group inhabiting a region with ca 2,000 persons (Chajaya, Canlaya, Wata Wata, Inca, Chari and Curva) and having its own language, the *Machchach-Juyai* (Oblitas 1968:13-14).

⁵⁵ The context of introduction of the kallawayaya medicine in the Inca Empire has been done within an imperialist colonization system (mitimaec) and not necessarily as product of a voluntary exchange, however. Anyway, the knowledge transfer of healers was well established and continues nowadays.

given “traditional” peasant community in relation to foreign THPs rely more on their effectiveness as on their origin (Wörrle 2002; Knipper 2003:132; Aliaga iw/2009). These scholarships give evidence of a systematic cultural practice in which the indigenous populations receive healers from other regions or traditions and make use of their medicines just as well as theirs.

Regarding the political position of the international community represented by the WHO, I want to cite here a call by Professor Appadurai (2002) ten years ago. Like other scholars, he puts into question the intrinsic pertinence and value of the international standardisation programmes promoted by the WHO, and asks if this could make sense in the current global political and economical context: “Those who today speak on behalf of the international community must tackle the following challenges: Can notions of global equity, peace, and freedom remain regulated by the relations between nations, when markets, migrants, and money have all slipped substantially beyond the control of the nation-state? Can the world continue to behave as if covenants between nations exhaust the limits of what happens with air, water, land, and all other biological resources, when the fate of the environment is clearly affected by transnational processes, interests, and profit-making strategies? Can the world continue to behave as if nations are the most significant receptacles of large-scale loyalty in a world where various forms of religious, moral, and political affiliations are plainly transnational in scope?” (Appadurai 2002:43).

2.3 Regional context

The Andean countries have undertaken some initiatives to confront common public health problems through the entrenchment of PHC programmes in the region. To this respect, a first Meeting of Ministers of Health of the Andean region was held in Lima in December 1971, with the participation of Bolivia, Colombia, Chile, Ecuador, Peru, and Venezuela. In this meeting, the attendant countries declared the creation of the *Organismo Andino de Salud* ORAS (Andean Health Organisation) as a first step towards a coordinated regional policy network for health.

In a second meeting in 1974, held in Caracas (Venezuela), they signed an additional convention protocol that complements the purposes of the ORAS, the *Hipólito Unánue* Convention (CONHU). Since 1998, the CONHU is attached to the Andean Integration System⁵⁶. The meetings led by the Ministers of Health of the Andean Area (REMSAA) have an executive secretariat with permanent headquarters in Lima. The lines of action established by the ORAS/CONHU foresee the development of several health programmes upon five strategic thematic areas. The axis includes:

- (1) Health Integration Axis, which includes the Integration Addenda, the Health Program on Frontiers PASAFRO, the Project for Malaria Control in countries frontiers, with a community health approach PAMAFRO;
- (2) The Epidemiological Screen, with the Andean Network of Epidemiological Vigilance and the Andean Network of Public Health National Institutes;
- (3) Access to medicines, including Policies and Access;
- (4) Human Resources on Health;
- (5) Universal Health Systems covering Economy and Health, and Evaluation of Sanitary Technology; and

⁵⁶ The Comunidad Andina is a regional network of four countries (Bolivia, Colombia, Ecuador, and Peru) with five associate country partners (Chile, Argentina, Brazil, Paraguay, and Uruguay) signed in the Cartagena Agreement in 1969. The goal is the improvement of peoples' standard of living through integration and economic and social cooperation among countries. See: <http://www.comunidadandina.org/endex.htm>.

- (6) Social Determinants on Health Axis, with programmes in Social Determinants on Health, HIV/AIDS, Intercultural Health, Prevention of Adolescents Pregnancy Program, Eradication of Child Malnutrition, and Disability.

In the area on Social Determinants on Health, the ORAS/CONHU seeks to ensure that PH policies and programmes in the Andean sub-region are oriented and carried out following the approach of the social determinants on health. The Program of Intercultural Health, directed by the Andean Commission on Intercultural Health⁵⁷, is the principal organ responsible to promote the exchange of policies among the region; to provide assessment and support to member countries for the development of coordinated policies on indigenous health; the medical and health professionals formation on intercultural issues; and the suitability of integration approaches of TM in HCS. It is important to note here that resolutions and recommendations adopted by the Commission or Meetings of Ministries of Health have not a binding character, i.e. their suggestions or agreements would not necessarily provide concrete directives in terms of legally procedures on the national policies of the respective countries (cf. SELA 2010:7).

At the First International Seminar on Intercultural Health held in July 2005 in Huamanga (Ayacucho, Peru) organised by MINSA and the Project AMARES⁵⁸, the ORAS requested the Ministers of Health and Social Protection to designate specific national focal points for the actions of intercultural issues to participate in this event (ORAS/CONHU 2006:12). During the seminar, the focal points designated by the Ministers of Health and Social Protection proposed a next meeting to study the establishment of an Andean Commission of Intercultural Health, to be held in the same year in Chile. The need to adopt measurements to tackle the problem of existing gaps in the health conditions of non-indigenous and indigenous populations, and its alarming indicators, was raised by the Minister of Health of Peru Pilar Mazzetti Soler, in the

⁵⁷ See: <http://www.orasconhu.org/areas-accion/comisi%C3%B3n-andina-de-salud-intercultural-0>.

⁵⁸ Programa de Apoyo a la Modernización del Sector Salud y Aplicación en una Región de Perú / AMARES, Financial Convey between the European Union and Peru (PER/B7-310/IB/97/209) carried out between 2002-2007. Principal purposes of AMARES were to support the implementation of the health reform at the national level, but with special focus on the regions of Ayacucho, Huancavelica and Apurímac.

XXVI Ministers' Meeting of Health and Social Protection of the Andean Area, celebrated in Santiago de Chile in March 2005. The outgoing resolution XXVII/417 from March 2006⁵⁹ signed in Colombia ratified the constitution of the Andean Commission on Intercultural Health and solicited to the Executive Secretariat of the ORAS-CONHU the coordination for the Andean Plan for Intercultural Health.

The first recommendations proposed for the Commission were to designate a representative for each country to constitute the Andean Commission of Intercultural Health; to prepare a database of the officials responsible for the actions of interculturality of every department, as well as on the experiences, and successful and not successful strategies on this topic; to propitiate the transversal incorporation of an approach of interculturality in all the actions integrating the plan of actions for the social development (PIDS); to count with the support of the ORAS and the Covenant Hipolito Unanue for the coordination and financial search to develop the mentioned activities (ORAS/CONHU 2006:12). The resolution XXVIII/432⁶⁰ approved the plan⁶¹.

2.3.1 The Andean Plan for Intercultural Health

The *Plan Andino de Salud Intercultural* (Andean Plan on Intercultural Health) was submitted by the commission in 2008 (ORAS/CONHU 2009a). In a first stage, the Plan suggested, among other activities, the incorporation by country members of epidemiological indicators and variables, such as the ethnic differentiation in the information's system of the countries. The development of training modules for health authorities, service providers, and communities to promote the acquisition of strategic intercultural skills; and the dissemination and exchange of information on existing legal frameworks to identify rules needing to be updated were also considered. Additionally, a special focus was placed on the endurance of legal devices to protect and promote the strengthening of TM in the Andean sub-region (ORAS/CONHU 2009).

The Andean Plan follows within their strategy 2009-2012 the evaluation of indicators of the objectives proposed and the identification of specific health attention needs by

⁵⁹ See: <http://www.orasconhu.org/documentos/REMSAA-XXVII-417.pdf>

⁶⁰ See: <http://www.orasconhu.org/documentos/Resolucion%20xxviii%20432.pdf>

⁶¹ See: <http://www.orasconhu.org/sites/default/files/SALUDINTERC1.pdf>

populations located in the geographical borders of the member countries (ORAS/CONHU 2009a:42-45). Yet on 6th December 2011, on the basis of the Declaration issued during the Regional Meeting on Intercultural and Reproductive Health of Indigenous Women in Latin America from the 30th of June 2011, the Ministers of Health and authorities of the Andean countries have identified that for the achievement of the Millennium Development Goals related to the reduction of maternal mortality it is necessary to improve the quality of care services with the adoption of an intercultural approach (ORAS/CONHU 2011a). The implementation of corresponding policies should respect the diversity and complementarity between health systems, with special emphasis in the maternal healthcare services, ensuring the access of women, particularly indigenous women, to information and health services. Due to these considerations, the Board resolved as lonely clause to instruct the Andean Commission of Intercultural Health for the elaboration of an Andean Policy of Intercultural Health that includes the recognition and adoption of the ancestral knowledge in health systems, the adequacy of health services, the incorporation of the variable ethnicity in the information's systems, the optimization of the human resources at the pre- and postgraduate level with skills in intercultural exchange, and to contribute to the reduction of the maternal mortality of indigenous women (ORAS/CONHU 2011). This plan should become a strategic tool for the Ministries of Health, in order to help them address the mentioned issues as important social determinants on health, and to ensure the right of healthcare access of the indigenous population.

The following reflections illustrate the standardisation trend and the conflicts existing by setting priorities on integration policies submitted by Andean governments in the last decades, which are principally oriented to obtain financial support from international agencies. In a discussion paper prepared for a seminar on Indigenous Peoples and Health, held at the Inter-American Development Bank in Washington D.C. in February 2001, the authors discuss the frameworks to be considered by the Bank in financing intercultural settings in the health sector. The specialists state that bank financing for indigenous medicine must respond to identifiable health problems that have relevance and priority for the country's health sector strategy: Bank operations that propose to study, incorporate, or support indigenous medicine should demonstrate the need for

such treatments or practices in terms of identifiable health problems in the beneficiary population, expected efficacy of the treatments or practices, and insertion in the country's national health strategy (Perafán and Savedoff 2001:3). The community of indigenous practitioners is considered a legitimate source of expertise regarding these criteria. Anyway, in practical terms, so the authors, studying, incorporating, or supporting indigenous medicine would then be carried out most effectively if they benefit from and contribute to larger health sector operations as a component or subcomponent of such operations. According to that, there seem to be three major areas where there is no "clear agreement" among state proposals: the priority setting; the criteria used to determine legitimate medical practices; and the general scope of the health sector. Finally, the authors ask what range of ailments is considered to be within the scope of health sector operations: "Many of the ailments treated by bonesetters, midwives, and curanderos are similar to ailments treated by Western medical practitioners. Should these be incorporated into public health systems? Should national health systems address the kinds of ailments treated by shamans?" (2001:8).

Effectively, a report of the WHO Region of the Americas (WHO 2005a) found that there are considerable differences among policies and regulations that were developed in the region regarding TM. Many countries have regulation and registration systems for herbal medicines; though the number of countries developing laws, regulations or national policies on TM and CAM is comparatively small. Interestingly, the number of countries that have expert committees, national research institutes and national offices without a national legislation is higher in comparison to those without surfacing academic infrastructure and research institutes. According to this report, this could mean that such policies and regulations are being developed or will be in the future (WHO 2005a:74).

As a result of the new Political Constitutions of some countries, like Ecuador and Bolivia in recent years, new structures of political decisions sensitive to intercultural perspectives on health have been raised. In Ecuador the National Board on Health for Indigenous Peoples, and in Bolivia, the Vice-ministry of Traditional Medicine and Interculturality. Due to its importance in making visible the chronological development

of policies in this Andean sub-region, from a radical to a mild-inclusions paradigm model, the integration policies in Ecuador and Bolivia will be briefly discussed in following, though not exhaustively.

2.3.1.1 Ecuador

As different as in other Andean countries, in Ecuador the concept of “interculturalidad” was born and developed in the bosom of the indigenous movement, and as basic opposition to the hegemonic political discourse prevailing in international health agencies. This throughout autonomic and, at the same time isolated proposal, seeks the incorporation of other ways of thinking in governance issues and policies, and were conceived far different from the colonial discourse with the principal purpose to restructure the state and its institutions at its roots. The *Confederación de Nacionalidades Indígenas del Ecuador* (Confederation of Indigenous Nationalities of Ecuador - CONAIE) raised a project on interculturality as an alternative model for a pluralistic society, as an ideological opening to an alternative restructuration process of the state and its policies. A recent consolidation of this community-basis-sustained development could be seen in the consolidation of the *Plan Nacional para el Buen Vivir 2009-2013*, approved at the National Planning Council of Ecuador on the 5th November of 2009⁶². This National Plan for Good Living proposes direct civilian participation, a model inspired in the Andean Quechua concept of *sumak kawsay* (life to the fullest), and in direct opposition to the international agencies promoting the concept of “human development” (UNDP 2010:12-14). The programme aims at the involvement of the different Ecuadorian social relegated groups in strategic political decisions, in health governance, international politics, the development of an own economic model, etc. (SENPLADES 2010:17-25).

Between 1993 and 1994, the Ecuadorian state began with the first concrete efforts in order to structure a special division on indigenous health. In the Constitution of 1998, Ecuador was declared a “multicultural and multi-ethnic” state, and adopted a series of collective rights to indigenous and Afro-Americans communities, including the

⁶² See: <http://www.senplades.gob.ec/web/18607/plan-nacional-para-el-buen-vivir-2009-2013>

implementation and development of TM. In response to one of the policy proposals regarding indigenous health formulated by the indigenous movement, the Articles 44 and 84 of the prior national constitution⁶³ established the *Dirección Nacional de Salud de los Pueblos Indígenas* DNSPI (National Health Board for Indigenous Peoples), founded by the Ministry of Health on 1999. To that time, the DNSPI should perform the mission established in the article 44, the promotion and development of THSs in Ecuador. This governmental institution explicitly coordinates with Ecuador's indigenous organisations and partners, principally with the Confederation of Indigenous Nationalities of Ecuador (CONAIE).

With respect to the integration model proposed by the DNSPI, Knipper calls to attention the great importance attached to the “men of wisdom”, also referred to as “men of medicine” and healers accredited by their own communities (2006:419). In the case of the indigenous Quechua-speakers, Knipper says, it would be precisely the yachak that fall into this category as explicitly “medicinal”, while all the competences of the men of wisdom, who have nothing to do with health and disease, are relegated to a level of minor importance, such as the “other traditional therapists” like parteras, curanderos, etc. (2006:419). Knipper notes that the key element content on the policy considering TM as indigenous is that the indigenous health system includes the THS of individuals of each ethnic group. Each system consists, according to the definition of the DNSPI, of the set of knowledge, technologies and healers, based on ancestral wisdom, with practical diagnostic, and treatment of diseases, prevention and health promotion, health and intercultural relations in Latin America. The DNSPI was replaced in 2006 by the National Direction of Interculturality, Rights and Social Participation in Health at the Ministry of Health, and now, in a minor level, by the *Subsecretaría de Pueblos e Interculturalidad* (Office of Population and Interculturality)⁶⁴ which shows at the present the addition of CAM to the concept of TM in Ecuadorian policies.

⁶³ That was the second last constitution. The constitution in force (2008) guarantees also in art. 57, nr. 12 the protection of TM, with a novelty inclusion of their right to recovery, promote and protect their sacred places. See: http://www.asambleanacional.gov.ec/documentos/constitucion_de_bolsillo.pdf

⁶⁴ See: <http://www.pueblos.gob.ec/?p=category/programas-servicios/subsecretaria-de-pueblos-e-interculturalidad>

In exploring the relationships between the community and the conventional modern health services and non-formal health systems in the region Ibambura, Pedersen and Coloma (1983) report the efforts of the Ecuadorian public health sector in undertaking an active search for some new ways of expanding the provision of health services to the population. Nevertheless, there was still non-acceptance of TM and its practitioners: “Its present strategy is based on the implementation of primary healthcare programmes with a view to satisfying basic health needs, thus generating active participation of the community in dealing with their own health problems... The proposed strategy tends to ignore the conceptual, ideological and cultural basis of illness and disease, and to underestimate or subordinate popular and traditional medicine practices, discarding the participation of those elements of the non-formal health system who are at present solving a considerable proportion of health problems” (1983:1254).

In 1983, in attending the initiative of the Indigenous and Rural Federation of Imbabura (FICI), the Health Centre *Jambi Huasi* was founded in the city of Otávalo, located 90 km from the capital Quito, with ca 40,000 mostly Quechua speaking inhabitants. The creation of *Jambi Huasi* embedded a goal of the FICI, which was to support the work of indigenous professionals trained in biomedicine to attend to large unsolved health problems of the community. The centre was originally conceived as a clinic with ambulatory patients offering first care services of both academic and indigenous medicine, for free. On the part of the indigenous specialists, there were available *yachaqs*, *parteras* and *fregadores*⁶⁵ for patient attendance, and the cleaning with the guinea pig was also part of the weekly performances in the centre (Droz 1997:93-94). It offered also the attention to non-indigenous, alternative therapies, such as Chinese massage and acupressure (Mignone, Bartlett and O’Neil 2006:107-108).

In a first period, from 1983 to 1992, the organisation provided free health attention for both urban and rural indigenous peoples (FICI 2009). Since its foundation in 1983, due to difficulties within the FICI and financial and infrastructural contingencies, the centre was closed on several occasions, to be finally re-opened in 1992. During its second

⁶⁵ Also known as *sobador*. A traditional specialist using manual techniques to relocate skeletal muscle complains or spasmodically related diseases. In some regions a *sobador* or *fregador* is also syndicated to use the guinea pig.

period of existence (1994-2005) the centre promoted itself as an intercultural health service (“Foundation of Alternative Medicine Jambi Huasi”), and also offered attention to non-indigenous, mestizos, and Afro-Ecuadorians. Over the time, it has successively implemented additional areas linked with the promotion of health, education, and research. In addition to the healthcare service, the centre also offers trainings in prevention, and leads advocacy activities between the Ecuadorian government and the community of Otávalo. In 1994, the director of Jambi Hausi, Myriam Conejo, a Quechua woman, and the *Jambi Huasi’s* team presented their project to the United Nations Population Fund (UNFPA), with whose approval economic support for the centre to develop a specific programme, called “Integrated Healthcare for Indigenous and Peasant Women of Imbabura”, thus, from that date to 2006, *Jambi Huasi* focused on a programme of sexual and reproductive health (Erazo 2008:11-12). The programme offers consultation by general MDs, dental service, and “culturally adapted” childbearing attention. Interestingly, and according to some recently statistics, half of the mestizo patients attending the centre call on THPs for attention, while the indigenous patients consult a MD or a dental surgeon (Campos 2004:144). For Campos, the first explanation for this tendency would be that the indigenous patients have the healers in their own quarters and communities and they wish the medical attention in a suitable intercultural setting, while mestizos have also a space where the indigenous medicine is endorsed and socially legitimate for a recognised sanitary institution⁶⁶.

The experience with Jambi Huasi has been presented over the years by local and regional PH policy specialists and international agencies as an example of best practice on intercultural health, arguing that Jambi Huasi’s system protects cultural and linguistic features of local communities by combining traditional and conventional biomedicine (Waters 2006:10). Its contributions to demonstrate the feasibility of intercultural health attention have been emphasised, i.e. offering patients the possibility to choose between a conventional or non-conventional therapist in a bilingual Quechua and Spanish environment (Calderón 2010:57-59), and to count on the supervision of

⁶⁶ According to some studies, biomedicine among communities is not a legitimate system per se on the basis of its sanitary certification or the possession of professional credentials; the legitimacy will be proved in each moment upon the medical-patient relationship and due to the positive outcomes of the treatments (cf. Tocornal 2006:163).

indigenous people trained as health professionals (PAHO 2002:38). However, the initiative has also found critics among researchers and PH specialists. Wörrle notes, concerning the integration of both medicines, that the project itself is, in spite of all positions, rather a by-side work than a real cooperation: The “X-ray with the guinea pig is for doctors, in fact, as irrelevant as their diagnosis is for a yachac. Nevertheless, by one means or another, they take some advantages from each other” (2002:298, t. g.). In a mostly PH oriented evaluation of the centre, Knipper also expresses his concerns about the inclusion of care services for tourists in the centre in the last years, such as “anti-stress” packages, and discusses this development in terms of the possible increase of a dichotomy between financial incomes for the centre and the local population attendance (Knipper 2006:425-426).

Although the experience with Jambi Huasi could be evaluated in different ways, the fact is that such initiatives are started, in the most of the cases, through the arrangements between the local population with support of international NGOs and agencies. These provide the necessary technical and financial support to improve these ideas and, in doing so, also the position to sway its original purposes.

2.3.1.2 Bolivia

Although inspired by Ecuador’s theoretical model of health, Bolivia does not link the approach of intercultural health to substantial transformations of the State and its institutions. The main interest of the actual policies lies on the incorporation and reevaluation of both the languages and the medicines of indigenous groups (intercultural education), which are considered to be essential for the appreciation and inclusion of all the expressions of the subaltern cultures in the country. Anyway, Bolivia is one of the first countries that had provided specific legislation with regard to the issue of TM in the region (Ramírez 2010:60-65) which date back from 1987⁶⁷.

⁶⁷ See the Reglamento del Ejercicio de la Práctica de la Medicina Tradicional Boliviana, Resolution nr. 0231 from 1987: http://www.plantasmedicinales.org/archivos/bolivia___reglamento_del_ejercicio_de_la_practica_de_la_medicina_tradicional.pdf. A list with following legislation can be accessed here: <http://www.redindigena.net/kallawayaya/Legislacion.htm>.

The Bolivian Society for Traditional Medicine (SOBOMETRA⁶⁸) was founded in 1983 and recognised as the principal society for TM by the Bolivian government in 1984 (Campos 1997:73). However, four year later, another institution, the Bolivian Institute of Traditional Medicine Kallawaya (INBOMETRAKA)⁶⁹ was founded on April 9th 1987, in the context of the struggles for the decriminalization of the medicine, but also within the escalating conflicts upon the different groups of associated kallawayas and THPs on both big institutions⁷⁰. As soon as the institution was organised, it committed principally to qualify and train THPs with Western approaches and organise numerous meetings, in which practitioners could exchange. This mechanism was destined to preserve TM, strengthening it before the biomedical medicine threatens it across its institutions, and to promote the recognition of the importance of THS. The juridical dispositions submitted by the INBOMETRAKA served as principal sustenance for the preparation of a folder presented to the UNESCO for the declaration of the Kallawayas as part of the oral and intangible Patrimony of the Humanity, which was approved in Paris, on November 7th 2003⁷¹. Herbal regulation in Bolivia was introduced in 1996 (Law No. 1737). The legislation is partly the same as the one regulating conventional pharmaceuticals; herbal medicines are regulated in Bolivia as over the counter medicines and in their own independent regulatory category. Yet there is no national pharmacopoeia.

The *Ley de Organización del Poder Ejecutivo* (Law of Organisation of the Executive) and its regulatory Decree from February 2006 have entrusted to the Ministry of Health and Sport (SNS) specific functions on the valorisation of TM, quoting that the promotion of the TM and its articulation to the Western medicine within the framework of interculturality and the cultural adaptation of health services is one of its principal

⁶⁸ See: <http://www.sobometra.kallawayas.org/>

⁶⁹ See: <http://www.inbometraka.kallawayas.org/>

⁷⁰ In times of biopiracy, a tighter control over the circulation of Kallawaya medicinal plants and knowledge of their use has evolved hand-in-hand with power struggles over how Kallawaya medicine and culture should be represented to outsiders and by whom: “that hold is loosening with the (re)institutionalization of Kallawaya medicine and the proliferation of Kallawaya organisations at community, regional, and national levels that seek greater control of how their culture is represented” (Callahan 2011:248).

⁷¹ Rösing notes about the contradictory situation of the daily-life and conflicts among Kallawaya-Healers and their denomination as part of the world cultural heritage by the UNESCO. See: Rösing, Ina. 2008. *Der Anden-Alltag. Im Schatten der UNESCO-Weltkulturerbe-Ernenennung der Kallawaya-Kultur*. Gnas, Austria: Herbert Weishaupt Verlag.

obligations⁷². In achieving this, the Vice Ministry of Traditional medicine and Interculturality was created on the 8th of March 2006⁷³ to develop policies and programmes for the promotion of intercultural health and to rescue TM.

The *Modelo de Salud Familiar Comunitaria Intercultural* SAFCI (Intercultural Community Family Health Model) guides the National Health Policy in Bolivia since 2008⁷⁴. The principal goal of this health model is to ensure the population's universal access to healthcare (*sistema único de salud boliviano*) within an Intercultural Community Family Health single system, which is said to be equitable, caring and with efficient performance. The model is organised and managed to provide comprehensive and intercultural health services with an emphasis not on disease, but on an individual's stage in life; on diet, spirituality, and world view in terms of the socioeconomic, cultural, and geographical origin of the individual (SNS 2009a:27-29). The principles of care in health facilities are universality, solidarity, equity, comprehensiveness, continuity, respect, and acceptance of cultural health practices, consideration of the individual's decisions and desires, fulfilment of commitments to the community, and recognition of the family's environment for interventions (SNS 2010:66-81).

Although article 35, inc. I, of the Bolivian National Constitution establishes that the Bolivian HCS is unique and includes the TM of all the indigenous nations in the country, the specific law that regulates the practice of THPs considered is waiting for approval⁷⁵. In the law project for TM (Naula and Ochoa 2006), there are considered six specialities to be included in HCS: parteras, bonesetters, naturists, nutritionists, *yatiris*⁷⁶ and herbalists, which are currently in the process of official registration at the Vice Ministry of Traditional Medicine and Interculturality⁷⁷. However, the process is long-winded. Alone in the city of Cochabamba, for example, 19 THPs' associations are

⁷² Subsection G of the *Ley de Organización del Poder Ejecutivo*, Law 3351 from 21st February 2006. See complete text at: http://www.planificacion.gob.bo/files/leyes/3351_ley_lope.pdf

⁷³ Supreme Decree 28631: <http://www.sns.gob.bo/documentacion/normativas/D.S.%2028631.pdf>

⁷⁴ See: <http://www.rm-safci.gob.bo>

⁷⁵ See press-note about at: <http://www.opinion.com.bo/opinion/articulos/2012/0109/noticias.php?id=38560>

⁷⁶ The Yatiri is a traditional therapist who was selected after his/her survivor of an accident occurred in a natural context (i.e. thunderbolt). He performs diagnostic and healing, and intercedes for his patients through offerings for the tutelary beings (PAHO/IIDH 2006:20).

⁷⁷ See: http://www.sns.gob.bo/aplicacionesweb/interculturalidad/web/censo_mision.php

affiliated to SOBOMETRA, each group has an average of 25 members, which accounts for 780 members overall. It is estimated that in Bolivia ca 7,000 THPs have joined an association. All the same, by 2011 there are 1,120 THPs officially registered at the Ministry of Health in all 9 departments of Bolivia (Escobar 2011).

Regarding the work of THPs in HCS, the current policy in Bolivia postulates that the principal activities of ancestral doctors –who possess natural and spiritual gifts– are to be recognised by the community, to work autonomously in the community, to make the remittance of sick and convalescent patients to conventional physicians, or to exert themselves with MDs, but only “if the community decides it” (SNS 2009:53). The policy establishes that working with THPs in HCS does not necessarily mean their incorporation in a health centre, and to have a certain timetable allotted to work within; working with them means, on a second thought, either to coordinate, make remittances and patients counter-transferences to MDs, or to attend jointly persons, families and communities with them (SNS 2009:53).

Concrete experiences of integration of traditional and Western medicine in Bolivia, with cases of indigenous insertion of *Kallawayas*, bonesetters and midwives in HCS are present. One of these experiences is the Comprehensive Strategic Development Plan of *Ayllus* in La Paz⁷⁸ that consists of a project involving six communities in the Municipality of *Pocoata*, in the Department of *Potosí*. The objective was to build a health centre, where both traditional and conventional medicine health services would be provided and the work of THPs and midwives would be recognised. Community pharmacies and other specific actions were also implemented with the participation of indigenous students and professionals (PAHO/WHO 2009:37-39). However, these experiences have meanwhile shown a limited combination of resources and been criticised by experts on intercultural health. In analysing the case of intercultural health policies in Bolivia, Ramírez argues that in most of the cases, the term “interculturality” has been used to refer to the relation between two cultures. In case of health, this

⁷⁸ Created by Supreme Decree nr. 602 from 18th August 2010. See: <http://www.lexivox.org/norms/BO-DS-N602.xhtml>

supposes the opposition between the biomedical and the traditional culture. “This classification ascribes first to the Western culture and the second to the indigenous, as if both constitute externally isolated cultural and internally homogenous. In doing this, it denies the existence of cultural heterogeneity among biomedicine, and also within traditional medicine. Each culture owns medical knowledge, and bears knowledge of health attention and healthcare; thus, it would not be necessary to speak of indigenous traditional medicine or Western or mestizo medicine” (Ramírez Hita 2009:5, t. sp.). In the same request, Menéndez (1987) recognises that the traditional and the scientific are not plenty homogenic categories, neither closed nor static or isolated, and that they are not the only known forms of health attention used by the population.

Fernández asserts to this respect that the “experiments” trying to Westernize the indigenous medicines, by the achievement of bureaucratic tools and properly biomedical scenarios have not provided successful results. This is, on the one hand, due to the non-recognition of this “hybrid” model by potential indigenous clients, and because this model discredits and obstructs the development and efficacy of their TM. “Indigenous medicines function in their own performance’s context. And they do so because they do not need to discharge the burdens and adherences of the bureaucracy of medical systems inspired in biomedicine. In the other side, to “indianize” the biomedicine does not seem to be a feasible proposal” (2010:28, t. sp.). Furthermore, Fernández argues that the basic criteria of any intercultural approximation to health must go beyond the simple “cultural competences” of MDs’ teams working in indigenous contexts, because this requires expressive approaches of models of intercultural dialogue between all the concerned parties in health. “The biomedicine should stay with its codes and scenarios, and the indigenous medicines with theirs” (2010:28, t. sp.).

Some authors want to see in these integrations attempts in the region the development of a secure tendency of slowly disappearing use of TM for the benefit of CAM in indigenous communities and extended to impoverished non-indigenous urban groups. In these programmes the indigenous TM seems to be a mere copy of a monolithic image of Western medicine, made with a selection of indigenous elements, hierarchically

organised providers –with the “men of medicine” at the summit– specialized in the illness treatment, with a particular nosology and corresponding pharmacopeia. Examples of such appropriate extensions of Western medicine would include hiring or training bilingual staff, including indigenous communities in managing health facilities, paying attention to taboos related to gender and age differences, or modifying the design of hospitals and other facilities – e.g. “intercultural hospitals”.

In the same vein, in a study about the intercultural health situation in Atacama (Chile), Tocornal asserts that although the biomedical team presents a good disposition to the possibility to approach the Chilean TM, at the time of generating models of intercultural attention they tend to a vision of surveillance of the traditional practices. The integration with TM implies a way of directing the medical practices of the atacameños to biomedicine, and the inclusion of TM in the biomedical hierarchic and bureaucratic format. This implies, rather, a clear tendency to control the practices and to regulate them under the dispositions and expectations of the biomedical care: “They are unable to visualize the *interculturalidad* as horizontal dialogue and as an expanded alternative for health for the communities, but as a way of controlling the atacameños’ traditional practices of health. They conceive of interculturalism as a measure of control of the Atacaman traditional medicine, a supervision based on the integration, an education of traditional practitioners on how medicine should be done. This type of scenarios would swallow up the traditional medicine of the atacameños, be it so much for the intention of homogenizing the forms of attention, or due to the poor legitimisation that the traditional practices have upon the biomedical team” (2006:178-180, t. sp.).

Along these reflections, it is important to address the challenges of a policy trend founded on the concept of a mainstreamed intercultural medicine. This concept goes across the basic categories around the conscious and instructive development of “culture” and “ethnicity”, which are supposed to match, and be conceived for the needs of indigenous patients. Consequently, Knipper also points out that it is necessary to include the perspective of the methods and knowledge provided by anthropology in a reflexive way, with all its considerations about intercultural medicine, and stressing the particular contexts in which this elaboration happens: “Why do we think what we think,

for example, about the relation between “ethnicity” and medical attention? Why do we think what we think about the “traditional medicines” and the role they have, or not, in developing the “intercultural medicine” inside the systems?” (2006:413-414, t. sp.).

The research conducted by Allué et al. (2006) represents a critical vision in relation to the application of the methodology of the social sciences by clinicians (MDs, nurses) of the region in the field of intercultural health policies. For these authors, the principal task in research should be the “experience”, in which the reference to self-critical exercises in relation to the own theoretical and ideological parameters and practice would be addressed, and that this can not be improvised: “This reflexive maturation requires elaboration, at common also supervision, and most of the times it conducts to rejection, making instead necessary either a de-construction within the training’s process, or a relativization of the designed curricular goals” (2006:21, t. sp.). Alongside the historical development of qualitative methodologies, the authors analyse those utilised the most in health sector, the action-participation approach, developed in the 1930s, which was gradually replaced for the *rapid assessment procedures* (RAP). Whereas the action-participation approach concedes empowering the subjects involved in research, the RAP research occurs in a market-oriented context that principally aims at the highest production of results at low costs (Ramírez 2010a:48). The authors see in this policy research situation a big handicap, in which the RAP is designated to clinicians without formation in social sciences, and with no specific training in social or cultural qualitative fields (Allué et al. 2006:24). By all these means, these are the most used research tools by NGOs and development agencies on health in the region at the present.

But, what is about the anthropology specialists in Peru that could offer an alternative to this situation? As is the case of Ecuador, Bolivia and Chile, in Peru most of the anthropologists and sociologists joining postgraduate programmes in intercultural health and working for/in intercultural health programmes –as well as the implementation of corresponding curricula at universities– applied consistently the same approach in their research and practice. Studies in this research area follow theoretical and methodologically an empirical access, in which culture and TM are analysed in terms of

local beliefs systems, and ignoring in that the underlying socio-economical conditions and the macro-social aspects involved on health attention (cf. also Menéndez 2002). To this respect, Ramírez comes also about and asserts that most of the published articles reflect this vision, establishing a polarization between TM and biomedicine, which strengthen the concentration of the analysis between both attention forms, as if they where the only ones in the country, and reaffirm with that the complementation between them, negating the role of the social, political and economical aspects as part of this process (2009:9). The intercultural health programmes in Peru in the last decades have been also built up under these conceptions, which are analysed in the next chapter.

3 Peruvian Healthcare System

3.1 Peru: Country and People

Peru lies on the west coast of South America, has a surface of 1,285,216 km² and estimated 30,135,875 million inhabitants by 2012 (INEI 2010:25; INEI 2010b). Geographically, the country is divided into three physical regions: the coast, a long desert strip of land between the Pacific Ocean and the Andes with 20 systems of valleys; the Andes themselves; and the Amazonian Basin, a forest region east of the Andes. Peru is a plural-ethnic and multicultural country shaped mostly by mestizo population and indigenous peoples of the Andean and Amazon region. The indigenous population is the highest, with 47%; 32% of the inhabitants are mestizos and about 12% whites (INEI 2008). The ethnic minorities, about 9%, constitute the direct descendants of Chinese, Japanese, and African immigrants (Figueroa and Barrón 2005:6-7).

In the pre-colonial history of Peru, the Inca Empire marked the summit of almost 3,200 years of social progression of the different pre-Inca cultures. The Inca period constitutes per se a short period of domination, with only 300 years (from 1200 to 1532). Making a brief comparison in relation to the development chronology of the ancient cultures in Peru, Figueroa and Barrón assert that if the pre-colonial period were made equal to one hour, “the Incas would represent the last five minutes only” (Figueroa and Barrón 2005:7). Beginning in the southern Andean region, the Incas expanded their domination over multi-ethnic territories where other civilizations had developed. At the time immediately before the Incas, denominated by Rostworowski the military states, the first state hegemony was of the *Wari* (7th to 10th century A.C.), which end fosters the rise of the regional dominions from the 10th to the 15th centuries (Rostworowski 1988:21). The dominion of the *Chimor* state, which came forth in the northern and central coast, enhanced a transitional period between the Wari and the Inca hegemonies. The summit of the Inca Empire began in the beginning of the 15th century, remained incomplete due to the arrival of the Spaniards in 1532. According to Rowe (1946:185-92, cit. by Eeckhout 2004:495), in the apogee of their power the Incas dominated an

Empire constituted of 90 different ethnic groups. The Spanish chronicles inform about the expansion and domination strategies of the Incas, which included the military force and the diplomatic negotiation up to provisional alliances between the Incas and the conquered populations. It is certainly difficult to know the precise zone in which each ayllu or ethnic group was located originally, because under the Inca dominion it was common to resettle the groups in new geographical zones (cf. Rostworowski 1988:24).

The colonial period lasted about 300 years (1532-1821). Spanish colonial domination was concentrated in the coastal area of Peru (with Lima and the port of Callao as centres) and also in some parts of the Andes where mines were exploited. The Republican period began in 1821 with the official declaration of independence of the country up to today. During the first half of the 20th century, besides the African slaves introduced during the Colonia, Chinese were integrated to the country as foreign workers. Since the colonial and republican period groups of European (German, French, and Italian) and Asiatic voluntary immigrants also came to the country (Korean, Lebanese, Palestinian, Syrian and Israeli).

According to the census of the year 2007, 33.3% of the total population reside in the region of Lima and Callao, followed by Piura (6.5%), La Libertad (5.9%), Cajamarca (5.2%), Puno (4.7%), Junín (4.5%) and Cusco (4.2%), which as a whole represents more than 60% of Peru's population (INEI 2008). Lima is of big economic importance for the country, which is evident in its contribution to the national gross domestic product (GDP), in which alone Lima generates 52.2% of the total of the GDP of Peru (MINSA 2011:14). The national urban population is around 76% of the registered population. The regions with a bigger percentage of urban population (more than 75%) are Lima and Callao with 98%, Tacna (91%), Tumbes (91%), Arequipa (91%), Ica (89%), Moquegua (85%) and Lambayeque with 80% (INEI 2008). On the other hand, those cities with a rural population bigger than 65% are Huancavelica (68%) and Cajamarca (67%). Regarding the age distribution, men constitute 50.3% of the Peruvian population and 49.7% are women. 23.9% of the population are children (under 12-years-old); 12.6% teenagers (12 to 17 years); 21.5% young (18 to 29 years); 32.8%

adults (30 to 59 years); and 9.1% correspond to major adults (60 to more years) (MINSa 2010a:14).

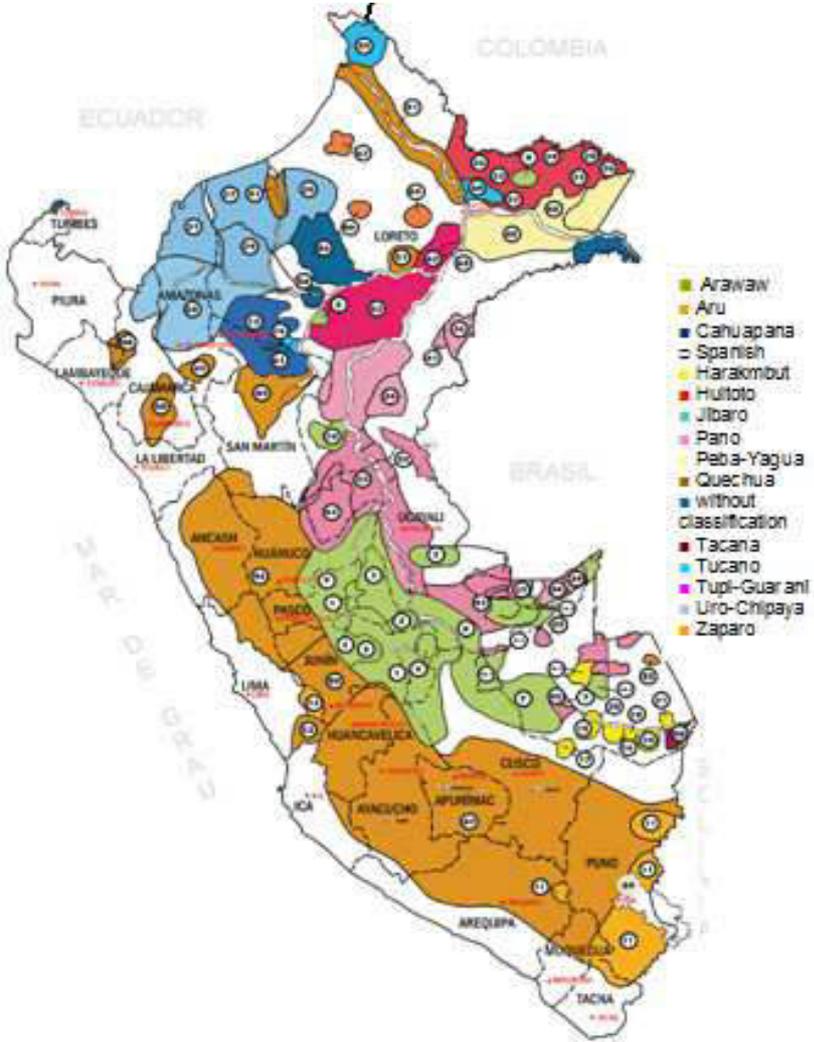
Politically Peru is divided into 25 *departamentos*, these again in 194 provinces. A long-dated decentralization process of the country has been concluded officially in 2002, after several unsuccessful attempts. The regional governments were elected to manage the departments until their fusion into definitive regions, which are also 25. Although considered by specialists a social conquest, the decentralization process after ten years of implementation is no longer fully accomplished. According to Monge, one of the principal difficulties refers to the fact that the decentralization of competences is associated with fiscal decentralization, which shows a conceptual error in which the transfer of functions has no cost, and on the other hand to think about the budget transfer without regard for what is transferred, when the logical thing is to give the necessary human and financial resources for the transfer of functions (CIES 2009:11). In the practice, there are transfers of powers without any level of fiscal decentralization, which makes the autonomous reforms, for a first implementation period, unviable.

The indigenous population is estimated at 8,793,295 people, eight million of which are Quechua-Andinos, 603,000 Aymara and 190,295 indigenous Amazonian peoples distributed throughout the national territory (Alcalde-Rabanal et al. 2011:245). Providing other statistics, the *Instituto Nacional de Desarrollo de Pueblos Andinos, Amazónicos y Afroperuanos* INDEPA has formulated an ethno-linguistic map of Peru, which has received contributions of official institutions and persons linked to indigenous matters such as INEI, and COFOPRI⁷⁹, among others. The map locates in the national territory the indigenous peoples at the present and its correspondent distributional area. For the outline of the map the INDEPA made a classification of the indigenous groups according to linguistic families. Following, there are 3,919,314 persons of 5 years and more who speak indigenous languages in the country; from this group, more than three quarters (3,261,750) are Quechua speaking; 434,370 Aymara

⁷⁹ Sp. *Organismo de Formalización de la Propiedad Informal* (Organism for the Formalisation of non-registered Property). Among other functions, this institution plans, executes and controls the actions of formalisation, physical and legal sanitation and qualifications of the rural properties of native communities and *comunidades campesinas*. See: www.cofopri.gob.pe.

speaking, and 223,194 speak other native language. All of them are organised in 7,849 communities, from which 6.063 are rural and 1.786 native. According to this distribution, there are 76 ethnic groups in the country; 15 are located in the Andean area: *Cañaris, Cajamarca, Huancas, Choccos, Wari, Chancas, Vicus, Yauyos, Queros, Jaqaru, Aymaras, Xauxas, Yaruwilcas, Tarumas and Uros*. 60 are situated in the Amazon and one on the coast, the *Walingos*, all of which are grouped into 16 ethno-linguistic families: *Arawak, Aru, Cahuapana, Harakmbut, Huitoto, Jibaro, Pano, Pebayagua, Quechua, Romance, Tacana, Tucano, Tupi-Guaraní, Uro-Chipaya, Zaparo* and one without classification.

Fig. 6: Ethnolinguistic Map of Peru (INDEPA 2010:290)



The INDEPA notices that with exception of the *Resigaros* –a group speaking *Huitoto*, which has been identified as part of the *Arawak* linguistic family– the Quichua, Inga and Alamas ethnic groups from the Quechua family are considered part of the language of the Napo-Pastaza-Tigre area. Similarly, the Walingos of the coast speak Spanish, but they still preserve their proper identity as mangrove culture. In the Altiplano area, the Peruvian Uros –in contrast to the Bolivian Uros that speak mainly Uro– speak Aymara, and keep on being identified as Uros. Also among the Quechua linguistic family the distribution is not categorical, with the exception of the Vicos belonging to the language *Ancash-Yaru*. The same is the case among the language Ayacucho-Cusco, for which the ethnic groups *Chopcca*, *Chancas*, *Wari*, and *Keros* exists; and for the language group of *Cañaris-Cajamarca* with two ethnic groups, *Cañaris* and *Cajamarca* and, inside the language *Jauja-Huanca*, the ethnic groups of *Huanca*, *Tarumas* and *Xauxas*. According to this study, there is not always a correspondence between ethnic group and language, and being indigenous of a specific group does not necessarily mean to speak its original language (INDEPA 2010:288-289). Although it could be a clear statement for many social scientists, it is necessary here to point out that the relation between ethnical and cultural relatedness and language is not a unique criterion to differentiate and classify ethnic groups, something that is more based on the history of the expansion and introduction of the Catholic religion among indigenous communities, an evangelisation process in Peru that dates back to the colonial period⁸⁰. This questioning is also included in the analysis provided by the INDEPA (2010), in which the 76 ethnic groups listed in their map are related to 68 languages. As is the case for many migrant and colonized groups in history, language could become lost, or in disuse, or get subordinated in order to adopt other mainstream language to be able to communicate. Anyhow, in this process, indigenous and non-indigenous cross-linguistic peoples do not inevitably lose their original ethnical ascription.

In case of the Amazonian basin, the approximately 1,786 ethnic groups are organised, for the most part, in native communities that are connected to the national society in

⁸⁰ See an analysis of the *Instituto Lingüístico de Verano* (Summer Institute of Linguistics) a non-profit organisation incorporated in Latin American countries, affiliated with the overarching parent organisation SIL International in: Stoll, David. 1985. *¿Pescadores de hombres o fundadores del imperio? El Instituto Lingüístico de Verano en América Latina*. Quito, Ecuador: DESCO, CINEP, Abya-Yala, AIDSESP.

some way. Due to the regional governments, on the basis of the Law 28736⁸¹ *Ley para la Protección de Pueblos Indígenas Originarios en Situación de Aislamiento y en Situación de Contacto Inicial* (Law for the Protection of the Indigenous Original Peoples in Isolation and Initial Contact), and the supreme decree 008-2007-MIMDES Regulation of the Law 28736, they have recognised and protect five territorial reservoirs: *Kugapakori-Nahua-Nantis* and others, *Mashco - Piro*, Madre de Dios (*Amarakaeri, Yaminahua* and *Yora*), *Isconahua* and *Morunahua*. For centuries, these ethnic groups have faced continuous forced intercultural breakdowns with foreigners, mostly merchants or colonists. Due to the amount of population in these areas and to the natural resources they possess, the *colonos* have converted the forest into the second migration destination of the country after the coast.

In regard to the indigenous population there are some discrepancies about the exact number of ethnic groups in the country. According to the *Comisión de la Verdad y Reconciliación CVR* (Commission for Truth and Reconciliation), 30% of the population in Peru is indigenous (CVR 2004:22). Based on the sociolinguistic criterion, the INEI estimates in accordance with the National Census of 2007 (INEI 2008) that 4,045,713 of all 3-year-old Peruvian children learned to speak in an original (indigenous) language, which represents 16% of the whole of Peruvians of this age (Benavides, Mena and Ponce 2010:16). Within this group, most of the indigenous population has Quechua as maternal tongue (83%), followed by Aymara (11%). In comparison to other indigenous groups, the Quechua and Aymara speaking populations reside in major proportion in urban areas: 46% and 43% respectively. In the Amazonia, the indigenous peoples are about 242,000 settlers (6% of the indigenous population in total) and most of them (more than 80%) reside in rural areas (INEI 2008). According to the PNUD, the Afro-Peruvians⁸² are about 3% of the whole population (Diaz and Madalengoitia 2012:18).

⁸¹ See: <http://www.congreso.gob.pe/ntley/Imagenes/Leyes/28736.pdf>

⁸² While the national census asks for the language of the inquired people –as a fact that the mother tongue is a secure indicator of ethnical ascription– the Afro-Peruvian population is not considered in the official statistics. It is necessary to include a self-identification item to cover this deplorable mistake. Anyway, the INDEPA has identified 112 towns in which they are more concentrated, such as Caravelí (Arequipa); Santa (Ancash); Chinchipe, Pisco, Ica (Ica); Chiclayo, Callao, Cañete, Huaral, Lima (Lima); and Morropón (Piura).

Table 4: Ethno-linguistic Groups in Peru

<p>I. ARAWAW (PENON ALTO)</p> <p>1. Asháninka (our relative)</p> <p>2. Ashéninka (brother)</p> <p>3. Atiri (fellow)</p> <p>4. Caquinte (people)</p> <p>5. Chamicuro (people)</p> <p>6. Madija (people)</p> <p>7. Matsiguenga (person)</p> <p>7.1. Noshaninkajeg</p> <p>8. Resígaro (people)</p> <p>9. Yanesha (we, the people)</p> <p>10. Yine (people)</p> <p>10.1. Kapexuchi-Nawa</p> <p>II. ARU (SPEAK)</p> <p>11. Aymara (old voice)</p> <p>12. Jakaru (people's talk)</p> <p>III. CAHUAPANNA</p> <p>13. Campo-Piyapi (we, the people)</p> <p>14. Shiwlú (people)</p> <p>IV. ROMANCE</p> <p>15. Castellano</p> <p>V. HARAKMBUT (BROTHER)</p> <p>16. Amarakaeri (people)</p> <p>17. Arasaire (human being)</p> <p>18. Huachipaeri (man living under the bridge)</p> <p>19. Kisamberi (human being)</p> <p>20. Pukirieri (human being)</p> <p>21. Sapiteri (employee)</p> <p>22. Toyoeri (human being)</p> <p>VI. HUITOTO (PLANT)</p> <p>23. Dyo' xaiya o Ivo'tsa (person)</p> <p>24. Meneca (person)</p> <p>25. Miamuna (people)</p> <p>26. Muinane (people)</p> <p>27. Murui (group of people)</p> <p>VII. JÍBARO (BATTLE-HARDENED)</p> <p>28. Achuar (people)</p> <p>29. Awajun (weaver)</p> <p>30. Candoshi-Shappra (more people)</p> <p>31. Jíbaro (brave)</p> <p>32. Shuar-Wampis (people)</p> <p>VIII. PANO (SIBLINGS)</p> <p>33. Iscobaquebu (people)</p> <p>34. Joni (people)</p> <p>35. Junikuin (genuine people)</p> <p>36. Masrónahua (water people)</p> <p>37. Matsés (people)</p> <p>38. Morunahua (people)</p> <p>38.1. Morunahu</p> <p>39. Nuquencaibo (our people)</p> <p>40. Onicoín (real people)</p> <p>41. Parquenahua (people)</p> <p>42. Pisabo (all the people)</p>	<p>43. Uni (people)</p> <p>43.1. Cashibo - Cacataibo</p> <p>44. Yaminahua (iron people)</p> <p>45. Yora (people)</p> <p>IX. PEBA-YAGUA</p> <p>46. Yihamwo (people)</p> <p>X. QUECHUA (MILD WEATHER)</p> <p>47. Ancash- Yaru</p> <p>47.1 Vicos (wrongfully thing)</p> <p>47.2 Yaruvilcas</p> <p>48. Ayacucho - Cusco</p> <p>48.1 Chancas (legs)</p> <p>48.2 Chopccas (selected folk)</p> <p>48.3 Quero (coloured wooden mug)</p> <p>48.4 Wari (Alpaca)</p> <p>49. Cañaris - Cajamarca</p> <p>49.1 Cajamarca (town or space with thorns)</p> <p>49.2 Cañaris (snake and ara)</p> <p>50. Chachapoyas - Lamas</p> <p>50.1 Llacuash (grill fingerboard)</p> <p>51. Jauja - Huanca</p> <p>51.1. Huancas (cliff)</p> <p>51.2. Tarumas</p> <p>51.3. Xauxas (valley)</p> <p>52. Napo - Pastaza - Tigre</p> <p>52.1. Alamas</p> <p>52.2. Ingas (inca, emperor)</p> <p>52.3 Quichua (mild temperature)</p> <p>53. Santarrosino</p> <p>53.1 Kichwaruna (harvester)</p> <p>54. Supralecto Yauyos</p> <p>54.1. Yauyos (warlike people)</p> <p>XI. WITHOUT CLASSIFICATION</p> <p>55. Aguano (mahogany)</p> <p>56. Duüxügu (people)</p> <p>57. Kachá Edze (people)</p> <p>58. Walingos (mangrove people)</p> <p>XII. TACANA</p> <p>59. Ese'ejja (children of water)</p> <p>XIII. TUCANO (SCALPS)</p> <p>60. Aido pa (forest people)</p> <p>61. Maijuna (fellows)</p> <p>62. Monichis</p> <p>XIV. TUPI-GUARANÍ</p> <p>63. Cocama-Cocamilla (people)</p> <p>64. Omagua (lower Amazonia)</p> <p>XV. URO-CHIPAYA</p> <p>65. Uro (dawn children)</p> <p>XVI. ZAPARO (PEOPLE WHERE THE SUN RISES)</p> <p>66. Iquito (pain)</p> <p>67. Ite'chi (people)</p> <p>68. Tapueyocuaca (sibling, family)</p>
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Area and population information of this list has been retrieved from official data by the INDEPA. The numbers correspond to ethnic groups signed in prior map (INDEPA 2010:291, t. sp.).

3.2 Health System: Structure and Organisation

*The healthcare system is clearly not a learning system
(Lachenmann 2002:459)*

3.2.1 Health Situation

Despite the macroeconomic performance and the positive financial indicators of the last decade, 49% of the Peruvian population live in poverty, and 18.1% in extreme poverty (UNDP 2010). Although for some specialists the Human Development Index (HDI) is a debatable measure to estimate both poverty and development, considering Peru's HDI of 0.725 for the year 2011 –positioning the country at 80 out of 187 countries and territories in the high category– when the value is discounted for inequality, the HDI falls to 0.557, which means a loss of 23.2 % due to inequality in the distribution of the dimension indices (UNDP 2011:4).

By the year 2000, approximately half of the population had no access to safe water and adequate sanitation, with 30% of the urban and 60% of the rural population (PAHO 2001:9-10). Unsafe drinking water, inadequate sanitation, as well as air and water pollution led to serious problems of the population's health and constitute environmental determinants of health (UN 2004:7) that could be avoided. In 2010, the INEI reported a positive change, in which, at the national level, nine of every ten households (91.5%) had access to safe water, a proportion that was higher in urban areas (95.9%) than in rural areas (82.2%) (INEI 2011:21-22). Anyway, the treatment of drinking water varies from region to region and means different levels of safety.

In effect, the risk of dying from acute diarrheal disease, septicaemia and malnutrition was 8 to 10 times higher among children living in the highest poverty stratum and those from the Andean region. Malnutrition affected 19.4% of children under the age of 5 in 2010 (INEI 2011:53-54). The highest levels of chronic malnutrition in children under five years were present in Huancavelica (44.7%), Cajamarca (32%), Huánuco (31%), Apurímac (30.9%) and Ayacucho (30.3%) (INEI 2011:11). By area of residence, the proportion of anemia in children of 6 years to less than 36 months of age is higher in

rural areas (56.6%) and presents 10% points of difference in comparison with children in urban areas (46.6%) (INEI 2011:14).

In 2010, the prevalence of diarrhoea in children under 5 years was 14.9%, compared with 15.4%, in 2000 (INEI 2011a:222). The ENDES survey of 2010 revealed that at the national level two out of every ten children under three years of age (18.9%) have had diarrhoea, the proportion of which was greater in the urban area (19.3%) than in rural areas (18.3%) (INEI 2011:18). In 2010, 32.2% of children with diarrhoea received *sales de rehidratación oral* (oral rehydration therapy) in comparison with 21.9% in 2000 (INEI 2011a:225).

The infant mortality rate fell from 88.2 per 1,000 live births in 1987 to 45 per 1,000 during the period 1995-2000 (PAHO 2004). In 1998, diseases preventable by immunization, acute respiratory infections, intestinal diseases, meningitis, septicaemia, malaria, and nutritional deficiencies caused 42% of all deaths in children less than 5 years old (PAHO 2002). In 2004, the leading cause of death remained the acute respiratory infections, followed by ischaemic diseases of the heart and brain-vascular diseases. A peak was reached in 2007, with a mortality rate of 18.5 per 1,000 births (MINSa 2010a:13). According to the INEI, during the last eight years 26 children of 1,000 born were going to die before they could reach the age of 5 years (INEI 2010a:152). Mortality in adolescents is lower than in the general population, external causes being the leading cause of death. In the case of adults, external causes among males and cancer of the uteri and breast among females were the main causes of death for the rank of 20-59 year-olds. The estimation of maternal mortality, i.e. women who die due to complications of pregnancy, delivery or within forty-two days after childbearing was estimated to be 185 deaths per 100,000 live births by 2000. In 2010 there were still 93 maternal deaths per 100,000 births (INEI 2011:355), somewhat distant from the goal by 2015 of 66.3 deaths per 100,000 live births. Fertility among women aged 15-19 years decreased by 16% in 1986-2000. In 2000, 15% of them were already mothers or were bearing a child for the first time (PAHO 2002). There is a rising curve in the reduction of fertility rates, starting a change in the overall composition of the ages of the population. This is now characterised by a lower

participation of the child population and growth of average age groups in productive age, as the rapid increment in the population over 60 years (INEI 2008, 2009a).

For the general population mortality conditions remained constant between 2000 and 2009. The life expectancy of the Peruvian population has increased 14 years during the last three decades. Life expectancy at birth increased from 43.9 to 68.3 years by the year 2000; by 2009 Peruvians lived, in average, 73.5 years (70.9 years for men and 76.2 for women) (INEI 2009a:11). Nevertheless, a comparative analysis by regions shows that life expectancy reflects the persistence of inequalities in the country that are deeply rooted according to cultural and socioeconomic factors. The risk of dying was three times higher in Huancavelica (13.0 per 1000) than in El Callao (3.6 per 1,000), something reflected also in the 21-year difference regarding life expectancy at birth in the same cities, with 56.8 years in Huancavelica and 78.0 years in El Callao. Additionally, it is estimated that nearly 50% of the deaths in Peru go unregistered (PAHO 2002). In his report on the Mission to Peru in 2004, Paul Hunt, UN Special Rapporteur on the Right to Health, placed a special emphasis on the enormous inequality access to services and health, indicating that many of the health problems in Peru are inextricably linked to problems of poverty and discrimination. He notes that both poverty and discrimination have perpetuated great disparities in the enjoyment of the right to health between rural and urban areas, between regions and among different population groups⁸³ (UN 2004:7).

Since the epidemic in 1992, there have been no reported deaths from measles; of the 5,256 suspected cases of measles-rubella reported through ESSALUD in 2000, only one measles case was confirmed (PAHO 2002). In the same year 10 cases of neonatal tetanus were reported, compared with 94 cases in 1995. Also, 41 suspected cases of jungle yellow fever (7 confirmed; 4 fatal) and 1,148 confirmed cases of hepatitis B were reported in 2000. Since 1990, vaccination coverage under the Expanded Program on Immunization (EPI) has maintained levels of over 90% (PAHO 2002; MINSa 2010a).

⁸³ At the time of the Hunt-Mission in June 2004, Peru was engaged in negotiations towards a bilateral trade agreement with the United States. The report expresses concerns that the agreement may result in “WTO-plus” restrictions, i.e. including new patent and registration regulations that impede access to essential medicines, such as antiretrovirals for people living with HIV/AIDS (cf. Hunt 2006).

Cholera continued declining steadily from 42,000 suspected cases during the El Niño phenomenon to 934 in 2000⁸⁴. In analysing the social conditions of the population during the cholera and dengue epidemics in 1999 and 2005 respectively, Cueto speaks of a *cultura de la sobrevivencia* (surviving culture) to describe the principal characteristic of the PH muster in Peru. “The principal similarity (of both epidemics) is that the principal social cause was to find in the living conditions of the population with lower economic resources. They deteriorated even more after the neoliberal structural adjustment programmes and the economic politics first applied by the government of Alberto Fujimori” (Cueto 2009:253, t. sp.).

In 2000 11,310 cases of AIDS were reported (PAHO 2002). The incidence of HIV/AIDS in Peru has increased during the last year, and an estimated 78,000 people are currently living with HIV/AIDS (INEI 2011a). Malaria is also a widespread infectious illness, in particular in the forest. It is estimated that 2.5 million inhabitants live in areas at risk for malaria transmission. In the year 2000 the annual parasite index was 2.7 per 1,000 people (PAHO 2004). The population in areas of dengue transmission risk is estimated at 3.4 million. In 2000, all four serotypes of the dengue virus were isolated and the cumulative incidence was 21.7 cases per 100,000 among the population. In the first 26 weeks of 2001 a total of 23,454 cases of dengue were reported, including the country's first cases of hemorrhagic dengue (206 cases, 3 deaths). A total population of 600,000 is estimated to live in areas of *Chagas'* disease transmission. The Peruvian population is also vulnerable to other infectious diseases such as leishmaniasis –by year 2000 a total of 9,588 cutaneous and 863 mucocutaneous cases were reported. In 2011 the presence in the country of *hanta virus* was also confirmed⁸⁵.

The *infecciones respiratorias agudas* IRAS (acute respiratory infections), are a set of diseases that affect the tracks where the air passes in the human body and they are caused by both viruses and bacteria. This group of diseases are the main cause of

⁸⁴ In 1991 more than 320,000 persons were affected by enfermedades diarreicas agudas EDA (acute diarrheic disease). The diagnosis of EDA was disputable, because it was impossible to verify if all cases of diarrhoea arriving at emergency hospitals were carriers of the *Vibrio Cholera* (Cueto 2009:268-289).

⁸⁵ Since July 2011 three mortal cases of Hanta virus in Peru have been confirmed (cf. Garcia et al 2011).

consultation in health services and causing more deaths, especially in children younger than 36 months and in people older than 60 years. The IRAs are more frequent when changes occur by swings in temperature and environments that are very contaminated. The biggest percentage of IRAS is in children under 36 months (24.4%) in the forest, followed by the Coast (18.3%); the Andean region presents the lowest percentage of IRAS (15.6%) (INEI 2011:17-18).

Tuberculosis has been on the decline since 1992 to an incidence of 155 per 100,000 populations in 2000 (PAHO 2002). Nevertheless, Peru has still the highest incidence of pulmonary tuberculosis in Latin America, with 100 cases per 100,000 people compared with the regional average of 17 cases (UN 2004:7), as well as a high incidence of multi-drug-resistant tuberculosis.

An unresolved PH problem is the consequences of Peru's *conflicto armado*, occurred between 1980 and 1992, and caused ongoing psychosocial and psychosomatic health problems for the population that remain unattended by Peruvian health institutions (cf. CVR 2003, 2003a). The *Partido Comunista del Perú Sendero Luminoso* PCP-SL (Communist Party of Peru Shining Path) resulted from a long sectarian, dogmatic and, violent adaptation of the harder lines of Marxism. SL defines itself as a “Marxist-Leninist-Maoist” organisation. From Lenin it took the thesis of the construction of a party based on exclusive and secret squares or teams, a sophisticated organisation (*el partido tiene mil ojos y mil oídos*) prepared to impose the “dictatorship of the proletariat”, with weapons. From Stalin, a minor figure among SL, it adopted the simplified version of Marxism as dialectical and historical materialism. In addition, the thesis of the single party and the cult of the leader's personality was inspired by Mao Zedong, for whom the conquest of power would take place in so-called semifeudal countries by means of a “popular prolonged war from the countryside to the city” (CVR 2003b:13-15). These issues make up the history of the PCP-SL and the enthronement of Abimael Guzmán as the “fourth sword of Marxism” (after Marx, Lenin, and Mao) and the incarnation of so-called “thinking Gonzalo” conducting war's ideology.

The *Comisión de la Verdad y la Reconciliación*, CVR (Truth and Reconciliation Commission) estimates that the subversive war in Peru produced at least 69,280 deaths, of which 75% were Quechua-speaking people, more than half were peasants, and almost 80% lived in the following five departments: Ayacucho, Junín, Huanuco, Huancavelica, and Apurímac (CVR 2003a:13-25). Except for the department of Junin, these four departments have the highest poverty ratio in Peru (PNUD 2002:45-48). According to the CVR's report, the peasant population was the principal victim of this violence, a situation that was combined with socioeconomic gaps, which highlighted the seriousness of ethno-cultural inequalities that still prevail in the country (CVR 2003:43-48). Some national and international *senderólogos* –experts on SL– have identified SL and its followers as one of the most violent, bloodthirsty, and cruel terrorist movements of the whole world history (cf. Roncagliolo 2007). For Degregori, SL could arise precisely as a result of the irreconcilable distance between the capital and the provinces, between the city and the countryside, between the Andeans and the criollos, and represented the authoritarian and defensive reaction of a narrow strip located at the pole more beaten and broken up by this antithetical specific development (Degregori 1988:8).

Based on almost 17,000 private and public testimonies in the early post-conflict period, the CVR devoted an entire chapter to the destabilizing and destructive psychosocial effects of Peru's war that challenged and exceeded the capacity of psychological defenses (Laplante and Rivera 2006:140). The CVR emphasised a host of psychosomatic problems that the conflict-weary population were experiencing, including feelings of insecurity, helplessness, impotence, loss of confidence in oneself and others, generalized anxiousness, fears and phobias, impulsiveness, and aggressiveness (CVR 2003c:167-179). The CVR also confirmed that political violence had left an indelible mark on the well-being of the communities in which these suffering individuals resided, affecting social functioning and limiting the possibilities of a dignified life (CVR 2003c:167). Laplante and Rivera (2006) reported that the unique nature of Peru's conflict had created an intense climate of fear and distrust, ruptured social bonds and solidarity due to community conflict and interpersonal violence. The deliberate and primary tactics of repression and terror used during the conflict (public

executions, disappearances, arbitrary detentions, rape) had caused a sharp sense of vulnerability within the population (CVR 2004:355). This terror imposed an atmosphere that made speaking out too dangerous, resulting in anxiety that created the perception of imprecise, but always imminent, risk that disturbed daily life⁸⁶ (CVR 2003c:169, t. sp.). Several subsequent studies on the psychosocial consequences of the political violence in Peru among indigenous population have shown specific post-war syndromes and cultural forms of affliction (idioms of distress) such as *llakis* (painful memories), *pinsamientuwan* (recurring concerns/tribulations) and *manchay* (fear, fright) (Pedersen et al. 2010). Also *iquyay* (weakness), *alcansu* (damage), *llaki nuño* (scared teat), and *ñakari* (cf. Malvaceda 2010), are extensively present in victims' tribulations. The CVR puts public policies on mental health in Peru's national agenda⁸⁷ by calling to special attention the devastating psychosocial damage caused by the war. In their recommended Integral Plan of Reparations (PIR), a mental health component is included, in which a communitarian approach that moved beyond an individualized clinical- and medical-based model was proposed. To the present, this plan has not been throughout implemented.

3.2.2 Structure, Functions, and Organisation

The Peruvian HCS has two big sectors, the public and the private.

For the provision of health services, the public sector is divided into subsidized or indirect contributions system –which will be mostly covered by the governmental budget– and a direct contributions system, which corresponds to the Peruvian Health Social Insurance (ESSALUD). The Government provides healthcare services to the uninsured population in exchange for the payment of a fee for the recovery of varying

⁸⁶ Although the rural population experienced the psychosocial effects of the war the worst, all citizens experienced its negative impact (cf. Velázquez 2007:36-37). During the second period of the war (1987-1992), I attended a private university in Lima as student. Up to the present I can revive and clearly feel the deep fear all of us students experienced during the sudden bombs detonations and the ensuing blackouts in the city. Most of us returned to our homes in complete darkness, hearing bullet sounds everywhere and fearing to be targeted. We did not have cell phones at that time or other ways to communicate with our families, so they could not know whether we were alive, or not. Some of my colleagues and friends were assaulted, one disappeared, and two of them were massacred during assassinations.

⁸⁷ In 2006 the percentage of financial assignation for mental health in Peru was only 4,25% of the total budget of MINSA, which was in turn 4,5% of the total GPD assigned to health (Velázquez 2007:41).

amounts subject to the discretion of the organisations or through the Universal Health Insurance System (SIS). The provision of services for both the subsidized system of open population and the population affiliated within the SIS is performed through the network of establishments from MINSA, hospitals and specialized institutes that are located in the regions and in Lima.

ESSALUD has two subsystems: the social security provision and the private provision. It provides healthcare services to the wage-earning population and their families in their own facilities, but since the enactment of the Law on Modernization of the Social Security from 1997, the private sector has been sold to ESSALUD personal services through the denominated Healthcare Providers (EPS).

The military, police and their families have their own health subsystem integrated into the *Sanidad de las Fuerzas Armadas* (FFAA) and the Peruvian National Police (PNP). The private sector is distinguished by the private for-profit and the private non-profit system. Part of the private for-profit system are the EPS, private insurers, specialized and non-specialized private clinics, medical centres and polyclinics, the medical and dental offices, laboratories, diagnostic services by images and health establishments of some mining, oil, and sugar companies. There are 54 service provider companies (EPS) operating in the subsector, with the latter responsible for serving 29% of the country's total population, while the remaining EPSs account for 31%. There are other urban administrations, under the direct responsibility of the municipalities that are required to serve 6% of the population, and community organisations that serve 34% of the people, primarily in the rural area (Edwards, Davis and Bellido 2004:10).

The private non-profit sector is typically represented by a set of nonprofit civil associations such as non-governmental organisations (NGOs), the Peruvian Red Cross, volunteer fire brigades, social organisations of some churches like CARITAS (ADRA), parishes' health services of the Catholic Church, and therapeutic communities, among others. Most provide services at the first level of attention and receive frequent financial resources from cooperating external and internal donors, other local administrations, and households (Alcalde-Rabanal et al. 2011:244-247).

MINSA is the predominant health provider for the poor population without health insurance. The model of care includes individual and collective health activities, which are reviewed in order to bring them into line with the new legal framework established by the Law 27658 *Ley Marco de Modernización de la Gestión del Estado*⁸⁸ (Law of Modernization of State Management) and the Law 26482 of 1997 *Ley General de Salud* (General Law on Health)⁸⁹. ESSALUD covers health attention for formal sector workers, and its establishments are located mainly in urban areas. The services of the Armed Forces and National Police cover only their respective employees and immediate family members. The private subsector concentrates its resources on the principal cities and is comprised of clinics, physicians' offices, and to lesser extent non-governmental organisations.

From a functional standpoint, MINSA exercises the steering role within the sector, and is in charge of issuing policy guidelines as well as technical standards and procedures to regulate sectoral activity. Adopting the function encompassed by MINSA according to the Law 27657 *Ley del Ministerio de Salud*⁹⁰ (Law of the Ministry of Health), within its institutional and sectoral management, it designs and rules the relevant organisational processes, which must be achieved principally due to driving and sectoral strategic planning of health; the organisation of the sector and the coordinated decentralized national health system; the establishment of norms and organisational models for the implementation of institutional strategic objectives; the creation of a culture of health based on the family as the basic unit of health and the acquisition of correspondent skills in the community; and the financial assurance of public health and comprehensive healthcare for all people, among others⁹¹.

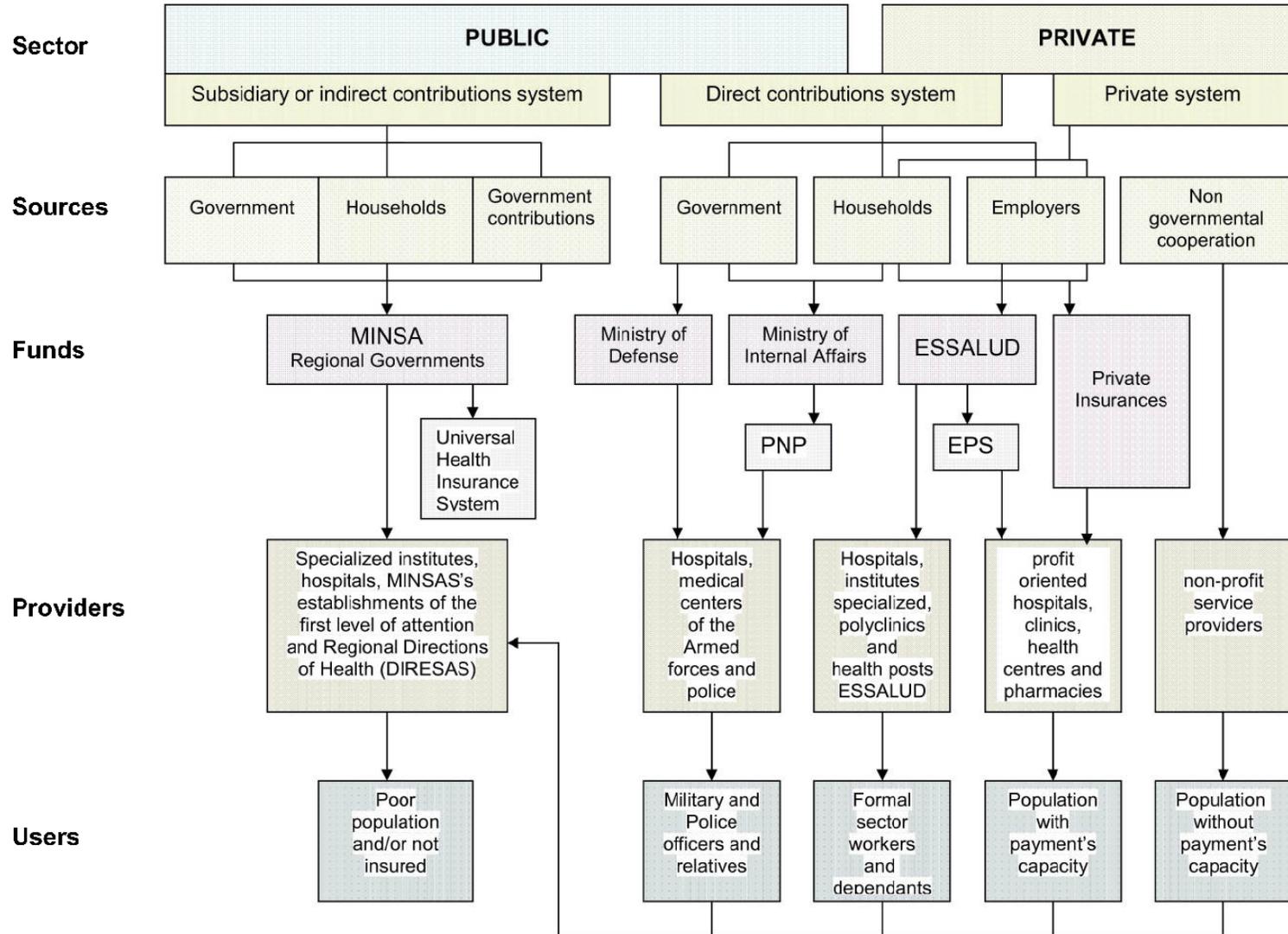
⁸⁸ http://www.bnp.gob.pe/portalbnp/pdf/ley_27658.pdf

⁸⁹ See: ftp://ftp.minsa.gob.pe/intranet/leyes/L-26842_LGS.pdf

⁹⁰ <http://www.digemid.minsa.gob.pe/normatividad/LEY2765702.HTM>

⁹¹ From: "institutional information: functional objectives" of MINSA. See: <http://www.minsa.gob.pe/index.asp?op=1>

Fig. 7: Structure of the Peruvian Healthcare System (adapted from Alcalde-Rabanal et al 2011: 244)



According to the PAHO (2001) the central level of the institutions of the sector issues guidelines on policy, standards, and technical procedures. At the start of 2001, an Advisory Committee on Health was established to advise MINSA on critical aspects of sectoral policy. The central structure of MINSA has a high-level management entity (Minister and Vice Minister), as well as entities that provide oversight and advisory services (Planning; Legal Advisory Services; Epidemiology; and the Office of Financing, Investments, and International Cooperation), support (Administration and Statistics and Informatics), and guidelines (Healthcare; Environmental Health, and Medications, Inputs and Drugs). There are also two types of deconcentrated bodies: specialized institutes (Mental Health, Rehabilitation, Child Health, Neoplastic Diseases, Neurological Sciences, Ophthalmology, and Maternal-Perinatal) and the Regional Health Departments (DIRESAS). The latter are assigned functions of oversight and sanitary control, as well as the delivery of zoned services through administrative units. Decentralized public agencies of MINSA are the National Institute of Health, the National School of Health, the National Institute of Environmental Protection, and the Superintendency of Institutional Healthcare Providers.

The public subsector institutions of MINSA organise their services by levels of complexity and arrange their services by levels of care; however, referral and cross-referral mechanisms are still deficient. A significant segment of the population still does not have regular and permanent access to these levels. Traditionally, the PH care networks are based on local and provincial coordination among the health post, the health centre, and the respective *hospital de apoyo* (reference hospital) in an increasing level of complexity (1 to 3). During the 1980s and the beginning of the 1990s, the sector's operations have met several problems due to this inoperating organisation's system. The coordination among the institutions did not take place on a regular basis, since there were no permanent consensus-building agencies (PAHO 2001). The integration with other providers –whether private or from ESSALUD– was minimal, as the integration of those local and provincial networks with service providers was of greater complexity.

MINSA offers 84.7% of the country's health establishments, followed by the private subsector with 7.0% and the rest of the institutions with 8.3%. By November 2005, MINSA had 6,821 establishments in operation; centres and health posts represent 97.9% of installed health infrastructure and carry out preventive and promotional health programmes; 2.1% of the establishments are hospitals that are principally engaged in recovery and rehabilitation tasks; their location is mostly in the capitals of provinces. MINSA's centres are distributed in all the departments of the national territory but in greater number concentrated in Lima, Cajamarca, Junín, Puno, and Ancash. Together, these departments possess 37.8% of the total number of establishments in the country, and at the same time, represent 48% of the population estimated for the year 2005 (MINSA 2005:3). There are no official current data for the last seven years.

Table 5: Health Establishments in Peru

Institution	Total	Hospitals	Health Centres	Sanitary Posts
TOTAL	8,055	453	1,932	5,670
MINSA	6,821	146	1,203	5,472
ESSALUD	330	78	252	0
PNP (National Police)	280	5	77	198
FFAA (Armed Forces)	60	16	44	0
Private Clinics	564	208	356	0

Information adapted from: MINSA (2005)

Between 1992 and 1996, the supply of professionals increased in all categories: the rate of MDs per 10,000 inhabitants has increased from 7.6 to 10.3; professional nurses from 5.2 to 6.7; dentists from 0.7 to 1.1; and obstetricians, from 1.1 to 2.1. In 1999, MINSA employed 11,157 physicians, and ESSALUD 5,237. In 2000, there were 27 schools of medicine (14 in 1990) and 43 schools of nursing; there were also 21 Master-level Public Health programmes with 11 major areas (PAHO 2011). By 2011, the number of medicine schools had increased to 30 (ANR 2011:15). An analysis of the institutional aspects of training resources for medical professionals shows that supply is deregulated and disconnected from the objectives and public health needs of the country. In addition, the distribution of MDs in Peru is centralist and inequitable, particularly for rural populations that are more remote and dispersed, with a resistance of health professionals to working in the rural sector; around 90% of them are unwilling to

stay there indefinitely. It is also confirmed that the profile for professionals working in the first and second level of care is significantly different from that of those in the third level. The first tend to be younger, have less experience and little or no specialization (Carrasco, Lozano and Velásquez 2008:23).

During the last decade of the 1990s, Peru showed an increase in the coverage of institutional care of the total number of people with symptoms of disease or injuries from accidents from 32.2% (1994) to 43.5% (1997) and to 49.3% (2000). MINSA also augmented its share of total institutional coverage from 16.3% (1994) to 25% (1997) and to 29.5% (2000) –above all due to increased resources allocated for PHC. Anyway, by the year 2000, of the total number of people reporting symptoms of a disease or had been involved in an accident and thought they needed medical attention, 31% could not gain access to health services, primarily because of a lack of economic resources; and only 69% received medical attention provided by a health professional (PAHO 2001:1).

On the other hand, by the year 2002, ESSALUD only covered 20% of the population that had stable work, having been reduced as a result of plant closings and layoffs produced during the 1990s. Estimations of MINSA asserts that only 3% of the population had access to private insurance, and another uninsured 12% were accessing private services (MINSA 2002a: 36). The results of the national census of the year 2007 reveal that 43.3% of the population had some kind of health insurance, i.e. 11,599,971 people. However, 57.7% of the population are still unprotected (INEI 2008:103).

A former programme, the *programa de salud básica para todos* PSBT (programme of basic health for all) created in 1994 as part of the Basic Social spending, intended to improve the health conditions of the population of lower income by ensuring universal access to a package of basic health with a promotional-preventive character and provide additional supplementary medical attention to major risk groups, giving priority to children under five years and pregnant women. In 2001, the *Seguro Universal de Salud* (SIS) (Universal Health Insurance) was created on the basis of the *seguro escolar*

gratuito (free school insurance) and the maternal-child insurance. The first one covers health attention for all of the population aged 3 to 17 registered in public schools⁹².

The Law for the *Aseguramiento Universal en Salud* (Universal Health Insurance System - SIS), enacted as recently as in 2009⁹³, establishes the normative framework for the SIS in order to ensure the progressive right of all persons to a set of interventions for various conditions of health and disease independent from its labor insertion (Velásquez and Ponce 2009:210). The SIS would be the mechanism to complement the efforts of extension of social security to formal health –i.e. from the contributory to the free paid scheme– to ensure financial security in health for the population in poverty and extreme poverty. The SIS is aimed at providing coverage of healthcare for women in stages of pregnancy, childbirth or puerperium, to protect them from emergency occurrences until one year after his affiliation; children and adolescents from birth until before the age of eighteen, through a set of benefit plans that respond to the needs of recuperative and preventive care, delivered without cost for the target population. The SIS incorporates, in addition, the attention of members of community-based organisations for the attention of pathologies treated as a priority (infectious diseases not included in the national health programmes, surgical emergencies, pneumonia, etc.), and adults.

In fact, the SIS is conceived only for people considered “poor”, and not for the rest of the population. In article 7 of the regulatory framework legislation of the SIS, the law establishes that the legal and financial character of the SIS is a “funds administration institution for health insurance” (MINSa 2010b); something that confers the SIS the attribution to select who can enter into the system and who does not. According to the text of the law, the principal criterion is established upon the financial income of the potential customers. Nevertheless, the law itself, like other posterior ministerial directives to this respect, does not define clearly how poor a person should be in order to obtain full access to the SIS. For example, the law establishes the non-eligibility of a person by the condition of being “not poor”, and if this person has no other health insurance, that the person responsible for the affiliation will provide guidance to the

⁹² Some evaluations indicate that this insurance has had a better focus in the metropolitan Lima rather than in rural areas (Alvarado 2002:67).

⁹³ See norms and procedures at: <http://www.sis.gob.pe/portal/paginas/normas.html>

possibility of entering the semi-subsidiary system of the SIS (MOH 2010b), i.e., to pay an amount in order to access healthcare services through the SIS. Contradictorily, this situation will turn the SIS in a non for-free health attendance insurance. In some informal conversations with ministerial workers regarding the SIS, the common criterion in considering a person “poor” was an income under the minimum wage, which in August 2011 was S/. 675 (ca. US\$ 256) (fq/2010)⁹⁴. In relation to the attentions of collective health with preventive-promotional content, the state promises to finance just those insurances granted by the condition of poverty, established in a previous qualification to the beneficiaries by means of a “System of Beneficiaries Identification”. The idea of the reform in this respect is that the State stops financing of services offered, and will give priority to the financing of the demand of attention through state insurances. One of these financed insurances is the Gratis School Insurance (SEG), determined by the government on August 1997, and the mother-child care insurance. The passed legislation, above all the law on modernization of ESSALUD (formerly IPSS), which transferred the 25% of the financing to private insurances, has as principal consequence that the bulk of the population remains uncovered by health attention, and fundamentally set out to the market rules of the supply and demand.

By 1998, the HCS was funded by the following sources: government, 25%; households, 38%; companies, 35%; and external funds, 2%. Since the government’s expenditure on health is financed by general tax revenues –mainly indirect taxes– the financing of the public component of the national health systems is, in general, regressive (Suárez-Berenguela 2000:23). In other words, the expenditure on health by the state tends to decrease. The total health expenditure in 1998 was the equivalent of 4% of the GDP⁹⁵, and the health expenditure per capita was US\$99 (PAHO 2001:6). By 2005, only 0.9% of Perus GDP is spent on the health sector (Yamin 2007:7-8). In the case of ESSALUD, the analysis of Petrera shows that ESSALUD rests upon a bismarckian model of insurance financed by contributions derived from earnings. According to the author, the principal limitation of this model resides in the very limited growth of the formal

⁹⁴ See: http://www.mintra.gob.pe/archivos/file/SNIL/normas/2011-08-14_11-2011-TR_1662.pdf.

⁹⁵ The Gross Domestic Product (GDP) accounts an index of the value of all final goods and services produced within a nation in a given year. A GPD per capita indicates the country’s living standard. In the last century GDP became the most important tool for measuring a country’s economy.

employment in the economy (Petrera 2002: 113). According to ESSALUD, in March 2012, the total insured population reached 9.240,715, equivalent to 28.46% of the total population (ESSALUD 2012). In 1998, this percentage was 25.1%, which indicates very slow growth within a period of fourteen years. An effort to increase the coverage was through the sale of insurance plans (called *salud personal y familiar*), which have had, nevertheless, a limited response from the population⁹⁶.

3.2.3 Health Reforms and Community Participation

The 1990s were a decade of structural reforms in most of the Latin American countries. After the disastrous economic performance from the 1980s to the early 1990s, rethinking the role of the state in the economy, the pursuit of economic efficiency and the new opening to liberal commercial, financial, and labour conditions were common elements in Latin American countries. Structural reforms were promoted in these countries by various multilateral financial institutions, within the framework of what has been called the Washington consensus⁹⁷, which proposed macroeconomic stabilization processes, the liberalisation of the markets, and the flexibilisation of labour policies. These policy proposals emerged in the global context of the collapse of Socialist regimes, and many of the proposals were applied to countries transitioning into a market economy. This context of the general policies of the countries was also expressed in health reform trials. In Latin America, health sector reforms have been conceived as a process-oriented to obtain substantive changes on different instances and functions of the sector in order to increase the equity of their benefits, the efficiency of its management, and the effectiveness of its actions (PAHO/WHO 1997:12). In fact, the model used was inspired by the structural reforms carried out in Chile during the 1980s, under the military dictatorship.

Undoubtedly, the processes of health reforms arise from the concern of multilateral agencies about the increase of health expenditure during the 1960s and 1980s in

⁹⁶ See to this respect the comprehensive analysis made by Francke, Pedro and Juan Carbajal. 2000. *La Seguridad Social en Salud: Situación y Posibilidades*. Lima, Peru: Pontificia Universidad Católica del Perú. (Also available at: <http://departamento.pucp.edu.pe/economia/images/documentos/DDD187.pdf>.)

⁹⁷ See: Guerra-García, Gustavo. 1999. "La Dimensión Política del Ajuste Económico en el Perú" Pp. 185-242 in *Repensando la Política en el Perú*, edited by Elsa Bardález, Martin Tanaka and Antonio Zapata. Lima, Peru: Pontificia Universidad Católica del Perú, Instituto de Estudios Peruanos.

developing countries –especially for hospital care– with the consequent escalation of costs, which contrasted with the slow economic growth and the deficit budget unprecedented during the 1980s and the consequent restriction of expenditure in the social sectors. The World Bank began making loans to the health sector in 1980, and by 1983 was one of the main financial suppliers for health programmes, mainly for PHC. In 1987, officials of the Department of Population, Health and Nutrition of the World Bank proposed an agenda for health reform, with four principal policy guidelines: (a) charging fees to users of recuperative care, seeking to protect the poorest with higher rates in hospitals and channelling resources towards public programmes; (b) the provision of insurance or other protection against risks, avoiding costs increased by a greater demand for services; (c) the efficient use of non-governmental resources, both of the lucrative private sector and the profitless; and (d) the decentralization of Government health services, through the decentralization of planning, the budget and procurement for government health services, in particular those private benefits charged to the users (Atkin, Birdsall and De Ferranti 1987:709).

The motivations that drove the process of reform in Peru were diverse. On the one hand, the multilateral financial agencies led to some changes, especially those regarding the focus and efficiency of health expenditure. On the other hand, there were also motivations of political and doctrinaire nature of some sectors of the government at the time, both not supported by technical studies on the situation of the country. Thus, a definitive unique influence of international economic agencies on the new policies is disputable. In a comprehensive analysis of the health reform in Peru, Gaillour et al. (2003) affirm in their final report of a base line of the health reform and the AMARES project, that evidence of pressure from international agencies for the promulgation of the law on modernization of the social security has not been collected; “the World Bank had agreed in the arrays of structural adjustment with the Peruvian government only on the restructuring of the IPSS (ESSALUD) and the adoption of measures to expand coverage of the real focus of this entity; these orders were underpinned by an old report conducted by the National Institute of Planning in Peru with the German cooperation, showing the inefficiency in the use of resources in the health sector....it has been also collected on lobbying versions of the insurance companies, as they apparently did not

have much interest in expanding its healthcare market. Indeed, the World Bank focused its operations in Peru in the draft of Basic Health and Nutrition, and this was not a modernization project” (2003:14).

Health, as a comprehensive state of well-being, is not the exclusive result of the services provided to individuals or communities; it also depends on the policies adopted by the different governmental sectors in relation to social equity. The process of globalisation is presented not only as inevitable and inexorable, but also as irreversible: the globalisation of finance, the market, capital, and trade are the ultimate goal that is evolving parallel to the creation of large multinational corporations and monopolies. As Pedersen notes, the privatization of vast economic sectors has increased inequality in the distribution of resources, which has a negative impact on the conditions of life, health, and welfare. Science and medical technologies are transformed into effective tools to stimulate competition, to widen the market and produce more goods and services, which in turn increases the needs and demands of consumers, increasing profit margins and generating inequity and greater inequalities (Pedersen 2009:53). From the perspective of the evaluation of the equalitarian access to health, the global health performance of Peruvian HCS ranked 129th in the world by the year 2002, which is one of the last places in the international rankings, and altogether the last in Latin America (MINSa 2002:9). The reforms shall emphasise the need to strengthen the health sector’s ability to meet the country’s reality, and negotiate the action of other sectors that could impact the population’s health situation. This process is widely complex, and its development involves not only management technical components, but also political, economic, social, academic, and cultural aspects that were not taken into account by policy makers during these reforms (cf. Crocco et al. 2000:137-139).

The current health reform in Peru arises in the context of the structural reforms initiated in 1990 during the administration of the ex-president Alberto Fujimori. The neo-liberal structural adjustment plan and ministerial changes between 1991 and 1992 opened the way for reform proposals of the sector closely linked to the guidelines of multilateral agencies such as the World Bank and the Inter-American Development Bank. The health sector reform implemented by Fujimori’s second government period had guiding

principles based on the “Health Policy Guidelines 1995-2000” (cf. MINSA 2002a) and a new legal framework. The work agenda emphasised several points: restoration of the problem-solving capacity of the first level of care by increasing public social spending; reform of social security to open the first level of care to private providers; the development of programmes that ensure care for targeted vulnerable groups, such as insurance for schoolchildren and maternal and child insurance; and community participation in the management of primary care facilities through Local Health Administration Committees (CLAS). Although the subject of institutional restructuring was proposed in the agenda, it did not move forward.

During this period, a series of actions was developed that was aimed at the establishment of a new organisation for the provision of health services. Some crucial provisions were done at the end of the 1990s, with the implementation of a neoliberal oriented legal regulatory framework. The *Ley General de Salud* 26842 from 1997 (General Law on Health), the *Ley de Modernización de la Seguridad Social en Salud* 26790⁹⁸ (Law on the Modernization of Social Security in Health) in the same year, and the creation of the Social Health Insurance (ESSALUD) in 1998 with the principal purpose of generating incentives to promote public and private forecasting systems to use additional resources in the context of competition and to improve efficiency in the use of these resources.

Continuing with this reform during the government of President Alejandro Toledo, in August 2001, MINSA established a high-level Commission responsible for relaunching the process of organisation of the national HCS, to arrange policies and coordinate plans and programmes of all institutions and organisations in the sector (cf. MINSA 2002). This final report of MINSA reflects the work of its six committees and proposes the creation of the National Decentralized Health System (SNDS). It listed a total of 51 problems with their respective concerted proposals and actions to perform on the process of organisation of the new health system, as well as different aspects of a new coordinated and decentralized model of healthcare, such as the access to services, universal assurance in health, procedure for institutional exchanges of services, creation

⁹⁸ See: http://www.mintra.gob.pe/contenidos/archivos/sst/LEY_26790.pdf

of the service of medicine and community health (SERMEC), decentralized organisation of levels of care, promotion and coordination for the formation and training of the human resources required by the system, research and investment in health, access and rational use of medicinal products for quality, coordinated health, and funding information.

Accordingly, the new *Sistema Nacional descentralizado de Salud* (SNDS) will establish levels of national, regional, and local organisation with priority on policy development. The National Health Council is the organ of consultation and national coordination of the SNDS. It will be chaired by the Minister of Health –or his representative– and shall be integrated by nine other members, representing MINSA, ESSALUD, the Associations of municipalities of Peru, hospitals of the Armed Forces and the National Police, health services from the private sector, the National Assembly of Rectors, the CMP, workers of the sector, and community social organisations. The regional and local levels will be organised according to the model of municipalization –coordinated in local health systems– that implies the transfer to the municipalities of PH services comprising authority and resources, with the obligation to arrange and coordinate actions, as well as share powers and responsibilities in regional committees and rural health. The Regional Committee of health will be the agency of consultation, coordination and regional articulation of the SNDS. It will be chaired by the regional health authority and shall consist of a maximum of nine members representing the same institutions and organisations that build the National Health Council (MINSA 2002:10). Since January 2007 –during the second government period of President Alan Garcia– starts the transfer of the management of PHC centres to the local governments within the decentralization process of the health system. The transfer is through pilot projects that should be implemented in each department and the constitutional province of Callao, respecting prior existing microgrids, services, and networks.

According to the General Law on Health, MINSA is responsible only for the governmental functions and the administration of finances for national health programmes, but not for the provision and direct production of services, whether for public care or medical attention. Effectively, in point 4 of the preliminary title of the

General Law on Health, it is asserted: “Public health is a primary responsibility of the state. Individual health is a responsibility shared by the individual, the society, and the state” (CRP 1997). As a direct result of this legislation, the state is only required to finance preventive and promotional programmes, but not individual medical care, the costs of which must be covered by the persons themselves. In the analysis of this health reform in relation to equity, Ugarte and Monje affirm that the citizens received the right to the prevention and promotion of health, but not for actual healthcare attention. In fact, any form of medical care attention for individuals financed by the state will be part of a political decision of the government, but it will not be recognised as an acquired right of the citizens. “This position”, write the authors, “adopted by the state in front of the legitimacy of the right for healthcare attention is the brand of the fundamental difference between the so called collective and individual health” (2000:572, t. sp.). In this way, MINSA transferred hospitals and establishments from the first level of attention to private entities with their own legal capacity. According to this perspective of the reform, this transfer –which has the main purpose of significantly reducing the costs of the state– stimulate competition, and thereby improve the efficiency and quality of the services.

In order to overcome the structural inequity inherent in the system, the neoliberal health reforms have demonstrated an action that was intended to cover the target of action for equity. It has developed several programmes trying to allocate resources for coping with disease in populations with higher risk and lower income or precarious living conditions within the strategy of collective health development and prevention activities, advocacy, monitoring, and control. Some of these programmes, such as the National Tuberculosis Control Programme, the Malaria Programme (Roll Back Malaria) and Bartonellosis Control Strategy seek to identify those affected at an early stage and provide –albeit only in part– food boni, diagnoses and treatments free of charge. These programmes have an underlying policy concept that implies the subsidiary demand, i.e. the assignment of funds will be principally focused on those health establishments attending these cases in order to enable greater access to health services. In terms of access and equity, new barriers due to the reform have been discovered, because the incentives to the organisational reforms, such as shared responsibility in the financing, cost recovery

programmes, and measures of checks, are focused toward the population with greater resources and neglecting large sectors of the population, making the process of achieving equity even more difficult.

More than two decades have gone by since the concept of local management of health first appeared in PH policies, and since the WHO and the PAHO propose the importance and the need to develop local systems of health. Since then, however, little has been advanced in specific applications, as well as the methodological development and instruments giving sustenance to these models in Peru.

The Peruvian Constitution of 1993 (art. 131) and the Law 26300 *Ley de los Derechos de Participación y Control Ciudadanos*⁹⁹ (Law of Citizens' Rights to Participation and Control) recognise and establish the right to participation of citizens in public affairs with a greater emphasis on its political dimension, such as the referendum, and the removal of authorities as mechanisms of participation, rather than in its social dimension (represented by accountability). However, the co-management in the provision of public services by the state has not been an explicit mode in the regulations at the beginning.

The Supreme Decree 01' 94-SA, which gave rise to the shared administration programme and established the co-management model, is a regulatory standard without legal status. This situation was corrected with the promulgation of the Law 27658 *Ley Marco de Modernización de la Gestión del Estado*¹⁰⁰ (Law of Modernization of the State's Management) and the Law 26482 of 1997 *Ley General de Salud* (General Law on Health), which is mentioned above. The first law declares the Peruvian state in a process of modernization in its different bodies, units, organisations, and procedures, and establishes that it must promote and implement mechanisms to ensure an appropriate participatory democracy. Similarly, it provides that the citizen has the right to participate in the processes of budget formulation, monitoring, implementation, and control of state's management. The second law was the first legal norm that changed the concept of "citizen participation", and extended it to the management of PH services –

⁹⁹ See: <http://www.congreso.gob.pe/ntley/Imagenes/Leyes/26300.pdf>

¹⁰⁰ See: http://www.bnp.gob.pe/portabnp/pdf/ley_27658.pdf

the preliminary title of the law being “the state promotes the participation of the community in the management of public health services”– within the model of co-management of MINSA, acquiring a legal status as a policy institutionalized by the Peruvian state. The latter was further emphasised in the Law 27657 from 2002 *Ley del Ministerio de Salud*¹⁰¹ (Law of the Ministry of Health), which establishes the political will to articulate efforts between public and private actors to achieve the goals of the PH policies on health, and to reinforce the leadership of MINSA to harmonize plans of action and strengthen efforts and activities to enable the development of the tasks of provision of health services.

MINSA’s models of co-management, which led to the *Programa de Administración Compartida de los Servicios de Salud* (Programme of Shared Administration of Health Services) have their regulatory framework in the supreme decrees 01-94-SA and 002-2000-SA¹⁰². They prescribed that the *comunidades locales de administración de salud* CLAS (Local Communities of Health Administration) be constituted as legal persons with the object to manage, together with the state, the public resources for the provision of health services at a local level. The regulatory framework of the model provides the attributions and responsibilities of the central level, the DIRESAS (Regional Directions of Health), the CLAS, and the community. It also establishes the shared management programme (CAP) and the local health programme (PSL) as instruments of the model.

However, the experience of CLAS as a social participation concept is not new and has an antecedent in the ZONADIS, a similar form of social participation in health administration. The Ministerial Resolution 650-92-SA/DM, promulgated on 30th October 1993, created the *Zonas de Desarrollo Integral de la Salud* ZONADIS (Development Zones for Integral Health) defined as a local health system, responsible for the development of the health of the population defined in a specific territorial area. Health facilities and cohesive units, which activities were related to the promotion and protection of health and the environment, were functionally integrated to the ZONADIS. The ZONADIS were conceived as the basic primary level of the national health system, based on a model of articulation of all institutions and organisations of

¹⁰¹ See: <http://www.digemid.minsa.gob.pe/normatividad/LEY2765702.HTM>

¹⁰² See: <ftp://ftp2.minsa.gob.pe/normaslegales/2000/DS002-2000.pdf>

the community with public health institutions for the local administration of health centres. The ZONADIS remain as a conceptual attempt of direct democratic participation of the community at PHC level; in opposition to the CLAS, they were explicitly proposed to incorporate THPs in their activities. According to Fernández Ibarguén, the ZONADIS constitute a positive factor for the integration of the academic and the traditional medicines. On having incorporated the traditional agents, the coverage of the integral attention is guaranteed, because they are present in all the areas of the territory. They act on their communities and the leaders are chosen by their bases, and are permanent entities in the service because they are also a part of the community; they have been born there, they live there and know the idiosyncrasy of the population; they understand its problems and priority needs; likewise, every traditional agent is a treasurer of a baggage of knowledge and experiences for the curative properties of the medicinal plants; they primarily handle and use them in the treatment as natural resources. The whole set of experiences of the traditional agents constitutes rich investigation sources to enrich the academic medicine, especially to Peruvian medicine (Fernández-Ibarguén 1994:52, t. sp.). The ZONADIS were active between 1992 and 1993; subsequently, they were functionally replaced by basic units of health services (UBASS), as administrative organs of the ZONADIS.

The model proposed with the CLAS promotes the formation of community-based non-profit civil associations, oriented towards making the effectiveness of communal resources more viable, the exercise of rights and the co-responsibility to improve population's health. The associations have a legal personality of the private jurisdiction and are conformed of representatives of the organised community. MINSA, through the *Direcciones Regionales de Salud* and *Direcciones de Salud* (DIRESA/DISA), has transferred economic, material, and human resources to the CLAS up to the insertion of the regional budgets in the context of the decentralization process. Besides the normative and technical assistances, as well as control and supervision, MINSA supervises its functioning, whereas the CLAS operates by using the basic management instrument of the local plan of health (PSL). The first thirteen CLAS were installed in Peru in July 1994 (4 in *Ayacucho* and 9 in *Chincha*). Since its emergence up to the present, there are 763 associations CLAS that manage 2,152 Centres and/or health posts

at the national level. This amount represents approximately 33% of all of the establishments of the first level of care. In their scope of operation, they serve a population of approximately 8,500,000 inhabitants, with layers of greater poverty living in rural and urban-fringe areas (MINSAs 2008).

In terms of initial success of the CLAS experience in Peru, some research (Altobelli 2002, Vicuña 2000) shows positive results, such as active participation of the civil society in the management of services and the enhancement of involved organisations. According to an AMARES report, the CLAS represent an innovative model of administration for the first level of attention, and was successful in promoting the empowerment of the civil society and improving the health standards of the community (AMARES 2003:268-272). Hunt also argues that while experiences have varied, CLAS have reportedly shown to be facilitators of enhanced community empowerment and participation in the delivery of health services and health promotion, commending CLAS as a good practice concerning health-related community participation, and further encouraging the government to take measures to improve and refine CLAS and to extend the scheme throughout the country (UN 2004:13). In regard to the participation of the community in the design, supervision, and evaluation of the PSL this is still relative, because it continues depending strongly on the capacities of professionals to establish equalitarian relationships in relation to the demands of co-administration. As reported by Ugarte and Monje (2000), health reform has circumscribed the social aspect of sustainability to the conformation of CLAS. Although it is an interesting form of participation and incorporates community representatives for health administration, the process has not taken into account the opinion of important actors in the sector, such as health professionals, building institutions, representatives of trade unions or politicians, and actually marginalizes local governments. "This leads to the fact that reform has a great social vulnerability in the medium and long-term, because it does not arise from social consensus but almost exclusively on the imposition of those who hold the government in the present period (2000:607, t. sp.).

Since 2002, ForoSalud (Forum for the Civil Society on Health¹⁰³) has taken on the role of civilian vigilance and social control over the health sector and the government at a regional level (ForoSalud 2007:3-4). The ForoSalud is a group of civil society, primarily Western-trained health practitioners and social scientists, who came together to evaluate the situation of PH and to develop proposals for improvements in different areas, from expenditures and contributions up to social participation in general health policies. In biannual national health conferences, members of ForoSalud meet to discuss public health projects, and to propose solutions to problems related to healthcare attention. Besides these meetings, there are permanent *mesas* (thematic committees) devoted to subjects such as Human Rights in Health, Medication, Environmental Health, and Traditional and Complementary Medicine, as well as specific regional committees (FOROSALUD 2007). According to Mérida Aliaga, coordinator of the *Mesa de Medicina Tradicional* (Committee of Traditional Medicine) of FOROSALUD, the association constitutes a social movement for health rights respecting human rights, gender issues, and interculturality, looking to support national development with equity and social justice (Aliaga 2006). The Mesa de Medicina Tradicional was formed at the second Conference of National Health in 2004, based on the work of several committees already in place, and focused on TM as a valid resource to guarantee the health of the population. It emphasises values of dialogue, solidarity, and justice as part of citizen participation in the definition of policies of health and the transversal subject of sustainable development in health and education (FOROSALUD 2005:93-97). The objectives of the Mesa are, in general, to systematize development proposals, and to promote and research TCAM in Peru. More specifically, the Mesa de Medicina Tradicional seeks to develop situational diagnostics of TCAM and to initiate politically positioned policies for the incorporation of these medical systems.

¹⁰³ See: <http://www.forosalud.org.pe/>

3.3 Intercultural Health Policies

When I worked at MINSA, I used to be in this botanical garden at least twice a day. I saw the plant of the ayawaska there; it was the biggest in the whole garden. And it's also the only one that reaches the window of the minister's office, in the second floor. But nobody is aware of it. Do you see? This garden is just like Peru (Psychologist iw/2009)

One of the pending tasks of the health policies in Peru is the recognition of the cultural diversity. The cultural diversity, also called *ciudadanía compleja o diferenciada* (complex or divergent citizenship) (Fuller 2004), implies a right to intercultural health, defined as a space of balanced dialogue and consensus building among the different medical traditions of the peoples.

The limited capacity of the state's response to promote and secure health attention for the majorities in the country led to the convergence of efforts among communities and organisations of the civil society, to reverse or decrease inequality and suffering of the poor and excluded groups. Also, the Catholic Church through their pastoral groups, NGOs, international, and –to a lesser extent– governmental cooperation, spurred rural programmes of basic HC, disease control, education and health promotion. A dynamic element was the PHC strategy, which included intensive work to extend coverage in the 1970s and 1980s (Nino and Vargas 2012:34). In Peru, the PHC is conceived as a set of two types of activities closely coordinated, which include the community itself regarding health, and the provision of basic services of the formal health system to the rural or poor population.

Following the WHO mandates on indigenous health, submitted nearly two decades ago, MINSA has conducted a set of strategies to promote comprehensive care among Andean and Amazonian populations, with a special focus on interculturality. From 2003 onwards, specific initiatives to achieve these goals have been carried out:

- (1) The creation of the *Centro Nacional de Salud Intercultural* CENSI (National Centre for Intercultural Health) in 2002 as part of the National Institute of Health INS;

- (2) The design of the National Health Strategy for Indigenous Peoples in 2004, with successive policy programmes. The most recent plan is for the period 2009-2012 (cf. MINSA/INS/CENSI 2010).
- (3) The Technical Standard Norm for Vertical Delivery Assistance with Intercultural Adaptation¹⁰⁴ in 2005;
- (4) The Technical report “*Adecuación Cultural de la Orientación/Consejería en Salud Sexual y reproductiva*”¹⁰⁵ (Cultural Adaptation of the Counselling in Sexual and Reproductive Health) in 2008; and
- (5) The Technical document “*Gestión local para la implementación y el funcionamiento de la casa materna*”¹⁰⁶ (Local Management for the Implementation and Function of Maternal Houses) in 2010.

3.3.1 The Ministry of Health – MINSa

3.3.1.1 The National Institute of Traditional Medicine - INMETRA

Making use of the trend to broaden the coverage of health services implemented in the country since the end of the 1960s, the health sector sought to draw human resources from the community. Primarily, THPs, once trained, were to be the first level of containment of the demand for care. The reference of cases and dissemination of personal hygiene measures, and the promotion of healthier life styles were the main activities. This constituted the movement of community health workers –a term involving the health promoters– traditional birth attendants, and other actors in the community, trained to assume a role in HC for their communities, although the greatest effort in the last years of the 1960s was aimed at training health promoters. International and national health development initiatives of capacity building, implemented since the 1970s, sought to train local healers in Western medical practices.

From the perspective of the international health policies, INMETRA appeared in the context of policy movements towards an “intercultural medicine” and the initiatives around PHC that marked the 1980s and 1990s, beginning in 1978 with the excerpts

¹⁰⁴ Resolution 033-MINSA/DGSP-V.01: http://bvs.minsa.gob.pe/local/dgsp/106_NORATENPARTO.pdf

¹⁰⁵ Ministerial Resolution nr. 278-2008: <ftp://ftp2.minsa.gob.pe/normaslegales/2008/RM278-2008.pdf>

¹⁰⁶ Ministerial Resolution nr. 815-2010: <http://spij.minjus.gob.pe/Graficos/Peru/2010/octubre/23/RM-815-2010-MINSA.pdf>

of the Conference of Alma Ata. As Iberico writes in regard to the creation of INMETRA, the Peruvian MDs Carlos Alberto Seguín and Fernando Cabieses – motivated after the Alma Ata Declaration– organised the First World Congress on Traditional Medicines with support of the WHO in Lima in 1979¹⁰⁷, with the attendance of delegations from 28 countries (Iberico 1992:1). The same organisers initiated the second international congress in 1988. This time, 4,200 people from 41 states attended sessions simultaneously in 10 cities in the country. Also, numerous members of the CM attended the conferences this second time.

Inspired by these experiences, MINSA, with the legislative decree 504 of 18th April 1990 in its chapter XI, article 31, created the National Institute of Traditional Medicine (INMETRA). The legal dispositions for INMETRA were provided by the General Law on Health 29842, in the article XVII, which establishes that “the promotion of traditional medicine is of interest to and demands preferential attention from the state”. The decree 584¹⁰⁸ of 1992, the law of the organisation and functions of MINSA, and the supreme decree 002-92-SA¹⁰⁹ for the implementation and regulation of management and duties, establish the assignments of the INMETRA. The institution was conceived as a decentralized governmental agency¹¹⁰ responsible for the coordination and the proposal of policies for TM, as well as to develop the investigation, education, and integration of it to academic medicine to contribute to raise the health standards of the population (DL 584, article 31; SD 002-92-SA). INMETRA initiated its activities in 1991 as a pioneer entity with governmental rank at the time of its formation in Latin America. Specifically, it prepared the mechanisms for the articulation –not the integration– of TM at the PHC level of attention.

¹⁰⁷ The organisation of this congress leads to the temporal obliteration of the medical practice permission of both organisers by the CM, appealing an “infringement of the codex of conduct” of the CM (Eyzaguirre 2005a). Peru’s Health Minister declined the invitation to participate in the inaugural ceremonies of the event.

¹⁰⁸ See: ftp://ftp.minsa.gob.pe/intranet/leyes/DL-584_LOF-MINSA.pdf

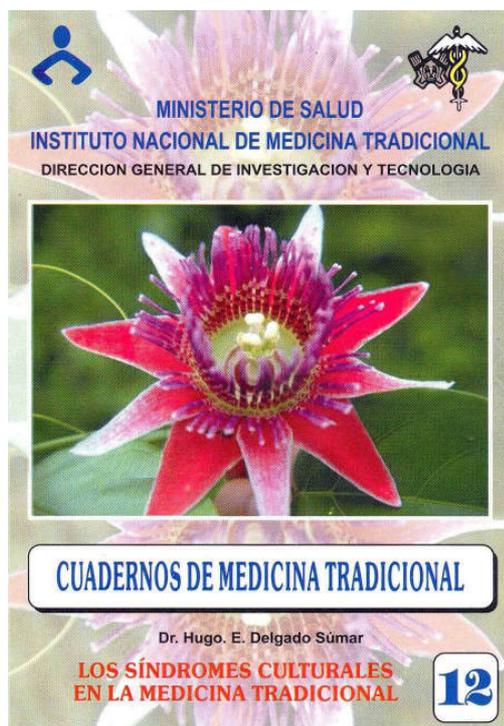
¹⁰⁹ See: ftp://ftp2.minsa.gob.pe/normaslegales/1992/DS-002-92-SA_ROF-MINSA.pdf

¹¹⁰ A public organism (a governmental administrative agency) is an autonomic entity responsible for an activity, or of several interrelated, whose regulation and existence derived from the public law and the constitution. The agency is the result of the division of activities within the public administration, each with a specialized regime. The autonomy is variable, since it may involve certain levels depending on the activity being performed. As a result, the public organism enjoys public legal personality, the same that implies certain privileges, in accordance with the constitution and the corresponding laws. Governmental agencies are: constitutional organisms, decentralized government agencies, ministries and local governments, with their own characteristics and their respective autonomy’s regime.

According to Iberico (1992:2-3) the principal objectives of the INMETRA were:

- (1) The promotion and development of research to identify, recognise, register, disseminate, and raise the value, concepts and knowledge underlying uses and practices, experiences and customs, and the diverse products and resources which conform the TM of the different ethnic groups of the country.
- (2) The advocacy, orientation, and development of educational actions enabling the acquisition and spread of knowledge related to TM among health professionals.
- (3) The decentralization of specialized services of the institute through the assessment and establishment of norms for the organisation and development of public and private regional services, and the education and training of their personnel in the field of TM.
- (4) The contribution to the democratization of health in Peru, by giving priority to indigenous, rural, and marginal urban populations in accessing health services.
- (5) The identification, recognition, registration, and promotion of persons identified as serious practitioners of TM, and subsequently their incorporation as potentially valued personnel in the implementation of specific functions and activities of the institute for the organisation and development of local and regional, public and private services.
- (6) The encouragement and advance of the production, commercialisation, and systematic utilisation of the diverse resources, products and elements used by the TM.
- (7) To norm and suggest appropriate legal dispositions to protect the medicinal flora of the country from indiscriminate exploitation, recollection, and commercialisation threatening their extinction.
- (8) The regulation and control of the application of traditional health practices and the use and commercialisation of natural resources with therapeutic purposes at the PHC level.
- (9) As a collaborative centre, to develop assessment, counselling, training, and organisational agenda on TM, in the academic and service fields, also in other countries of the region.

Fig. 8: Publications of INMETRA



The Series “Cuadernos de Medicina Tradicional” by Hugo Delgado Súmar, published between 1998 and 1999, counted 24 bands with information about Andean medicine (Photo Pribyl 2010)

The geographical focus of action of INMETRA was concentrated particularly in towns of the Andean region, but also in urban poor settlements on the coast. However, INMETRA expanded its activities to the Amazonian region, as in 2001 the multi-sector Commission for Native Communities was created. INMETRA joined this advisory commission formed by several governmental agencies in representation of MINSAs. Afterwards, the work was extended to the department of Amazonas in the rainforest, for communities of the Awajún and Wampis alongside the Santiago River (Eyzaguirre 2005a). At the end of 2001, INMETRA had established 18 branch offices in all of the country’s regions. The set of activities assumed by INMETRA can be subsumed under four principal headings: the interchange of experiences with THPs; the development of training courses about the utilisation of medicinal plants to health professionals; the implementation of botanical medicinal gardens; and the submission of guidelines, norms, and publications. The publications of congress memories, fact sheets, and meetings by INMETRA included important contributions on the medicinal flora of the

Peruvian highlands and the Altiplano; further publications of INMETRA also included THSs of the Peruvian Amazon region.

The former, and during its existence the only director of INMETRA, was the neurosurgeon Fernando Cabieses Molina. Son to a Peruvian diplomat and a Mexican woman, Fernando Cabieses Molina was born in Mexico in 1920. During the Mexican revolution, he and his father returned to Peru in 1935¹¹¹. His intellectual work is prolific and abundant since he graduated in medicine and biological sciences from the Universidad Nacional Mayor de San Marcos in Lima in 1945. At the University of Pennsylvania, he obtained a degree in neurology and brain surgery. He was a member of the American Medical Association, the American College of Surgeons, and also worked as professor of clinical neurology at the University of Miami. On his return to Peru in 1950, he introduced the surgical treatment of brain aneurysms and the surgery of epilepsy, and founded the neurology departments at the *Instituto de Enfermedades Neoplásicas*, *Hospital del Niño*, *Hospital Arzobispo Loayza*, *Hospital Dos de Mayo*, and in three other hospitals of the Armed Forces. In the first decade of his academic work, between 1945 and 1955, Fernando Cabieses published more than 50 scientific articles in prestigious journals, mainly in the Peruvian Society of Neuropsychiatry (Dextre 2008:222). He was the director of the Peruvian Museum of Health Sciences from 1976-1990, and the founder and first director of the National Museum of Peru, from 1988 to 1990. After INMETRA and his parallel work as university professor in Peru, his last principal activity was as Rector of the *Universidad Científica del Sur*. He published 36 books and over 300 scientific papers. He died in January 2009 at the age of 90.

Aside from his indubitable prolific scientific and academic work, the role of Fernando Cabieses as director of INMETRA (1990-2000) was contentious for some Peruvian scholars and specialists on intercultural health. At the beginning of an interview to this respect, an MD summarized this apparently conflicted perception as “all what you’ve heard about him, the good and the bad, is true” (MD iw/2009). On achieving more

¹¹¹ Through the Mexican revolution (1910-1920), the dictatorship of the president Porfirio Díaz succumbed, who had favoured the middle and upper Mexican class to the detriment of the majority of Mexicans during 35 years of porfiriato. The land reform affected Cabieses’s father’s landholding and was the principal reason to return to Peru in 1935, at the age of 15.

specific information about his role in the elaboration of public policies in TM, I interviewed former INMETRA staff members accurately. Most of the opinions cited here may starkly contrast the institutional and academic publications about him and his work in INMETRA.

He used the institution only to write his own things. His books were financed by INMETRA... Alan Garcia gave him INMETRA as a gift -but for him, not for the nation (Psychologist iw/2009)

His strong personality was the reason the experience of INMETRA did not succeed. In a moment it seems to be an interesting work team, but he was the star, he was the authority, and he never wanted to give space to other people. Thus, the experience of INMETRA was a frustrating one (Sociologist iw/2009)

INMETRA served him mainly to propagate his own work, to be able to edit them luxuriously and to show that all the work going out of the institute was from him. On the other hand, he used to “cut heads” when someone wanted to become more important than him, or sent people with little experience and knowledge to do fieldwork. He was clearly not interested in the healers (MD iw/2009)

I never liked him because he said something with the one hand, but with the other hand did the opposite. For example, he talked about the benefits of the medicinal plants and the Amazonian resources, but he was the first in bitterly criticising the traditional therapies and rites (University Dean iw/2009)

During the twelve years in which Cabieses was in INMETRA, how many medicinal plants do you think came into health centres for treatment? Not even one! (Coca Specialist iw/2009)

For him the parteras were only “chicken breeders”. He said exactly that in a public forum (Anthropologist iw/2009)

INMETRA was him and only him... he had an ego inversely proportional to his size, and was in possession of very good manners, fabulous knowledge and contacts... he won prizes and made a name as the engine of the traditional medicine in Peru -although he wasn't, and he didn't like it, neither the traditional medicine, nor its practitioners (MD ec/2011)

Cabieses has already passed by. He didn't named successors before he died, thus, INMETRA turned back into the orphanage. But, in fact, INMETRA was made for him, not for the people (Anthropologist iw/2009)

The books of Cabieses about traditional medicine are almost fiction novels. For him, traditional medicine was rather something for museums, meaning that traditional medicine had existed in the past and was very nice and exciting, and for sure we could be proud of it, but for him it had no value at the present (TM Researcher, University Professor iw/2009)

He didn't have field experience. He did all his work from the desktop. I don't want to talk about Dr. Cabieses. From my point of view it was a very negative experience. Although we all still remember him as the promoter of traditional medicine, that's not true. All those who have lived the experience with him know that it was not the case (Sociologist iw/2009)

According to some of my informants, the work realized by INMETRA has constituted, indeed, a first concerted and useful attempt in the generation of intercultural spaces of meeting and rapprochement, with a different look and without prejudices, to a medical system that followed a process different from that of the Western medicine, and that has solved, and continually solves, health problems of a considerable percentage of the Peruvian population. Beyond the indisputable contributions of Cabieses to the study of TM –and the considerable efforts of its staff through its different periods– INMETRA constitutes probably one of the most representative and interesting cases for the analysis of local policy making structures in Latin America. Strictly speaking, one could assume that we are in front of an institution that was systematically confounded with, or even disappeared, under its leader's impressive personality. Yet, the study about the origin, development, and decline of INMETRA and its importance in relation to public health discourses in Peru has yet to be properly investigated.

3.3.1.1.1 The Integration Model Proposed by INMETRA

Although the focus of the founder of INMETRA was –and in most of the cases continues to be– a standard approach when studying the academic contributions of the institute, in contrast, analyses of the policies' proposals submitted by INMETRA are modest, if existing.

Before the creation of INMETRA in 1990, MINSA addressed TM above all as a local resource that should become useful for the formal HCS at the PHC level. Besides the advisement of policies and strategies for the harmonization of the different cultural groups of the country (Cabieses and Fernández 1994:200), INMETRA follows education and training activities with the purpose to fulfil the directives of MINSA in this regard, and to make suitable the “adaptation” of THPs for their work in HCS.

The central motive to advocate the integration of TM in HCS is defined a priori by INMETRA as a public health need in Peru. By using existing local resources, i.e. THPs, the low HC coverage of the rural population should be compensated, since there are no other options to improve it, and the costs are too high to attempt other solutions. The main conception has an instrumental and pragmatical character: “No budget could have sufficed for a country like ours. For this reason it is necessary to communicate with the agents of the traditional medical system. The academic or Western medical system increasingly seeks a sophisticated expensive acquisition of more complex equipment and auxiliary devices for diagnosis and treatment. It requires a high investment to equip these services that, in addition, are faced with sometimes impassable cultural and logistic obstacles... at the PHC level, where the activities of both medicines should be articulated, there is no need of high-cost equipment or materials, and it is more likely to overcome the cultural barriers. Furthermore, the financial amount of linked activities at this level is comparatively low in relation to the urban academic system. Then, it becomes feasible to extend the comprehensive coverage of healthcare by linking the human resources of the traditional system” (Cabieses and Fernández 1994:204, t. sp.).

The rural population also adduces the need for this integration in terms of geographical disposition and the physical reachability of HC centres. The premise was that “TM has conquered those territories to which the scientific medicine has not come, because of economical, logistical or cultural reasons” (Cabieses and Fernández 1994:217, t. sp.). In other words, if Western medicine reaches new territories and brings biomedical HC attention to the population –which is the principal goal– TM is no longer needed there and consequently has no more reasons to continue existing. Meanwhile, as long as TM is the only possibility available in those regions, the local health resources should be trained and adapted according to biomedical HC standards in order to make possible the access of the population to Westernized HC attention.

A desideratum of INMETRA was the revalorization and preservation of the “positive aspects” of TM; a postulate that was repeatedly reflected –under other referential points– in further publications of the institute (cf. Cabieses 1993a; Fernández-Ibarguén 1994; Delgado Súmar 1999d). Regarding the emphasis on differentiating the “positive”

aspects of TM, Cabieses and Fernández alleged that although in pre-Hispanic times the medicine reached a highly developed degree within an interesting holistic model of care, the Conquista of Peru produced a process of *deculturación*, which led to the obstruction of TM's development, and to its withdrawal to the “lower and marginalized socio-economic strata” (Cabieses and Fernández 1994:198, t. sp.). Delgado asserts that once produced, the de-structuration of the Andean world due to the European presence, it is undeniable that an important part of the technological and scientific knowledge managed by the governing elites disappeared during the process of the extirpation of idolatries. “However”, Delgado writes, “another part, no less important, was kept alive in the villages, transmitted from generation to generation, to endure until our days. Since then, this knowledge suffered a permanent deformation; at first, it was the result of an acculturation process, and as a consequence of the domination process started in the colony, forced the Andean medicine, as well as the religion, to a clandestine and undercover exercise” (1999d:4, t. sp.).

As a result of these conceptions, INMETRA was basically dedicated to the investigation and promotion of the retrievable –i.e. profitable– therapeutic aspects of THS. INMETRA was in charge of the *Dirección General de Investigación y Tecnología* (General Direction of Research and Technology), a programme that was responsible for carrying out clinical research, conducting medical anthropological research, gathering demographic statistics, and facilitating the integration of traditional and allopathic medicine. The evaluation of studies on TM with scientific bias and the promotion of focused research on phyto-pharmaceuticals and natural products, i.e. the promotion, control, research, and cultivation of medicinal plants, were the most important thematically issues addressed in INMETRA submissions, with some variations among the different periods. Ten years after its implementation, the institution was about to accomplish an ethno-botanical atlas, the creation of a guideline for identification and register for THPs and the introduction of comparative research of psychoactive substances and neurotransmitters in Peru and Latin America (PAHO 1999b:28). During his time as director of INMETRA, Dr. Cabieses was instrumental in coordinating a network of 16 ethno-botanical gardens in Peru, which included the cultivation of medicinal plants used by traditional herbalists. He also facilitated scientific research on

TM by building a large database of herbal plant uses. According to the PAHO (1999b), the subsequent administration discontinued these innovative programmes and erased the database.

Although centuries and decades of the Peruvian history have passed by with numerous cases of systematic persecution of THPs, Cabieses himself consistently purported that TM was always accepted by the *oficialidad* in the country, and that THPs had never been proscribed from their work: “There is in our country a special symbiosis between the traditional and the official medicine that was always accepted... Both have been living for years together; nobody persecutes the professional work of the agents of TM” (BBC 2007, t. sp.).

In fact, INMETRA represents a “purist” tradition among scholars in relation to the population’s medical practices and preferences. They have conceived the population’s choices of use and decisions in health attendance as a matter of excerpting exclusion; i.e. people seek medical help *either* in the academic *or* in the traditional system, but in any case attend *both* systems. “As we already know, academic medicine constitutes the official or formal system and the traditional medicine the informal one. Over centuries, both systems have gone by themselves, and the Peruvian population is divided into two big groups: the ones using the academic system and the other ones utilising the traditional system” (Cabieses and Fernández 1994:209, t. sp.). Nevertheless, informed research conducted during the last two decades gives contrary evidence to this postulate, asserting a combined use of both biomedical and traditional medicine in Latin America (cf. Pedersen and Coloma 1983; Menéndez 1993, 2003; Koss-Chioino, Leatherman and Greenway 2002; Armus 2002; Albó 2004; Fernández-Juárez 2004; Campos 2004; Mignone et al. 2007; Ramírez 2010; etc.). Furthermore, this pattern seems to be extensively constituent of the popular medical practices in Peru (cf. Cárdenas 1990; Schupp 1991; Chiappe 1993; Andritzky 1999; Eyzaguirre 2005). Recent studies found that the tendency of the population is the consumption of pharmaceuticals and medicinal plants combined in alternated or parallel ways. Although herbal use and the consultation of herbal specialists is continually present, there is some evidence of its decreasing use in favour of pharmaceutical products consumed in local communities, at

least in northern Peru (Bussmann, Sharon and López 2007:194); however, in the Andean region a conversant herbal specialist uses between 300 and 400 different plants with specific healing purposes (Bussmann et al/2009). Another study has found that participants in Cochabamba (Bolivia) and Pitumarca (Cuzco, Peru) perceived the different treatment options not as mutually exclusive, but as complementary. Increased presence of the formal health sector does not necessarily displace indigenous medicine in the rural Andes; if anything, these two systems can coexist in complex ways. As Mathez-Stiefel et al. assert, health strategies of Andean households denote a strong aspiration for autonomy in the management of health based on own cultural beliefs: “This was observed in the prevalence of self-treatment over other therapeutic strategies and in valorization of own knowledge about natural remedies. This striving for autonomy echoes current struggles of Andean peasants in other spheres of daily life, such as in governance and management of territory and natural resources” (2012:17).

3.3.1.1.2 The Training Programme for Traditional Health Practitioners

The MD Manuel Fernández Ibarguén, sub-director of INMETRA and close collaborator of Cabieses, submitted an interesting publication in 1994 addressing a proposal for an integration model for THPs in HCS (Fernández-Ibarguén 2004). According to this, the national HCS integrates autonomous health institutions, such as MINSA, ESSALUD, FF.AA and PNP, as well as the private sector that offer opportunities for the community to work co-ordinately and actively in the elaboration of health policies. “In this task”, the author says, “the agents or practitioners of TM have an important role; once incorporated into the formal system they turn out as official guardians of the community’s health; after receiving according training they acquire more leadership and major effectiveness in the treatment of the community’s patients”. The incorporation of THPs means the conquest of a worthy ally for health, because they are the ones who know the environment and the natural resources they use to tend to their patients: “The community relies on them since they are recognised leaders by the community itself and as such, they have influence over the population they serve” (1994:19, t. sp.).

In facing the PH problem in Peru, the articulation of the academic with the traditional system arises through a programme of recruitment, selection and training of THPs, to be incorporated as part of the formal staff of MINSA. The education of THPs constitutes the cornerstone of the articulation. These agents should be chosen by their own communities and, after being “properly” trained, they will continue serving in their respective communities. The model suggests the inclusion of these agents in the formal system of MINSA within a paid model, in which they receive a vital minimum wage for their work. In doing so, an “indirect way” of supporting the community in the socio-economic aspect could be reached. The success of the programme will be carried out based on health measurement procedures, considering the variables and indicators of epidemiology, health status, and a statistic of the vital and demographic facts of the target population, in general. Additionally, THPs should collaborate with MINSA in registering information (Fernández Ibarguén 1994:20).

Fernández argues that the articulation model proposed is not only merely a strategy to extend the coverage of healthcare attention, but also a plan of action with very significant impact in favour of the real democratization of health and the psychosocial development of the population, towards a mainstreaming homogeneous national identification: “the articulation... is founded also on the principle of cohesion of human and material resources in the sector. Instead of maintaining separate the two medical systems, they should be articulated for a common goal, using the same services at the primary healthcare level, where the simplified medicine would be taught” (1994:20-21, t. sp.). This is the principal point of contact to realize the articulation of the two systems. The feasibility of the model is given principally by financial considerations, because the cost for it will not increase the expenditures on health whereas a comprehensive coverage of human resources trained in rural areas could be implemented. The proposed training covers all of the country and all traditional agents, it should be permanent, and with active participation of the universities in the training programs. The cost of this methodology will be measured by the indicators of health standards, in relation with the targets of MINSA (Fernández Ibarguén 1994:21).

The THPs selected to join this training programme are specifically identified: they are parteras, curanderos, herbalists, and bonesetters, who will be divided into two groups, the illiterate and those who can read and write (Fernández Ibarguén 1994:63-64). The progressive implementation method is proposed for all THPs, including preferentially the parteras who, after a proper training, are incorporated into the formal system, receiving the vital minimum salary “for their needs, and with the purpose that they do not surcharge additional money from the patients; anyway, they may receive rewards in species”. This wage system would indirectly support the community as onwards it would continue to provide access to care attention for the community by their traditional doctors, but in a traditional system of solidarity exchange (Fernández Ibarguén 1994:35-36). “This methodology is a way to democratize health attention... a vital minimum fee for traditional health workers has significance and has a multiplier effect in the economy at community level. The community is relieved in its economy due to the non-charging of money by healers; however, through this mechanism, the population will become aware of the support of the state, and could value its indirect presence on their territory” (1994:35-36).

For the implementation of the pilot training program, INMETRA set some basic conditions (Fernández Ibarguén 1994:65-66):

- (1) The THPs (i.e. parteras, curanderos, herbalists, and bonesetters) should be selected by the rural community where they work, on the basis of a professional activity of more than three years of duration, certified by the leaders themselves. This is the only but avoidable condition to be admitted to the programmes without any other requirement.
- (2) The participation of the local universities in the development of the programs is intended to raise the category and give prestige to the training program, revaluing the social and community position of the traditional agents.
- (3) The training courses will have a maximum duration of four weeks. Each agent selected for the training may not take more than two courses per year, separated by a period of at least six months. During this time, they will have to keep on serving their community.

- (4) The training courses are designed by the National Institute of Traditional Medicine with the advice of the National School of Public Health, the National Research Institute of Industrial Agriculture, the involved universities, and other institutions related to the purposes of the project.
- (5) Some example topics of the courses are: Care and maintenance of safe drinking water; organic gardens with medicinal and nutritional plants; care and maintenance of domestic animals; primary treatment of diarrheal processes; primary treatment of wounds; primary treatment of respiratory processes; use of sedatives, narcotic and psychoactive plants; fight against the use of alcohol and other drugs; attention of the childbirth and newborn care; pregnancy and family planning; breastfeeding and child feeding; construction and maintenance of latrines; excreta disposal; vaccination programmes; and health and nutrition educational programmes.

In the stage of planning and the execution of the training programmes, some assignments should also be accomplished, such as the definition of the specific tasks and functions of THPs; the selection and preparation of professors and trainers (in which the trained THPS could also participate); the number of health trainers of the jurisdiction; selection of the trainees with participation of the community; determination of the incentives for THPs; evaluation of the learning and teaching materials; and, subsequently, the evaluation of the trainers and teachers (Fernández Ibarguén 1994:67). The articulation's process of THPs in health services should be achieved during the training programmes. They will be supervised in this regard, to determine the degree of "amalgamation" with the formal care services, or to identify the problems they are confronting. In achieving results on this, the health personnel of the centre should be oriented to receive and work with the trained THPs; the THPs will required support such as transport and communication fees; the supervision should be conducted by a technician in PHC with experience in peripheral work –this person could be a nurse, obstetrician or even a trained THP–; as well as the evaluation of the formation's program, THPs' performance, quality of healthcare services, and impact on the health status of the local population (Fernández Ibarguén 1994:67-68). The model concludes

with a statistical estimation of the health promoters required according to each geographical area in the country.

In analysing a previous experience carried out in the region of Cajamarca with parteras and supported by UNICEF and the Cajamarca Hospital in 1977, Fernández proposed a specific strategy to fulfil the enforced data schedules of the centre, and to provide statistical information to MINSA. As it was commonly the case, when THPs are illiterate, the use of colour threads was proposed as a solution. The colour and the number of knots can establish the sex and condition at birth: red with a knot means a male newborn; red without knot a female newborn; for sick newborn a yellow thread; and a black one for a dead infant (Fernández Ibarguén 1994:69). It is noticeable that by the selection of this ingenious strategy, they do not conceive a literacy course for THPs as a possible solution for the registration process of births, or even as a preparation course for the training programmes¹¹². On the other hand, a special database administration in Quechua would also have been a solution, however this possibility was not even perceived.

The focus on the necessary training of THPs to become part of the formal system under these conditions essentially demonstrates a utilitarian perspective. Additionally, it would only be applicable if THPs learn basic technical abilities of Western HC, and move away from the “irrational” or magic aspects of their practices. Thus, one of INMETRA’s directives asserted that “the training of agents of traditional medicine plays a preponderant role to change the mentality and the behaviour of these human resources” (Cabieses and Fernández 1994:209, t. sp.). I identify in this institutional statement of INMETRA a basically negative perception of THPs. They are perceived in essence as persons that are intrinsically wrong in their worldview, with defective habits or practices, and inherently inefficient to deal with healthcare. However, they are still needed, and therefore it is necessary to get them instructed in the “appropriate” knowledge.

¹¹² Anyway, 6 to 8 months of courses attendance do not guarantee the achievement of solid reading and writing skills; it depends more on continuous and progressive educative processes (Vásquez, Luis ec/2012).

It would be reasonable to think that such a strategy should go beyond this unidirectional perspective to a bidirectional one, which would imply, for instance, the implementation of training programmes, courses, and education for medical students to enable them to understand and accept THS and its practitioners. Nevertheless, this point was never contemplated within the integration proposals of the INMETRA¹¹³. Moreover, Cabieses pointed out in several occasions that this idea is absolutely irrelevant: “The doctor and medicine students already have the possibility to come into contact with surrounded traditions in the everyday life of the village. Traditional medicine is not something that one could find in libraries, because the grandmother or the woman who handles the plants at home is the one who best teaches the students. For this reason, a formalisation of this teaching is not necessary, because such education will filter slowly in the daily life of students. The introduction of a special course about traditional medicine in the medicine curricula is pointless for sure” (BBC 2007, t. sp.).

3.3.1.2 The National Centre for Intercultural Health - CENSI

The National Centre for Intercultural Health (CENSI) was created on 28th January 2002 as an organ line of the National Institute of Health (INS) on the basis of the functions assigned to INMETRA. CENSI is conceived as a governmental entity with specific competitions on the subject of TM and CAM, nevertheless with a lower category as the former INMETRA¹¹⁴. The calls given to CENSI were the same as to INMETRA in relation to research, systematization of ethno-botanical databases, and the proposal of policies, programmes, and strategies related to TM –though with the interpolation *quid pro quo* of CAM as avocation’s subject. The principal functions of CENSI are the knowledge and practice’s articulation of TCAM within the academic system in the national coordinated and decentralized HCS (MINSAs 2008). For the achievement of these purposes, CENSI develops activities of scientific and technological research,

¹¹³ For sure, some courses about TM were imparted to medical students and health professionals in several institutions such as medical faculties, branch offices of INMETRA, the CM, and the Peruvian pharmaceutical association, among others. Nevertheless, these courses were not conceived as part of INMETRA’s integration model, rather as informational courses, not conceived to be part of the formal medical curricula, and therefore not susceptible to be evaluated and monitoring.

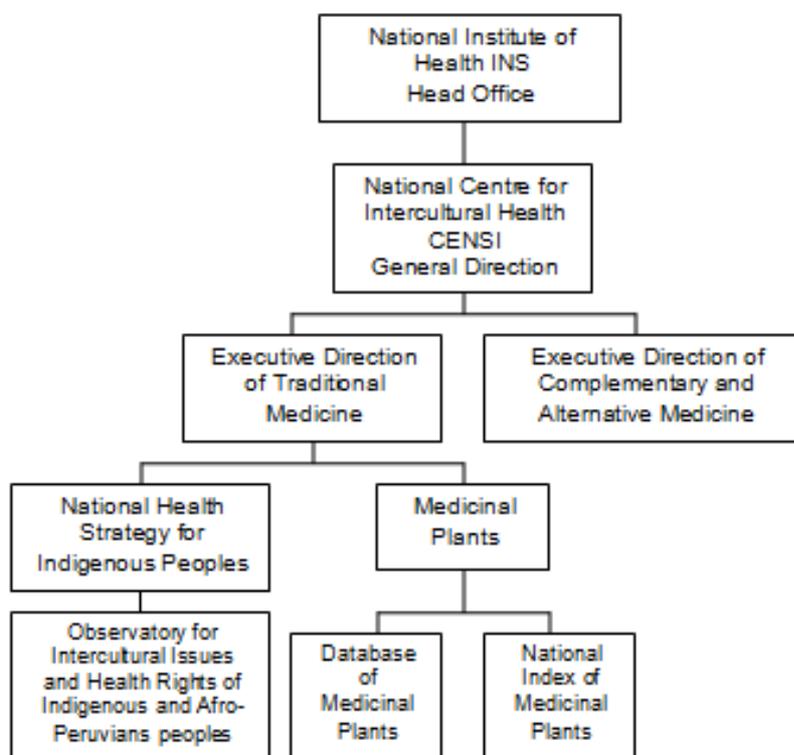
¹¹⁴ INMETRA was a governmental administrative agency with autonomy and a specialized regime, as the INS. CENSI is only one of the four centres of the INS with the category of organ line (equivalent to a department or management direction) that executes and supervises the tasks provided to it by the INS in the field of intercultural health.

training, dissemination, and promotion of health programmes, as well as the development of policy proposals and strategic health with an intercultural approach. CENSI is responsible for the development of the national herbarium and the pharmacopoeia of medicinal plants, as well as the promotion of supplements' alternative uses in health. Other of its principal assignments is the implementation of a model of interculturality in health. In this point, principal functions regarding intercultural health programmes are the promotion of trans-disciplinary research on health prevention and care practices, as well as the evaluation of risk behaviours in the context of social change and cultural collision.

The following commissions underlay the activities of CENSI:

- (1) The proposal of policies and strategies for intercultural health;
- (2) The promotion, development, and dissemination of scientific research and technology in the field of intercultural health;
- (3) The design, implementation, and strengthening of botanical gardens, herbariums, and bio-gardens of medicinal and nutritional plants;
- (4) The submission of suggestions for the execution of plans, programmes and projects for the transfer of technology, capacity building and educational extension in the field of TCAM;
- (5) The programming, standardization, controlling, and evaluation of the development and articulation of TCAM;
- (6) The development and proposal of standards that regulate and promote the application of practices of intercultural health in healthcare;
- (7) The production, use, and commercialisation of resources and natural products of medicine, nutrition, and their derivatives;
- (8) The establishment of protocols of integration for the articulation and complementarity of intercultural health;
- (9) The participation as a technical, scientific, and standardized entity for the public and private health sector.

Fig. 9: Functional Diagram of the National Centre for Intercultural Health – CENSI



In accordance with the scope of the Law 27300 from 2000¹¹⁵, the Law of Sustainable Use of the Medicinal plants, in its third article, the responsible institution for the elaboration of the official national database of medicinal plants is CENSI on behalf of the INS and MINSA. The CENSI has elaborated two information sources that are electronically available. The first one is the *Monografías de Plantas Medicinales Peruanas* (Monographs' Database of Medicinal Plants), with 3 registers¹¹⁶ and the *Inventario Nacional de Plantas Medicinales* (National Index of Medicinal Plants) with more than 415 records¹¹⁷. The preparation of this inventory is based on the search, registration, systematisation, and validation of information from various sources concerning medicinal plants in Peru. The inventory is characterised by the exhibition of the traditional uses of medicinal plants within a dynamic update process. The

¹¹⁵ See: <http://aplicaciones.indecopi.gob.pe/portaltcpi/archivos/docs/legislacion/91-2005-1/127300.pdf>

¹¹⁶ See: <http://www.ins.gob.pe/portalt/jerarquia/7/109/monografias-de-plantas-medicinales/jer.109>. (Retrieved April 21, 2012).

¹¹⁷ See: <http://www.ins.gob.pe/plantas/VerTodosCenci.aspx>. (Retrieved May 4, 2012).

monographs and case studies have been developed by CENSI with the collaboration of a group of experts acquainted with the subject and who perform a detailed search in existing sources. The information entered for each plant species is supported by some technical and scientific literature. The purpose of these databases is to contribute to health professionals and the general public that make use of medicinal plants for the prevention and treatment of diseases.

We make efforts, together with other institutions; we have elaborated a matrix in which other institutions could merge their information...There are several institutions that have done a lot of work on this, for example, the Institute of Amazonian Research¹¹⁸, but we have not yet got a national inventory...We must see first that some willingness comes together, because each institution has its own work, and they do not relay their work so easily with us. All this is a process of coordination, negotiations, and goodwill (MD, Executive Director of CENSI iw/2009)

An important initiative followed by CENSI is the creation of the *Observatorio de Interculturalidad y Derechos en Salud de los Pueblos Indígenas y Afroperuanos* (Observatory for Intercultural Issues and Health Rights of Indigenous and Afro-Peruvian Peoples) in September 2008. The observatory is a space of civil society created to articulate the actions and to guarantee the full exercise of the information and participation of the people on health administration. The formation of the observatory was organised through a leading group that brings together representatives of NGOs, donor agencies, and CENSI and operating in a group called Focal Points that is assumed by representatives of the health sector and the civil society. Its principal commitment is to provide information on situations of the violation of health rights of indigenous people, as well as the actions of citizen monitoring of health compliance in regions and areas of influence. It is conformed by PH officers and representatives of the area of Bilingual Intercultural Education, public universities, district or provincial municipalities, indigenous associations, and coordinators of the National Strategy on Indigenous Health from the 11 regions of the Amazon basin (Meneses 2008). The observatory arises from a deep concern about situations of great inequality and social injustice derived directly from a poor exercise of rights on healthcare on the part of the citizens and, in particular, of the indigenous peoples. The observatory assumes the tasks relating to the monitoring of non-compliance of the obligations of the Peruvian state

¹¹⁸ Sp. *Instituto de Investigaciones de la Amazonía Peruana* IIAP. For an electronic access to the different research projects see: <http://www.iiap.org.pe/Proyectos/ProyectoListar.aspx?TabId=4>.

regarding health rights of the peoples according to the national and international norms in force¹¹⁹. In January 2009, after administrative coordination, a website was achieved in the portal of the INS¹²⁰.

On the part of the actions related to the innovation of health technology, specifically in the field of the adequacy of care centres with intercultural approach, the methodology of “intercultural dialogues” has been also developed. This method aims to facilitate the participation of those involved in community health (THPs, educators, and community leaders) in the analysis of health problems from a socio-cultural perspective, and achieve concerted work formulations to improve the comprehensive health conditions of the communities (INS 2010:47). The dialogues should favour the harmonisation between the TM, the demands of the population and the state’s offer regarding health services, and the achievement of a major knowledge about TM and cultural affiliated syndromes. In 2009, two of these activities were carried out, in the province of Ilave (Puno) and Yauyos (Lima). This technology is aimed to be implemented in other regions through a methodological guideline, in order to facilitate the incorporation of the intercultural needs of the indigenous peoples into the local health plan. Several sensitising courses for health personal working in rural areas have been also created (cf. UNPF 2011). Other instruments developed by CENSI are the “Intercultural Communication Guides”, a handbook with terms in the native language and concepts about health and disease, therapeutic practices, and medicinal plants of the local population. As a result of different research activities, the first Guides on Health Attention in *shipibo* and *jaqaru* language were also completed, and should have been validated in the respective communities last year (INS/2010:48).

Since the establishment of CENSI, the organisation of meetings and regional symposia with THPs were the principal focus during the first period of CENSI’s existence (2002-2005). The first of these encounters was realized in 2005 in the department of La Libertad (INS 2005) congregating some regional healers, health workers, and local

¹¹⁹ A key organisation to promote observance and record incidents on this matter is the *Defensoría del Pueblo* (People’s Ombudsman Office) through the “informes defensoriales”. See e.g. Defensoría del Pueblo (2008).

¹²⁰ See: <http://www.ins.gob.pe/portal/jerarquia/7/86/observatorio-de-interculturalidad-y-derechos-en-salud-de-los-pueblos-indigenas-y-afroperuanos/jer.86>.

authorities. A second experience was done in November of the same year, in collaboration with the INS and MINSA in Lima. This appointment concluded with a working meeting between authorities of MINSA, INS, CENSI, and THPs. On this occasion, THPs and a group of experts in intercultural issues attending the meeting elaborated an initial document with considerations and recommendations supporting the incorporation of TM in a pilot model of intercultural health attention (Camino ec/10/01/2011).

Fig. 10: First Working Meeting between Authorities of MINSA, INS, CENSI and THPs in Lima 2005



(Photo courtesy: Lupe Camino)

In a second period (2005-2008), the focus on the evaluation of experiences in health services and programmes with intercultural approach at the regional level became the principal focus of activities of CENSI. In 2006, a first Congress in Interculturality and Traditional Medicine was organised. The congress congregated health officers and scholars of Bolivia, Ecuador, Chile, and Venezuela, and indigenous organisations and representatives of the Diresas of Peru. Legislative aspects of the practice of TM and integration experiences in the Andean region were discussed during the three-day congress (INS 2006). Subsequent congresses and meetings in 2007 and 2008 also described the interest in achieving more information on regulation strategies.

3.3.1.3 Complementary and Alternative Medical Centres of MINSA

The use of CAM therapies in specific establishments is not a new activity in MINSA. In the 1990s, this service was launched at first in the DIRESA of Callao (Lima) through directorial resolution 001-1994-DISURS-I-C/DG, approving the implementation of such services at the national level. CENSI's Executive Direction of CAM carried out diverse activities and technical meetings to provide informed access about CAM therapies during 2008 and 2009, for the purpose of basic information on the suitable use of the MAC facilities to health professionals, community health agents, and social organisations at the regional level (MINSA 2010c), and has identified existing CAM services in Lima and in other regions¹²¹.

3.3.1.3.1 Centro de Medicina Alternativa - Hospital Maria Auxiliadora

The *Hospital Maria Auxiliadora* belongs to MINSA and is located southwest of Lima in the *San Juan de Miraflores* district, 17 km from the *Panamericana Sur* highway. It is the only hospital with Category III-1 in the area (i.e. hospitals with medical specialities such as internal medicine, obstetrics, paediatrics, special chirurgic, emergency departments, labour and pharmacy). Due to its geographic position it has an influence area of 200 km throughout the southeast provinces of Lima, reaching Ica, Huancavelica, Andahuaylas, Ayacucho, and Apurímac (see Fig. 1). The hospital attends to approximately two million inhabitants, mostly young (under 49 years), poor (45%), and extremely poor (15%) people living in urban and rural areas (Mayorga 2009:2).

The centre was officially created in 2005, as the second service of MINSA that offers CAM¹²². The head of the centre is the neurologist Dr. Maria Elena Heraud. The centre has an interdisciplinary team, made up of 12 persons. Nevertheless, only 5 are officially employed and the rest of them work at the centre as volunteers. The centre offers Chinese acupuncture, bioenergetics medicine, mind-body medicine, psychology, neural therapy, floral and herbal medicine, Ayurveda dietetic therapy, and manual therapies

¹²¹ A complete list of the 18 health establishments of MINSA identified with CAM services by the year 2009 can be found at: http://www.ins.gob.pe/repositorioaps/0/7/7jer/censi_ofer_rela/EESS_MINSA_servicio_MAC.pdf

¹²² The first CAM centre officially recognised by the MINSA is in the Hospital San José del Callao in Lima, founded in 1994 (INS 2009).

like Shiatsu, Tuina and Reiki. The centre encounters several financial and infrastructure problems. The demand of patients exceeds the physical capacity of the centre. There are not enough places for all, not enough privacy during the treatment and no money to repair the often-damaged litters and hygienic services. Dr. Heraud and her team have no support from the general director of the hospital to obtain financial resources. In fact, they themselves organise *polladas*¹²³ with patients and relatives in order to obtain essential utensils to enable patients' attention. "I myself often go to the scrapers in the periphery of the district to look for metal pieces to repair the stretchers, doors, and tables. We have also made even the toilette (which we did not have) through donations and without any support from the authorities" (Heraud iw/ 2010).

Fig. 11: Centro de Medicina Alternativa del Hospital Maria Auxiliadora



The centre occupies only half of this construction, at the right side (Photo de Pribyl 2010)

For the hospital it is a mega-project to rebuild the whole infrastructure. For all medical departments there are specific places designed by the building contractor –except for the centre¹²⁴. Although Dr. Heraud has continually asked about the location for the centre, she did not get answers. "The major problem is the attitude of my colleagues. When you ask where the place for alternative medicine is, they say, "we'll see", "we would find after a place", etc. In fact, we don't figure in this project" (Heraud iw/ 2010).

¹²³ Popular grill lunch parties organised to collect money for social, health or humanitarian purposes.

¹²⁴ See designed project online at: http://www.minsa.gob.pe/HAMA/Informaci%C3%B3n_Hma/MEMORIA-PLAN-MAESTRO-HMA.pdf.

Fig. 12: Panoramic View of the Hospital



*The centre is located apart from the central construction (white pen)
(adapted from Mayorga 2009:4)*

Since Dr. Heraud travelled to South Korea five years ago with a scholarship to learn alternative therapies and develop skills to administrate integrative centres, she has a cooperation idea to obtain two million dollars from the KOICA¹²⁵ to equip the centre. Nevertheless, the project has yet to be logistically developed in order to reach the AECI instance (MINSA's international cooperation office) after a long and complicated bureaucratic procedure, for which she alone has no time because she is the only MD in the centre. For her, the lack of support from MINSA is due to many interests, "principally from the pharmaceuticals, because this is a cheap and effective health alternative treatment (...) MINSA does not want us, they want the centre to disappear" (Heraud iw/ 2010).

In 2004, she led a CAM training course for health professionals in coordination with the INS and MINSA. After she invited a guinea pig healer to demonstrate his techniques in the course, the immediate response of the director was to discharge all the lecturers, and to discontinue the training programme: "They argued that we did sorcery in the courses" (Heraud iw/ 2010). In the last communications with Dr. Heraud, it is virtually sure that the centre continues without support from the central health administration of MINSA: "Last encounters with possible donors and interested people from the health

¹²⁵ Korea International Cooperation Agency, see: <http://www.koica.go.kr/english/main.html>.

administration are flopped out. The supposed intention is to make a new centre in Hospital Arzobispo Loayza and not here. I am very upset” (Heraud ec/12.04.2011).

In the face of the results of the exploration of this centre, a reluctant attitude from health administrators to CAM practices in health establishments of MINSA seems to be present. However, in this particular case it is also important to note the special and well-known disposition of Dr. Heraud to also incorporate THPs in the centre, a willingness that is not commonly present among most of the MDs working in CAM services. Thus, it is indeed possible to think that her difficulties in dealing with the central health administration of MINSA have to do in part with this last specific reason, and that it is not directly implicit to the CAM practices. There is some evidence that supports these reflections, which have been extensively discussed in chapter 2.2.

3.3.2 The Peruvian Health Social Insurance – ESSALUD

3.3.2.1 The National Programme on Traditional, Complementary and Alternative Medicine

The experience related to the introduction of a CAM in a specific National Programme in ESSALUD began in 1992, with the implementation of a research centre of TM, the *Instituto de Medicina Tradicional* of ESSALUD¹²⁶. The centre is located in the city of Iquitos, the capital of the department of Loreto, in West Amazonia. By the time of the establishment of the institute, “there was not much knowledge on how to properly research medicinal plants, and the experience was an ambitious project indeed, that initially focused on the implementation of infrastructure, and the construction of a botanical garden and the first laboratories” (Villar iw/2009). The need to work out practical applications of TCAM arose little later, in 1994, in which an analysis of the most common sicknesses treated in ESSALUD showed that these were principally related to hypertension, anxiety, depression, and rheumatism. The analysis of medicines consumed for these diseases showed also that most were related to anti-inflammatory, steroidal, anxiolytic, anti-depressive, and antihypertensive drugs. The findings of this

¹²⁶ See information about at: <http://www.essalud.gob.pe/instituto-de-medicina-tradicional/>

study led to the search for alternative methods to decrease this consumption, and to develop a better treatment of the insured population.

To cope with this need, an experimental study was carried out in the *Clinica Negreiros* of ESSALUD in 1995, in which a CAM centre had been previously installed, offering acupuncture and medicinal plants as alternative treatments. The principal results proved an effectiveness of 70% of the alternative methods over the conventional ones in the treatment of e.g. gonarthrosis¹²⁷, a common disease among adults attended to in the centre. A year later, a consulting company conducted a further study on the preferences and receptivity of the population of such complementary techniques in health centres, showing that 98% of the patients agree with the introduction of complementary medicine services in ESSALUD. A three-year period of preparation and training of health professionals and infrastructure implementation led to the official creation of the National Programme of Complementary Medicine of ESSALUD in 1998.

The National Programme of Complementary Medicine of ESSALUD¹²⁸ began its functions in May 1998 with the principal goals to relieve specialized health services of the conventional system from patients' increasing demand; to improve the service's effectiveness in the treatment and the prevention of sickness that responded poorly to the conventional interventions; and to reduce the costs of the excessive use of medicines for chronic diseases (ESSALUD and PAHO 2000:5). Additionally, the CAM National Programme of ESSALUD in cooperation with the PAHO carried out a study between 1999 and 2000 to compare the effectiveness of CAM in relation to allopathic medicine in clinics and hospitals of ESSALUD (ESSALUD and PAHO 2000). Treatments for osteoarthritis, back pain, neuroses, asthma, peptic acid disease, tension and migraine headache, facial paralysis, and obesity were analysed. The results showed that the cost of using CAM was less than the cost of Western therapy. In addition, for each of the criteria evaluated –clinical efficacy, user satisfaction, and future risk reduction– CAM technique's efficacy was higher than that of conventional treatments, including fewer side effects, higher perception of efficacy by both the patients and the clinics, and a 53-

¹²⁷ A disorder of the knee joint generally implying early joint surface damage, characterised principally by an increasing destruction of the joint cartilages (fq/2009).

¹²⁸ See: <http://www.essalud.gob.pe/medicina-complementaria/>

63% higher cost efficiency of TM over that of conventional treatments for the selected conditions (ESSALUD and PAHO 2000:3-4). In ten years, the number of CAM health centres of ESSALUD has increased from 3 in 1998 to 20 in 2009, and have attended to 80,000 mostly adult patients on average (Villar t/2009). In each centre there is a team made up of an MD, a nurse, a psychologist, a physiotherapist, a pharmacist, and a technician nurse.

The concept of CAM applied by ESSALUD refers to a system of healthcare practices that is not part of the medical traditions of the country and is not integrated into the dominant system of medical care, but whose methods have shown scientific evidence to be considered an alternative or complementary in patients' management of health and illnesses' treatment (ESSALUD and PAHO 2000:5). Although the expression TCAM is mostly appealed by CAM public officers of ESSALUD referring their medical and academic activities among the CAM's National Programme, the emphasis is on CAM and not on Peruvian TM.

3.3.3 Programmes and Strategies

3.3.3.1 The National Health Strategy for Indigenous Peoples

The work with and for indigenous peoples is a concern of the Peruvian state explicitly stated in important documents. There are statements collected in the National Agreement and State policies, which are implemented in the corresponding area in MINSA, in the *lineamientos de política sectorial* (Sector Policy Guidelines) for 2002-2012. This intention is materialized in the creation of the National Health Strategy for Indigenous Peoples (ESNSPI) of 2004, applied within the 15 national health strategies. The strategy looks for the “cultural appropriateness of healthcare services, to allow greater access of the population's ethnic minorities through the subsidiary system, and the decreasing of existing health gaps” (MINSA 2002a:5, t. sp.).

CENSI, in charge of the INS, is responsible for the coordination of ESNSPI, which seeks the incorporation of interculturality in health services annexing the representatives of indigenous organisations, institutions and local authorities, and is responsible for the

design, implementation and evaluation of health models developed at the local level. In this sense, the national coordination of ESNSPI and CENSI, who assumes its leadership, has assumed by ministerial mandate the objective to achieve the formulation of proposals for regional intercultural health policy at the regional level, enabling the implementation of regional plans on the subject.

ESNSPI undertakes the development of strategies to set up the cultural appropriateness of health services. In that sense, its main feature is the transversality of the intervention, in all the strategies and provision of services by segments that MINSA offers. According to the strategy, the incorporation of the concept of interculturality in health services for the indigenous population begins with respect for their culture and their practices, since they have resolved their health problems “from ancient times, when the isolation of Western societies did not alter the balance that is maintained between man and his environment”. Due to the contact with the Western society –so the strategy– other health problems were added to their environment, and they tend to be poorer and less protected, since they also have geographic, cultural, and economic factors acting as barriers and limiting their access to health services. National initiatives to act on specific problems concerning indigenous peoples have been prompted several times. However, they were dispersed, atomizing their impact, and preventing, i.e., their replication in other areas. Thus, another element of the National Strategy on Indigenous Health is the development of the ability to systematize experiences of public and private institutions that have been successful, and can be adapted to other people with the same needs.

The approach of the strategy is developed in the context of decentralization; the implementation of intercultural adaptation at the local level must be conducted, executed, and evaluated by local authorities from the Regional Departments of Health (DIRESA) to the establishments in which this type of care is implemented. The technology transfer from central levels of MINSA and its regulatory capacity to enable the regional level design and implement changes should accompany the process, respecting the previous experiences of working in the field of intercultural health. That is why the plan of the National Strategy on Indigenous Health is designed to be the

framework on which the regional level can plan their intervention and technical assistance, maintained as a permanent process (MINSA/INS/CENSI 2010). In the opinion of some experts, although promissory, less than eight years after the introduction of the strategy basic tasks have not yet been attained, including the design of a policy of intercultural health in Peru, the health situation analysis of the Andean populations (Quechua and Aymara), and bringing the national health system to the indigenous culture, among others:

In CENSI there is a research area on traditional medicine. Do you know that there are no anthropologists there? Who understands this knowledge? There are only medical and health professionals who make attempts, but they do not manage this. Until now they've investigated absolutely nothing. The leaders there do not have any idea what they are doing, and when they want to defend positions in academic discussions, they hide under the table. Instead of protecting and validating this knowledge, they hamper it. Traditional medical systems of the communities do not have a political or academic voice in their decisions. For this reason, I think that the extinction of indigenous medicine is a matter of time. So the concern of the anthropologists is to register what remains of the cultural evidence of these health systems (Anthropologist iw/2010)

3.3.3.2 The Indigenous Health Programme of AIDSESEP

The largest indigenous organisation in the country, the *Asociación Interétnica de Desarrollo de la Selva Peruana* AIDSESEP¹²⁹ (Interethnic Association for the Development of the Peruvian Forest) aims to represent and defend the historical and present interests of the indigenous peoples of the Amazonia by ensuring the conservation and development of their cultural identities, territories, and values, and promoting sustainable human development, facilitating the exercise of self-determination of indigenous peoples recovered in the Peruvian and international law (AIDSESEP 2005:3). In 1991, AIDSESEP implemented the Programme of Indigenous Health (PSI) as an important proposal for intercultural health in the Peruvian Amazon that aims to raise the living standards and the re-evaluation of the health culture of indigenous people by strengthening and developing existing intercultural approach in THSs.

One statement of AIDSESEP is that the programmes established in accordance with a Western perspective have shown to be ineffectual in alleviating the health problems of

¹²⁹ See: <http://www.aidesepe.org.pe/>

the Amazonian indigenous people. There is an urgent need to build effective health programmes on the basis of the identification of problems and potentials actually existing among the communities (AIDSESEP 2007).

The PSI designs and implements specific strategies and methodologies in order to reactivate Indigenous health systems. They build and improve specific conditions to facilitate the development of the ancient wisdom, as well as to extend the presence and practices of “shamans” of the communities. Other goals include:

- (1) The provision of required essential resources for properly functioning indigenous health systems in the communities.
- (2) The promotion of shamanic meetings to exchange experiences and share knowledge.
- (3) The dissemination of shamanic knowledge and rituals through their inclusion in the school curriculum in bilingual intercultural education and other forms of communication.
- (4) The spreading of information on the indigenous health policy and the activities of the PSI both within the indigenous nations and the national society.
- (5) The definition of a policy for students and professionals of the area of indigenous health, seeking their integration into the programme and to support them in their concerns and projects.
- (6) The improvement of health indicators of indigenous peoples and
- (7) The identification of PH priority issues in the Peruvian Amazon that could be controlled. To call MINSA, universities and related institutions, into a joint effort with indigenous organisations to manage and enforce projects and programmes for the solution of these problems.

In order to achieve these purposes, AIDSESEP created the Secretariat of Health in its XIII General Assembly in 1991 under the leadership of a professional young indigenous person, who had to face the serious problem of cholera in indigenous people in the Peruvian Amazon (AIDSESEP 2009). In the framework of this policy, the Secretariat presented a proposal for integrating indigenous health that substantially raises the re-evaluation of the culture of health of the indigenous people of the Amazon and the

restructuring of the services of health provided by the national government. In order to enforce these proposals, AIDSESEP began to start some projects and programmes in the basins of the Marañón River, Ucayali and Madre de Dios in 1991 –some of which continue to exist up to the present. On the basis of these experiences, the creation of an Indigenous Health Programme at the national level was proposed to the Board of Directors of AIDSESEP in December 1995. In August 1996, the XVII General Assembly ratified the creation of the current PSI in replacement of the Secretary of Health, as a specialized and decentralized organism, with technical and administrative autonomy, of AIDSESEP.

The greatest project of the PSI has been the Development of Indigenous Health Systems Project (DESSAI) carried out in 120 communities. The first objective of the DESSAI was the recovery of indigenous human resources in health and the improvement of knowledge and technologies; and the training of promoters on indigenous health with an intercultural approach in the regional government of Ucayali. The PSI establishes that an intercultural health system must be achieved through the design of a training system for technicians in Intercultural Health (TSI) that should be carried out through the Amazon Institute of Intercultural Health (INSIA), ensuring the coordination and cooperation between MINSA's health posts, the communities' human resources of the indigenous medicine, the regional indigenous organisations, and the HCS in general. According to the director of AIDSESEP, the DESSAI has worked towards these goals and innovated and respectfully reworked. After 10 years of implementation, the training of 264 health promoters who work directly for 120 communities has been achieved, through the displacement of technical teams to each of the three sub-areas of the general scope of the project, in the region of Atalaya. Each team was integrated by a sector-coordinator elected by the corresponding indigenous organisation, a *vaporadora* (partera) or a nurse. "With this method", purports Reátegui, "a programme of indigenous health 2 to 4 times per year has been managed, which is absolutely alternative, and demonstrates with impressive results that it is possible to articulate parteras, curanderos, vegetalistas and other local health practitioners with specialists of the Western medicine and local indigenous representatives" (Reátegui 2009).

However, AIDSESEP decided to design an alternative project to the INSIA without the direct support of MINSA. The alternative project designed was the training of technicians in intercultural health that should operate with private investment. The pilot project was presented to educational authorities for the recognition of the project as a proposal for community education in accordance with the New Educational Law. The unit of educational management of Atalaya approved and gave legality to the project, under this modality, by Local Directorial Resolution 057-2005-UGEL-Atalaya¹³⁰.

The PSI foresaw that this training programme should consider at least three fundamental aspects: The process of formation could not abstract the multiple indigenous realities in which technicians executed their work; the development of skills in a better and greater understanding of the social health epidemiology of the Amazonian people is essential; and the central guarantee for the functioning of any proposal to be articulated in the programme should necessarily stay under supervision and decision-making among the central bodies of representation and organisation of the Amazonian indigenous people.

In the Addenda 2007, AIDSESEP evaluates the participation of the state and government in indigenous health as a profound error, through the implementation of health policies that have systematically ignored indigenous health systems. Consequently, they demand the implementation of a Health Programme for Intercultural Indigenous Health through the creation of the National Institute of Intercultural Health of the Amazonia (INSIA). The INSIA should provide the formation, training and the accreditation and recognition of intercultural health technicians (AIDSESEP 2007:15). They also demand full health coverage for indigenous communities of the Amazonia, the incorporation of an intercultural health approach in all the state's services; to implement the knowledge and indigenous health technologies in the training curricula of healthcare; to respect indigenous reproductive cultures of health; and to incorporate the SIS to all the indigenous people of the Peruvian Amazon (AIDSESEP 2007:16-17).

¹³⁰ See: <http://www.asesorempresarial.com/web/pdf/25042005.pdf>.

In 2009, AIDSESEP presented to health and educational authorities an educational project for the implementation of a Programme of Formation for Technical Nurses in Intercultural Health with the objective of strengthening the indigenous health systems of the Jivaro Peoples in northern Amazonia (AIDSESEP 2009a). This project led to the establishment of a Diploma Formation for Intercultural Health Promoters at the Postgraduate Unit of the Faculty of Education of the Universidad Nacional Mayor de San Marcos, in cooperation with the Nordic Agency for Development and Ecology¹³¹. The participants are health professionals and trainers of the Programme of Formation for Technical Nurses of AIDSESEP in Bagua, Iquitos and Pucallpa.

The principal impact of the project is that indigenous health has won a space for discussion and participation in the political governmental strategies and current health policies. Today there are state agencies that address these priority issues of health, through action plans that provide spaces for the incorporation of community health promoters. Some formal education institutions have recognised the value and importance of the technicians in Indigenous Health, as a new technical profession at the service of the healthcare of indigenous people.

3.3.3.3 The National Programme for Sexual and Reproductive Health

Maternal mortality has been qualified by the PAHO as one of the most typical examples of discrimination and demonstrates the low social status of women in the indigenous Americas. It has also been identified as a secure indicator to evaluate the level of compromise of the state in relation to the right for health attained for the poorest in a given country. Certainly, poverty has a major impact on women's health. Due to their lower income, and in contrast to their male counterparts, the major expenditure on health restrains the access to healthcare and related services, something that makes visible their structurally disadvantaged situation.

In this regard, the recommendations and mandates that have been undertaken at the international level of health policies in relation to sexual and reproductive healthcare as a right of the people deserve special attention. This must be recognised for men and

¹³¹ See Programme details at: <http://www.saludintercultural.org/>

women, including the decision whether or not to have children, to have healthy pregnancies and deliveries, to avoid getting sexually transmitted diseases or becoming a victim of violence, as well as to receive professional and traditional assistance in order to be able to bear children. At the forefront of state-sponsored intercultural initiatives in Peru, the *Estrategia Sanitaria Nacional de Salud Sexual y Reproductiva* (National Programme for Sexual and Reproductive Health¹³²) was created in July 2004¹³³ and tries to cover the mentioned international health mandates.

In the UNICEF agency in Peru, the institution co-responsible for this programme, I recovered crucial information on the circumstances at the time when the programme was installed. During the 1990s, notwithstanding the terrorism war in the country, a significant expansion of the state and the public presence in the provinces and across the “inner side” of the country took place. The number of health establishments in rural zones was duplicated, and several programmes focussing on social costs (*Programas de focalización del gasto social*) were introduced in the country. In the health sector, this programme was called Basic Health for All (*Salud Básica para Todos*). One of the principal consequences was the creation of over 3,000 health establishments countrywide in cooperation with the FONCODES¹³⁴. In the international context, Peru adopted the Millennium Declaration at the United Nations Millennium Summit in 2000. The *Millennium Development Goals* (MDGs), which were contained in this declaration, established the commitment of the concerned countries to reduce maternal mortality by 75% from the 1990s by the year 2015. Therefore, in the statements for the national program, the physicians’ position was to put the most attention in the first moments during and immediately after delivery (neonatal period), because the most complications do not occur during pregnancy, but rather during delivery (Tavera iw/2009). The DIRESAS reported as leading causes of death in the last eight years and for 2007: haemorrhage (41%), hypertension induced by pregnancy (19%), abortion (6%), and infections (6%); in addition, major deaths occur during labour (retained

¹³² A list of guidelines and technical documents and reports of the strategy can be found at: <http://www.unfpa.org.pe/publicaciones/2005.htm> and: http://www.minsa.gob.pe/portada/est_san/salud_sexual.htm.

¹³³ Ministerial Resolution 771-2004/MINSA. See: <ftp://ftp2.minsa.gob.pe/normaslegales/2004/RM771-2004.pdf>.

¹³⁴ Fondo de Cooperación para el Desarrollo Social (Cooperation Fund for Social Development) of the Ministry of Development and Social Inclusion. See: <http://www.foncodes.gob.pe/>.

placenta) and after delivery (uterine atony) (MINSa 2009:27). In fact, leading causes of maternal mortality in Peru are the same obstetric complications as for the great majority of maternal deaths around the world like postpartum haemorrhage, toxemia, abortion-related complications and infections. Nevertheless, indirect causes of death include malaria and tuberculosis, which is highly present in rural populations and women from indigenous communities, and reveals the disparities in patterns of maternal mortality and the programmatic interventions to reduce it (Yamin 2007:7).

The program focuses on sexual and reproductive health as rights that are intimately linked and interdependent. Within this perspective, reproductive health is defined as a general state of physical, mental, and social well being of the people, and not the mere absence of disease or infirmity, in the sexual and reproductive sphere. The reproductive health includes the ability for people to have a safe and satisfactory sexual life with the implicit freedom to choose when, how, and with which frequency this should be done. This concept implies the exercise of a responsible sexuality, based on relations of equality and equity between the sexes, the full respect of the physical integrity of the human body, and the will to assume responsibility for the consequences of the own sexual conduct (MINSa 2005). In general, most problems attributed in the program to inequity in accessing sexual and reproductive healthcare are found in the differences among women and men due to biological reasons, and less on the political, socio-economical, gender, and cultural stigmatization contexts in which people live. Thus, sexuality is “a reality in which they live on a daily basis that goes beyond the physical aspects (sexual intercourse) and that is translated into different forms (behaviours) that people have to express themselves and interact with their social environment according to their sex” (MINSa 2005). It is an important source of comfort and pleasure- they continue- both physical and mental, but it is also one of the fundamental axes on which the inequalities and inequities are built: “While sexuality is present and is part of the entire life, reproduction is the temporary capacity to procreate than have men and women. In women, this capacity is limited to the fertile days of the menstrual cycle, in the period between menarche and menopause, while in the man this capacity is more prolonged” (MINSa 2005).

Among other programmes and dispositions, the strategy considers the implementation of an “indigenous perspective” in healthcare attendance. Appropriately, a culturally adapted delivery care model was first developed in rural communities in the department of Ayacucho and implemented between 1999 and 2001 (Gabrysh et.al. 2009:726). In 2005, MINSA submitted the *Norma Técnica de Atención de Parto Vertical con Adecuación Intercultural* (Vertical Delivery Assistance Model with Intercultural Adaptation), which was the first official attempt in including cultural preferences of rural women in health centres, such as the vertical position during birth (MINSA 2006:15). The programme includes the disposition of *casas de espera*¹³⁵, which are establishments including the use of herbs and other products used traditionally during labour and childbed, the utilisation of traditional birth attendance techniques, according instruments and physical environments, and including the presence of parteras before, during, and after delivery in the health centres (MINSA 2006:34-36). The model proposes the building of mutual enrichment bridges between occidental and traditional models that, while different in their conceptual frameworks, do not need to oppose but complement each other: “This implies rescuing their traditions and positioning the women’s right to actively participate in the way they wish to be assisted, strengthening the affective link between the mother, the baby and the family environment” (MINSA 2006:15). Some studies suggest, however, that trained health professionals working in these programmes approached exclusively Western medicine and persist on disregarding social and cultural preferences of indigenous women for childbearing (Camino et al. 2003:7-12, Pesantes 2005:4).

In Peru, 68.8% of the population do not utilise health services due to the difficult geographical access, because of distrust of Western medicine, a perceived lack of proper respect and treatment by healthcare professionals, and also because they prefer to be attended to by THPs (Lama 2000:6). These findings show that there are not only the geographical, but also the cultural dimension that must be considered when implementing health services. Early on, applied PH theory also identified that some cultural beliefs and therapeutic traditions could stay in opposition to the expansion of

¹³⁵ Sp. Waiting houses. Quarters in health centres especially furnished to prepare rural pregnant women for vertical delivery. Commonly, they give birth there under medical supervision instead of with a partera in their own homes.

biomedicine and its facilities. This idea motivated most of the designed health programmes for the population on the “Third World” in which the fundamental strategy is mostly the direct modification or even elimination of such popular knowledge and cultural preferences. Similarly, in others programmes designed to combat poverty, family planning figures as one of the basic objectives to find a solution or at least to reduce some of the cultural characteristics considered, simultaneously, as cause and effect of poverty. As Menéndez asserts, the strategies oriented to reduce fertility in women include the economic compensation of the health team that obtains a higher number of “controlled” women in their health centres, which includes the application of feminine and, to a lesser extent, masculine sterilization, mostly applied without the consent of the patients (Menéndez 2005:52). In Peru, this tension was heightened during the governments of Presidents Alberto Fujimori (1990-2000) and Alejandro Toledo (2001-2006). Both presidents implemented aggressive neoliberal political reforms in the health sector and funded programmes aimed at reducing birth rates among indigenous communities in an effort to reduce poverty and increase economic growth. The Voluntary Surgical Contraception Programme, approved by the Peruvian parliament during Fujimori’s second administration, performed unsafe tubal ligations and vasectomies on indigenous people and ethnic minorities without their informed consent or even their knowledge. Between 1995 and 2000, over 260,000 Peruvian women were sterilized, mostly in rural areas. These medically unnecessary sterilizations were not confined to simply leaving women unable to bear children. In a number of cases, women died as a result of complications from the surgical procedure (Collier-Wise 2009:10-11). This programme was later discredited and denounced as a violation of human rights by international courts.

Nowadays, some of these approaches prefer administrative and medical mechanisms that could generate cultural modifications of the patients, instead of creating educational modules aiming at substantially changing health professionals’ attitudes to this respect. Despite the fact that Peru is one of the countries in South America with the lowest social expenditure in health, the efforts by the infrastructural development of health centres to attend to pregnant women did not work, because the women did not use the services as expected (Gabrysh et. al 2009:724). In the middle of the 1990s, several

consultancies and studies were done to find the reasons for this situation. Policy makers and programme officers came to the conclusion that socio-cultural factors were the origin of this rejection. Mistrust, mistreatment, different cultural codes, language, delivery positions, the absence of accompaniment by family members, among other reasons, were identified as the principal factors.

We physicians have begun to criticize the hyper-specialization and the indiscriminate use of technology in certain processes, like pregnancy, that is indeed natural and has cultural connotations... We made these surveys and share them with another institutions such as USAID with the project of *Reprosalud* from Manuela Ramos¹³⁶... we saw that there were several reasons why the people did not go to the centres. Then we developed the concept of “barriers”, the breaches that separate mothers from the health centres... it is not because the people want to stay at home, rather than the *partera* covers a need that the health centre does not do (UNICEF Peru Officer iw/2009)

As a result, several documents and evaluation reports from consultants and scholars indicate permanent discriminatory practices and mistreatment of patients by health professionals because they do not understand or accept those cultural ascriptions (Aliaga iw/2009). According to Nureña, cultural barriers and ignorance of TM are the principal problems in changing attitudes of health professionals working in centres applying the vertical delivery model (Nureña 2009:370). In these programmes, indigenous women are not perceived by health professionals as full citizens because they do not speak Spanish properly and practice different ways of eating, dressing, and living (Huayhua 2006:14-17). Furthermore, these populations are compelled and sometimes manipulated to accept treatments or to join health programmes they do not want to, or that they do not consider suitable for them (Montibeller iw/2009). Anyway, the expansion of the programme has shown an increment on the imposing acceptance among rural women. Recent statistics show that the number of woman with the last child receiving prenatal control during the first quarter of pregnancy was in urban areas 76.5% and in rural areas 66.3%. At the national level, the proportion increases in comparison to the survey of 2007 from 71.3% to 73% in 2010 (ENDES 2010a:25).

¹³⁶ A five-year project on reproductive health developed in 1995-2000 with a renewal for five years more in 2001. *ReproSalud* focused on social barriers to women’s access to reproductive health services, including limited power to negotiate within sexual relationships, social isolation, domestic violence, lack of cash, and low self-esteem. It targeted the poorest, hardest-to-reach, Peruvian women, ages 15 to 49, many of whom begin childbearing by age 15 and live in urban and rural areas where healthcare services are underused. See report at: <http://www.advocatesforyouth.org/storage/advfy/documents/transitions1403.pdf>.

According to the consultants and experts interviewed who evaluated the programme in different regions and cities in the country, the reality is something different from what is presented in the most favourable reports on the programme and the state's official evaluations:

I evaluated them in *paruro*¹³⁷, two years after the introduction of the programme... The authorities said that the *casas de espera* were in full swing. But in my evaluation it was terrible. I speak Quechua, so I could talk with the people of the community, and I could stay indoor for many days. I told X¹³⁸ that this could not function in that way. As you have planned it, I said to him, it is maybe convenient for you, but it is not the same for the people... The women were almost captured in their work centres, in the field, or wherever they were. They brought them to the centres and they had to wait there, far away from their community, from their family. In many cases they were just kidnapped. The husband didn't know where his wife was, the children were without their mother, the husband didn't want to know more about his wife. The women felt desperate and cried out because she was kept under locks. Things like that have occurred. I don't know, does it mean "success"?! (Consultant iw/2009)

The official medicine has a totally different conception of pregnancy, birthing, and childbed. There is no dialogue and willingness to find a middle point between both conceptions. In that way it cannot work, never, anywhere. In Huancavelica¹³⁹ it is the same, maternal mortality is even so high as before; the women still died alongside the centre (Anthropologist iw/2009)

These situations are the product of the signalised authoritarian medical training and the depreciation of the cultural characteristics of the indigenous population. Nevertheless, at a second glance, attention should also be paid to the surrounding employment situation of health professionals in the country and the less-protective labour laws applying to them, which are in part the result of external pressures of the international health community over the state demanding cost reductions in healthcare. Furthermore, international health agencies and financial bank investors expect from development countries to cover minimal standards in HCS in terms of number of daily attentions, to spare costs in medicines, personnel, and infrastructural investment, among the principals.

MINSA fears that Peru still appears as one of the countries with the highest maternal mortality. But here the attitude of the physicians and health personnel should be understood. MINSA should stay at the front in Geneva and recognise that although the data is lower compared with 1998, we continue to be, alongside Ecuador, Bolivia, and Haiti, one of the countries that have not yet resolved the problem of maternal

¹³⁷ Province located in the region of Cuzco.

¹³⁸ MD responsible for the programme.

¹³⁹ Region and city located southwest from Lima, with majority Quechua population. Chronic malnutrition is here the highest in the country, with 44.7% of the children under five years by 2010 (INEI 2011:13).

mortality... In my opinion, it is a discussion that does not take place on a real basis. Meanwhile, physicians, midwives, and nurses stay really under personal intimidation. When you allow that a woman dies in your responsibility, the ministry will come down with all forces on you, you should then grasp on your better godfather, or the *vara*¹⁴⁰, or whatever protection you have; otherwise, you lose your job or you'll be transferred to the most remote and less desirable health post in the whole national territory. Hence, health personnel lives under constant panic... and responds accordingly with these attitudes (Anthropologist and Consultant, University Professor iw/2009)

3.3.3.4 The Committee of Traditional, Alternative and Complementary

Medicine of the Peruvian Medical Association

The use of TCAM has increased exponentially, being recognised officially by the WHO as a medicine of wider use for the world population (WHO 2011). The increasing demand for health services of the TCAM worldwide and the existence of a non-regulated offer of these methods is a reality recognised by the WHO through different resolutions¹⁴¹. In this sense, the WHO invokes member states to generate rules and policies based on scientific information to support the safe use and efficacy of TCAM therapies in public and private health services.

In Peru, the utilisation of these therapies is not yet properly regulated by state norms, something that on the one hand generates public health risks, and on the other hand tends to discredit the serious use of these methods. The exact number of MDs in health services working with CAM therapies is still unknown, and there is no systematic information on research methodologies and suitable models of CAM training that have been done in some institutions without minimum standards of quality (CMP 2011:2). This situation has called into question the type of training received by medical professionals in this field, raising doubts about the ethics and deontology in the use of CAM in health services. An exception in this respect is the Diploma on Alternative Therapies for health professionals offered at the Postgraduate Unit of the Faculty of

¹⁴⁰ Peruvian jargon (staff, rod). The relationship with some person with key positions at institutions that help or support career advancements or the acquirement of jobs or the reception of special benefits on.

¹⁴¹ In 2007, it was reported that 110 of the 193 WHO Member States had some type of policy in place regarding regulation and/or registration of TCAM (WHO 2011:3). Peru has not yet a clear regulation of these practices.

Medicine of the Universidad Nacional Mayor de San Marcos¹⁴². This one-year formation exists since 2003 and exerts a curricular structure that is differentiated for each professional group. To date, it accounts more than 300 graduates, who have been working in ESSALUD, MINSA and also in the private practice. In comparison to some other 3 cases in the country¹⁴³, the Diploma of the University of San Marcos still constitutes the only training at postgraduate level with quality standards.

In accordance with the recommendations proposed by the WHO to this respect (PAHO and WHO 2002), the CMP has carried out since 2001 different activities related to the field, and has developed a gradually active positioning and key role in the organisation of international congresses and academic events about TCAM in collaboration with universities, international agencies, and professional associations. The share of experiences of integration policies in Peru and other countries in the region were mainly addressed between 2001 and 2005. Specific goals of the World Congresses in 2002 and 2005 were defined in terms of the evaluation of studies about TM, natural resources and integration policies at the regional and national level. The analysis of articulation mechanisms of TM in HCS, the legal status of the THPs and the legislation was specifically released in subsequent national and international activities in 2007 and 2009. The last National Congress of Traditional Medicine, Alternative and Complementary Medicine: Toward an Integrative Medicine realized in November 2011¹⁴⁴ convened national and international experts from Argentina, Chile, Colombia, Spain, France, Germany, Japan, and Russia, and was attended by more of 600 persons, of which 70% were health professionals.

Meanwhile, in March 2006, the CMP implemented a Committee of Traditional, Alternative and Complementary Medicine (CMTAC) within its formal structure¹⁴⁵. The principal aim of the CMTAC is to contribute to the establishment of standards for the regulation, control, and ethics in the practice of TCAM in order to contribute to the improvement of the Peruvian population's health. At an early stage, the CMTAC was

¹⁴² See: <http://medicina.unmsm.edu.pe/upg/index.asp>.

¹⁴³ In the departments of Puno and Arequipa there are Diplomas in alternative therapies and CAM in the Faculty of Obstetrics and at the Nursing School respectively, but not in the Faculty of Medicine.

¹⁴⁴ See: <http://cmtacperu.org/congreso/index.html>.

¹⁴⁵ See: <http://www.cmp.org.pe/institucion/organizacion/144.html?showall=1>.

part of a transitional committee. Since March 2010, according to the Resolution of the National Council of the CMP 8342-CN-CMP-2010, it was part of a Permanent Advisory Committee. The committee is constituted by a team of experts, and is aimed at reaching the consultative local status provided by the WHO, serving as referential support to the CMP for all the topics related to the exercise, policy development, and research in TCAM. The committee geared towards the formulation of recommendations and proposals for specific regulations related to the systematic collection of information, protection, research, and quality control in TCAM, and to facilitate the construction of state policies that should be reflected in a legal framework supporting the systematized scientific work and applications in the field of TCAM.

The principal objectives assumed in the CMTAC are to identify the situation of TCAM in the country by preparing and proposing policies and norms in TCAM and herbal regulations¹⁴⁶, to supply and to propose scientific criteria for professionals' formation and research in MAC, and to identify and register MDs who exercise the MAC in order to promote its specialization. During the last two years, the CMTAC has achieved the installation of committees of TCAM in 98% of the regional councils of the CMP at the national level. The realization of regional and national meetings to promote awareness of the necessity to articulate the TCAM in HCS has derived in a policy work assumed by the CMP through the CMTAC during the last years.

A statement of the CMP in the First World Summit of 2007 asserted that at a global level, it is necessary to obtain consensus on the systematization, investigation, formation, and regulation of the contexts in which TCAM is used, in order to put this topic on the discussion agenda in a formal and proper way and to formulate suitable policy alternatives to the government's. "In this purpose", so the call, "the medical association and related institutions, responsible for people's health and medical formation, has considered as convenient the periodical organisation of Global Summits that would allow educational and health policy makers to obtain up-dated information

¹⁴⁶ A proposal in the regulation criteria for the clinical research of medicinal plants to be incorporate in the Law of Pharmaceutical Products, Medical Devices and Healthcare Products nr. 29459 was submitted in 2001, in coordination with the INS and the General Direction of Medicines Supplies and Drugs (DIGEMID) of MINSA.

and to know about and exchange experiences with other countries” (CMP 2007). At the end of the congress, the participants reached a compromise, the Declaration of Lima. The paper suggests, among other items, acknowledging the existence of different models and medical systems in the countries, and primarily addresses the importance of studying their worldview –especially in the case of TM– that should be better studied, investigated, valued, respected, and promoted. The participants acknowledged the existence of different HC paradigms and appeal for the promotion and articulation of TCAM systems within the official systems of PH in order to improve the quality of life of their population. The document recommends the states also to be permanently alert and to protect traditional knowledge and therapeutic natural resources from illegal appropriation, biopiracy or patent traffic, and to stimulate their recognition as a national patrimony and its fair economic value to the communities that use and preserve them. The universities and other academic institutions are also urged to include in their undergraduate and graduate curricula the teaching of TACM and the validation of its knowledge and practices through research and pertinent scientific activities; governments should also assign greater resources and technical support for the expansion of their national HCS in order to integrate TACM and obtain a unique, cost-effective, population-based HCS (Gonzales et al. 2010:273-274).

3.3.3.4.1 The Subcommittee of Traditional Medicine

The Subcommittee of Traditional Andean Medicine and Intercultural Issues of the CMTAC have been established since the beginning of the formal activities of the central committee in 2007. General activities delegated to the subcommittee refer to the elaboration of a situational diagnosis in relation to the practice of TM and THPs in the country, the establishment of a conceptual terminology and identification of THS practiced in the country, to document and identify culture bounded syndromes present among the population at the national and regional levels, and the coordination and contact with THPs through periodical meetings and academic and joint activities realized in the central location of the CMP in Lima.

The subcommittee is integrated by 4 MDs –with specializations in PH, herbal medicine, and CAM– elected by the general direction of the CMTAC. In order to conduct its

activities, the subcommittee also counts several collaborators organised in a functional sub-structure that is made up of 4 principal groups:

- (1) Permanent commission: Is composed by an interdisciplinary team of 15 national and international experts and scholars in the field of Amazonian and Andean medicine and intercultural issues, led by the president of the subcommittee, the immunologist Dr. Hugo Rengifo. The topics for the symposia and the meetings' agendas are discussed and selected by this commission and should count with the approval of the central coordination of CMTAC.
- (2) Group of associate members: 15 MDs, researchers, experts and PH specialists mostly located in the regions.
- (3) Permanent council of THPs: At the present composed by 10 specialists (1 *Altomisayoc*¹⁴⁷, 1 *Kallawayaya*, 1 *Pampamisayoc*¹⁴⁸, 1 partera, 1 guinea pig healer, 1 herbalist, 2 Ayawaskeros, 1 *Q'ero Priest*¹⁴⁹, 1 wachumero).
- (4) Group of collaborators: made up of 20 professionals of different disciplines, university professors, and AHPs.

During 2010 and 2011, the subcommittee conducted 9 monthly symposia on several topics of Peruvian TM called the *Conversatorios Rimanacuy*. The symposia are conceived as encounter spaces for health professionals, scholars, and agents of TM to discuss different issues pertaining to Peruvian TM at an academic level. The topics developed during the symposia were: Introduction to Peruvian Traditional Medicine: Significance and Perspectives; Food and Nutrition in the Andean World; Culture Bounded Syndromes; Philosophical Basis of Peruvian Traditional Medicine; Andean

¹⁴⁷ Specialists of Cuzco from the maximum hierarchy that has the power to call and to speak with the regional "Apus" and the Pachamama in order to absolve consultations, to ask for advice or to find out the origin of illnesses. They are able to treat the evil caused by malignant spirits; people consult them for very complicated cases or to solve matters of great importance. It is considered as an instrument (*pongo*, the intermediary) of the Apus with aptitude to recover and establish the balance, and receives these powers straight from the thunder. He can be male or female and enhances three different grades, depending of the hierarchy of the spirit guide of the priest: *Suyu Altomisa (Suyu Apu)*, *Llaqta Altomisa (Llaqta Apu)* and *Ayllu Altomisa (Ayllu Apu)* (cf. Delgado 1999:10).

¹⁴⁸ According to Delgado, the *Pampa misayoq* or *Pampa mesayoq* occupies an inferior status among the hierarchy of the Andean priests. They are the specialists for pagos (oblations) to the Andean deities, and can also cure all types of illnesses. There are different expertises among them, such as to be a paqo (healer) curing illnesses caused by an encounter with a ghost or the contact with a cadaver; they can also practice sorcery or black magic (1999:10-11). For Cáceres, the *Pampamisayuq* or *Waynillu* is basically an initiated or novice, with clairvoyant abilities as a medium, and with capacity for diagnosis (2002).

¹⁴⁹ Passed by on December 2011.

Worldview I, II and III; and Diagnosis and Therapeutic Methods of Peruvian Traditional Medicine. Also in this period, the subcommittee held 45 coordination meetings with various institutions, health professionals, and scholars such as anthropologists, psychologists, sociologists, philosophers, archaeologists, chemists, engineers, indigenous representatives, and THPs with a frequency of twice a month. In accordance with the functions provided by the CMTAC, the activities of the subcommittee are strength oriented to the promotion of spaces of dialogue, exchange and documentation of topics related to intercultural health and TM. There is a webpage located at a social network online, where there are several articles, comments, and announcements on topics related to the field, counting an average of 750 national and international visitors per month¹⁵⁰.

An important innovation achieved by the subcommittee was the establishment of an institutional cooperation agreement between the CMP and the Ministry of Culture of Peru to elaborate coordinated policy proposals in TM, intercultural issues, and population's healthcare. The Vice Ministry of Intercultural Issues of the Ministry of Culture¹⁵¹ was created in October 2011, and has as general objective the formulation of policies, programmes and projects to perform specific actions to achieve visibility and inclusion of indigenous peoples in the country. It promotes the concept of "interculturality" as a guiding principle for the construction of a citizenship that includes the right to cultural diversity, inclusion, and sustainable development with identity, and combats all forms of discrimination between the different cultural groups in Peru (MINCU 2011:122). The areas of work of the vice-ministry of intercultural issues include the formulation of a national policy and a national plan on multiculturalism and social inclusion, as well as the elaboration and management of documents of public and private institutions related to these issues (MINCU 2011:123). The vice-ministry assumes specific tasks aimed at the recovery, reaffirmation, protection, and transmission of diverse cultural expressions of the Peruvian people and the formulation of related policies, such as values and cultural practices in related

¹⁵⁰ See: <http://www.facebook.com/pages/Sub-Comite-de-Medicina-Tradicional-del-Colegio-Medico-del-Peru/150490171667256>.

¹⁵¹ See: <http://www.mcultura.gob.pe/alta-direccion>.

topics, history, languages, worldviews, TM, festive and religious expressions as well as forms of social organisation and oral tradition (MINCU 2011:152).

Through the General Direction for the Inclusion of Ancestral Knowledge, the Vice-Ministry of Intercultural Issues has taken action in relation to the promotion and documentation of TM during the last three years. Regarding the national policy-making for the protection of TK and biodiversity, some of them include the compilation and review of existing supranational norms, and international and national regulations on TK and biodiversity, in order to provide a situational diagnosis for the case of Peru in relation to the legislation about TM. They have managed to complete and chronologically order 14 national laws, 1 International norm and 10 linked supranational norms to this respect, among others a qualitatively important legislative documentation database. An interesting submission constitutes the elaboration of a proposed Plan for the Protection and Promotion of Traditional Medicine, as well as the formulation of new theoretical and conceptual approaches for the methodological implementation of TM. A second line of work is related to the study, research, and record of uses and customs of TK and its relationship with biodiversity. In this area, the vice-ministry has signed an agreement with the CMP, and formulated a collection plan of information on TM in rural communities in Junín, an ethnographic collection of the customs of ancestral water rites in *Llambilla-Huarochirí* peasant community in Lima, and festivals and traditions in the rural community of *Yabroco-Tarata* in Tacna. An elaboration of a project of the Museum of TM is also in preparation (MINCU 2011:153-154).

4 Traditional Health Practitioners in Peru

4.1 Between Persecution and Acceptance

4.1.1 Brief Historical Review

Solían en sus sacrificios derramar sangre de ovejas y corderos, desollándolos vivos sin degollarlos, y luego con gran presteza les sacaban el corazón y asadura, para mirar en ello sus señales y hechicerías, porque alguno de ellos eran agoreros, y miraron (a lo que yo supe y entendí) en el correr de las cometas, como la gentilidad. Y donde estaban sus oráculos veían al demonio, con el cual es público que tenían sus coloquios. Ya estas cosas han caído, y sus ídolos están destruidos y en su lugar puesta la cruz para poner temor y espanto al demonio nuestro adversario (Cieza de León 1544-1552:219)

Several manuscripts and documents from the middle of the 16th century and onwards¹⁵² provide evidence of the intense persecution of Peruvian curanderos by the Spaniards and the political and religious administration during the colonial era. Indigenous, mestizos and Spanish Chroniclers, missionaries and extirpators such as Pedro Cieza de León (1544-1552), Polo de Ondegardo (1567), Joseph de Acosta (1590), Francisco de Avila (1987) [1598], Cristóbal de Molina el Cuzqueño, Joan de Santa Cruz Pachacuti Yamqui Salcamaygua¹⁵³, Garcilaso de la Vega (1609), Guamán Poma de Ayala (1615), Pablo José de Arriaga (1621), Bernabé Coco (1653), and Baltazar Jaime Martínez de Compañón y Bujanda (1978) [1782-1788]¹⁵⁴; among others¹⁵⁵ described not only the practice of healing rituals and the properties of medicinal plants, but also documented

¹⁵² The English translations of the Chronicles cited in this chapter should be understood by means of Spanish and Quechua original documents from the 16th and 17th centuries. I maintain the sense and the figurative content of the passages, rather than privilege the grammatical accuracy. In this sense, some quotations will remain as in the original Spanish/Quechua texts.

¹⁵³ “Relación de antigüedades deste reino del Pirú”, written towards 1613.

¹⁵⁴ The work of Martínez de Compañón, which consists of 9 volumes, is one of the most important graphic testimonies of the life and customs of the 18th century in northern Peru, as it allows delving into a wide diversity of topics ranging from the analysis of medical practices to everyday life, popular culture, music, and ritual practices. It contains more than 1,411 beautiful drawings done by anonymous authors employed by the bishop to illustrate his work. It is said that these volumes were accompanied by a manuscript, but the date is missing. Volume II illustrates general aspects of the life of the indigenous people, in particular their medical practices; volume III and IV accounts for vegetables, fruit trees, and medicinal plants.

¹⁵⁵ An exhaustive overview of the work of the Cronistas can be found in: Porrás Barrenechea, Raúl. 1986. *Los Cronistas del Perú (1528-1650) y otros ensayos*, edited by Franklin Pease. Lima, Peru: Biblioteca Clásicos del Perú, Banco de Crédito del Perú, Ministerio de Educación, nr. 2.

the conflicts and consequences of the encounter of the Spaniards with the curanderos¹⁵⁶ and their driven actions.

The Inca rituals had different modalities such as rites of defence and disposal, magical séances, resettling, transitional rites, purification and sacrificial proceedings, etc. that were not always truly understood among the Spaniards. As Rostworowski asserts, it is necessary to try to differentiate what is truly indigenous from the Spanish mentality of the 16th century. One can imagine the traces of apostles preaching the gospel in America, and at the same time be horrified with the constant presence of the devil: “They were as naive in their fear as the indigenous people themselves” (Rostworowski 1983:32, t. sp.).

Like in other agrarian societies, a fundamental part of the Inca rituals referred to the agricultural ceremonies, described in detail in the *Crónica* of Arriaga (1920 [1621]). Festivals such as the *Hatum raimi*, at the end of August, when the harvest is brought in, or the *Camay Quilla* in December, to ask for the winter to bring water, are key milestones in the life cycle of the Inca Empire.

Hallose que en todas partes tenian sus Huacas comunes de todos Pueblos y Ayillos, y particulares de cada vno, que les hazian sus fiestas, y ofrecian sacrificios, y tenian todos guardados ofrendas para ellos, Sacerdotes mayores, y menores para los sacrificios, y diversos oficiales para diversos ministerios de sus idolatrias, muchos abusos, supersticiones, y tradiciones de sus antepasados, y lo q' causava mas lastima, summa ignorancia de los misterios, y cosas de nuestra fe, que es vna de las causas principales de todo este dano. A esta ignorancia se consigue la poca, o ninguna estima que tienen del culto Divino, ceremonias (Arriaga 1920[1621]:13).

Although most of the scholarships refer to the extirpation of idolatries from a historical perspective, there are only few studies of the social and political situation of THPs before the arrival of the Spaniards, or even in the first years after 1532, a time when the persecution of healers was not part of the evangelisation process. In fact, the rise of the Inca state began at the dawn of the 15th century and its development was truncated by the appearance of the Spaniards (Rostworowski 1988:21). The Inca state began its consolidation with the victory of the cuzqueños over the Chancas' Confederation of

¹⁵⁶ In the crónicas, the terms priests, hechiceros (sorcerers), healers, augurs, and clairvoyants to refer to religious as well healing specialists are used indistinctively. Consequently, the use of these expressions will be done in accordance to the quotation.

States in 1438, a war led by the ninth Inca Pachacutec Inca Yupanqui (or Cusi Yupanqui). After the victory, the Inca Empire was reorganised by Pachacutec, who conducted several reforms in the empire during his government, from 1438 to 1471. With him began a continuous stage of expansion of the empire, which was followed by his brother Capac Yupanqui, then by the tenth Inca Tupac Yupanqui, and finally by the eleventh Inca Huayna Capac, who had consolidated the conquered territories. In this period, the Inca civilization achieved its maximum development of culture, technology, and science, through the development of proper skills and the assimilation of the knowledge of the incorporated states.

The numbers of religious and medical specialists mentioned in the Crónicas is considerable. Acosta (1539-1600:172) mentions an infinite variety of curanderos, like “adivinos, sortilegos, hechiceros, agoreros y otros mil géneros de falsos profetas”. The lists provided in the Crónicas include priests, clairvoyants, healers, and sorcerers such as the *pachacuc* (who works with spiders), the *ayatapuc* (who talks with the spirits of the dead), the *hechecoc* (a specialist for diagnosis through the lecture of coca leaves and tobacco), *arpac* (a minister of the temple), *callparicuni* (including the *cuiricuc*, who “reads” the guinea pig), *hambi qamayoc*, *achicoc*, etc¹⁵⁷. Also some Incas are reported to have been great augurs with healing abilities, such as the eighth Inca Tupac Inca Yupanqui.

And he spoke with all the idols and guacas each year. And with the help of the devil he knew everything about Castilla, and Rome, and Jerusalem and Turkey... And he died in Cuzco, of pure old, at the age of two hundred years. He died by eating and sleeping; he did not feel the death (Guaman Poma 1615:111, t. sp.)

Garcilaso mentions in chapter XIV the existence of “hechiceros y hechiceras” and suggests that the motivation to become a sorcerer lay in a social need of the curanderos: “Huvo tambien hechiceros y hechiceras; y este oficio mas ordinario lo usaban las Indias que los Indios: muchos lo exercitaban solamente para tratar con el demonio en particular, para ganar reputacion con la gente, dando y tomando respuestas de las cosas por venir, haciéndose grandes sacerdotes y sacerdotisas” (Garcilaso de la Vega 1976[1609]:46). Similarly, in the chapter about Inca medicine, Garcilaso did not

¹⁵⁷ For specific descriptions of curanderos in the Crónicas see e.g. the works of González Holguín (2007 [1608]), Valdizán and Maldonado (1922), Cabieses (1984, 2007), Polia and Chávez (1994), Delgado Súmar (1999).

mention any priests or clairvoyants. He merely describes herbalists as “great experts”, who transferred their knowledge to their sons, and also women who were responsible for bloodletting and purge treatments.

“These purges and indents were done by the most experienced among them, particularly old women (as here the midwives) and great herbalists. Among these, many were very famous at the time of the Incas, who knew the virtue of many herbs through tradition, and taught them to their children. They were considered doctors, but not to cure the people, rather the kings, and their relatives, and the *curacas* and their relatives. The ordinary people healed each other by what they had heard about the medicines... [they were] unable to take the pulse and even less to look at urine; the fever was known merely by touch too much heat from the body...When they felt surrendered to the disease, they did not make any medicine or take it; they just let the nature work, and kept a diet” (Garcilaso de la Vega 1976 [1609]:115, t. sp.).

In contrast to Garcilaso de la Vega, who certainly shows disdain for the magical practices of the *cuzqueños* and does not mention them in much detail in his work, Polo de Ondegardo (1567:218-221) dedicated chapter four to four sorts of curanderos, the two principal ones being the *ccamascas*¹⁵⁸ (curanderos) and the *sonccoyoc* (the inspired, the ones who heal with the hearth). The third type, the “hechizeros”, old and young people, were instructed in this and came to the profession as curanderos through an initiation process, curing in dark places or during the night, “so that nobody sees them”. The fourth class were the soothsayers or oracles who used psychoactive plants¹⁵⁹. Polo also affirmed that there were more women than men dedicated to this profession, and Calancha mentioned the confessors as the most common type of curanderos.

[*The indigenous people*] consult them about everything, and anything they doubted. And they asked them for prayers, helping them to negotiate the wealth of their pretensions. By them and with the hechiceras they used to confess, afterwards putting on them rough atonements, giving to the guacas and sacred places gold, silver, clothes or meals. They fasted, three, and four, and six continuous months, or stayed isolated or without moving for many days, and other afflictions full of cruelty, which they had to fulfilled, although they were dying by doing these. They call these hechiceros *Aucachic*, and in Cuzco *Ichuris*, they confess all people in their ayllu, although he could be its wife or son. Its confession matter was the robbery, the adultery, killing with poison, and the top faults were not to serve properly their Gods, and to break something that the Inca had ordered (Calancha 1639:570, t. sp.).

¹⁵⁸ This name refers to a special class of diviners and therapists-herbalists, as well as specialists in killing with herbs (Polia and Chávez 1994:18).

¹⁵⁹ Polo and Cobo mention the employment of the *Willka* (*Anadenanthera colubrina* var. *cebil*), also known as *Villca*, *Huillca*, *Wil'ka*, etc., as an addition to the maize beer (*chicha*) to see in the future (Polo de Ondegardo 1906[1567]:221; Cobo 1964[1653]). The *Villca* was in the pre-Spanish time in Peru of greater ritual and religious importance. The Inca's priests as well the foretellers (*umu*) were also called *Willka Umu*, *Villca* or *Vilca Camayo* (cf. Räsch 1998:34; Schultes et al 2001:122).

According to Cabieses, most parts of the Crónicas have contradictory information on the techniques, denominations, and social status of the Peruvian curanderos; he asserts that they were plenty of different names and descriptions, a chaotic multitude of professional curanderos, that would remind of some researchers of the Western society the confusion about medical activities during the Roman Empire (Cabieses 2007:150). In addition, Cabieses writes, the Cronistas Cobo and Polo de Ondegardo comment that in Cuzco there were more than 450 *adoratorios*¹⁶⁰ with different names (Cabieses 2007:150). Probably there were even more, and each group had its own devotion and ritual practices in times of sickness and need. Therefore, they should be considered a second sphere of organised professionals not belonging to the official clergy, but that in many occasions and in diverse circumstances were dedicated to the practice of the curative sciences in narrow connection with their religious and magic activities.

4.1.1.1 Social Status and Criminal Law During the Incas

Polo de Ondegardo writes about the sorcerers as “poor and humble people” whose occupation was deemed “vulgar and vile”, and notes that this profession was indeed intended to persons who, due to their old age, physical limitations or special conditions, could not perform any other occupation. In fact, this kind of occupations’ selection is in concordance with the social ethic characterised among the Incas, in which they established that no community member should stay inactive or unemployed. However, Polo de Ondegardo interprets this ostensibly social selection of healers as a prevailing norm “and as there are many poor and old, there are many sorcerers”

It must be said that the officials of the sacrifice, who were great and very common, were chosen in this form: If some male or woman was born in the field in a time of thunders, he was born in mind, and they called him *chuqui illa*, and when they were old, they were sent to do what was understood of this, believing that the sacrifice that was done at the hands of these people would be more seriously recognised. Also some were called children of the thunder, women affirmed that they had conceived of the thunder, and after giving birth, their children were indicated for this trade. And finally, all those in whom nature put more of what is common were indicated for that; two or three born from a belly, calling them Indian tombs. Without much idea, anything that was happening to them, or in the small farms or in its persons themselves that was different from others, was considered as an attribute to do this (Polo de Ondegardo 1906 [1567]:219-224, t. sp.).

¹⁶⁰ A name given by the Spaniards to temples constructed for idols in America.

Also in this sense, Calancha notes that “there was in this Peru a big number of sorcerers, and it was the cause of Inca Kings’ order in all their laws to work and to eat of the perspiration of its hands, and that the disabled persons, crippled ones or incompetent for farming or wars should learn to be herbalists to recover patients, or learn to be hechiceros for the ministers of its idols. It was a mop trade, and in this way the multitude of hechiceros grew in number” (Calancha 1639:570, t. sp.).

In his last book, Cabieses (2007) develops a theory on the persecution and social degradation of healers during the apogee of the Incas¹⁶¹. Accordingly, the assistants’ organisation of the *Willac Umu* (the supreme priest) was very competent, although complicated. However, being a member of this institution was one of the greater dignities that an individual could aspire to. “The important priests were people highly appraised in the community... it is said that they carried out a holy life, and during the official festivities... they preached the basic truths of the religion of the sun”. Next to their very active role as the judges and supervisors of the system of religious taxation, and of their intense activity in the organisation of social festivities, they were also in charge of the communications with the Sun, the Moon and the Stars, their main deities. These divinities, Cabieses asserts, were in narrow relation with the general welfare of the empire, but they did not have to do with the personal health of the individuals, except probably those who played some significant role in the community. The priests carried out sacrifices and ceremonies related to war and political issues, and to agricultural and climatological events and other circumstances with economic importance for the empire. The priests’ activities related to medicine were limited to matters of public health and general recommendations, with only some occasional acts related to the health attention to some distinguished person. For the latter they were indeed competent, since many of them had been originally selected among holy men who, for many years, had actively practiced magic medicine as part of the group of independent medical assistants.

The political influence of the priesthood was enormous... Therefore it should not surprise us that the Inca wanted the appointment of the greatest priest, the *Willac Umu*, always under his personal control. In fact, there are reasons to believe that the name “Inca” only became a title for the emperor after a conflict between the military caste and

¹⁶¹ Although his theory about is plausible throughout, the citation style of Cabieses, without page references and exact quotations, makes a follow-up of his asseverations difficult.

the priesthood during the first phases of the Inca dynasty. ... The Inca Wiracocha ... had serious political difficulties that could not be completely erased from the memory of the depositories of the traditions of the empire. An anonymous Jesuit¹⁶² ... wrote that this emperor had to fight a ferocious political battle to maintain his authority in one of the four regions of the world, the Chinchaysuyo, because in his time, the priesthood, whose power was almost unlimited, started a subversive movement that almost destroyed the unity of the empire. His son, who later took the name of Pachacutec, and who is considered an excellent organiser, took command of the armies, and with great difficulty succeeded in converting a defeat into victory, sending the leader of the revolt to Cuzco, called *Hantan Huaylla*, and a multitude of priests were degraded and heavily punished in the capital. When Pachacutec ascended the throne of the Inca –continues the Jesuit writer– he fully reformed the laws and rules of the priesthood, thus establishing his reputation as a reformer of the world (Cabieses 2007:142-144, t. sp.).

Guaman Poma delivered a description of Pachacutec as

A gentle man, big of body, with a round face, lunatic and daft, with eyes like a lion. All his property was not his; he was conspicuous by dining and drank a lot; he was a friend of the war, which always ended successfully for him. He founded temples of gods, idols, *guacas*, and built the houses of the virgins, the *acllaconas*, for women as well as for men. He also founded the pontiff *ualla uiza*, *conde uiza*; the hechiceros *laycaconas*; priests and confessors.... And he ordered the killing of the fake sorcerers and those roadblocks and the adulteress, and punished too much public sins. In this time there was a lot of carnage among Indians, and thirst and hunger, pestilence and punishment of God, drought for seven years; others say ten years¹⁶³. And there were storms; most of the time it was all about mourning and burying the dead (Guaman Poma 1615:109, t. sp.).

Also Garcilaso says about Pachacútec that he “ordered the construction of the noblest and richest temples in the provinces to honour and adore the sun, where the Indians worshipped him; and also founded the houses for the *virgenes escogidas*, because they never founded the one without the other. This was made in favour of the natives of the provinces, because this made of them neighbours of the natural Cozco... [Pachacutec] ordered many laws and private charters, in accordance with the old customs of those provinces, because those Incas kings let each nation use anything that was not against their idolatry or against the common laws and was good, as they had in the antiquity. Thus, it does not seem that they tyrannized them; he drew them instead from their

¹⁶² Cabieses is probably referring to the manuscript attributed by some authors to the Jesuit Blas Valera from 1594. See: Anónimo. 1968. *Relacion de las costumbres antiguas de los naturales del Piru*. Madrid, Spain: Ediciones Atlas, Biblioteca de Autores Españoles, Crónicas Peruanas de Interés Indígena, Vol 209:151-189.

¹⁶³ The use of “seven” or “ten years” reminds of the episode narrated in the Bible about the ten calamities inflicted on the Egyptians to overcome the obstinacy of the Pharaoh, and forced him to let the Israelites leave Egypt. Seven of these catastrophes were produced by the intervention of Moses and Aaron, and three from God directly (cf. Exodus chapter 7-12). Calancha –who read the work of Garcilaso and Guaman Poma– also mentions this drought period during the government of Pachacutec: “En siete años no llovió en este Reyno, negando el cielo su agua a los que sólo merecían su fuego” (Calancha 1639:160).

whooping life to a human existence leaving everything that was not against the natural law, which was more of what these Incas wished to save” (Garcilaso de la Vega 1976 [1609]:287, t. sp.). Cobo is one of the Cronistas who has described in great detail the life and heroic feats of Pachacutec. Cobo describes Pachacutec as

The bravest warrior, the wisest, and most republican of all the Incas before him. He ordered the republic with the concert of laws and statutes, keeping them all the time until the coming of the Spaniards. He put account and reason in all things; he attained and added rites and ceremonies; did the cult of their religion; and established the sacrifices and solemnity with which their gods should have been venerated. He illustrated the temples with magnificent, established rents for them, and a large number of priests and ministers; he reformed the chronology of the time, dividing the year into twelve months, giving a name to each of them and prescribing feasts and solemn sacrifices that should be done during the year. He composed many elegant prayers to invoke the gods, and commanded the priests to recite them during their sacrifices. He did not pay less attention and diligence to the wealth of his republic, giving trace to his vassals as they tilled the fields and to use the lands that were useless and unfruitful; for rough and bent lands he commanded to construct platforms in the bitter slopes of the hills, and extract irrigation channels of the rivers for watering. In short, he did not ignore anything that could be put under well-ordering and concert; for this reason, they gave him the name of Pachacutic, which means “the return of the time of the world”, because the things were improved in such a successful way during his government, that the times seemed to have been exchanged, and the world turned out. And so his memory was held among the indigenous people, giving more honour and poetry in his songs than any of the other kings who preceded him, or those who came after” (1653:68, f/077000, t. sp.)

Among others things, Pachacutec decreed that the priests should be chosen from the common people and, consequently, they should be subject to the common law and to the death penalty when this was indicated. His successor, the Inca Tupac Yupanqui, confirmed these ordinances and perfected them including a new rule that permitted that women could be orderly priestesses

It seems that this Inca always maintained a certain prejudice against the faith healers, but these achieved in every moment to maintain their rights and to exercise their influence. Juan Santa Cruz Pachacutec tells us to this respect that when Huayna Capac was born, his father Tupac Yupanqui pardoned all the sorcerers thanks to the intervention of the Coya¹⁶⁴. The sorcerers had been sentenced in secret to be executed, and the wife of the Inca managed to obtain this exemption, because of the birth of her son...Tupac Yupanqui was always very stern with the sorcerers, although these never disappeared from the empire; on the contrary, they multiplied in number (Cabieses 2007:144-145, t. sp.).

It is not clear if there was a real system of specialization techniques, or the focus of interest in the procedures of curanderismo and divination according to the different

¹⁶⁴ The Inca’s wife.

members of this powerful religious caste. This great variability in the knowledge achievement of the depositories of these sciences must have led to one of the emendations of the Inca Pachacutec to this respect, in which a curandero had to demonstrate pundit knowledge on the virtues and properties of plants. Citing the work of Blas Valera, Garcilaso de la Vega resumed this disposition as follows:

The doctor or herbalist, who ignores the virtues of the herbs, or those knowing some of them, but not trying to learn all of them, knows little or nothing. He should work up, to know all of them, both the useful and those which are harmful, to merit the name which is intended to (Garcilaso de la Vega 1976 [1609]:334, t. sp.).

Dobkin de Rios says that as societies became more complex and segmentation occurred, access to altered states induced by drugs was controlled and regulated by elite groups. When such societies underwent social change and conquest, drug rituals and esoteric knowledge were often lost to posterity, although clues to these beliefs and rituals remained coded in art (1989:285). In other words, the access to altered states of consciousness induced by drugs provided mechanisms of social control and was, accordingly, regulated. Consequently, the attributed supernatural powers of a curandero and the social importance adduced to them could have entailed a counter-effect. The more powerful and effective a healer was considered by his patients, the more responsibility he had to assume for his mistakes, sometimes with fatal consequences. In the *Crónicas* lots of evidence can be found that these errors –or their inability to heal important authorities– could end with severe punishments and even with the death of the curandero.

Although disputable because of their position as catechizers and their religious view¹⁶⁵, some Cronistas give information supporting the above-mentioned affirmations. The indigenous Cronista Guaman Poma speaks of *hechizeros* specifying their classification and names: those who kill by poisoning, the ones who bring together men and women¹⁶⁶, or made distinctions about sorceries carried out by hechiceros to save somebody from justice, to bring illness, to produce *daño*, or even death, and stresses

¹⁶⁵ In opinion of Rostworowski, the documents written by the Conquistadores reveal the amazement produced in the Spaniards with the mere idea of Evil's presence: "Satan in person was around the country and could tempt saints" (Rostworowski 1988:204).

¹⁶⁶ The entire paragraph 5 of the chapter IV of the "Instruccion..." from Polo de Ondegardo is dedicated to the practice of magic-loving sorcery, the *huacanquis* (Polo de Ondegardo 1906 [1567] 197-198).

descriptions of their operations (Guaman Poma 1615:266). Descriptions of the punishment that the Incas imposed on them are also present:

“QVINTO CASTIGO: Castigo de los que dan ueuedizos y ponsoñas, los que mata a los yndios: Que a éstos les llamauan hanpiyoc, collayoc, runa uatoc, ynca uatoc, pachata pantac, yma hayca hanpita, machacuayta, hanpatota, pizacata, runa uanochinata uacaychac caycunata, astaya, ayzay uanochi. Yauar pampapi tucuchon churinue mitanuan [curanderos, herberos, adivinos del pueblo, adivinos del Inka, los que engañan al mundo, los que guardan toda suerte de medicinas, culebras, sapos, perdices y objetos que matan la gente, a éstos, maldita sean llévatelos, mátalos. Que se acaben en un campo de sangre con sus hijos y sus semejantes. Que estos yndios murían con este castigo todo su casta y aylo y sus hijos y nietos. Escapaua los niños que fuesen de teta porque no sauía el oficio y ancí se escapaua de la muerte. A éstos no les enterrauan, que lo dexauan comer los condores y gallinasos y sorras en el canpo. Este oficio de matador de los adúlteros fueron Mayo ynga, Equeco ynga, que en aquel tiempo eran uerdugos. Y ancí en todo el rreyno estaua executado esta sentencia. El Ynga y su consejo que los corregidores, tocriloc, le sentenciau y desto le abizan al Ynga de todo lo que pasa. Que el Ynga tenía citios y lugares deste rreyno señalado para el castigo de los malos en peñasgos y serros y rriós y lagunas y cárzeles y preciones llamados Uatay Uaei, Zancay y Pinas Runa Uanochinan, Yauar Caca, Anta Caca, Arauay, Uinpillay, Ancas Cocha, Muyoc Hatun Yaco. Castigo de los pontífises: Por sus mentiras o falsos o leuantamientos le castigaua grauemente, cin apelación. Le sentenciau hecho quarto; le daua a comer a los animales, leones y serpientes de sancay [cárcel]. Este dicho castigo hacía para que fuese fiel y cristiano exemplo en su ley, que tubiesen hordenansa” (Guaman Poma 1615: 311-313)

Calancha (1639) asserts that if the patient died as a result of a mistreatment by a curandero, the latter was declared a killer and judged as such. The penalty implied a tortuous death, in which the curandero was humiliated and vilified afterwards. Not enough with that, when the corpse of the patient was buried, a cord was stuck between the deceased and the corpse of the curandero, who stayed outdoors, outside of the grave, and where he was devoured by wild animals and birds of prey. Similarly, Polo mentions sorcerers who were punished by the Inca law, exterminating their properties and families, letting live only the breast children (Polo de Ondegardo 1906[1567]:219-220). Also Cobo mentioned among the Incas the use of religion to subjugate the people and the severity of the punishments foreseen for curanderos who failed in their activities

Because the fundament of their political government resides in ordered media to maintain their people subjugated and to lessen their resolve to rise up against them, for this same purpose were also aimed the views that based among them with regard to their religion, whose title was carried by and ahead in their conquests, under pretext to give that honour and obedience to *Viracocha*, as breeder in the world, and the Sun, Thunder and his other gods, who were deemed to be the cause of the conservation of their superiority... As they were tyrants, the time and the occasion taught them all the means necessary to sustain their tyranny and to domain others with more security (Cobo 1964[1653], t. sp.).

Viracocha or *Ticcsi-Viracocha* was one of the principal local deities of the Incas in and around Cuzco. His adoration, as well as the Sun's cult after him, was imposed as official among the conquered nations in the Tawantinsuyo, although the Incas mostly tolerated the religious practices of each local community. González Holguín remarks as synonyms of *hatun viracocha* the expression "*hatun señora, hatun padre*" (González Holguín 2007 [1608]:121) suggesting that the typical gendered duality of the divinity is present in indigenous ideology. Following the logic of the mirrors proposed by Platt (1978:1078 cit. by Rostworowski 1983:23), the union of a man and a woman constitutes an anomaly. The body of the man or the woman is indeed symmetrical; its image reflects another body of the same sex. When we see the possibility of the union between a man and a woman, the concept of the mirror will give a combination of two masculine and two feminine elements, which results in the number four. This cuatripartition will be transformed in an opposition of masculine men, masculine women, feminine men and feminine women. "We find so the cuatripartition under diverse forms not only within the religious systems and in the socio-political organisation; it will be also reflected in diverse activities and cultural events" (Rostworowski 1983:23, t. sp.). This also explains the relation between the deities *Pachacamac-Mama Cocha* (the sea), and *Viracocha* or *Ticcsi-Viracocha* with *Viracocha-Pachayachachic*.

The Spaniards misinterpreted *Viracocha* as the "creator of all things", as a figure equivalent to the Christian God, but this was not correct. For indigenous ideology, humankind originated (not created) from different *pacariscas* or *paqarinas* (places of origin) like caves, stones, lakes, rivers, animals, plants, etc. (cf. Rostworowski 1983:30-31). In fact, it is only after the government of Pachacutec that *Viracocha* officially turned into *Viracocha Pachayachachic*, which was a masculine God, more in the sense of a Christian God. Whatever reasons Pachacutec had for this change, it is interesting to note the way in which Cobo interprets the reasoning of the Inca in discovering the existence of *Pachayachachic*, as a quasi-rational enlightenment and a source of intelligence

(Pachacutec) considered how it was possible that a thing so subject to movement as the sun was a god, since it never stops or rest for a moment, and every day turns around the world. And he reasoned that the sun should not be but a messenger, sent by the Creator to visit the universe; because, if it was a God, it would not permit that a part of a cloud was in front of him and prevented its glaze and luminosity over the earth. If he was the

universal creator of all things (Pachacutec thought), he would rest some day and illuminate the whole earth and send what he would like to... there should be another most powerful Lord who was ordering it, and this was undoubtedly the Pachayachachic. (Pachacutec) reported this thought to those members of his Council and they determined that the Pachayachachic would be preferred instead of the sun, for whom a special temple, that was called Quishuar-Cancha, was built on the city of Cuzco; they put there a simulation of the Creator of the world, the Viracocha Pachayachachic, a resplendent figure of a man of pure gold, in the size of a ten year old boy (Cobo 1964 [1653]: f/078920, t. sp.)

The necessary care in the ceremonies and rituals carried out by priests and curanderos to avoid severe sanctions is also reflected in this passage from Cobo:

They believed anything that the priests or the Incas wanted to invent, so their opinion received strength and corroboration; and using this facility, priests and ministers of the guacas, for being so interested in the offerings and sacrifices offered to the people, invented every day thousand of novels and mysteries of visions, and miracles occurring in their guacas, and made simple common people believe in that; in order to increase their reputation and the fame of their gods, they augmented their offerings, and there were received and settled some things so apparent and unfounded, that is not possible, some would stop looking at them and knew their falsehood and fraudulence... Because it is clear that many philosophers were laughed at and their gods got crowded on, and still with all that, they did not dare to talk about this, as to not contradict the majority of people. This was especially common among these Indians, whose freedom was little, because of the big punishment and the big number of people who kept these occupations (Cobo 1964[1653]:f/147960 t. sp.).

The principal asseverations of the Cronistas in relation to the status and characteristics of the curanderos and *sacerdotes andinos* in the Inca state can be resumed as following:

- (1) The priests of the highest religious hierarchy held political, social, and economic power comparable to that of the Incas. They were elected directly by the Willka Umu (supreme priest), and belonged to one or two main castes of the Hurin Cuzco, such as the *Tarpuntaes*¹⁶⁷.
- (2) The priests did not necessarily exercise activities directly related to health or healing. There are no records in the Crónicas that demonstrated a purely curing or healing activity by the sacerdotal elite. Some Cronistas (Cobo, Polo de Ondegardo and Garcilaso de la Vega) mention situations that reveal a pattern more or less constant: In case of a difficult sickness or unclear diagnose of the

¹⁶⁷ According to Cristóbal de Molina (1916 [1576]:f/064006) the priests of the Sun came from the group of the Tarpuntaes, and were responsible to feed and make the oblations to the huacas during the festivities for planting and harvesting: “Es una gente como sacerdotes, tenían cuidado de ayunar desde que sembraban el maíz hasta que salía de la tierra como un dedo de alto; y en este tiempo no se juntaban con sus mujeres, y así mismo ayunaban sus mujeres e hijos de estos... los sacerdotes del Sol, llamados tarpuntaes”.

Inca or their relatives, the priests or the same Inca requested the extraordinary visit of healers, even from distant regions (such as the Kallawayas) to ask for adequate intervention.

- (3) In some occasions, the priests were responsible for suggesting decrees and emergency measures in relation to public health issues of particular or exceptional importance for the Inca state. Tasks of divination, which were aimed at clarifying situations with the state's political character or relating to agricultural and economic production of the Kingdom, were part of their functions as members of the Council of the Inca.
- (4) On the other hand, the healers are described in the *Crónicas* as people of "low social level", with "moral and/or physical limitations", or "congenital or structural impediments". According to existing descriptions, minor sorcerers or healers were considered "poor" and were dedicated to this profession because they were unable to exercise another. This profession was entrusted to persons who, by age and need, could not address another trade. In the logic of the Inca's social ethics, nobody should remain idle and without performing any activity for the benefit and advantage of the community¹⁶⁸.
- (5) In addition, it is constantly mentioned that the number of these healers was extremely large. They were generally considered as exceptional people because of their personal characteristics, and simultaneously generated fear and admiration among the population.
- (6) In fact, the activities of the curanderos were not clearly regulated until the government of the Inca Pachacutec, who was the first Inca to release specific norms about their activities.

Regarding the last point, it is possible that the different activities previously performed exclusively by priests (divination and counselling) and healers (healing activities) became increasingly equivalent after Pachacutec's regulations. According to Cabieses, the Inca Pachacutec changed the priesthood laws stating that *any* man or woman could practice medicine or carry out a role of sorcerer or priest, if he or she showed sufficient

¹⁶⁸ Evidently, the negative value of the social origin and characteristics attributed to the curanderos by the Cronistas does not mean necessarily the same perception among the native population in relation to their healing specialists.

interest and capacity to do so. Consequently, the healer could exercise religious activities through three different selection systems: (1) All those who were born in an ayllu linked to priestly activities might be elected for that purpose; (2) those who were born under circumstances considered of magic meaning (e.g. children of the thunder or *libiac*; women who were pregnant without explanation; or births occurred under obstetric special conditions, such as the twin birth or the breech delivery). Finally, (3) there were those who were elected or chosen due to any other justification, real or fictitious, simply authorised by the local authorities to practice sorcery or curanderismo in a particular community¹⁶⁹. Additionally, since this time, both women and men could assume the position of priest (Cabieses 2007:163).

Cabieses asserts that the primary reasons for the reforms delivered by Pachacutec, which directly affected the status and power of the priest hierarchy, were the financing of the growing domestic costs and due to the monetary course of the macroeconomic system of the empire. “Not having developed a monetary system with strict regulations of individual property, the concept of wealth or poverty was essentially linked to their capacity of work. When war and political conquest plagued the country, orphans, widows, and disabled persons increased the demands on government resources for their primary needs. Therefore, it is not surprising that Inca rulers decided in that time to allow the development of a liberal profession –the magical curanderismo– that was gradually established as a quite disorganised activity, far different from the careful systematization of the Inca state” (Cabieses 2007:165-166, t. sp.). Valdizán also mentions that the Incas dispensed special public health dispositions and legislations for the care of disabled people and that the state willingly assumed this responsibility. The law for invalids, for example, demanded that they should be fed through the public funds of the state, including the “deaf, dumb, lame, cripples, decrepit and sick”, and according to this law, “the invalids were called two or three times per month to the treats and public meals, so that in the general rejoicing they could forget their miserable state”; the *oncomayoc*, or *superintendente de enfermos* (inspector of diseased), was the executor of this law (1915:92). Valdizán suggests also, that the therapy of mental alienation, in the forms which were known by the ancient Peruvians, were mostly

¹⁶⁹ I did not find any reference in the cited Crónicas to this affirmation. It seems to be a personal statement of Cabieses.

reserved for “sorcerers” (Valdizán 1915:92-93). In opposition to Cabieses’ thesis, it is not reported if the achievement of economic resources for the funds for disabled care were considered a social problem that threatened the economy of the state, neither in time of peace nor during war.

To this respect it is my contention that it was probably not the economic, but the political situation in the empire that induced the Inca Pachacutec to make these reformations with the principal purpose to debilitate the power, status, and influence of the sacerdotal class. Due to the dual character of the Inca clan, which was divided into two principal castes, hanan (high) and hurin (low) cuzco, it is certainly possible that the Willac Umu belonged to the lower (hurin) segment, since –according to Molina el chileno, cited by Rostworowski– the Vilaoma was the second person behind the Inca and was called “*siervo o esclavo del sol*” (Rostworowski 1988:205), a position endowed with a considerable amount of political and social power according to the dual conception of the Incas. In the same light, Gareis points out that the healers and diviners of the Incas also had a high status just like the Amauta doctors, belonged to the state of the scholars, and thus enjoyed a high reputation (1999:137).

However, the sacerdotal class had indubitable power and influence on the states’ commitments, and their actions were certainly decisive in the empire’s administration and political governance in a time prior to Pachacutec, specifically since the government of Yahuar Huacac (the seventh Inca). As the position of the priests turned against the Inca Yahuar Huacac, the previous confidence in them waned. According to Cobo, the priests predicted a sad and unsuccessful life for the Inca Yahuar Huacac, considering him a “weak” person, both among the indigenous people, priests, and soldiers

His name means “who cries blood”, and the people gave him this name because once, as the Inca were defeated and imprisoned by their enemies, he cried blood of pure pain and shame of being in such a miserable state. His vassals did not have a high opinion of him, due to his reputation as a coward, and they saw themselves confirmed in their view by the forecasts of the augurs, according to which he had to be unhappy and unfortunate; and the same Inca, fearful of these omens, did not dare to go to war in person; and so, in the memory of the stories and songs of the Indians, he did not participate in any conquests from Cuzco after he was crowned (Cobo 1653:64, f/073940, t. sp.)

Certainly afraid because of the priests' prognoses –Cobo continues– Yahuar Huacac also saw a potential risk for his government in his impetuous son Viracocha (the eighth Inca, precursor of Pachacutec) and decided to exile him from Cuzco (1653:64, f/074300). However, the priests stayed at the side of Viracocha Inca in the regain of the Chanca's territory, because of the visions and dream Viracocha Inca was said to have had and consequently supported his leadership as new Inca among the population. Such demonstration of power and influence of the priests in the political governance of the empire had as a consequence that they began to be perceived as increasingly hazardous for the Inca.

The prince, in order to be credited, manufactured a fiction that was the beginning of his venture, good luck and name. He told his followers that while he was in exile, one day as he was leaning back in the shade of a rock, the god Viracocha appeared to him... and although he was lonely and disadvantaged from his father, people got up on his behalf, because although the Chancas were numerous and they went about victorious, with Viracocha's favour and aid he would defeat them and make him lord of the earth; because, at the time of the battle, it would send relief supplies for people, that without being seen from anybody, he will help him against his enemies; and in gratefulness of this favour to him, and by his devotion, he should be thus name Viracocha. This revelation or fable that he told the Indians was of great importance for their attempts; because the priests and augurs, trusting it, called upon the people and persuaded them to obey the prince Viracocha, and to continue in his company against the Chancas (Cobo 1653:64, f/074630, t. sp.)

One anonymous author in particular lends additional support to these affirmations (Biblioteca de Autores Españoles 1968:161-167, cit. by Rostworowski 1988:205). In this manuscript, he recounts how in the times of the Inca Viracocha, the priests caused revolts and riots in the empire. After these events, the priestly caste lost much of its former power. Coinciding with this news, the author continues, the attack of the Chancas on Cusco occurred, and the subsequent defeat of the Inca in the city. In light of these events, Rostworowski comments: "After the enemies were vanquished, it is possible that the priests were deserving punishments for that, and this could have promoted a religious change; since this moment the cult of the sun gains preponderance over the other huacas" (Rostworowski 1988:205, t. sp.). These alterations are consistent with the innovations introduced by the Inca Pachacutec in the temple of the sun, and the splendour that the sanctuary reached during his government. With the consolidation of the state and the sun's cult religious special visitors were appointed, who were

responsible for instating and removing huacas, and establishing new priests instead of the former ones (Rostworowski 1988:205).

The openness towards priests of other regions and social classes resolved by Pachacutec involved great social unrest for the priests, and their prior political position in the Inca state. In fact, through Pachacutec's regulations, the priests did not only lose their social status, but also their exclusive religious duties slowly began to be replaced, becoming gradually displaced from their prior importance in the Inca state, and more and more confined to a clandestine practice of their profession.

4.1.2 The Extirpation of Idolatries

Y aunque se ha puesto suma diligencia en descubrir todo lo sobre dicho, y en quitalles todas estas cosas no solo de los ojos, sino mucho mas del coracon, con los continuos sermones, y catecismos, se puede temer mucho, que rayces tan arraygadas y antiguas no salgan, ni se arranquen del todo con la primera reja, y para que no tornen a brotar, y se acaben de desarraygar, sera menester segunda, y tercera reja. (Arriaga 1920 [1621]:f/17)

During the 16th century, the Spaniards mainly showed interest for a rapid acquisition of treasures, and not necessarily for the persecution of local superstitions. The indigenous customs and rites were tolerated as long as they did not run counter to their objectives. However, some local cults directly questioned the Catholic Church and the Spanish rule. Since the 17th century, criminal courts passed judgement on healers in special procedural instances and inspections during a period known as *extirpación de idolatrías* (cf. Sharon 1993:13; Silverblatt 2004).

In Peruvian historiography, the expression “extirpation of idolatries” usually has two different meanings. First, it designates the general principle of evangelisation in which it was necessary to eradicate the uneducated pagans as a prelude to the diffusion of the Christian doctrine. In relation to this period, Urbano says that the main idea of “idolatry” designated the beliefs and indigenous religious practices that were intrinsically separate or differentiated from Catholicism (1993:16). The Christian doctrine had to be taught and everything that seemed to be part of pre-Columbian

religious forms should be eradicated; these “pagan” customs were the target of the missionary activity of the Spaniards. This was a basic universal principle that the country shared with other Evangelistic experiences and it was clearly reflected in the ecclesiastical law, councils and synods reflected and wrote about this particular aspect. The set of rules and laws that led to this principle were on the basis of a variety of legal proceedings against idolaters and sorcerers. In the extensive area covered by the old archbishopric of Lima, the headquarters of the civil and ecclesiastical power, the extirpation of idolatries also meant a historical period in which the struggle against paganism, or their remnants, became the main evangelisation policy for the archbishops.

Brosseder asserts that the demonic conceptions of indigenous healers were assumed to exist in the late 17th century, which had practical influence on the work of missionaries who were actually dealing with sick Indians. “Missionaries sought to use Christian healing to direct indigenous people away from idolatrous customs. Therefore, Jesuits set up their pharmacies in their missions and sometimes served Andeans in their *enfermerías*. But throughout the colonial period, most indigenous people in the hinterlands of Lima, in the Central Cordillera, in the Andes around Cuzco, further south in Potosí, and along the northern coast continued to consult indigenous healers, who (much like the judicial astrologers) had learned to conceal their arts” (Brosseder 2010:152). So defined, it could be said that the motor of the extirpation of idolatries lay on the mental filters of the Spaniards at that time and the need to obtain more new Christians among the indigenous people for the evangelisation enterprise of the Spanish crown. The more important assumption among the Spaniards was that the possibility of cure and augurs was only possible through the intervention of demons. The common belief was that healers made a pact with a demon, and through this agreement, the demon transferred part of its power on the healers. Evidently, in the files of the process of extirpation of idolatries, it is easy to recognise in the statements of the accused and the witnesses how the judges and ecclesiastical administrators’ ideas influenced the indigenous testimonies. Also, Larco asserts that the answers to any questions and requests for information in processes of idolatry were ambiguous and changing. “When the defendants were asked about the demon, in some cases they claimed to have

“known” him or to have been in his presence, but soon later they deny this information and present instead another version of the events” (2008:35, t. sp.).

Religion was not the only reason for the persecution and paganism’s extirpation process. It was also based on the consideration that the indigenous religion not only violated the practices and beliefs of the Catholic faith, but that it was also a refuge and a cultural focus of resistance against the Spaniards.

4.1.2.1 The Stipulations

The first legislative text concerning the extirpation of idolatries issued by the Peruvian ecclesiastical hierarchy was the *Instruccion de la horden que se ha de tener en la doctrina de los naturales*, written by archbishop Jerónimo de Loayza in 1545 and adopted in 1549, two years before the celebration of the first Council of Lima. Martínez de Codes argues that the spirit of Loayza’s statement reveals a liberal and optimistic conception of the evangelisation, starting from the conviction that the idolatry of indigenous peoples is the result of religious ignorance, and that it can be remedied using a correct doctrinal statement (1990:527).

In the Councils of Lima from 1552 and 1567, criminal regulations were bargained for indigenous Christians that still carried out pagan rites. The first Council of Lima realized between 1551 and 1552, severely punished both the hechiceros as well as those interfering with the conversion of the Indians or making the already baptized return to their old beliefs. For the Indians, the penalty consisted of fifty public lashes and a haircut. For those relapsing, the penalty increased to one hundred public lashes, ten days of imprisonment and the confiscation of a third of their properties by the village church (Tineo 1990:114-130). The second Council of Lima of 1567 placed special emphasis on the need to identify and imprison the hechiceros who continued with these practices, not including indigenous herbal medicine, provided that it were stripped of all ceremonial or superstitious ritual (Tineo 1990:182-201). These regulations were reinforced in the third Council of Lima (1582-1583) which repealed the provisions of the first Council and urged the exact fulfilment of the second Council agreements (Specker 1966:120), ordering among others resolutions, the application of mild corporal punishment to the

Indians, due to the absence of “considerably understanding the spiritual order and interdictions from the church” (Tineo 1990:393-399, t. sp.).

While the evangelisation process was in advance, a religious native movement arose in the archdiocese of Cuzco and reached the area of Lima in the middle of 1500. The so-called “Guerra de Vilcabamba” was a military counter-war of the Incas against the Spaniards, which lasted from 1533 to 1558, starting with the meeting of Inca Llupanqui in the hills of Wilcaconga (Willkakunka) with the Spaniards, and until the output of Sayri Thupa from the Peruvian redoubt of Vilcabamba, in Cuzco¹⁷⁰. Despite the apparent victory of the Spaniards, the movement was not at all extinguished, and generated another form of expression of cultural resistance, the *Taki Onqoy*. According to Millones (2007), the Taki Onqoy is one of the earliest messianic movements of the Andean region, whose importance grows because its ideology addresses gods not known by the Incas and, at the same time, emphasises minor deities of the Tahuantinsuyu. Additionally, it neglects the power of the Inti, the solar god and divine father of the ruling dynasty (cf. Millones 2007). Cristóbal de Molina (1916 [1576]) and Cristóbal de Albornoz (1583) wrote about this movement between 1574 and 1576. For Molina, whose account provides interesting details about this movement, this Andean “apostasy” was motivated by the last Incas of Vilcabamba and was the work of the hechiceros. Molina did not give a name to this movement but wrote that its adherents “made a sort of song, which they called *Taqui hongó*” (1916 [1576]: f/142041).

Ellos creyeron que todas las huacas del reino, cuantas habian los cristianos derrocado y quemado, habian resucitado...que agora daba la vuelta al mundo, y que Dios y los espanoles quedaban vencidos desta vez y todos los espanoles muertos, y las ciudades dellos anegadas, y que la mar habia de crecer y los habia de ahogar, porque dellos no hubiese memoria...Salieron muchos predicadores luego de los indios, que predicaban asi en las punas como en las poblaciones; andaban predicando esta resurreccion de las huacas... que ya volvia el tiempo del Inca y que las huacas no se metian ya en las piedras, ni en las nubes, ni en las fuentes para hablar, sino que se incorporaban ya en los indios y los hacian ya hablar... asi lo hacian con muchos sacrificios los hechiceros que en aquel tiempo estaban recogidos y castigados... con libertad usaban sus oficios volviendo a ellos...no solamente los indios en los repartimientos, pero los que vivian en las ciudades entre espanoles, usaron y creian en esta miseria, ayunando y apostando... porque como habian creido que Dios y los espanoles iban de vencida, trataron de alzarse con la tierra, como se entendio publicamente en el ano de setenta y cinco... Durante este

¹⁷⁰ See: Guillén, Edmundo. 1984. “Tres documentos inéditos para la historia de la guerra de reconquista inca: Las declaraciones de Lorenzo Manko y Diego Yuqra Tikona, servidores de Manko Inka Yupanki y de Francisco Waman Bimachi, testigos presenciales de los sucesos de 1533 a 1558”. *Bulletin Instituto Francés de Estudios Andinos* 13 (1-2):17-46).

tiempo hubo diversas maneras de apostacias en distintas provincias, unos bailaban dando a entender tenian la huaca en el cuerpo, otros temblaban por el mismo respecto, dando a entender la tenian tambien; otros se encerraban en sus casas a piedra seca, y daban alaridos, otros se despedazaban, y despenaban, y mataban, y otros se echaban a los rios ofreciendose a las huacas (Molina 1916[1576]:f/142041, 143019, 144017, 145009, 147016, 148012, 149001)

The viceroy Francisco de Toledo (1569-1581) managed to adopt a series of punishments and punitive penalties to eradicate these movements and its leaders and sorcerers. Thus, the eradication of idolatry became a matter of the state, became to depend largely on the viceroy who implemented a series of dispositions such as general visits, the foundation of the *Tribunal de la Inquisición*¹⁷¹, reductions of indigenous such as the *mita*, etc., all of them conducive to suppressing and destroying any stronghold or symbol of the Andean religion. The ecclesiastic visitors established during his government were the precursors of a system of extirpation that became institutionalized in 1610 with the creation of a specialized body of “*jueces eclesiasticos visitadores de idolatrias*” (Martínez de Codes 1990:537).

The wide range of physical punishments who were applied are listed on the *instrucción para descubrir todas las guacas del Peru y sus camayos y haciendas* de Cristobal de Albornoz written in 1583, a work that constitutes the greatest influence on the ideology of the extirpation, constituting in fact the prototype of an extirpator manual, a model for the subsequent instructions written by Arriaga (1920[1621]) and Villagómez in 1649¹⁷². According to Griffiths and Baliñas (1998), Albornoz was the first extirpator in Peru who reinforced the identification of the Andean religious specialist with a hechicero. These hechiceros were characterised as servants of the devil, whom they invoked in their superstitions, and as liars who used the Indians with their false preaching. The indigenous doctors, who cared in considerable numbers for the health needs of the indigenous people, were all considered sorcerers, begging the help of the devil before

¹⁷¹ The Inquisition was created by King Felipe II in 1569 and was a provincial branch of the Council of the Supreme and General Spanish Inquisition. The Inquisition of Lima entered into force in 1570, being the viceroy of Peru Francisco de Toledo. The Inquisition was abolished by decree of the Cortes of Cadiz, on 22th February 1813. For Peru, it was definitively abolished in 1820 following the emancipatory process, in which all type of political dependency on Spain was eliminated (Museo del Congreso y de la Inquisición 1999).

¹⁷² Villagómez, Pedro De, Horacio Urteaga and Carlos Romero. 1919[1649]. *Carta pastoral de exhortación e instrucción contra las idolatrias de los indios del arzobispado de Lima*. Lima, Peru: Editorial Sanmarti.

exercising their practices (Albornoz 1583:172-173, cit. by Griffiths and Baliñas 1998:113).

4.1.2.2 The Discovery

Towards the end of the 16th and the beginning of the 17th century, great optimism prevailed among the insular and peninsular ecclesiastical and civil authorities of the viceroyalty, because they assumed that the task of the evangelisation in Peru was unproblematically carried out, and that all the Indians had taken the Christian faith. The repression by the state executed by the viceroy Toledo through the above-mentioned corrective measures made to believe that the resistance or systematic opposition to the work of the evangelists had been extinguished, and that the limited existing data on idolatry was merely a sign of residues from the past. As Bartolomé Lobo Guerrero was promoted to the third archbishop of Lima (1609-1622), he was convinced that the problems with the idolatries in Peru were already resolved. In Peru, the prelate believed, there was a broad system of doctrines, the rules of the third Council of Lima were met, and the catechism translated into the major Indian languages guarantee a correct teaching of the doctrine. As a result, the idolatries should have been extinguished. According to Martínez de Codes, the non-formulation of precise criteria on the part of the ecclesiastical hierarchy that should set the limit about which indigenous people could be considered either true Christians or idolaters, and the negligence of the clergy auxiliary led, with the time, to consider the problem of idolatry resolved (1990:540).

Nevertheless, in the early 17th century, there were references to the survival of the ancient indigenous religions in the archdiocese of Lima. The criollo Catholic priest Francisco de Ávila (1573-1647) was the key character in this discovery. To that time, Avila was the priest of the parish of San Damian (Province of Huarochirí, Lima). According to Avila (cited by Garcia 2009:6), the discovery of the idolatry of the Indians from his *doctrina* took place in August 1607, during the Catholic feast of the Assumption. Avila recounted in his text, that on the way to Huarochiri, he was approached by an indigenous man of his *doctrina* who said to him that the vast majority of the people there, although they pretended to celebrate the Catholic holidays, in reality were profiting from the place to perform ceremonies in honour of their two most important deities: *Pariacaca* and *Chaupinamoca*. The next day, during the sermon that

preluded the feast, Avila took the opportunity to insert a paragraph in which he warned the assembly that he was aware of everything. Avila's sermon turned the indigenous people very angry. At the end of the fiesta, the main priestess of the idols gathered with the caciques and demanded the expulsion of the priest from the doctrina¹⁷³ (Garcia 2009:6-7). After several expeditions to confirm the amount and expansion of these practices, Avila communicated the existence of idolatries in his archdiocese to the archbishop in Lima, from which the necessary logistical and legal support for Avila for the extirpation process was organised. Around Lima, centres of idolatrous practices were identified in San Damian, San Pedro de Mama and Santiago de Tuna. According to Arriaga, the indigenous man Hernando Paucar was the main spreader of these ancestral beliefs in this region.

Destos idolos se hizo vn auto publico en la placa desta ciudad de Lima, conuocando para el todos los Indios de quatro leguas al rededor. Hizieronse dos tablados con pasadico del vno al otro. El vno de terraplano, y en el mucha lena donde ivan pasando los Idolos, y todos sus ornamentos, y se arrojaban en la lena. Donde tambien estaua amarrado a vn palo vn Indio llamado Hernando Paucar grande maestro de Idolatria, y q'hablaba con el Demonio, natural de S. Pedro de Mama, a quien en todos sus contornos tenian los Indios en mucha veneracion (Arriaga 1920 [1621]:f/6)

As an official and autonomous institution, the extirpation of idolatries had its greatest period of activity from 1610 to 1660 (Martínez de Codes 1990:537). This extent of time coincides with the government of three bishops in particular, Bartolomé Lobo Guerrero (1609-1622), Gonzalo de Campo (1625-1626) and Pedro de Villagómez (1641-1671) (cf. Tomoeda 2004:122; García 2009:2).

As witches, sorcerers, idolaters, heretics, doctrinaires, etc. were considered all the indigenous religious specialists whose break with the Catholic religion was perceived by the persecutors, at least since the 17th century, as prosecutable. As Tomoeda argues, the central characters of these persecutions were the *laiqa* of the south-central Sierra and the healer of the coast and northern sierra (2004:121). Accordingly, the focused regions of extirpation work were especially northern Peru and the highlands around Lima (Larco 2008:13). The condemned healers were put in prison because of their heretical practices, constrained to give their material possessions as indemnification to

¹⁷³ A month later, already returning to his parish, Avila received a letter from the archdiocese: the indigenous person from his doctrina had been lowered to Lima to await a trial against him with the charges of economic abuse, mistakes in his work as priest and offenses against morality (cf. Garcia 2009).

adjudicators and aggrieved partners, and did communal service as reparation of their faults (Millones 2002). Although one of the principal dispositions was that they should not wield their knowledge to cure other people, many of the condemned curanderos were committed to work as hospice assistants in *hospitales de indios* at that time. Thus, Arriaga writes “where there is no house for reclusion, they could be sent to monasteries and hospitals, and in houses of pious people, where they would be well protected, taught and sustained” (1920 (1621): 112, t. sp.).

The latter suggestion is not surprising since the extirpation’s amends were never disposed against the curative activities of the healers. In fact, the success of their healing work was never questioned. MacLean y Estenos writes that the hechiceros of the colonial period were excellent healers (1953:142, cit. by Andritzky 1999:28). They knew the curative properties of plants, and possessed a large amount of knowledge about herbs: “So great was the reputation they enjoyed in the society, that a Spanish doctor reportedly said that he had himself opposed to the establishment of a medical school, because the indigenous heal better than the doctors”. Conceding that it would be possible to separate the different aspects of healing activities, it could be said that the incrimination concerned the rituals and religious expressions of healing activities, considered as devil’s work, and not the healing abilities themselves. Therefore, only the magic-religious aspects were criminalized, described as fraudulent and blasphemous, and caused (or justified) the interdiction of healers to extirpation processes.

Many of the hechiceros are ambicamayos, as they say, or healers, but with too much superstition and idolatries, that they precede the Catholic priests...it must be ensured that the priest teaches especially those hechiceros who should heal -the superstitious omitted- so they make use of what is good, as the knowledge and the use of herbs and other simple substances they use to cure diseases (Arriaga 1920[1621]:114, t. sp.)¹⁷⁴.

According to Larco (2008) the sixth archbishop of Lima, Pedro de Villagómez, indicated that the principal cause for the existence of idolatries was the lack of education in the Christian doctrine. Besides the *Carta pastoral de instrucción y exhortación contra las idolatrías*, the archbishop wrote instructions on how to carry out an extirpation process, which were the general proceedings also applied to the

¹⁷⁴ Although this quotation is almost four hundred years old, its content would have well inspired the basics of the current standardisation model of TM (see chapter 5).

jurisdiction of Trujillo during the 17th century¹⁷⁵. In a first instance, the head of the process against them was confirmed, containing the name, place, origin, race, and type of accusation. Afterwards, witnesses were interrogated in presence of a notary, followed by a confession, in which the defendant provided detailed information to several questions about his/her activities. “Sometimes”, Larco writes, “the examination was repeated one or more times during several days. It was during the confession in which the accused was suggested to declare him or herself guilty” (2008:41, t. sp.). Once the culpability was established, the remission of the defendant to the jail of Trujillo was ordered, with a detailed report including the witnesses and confessions. A defender for the accused was nominated, and the archbishop or his advocate interrogated him to determinate the culpability and to issue a judgement about the case. If the evidence was not conclusive, the case was closed; otherwise, the properties of the defendant were confiscated and the healer was imprisoned. Larco notices that the accused was already considered guilty before the interrogation, and was immediately transferred to prison (2008:41).

In the processes carried out in Lima, once the objects of idolatry had been collected, they were brought to a place on the outskirts of the town, and burned in a great fire. Then, on the day appointed for the celebration of the process, the hechiceros, carrying a big cross around the neck along with other humiliating symbols, had to make a public retraction of his faults and errors. Those accused of more hazardous and persistent in their practices were taken to Lima, and held at the *Casa de Santa Cruz* in el Cercado¹⁷⁶, where each day a priest explained the Christian doctrine to them. At the end of the temporary condemnation, or once regenerated, they were released from prison.

En la casa de santa Cruz, que sirve de reclusión para los más perjudiciales maestros y ministros de Idolatría, ay al presente cerca, de quarenta, los más son muy viejos. La casa está hecha muy de propósito, y muy capaz para tener muchos no salen sino en los días de fiesta a Missa, y Sermón en procesión con sus fiscales, aquí les enseña cada vno de nuestros Padres la dotrina. Dáseles por orden del Virrey muy suficientemente de comer, porque aunque tienen muchos tomos armados para hilar lana, que es oficio fácil, y muy vsado de los Indios, para que ganen su comida, es muy poco, para los que gastan, porque trabajan los que pueden, y los que quieren... Los que vienen aquí por tiempo

¹⁷⁵ The province of Trujillo was one of the biggest and most important of the 18th century and embraced the coast, Andean and forest regions of Peru with some 150 thousand km² (Larco 2008:31).

¹⁷⁶ This prison was founded around 1617, with direct financing from the crown through the viceroy of Peru Prince of Esquilache (1615-1621). The most prominent and influential Andean priests were brought there, above all those who were considered a serious threat to the Catholic religion (Pino ec/2011).

limitado, salen quando se cumple, los demás, quando se entienden, que están escarmentados, emendados, y enseñados. Pero como los más son tan viejos, que pasan de ochenta años an muerto muchos (Arriaga 1920 [1621]:168)

Since the Inquisition did not have jurisdiction over the indigenous population, the zeal for Christianity was in the hands of missionaries and pastors. Ayllón (iw/2009) affirms that the Tribunal of the Inquisition, which operated for 300 years in Peru, had a jurisdictional exception: The Indians. The inhabitants of other races were subject to its jurisdiction, but the indigenous had their own judicial system and were not in the scope of the Inquisition's activities. Thus, although the persecution of the idolatries followed inquisitorial models, with judges and researchers who could act *ex officio*, it did not participate among the Tribunal of the Inquisition. The special researchers working for the expeditions in search of idolatries were called "inquisitors" because they acted in the role to inquire (investigate), but they had no relationship with the Tribunal of the Inquisition. The field of "superstitions" (witchcraft, sorcery, etc.) covered a third of the inquisitorial activities, but did not include similar acts practiced by indigenous peoples (Ayllón iw/2009). However, Duviols (1971) asserts that there were serious efforts to extend the jurisdiction of the Inquisition to handle the cases of Indian idolaters. Although these efforts failed the legal requirements, Duviols proves that they succeeded in the daily task of making the Indians conform to the tenets of Christianity. In their expeditions and religious inspections, the visitors of idolatries followed the traditional procedures of the Spanish Inquisition, and were constantly inspired by the juridical practices of it. According to him, there is no doubt that a true *Inquisición Indiana* developed in Peru in the 17th century, and that its role and impact among the Indians differed little from the role and impact of the Spanish Inquisition among the non-Indians

The first synod of Quito in 1570 decided specifically that unrepentant hechiceros would be "arrested and sent to the vicar of the nearest town who might legally proceed against them". On that same date, the Viceroy Toledo, wishing to impose a rigorous repression, while they refused to commit the Indians to the Inquisition, tried to get around the difficulty by recalling that the crimes of witchcraft should be also covered by the civilian as well as the ecclesiastical courts, and that these causes should be judged as *mixto fore*. This allocation of jurisdictional attributions to the civil courts was based on an unreasonable interpretation of the royal instructions of 1538 and 1551. Also, a royal decree of 1575 put the record straight by stating that the causes of non-criminal idolatry and witchcraft come within the competence of the ecclesiastical official court and only hechiceros whose practices result in death would be treated by civil justice. The vast majority of crimes of idolatry and witchcraft depended exclusively on ecclesiastical courts. But it happened, especially after 1650, that the civil authorities, after opening and conducting trials of idolatry, entrusted the ordinary ecclesiastical court with the

case, and leaving the court the right to pronounce the sentence. It is in this sense that the processes of idolatry were subjected to the procedure of *mixto fore* (Duviols 1971:229, t. fr.).

I also found a reference in an edict of the Tribunal of the Inquisition of Lima from 1629 supporting Duviols' assertions. This decree made explicit reference to cases involving the indigenous ritual use of the cactus San Pedro (also known as *achuma*, *gigantón*, *aguacol*, *aguayol*, *ayuma*, *wachuma*), suggesting they were under the jurisdiction of the Inquisition

Iten, que muchas personas, especialmente mujeres fáciles y dadas a supersticiones, con más grave ofensa de nuestro Señor, no dudan de dar, o cierta manera de adoración al Demonio, para fin de saber de las cosas que desean, ofreciéndole cierta manera de sacrificio, encendiendo candelas y quemando incienso y otros olores y perfumes, y usando de ciertas unciones en sus cuerpos, le invocan y adoran con nombre de ángel de luz, y esperan de las respuestas o imágenes y representaciones aparentes de lo que pretenden, para lo cual, las dichas mujeres, otras veces se salen al campo de día y a deshoras de la noche, y toman ciertas bebidas de yerbas y raíces, llamadas el achuma y el chamico, y la coca, con que se enajenan y entorpecen los sentidos, y las ilusiones y representaciones fantásticas que allí tienen, juzgan y publican después por revelación, o noticia cierta de lo que ha de suceder... exhortamos y requerimos, y en virtud de santa obediencia y so pena de excomunió mayor, *latae sententiae trina canonica, monitione praemissa*, mandamos que si supiéredes, o entendiéredes, o hubiéredes visto o oído decir que cualesquiera personas vivas, presentes, ausentes o difuntas, *de cualquier grado o condición que sean*, usan o hayan usado de la dicha astrología judiciaria, o la arte mágica, o otra alguna en que se contienen sortilegios, augurios, encantamientos, invocaciones y otras supersticiones semejantes... lo vengáis a decir y manifestar ante Nos, o a nuestros comisarios diputados para esto (Medina 1956:37-38).

This edict is of special importance since it contradicts the assertions that indigenous people were exempted from criminal processes in the Tribunal of the Inquisition. By analysing the text, I found several circumstances that indicate a potential inclusion of indigenous people in the processes in specific cases. Moreover, since these situations were evicted and regulated in an exceptional context, the practice seems to have been more common than previously assumed:

- (a) There are “many persons”, especially “easy women inclined to superstitions”
- (b) It is stated that “we order if somebody knows, has seen or heard, of any living person, present, absent or dead, *of any condition*, that uses or has used such astrology, magic art or anything else connected to incantations, omens, invocations, and other similar superstitions, and they say and declare the future contingents and those who will come...”.

- (c) The rural context of the consumption of psychoactive plants is also explicitly described in the edict: “they wait for answers or visions and representations they want; and for this, these women sometimes go to the fields during the day and late at night, and drink beverages made of herbs and roots, called *achuma*, *chamico*, and coca”.
- (d) The edict is from 1629, almost a century after the irruption of the Spaniards in Inca territories, and 80 years after the installation of the Inquisition in Peru in 1570. This suggests enough time for an expansion of the use of the *achuma* –the use of which originated in northern Peru– to Lima.

At first sight, it is also interesting to note that *achuma* is mentioned first in the edict because such explicit references were only found in files of the extirpation of idolatries, but not in inquisitorial documents. After all, if the women mentioned were not curanderas themselves, it would have been difficult for them to have direct access to drink achuma. According to the well and carefully documented files of the process of the Extirpation of Idolatries, around the 17th century, achuma was drunk by healers in order to have “visions”, and was given to their clients only in exceptional cases. To this respect, some questions arise that are important for the identification of criminal procedures around these centuries and the role of the apprenticeship and the consumption for the expansion and the preservation of these healing traditions: Were these women non-indigenous? If they were non-indigenous, is it possible that they were apprentices, and because of their non-indigenous status would have been subject to criminal processes in the inquisition? Moreover, because of the severity and evident prevailing of such cases, could this mean that the inquisition was also able to judge, exceptionally, indigenous people?

4.1.2.3 The Processes

Both the persecution and the healing arts of indigenous people have been described in detail in the extirpations process files and documents in the archives of the archdioceses of Lima and Trujillo, and have been well analysed in some studies (cf. Polia and Chávez 1994; Osorio 1999; Millones 2002; Larco 2008). The tribunal process charged the

healer Juan Vázquez from Cajamarca in the early 18th century in Lima, an indigenous man who learnt his “artes” from a woman, which illustrates the apparent contradictions of the conception above-mentioned, the importance of the healing abilities for public health and the social circumstances surrounding the judgement of idolatries and its jurisdictional superposition in ecclesiastical and civil courts. Although the evidence against him was considerably persuasive, Vázquez was finally acquitted of the charge, based on the social need for his healing work in the community and his herbalist knowledge. Millones has analysed this case in a specific publication (Millones 2002). According to him, the descriptions with which Vázquez was judged during the whole process –and finally absolved– varied considerably. At the first stage, he was accused of conducting “diabolic operations”, but in the end, the sentence exonerating him defined these operations instead as “empirical”, alluding to the shortage of doctors in the region, and the need to accept the practices of those healers who replaced them, although without diplomas (Millones 2002:37-38). Vázquez’ attorney employed a clever strategy: He led the debate with arguments far from the religious, magical or spiritual aspects, and instead stressed Vázquez’ healing abilities. He focused on the professional managing of curative plants that his defendant used, and that these plants were also recognised by the Protomedicato of Lima which attested healing properties (Millones 2002:35-42). His argument worked. In 1710, Gregorio de Loaysa, provisor and general vicar of the archbishopric of Lima sentenced Juan Vazquez

that for all the days of his life he should not use such healings or inform no one about the herbs that are worth to this effect, with the warning that if he relapses, he will be punished with all the vigorously right due to recalcitrant [f.80v] delict by the media to be illicit and superstitious. And I also sentence him to two continuous years of attending the poor indigenous convalescents in the monastery of the Belemítica religion where he will be without breaking them in any way, otherwise he will be banished to Valdivia... the two years of work assigned to Juan Vázquez must be completed by serving and assisting the poor (“criminal cause against Juan Vázquez, Indian, because he is a wizard”. Bishopric Archives of Lima. Sorcery XI: 2. Lima, 1710, cit. by Millones 2002:143, t. sp.)

The tribunal absolved the defendant of sorcery and all the imputed crimes against faith, and decided to send him to “attend to the Indians convalescing in the convent of the Bethlehem order” (Millones 2002:18, t. sp.). In other words, with this decision Loaysa drew the accused from prison, and again put him to exercise his profession. Millones means that this judicial decision makes sense upon the prevailing logic of the century

with the illustration that corresponds to the government of the Bourbons in Spain. In this time, due to the indisposition of better-qualified systems for non-medical practitioners and the healthcare demand of the population, it was not exceptional to accept the possibility to consider a healer's activity as legitimate, under some conditions (2002:23). Nevertheless, these types of decisions were highly exceptional and controversial.

The case of the indigenous healer Marcos Marcelo accused of sorcery and superstitions and processed in the doctrinal jurisdiction for idolatries, maleficence, and superstitions in Pueblo Nuevo¹⁷⁷ from 1768-1771¹⁷⁸ is probably one of the most complete descriptions of the healing activity of a wachumero in the archives of idolatries. To this respect, Tomoeda asserts that the use of the San Pedro cactus in ceremonies by priests is documented throughout the colonial and Republican period, and continues to this day: "The ritual does not seem to have changed a lot. In a document of the 19th century, in the description of the arts of Juan Villa, healer of Cajamarca, all the elements of the contemporary sessions can be clearly recognised" (2004:123-127, t. sp.).

Astoundingly, in the case of Marcos Marcelo, the descriptions of his instruments, the ritual self and the requests of the patients who consulted him were almost the same as in the present practice of wachumeros.

Preguntado como y de que manera se manejaba en las curaciones que hacia, que movimientos, y que seremonias executaba en ellas, ó si en el acto de la Curasion imbocaba berbalmente ó interiormente en su Corazon al Demonio? Dixo que quando alguna persona enferma aprehendia estar maleficiada solicitaba al Declarante para que la curaze, lo que hacia el Declarante; era; primeramente cosinar una yerba, que siempre tiene el declarante; la qual se llama gigantes; la qual regularmente se halla en las faldas de los Cerros, y que el caldo de esta yerba bien cosida lo bebia el declarante con lo qual el declarante venia en pleno conosimiento y patentemente via con los ojos el maleficio de el enfermo y si tenia algun, sapo, ó culebra, ó otro animal en la barriga, y que con este conocimiento //f.4v// cierto le daba la noticia al enfermo del estado en que se hallaba y como la enfermedad que tenia era maleficio; y tambien conosia el hechizero que havia hecho el daño; y que cersiorado el enfermo de el estado de su enfermedad, le suplicaba al declarante que lo curase; y entonzes, para proseguir la curasion lo que hacia, era, darle a beber al enfermo de la misma yerba; luego que la bebia se emborrachaba el enfermo, y caia rendido, y lo cobijaba y que si el enfermo estaba en estado de curasion, sanaba, y que sino moria.

¹⁷⁷ Pueblo Nuevo District is one of the three districts of the Chepén Province, in department La Libertad.

¹⁷⁸ Palaeographic transcribed by Larco (2008:67-87).

Fig. 13: San Pedro Cactus Beverage



Mesa José Levis Picón (Photo Pribyl 2009)

Y para venir en conocimiento de si era capás de sanar ó nó el enfermo lo que hacia era, luego que arropaba bien al enfermo ebrio, entretanto, con una sonaja de calabazo y cascabal annexo á ella, y juntamente silbando llamaba su viento, que tenia, el qual venia de un zerro nombrado cuculi, en forma y figura de un remolino, y que este venia y cobijaba al enfermo, y que con todo esto sanaba, y que quando el viento no venia, ni se llegaba al enfermo; era la señal fija de que el maleficiado estaba //f.5r// incapás de curasion... dixo... que los quatro trozos de Yerba llamada gigantes; era para curar maleficios... que la ollita y cantarito era para cosinar la dicha Yerba; que un potito que estaba en la erramienta era para dar la bebida; que la sonaja de potito, y cascabel, era para llamar á su biento: que un sirculo de cacho en el que estaban esculpidos algunos pedasos de concha de perla; y en el medio esculpido una figura de gato; se lo compro a un cerrano nombrado Ballejos de las montañas; para el efecto de libertarse de echisos: que el tabaco que estaba en la heramienta era para darle al enfermo para que la yerba hiziese operasion;

Fig. 14: Whistles, Pumpkin Rattles, and “Perlitas” to “Raise” Tobacco



Mesa José Levis Picón (Photo Pribyl 2009)

f.5v Preguntado que significan ó para que fines mantenía varias piedras de diferentes colores, tamaños, y figuras entre de la erramienta? dijo que las doze de ellas, le servían para limpiar á los enfermos, despues de la curasion; las quales piedras les havia sacado de el serro llamado cuculi en donde vivía su viento: Que las otras piedras restantes pequeñitas redondas en forma de balas le servían para recistir, y oponerse al enemigo de el mismo arte, quando le tirase al corazon” (Larco 2008:71)

Fig. 15: Stones, Gentiles and a Goat Paw for “Respaldo”



*Extension of the mesa positioning vis-a-vis of the maestro.
Mesa José Levis Picón (Photo Pribyl 2009)*

4.2 Current Juridical Status and Legal Situation

4.2.1 Peruvian Legislative Framework for Traditional Medicine

According to the ground principles of its political constitution, Peru is a humanist state. The human being is its supreme goal and inspiration: “The defense of the human person and the respect for his dignity are the supreme purpose of the society and the state” (CRP 1993:art. 1). In light of this basic thought and its humanistic foundation, in terms of the subjects of the right to health (the individual exercise of law), a person’s life and physical integrity are the principal fundamental rights of the individual, established at the first order of importance by the Peruvian legal system. “Every person has the right to: life, to his/her identity, to moral, mental, and physical integrity, and to his/her free development and welfare. The unborn child is subject to the rights regard him” (CRP 1993:art. 2, inc.1).

In Peru, there is a comprehensive legal framework for the protection of TM. In terms of the right to health, i.e. the individual exercise of the right; and as a constituent element that is part of the collective knowledge and Peru’s intangible CH –the collective exercise of the right– the Peruvian state guarantees the right to ethnic and cultural identity, protecting them:

The right of indigenous peoples is the right of peoples to enjoy and exercise their own right: to their territory, their language, their customs, and their autonomy. Included in their customs is the right to use their traditional medicine (CRP 1993:art. 2, inc.19)

The right to health is also a collective right, not only for the individuals who practise and safeguard the collective indigenous knowledge. Regarding the protective role of the Peruvian state, it assumes the promotion and defense of TK, which is established in article seven of the National Political Constitution (CRP 1993:art. 7). In addition to general provisions relating to the right to health, the constitution and other domestic legislation offer a range of additional protections of the specific right to health norms, or relating to other human rights closely linked to the right to health.

At the same time, the state imposes the task of determining the national health policy, through the executive branch that must regulate and supervise the implementation of a

pluralistic and decentralized system, thereby facilitating the equitable access to health services for Peruvian citizens (CRP 1993:art. 9). The form is not enunciated in explicit form, nevertheless, this task is up to special laws. Here an extensive interpretation of the juridical norm must be considered, where both systems have to be integrated, that of public health and that of indigenous collective knowledge. This is the case of public health services provided through MINSA or ESSALUD for indigenous and peasant communities who live scattered throughout the national territory. Furthermore, the National Political Constitution of Peru of 1993 establishes, in a restrictive way, the right of all Peruvian citizens to access social security, including the free access to health services (medical attention, hospitalization, and others) (CRP 1993:art. 10-12).

It is necessary to say that in Peru, as in many other countries, several legal systems coexist. This is recognised in article 149 of the National Political Constitution. “The authorities of the peasant and indigenous communities, with the support of the Rondas Campesinas, can exercise jurisdictional functions within their territorial area in accordance with customary law, provided that they do not violate the fundamental rights of the person. The act establishes the forms of co-ordination of this special jurisdiction with the magistrates’ courts and other instances of the judiciary system” (CRP 1993:art. 149). Although this article expressly refers to the jurisdictional issue, i.e., the administration of justice, in a broad interpretation of the law it could also be applied to the use of collective indigenous knowledge as a basis for the exercise –which is still not regulated– of healthcare for communal and rural areas. Furthermore, as Peru is a pluricultural state, there are possibilities of establishing an intercultural dialogue, because these rights are already recognised both by the political constitution of the state, as well as by international conventions that have been ratified by the congress of the republic and which therefore confere to it the status of a law (Meneses 2008). One of the positive effects of the globalisation process on a global scale is that the right tends to be unified, with the consequence that the protection of the states in respect of human rights is unavoidable. This is an increasingly common fact, which is agreed upon at the international level in the topic of human rights. The suscription of states in these agreements, for example, is a prerequisite for the participation of a country in international trade agreements; such is the case of Peru i.e. for the Free Trade

Agreements between Peru and the United States, and the multilateral compromises among the states participating in the APEC (Asia-Pacific Economic Cooperation).

The ratification of international and regional Human Rights Treaties gives rise to obligations that are binding under international law respecting the right to intercultural HC attention. To this respect, the government of Peru has ratified a range of international and regional human rights treaties recognising the right to health and other health-related rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the American Convention on Human Rights, the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Hunt 2004:5).

Peru has ratified a range of important International Labour Organization Conventions, including the Convention 169 of the International Labour Organization (ILO) of 1999 (adopted in 2004), which is a milestone in the recognition of cultural diversity. Article 1 of the convention defines the characteristics of indigenous peoples as “those descendants of indigenous peoples, who have maintained and are aware of their identity, through their social institutions and policies”. In article 5, it was also agreed that indigenous peoples have the control over their own institutions, such as their healers or specialists in herbal medicine (ILO 1989). TM has been also legally recognised as part of the intangible CH of Peru and of those communities who practise it. This is normed both by the Unesco 2003 Convention on the safeguarding of the Intangible Cultural Heritage in its article 2, which has been ratified by the congress of the republic and is therefore applicable to the Peruvian law (UNESCO 2002). The relevant legislation is discussed in chapter 5 under the cultural heritage approach.

4.2.1.1 Criminal Law and Traditional Health Practitioners

For persons practice healing activities without accreditation from a professional association in the country, the possibility of prosecution is prevalent in Peru. Generally, the situation is underrepresented in statistics of the criminal department of the Peruvian Ministry of Internal Affairs, because the causes would be allocated under a general criminal figure *delitos contra la salud pública* (offenses to the detriment of public health), in the rubrics “illegal practice of the medicine” and “attempts against public faith”. In cases of THPs, the law applies the same prohibition, but with some specifications through the special indigenous jurisdiction in Peru (Irigoyen 2000) and the general and specific legislation about traditional healing practices, TK, and CH.

“Illegal practice of medicine: Punishable with imprisonment of not more than two years or with community service for 20 to 52 days, are those persons who, lacking title, perform any of the following actions: 1. Announce, emit diagnostics, prescribe, administer or apply any medium supposedly intended to healthcare, although acting in free mode. 2. Issue opinions or reports designed to support the diagnosis, prescription or the administration referred to in paragraph 1” (CRP 1991:art. 290, t. sp.)

Although there is enough supporting legislation within the Peruvian statutory and legal system for the exercise of the TM, the practice itself is not specifically regulated and recognised by authorities of the health sector, governmental, and educational institutions. Peruvian THPs face a contradictory situation in light of the absence of clear legal regulations. Despite their enormous contributions to global pharmacopoeia, the formal, regulated public exercise of Peruvian TM by its specialists does not encounter juridical regulations that support and justify it, causing an “escape clause” leading to a performe informal practice (cf. Espinoza 2008). THPs carry out their work apart from an official recognition by health and educational institutions in the country, and parallel to the formal HCS, which offers only specialized care by academic medicine.

Although there are very different legal, occupational, and social positions among THPs at the same time, the practice of many of the interviewed THPs in this study was not exempt from legal complications, basically because of to the unclear position of THPs in the national legislation, the level of knowledge of bureaucrats about psychedelic plants and their practice, and the regulations for the use and commercialisation of their

products and services in the national law. The religious, ideological or political ascriptions of some authorities complicated the situation even more¹⁷⁹.

He has problems with the law. He was three years in jail because one patient died in the mesa. That's the reason why we should see how much *remedio*¹⁸⁰ is given to somebody... He knew how to handle the *hierba*, but maybe it was too much, the patient had a heart attack and died. Therefore, when somebody is not healthy, you should give it only little by little (wachumero iw/2009)

My uncle has problems now; there is a criminal complaint against him... he went to Lima to do a *ceremonia*¹⁸¹ with a friend. After it was finished, each of them took different ways to go home. On his road, the friend was kidnapped and murdered. His girlfriend denounced my uncle to the police, they said my uncle is guilty because the man died due to the *ayawaska*... He was accused of kidnapping and murder... now he must hid in the forest (ayawaskero ec/2011)

The right to social affiliation, as well as the right to be different are two basic principles, which do not constitute in themselves special rights within the special rule of law, but are inserted within the general rule of Peruvian statutory regulations. These legal provisions should inspire the management of PH policies, ensuring consensus among peoples and communities from the commitment on the part of the State considering these two types of rights and their implementation (WHO 1999a, 1978b). This consensus could only be the result of cross-cultural agreements based on a sustained dialogue linked to core tasks of the state and the nation as a whole for the granting of legal tools and institutional frameworks that facilitate them. What is required in the field of intercultural dialogue in health is to confer specific semantic frameworks on these rights, to include the “difference” and rethink this notion of “belonging”, a task that has partly been assumed by the subaltern studies (Escobar 2003:52).

¹⁷⁹ In the jungle town of Balsapuerto, in Alto Amazonas, about 800 km northeast of Lima, up to fourteen shawi healers have been killed since 2010, in a sort of “religious war”. The victims were accused of been brujos practising witchcraft. Although there is conclusive evidence that accuses the mayor of Balsa Puerto –a member of a religious group which conceives healers as persons dealing with evil– of these murderers, there have not been any arrests of people responsible for theses crimes. See: ICEERS (2012)

¹⁸⁰ Sp. Remedy. Means the san pedro cactus beverage, the ayawaska or other major psychoactive plants.

¹⁸¹ Sp. Healing or ritual retreat.

4.2.2 Regulatory Proposals for Traditional Health Practitioners and the Incorporation of Traditional Medicine into the Healthcare System

4.2.2.1 Approaches to Legislative Regulations

A conception of regulations of healthcare in a monopolistic system administered by the state was introduced in Peru during the last century of the Inca state since the expedition of legislation of the practices of priests and healers by the Inca Pachacutec (See chapter 4.1.1.1). The restrictive regulation of the medical practice as a state matter was reinforced by the colonial legislation as a prerogative reserved for professionals with licensed registration.

The main idea inspiring the models of integration of TM in HCSs at international level came from the WHO. The principal statement is based on the assumption that THS, in order to contribute “usefully” to PHC, “must be functionally integrated into the country’s health system” (Mutalik 1983:281). According to this, one of the organisational aspects for manpower planning is an official recognition through the registration of THPs. However, the absence of a rational way to classify and accord appropriate registration categories has often resulted in a conflict of interest between different categories of conventional manpower: “Here, the national policies have to address themselves to the rationalization and simplification of the existing classes and the establishment of precise qualification requirements for registration of the various categories... perhaps greater selectivity in choosing traditional practitioners for primary healthcare may prove necessary” (Mutalik 1983:285).

The motives underlying such laws and regulations worldwide were partly the concern for the health of the population, perceived as requiring special protection from unqualified healers and charlatans, but also the protectionism in favour of those already established in their occupations. Leslie speaks about the irrational element in this situation. For him, it is irrational that for more than a century, the movement to professionalize modern scientific medicine has used the state to eliminate or drastically curtail and subordinate others forms of practice: “This movement has shaped the education of health professionals to an occupational perspective that distorts their

comprehension of other systems” (1983:314). This distortion follows a “trained incapacity” that, according to Kleinman, is characterised by studies that often equate modern medicine with the entire system: “The professional socialization of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and “unscientific” (1980:56). In the same light, Stepan notes that the attempts to relax the monopoly in some fields of healthcare met with strong resistance from organized professions which, under the existing laws, enjoyed monopolistic positions (1983:290-291).

In order to provide visibility to the juridical development of countries in relation to the incorporation of TM in HC, Stepan (1983:292-308) identifies four broad categories of existing legislative regulations: (1) the *exclusive* or *monopolist systems* in which only the practice of biomedicine will be recognised as lawful, with exclusions and sanctions of others forms of healing or THSs; (2) the *tolerant systems*, in which at least to some extent the practice of various forms of TM is tolerated by law, although only the system based on scientific medicine is fully recognised as official; (3) in the *inclusive systems* other systems than the scientific medicine are recognised as legal, but their practitioners should follow certain standards to practise their form of healing in a legal form; (4) the official promotion of the integration of two or more systems within a single recognised service is included among the *integrated systems*, in which the integrated training of health professionals is also the standard policy (1983:292).

The exclusive system holds that only those persons who had been duly trained and registered are authorised to practise medicine, midwifery, dentistry, or pharmacy. This automatically implies a prohibition of healing activities by persons who are not members of medical or health professions. In some cases, the prohibitions and specific sanctions of violations are expressly declared. As Stepan asserts, the exclusive or monopolist system is more common in developing countries in the Middle East, in both north and sub-Saharan Africa and in South and Central America. In these regions, where the expensive and complicated structure of biomedicine is unable to satisfy even the most basic health needs of the population, and “where people since time

immemorial have been used to native forms of healing”, legal prohibitions on TM are unrealistic. “The dead letter of the law does not interfere with the daily practices of all sorts of traditional healers. Unless “something goes wrong” –mostly where a conspicuous death results from evident malpractice– such healers are unmolested, informally tolerated, although they have no official recognition”. Thus a contradictory situation emerges, where the effect of the prohibitive legislation is minimal or non-existent. According to Stepan, this may be one of the reasons why, during a period of several years after becoming independent, many developing countries did not repeal or amend their monopolistic laws and did not pass legislation supportive of TM (1983:295).

Some Latin American countries have a pattern of tolerant legislation and/or policies limited to only few forms of TM, typically those of herbal medicine and parteras (cf. Nigenda et al. 2001:45). In Guatemala, for example, TM is recognised as a “therapeutic resource” in PH system; the government of Guatemala created the “Programme of Traditional and Alternative Medicine” (Ministerial Agreement 239-2004) in 2004 and the “Health Attention Unit for Indigenous Peoples and Interculturality” (Ministerial Agreement 1632-2009) in 2009 within the Ministry of Public Health and Social Work, responsible for the political agenda on the subject of politics of health of indigenous peoples¹⁸². Although an express recognition exists, only some types of THPs (comadronas and herbalists) are permitted to work in specific PH programmes (Xitumul 2011:2). Similarly, in Nicaragua there is a special dispensation for *miskitu* healers whose healing methods seem to be the better alternative –also from the perspective of the biomedical health authorities– in dealing with a mass-possession phenomenon called *grisi siknis*¹⁸³. In countries approaching this model, the legislation tends to concede exceptions in the context of specific healthcare programmes, mostly at the PHC level. However, these exceptions from the prohibition of the unauthorised exercise of

¹⁸² See: http://www.mspas.gob.gt/index.php?option=com_content&view=article&id=181&Itemid=74.

¹⁸³ Also known as *pauka prukan*. The victims are mainly adolescent men and women, who first feel anxiety and irritation, followed by headaches and dizziness; afterwards they go into a state of trance, in which severe convulsions and a hysterical reaction follows. “They may rip their clothes and hairs, try to bite or hurt others, and finally grab a knife or machete and begin to run around... During a trance, the afflicted often experienced a duende or a black man on a black horse who threatened them with a knife...Grisi siknis may afflict only one person, but if a sorcerer has used one or more spirits to provoke an epidemic, a large number of people are likely to be affected” (Wedel 2009:57).

healing practices to specific healing systems are opposed to permitting the practice of indigenous methods of healing in general.

Although some policy makers and researchers have identified Peru as a country with a “tolerant system”, this does not all apply. Theoretically, this could be the case for the parteras in Peru that are considered within the Vertical Delivery Assistance Model with Intercultural Adaptation of the National Programme of Sanitation Strategy for Sexual and Reproductive Health. In reports available about the programme, there are descriptions of the techniques employed by the parteras, as well as brief indicators of their social status, income expectancies, and attitudes towards health professionals and dispensaries managed by the state (cf. Gabrysh 2009). However, there is no legislation or existing norms regulating their work per se. A specific legislation for their work and permissions to work independently –or an official document acknowledging their contributions to maternal and child care– do not exist.

4.2.2.2 Peruvian Policy Context

On the topic of TM, Peru has the Law on Health nr. 26842 of 1997, which in its preliminary title, art. 17 indicates: “The promotion of traditional medicine is of interest and preferable attention of the state”¹⁸⁴. Within Peruvian law, there is also the legal recognition of the practice of indigenous knowledge related to health. This knowledge is recognised by the Peruvian constitution and in international conventions and treaties signed by the Peruvian state that have already been mentioned. However, as Zuluaga notes, “if TK is already internationally legally recognised, its recognition is still lacking in the field of Western science and in the academy. This is to accept or reject the source of the knowledge, method, or the results. In the specific case of the discussion of intellectual property, corresponds to TM an important chapter since they have generated the greatest amount of knowledge about the medicinal properties of the natural resources, with special emphasis on medicinal plants” (Zuluaga 2006:7).

This situation in particular has been reversed with the inclusion of a national commission for the fight against biopiracy; the subscription of the state to the Rio convention of biodiversity (which provides access to the TK associated with genetic

¹⁸⁴ See: http://essalud.gob.pe/transparencia/pdf/informacion/ley_general_salud_26842.pdf

resources and intellectual property) in regional and national health plans and policies¹⁸⁵. The Ministerial Decree for the Creation of Rural and Urban Peripheral Health Services places priority on the investigation and preservation of TM. Section 4 of the Supreme Decree 010-97-SA of 1997 regulates medicinal plants and natural resources of medicinal value¹⁸⁶. It defines and classifies medicinal plants and natural resources of medicinal value, outlines procedures and requirements for their registration, and details the requirements that must be met for their manufacture and sale. At least, the topic has come to be positioned within the framework of the international discussion on bioprospecting and the access to biological resources, which directly impacts the use, practice, and marketing of the traditional pharmacopoeia and the practice of THPs (cf. MINSA 2010).

The development of standards and policies for the construction of an intercultural citizenship is an obligation of the Peruvian state. This includes specific topics such as providing conditions for the generation of dialogue instances with the indigenous peoples and the fight against poverty, the development of indigenous peoples with the preservation of their identity, the visualization of the discrimination of Andean, Amazonian and Afro-Peruvian nations, the right to consultation, among others. This mandatory compliance is also guaranteed in the Supreme Decree 027-2007-PCM in the art. 2, inc. 4, which defines and establishes national policies of “obligatory compliance” for entities of the national government¹⁸⁷. Specifically, it amends a national policy of obligatory compliance for all and each of the ministries and other entities of the national government for the formulation of policies in relation to Andean, Amazonian, Afro-Peruvian, and Asian-Peruvian nations that must be complemented by a policy proposal of the sectors involved (i.e. MINSA, Ministry of Education, and the Ministry of Culture).

4.2.2.3 Law Projects

Since 1997, the Peruvian Congress of the Republic has discussed potential laws and statutes for the regulation of TM as an accredited healing practice within the HCS.

¹⁸⁵ See chapter 5 “cultural heritage’s approach” for a description of supporting legislation.

¹⁸⁶ See: <http://www.digemid.minsa.gob.pe/normatividad/DS01097.HTM>.

¹⁸⁷ See: <http://can.pcm.gob.pe/files/Normatividad/DS-027-2007-PCM.pdf>.

A bill on traditional medicine was proposed for the first time in December 1997 through the congresswoman Ivonne Susana Díaz. The Law Project 03298, called *Proyecto de Ley de Medicina Folklórica Tradicional y Legalización de la Actividad del Curandero* (Bill of Traditional Folk Medicine and Legalization of the Activity of Healers) proposed the establishment of “folk medicine” as part of the legislation of the national health policy, as well as the incorporation of practitioners of the traditional folk medicine of Peru in the health sector (CRP 1997a). The project considered as “traditional agents of health” the following specialists: curanderos, herbalists, bonesetters, prayers, and parteras, expressing that in order to be considered as such, the traditional agents should be guaranteed the recognition by their community. After its review and discussion on the plenary of the congress, the project was not passed in the Commission of Health, Population and Family in 1998, and went disapproved in the parliament. The principal objection of the Commission of Health appealed the General Law on Health nr. 26842. In title II of this law about “duties, restrictions and responsibilities in regard to the health of third parties”, the chapter I “of the exercise of the medical and related professions and technical and ancillary activities in the field of health” article 22 rules that “to carry out professional activities of medicine, dentistry, pharmacy, or any other related healthcare, requires professional title in cases where the law so provides, and comply with the requirements of licensing, specialization, and others that the law establishes”. Therefore, “no therapeutic act can be performed or exercised by a person not registered in a professional association related to the field of health; otherwise, they are susceptible to denunciation, trial, and punishment for the illegal practice of medicine”, sanctioned by article 290 of the Penal Code, “so the legislative initiative should involve a further reform of this body of rules” (CRP 1998). It is necessary to specify that this legislative initiative was previously filed by the Commission of Health, Population and Family of the Peruvian Parliament in March 1996; this previous bill was recorded under the nr. 763/95-CR and the same congresswoman submitted the same proposal for the second time with minor modifications.

Ten years after this first proposal, on December 2007, a new bill was proposed, the *Ley de Reconocimiento de la Medicina Tradicional, Alternativa y Complementaria y de los Agentes que la Ejercen* (Law of Recognition of Traditional, Alternative and

Complementary Medicine and its Practitioners). The law project proposed the creation of an official register of the practitioners of the TCAM, to be ruled by Peruvian's PH governing institutions (CRP 2008). According to the legislative initiative, those who practise TM in Peru –upon increase of selection criteria determined by four official entities– will be included officially in a special register, and these practices shall be considered as a complement to public health strategies. This proposal, driven by the indigenous congresswoman Hilaria Supa, established a number of mechanisms of control and sanction for healers who remain in the situation of illegality, once the standard is adopted by the full congress and promulgated by the executive. Two years later, in May 2009, the Commission of Health Population and Family of the Peruvian Congress approved it and passed it to the executive for its promulgation.

Nevertheless, the proposal was observed in a document submitted by President Alan Garcia (CRP 2010a). The executive noted that the law does not clearly indicate the criteria to distinguish these systems from other traditional physician practices, which could distort the scope and objectives of the norm. In addition, the register of agents should be directed towards those engaged in activities directly related to the process of health-disease. Moreover, the executive continues, the phrase “activities related to traditional medicine” is extremely inaccurate and can include, for example, suppliers of medicinal plants, or sellers of the same, which does not seem to be in the spirit of the regulation. Similarly, the term “insertion” has been not defined, and this could be interpreted as if the THPs were to be incorporated into the personnel of MINSA, when what is required is to articulate both systems, which means even that there are reference and counter-reference processes between the two systems (CRP 2010a).

After modifications, in May 2010, the corrected draft was approved through the Commission of Health, Population and Family and the Commission for Andean, Amazonian and Afro-Peruvian Peoples, Environment and Ecology. A year later, on 16th June 2011, an “expansion of agenda and priority in the debate” document for the improvement of this law was submitted by the president of the ministers' council. Additionally, a technical report on public policies for indigenous peoples elaborated by the congress of the republic in 2010 recommend to the executive branch, that in

cooperation with INDEPA, the ministry of environment and ecology and the commission of health, population, and Family, to consider the approval by the plenary of the opinion on the draft law, as a form of recognition to promote intercultural medicine with protection of the TM, the ancestral practices and other forms of health of the communities according to was contained in the ILO Convention of 169 (CRP 2010:232-233). Nevertheless, the law went not approved.

In the same year of 2011, a third law project to this subject was submitted by the legislator Margarita Sucari Cari (CRP 2011). Previously, the original proposal of the precedent law project elaborated by Supa was amended by a technical team of the CMP composed of ten experts on TCAM (Villar ec/2011). This document was also validated through Macro Regional Meetings in the South (Cusco), Centre (Junín) and North (La Libertad) of the country. The proposal establishes a comprehensive regulatory framework that includes, in addition to TM, techniques of CAM by linking them to the coordinated and decentralized national HCS in their different levels of care, and not only at the PHC level. The project is to be shared with the Commission of Health, Population and Family, in order to be the starting point for achieving the consensus with all health institutions and organised sectors of the population. A worked out version of this proposal was submitted to the Congress of the Republic in May 2011 as an initiative of the CMP, and is still awaiting approval.

One of the main factors associated with the lack of legal regulation of TM and its agents, as well as its formal integration as part of the formal HCS, is the subaltern relation that has characterised it in relation to the Western medical system. The absence of dialogue between the social, medical and legal disciplines in respect to its foundations, techniques and opportunities resulting in a coherent theoretical framework is also another important factor to be considered. Additionally, the prior legislative initiatives have not been constructed on a coherent basis of empirical and theoretical scientific information that could be applied to the development of strategies and mechanisms for the implementation and coordination between the different health regulatory institutions.

Of course, the need of integration of TM in HCS is still a big inquiry. Some experts, such as Jacques Mabit, question the mere idea of a possible articulation, alleging that the priority is in the non-intervention of the state to legislate the contents of the practices of traditional medicines, or for the recognition of its agents. “The only acceptable intervention should aim to protect the space of these practices and promote their self-regulation in the same way that associations such as the psychoanalysts or psychotherapists or professional associations accept a responsible self-control for an ethical supervision of its affiliates... Neither the state, nor indigenous groups or traditional health workers benefit from trying to govern and control traditional medicines by public formality” (Mabit 2004:24, t. sp.). For Mabit, any “abuses” of practitioners of traditional medicines (rape, fraud, etc.) should be regulated by the criminal law in force, as it is established for any citizen. It does not require any particular legislation.

4.3 Mystical Tourism and Sociomedical Problems

That's why Luis Culquitón, the great shaman of Manacamiri, wishes to share his natural medicine: "We have a living pharmacy in the world, and it's the Amazon. Cocona extract is good for the heart and high blood pressure..an ungrave seed for your garden -let's plant...let's plant! - We can plant it in our garden. Here you go, for your arthritis. Knowing its effectiveness, you won't have to queue up for a pill anymore; and it will be easier to have a happy life... Huasai to feed and heal you; and ayawaska, to see our inner being" (PROMPERU 2012)

The development of certain kinds of services promoted and offered by healers and adapted for foreigners in Peru and overseas since the middle of the 20th century gives insight into the way in which a postmodernist economy was established among some groups of healers in the country, especially those from Western and eastern Amazonia. Mystical tourism flourishes as it is promoted assiduously by government touristic institutions and private tourist agencies since the 1970s, and is nowadays probably the most profitable and therefore the most competitive branch of the Peruvian tourism business¹⁸⁸. Accordingly, one is presently hard-pressed to find a conventional tourist package offered in any peripheral country¹⁸⁹ without the inclusion of a visit to a "shaman".

To address the development and characteristics of this phenomenon, some researchers as well as the public contrived different denominations in referring to this controversial subculture. For the first group, terms such as "drug tourism" (Dobkin de Rios 1994, 1992), "psychedelic medicine" (Winkelman 2005), "experiential tourism" (Smith 2006), "ethno tourism" (Comaroff and Comaroff 2009:23), "mystical tourism" (Aliaga iw/2009); "mestizo shamanism" (Beyer 2009:281), and "spiritual tourism" (Herbert 2010) are just a few of the most used. Whereas some expressions seem more technical, such as the concept of "Peruvian mystical touristic industry" proposed by Hill (2008), which defines a type of spiritual-new age tourism centred in and around Cuzco, other definitions like "spiritual post-colonial tourism" (cf. Peluso 2006) have the potential to cause contentions among scholars, because it questions the political correctness of the

¹⁸⁸ This type of organised tours cost up to 200 U.S. dollars per day. Tourists who take such a journey are mostly people from an upper-income class (Binder 2002:39).

¹⁸⁹ Countries formerly colonized and in process to industrialisation.

consumers and providers of these services. The focus given to these concepts varies widely; however, all of the authors mentioned share the same field of interest, i.e. the use of psychedelics in the context of tourist consumption.

Generally speaking, this type of tourism involves customers intentionally leaving their home country for a specific period of time to access spiritual-like experiences abroad¹⁹⁰. Although it is argued that this type of tourism is primarily a spiritual quest, the use of psychedelics in the context of Western spiritual search experiences is intrinsically embedded in the structures of consumption that has grown out of the new age movement. According to Aldred (2000), new age refers to a movement that emerged in the 1980s, and whose adherents ascribe to an eclectic amalgam of beliefs and practices, often hybridized from various cultures, and the vision of a literal New Age, which is described as a period of massive change in the future when people will live in harmony with nature and each other. Only in this New Age, Aldred continues, will they realize the full extent of human potential, including spiritual growth, the development of psychic abilities, and optimum physical health through alternative healing. This “human potential” will not take place through a direct political change of existing unfair structures and institutions; rather, it will be achieved through individual(istic) personal transformation. “The New Age is only a movement in the loosest sense of the term. There is no circumscribed creed of defined tenets... There is a wide and burgeoning number of practices associated with the New Age, including interests in shamanism, goddess worship, eastern religions, crystals, pagan rituals, extraterrestrials, and channelling spirit beings” (2000:330). The author sees a “fetishization” of native spirituality in such practices that masks the marginalization of indigenous peoples, and which could lead to the dissolution of indigenous spirituality and identity.

¹⁹⁰ A historical overview of the development of academic and journalistic work informing on ayawaska consumption within tourists is provided by Homan (2011:54-74).

4.3.1 Ayawaska Tourism

Introdúceme en tu cuerpo, desde allí yo te hablaré./ Introdúceme en tu mente, desde allí te alumbraré./ Introdúceme en tu corazón, desde allí te daré calor./ Oirás mi voz de serpiente deslizarse en tu oído./ Verás mi luz sin verla a través de los sentidos... y mi calor te seguirá más allá del frío frío/ Y seré parte de ti, tierra lanzada al infinito (Giove 1993:4)

In the context of psychedelic tourism, the ayawaska has particularly undergone a special role of commoditization in Peru. Due to the current predominant focus on the ayawaska brew among these practices, some researchers simply called it “grass-roots ayahuasca tourism industry” (Grunwell 1998), or even directly “ayahuasca tourism” (Holman 2010). The Ayawaska tourism is a special example of a rendered invention of a “traditional” therapy simultaneously constituting an academic field of interest, Western needs, and promoting the insurgence of new commercial networks for healers and investors. Growth in the popularity of this practice has resulted in a significant amount of attention paid to it by researchers, policy-makers, and the media.

Dobkin de Rios (1970, 1992) and Luna (1986:15-16) define the *vegetalismo* as a group of folk healing traditions of predominantly mestizo curanderos, or healers of mixed indigenous and non-indigenous ancestry who use ayawaska and other master plants for the diagnosis and treatment of illnesses. For Luna (1986:73–74), the etymology of the Quechua word ayawaska is *aya* (person, soul, spirit) and the suffix *wasca*, which means rope, liana or vine. According to this author, the name is predominantly used either to refer to the brew itself, or for the plant that composes it, the *Banisteriopsis caapi*, also known as “the vine”.

The use of *ayahuasca* under a variety of names is a widespread practice among various indigenous aboriginal tribes endemic to the Amazon Basin (cf. Schultes 2004, 2001). It is commonly mentioned that such practices undoubtedly were established in pre-Columbian times, and that ayawaska consumption might have been known by the earliest human inhabitants of the region. Thus McKenna, Callaway and Grob assert that the ayawaska is widely distributed among numerous Amazonian tribes, something that argues for its relative antiquity (1998:65). In the iconographic depictions of a ceramic

vessel found in Ecuador, Naranjo (1983:31-32) sees evidence of the practice dating back to at least 2400 B.C. It has also been mentioned, that the ayahuasca-based shamanism –as an essential indigenous phenomenon– belongs to the indigenous people of Western Amazonia, “who hold the keys to a way of knowing they have practised without interruption for at least five thousand years” (Narby 2004:169). In opposition, recent scholarship asserts that the use of the ayawaska brew (*Banisteriopsis caapi* in combination with *Psychotria viridis*) is not as old as supposed, and that it has been incorporated as part of traditional healing practices by Amazonian indigenous and non-indigenous communities more recently. Gow (1994:91-92) and Brabec (2011:24-31) assert that in Peruvian lowlands, the use of ayawaska is less than 300 years old. Among some ethnic communities as the *Kakataibo* and the *Madija* it has been in use for less than 50 years; the *Iskobakebo* in Ucayali apparently have never used it before (Brabec 2011:31); and the *Ese Eja* of Madre de Dios were trained as recently in the mid-1980s from Shipibos working in NGOs (Peluso 2006:492). These authors conclude that the mestizo river population –and not the indigenous people– have developed and spread the use of the ayawaska brew on this region.

4.3.1.1 Consumption

“quiero meterme una ayahuasquita, eso me va a curar”.
“yo no voy a terapia, yo tomo ayahuasca”
(Patiño 2007:141,145)

In 1936, Philippe De Felice wrote a pioneering book about the nexus between the plants and the visionary sacred food of old and new religions, including the soma of the Vedas, the peyote among the *Huichol*, and also the use of ayawaska in the context of shamanic healing (cf. De Felice 1975). He puts forward the hypothesis that the use of psychotropic substances is deeply embedded in human culture, and that it is intrinsically intertwined in a most basic human instinct which is “the search for transcendence” (cf. Shanon 2002:86). According to Fuller (2009), “experiential tourism” emerges from a description given by MacCannell (1999)¹⁹¹, who argues that this type of tourism can be understood as a modern form of religious quest for the meaning of existence. This practice would be a response to the vacuum and the conceit of life, a way to find

¹⁹¹ MacCannell, Dean. 1999. *The Tourist: A New Theory of a Leisure Class*. Berkeley: University of California Press.

motivation through the experiences of others. According to Fuller, this type of tourism is characteristic of persons who undertake the search for alternative forms of life, and is akin to those post-modern and disoriented travellers, particularly the so-called backpackers, with lack of defined priorities and stable commitments in life, and that are willing to test all modalities of which the trip would be one of them, along with the use of drugs and mysticism, among others (2009:45, t. sp.). On the other hand, experiential tourism implies a fully committed traveller with a spiritual centre outside of their native culture. This experience is close to religious conversion, although the content of symbols and values that are taken may not be religious in the strict sense, rather of an aesthetic, cultural or ecologic character: “It is the case of the attraction exercised for certain rituals practised in the region of Cusco, as the famous *Qoyllur Ritt'i*, which is attended by pilgrims seeking to establish contact with other religious expressions supposed to be more authentic” (Fuller 2009:45-46, t. sp.).

The consumption of ayawaska among tourists has continually been on the rise since at least the 1950s due to the proliferation of popular and academic information in the occidental ethno-sphere (Homan 2011:67). This has arisen from the organisation of different kinds of socio-cultural practices, including what has been called the “cross-cultural *vegetalismo* practices” (cf. Tupper 2008, 2009). For Peluso (2006:484), this is a form of shamanistic and “new age adventure travel” whereby Westerners journey to exotic locations in order to ingest ayawaska under the supervision of an ayawaskero, a person or perhaps a “specialist”. The author argues that in this transaction a triple displacement process occurs: the ayawaska is dissociated from its local context, the shaman has moved out of his own community, and the tourists out of their own cultural traditions (2006:491). By all means, this practice means the development of indigenous-like rituals or encounters conducted primarily by non-indigenous for non-indigenous people, and in non-indigenous contexts.

Winkelman (2005:214) found that the Western motivations for attending ayawaska settings are primarily focused upon “issues of spiritual relations and development” and participants reported that their experiences resulted in an “increased and enhanced awareness of their own self, having obtained insight into deeper levels of their being”.

However, the Western search for the “sense of life” is not a traditional concern among Andean and Amazonian cultures. In fact, the indigenous origin of these practices gradually disappears from the perspective of Western customers in favour of the expected gained psychedelic experiences or identity search through the participation on ayawaska retreats, also among new age middle-class Peruvians (cf. Engel 2006; Patiño 2007). Patiño found among her sample of ayawaska consumers in Lima the search for identity through the distinction as a principal element that conduced them to undergo the experience with altered states of consciousness using a practice that is legitimised by the curanderil tradition of the Amazon. This is a “way to lead their lives, in a sense creating a transitional identity, rescuing some elements of the curanderil tradition and leaving others, and reinterpreting them under its own logic” (Patiño 2007:163, t. sp.).

Fig. 16: Ayahuasca Session in Lima



The shipibo ayawaskero Rogelio Reátegui conducting an ayawaska ceremony in a private dentist's office in the middle-class district of San Borja (Photo Pribyl 2009)

Although other ways of realizing the ayahuasca consumption exist, and it is done in other terms and under other logics, the consumption of ayahuasca purports some introspection skills, a discipline to govern their lives, a speech that legitimises them, and a sense of life they do not find in the culture in which they are immersed. The consumption of ayawaska among foreigners or middle-class Peruvians responds to a new necessity –and not to an old one, as it has been continually affirmed by other

authors— and indeed represents a kind of self-disciplinary technology of the self, which consists in specific techniques that work on the body and on the mind, and that lead to self-discovery and self-care. Dobkin de Rios (1994:16) speaks about foreign ayawaska users as people suffering from an “empty self syndrome”, and interprets this as a psychological mechanism to compensate the personal isolation contrived due to Western materialism. Also in this sense, Patiño concludes that the consumption of ayahuasca and all practices that revolve around this are technologies of the body and the mind that offer cultural and historically specific paths for the realization of the self (Patiño 2007:164). In the light of the new age discourse it is probably much easier to concede that one is embarked in a spiritual search, rather than to voice the embarrassing confession of having no sense of life or identity. This is why these self-technologies are not always assumed and named as such —also among some scholars personally involved— but instead with a more neutral term such as “sacred technologies”.

Some ethnographic studies report that the consumption of ayawaska was designated to the “shaman” and not for his/her patients, and that this was only achieved in exceptional cases. In the opinion of Brabec, e.g., the ayawaska serves primarily to contact non-human entities (spirits, plants, ancestors). The therapies depend on their effectiveness and are part of a complex system of natural remedies, from spiritual techniques, in particular magical songs, and on the execution and response against witchcraft and *daño*. “Western Amazonian medicine can be learned and applied, without that anybody must drink ayawaska only one single time... In the Amazon region, commonly only the *medicos* —such as the healer, and the *brujo*, as they are regionally named— take the brew, but not their patients; the ayawaska is propagated in the West as a cure itself, and all the participants drink it in a session” (Brabec 2008:24, t. g.).

Beyer notes that the enlightened seekers of ayawaska came to the “shaman” with their own set of etiological and nosological concepts, rooted primarily in popular psychology and alternative medicine. And they brought with them assumptions about the nature of ayawaska and its healing potential that often differed radically from the concepts of the mestizo and indigenous shamans to whom they came for gringo-style healing of what were conceptually gringo diseases: “Few gringo tourists understood —or cared about—

the cultural assumptions underlying the ayahuasca ceremony or the nature of the diseases that the shamanic healer actually addressed, which, in the Upper Amazon, are essentially signs of a failure of a right relationship –a social rather than an individual pathology” (Beyer 2012:3). So there lies no surprise in the increasing number of “neo-shamans” or “plastic shamans” with many different backgrounds, who are primarily individuals of European descent who have heaped together freely, adapted indigenous rituals and spiritual neo-indigenous speeches for Western customers, within a structure based on the New Age ideology.

When you go to an indigenous therapy it rattles you, you vomit, you suffer, and there is no beauty in that. The Western aesthetics, for which all is cute and there are pretty songs, excuse me, what a bloody mess! You go to get cure from a sickness, the anguish of the sufferer goes out there and it’s heavy. Not everyone can resist that. It is a very complicated thing, the *ayawaska* is a very serious thing; it is also very imposing, it talks to you and you get smaller, you turn into a worm. If these “curanderos” did *really* drink *ayawaska*, they wouldn’t venture themselves to do what they do (Anthropologist iw/2009)

Martínez asserts that the apparently positive valorisation of shamanism has not implied the abandonment of the idea that indigenous people mistake reality and belief; on the contrary, it is exactly in this point that the virtuosity of shamanism resides, the access to other realities unreachable for Western mentalities. “In fact, it is just about a reformulation of a central aspect of the myth of the noble savage... in the past the thought was that the Other possessed plenty material richness (like El Dorado) and now he is perceived as the depository of intellectual greatness, that could be also used in the West for benefit” (Martínez 2009:207, t. sp.). This conception is not particular to South America. In approaching the situation of commercialisation of the Native Indian spirituality in the USA, the indigenous activist Andy Smith wrote merely two decades ago: “The new age movement completely trivializes the oppression we as Indian women face: Indian women are suddenly no longer the women who are forcibly sterilized and tested with such unsafe drugs as Depo-Provera; we are not longer the women who generally live below the poverty level and face an average 75 percent unemployment rate. No, we’re cool and spiritual. The trivialization of our oppression is compounded by the fact that nowadays anyone can be Indian if she or he wants to. All that is required is that one be Indian in a former life... the term “Indians” no longer refers to those who have survived 500 years of colonization and genocide... when

everyone becomes “Indian”, then it is easy to lose sight of the specificity of oppression faced by those who are Indian in *this* life” (Smith 1994:170).

We can talk of an outright rejection of these customers of the things that the world ostensibly offers to lessen the pain of their existential wounds or isolation, namely recreational or pharmaceutical drugs to dull the pain, and simple empathetic (indigenous) human connection to ease the burden. By those seeking such experiences, ayawaska works as a recreational drug that does little but widen the expanse between themselves and the rest of the world that is promoted by the social media and the self-discovering new age discourse. The arms that have held them over there will do so only to hold them back to their own reality, freighting their needs with a new significance of belonging and sharing, although “real” in the human experience, no longer free of questioning the impacts on the local population and the future of the cultural heritage of these countries. Probably the best evidence of the real basis of this trend –i.e. consumerism– is the emergence of a large group of *psychonauts* in the context of the commoditization of ayawaska. This is a group of people that prefer to consume or drink ayawaska or another psychoactive substance on their own, do not necessarily want to make the experience in the context of a ritual setting, and under the direct supervision of a vegetalista. They buy the selected plant online, from an informal provider in their own country, or even plant and cook the psychoactive substance themselves at home¹⁹².

It is worth mentioning in this context, that the National Directorial Resolution nr. 836 of the National Institute of Culture of Peru, has declared the knowledge and traditional uses of the ayawaska practised by Amazon native communities part of the CH of the nation (INC 2008). The resolution is based on a report of May 29th 2008, originally submitted by the MD Rosa Giove Nakazawa from the Takiwasi Centre in Tarapoto to the Regional Bureau for Economic Development, a local governmental entity in the Peruvian department of San Martin. The resolution explicitly differentiates the traditional use and sacred character of indigenous ayawaska rituals from “decontextualized, consumerist, and commercial Western uses”. The resolution states that ayawaska is “a plant species with an extraordinary cultural history, by virtue of its

¹⁹² See e.g.: <http://www.psychonaut.com/forum.php> (in 7 languages) or <http://ayahuasca.tribenetwork.com/>

psychotropic qualities and its use as a drink combined with the plant known as *chacrana*.” The resolution establishes that the ayawaska is known to the indigenous Amazonian world as a wise or teaching plant, which initiates the very foundations of the world and its components. “The effect of its consumption is to enter into the spiritual world and its secrets... The effects of *ayahuasca*, widely studied because of their complexity, differ from those usually produced by hallucinogens. Part of this difference consists in the ritual which accompanies its consumption, which leads to a variety of effects which are always within culturally defined limits and with religious, therapeutic, and culturally affirmative intentions”. Given the specific disclaimer language of the resolution, it is still not clear what impact the resolution might have on drug prosecutions in foreign countries. It is probable that it would make the access to ayawaska more difficult for foreigners in their own countries, and consequently press them to claim religious exemptions from national drug regulation laws in order to consume ayawaska. However, the ayawaska providers overseas as well as the consumers have already found alternative legal ways for the consumption, for example, through the participation in rituals of contemporary religions originating in the Brazilian Amazon which principally uses ayawaska as sacrament during the liturgy and that are nowadays established in other countries, such as the *Santo Daime* and the *União do Vegetal*¹⁹³.

¹⁹³ As it was the case for *peyote* (*Lophophora williamsii*) in Native American churches in Canada and in the USA, or the *Iboga* (*Tabernanthe iboga*) in Gabon (west coast of Central Africa), these Brazilian religions inserted the ingest of the ayawaska brew into a religious practice combining local belief systems and Christianity (cf. Labate, MacRae and Goulart 2010:2). The use of ayawaska is thus legal in some countries (e.g. Netherlands, Spain) in the context of the religious liturgy. An extended bibliographical review for the development of these religions in Brazil and overseas can be found in: Labate, Beatriz, Isabel Santana de Rose and Rafael Guimarães dos Santos. 2008. “Bibliographical Overview of the Ayahuasca Religions.” Pp. 25-52 in *Ayahuasca Religions: A Comprehensive Bibliography and Critical Essays*, edited by the authors. California, USA: Multidisciplinary Association for Psychedelic Studies.

4.3.1.2 The Globalisation of Ayawaska

The ayawaska is not only in Peru. The ayawaska is in Spain, in Germany, in the United States, in Colombia, in Brazil. If we've realized it a little late, it doesn't matter! We must be critical, analytical and self-critical. We are no longer at the time in which our grandparents surfed on a raft. Now is another time! (Ayawaskero, t/2010, t. sp.)

The academic interest in Ayahuasca began about twenty years ago, in 1991, with the publication of the book “Ayahuasca Visions” (Luna and Amaringo 1991). Beyer is of the same opinion, and asserts that despite the brief spotlight that Allen Ginsberg and William S. Burroughs shone on ayahuasca in “The Yage Letters” in 1963, the groundbreaking publications of Marlene Dobkin de Ríos in 1970 and Luna himself in 1986, and even the presence of a Santo Daime center in Boston in 1987, “it is probably fair to say that the popular interest in ayahuasca that began in the mid-1990s –and the accompanying surge of foreigners seeking out ayahuasqueros in the Amazon– was driven in large part by Amaringo’s extraordinary paintings” (Beyer 2012:2).

While some authors questioned the authenticity of non-native ayawaska use based on the participants’ lack of understanding of the “traditional” forms and the differences in practice between the “tribal” and the modern, others have situated the practice within the modern condition and can accept it as a new and distinct cultural form (cf. Kosovych 2010:60). Tupper (2008, 2009) originally speaks about the “globalisation of ayahuasca” from a post-colonialist perspective and in name of the analysis of cultural appropriation, which involves, in essence, processes of commoditization, commercialisation and secularisation. According to this, the number of types of ayawaska drinking practices are what contributes to its globalisation, in particular that of the “cross-cultural vegetalismo”, which are indigenous-style ayawaska rituals conducted primarily for non-indigenous clients (Tupper 2009a:117-118).

A common approach addressing the expansion of transnational circuits of the Peruvian vegetalismo focuses fundamentally on the perspective of the consumers –mostly

foreigners– travelling to Peru for ayawaska drinking (cf. Shanon 2002a¹⁹⁴; Labate 2011). Ayawaska tourism has also been addressed by ayawaska-scholars as a misunderstood development opportunity for natives or mestizos who utilise these new income possibilities in a shredding and ingenious way. In studies following this perspective, the role of the commoditization of indigenous spirituality, neo-colonialism and the consequent conflicts raised between local and national priorities are thoughtfully not considered, because the central conceptualization is based on the idea that these practices are the product of deliberate local strategies to adapt to changing socio-economic conditions.

Among these scholars, it is mostly recognised that the negotiations between the “world of the gringos and their expectations” and the local traditions are done under “different hierarchical conditions”, but a “fair structure” has arisen, in which “creative translations are performed on both sides” and that these changes correspond to a historical continuity which is typical for Peruvian *vegetalismo* (cf. Labate 2011:vi). Although it should be considered that knowledge transfer in the context of the commercialisation of products of TM endorses a bidirectional flow of information, commodities distribution and benefits between customers and producers are not the same. Existing commercial partnerships show a dramatical contrast to the liberal utopia of full commoditisation, i.e. universal competition and ideal type market relationships and exchangeability, because they are carried out under unfair structural competitive conditions. In this sense, it is noticeable that authors like Labate (2011:42) speak about a “legitimate processes of cultural transformation” to refer to these practices, when it is clear that such arrangements do not arise spontaneously from the interaction of the community with deliberately chosen partners; the settings are artificially constructed according to the expectations and demands of the consumers; and are not disposed and managed under similar transactional economic conditions.

The proliferation of adapted versions of applied TCM in some European countries illustrates a forewarning situation of an appropriation process of traditional medical cultures of former “peripheral” countries. Nonetheless, due to its all-embracing

¹⁹⁴ In a period of 10 years of fieldwork, Shanon studied the effects of ayahuasca consumption in ca. 200 people from the perspective of the cognitive psychology (cf. Shanon 2002).

economy growth, this expansion presents a dissimilar outgoing situation in comparison with Latin American countries, and far different from those THS of non-emerging markets. Accordingly, the internationalization process of TCM –also at the institutional level– constitutes an additional sign of its modern economic regency worldwide, and the expansion of its hegemonic financial and political development. This process is also explicable, in part, due to the centenarian mass migration process from China to different regions of the world, with the settlement of their own, mostly informal, care systems in the receptive countries from migrant workers (Menéndez 2005:36). However, even in the case of China, this process of acculturation, adaptation, and assimilation of techniques of the TCM indeed obeys an appropriation process, because it is principally imposed and managed by specific social and ethnic groups with great economical and political influence in these countries.

However, the doctrine of the new era makes possible the transfer and marketing of foreign knowledge with the conceptual establishment of imagined communities, in which all the human beings have, theoretically, similar conditions and opportunities to exchange. So defined, the ayawaska tourism can be conceived of as a field of exchange between cultures, and accordingly promoted as an authentic cultural globalisation process without any sign of exploitation or appropriation. Nevertheless, such communities do not exist. Todorov asserts that since its first formulation, the doctrine of inequality is going to be fought by another one, which affirms, to the contrary, the equality between all men (1998:157). The radical antagonism of both theories put at the stake the opposition equality-inequality, but at the same time that which exists between identity and difference: “The difference degrades itself in inequality; the equality in identity; these are two big figures of the relation with the other, which draw its inevitable space... the discovery on the part of the “self” on “them” who inhabit it is accompanied by the much more frightening affirmation of the disappearance of the “me” in the “we”, which is typical of totalitarian regimes. The exile is fecund if one belongs to two cultures simultaneously, without being identified by any: but if the entire society is made up of exiles, the dialogue of the cultures stops: he turns out to be replaced with the eclecticism and the comparison with the aptitude to like a little everything, to sympathize mildly with all the options without never adopting any”

(Todorov 1998:261, t. sp.). Situating Todorov's remarks in the context of ayawaska tourism, some scholars' assumptions asserting that appropriateness is not occurring are, at least, naive. Indeed, this imaginary process includes a mainly transactional concept responding to a phenomenon that is, in its roots, a consumption trend. Accordingly, the main research interests of this group usually lay in the search of scientific evidence to support the therapeutic properties of the plant.

The interest among academics and activists to the advantages of the use of this psychedelic is related to an interest for drug policies legalization in other countries, and the trans-national use of a foreign plant to resolve their own local and national health and social problems that are far different from those of the original country¹⁹⁵. The goal of the globalisation of the ayawaska academic movement –an activists' extension of the prior ayahuasca studies– is to divulge the apparently safe use of an Amazonian plant to support the liberalization of drug consumption in industrialised countries. So Kaplan states in the foreword of the book “The Internationalization of Ayahuasca” that the liberalization of consumption as a prior statement to facilitate the conditions for continuing the research on the therapeutic properties of the plant: “With the growth of knowledge and experience of ayahuasca in the Amazon came a corresponding rise in its use in Europe and North America. Ayahuasca was consumed in various contexts eventually resulting in its continuous suppression involved targeted arrests and challenging legal cases in numerous countries. This prohibitionist response has made it difficult to scientifically investigate the therapeutic benefits as well as the health risks of the use of ayahuasca” (Kaplan 2011:15). Tupper (2011:40) even now proposes an “entheogenic education” approach inspired in the “plant teacher metaphor”¹⁹⁶, which opens up the conceptual possibility that ayawaska is “a kind of archaic cognitive tool

¹⁹⁵ The Multidisciplinary Association for Psychedelic Studies (MAPS), e.g., is a non-profit research and educational organisation in the USA for the development of psychedelics and marijuana into prescription medicines, training of therapists, and the establishment of a network of therapy centres. A Latin American version is NEIP (Interdisciplinary Group for Psychoactive Studies) See: www.maps.org; www.neip.info and the “the jungle prescription” project of Dr. Maté Gabor, a MD specialist in the treatment of drug addicts in Canada and best-seller author: <http://flavors.me/ayahuasca>.

¹⁹⁶ Tupper interprets the animated character of plants given by indigenous people as a metaphor, in which the plants owns “a kind of consciousness, or an organic non-human sapience and can function as metaphysical interlocutors to bestow esoteric awareness or knowledge upon the sufficiently humble and adequately prepared drinker” (2011:155). However, spirits of the plants are not analogies; in the Andean and Amazonian cosmology they are just other beings as alive and autonomous as oneself (cf. Cárdenas (1989:199).

that can provide profound psychological, spiritual and other insights to adepts who become skilled in negotiating its extraordinary effects” (Tupper 2011:155). Due to the contemporary policy challenges arising from the outspread network of ayawaska users in countries such as Canada, the United States, and a number of European states –which have robust regimes of international drug control– this is surely an approach of particular importance for them.

4.3.1.3 Consequences on Public and Local Health

The ayawaska is not a primary option for my patients... in the imaginery of the people is that witchcraft, or something for superstitious, evil or low level people. There is a negative connotation, and those ones who arrive to the ayawaska do it mostly when they're desperate; desperate because of love, money or drugs (Psychologist iw/2009)

Existing studies about ayawaska tourism mostly investigate either the tourists or “gringos” who participate in the ceremonies (Dobkin de Rios 1994; Winkelman 2005; Labate 2011); the healers who conduct the retreats (Dobkin de Rios 2008) or even the interaction among both (Sieber 2007) in the context of tourism research (Smith 2006). Anyway, few studies focus on the local residents with whom the tourists may interact or impact. In the context of academic work, this trend has little impact on contributions for the conservation of THS, and has an indirect effect on the Peruvian socio-medical situation.

Homan mentions that the practices surrounding the post-modern consumption of ayawaska have become facets of a multi-million dollar enterprise, moving throughout the global. “While a number of options exist for drinking ayahuasca, such as drinking with a local curandero in a small town or village, many tourists choose to visit all inclusive lodges. Usually located on the outskirts of Amazonian urban centers, such as Iquitos, Pucallpa, Tarapoto, Yurimaguas, and Puerto Maldonado, lodges charge upwards of \$3000 for a one to two week stay. This fee usually includes a number of ayahuasca sessions, seminars, lectures, workshops, as well as general accommodations” (Homan 2011:68). Of course, the ayawaska tourism offers an opportunity for the production of financial resources in areas of poverty and extreme difficulties to obtain

jobs and maintain incomes. The activities of *curanderos ribereños* (river dwellers)¹⁹⁷ giving workshops in Europa and the USA or their numerous *encuentros de espiritualidad indigena* (encounters for religious and spiritual dialogue) as well as their involvement in the mystical or psychedelic tourism can be also gently viewed as part of their role as cultural emissaries. An immediate consequence of this financial alternative is the loss of healers to the communities themselves. This is also the perspective of some *ayawaskeros* interviewed:

In May I've had also a *pasajero*¹⁹⁸; in June the Germans come to me again... And this woman from London, she wants to pick me up and work with me there... But first, I should talk clearly with her, to see how many times I will come back to Peru, how is my pay there, how will I work... I am decided to go; my mind is over there, really! (Ayawaskera iw/2009)

We have already healed several people, ten drug addicts, totally drugged, we cured them. And they are already telling their friends about us. In May, my nephew will travel to the Netherlands to work there... we are working in a group (Ayawaskero iw/2009)

A short but elucidated article about the impact of *ayawaska* tourism on local health was published a decade ago in the *Cultural Survival Quarterly*, in a special issue on “Intellectual Property Rights and Culture as Commodity”. The author, Rachel Proctor, interviewed two *Shipibo* healers from the community of San Francisco de Yarinacocha, in Loreto, to obtain information about their rights to the innovation and promotion of TM and its commercialisation for an international audience. Proctor suggests that the interest of foreigners in these practices could positively contribute to the preservation and revitalization of the indigenous traditions, above all among young *shipibos* interesting in a career as *curandero*. But, at the same time, Proctor stresses the risks and problems involved in a “commercialisation of the shamanism” and the temptation experienced by *curanderos* to neglect the attention of their own community's people: “If shamans are too busy entertaining tourists to help their communities, one can't say that a tradition has been preserved. It will have mutated into an empty commercial endeavour that does little to preserve *Shipibo* heritage or help the community as a whole” (2001:14).

¹⁹⁷ According to Beyer (2009:296) the religious beliefs of the *ribereños* are a mix of folk Catholicism, *ayahuasca* shamanism, and beliefs in spirits that inhabit the jungle.

¹⁹⁸ Sp. Passenger. Mestizo *ayawaskeros*' jargon referring to a foreigner coming to participate in healing retreats or self-discovering adventures (fq/2009).

As it has been reported in scientific literature, before the introduction of these post-modern contexts of consumption, the transmission of knowledge has only been passed on to those who have gone through often lengthy apprenticeships periods with THPs, following the completion of arduous periods and processes of self-cleansing and preparation. Young people, however, influenced by dominant society and the need to obtain remunerative employment in order to survive in a liberal economic system are less likely to undergo years of initiation in order to be prepared to receive this knowledge like Western apprentices can. In turn and as Tobin and Taylor also note, elders are reluctant to pass on traditional knowledge to the uninitiated, thereby disrupting the flow of knowledge to new generations. This may often be due to concerns about placing potentially dangerous information regarding medicinal plants, etc., into the hands of those who are not fully prepared to control them (2009:6).

That makes me sad. There has been a sort of utilisation from the outside, an influence. In cuzco it is worst. Now you find there people offering ayawaska, and it's not the zone of it! Not even the practitioners are Amazonians, they are Andean people. I don't mean by this that we Andeans cannot understand this medicine, but we must be there at least ten or twenty years to be able to invite others to drink ayawaska. And I also knew psychologists or anthropologists or non-professional people that sometime drink ayawaska and think now that they could invite also (Ms. PH iw/2009)

According to all what I've seen, I think that this cannot be stopped anymore. Because it has, in a short time, become fashionable. But, on the other hand, it is just a trend. I only hope that the ayawaska trend drops down, and then they [the consumers] will forget it (Anthropologist iw/2009)

Although the globalisation ayawaska researchers highlight in the academic discourse the importance of the free commercial trade of ayawaska at the international level, there are in fact very few researchers in Peru that are interested and follow up on this development. Even the local population does not see in ayawaska a main alternative to solve their health problems or personal conflicts. With this statement I do not want to diminish the importance of ayawaska as a local cultural resource and as a decisive healing alternative. But, in fact, and based on my systematic observations, the popular classes and low income social groups in the country –which constitute the majority of the population– do not join ayawaska rituals as often as other alternatives, such as the herbal medicine, the limpieas, the guinea pig healing, and even the mesas with San Pedro. Moreover, ayawaska is indeed not perceived as a popular medicine, rather as an

exclusive product for tourists or *pitucos*¹⁹⁹, or even something that is indeed a very delicate or hazardous thing. Similarly, Brabec affirms that even under the famous “ayawaska-nations”, the majority of the population is not interested in drinking ayawaska, and sees no reason to establish a relationship between their songs, their art, and their stories with ayawaska (2011a:65, t. g.). However, since the growth of tourism in this field, there has been a change to this regard.

The idea that the same Amazon settler usually has about ayahuasca is that it is a gulp or liquor or even a drug. The non-native settlers of the amazonía do not know Ayahuasca and they usually do not drink it, unless they are quite sick (MD iw/2009)

The experience I have is with people from overseas. They said, “whe don’t have this, it is forbidden in Europe, in the United States, here it is free”. The foreigners come because they are missing something, something that cannot be learned in a book or at university, but they have to learn taking a glass of this medicine, and then they will learn something, that’s going to be its complement for their studies. Drinking this medicine is like putting the finger in the wound.... Who are the people who come from outside? They are not the housewife or the taxi driver, but mostly are intellectuals and people with money, from an above average economic level. Because a trip up to here costs a lot of money (Wachumero iw/2009)

A brief note from my fieldwork research might bring another argument supporting these affirmations. Although due to my research questions I have not considered the ayawaska rituals in the context of tourism as part of my selected focus, during fieldwork my encounter with this new age scene and the ayawaska tourism was unavoidable. As expected, this has raised a number of secondary questions of some importance due to its exceptional position in relation to local public health policies that could not be answered by using conventional ethnographic methods. My research thus also led me to explore the primary medium through which ayawaska is promoted, i.e. the internet. Accordingly, an active exploration on existing social networks, and online ethnographies, were also referential to my grounded data. I have also actively sought the opportunity to talk with foreigners and middle-class Peruvians attending ayawaska-drinking ceremonies. What I have found to this specific aspect is that their most alleged criteria to visit an “ayawaska shaman” was the clear wish “to obtain visions” rather than a spiritual search, and accordingly, the shaman was selected due to his specific reputation in inducing visions. Further, I could confirm this prior interest in the visualization in several ceremonies I attended, in which I observed a “negotiation-for-

¹⁹⁹ Sp. Peruanism referring to Peruvians from the middle and upper class.

more-dosage-pattern” arising in the middle of the ceremony between clients and healers. During these arrangements, those participants who did not obtain the desired visions demanded to receive more of the brew, and commonly explained to the healer this process in terms of a demanding frustrating experience. In most of the cases the healer did not give them the requested additional concoction, but gave them instead explanations in terms of personal problems of his patients as an ordinary reason for this visual blockage.

With ayawaska you can see your future. You’ll visualize all what will be. This is why a lot of foreigners come to Peru, they want to see all about their projects, if it works or not; if it doesn’t work they’ll do another thing. I speak quite with foreigners when they come and go to see these things (Ayawaskero iw/2009)

And the gringa stopped with crying and began to visualise, she threw up all the images that came, because she wanted to see all I have seen. And when I am dizzy I use to talk more. I explained and explained this is this, and so on. And the *gringa* had finally understood (Ayawaskero iw/2009)

Some of the principal psychopharmacological studies on ayawaska report arousing properties and positive subjective effects on the sample measured such as comfortable visual effects, improvement of visual distinctiveness, and quality of thinking²⁰⁰, among others (Riba et al. 2003:77); anyway, there are also present dysphoric reactions such as disorientation and anxiety (Riba et al. 2001:92). Additionally, it is not difficult to find among this consumption trend the presence of health problems or complications in some customers, above all foreigners drinking ayawaska with the combination of another psychedelics or medicines, without the supervision of an experienced *vegetalista*, or without the proper preparation (Peluso 2006:489). In not few cases there have also been reported medical complications or physical injuries; and also psychiatric episodes after consumption (cf. Labate 2011:265-266).

According to a review of existing pharmacological and neuropsychiatric research on ayawaska provided by Bouso and Riba (2011), ayahuasca induced cardiovascular effects, basically consisting of elevations of diastolic blood pressure²⁰¹. This is even more relevant considering recent reports in the media concerning the unexplained

²⁰⁰ Modifications on quality and type of thinking is generally explained by studies’ subjects as centred on personal psychologic content and introspection. See e.g. Riba (et al 2001); Shanon (2002a).

²⁰¹ The authors note that while these increases were moderate, caution should be exerted by people who have elevated blood pressure or other cardiovascular problems.

deaths of people participating in ayahuasca rituals²⁰² (Bouso and Riba 2011:57-58).

Among my interviewees, I found also reports about these complications

Some people simple don't want to realize the situation... there are people who have drowned in the river because of the visions, also they have slipped in the jungle because they wanted to see the full moon... another cut through his abdomen and began to wash his intestines, because he saw them dirty, in his body. They had to move him with a helicopter to the city (MD iw/2009)

To this respect Dobkin and Rumrill (2008) write that the primary concern of the scholar and that of public health officials is what happens when an individual with some underlying psychological disorder, such as severe depression, anxiety, or schizophrenia, drinks the tea –even if in a ritual setting and even when accompanied by a skilled guide: “...There are particularly adverse effects in perception and emotion, with one of the most problematic effects being that of panic, psychotic-like confusion and disorientation –still more reason why these substances need to be used in a controlled setting, either medical or religious, with a skilled guide present to respond to and minimize any of these problems” (2008:10). These concerns are supported also by testimonies like the following, in which an ayawaska apprentice and Andean music healer experienced with a foreign patient

This woman came from Turkey. She is also a *sanadora* [healer], she makes something with self-discovery or so, I don't know. Anyway, she went to our ceremony, but I guess she was thinking of that as a music concert. We sat down in circle and we began to play, only with the little bones first, which have a very sweet and pretty sound. Suddenly, she went dizzy, and began to touch herself and to cry... but, you can't imagine how she cried! She cried more than an hour! She couldn't stop! It was very gloomy! We changed our sound immediately to harmonize her, to calm her down, but it didn't work (Andean Music Healer, iw/2009)

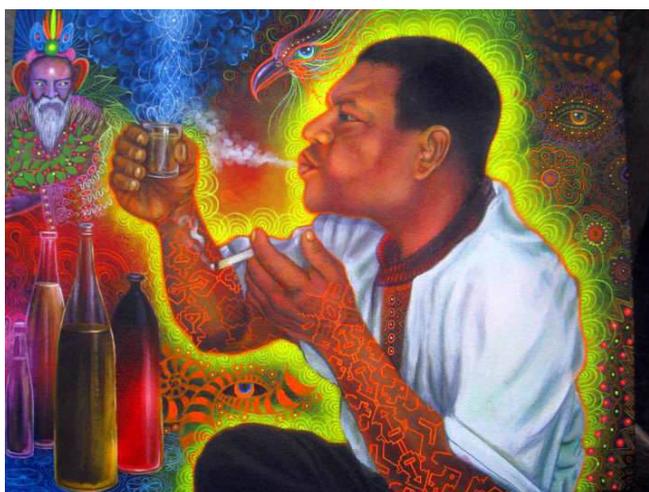
At least, it is not rare to find negative experiences, as consumers suddenly get insight into psychic and psychosocial problems they have not realized at all before, and which they are not prepared to confront or to obtain the specific professional help in dealing with.

If we say, for example, that a person's body fulfils the roll of a dashboard, like a board of a jigsaw puzzle, the spiritual truths and mystical experiences I am obtaining through the use of these substances constitute pieces of this board, and if this board is already developed in what is the physical, psychological, and spiritual structure, then it is going to be easy for me to integrate these experiences. On the other hand, the person who enters the use of these substances without having this capacity tries to integrate these pieces in the air, because this board does not exist, the body is not developed, and it's

²⁰² See e.g.: <http://www.ntn24.com/news/news/french-woman-dies-peru-after-drinking-ancient-incan-tea>.

not prepared. Many people ask me why, when they have an ayawaska vision, then they forget it, or can't integrate it. I say to them, this is because your structure is not prepared to integrate that... As Jacques²⁰³ says, it is just as if a little firefly wants to follow a very big light; it is fascinated by the sheen of the light, and ends up by being burned because it is not prepared to receive this light. Many people who look for this spiritual world are not yet prepared; it must be a process of maturation, of comprehension. People want to gain access to the other world, to the spiritual truth, but without working first on the individual truth...They want to go to the essence without passing through the existence (MD iw/2009)

Fig. 17: “Ronald Rivera, Ayahuasquero”



*A vegetalista working in supervised settings with MDs and psychologists*²⁰⁴

This is an additional public health problem that experts and policy makers have not resolved yet, because it is mostly underreported in health systems registration programmes²⁰⁵. In this point, the work and intervention of health professionals could be helpful with experience in the treatment of patients with psychedelic consumption that could orientate and inform patients before, during, and after their participation. In my sample study I met two psychologists in Lima and three MDs, whom have acknowledged this task and are attending to such cases. It is also possible that there are much more of these undercover specialists dealing with such psychological complications in this specific area of intervention²⁰⁶.

²⁰³ Jacques Mabit, MD Director of the Takiwasi Centre in Tarapoto (San Martin).

²⁰⁴ Posted in the Facebook Page of Ronald Rivera (iq/ 30.12.2011).

²⁰⁵ Most of the entries in the Peruvian SIS (health information system) to this respect are quoted as “other complications” or “drug abuse” and not identified as ayawaska consumption as such (fq/2009).

²⁰⁶ An interesting initiative to this respect is carried out by *Nimairama*, a Peruvian organisation leadership on this approach, which offers special weekend settings with purging, and medical and psychological supervision before and after the experience. See: <http://www.nimairama.com/>.

4.4 Healers and Their Practices: Two Ethnographic Accounts

Although it is not the primary focus of this research to study the ritual aspects involved in the work of THPs, it is of key importance here to illustrate the different ways in which healing activities are presently carried out. Therefore, I have selected two ethnographic accounts of healers who work with the population in a representative way, and that demonstrate expertise in dealing with the imposed dichotomy between the ancient and modern practices of their profession. Additionally –and different from other healing specialists– these two healers follow traditions that have not gained too much attention on the part of ethnographers and researchers, i.e. healing with the guinea pig and bone setting. Both healers have considerable experience in these THS, attend to a large number of patients from all cultural backgrounds and socio-economical conditions, and work in a vast geographical network in the country. Due to their commitment, experience, interest, and involvement in the academic life in the country, it seemed important to me to give their ideas and motivations an important place in this research. Consequently, the speeches elaborated by them during the interviews and participant observations are reproduced here largely in quasi-literal form. It is desirable that subsequent studies would focus more on the variables around the work styles of THPs and its impact and importance for the implementation of integration policies.

4.4.1 Iván Reyna Mercado, the Inca Chiropractor

Kayman, riki, qamuchkani. Lliw pachata kuyuchispa, chay llapa puriq ayakuna: tayta mamankunata qayaspá²⁰⁷ (Iván Reyna Mercado, ec/2011)

In contrast to other healing systems, palpation technologies and bodily therapies are alike worldwide. In relation to this point, Prinz asserts that no traditional health system in the world can renounce the contact between the hand of the doctor and the body of a sick person: “If one would carry out movement analyses on the muscle play in hand and arm, one would not identify differences between an African witch doctor, an Indian

²⁰⁷ Qe. “And here I am. And all those dead men walking make the whole earth tremble: They are calling for their ancestors”.

shaman or a Western doctor” (Prinz 1996:4, t. g.). Still, this practice, performed by a wide variety of clinicians and lay practitioners from around the world has been differently regulated through time and regions, a condition termed “sanctioned and non-sanctioned environments” (Mintken et al. 2008:50).

The treatment of a variety of musculoskeletal conditions, including spinal disorders, has been widely practised in many parts of the world in different cultures at different times (Pettman 2007). References to the techniques of the manipulation of the body date back over 4,000 years, with discussions found in Egyptian scrolls (Edwin Smith papyrus) and enshrined in ancient Thai sculptures (Mintken et al. 2008:50). Hippocrates was the first MD describing joints, the anatomy, spinal manipulation, and the reduction of dislocations and fractures –especially scoliosis– with manipulative techniques (Pettman 2007:165).

The most existing scholarship about bonesetters is concentrated in Africa, above all in Nigeria and Ghana (cf. Dada, Wahab and Giwa 2011), as well as in India (cf. Agarwal and Agarwal 2010). The practice of traditional bonesetters in South America is still an understudied field; specialised accounts of their work are more common to find in Middle (e.g. Cosminsky 1987) and North America (e.g. Anderson 1987, Hinostroza 2002). For the *nahuas* in Mexico, the skeletal remains were part of the vital forces of the individual, so the bone of the sacrifice was kept in the house of the warrior who had captured him in combat and when they went to war again, their wives hung it from the ceiling, covered it in paper, and offered a copal, while calling for their husbands to return alive (Huicochea 2002). Among the Aztecs, the contractures were viewed as weaknesses that penetrated the body with supernatural forces, and which were housed between the bones to cause disorders, were invaded by cold beings known generically as “aires”, causing pain in the joints, associated with increased humidity and temperature drops. For the treatment of fractures, bloodletting was used to reduce distension, and medicines to stimulate the blood circulation and to avoid stagnation. The *entablillados* were used to immobilise the fractures, and to treat complications like distension in the area of the fracture, touching it with an obsidian lancet applying a miscellany of plants that served as plasters (Sahagún et al. 1990).

Like Sahagún among the Aztecs, in Peru, many years after the conquest, the Catholic priest Martin de Murúa wrote about some female healers²⁰⁸ dedicated specifically to curing bones and, once they had put the fracture in the right place, used to make sacrifices to the gods to promote healing (Murúa 1987[1611–1616]:403):

Otras indias había que curaban indios y criaturas quebradas, y mientras dura la cura del lugar quebrado, o desconcertado, sacrificaban y generalmente en ello usaban palabras y unciones, sobando la parte y con otras supersticiones... Cualquier indio que tenía quebrado brazo o pierna, u otra parte del cuerpo, y sanaba antes del tiempo que solía sanar los otros enfermos, de tal mal era tenido por maestro curar semejantes enfermedades

Cabieses mentions that these healers treated the fractures with branches and fresh leaves of *huaripuri* (*Valerian coarctata*) or *anchacocho* (*Baccharis latifolia*), which were kept in place using bandages of cotton and mud. Sometimes they put on the fractured bone remedies that had the purpose of speeding up the consolidation of the fragments. Among these remedies he referred to a mixture of coca leaves with salt and ground egg shell. Other times they would give infusions of *tola* leaves (*Lepidophyllum quadrangulare*), which are also used externally (Cabieses 1993a:79). Garcilaso de la Vega (1976[1609]:425) also mentions coca as a common remedy to cure broken bones: “La coca preserva el cuerpo de muchas enfermedades, y nuestros médicos usan de ella hecha polvos, para atajar y aplacar la hinchazón de las llagas; para fortalecer los huesos quebrados; para sacar el frío del cuerpo o para impedirle que no entre; para sanar las llagas podridas, llenas de gusanos”. Valdizan and Maldonado write about the exceptional abilities of “componedores de huesos”, and dedicate an entire chapter to describe their manual techniques and both plant and animal remedies used by them (Valdizán and Maldonado 1922:123).

The traditional bonesetters are best known as *huesero* or *sobador* in the Peruvian traditional medical landscape. According to the classification given by the bonesetter this ethnography is about, Iván Reyna, bonesetters in Peru include different types: those who apply *ventosas* (who handle the affected zone with an air-holed cupping glass); the *recalqueros* (who squeeze or clenche the body); los *sobadores* (who apply compresses

²⁰⁸ In the editions of this Crónica edited by Osorio (2004) and Urteaga, Romero, and Jiménez de la Espada (Murúa et al 1922-25), the bonesetters are identified as female. This is probably due to the fact that parteras also worked with manual therapy.

and massage); the ones who *sacan el shucaque*²⁰⁹; the *arregladores* (who set the articulations straight); the *curiosos* (who apply a free interpretation of techniques of allopathic medicine with those from traditional manual therapy); the *hueseros* (who set the bones straight) and the *componedores*, who work not only on a specific part of the body, but on it as a whole and also operate on the head, neck, arms, hands, back, torso, knees, and feet (Reyna iw/2009, 2010).

An important research contribution on bonesetters in Peru was delivered by Oths (2002). She mentions the *componedor* as a general category of bonesetters who asset their principal assistance on a set of techniques and healing traditions utilising the hands and manual manipulation over the body (Oths 2002:64). According to Oths, the word *componedor* means “one who fixes or repairs”, and refers to a healer who mobilises joints and repositions or sets straight minor movements or major dislocations of the vertebrae as well as other joints, muscles, and even organs whose improper position may cause pain, discomfort, dysfunction, and immobility: “They are alternately said to *componer* (compose, fix), *arreglar* (arrange, put in order), *juntar* (join, connect), or *acomodar* (arrange, adjust) the bones and muscles, and a treatment is commonly called a *compuesta*” (2002:64). Coinciding with Reyna’s explanation, Oths distinguishes between a *componedor* and a *huesero*; whereas the *componedor* is the rough equivalent to a lay physical therapist or chiropractor, the *huesero* (bonesetter) is the more skilled of the two practitioners, sets broken bones as well as performing the skeletal manipulation of the *componedor*. In other words, while all *hueseros* are *componedores*, not all *componedores* are *hueseros*. Besides the *componedor*, the midwife is a regular practitioner of the musculoskeletal healing arts, with shamans (*curanderos*), herbalists, and others occasionally employing simple techniques of bodily manipulation as well. Oths argues that a review of the literature reveals that, in contrast to the Andes, in the Southwest or Mesoamerica, there is a great deal of ambiguity in the use of terms for the

²⁰⁹ *Shucaque* (sp. *vergüenza*, shame) is characterised by a seizure state of nausea, headache, and stomach pain (also diarrhoea) with weakness, irritability or procrastination caused by an embarrassing or worrying situation (cf. Chiappe 1993:196). The affected person feels annoyed and ashamed at the same time. In the treatment, portions of hair from the person are pulled strongly; pops and cracks indicate that the *shucaque* has been removed. Also, the navel is spit at, air is sucked from the head (*chupadas*) or the head and chest massaged in a circular motion. The “*colerina*”, also a cultural syndrom in northern Peru, has similar physical symptoms but with feelings of anger and impotence. *Shucaque* should not be confounded with another syndrome called *chuchaqui*, which refer to symptoms of being drunk.

two types of healers, with bonesetter the preferred translation in English. Effectively, at times, the term *sobador* (similar to the *componedor*) in Mexico appears to refer to one who only massages, but usually includes those who adjust bones and or set fractures (Anderson 1987). Graf (2009) mentions distinctions between *masaje* and *sobada*. While the first rather regards the physical level and can be translated as “massage”, “sobada” can be understood as extending beyond this. A *sobadora* (someone who performs *sobadas*) is aware of the effects of therapeutic actions on the body on mental-spiritual and emotional levels (Graf 2009:91). The multifaceted work of the healers reaches its highest level in the multiple definitions attributed to the wide spectrum of bonesettlers’ abilities.

In few words, bone setting consists of a wide set of practices of joint manipulations of sprains, dislocations, and simple to complex fractures, by manipulating the bones and muscles and even organs through massage, and applying splints to the area around the fracture or wound. In the ethnographic literature, the use, in some instances, of incantations or prayers, which are made on the affected area as a way of invoking ancestral spirits for divine intervention and healing is also mentioned (cf. Anderson 1987). However, this is one of the THS in which the use of religious or magical elements seems to be minimal²¹⁰.

There is some evidence to say that the bonesetter is found to meet medical standards of practice for safety, efficacy, and cost containment. According to Panda and Rout, 71% of patients of the 198 cases in a three-year prospective observational study were satisfied with the treatment of *Vaidyas* (bonesettlers) of Puttur (Andhra Pradesh, South India) with minimum complications (Panda and Rout 2011). Anderson (1987), after evaluations of ranges of motion together with patient reports of pain levels, provided crude measures of effectiveness by a Mexican bonesetter. For the Peruvian population, bonesettlers are considered the most efficacious of all THPs, with over 50% of respondents stating a preference for these healers in the case of injury or other trauma of the bones and over 63% acknowledging their efficacy in such disorders (INEI 1998).

²¹⁰ Though widely used, one reason to explain the lack of research about bonesettlers may be the shortage of exotic or magical aspects of this practice.

During fieldwork, I observed that people claimed to seek these treatments because of their effectiveness and the empathy perceived on the part of the healer.

4.4.1.1 “I am Just the Tip of the Iceberg”

In the specific case I studied here, the bonesetter defined himself as an “Inca chiropractor”. Since statistically seen, the cases of broken bones are rare in his practice –or once diagnosed by him they will immediately be redirected to an orthopaedic surgeon– I will subsequently refer to him in his own terms whether he can be labelled a componedor, i.e. a type of bonesetter.

I’m only the iceberg’s tip. I don’t have all the knowledge; maybe I have only recovered a part of the best, but we have a lot of hueseros, and some of them are already dying. In Callao, we had Hugo Bazalar, for example, he was a wonderful bonesetter, I also learned with him. But he died, and this science died with him... The bitter thing is that we don’t rescue anything from this enormous knowledge (Reyna Mercado iw/2010)

Ivan Reyna was born in November 1953 in Santiago de Chuco, in the department of La Libertad, in northern Peru. He primarily learned his healing art from his grandfather, who was an eminent huesero in his community. He has four children, who are also learning his techniques²¹¹. Due to the economic situation of his family, and his troubles with some university professors in Lima because of his appeals to promote the implementation of traditional healing techniques in the academic medical curricula, he completed only the fifth medical school year at a national university in Lima before he travelled to the USA and stayed there for 18 years, after which he returned to Peru²¹². Like other traditional practitioners without official diplomas, Reyna instead completed an online specialisation in natural medicine, in order to obtain professional accreditation²¹³, although his intervention setting and techniques are principally based on traditional manual therapy.

²¹¹ His oldest son Jorge has begun to work in his own Quiropraxia Inca’s practice in Cuzco this year (ec/2012). The second daughter, Marilu, also works as Inca chiropractor in Sullana (Piura).

²¹² In the USA, he attended to Mexican work migrants who did not have health insurance. Since his return to Peru, he regularly participates in encounters with traditional Mexican chiropractors.

²¹³ He obtained a Ph D in Natural Medicine at the Clayton College of Natural Health, an organisation operating in Alabama (USA), which is considered by specialists a disputable centre offering online formations (cf. Lange 2010).

After I returned from the USA, I said to myself I will search for the best bonesetters in my country, and I have found only the best. Together with my knowledge, my projection is that this became a science that could be taught to others, that can be repeated thousand times in all the people who are touched. The problem is precisely the absence of rules that ordered this work with a scientific basis. There is an enormous amount of knowledge, there's too much work to do. But the government has no interest in it, unlike in China with their acupuncture, the acupressure and all those things. So, this is my struggle (Reyna Mercado iw/2009)

Fig. 18: Reyna Evaluating a Patient



(Photo Pribyl 2009)

Besides its effectiveness, another determining factor for the population to attend these practices is its lower cost. The Reyna's pay structure is similar to what has been reported for hueseros from other regions. Reyna does not charge a fixed fee. It could be from nothing to around 100 Soles (38.4 US\$) for his services, and this is fixed according to patients' economic situation and disposability at the time of the consultation. Cardoso et al. (2008) mention in their study a similar fee relation among bonesetters in Mexico, who offer the disappearance of the problem in one or two sessions, which means no more than 100 pesos (ca 7.59 US\$), though, if in the first session of the treatment the necessary improvement is obtained, the person will give 50 pesos (3.80 US\$) once concluded (Cardoso et al. 2008:69).

4.4.1.2 Indians on the Body: Reyna's Clients

An in-depth description and follow-up of a representative sample of Reyna's patients in relation to aetiology, frequency, and diagnosis of specific musculoskeletal disorders was not done. In the five cases documented, the diagnosis, interventions, understandings, and outcomes were reordered and analysed together with the patients, the healer, and his assistants²¹⁴.

According to Csordas, to attend to a bodily sensation is not to attend to the body as an isolated object, but to attend to the body's situation in the world. Csordas' notion of a "somatic mode of attention" suggests that the field in which we can look for phenomena of perception and attention broadens and suggests that attending to one's body can tell us something about the world and others who surround us (1993:138-139). This occurs within a culturally elaborated attention to and with the body, in the immediacy of an intersubjective milieu, in which intuition, imagination, perception, and sensation play a special role (Csordas 1993:139-147). These categories may seem to be too psychological, but indeed, it is a basic synthesis that is part of a sort of specialised knowledge. Approaching this complex construct of intersubjectivity in manual therapies, it could be affirmed that this intersubjectivity occurs basically in a shared cultural milieu. The emotions or complaints of someone else are also immediately perceived and could also be familiar when the same habitus is shared (Csordas 1993:151).

Many highland immigrants living in Lima come to Reyna for a consultation²¹⁵. Most of Reyna's patients I interviewed or observed during the treatments performed heavy physical work under mostly extreme unfavourable labour and economic conditions, like transport or cargo occupations with overtime, few free days to restore the body from the stress implied in this type of work and with minimal wages. The most common among them, the *estibadores*, from the Spanish *estibar* (stove, load or pack) have to climb narrow tables while transporting heavy loads, sustaining them on a single foot, and cover long distances full of difficulties to reach their goal. According to a study of the

²¹⁴ The healer demanded the presence of his apprentices in three of the five cases documented.

²¹⁵ According to Reyna, there is no age limit for his patients. The youngest was 15 days and the oldest 97 years old.

INS in 2005, 38% of *estibadores* in the *Mercado Mayorista de La Parada* (Central Wholesale Market of La Parada in Lima) suffered work-related accidents such as broken bones, sprains, and a total of 35% of them showed lower back pain and muscle aches. Additionally, 78.7 % of them used a *chumpi*²¹⁶ as protection (INS 2005a:4). They loaded on average 140kg sacks each time they carried, while the maximum weight allowed is 50 kg, and may have loaded up to 1,000 kg a day for 0.50 to 0.70 Peruvian soles (US\$ 0.23) per sack in Lima (ISCOD 2010:36).

In La Parada, there are the *estibadores*, who are migrant persons of Incas' pure progeny. Most of them are not so big, but they can load easily a large number of kilos on their backs. And they do not only walk with that, they run with the fruits, the vegetables, with the sacks! What can they do? They can use the *chumpi* or strip as a protection; it has a function, and is very good to avoid damages in the lumbar area. I recommend it to my patients who have this type of work, so that the lumbar area remains, at least, somehow protected (hs1-reyna/2009)

Every year, 12% of the *estibadores* of the wholesale markets in Lima stop working due to health problems like arthrosis, spinal deviation, dislocations, and broken bones, produced by the excessive loads (INS 2005a). The report also informed that 15.7% of the 183 *estibadores* interviewed (between 25 and 35 years old)²¹⁷ had tuberculosis. The study concluded that working conditions in the market were unfavourable because of the excessive weight, shape and position of the loads. Similar results were found by Vigil et al. (2007) in Huancayo (department of Junín) where 42% of the *estibadores* presented dorsal hiperkyphosis as a direct result of the way of loading the bags on the head and bent neck, and 55% lumbago. Musculoskeletal disorders are among the most frequent complaints of the loader workforce (42%), specifically among *estibadores* these are present up to 84.6%.

²¹⁶ Qe. Knitted wool belts. *Chumpi*'s definitions go always accompanied with a protective function, such as *chumpi lliccuni*, which means to wrap oneself with a strip (sp. *Faxarse la faxa, ponerse el cingulo*) or to bundle the body with a *yacolla* to walk (sp. *cenirse la yacolla para caminar*) (González Holguín (2007[1608]:101).

²¹⁷ In spite of the fact that the law sets a minimum of 16 years to perform this activity, also children and adolescents work as *estibadores* (cf. Vega 2008:7). A documentary (Legaspi 1987) accounts two testimonials of children-*estibadores*.

Fig. 19: Estibador in Mercado Mayorista de la Parada in Lima



(Photo courtesy of Marina García Burgos)

The Law 29088, *Ley de Seguridad y Salud en el Trabajo de los Estibadores Terrestres y Transportistas Manuales* (Law on Health and Security for the Work of Terrestrial Estibadores and Manual Transporters) and its regulation, by means of the Supreme Decree N° 055-2009-TR²¹⁸ established in art. 2 the maximal weight load permitted for estibadores. Although the law also determined the existence of a specific health program for estibadores, the *Programa de Salud y Seguridad Ocupacional* (chapter III, art. 11), to evaluate once a year the health and work conditions of estibadores, the majority of them have not public health insurance²¹⁹.

The estibadores of tubers (potatoes, sweet potatoes) are those who have the harder task because the sacks do not weigh less than 130 to 140kg. At the end of a day, they will have loaded up to 25 tonnes of the product. This effort brings results in the estibadores feeling collapsed physically and mentally... often, they do not use chumpis, gloves or helmets during work, so it is frequent that they suffer accidents to the head and face if the products inadvertently drop on them (ISCOD 2010:36, t. sp.).

In 2010, the estibadores' labour union (FETTRAMAP) published a testimonial book about their struggles during the last 42 years and show that the law's regulations are not applied at all. They continue carrying the prohibited weight: "the authorities do nothing to stop gangs of sewers that surround the wholesale markets and manufacture sacks of 130 to 140 kg, in order to favour the wholesalers, with the detriment to the backs of the estibadores" (ISCOD 2010:16-17). And the damages are not only physical. 18% of the

²¹⁸ See: <http://agroaldia.minag.gob.pe/biblioteca/download/pdf/manuales-boletines/papa/reglamentoley29088.pdf>.

²¹⁹ See e.g. <http://www.andina.com.pe/INGles/Noticia.aspx?id=91NO3Odgq3w=>.

estibadores also present indicators of anxiety and depression because the working conditions are deplorable, and they do not fulfil minimal standards of an activity with human quality (ISCOD 2010:55).

Fig. 20: Patient Juan, Estibador



*Reyna's patient is 43 years old and works loading fruit at mercado mayorista
(Photo Pribyl 2009)*

Pain and physical hurt set up in emergency consultation situations. As a patient expressed in relation to his bodily state, the angst-inducing idea “not to be able to move or work any more” is an additional stress that requires a short and efficient intervention. Reyna’s patients seek the huesero’s help as a first alternative to alleviate their painful symptoms. As it has been continually addressed among ethnographic accounts on Peruvian healers, the term “symbolic effectiveness” seems to find no place in the practice of this healer, since he works on and with the body, and there is nothing magical or exotic about that. Anyway, in such patients’ health conditions, mostly perceived as critical and urgent to be solved, this interesting pattern of first medical choice for a THP could be explained in terms of social advances and cultural identity. One of them is the image Reyna reflects as a successful highland Quechua speaking immigrant living and working in the biggest Spanish speaking coastal city. The perception of Reyna as an indigenous person and “doctor” at the same time plays an

illustrative role in the relationship between migrants' emergent social and cultural identity and medical choices in the capital of Peru. In contrast to other immigrant *serranos* in Lima, Reyna does not abnegate his roots, customs, and traditions. On the contrary, he uses every opportunity to reaffirm his identity as an indigenous man. Thus, besides his healing abilities, it is possible that for highland immigrants, Reyna also incarnates an important social ideal to be emulated, which combines, apparently, the conservation of the own indigenous identity, the healing tradition of a bonesetter and the academic accreditation of a health professional. In this sense, a treatment by him involves, indeed, a double value. A treatment by Reyna can offer not only the possibility to find a culturally adequate comprehension of their complaints and social problems, but also implies an additional way of social affirmation and identification.

Besides the somatic mode of attention described above, it is probably more exact to speak about an indigenous mode of experiencing the own body among Reyna's patients, that goes beyond the ethnically or socially attributed ascriptions of Reyna's clients and that permits the identification with the bonesetter's efficacy. Crandon speaks about an "Indian mode of existence", in which indigenous people retain much of their pre-colonial social structure, including a peasant economy based on barter exchange within a patriarchally controlled capitalist sector or the urban elite-marginal economy (1986:470). This modus is based on relations of production that differ from those of the capitalist domain, yet are exploited by it: "Participation in this mode requires (or is limited to) the adoption of Indian ethnic identity. It is a closed sector that feeds its members and exists within a larger sociopolitical environment" (Crandon 1986:470). Although mostly highland immigrants working in Lima with heavily demanding physical activities, Reyna's clients are also mestizos and white urban Peruvians (*criollos*). In contrast to the highland immigrants, they came to Reyna as a second medical choice, with dissimilar work conditions, and brought different explanations about the origin of their physical complaints. However, they addressed to some extent the ways of feeling the body and complaint experiences managed by Reyna, something that besides his efficacy should be understood under the Indianization process of non-indigenous traditional medicine users in the city, as well the liberal work structural conditions imposed in the country.

4.4.1.3 Diagnosis and Techniques

Reyna's method affords few or minimal number of sessions. The average number of sessions in a treatment period is from one to five. The duration of a session is up to fifteen minutes. In his concept, the evaluation and some tactics require two or more *Quiroinkas* (specialists in Quiropraxia Inca) in order to make a more equilibrated intervention, working in unison during diagnosis and manoeuvres, at the right and the left, and at the top and the bottom side respectively. Reyna's basic idea is to work on the whole body without approaching a specific step-model of intervention. The standard target is to relieve patients' pain, also in order to continue with body manipulations. Reyna does not use any diagnose tools except a short information by the patient about the complaint's form and nature, occupational activities, and their possible explanations of their own complaints. He uses his hands and a careful observation of patients' body structures and movements, which succeeds in few minutes.

Fig. 21: Quiroinkas



(Photo Pribyl 2009)

Reyna works on the basis of the osteoarticular system, including articulations, muscles, ligaments, and nerves, and sometimes with inner organs. He believes in the concept of *subluxación*, a vertebral or joint displacement considered to impair nerve function, and the cultural concept of “aires” (air) as decisive factors for pain and contractures. Although in Reyna's discourses there are many references to traditional remedies and

plants²²⁰, as well as local and popular explanations to body located ailments, Reyna regards the concept of subluxation critically in his understanding of musculoskeletal disorders as conventional chiropractors do. Since Reyna's scope of mind is the accreditation and legalization of THPs, this is not surprising. The chiropractic is recognised by the WHO as a healthcare profession concerned with "the diagnosis, treatment and prevention of disorders of the neuromusculoskeletal system and the effects of these disorders on general health, with emphasis on manual techniques, including joint adjustment and/or manipulation, with a particular focus on subluxations" (WHO 2005b:3). For the Quiropraxia Inca, the subluxation implies a dislocation of a vertebral notch, when this goes partially out of its original position (Reyna Mercado iw/2010). The Quechua name for it is *churuna*. Other symptoms and nosologic categories most frequent in his practice imply at first the *nanay* (pain), *human nanay* (head ache), *nanacuy* (complaint, ailment), *chakinta qiwikuy* (twisted foot), *wasá nanay* (back pain), *wasá-tullu* (kyphosis²²¹), *wasanchu* (arched back), *chukulli* (muscular cramp), *hancca* (cripple) and *hanccani* (hobbling), *chirayac* (paralytic), and *chocmi* (head haematoma), among the principals. Besides these symptomatic conditions, Reyna asserts to be able to correct *scoliosis* and *discopathies* (dysfunctions of an intervertebral disc). He did not make any diagnostic distinction between his patients in Lima or in the semirural area of Végeta²²².

There are a few instruments that he always uses in his interventions: the *jawina* (a herb-composed salve made principally on the basis of *congona*²²³), the *lliclla* (a blanket to cover the patient during the maneuvers), the *sanhuana* (an extended plain although not so commonly used, for big segments of the body) and the *chiquanchay* (a pillow to set

²²⁰ Besides unguents and balsams made of medicinal plants and minerals, he also uses *alumbre* (alum) to extract air and pain from the body (Reyna iw/2010). For alum's use in urban contexts in Lima see e.g. Schupp (1991).

²²¹ Implies a symptomatic over-curvature of the upper back with different etiologies.

²²² The Peruvian semi-rural District of Végeta is one of the 12 districts of the Province of Huaura, in the northern area of the department of Lima. Nearly 60% of its inhabitants are Quechua and the rest mestizo population.

²²³ The *congona* (*Peperomia inaequalifolia*) is an aromatic herb whose leaves as tincture are used externally to massage the whole body in case of low blood pressure, psychological depression, and sight and respiratory problems. According to De Feo, the plant tincture and infusion are also prescribed as sedatives for colic pains, along with "Cola de caballo" (*Equisetum bogotense* or *E. giganteum*) and "Grana dulce" (*Cynodon dactylon*) (De Feo 2003:245). All mentioned plants are originated in and traditionally used in Northern Peru (cf. Bussmann, Sharon and López 2007:189). Reyna ascribes to this plant an anti-inflammatory and analgesic property (hs2-reyna 2009).

under the head when applying the third manoeuvre *allinchay*). Additionally, he utilises a *K'ero* (ceramic mug in Inca style) to carry out a *ventosa* (cupping-glass) to “extract the air causing pain or contractures” (hs3-reyna/2009).

Fig. 22: Bonesetter’s Instruments



*lliclla (expanded over the massage couch), sanhuana and chiqanchay (right)
(Photo Pribyl 2009)*

Reyna has elaborated a pain scale to calculate the ailments of patients, and to evaluate the process of change in relation to the pain and the annoying symptoms that occur in the vertebral disc problems after adjustments have been applied.

Table 6: Quiropraxia Inca’s Pain Scale

0	Without pain
A	Low complaints or low pain feeling. Modest lost of sensitivity
B	Passing cramps, medium-sized to strong pain that appears and disappears, medium-sized muscular loss of sensitivity, constant muscular spasms
C	Severe pain that subsides with analgesics and/or anti-inflammatory drugs. Might also have constant painful cramps; muscle spasms, it begins to lose muscle strength to perform work; loss of sensitivity in distal areas of the body
D	Continuous, very strong pain. Constant cramps, great difficulty of movements and muscular contracture; it is very difficult to maintain an anatomical position; can yield with strong anti-inflammatory analgesics but only for a short time
E	Excruciating pain which does not yield to drugs and when it relieves, reappears soon; loss of joint movements; enormous muscular contraction

Among the most common intervention modalities of the manual therapy in the Andes, which include having the patient lie face down and afterwards up, kneel, sit in a chair, or be rolled in a blanket (Oths 2004:205) while the healer works, Reyna privileges the first position to work. According to Reyna's method, there are six maneuvers foreseen. For all the cases, the goal of the first session is to correct the whole spine (*churana*).

1) **Kasay**

The expression *kasay* means “the key which opens the door”. In this first intervention lies the key to the success of the therapy, and it constitutes the basis of the Quiropraxia Inca's therapy. Correctly applied, this technique allows the spine, which is apparently activated through specific sensors, to turn straight automatically, almost without the intervention of the Quiroinca's hands, i.e. the correction or *compuesta* itself is intended to be obtained through the activation of the self-regulation (homeostasis) principle of the nervous system. The back should tend to stretch out, the pain disappears, and first dislocations corrected.

Fig. 23: Kasay



(Photos Pribyl 2009)

According to Reyna, the foundation of this technique is based on the existence of five *qosqos* (navels or master joints) alongside the body. These *qosqos* are the coccyx, the fifth lumbar, the sacrum, the seventh cervical, and first and second cervical. When these elements are dislocated, they generate serious changes in the architecture of the axial skeleton; once corrected through this first intervention, the abnormalities should be extinguished. This intervention is specially made and applied according to the

pathology each patient presents; it is exclusive and personalized and cannot be used as a standard method.

2) **Llampuchay**

The Quechua word *llampu* means the quality of something soft, plain, smooth or straight. *Llampuyachini* consists on the action to appease, to lessen, to be calm or become composed. *Llampuyachicuni* is a reflexive form, and denotes to let one yield or to consent something; in case of animals to become tamed. Probably, the Quechua expression *ñam soncoyta llampuyachicuni* could describe this technique the best, because it means to be calming down whereas at the same turns a state into a good condition (cf. González Holguín 2007[1608]:151). The tactic of *llampuchay* consists of the decompression made by the two quiroinkas alongside patient's back beginning from the dorsal area up to the lumbar zone. The first step is to apply the jawina on the patient's back. By quelling the back, it prepares the body for the final corrections of those vertebrae that have been detected to be still out of place.

Fig. 24: Llampuchay



(Photo Pribyl 2009)

3) **Allinchay**

Allinchay means a perfect thing or the action to “refine by improving something which is already perfect” (*allinchani, allinnequenchanic, chaycama checcamanta allin*) (cf. González Holguín 2007[1608]:395). The third step is the correction of disjoined vertebrae and discs using the bonesetter's manual corrective instrument called *chiqanchay*, which is made of alpaca and sheep wool. Reyna asserts that this instrument assures a correction without pain or traumas, and above all, with precision. The

chiropractor and the assistant must realise it by doing a compression and “opening” synchronous on the vertebrae through pressing down alongside patient’s back.

Fig. 25: Allinchay



(Photo Pribyl 2009)

4) Anchuy Wasampi

Anchuy (to remove or move back), and *wasampi* (behind, at the back), consists of the lateral correction of the patient’s body. The patient adopts a position lying on one side, whereas the Quiroinka makes a profound compression on the posterior superior iliac spine. It corrects problems situated between the L5-S1 –such as degenerative joint diseases, spinal arthritis, etc.– and the hip bones situated inferior to the iliac crest, and overlying the femur, or “thigh bone”.

Fig. 26: Anchuy Wasampi



(Photo Pribyl 2009)

5) Piki Chaqui

As a noun, the word *piki* refers to a flow or something of small size, whereas *chaqui* means foot. As an adjective, *piki chaqui* aims to describe the condition of being agile or fluent. This fifth step consists in the correction of the hip region, specifically the pelvic inclination angle. The quiroinka and the assistant each take a leg, simultaneously making a deep flexion and subsequent immediate extension of the two legs of the patient. Additionally, a cervical correction is performed due to the manual decompression of the vertebrae being the patient in the supine position. The *piki chaqui* includes finally the correction of the kneepans or patella.

Fig. 27: Piki Chaqui



(Photos Pribyl 2009)

Fig. 28: Repositioning of the Kneepans Modality 1



(Photo Pribyl 2009)

Fig. 29: Repositioning of the Kneepans Modality 2 with Inclusion of the Talus



(Photo Pribyl 2009)

6) Q'iwiray

The denomination of this technique means “to stir and move nimbly”. The last step consists in the final correction of the head, shoulders, thorax, and hip of the patient. The patient sits on the couch, and is afforded to do specific movements. The assistant stays in front of the patient to observe the position of the different parts that have yet to be corrected. The patient looks straight at the assistant and this tells the Quiroinka the areas to be adjusted. This technique enhances four parts:

- a) Correction of the head with rapid and exact movements;

Fig. 30: Q'iwiray: Correction of the Head



(Photos Pribyl 2009)

- b) Correction of the level of the shoulders. The Quiroinka hold up with the wrist the unbalanced shoulder, whereas with the other hand raises strongly but precisely the shoulder to be fixed;

Fig. 31: Q'iwiray: Correction of the Shoulders



(Photos Pribyl 2009)

- c) Decompression of the back by stretching the patient, who places his arms behind the head with clasped hands. This technique is widely use among recalqueros;

Fig. 32: Q'iwiray: Correction of the Back



(Photos Pribyl 2009)

- d) The Quiroinka presses down the patient's back towards the front to obtain a complete flexion of the waist. This assures that the decompression of previous manoeuvres allows patients' correct motion.

Fig. 33: Q'iwiray: Correction of the Waist



(Photos Pribyl 2009)

The conception that air causes muscles pains has a large cultural tradition among highlanders in Peru. Valdizán mentions that the vast majority of headaches that are not satisfactorily explained with the knowledge of the common people are attributed to air, a blast of air or a casting wind, and are treated by friction of various herbs macerated in alcohol or by the application of sulphur (Valdizán and Maldonado 1922:94). The following short dialogue at the end of a ventosa-treatment for a patient shows the importance of the concept of “aire” (air) to explain and understand some corporal complaints and share explanations about musculoskeletal disorders

Reyna: Some sciences do not recognise or accept the effect of these *aires* percolating the body. And one can feel it. Sometimes, when we open the window, and our body is warm, oneself can feel a tremendous blow in the breast. We use the ventosa and the pain disappears.

Patient Yolanda: Yes, I felt here, on my back, as I had a hole on it.

Reyna: Yes, yes, it feels so

Patient Yolanda: I felt a hole, right over here (shows back) and I could only wrap myself!

Reyna: of course, that was an *enfriamiento*²²⁴.

Apprentices' unison: yes, yes, an *enfriamiento*.

Reyna: The pain travels along the arm, right? The ventosa we use is to correct it (hs2-reyna 2009)

²²⁴ A not unexceptional, but very popular syndrome in Peru in which the feeling to be cold or to be caught by chilliness is present, no matter how often the body is exposed to warm temperature.

Fig. 34: Reyna Applies a “Ventosa” Using a K’ero



(Photos Pribyl 2009)

4.4.1.4 From Q’iwiray to “Bioenergetic Chiromagnetism”

During my first visit in 2009, Reyna attended to his patients in two establishments (*Instituto de Medicina Tradicional, Quiropraxia Inca y Enseñanza Naturamanecer Ancestral*) in urban and semi-rural areas of Lima. He shared his office with an MD in a district in Lima’s downtown area, in a private medical centre. His other office was located in Végeta. At that time, Reyna argued that he did not implement any “mystical” or “religious” elements in his practice since he considers his methods scientific and efficient, and adequate for all people, regardless of their cultural backgrounds

Fig. 35: Reyna’s Place of Work in 2009 in Lima



(Photo Pribyl 2009)

Our medicine shall get internationalized, but with a methodology that can be used in any part of the world without problems.... but to do this, it is necessary to “polish the thing” because there are people who say to me “why don’t you put the sun, and neither you adore it and do not make pagos to the earth?” These are questions that are well in

the persons who can offer it, but not in a place where you are going to practise with all kinds of persons, with all kinds of religions... in a manner of speaking, at a cosmopolitan level... I cannot put here figures or anything like that because patients should feel comfortable (Reyna iw/2009, hs3-reyna 2009)

One year later, he changed his office location in Lima to another building in the same district. It was in turned into a full-fashioned “Inca” style, with colourful restyled ceramics, tapestries, upholstered walls, and figures alluding pre-Inca and Inca cultures. As I visited his new office in 2010, I was wondering which situations would have influenced in such a decisive way as to this new tendency in Reyna’s setting style.

Fig. 36: Reyna’s Place of Work in 2010 in Lima



(Photo Pribyl 2009)

In 2010, I was invited to observe and participate in a new technique created by Reyna, called *quiromagnetismo bioenergético* (bioenergetic chiromagnetism). The widely used concept of “energy” was now present in his techniques, understood as a central element of a “human energetic field”. In relation to this technique, Reyna says that it was originally inspired by his observations of the *soba del cuy* and its benefits for human well-being (hs4-reyna 2010). The first step of the technique consists of placing stones, plants and minerals –in closed decorated magnetos– which after being electrically charged are positioned on specific parts of the body to detect the general and specific energy level of the patient in each region. The function of the magnetos is to restore and redistribute the energy over the body.

Fig. 37: Magnetos



(Photos Pribyl 2010)

The energetic poles are selected on a seven-point body map, in which the centres are identified at (1) the eyebrow point (caudal third ventricle), (2) pharyngeal plexus (throat, cervical point four); (3) cardiac plexus (behind the heart, thoracic nine or ten); (4) celiac plexus (Navel point lumbar four), (5) hypogastric or lumbar-sacral plexus (genital point sacral four) and (6) and (7) the palms of both hands (Fig. 38). Despite the quasi exact correlation of these centres with those of the chakra system²²⁵, Andean Medicine also counts some concepts to locate energy centres in the body, such as the *ñawis* (chakras) or the *ceques*, which are energy channels on the body or terrestrial lines connecting with each other similar as the *wakas* or sacred places in earth do.

I have done what is called the “synergism” in chemistry. I have joined the properties of plants and minerals and have praised it with the use of the magnet. The effects are wonderful. If you have a problem of the liver, it goes to the liver and begins to discharge...And the patient recounts it... we consider that the energy of somebody does not come into you and make you bad. The problem is not that the energy comes into you, because the organism is a self-regenerated system, nothing bad can occur... the problem is that someone can extract the energy from you. This is described in the bible. Jesus was with a multitude, and a woman who was bleeding touched his clothes; and without seeing her, he said, “someone has touched me”. He felt how someone took his energy. It is the same with us, people who only by watching you caused the *mal de ojo*, or *susto*. Your energy can leave you, and the rest turns to distribute on your body. This technique helps to create, to increase or regenerate this energy, and to distribute well on your body (hs1-reyna 2010)

²²⁵ Following the Hindu yoga tradition these centres are: (1) *Ájiná*; (2) *Vishuddha*; (3) *Anáhata*; (4) *Manipura*; and (5) *Svádhist'hána* (Maxwell 2009:810). I have not found similar centres for the hands in other traditions. But, coincidentally, Feuerstein writes that yoga formulations typically describe seven chakras. He defines them as “psychoenergetic vortices forming the major “organs” of the body composed of life energy (prana)” (Feuerstein 1997:68).

Fig. 38: Disposition of the Energetic Poles and Magnetos



(Photo Pribyl 2010)

The second part of the technique, i.e. the imposition of hands, is intended to work ensuring the etheric body, by mobilising the amount of energy alongside it, with the corporal physical space. Anyway, the technique seems to me to have a deep influence of non-traditional hand-healing and contemporary new age energetic methods, such as reiki. It is possible to recognise some of the typical movements of reiki, in a sort of healing hands or reiki schema revisited or “Incanised”.

Fig. 39: Imposition of the Hands in the Quiropraxia Inca



(Photos Pribyl 2010)

In prior periods of his work, his techniques were principally oriented to pain relief and setting straight bodily segments such as bones, muscles, tendons, nerves, and organs inclusively, at a prior and exclusively physical level. In this case, it is interesting to note that this new technique introduces a concept of “wellness” in Reyna’s approach, in which other kind of ailments such as stress; emotional suffering and burnout are strongly represented. Nevertheless, according to Reyna, this technique is also appropriate to be used in cases of patients presenting *lumbalgias* (spinal pain of different etiology) or *ciática* (inflammation of the sciatic nerve).

This energy is provided through the minerals, because we are part of the earth, made by earth. We have iron, magnesium, and copper. So, we need these minerals to reactivate through the minerals themselves. The plants also absorbed these minerals. All this energy is what we transmitted with this energetic multiplication. And the effects appear immediately. I have had reiki masters as patients. They called me as an emergency. One was very bad, she went too pale, dropped in blood pressure, with nausea dizziness, vomiting. I took the minerals and distributed all of them over her body– I didn’t do any manual therapy. After 15 minutes all was back (Reyna iw/2010)

In the case of Reyna, much of the last changes observed in his practice a year later, his overflowing presentations on the media and presence in social networks in the internet, the rapid acquisition of new techniques with clear new age influence and the re-accommodation of new work places and additional training and treatment offers are possibly explained by the typical acquisition pattern of bonesetters. One would think that these changes are due to the influence of the city and modern life style in globalised urban centres. Anyway, bonesetters’ itineraries in the development of mixed techniques are not specific for urban curanderos. Oths asserts that *componedores* in the Andes “employ various styles of treatment and often mix bone setting and manipulation with other therapeutic modalities in their quest to heal patients” (Oths 2004:205). The author wants to see in these variations on treatment styles a product of “self-teaching, born of the inconsistent manner of recruitment into the profession” (Oths 2004:205). Other authors, as Kleinman (1980) and Hinojosa (2002) argue that bonesetters incorporate different techniques in order to improve their efficacy, without ulterior concerns about their “purity” or consensus with local cultural traditionalism.

In 2011, a religious and nationalistic discourse gradually found a secure physical place in Reyna’s work setting –previously sceptical and frugal– and also among his

techniques. In the case of Reyna, the principal changes in his work style are also explained by the influence of the state's activities trying to use THPs to promote mystical tourism, not structured within a comprehensive legislation and management of TM and THPs. The influence of some governmental institutions promoting and benefiting from mystical tourism in the country has a long story– always without an official regulation context of the practice of THPs.

On 10 March 2011, the ministry of culture of Peru (MINCETUR) and the *Comisión de Promoción del Perú para la Exportación y el Turismo* (PromPeru) presented a new campaign called “Marca País Peru”. This initiative should represent Peruvian culture and promote tourism, exports, and investment in the country with the objective to gain position in “the minds of key audiences as a distinctive country at the global level” (PROMPERU 2012). In 2012, the brand was recognised by means of a governmental supreme decree as the Peruvian government's official trademark. For grant seekers, who have to undergo a selection process to obtain the permission of use of the brand in their establishments, advertisements, and services²²⁶ the brand does not per se have an additional legal value. Reyna says to this respect, that his principal interest to obtain the brand was because of the possibilities to expand his knowledge to other markets, to obtain a partial recognition of his work, and at the same time to guarantee the protection of national cultural heritage (ec/2012). The financial support for him, for the organisation and participation of congresses and encounters was also afore-mentioned by this instance, but his expectations remained unsatisfied. Anyhow, this legally unallocated governmental initiative, which might offer healers a substitute opportunity to promote their services in a relatively affluent environment, is restricted to the touristic demand and does not attest to his original interest in the population's care.

²²⁶ See e.g. the activities of an ayawaskero from Pucallpa who gathered also the license to use the brand “marca pais peru” at: <http://www.ayahuasca.com.pe/>.

4.4.1.5 Reyna's Integration Approach: Healers' Education

The documented case of this healer is of particular importance due to its alternate failed strategies to obtain a recognition from the state, which in many occasions derived in a – for many health practitioners– disputable form to promote his work beyond the official and institutional conventional paths²²⁷. A central cluster of Reyna's discourse argues passionately for an official recognition of bonesetters by the state. In Reyna's point of view, a way to obtain the legalisation of bonesetters is to complete specialisations and undergo studies at university level.

I think that a bonesetter should be legally registered. But they must study. The universities should open their doors to the bonesetters. And this should be accepted as Peruvian traditional medicine, and not as they do with other medicines from abroad. This is important to prepare them in what is still missing. This can be reached not only at universities. Also in health centres, there are places, there are doctors, and without spending more money, only using the existing infrastructure of the state. There are many doctors already working in naturopathy or in complementary medicine. But it is necessary that anyone who practises TM also has medical knowledge... Hueseros have more knowledge, more capacity, but they don't have the opportunity to make studies, to make the thing more scientific, to get a diploma availing that this person has studied, has done training, and is good in this field. These serious things should be promoted, but it must be established a commission to evaluate the persons who might be considered as traditional practitioners. The recognition of traditional medicine is very important. The community must recognise that these persons have worked for many years, and what they do is on benefit for too many people. All the practitioners of TM should also get this formation (Reyna Mercado iw/2009).

For Reyna, the integration of TM in the HCS is only possible through the implementation of training and education programmes for THPs. Reyna does not consider as part of TM what he calls “folkloric medicine”, which means the work with sorcery and elements that are not part of the cultural heritage or traditions of the country such as candles, Catholic saints, etc. In the case of integration, he argues for the implementation of a careful selection process of those THPs who work with recognised THS (parteras, hueseros, and naturists, for instance). For him, TM constitutes a possibility to enhance (as a complementary medicine) the efficacy and coverage of Western biomedicine in the country. Accordingly, he participates with assiduity in congresses and academic meetings in the country, showing his techniques to health authorities, health professionals and MDs.

²²⁷ Several of his home-made videos of treatment and interviews can be found on video-sharing web sites like youtube.

We are the complementary part for the doctors. When allopathic medicine does not work anymore, we come to help and support. That's the reason we are part of the complementary medicine. We are not better than them, I have studied medicine at a university, I value that, I had wonderful teachers there... worldwide there is complementarity, there are places where the medical doctors and the complementary medicine work together. In ESSALUD there is a programme on complementary medicine, also in the Hospital Maria Auxiliadora, they do it very well (hs3-reyna 2009)

His relation to MDs shapes a confliction on the part of the doctors, who acknowledge his traditional techniques, but criticise at the same time his use of the title of MD.

Blessedly I have many MDs as patients. I have cured a good friend from school time, Dr. X²²⁸, he's a neurologist working at ESSALUD (Reyna Mercado iw/2009)

Although mostly based on TK and traditional manual therapy, Reyna has registered his techniques as a patent to avoid the appropriation by third parties. His ultimate goal is the internationalization of these techniques for a wider public, without any cultural, magic or religious connotations (hs3-reyna 2009)

I must register the *quiropaxia inka* at INDECOPI like a copyright²²⁹, because this is increasing at an international level. There are people coming from Argentina, Mexico, USA, etc. seeking to cure themselves and to learn this technique... This is like oil spilling out on paper, it will extend more and more, and I should protect the property of this country, because osteopathy was born in our country (Reyna iw/2010)

I consider Peruvian TM of an incomparable richness due to the natural pharmacy we have in the Andes and Amazonia. If we had a vision of all that we can build up with this knowledge in relation to health, economy, and the positioning of ancestral knowledge, I am sure that Peru could be one of the principal countries to export medicinal plants like China or India... I only hope to see the law of traditional medicine before I die (hs2-reyna 2009)

Since the establishment of his consultation practice in Lima in 2005, Reyna teaches his techniques within a one-year training programme called "formación en Quiropaxia Inca". This is a formation that is still awaiting approval by MINSa and the Ministry of Education MINED to reach the status of an accredited formation. There are no major requirements to join the programme; though most of the apprentices are already

²²⁸ Although I have personally read the hand-written thanks letter from this MD, in which he acknowledges Reyna for his "own cure and successful treatment", when I called him for an interview he rejected upset, arguing he did not know Reyna (fq/2009).

²²⁹ It is not a copyright, but a patent. See: Patent nr. 09-379574 "Manos peruanas curan quiropaxia inca" giving to Iván Reyna Mercado at <http://www.rubiolawyers.com/userfiles/Peru%2020090228%2002%207%2009.pdf>.

chiropractors or have experience with bodily therapies and are “at the search for more effective techniques” (Vela iw/2009).

He had recovered all these manoeuvres from the traditions, he took them nearby medically, scientific, and convincing. That is the big merit that he has. I devote myself a hundred per cent to learn and dominate these skills... Dr. Reyna has an immense scale of manoeuvres, which are not only placed on the back but any problem that is subordinated to the spine. These techniques are good, that's why I do it every day (Quiroinca apprentice iw/2009)

Fig. 40: The Inca Chiropractors



*Some members of the second training group of Quiropraxia Inca
(Photo Pribyl 2009)*

The formation includes theory and practice hours under the supervision of accredited MDs with complementary participation of the apprentices in *campañas de salud grauitas* (health campaigns) in Lima and provinces. Under the supervision of Reyna, his apprentices themselves apply the techniques that they have learnt up to that time. Additionally, each apprentice should undergo himself the therapy to corroborate its efficacy or application. Currently, almost 70% of his apprentices are Peruvians, and 30% foreigners (Ecuador, Mexico, Spain, Switzerland, Italy, etc.). By the year 2012, 50 people have completed this formation (Reyna ec/august 2012).

4.4.2 *Con Ojos de Ver*: Jorge Hierro and the Guinea Pig

My aunt showed me some aspects, but other things I already knew. Besides that, I have a gift. I have an “ojo de ver”. I had a vision, as a seer... It is a gift that perhaps God gave me; I can see the spirits. I had this eye to see (Hierro iw/2009)

4.4.2.1 The *Limpias*: An Undervalued Healing Method

The *limpias* or purification rituals are widely used first intervention techniques that occupy an important place among THS in Peru. These different types of proceedings include a principal diagnosis and extracting or purifying function. The process is mostly accomplished by a sacrifice, oblation or disposal procedure, completed with a *florecimiento*, a cleaning and purging process. Besides the use of animals, some of the times these procedures use an add-on of minerals, plants, and vegetables, representing harvesting and the human connection to earth's elements, following the reciprocity principle surfacing in Andean cosmology.

Fig. 41: Qaqoy or Limpia con Aji²³⁰



*The curandera Tina González interprets the roasted chilli to a client after a rubbing session.
La Victoria District, Lima (Photo Pribyl 2009)*

²³⁰ Little research has been taken upon about the traditional “limpia con aji”, a technique used in the Andes and the coast of Peru, which is tending to disappear. The procedure consists in scraping the body with the Peruvian yellow chilli pepper (*Capsicum baccatum*). It is usually accompanied by other procedures to cure the *susto*, but above all the *ojeo*, which is unintentionally caused by the personal (immaterial) or natural (material) characteristics of a person who faces a baby or child. The affected child cries constantly, has no appetite, and looks sad and sick. It is usually interpreted as a (temporal) lost soul. González Holguín mentions this syndrome as the *Huañuyta kahuapayani* or *piñapiñacta kahuaycuni*, which means “looking at somebody with a bad eye or angrily” (González Holguín 2007[1608]:107, t. sp. qe.). Delgado affirms that the *ojeo* could also be produced by some nature spirits (*Orcco*) or things and actions made by humans called *wasi* (Delgado Súmar 1999e:8).

The use of animals with healing purposes has a long history among traditional healing systems. A specific group of limpieas originated from Andean ritual traditions employing the use of animals as a principal element to envoy the healing process. The use of the *cuy* (guinea pig) with healing purposes is one of the most popular limpieas in the coastal and Andean regions of Peru since pre-Hispanic times.

Table 7: Limpias in Peru

PHASE	RESOURCES		USES	
Diagnosis	<i>Watuy</i> discover	Egg ²³¹ , chilli pepper	<i>Jobeo / jubeo</i>	<i>Massage</i>
	<i>watukuy</i> investigate	white Alum (<i>aluminium sulfate</i>)	<i>Qaqoy, Qollpasqa, Collpasqa, Kollpasqa</i>	<i>scrubbing</i>
	<i>Maskay</i> search <i>rastreo</i> exploration	Guinea pig	<i>Qaqopa / Jank'u Yati / Uywacha</i>	<i>rubbing</i>
Healing	<i>Jampiy, Alliyachiy</i> curing	Animals and fats (pig, llama, alpaca)	<i>Qaqopa</i>	<i>friction</i>
	change	Egg	<i>jobeo</i>	<i>rubdown</i>
		Guinea pig, dog, hen, pig, cat (black), and snake	<i>Muda/ Mora/ Mura/ Uywasu Jojopa</i> Change or cleaning with animals	<i>Scrubbing, friction</i>
Offerings	Egg, animals, guinea pig , fat, minerals, coca leaves, flowers, fruits, corn (white), seeds, beans, etc.	<i>Paqapu</i> <i>Qosnichisqa</i> (after <i>turqasqa</i>)	<i>Pampay bury</i> <i>Drop</i> <i>plaster/ unguent</i>	

Partially based on Delgado Súmar's compilations (cf.1999b)

²³¹ Sp. *Limpia con huevo*. A possible origin of this ritual technique is in Spain. Different from the guinea pig, eggs are principally utilised in children for the treatment of susto (q. *Wawa Mancharisqa*) (cf. Delgado Súmar (1999a:11).

The cronista Calancha mentions the use of the cuy in the context of major religious ceremonies: “The sacrifice to the sun, to pachacamac and Viracocha. They had a celebration for them once a month, offering silver, gold, rams, cuyes, a drink of them made of mais called chicha as the malucos, Japanese and kingdoms of India... the ninth month calls Yapaquis; here they behead brown cattle and thousand cuyes, so the ice, air, and the sun do not damage their sown fields and multiply them. This was August” (Calancha 1639:f/49/51, t. sp.). Also Cieza stresses the principal role of the cuy in religious ceremonies among the Incas. Together with lambs, sheep, and pigeons, guinea pigs were brought to Cuzco and killed for sacrifices: “And having slit most of the cattle, they coated then the statues and figures of their gods or devils, and the doors of temples and oracles with their blood. After a while, the diviners and foretellers looked in their entrails the signals, as the gentiles, announcing what they wanted; for this they were given much credit” (2005:368, t. sp.).

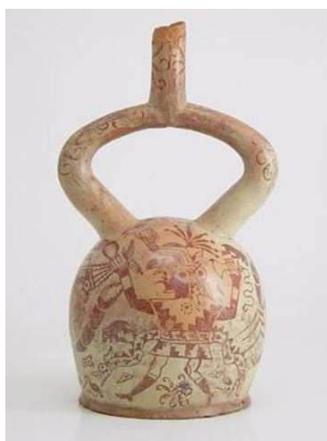
The utilisation of the guinea pig as a divinatory technique has been widely described among the Cronistas. Arriaga recounts that in the celebrations of the Huacas, the indigenous people went to “confess their sins by the sorcerers, the ministers of idolatry, and when they are sick or on other occasions some jobs happened to them, the sorcerers washed their heads with a pebble they call pascas or with ground corn, killing a guinea pig, and seeing by the blood of the bowels certain signals where they guess future things” (Arriaga 1920[1621]):199, t. sp.). Arriaga mentions the *hacaricuc* or *cuyricuc* as a specific profession among the Incas. These specialists have been born commonly through the breech birth modality, known as *chacpas*, “quando nace alguna criatura de pies, que llama Chacpas” (Arriaga 1920[1621]):57). This specialist

looks at the cuyes, opens its body with a fingernail, looking the direction of the blood, or which part of its guts is still moving... The ordinary sacrifices of cuyes, which serve the evil, are not only for the sacrifices and offerings, but to foretell through them, and to heal with thousand frauds...when they sacrifice them, sometimes they open them in the middle with the thumbnail; other times -as I saw by two wizards who were examined by Dr. Ávila- they drown them in a water pot, putting the head inside until they die, whereas they talk with the Huaca, and then they open them with ridiculous ceremonies. This is the ordinary way how they killed them by those who prophesy with them (Arriaga 1920[1621]):35-44).

The guinea pig (*cavia aperea f. porcellus* or *cavia cobayo*), is a rodent species from the family of the caviidae. It is the same animal that appears in the crónicas of Gonzalo

Fernández de Oviedo with the name *cori* (Fernández de Oviedo 1851-5). Garcilaso says *coy* to it, using the northwest Quechua dialect of Cuzco (Garcilaso de la Vega 1976[1609]: chap. VII:350, chap. XVII:432). Molina always describes it in plural as *cuyes* (Molina 1873[1576]:85). The Guinea pig is usually known by the name of suckling pig of the Indias, and is native of South America, where, however, it has as yet not been found in the wild. It is in the Peruvian cultures where the guinea pig has reached the maximum technological development as upbringing for domestic consumption; it has been demonstrated that the process of domestication of the guinea pig started at least 4,500 years ago (Lewejohann et al. 2010)²³².

Fig. 42: Cuy



Ceramic of the Moche culture (early intermediate period 200 BC - 600 AD) with pictorial representation of a combat between the Moche god Aia Paec with an anthropomorphic character. The cuy is represented in the left side (Photo Museo Larco ML003614c- 2011)

The cronista Acosta mentions the cuy as an important domestic animal among the Incas: “They are in the highlands of Peru, where also there is another very common odd-looking animal they call cuy, which the Indians consider as a very good meal; and in the sacrifices they use to offer very often these cuyes. They look like little rabbits, and have their dens under ground... Some of them are brown, other white” (Acosta 1894[1590]:438, t. sp.). The Incas already acquired by assimilation of the previous

²³² Information on parenting and domestic ritual use of guinea pigs has been found in archaeological ruins. See e.g. Jiménez Borja, Arturo. 1988. *Puruchuco*. Lima, Peru: Serie Perúlibros, Biblioteca Nacional del Peru and Sociedad Paramonga, p. 28-31; Larco Hoyle, Rafael. 2001. *Los Mochicas*. Lima, Peru: Museo Arqueológico Rafael Larco Herrera, vol. 1, p. 53-61.

cultures a technology for cuy's domestication that continued as an obligation to complete the diet of the indigenous population²³³ (INIA 2004).

In contrast to the nutritional and economic benefits of the domestication of the cuy²³⁴, there are only few studies about the healing aspects involved in the *limpia con cuy*. The contributions in this respect are mostly related to descriptions of techniques in specific cases managed by healers: E.g. Gushiken (1979:40-42) and Sharon (1978:75) described the use of the guinea pig (*limpia con cuy*) by the same curandero Eduardo Calderón, the first for the cure of mental disorders, and the second giving weight to its use against *daño*. Molina (1984) describes the use of the cuy made by the curandero Hermógenes Miranda “*pato pinto*” in Pacasmayo (La Libertad) (p. 348-350,374-375,381-384). Other authors have approached the technique as one of the principal healing methods used in Peru. Frisancho (1968:74-76) describes the *Jank'u Yati* in Puno as the “x-ray of the aymaras”; Camino (1992) writes about the “*caypa del cuy*” in the treatment of *susto* in Piura; and Andritzky (1999:173-184) describes its use in the context of the work of an urban curandero, citing historical and archaeological sources. The *limpia* or *soba con cuy* has also been mentioned in the context of diverse techniques (cf. Valdizán and Maldonado 1922; Chiappe et al. 1985; Polia 1994a:47, 1988). Valdizán talks about the *Hacaricuc* or *cuyricuc* (1915:86), who performed these activities; afterwards, in his *Historia de la Medicina*, he offers a description of the *cavia cobaya cuvier* in its different regional Quechua and Aymara denominations –such as *ccoui*, *ccuy*, *acass*, *huanko*, etc.– and the principal mentions he found by the Cronistas (Valdizán 1944:523). In the opinion of Cabieses (1993a:66), healing with the guinea pig constitutes a divinatory archetype called the *callpa*, and constitutes a repetition of “similar ceremonies existing in Mesopotamia and the Etruscan medicine”. His observations borrowed what is described by the Crónicas of Arriaga (1920[1621]) and is not based on systematic field research observations: “The most important part of the sacrifice was to discover if the *cúnchur* has accepted him or not; and this was deduced from certain signs that showed the livers and the bowels of the cuy sacrificed. For this,

²³³ Publications about the production, commercialisation and nutritional parameters for cuy consumption in Peru can be found at: <http://www.inia.gob.pe/documentos/cuyes.asp>.

²³⁴ The guinea pig was declared part of the cultural heritage of the nation in 2005 (law nr. 28477). See: <http://aplicaciones.indecopi.gob.pe/portalcopi/archivos/docs/legislacion/104-2005-1/28477.pdf>.

the priest will travel along with the nails of the fingers of both hands the skin and the belly while it was still alive, and he blows then with the mouth. If the inspection of the entrails of the victim showed a favourable omen, everything was finished and there was no more to be done, but if the bowels of the victim were dumb, the sacrifices were renewed without term, until finding a definitive answer. The priest was so able to discover which god was angry, and immediately took one of the stones with the dusts of colours, and blowing in the direction that the supposed irritated deity was in” (1993a:145, t. sp.).

The use of the guinea pig for nutritional, religious, and healing purposes is, undoubtedly, a tradition that has been practised since pre-Hispanic times (cf. Acosta 1894[1590]:379; Polo de Ondegardo 1907[1567]:197-198; Cobo 1964[1653]:II:306; Basto 1977:93-117). The popular preference for the guinea pig as one of the favourite *limpia* elements lies in its traditional use as a domestic animal for human consumption, but is at the same time due to the assumption that it possesses exceptional absorption properties²³⁵. Valdizán describes multiple medicinal applications of different parts and products of the cuy (e.g. head, entrails, penis, fat, blood, bile, urine, excrement, etc.) and meals prepared with the whole cuy, or some parts, to combat the *tabardillo* (typhus), headaches, liver infections, laryngitis, depletion, *irijua*²³⁶, etc. (Valdizán 1944:525-526). The use of the cuy in the treatment of *susto* (*Manchariska* or *jabjaska*) has a special importance among the existing literature. The most detailed studies of the *soba con cuy* were delivered by the psychiatrist Sal y Rosas (1972a:250-260, 1964) in relation with the diagnosis and treatment of *susto* and epilepsy. According to Sal y Rosas (1964), the cuy is loaded with the interfering evil spirit through the *soba* or “*rantin*”, which is afterwards carried to the belonging *huaca* and released there. Sal y Rosas mentions that this ritual enhances a high value and “psychotherapeutic efficacy”, considering it as an

²³⁵ Dr. Víctor Reyna –principal professor of organic chemistry of natural products (phytochemistry) at the *Universidad Nacional de Ingeniería* in Lima– made the first empirical approximations to demonstrate the effectiveness and healing properties of this traditional technique (cf. Reyna 2002). His fascination with this healing ritual began twenty years ago with his friendship with the famous healer Salomón Melchor Arroyo (cf. Arroyo and Reyna 1994), whom Hierro has worked for. Andritzky had also published an ethnography about the work of Salomón Melchor Arroyo (Andritzky 1999:64-67, 179-183) –although he names him Melchior Salomon.

²³⁶ This disease attacks children whose mother saw a dead man during pregnancy. The symptoms are sadness, weight loss, diarrhoea and vomiting (Delgado Súmar 1985:9).

“irreplaceable” ritual in curing *susto*: “its action is superior to that of the official medical doctor, who cannot penetrate the indigenous spiritual world as the *jampek*²³⁷ does” (1970:255). Forty years later, Maguiña²³⁸ corroborated the efficacy of the *soba del cuy* as diagnostic tool, but emphasised the role of science to explain this phenomenon: “We were surprised when we saw the two lungs of the *cuy* with hemorrhagic lesions. It was a surprise for me, and even nowadays it continues to be a mystery. During the 25 minutes of the *soba del cuy*, the *curandera* made no manoeuvre of trauma or blow on the animal... Still in Huaraz, we talked with another colleague doctor who told us about another patient with a severe abdominal pain: another healer was able to diagnose an intestinal obstruction by applying the guinea pig, which was confirmed when the patient was operated in the hospital of Huaraz... That night the students and I, anxiously, talked and speculated about this phenomenon. How could it be possible that the *cuy* served as diagnosis for the patient’s disease? Were Inca healers right into use this therapy? Was this a fluke or a contingency? Was it a manipulation of the *curandera* to deceive us? In fact, we have no explanation for this event. Only science and medical advances might explain this famous “*cura o soba del cuy*” (Maguiña 2005:44-46, t. sp.).

Delgado Súmar (1999b) indicates two different types of functions to the guinea pig ritual. In the first case (diagnosis) the procedure is named *Qaqopa*, *Jank'u Yati* or *Uywacha*, which is just exclusively made with a guinea pig. It consists in rubbing by continued friction the body of a person to obtain information about the persons’ illness and the exactly affected organs through the examination of them in the animal. In the other section (healing) called *Muda*, *cambio* or *limpia con animales*; *mora*, *mura*, *uywasu jojopa* or *pagapu*; *huyhuachay* or *Jubeo*, a technique in which the body of the patient will be rubbed with a living animal, generally a guinea pig, a dog, hen or pig (in some cases also a cat or snake), preferably dark, with the purpose to clean the evil from the body, achieving that this goes from the person into the animal. The animal is used at the end as part of an oblation or offering (*ofrenda*); hereafter it will be offered to the Andean deities through the *Paqapu* ceremony (1999b:9). Van Kessel (1983:170) notes that this ceremony is also known as “*pichka*” or “*trucakha*” (from touching) in the

²³⁷ Yatiri (aymara healer) specialist in the treatment of the *manchariska* (*susto*).

²³⁸ MD specialist in infectious, tropical diseases and dermatology. Until 2011 he was National Dean of the CMP.

Aymara region. However, the word *turqasqa* (from *turqaña*, change) is the aymara expression for a healing ritual consisting in the transfer of the illness from the human to the animal body, commonly a little animal such as a cuy, a cat or a dog, in which the sick person is rubbed with the animal.

The practice consists of lightly passing or rubbing over all parts of the body of the patient with a healthy guinea pig. Oths mentions that the animal extracts or pulls the sickness (*jala la enfermedad*) out of the patient into its own body and dies (1992:79). Reyna defines the *soba o limpia con cuy* as a diagnostic and healing procedure carried out by rubbing the whole body of the patient with a cuy, sacrificing afterwards the animal to examine its organism (2002:3). The procedure is similar to an x-ray examination: The animal is believed to be so sensitive that it will absorb patient's disease, causing the illness to be imprinted on the identical body part of the guinea pig (cf. Chiappe, Lemlij and Millones 1985). Reyna enhances this opinion and adduces that the guinea pig rubbing does not operate as an x-ray, rather as a tomography, because it offers three-dimensional high-dynamic pictograms of the inner organic condition of the patient (Reyna iw/2009).

Valdivia stresses the personal intuitive and visionary abilities of the cuyricuc over the scan or healing properties of the cuy itself. He establishes an equivalence between the *calparicuqui*²³⁹ or Inca seer with the cuyricuc (Valdivia 1975:30) with the only difference that the former uses preferably birds, llamas or sheeps for divinatory tasks and prognosis in religious contexts, whereas the cuyricuc “has foreseen by looking at the innards of the cuy (cobayo) towards the diagnosis of the disease, and established the prognosis through certain signals he could recognise in them. He carried out the therapy using the same animal; through this contact with the sick, it removes the evil from the patient” (Valdivia 1975:90, t. sp.). Also Reyna asserts that it is not only a matter of the guinea pig in interaction with the body, rather certain divination skills in the curandero's mindset: “In the guinea pig there's a very rational part, but also something that transcends our daily experience. And that is what doctors do not accept” (iw/2009).

²³⁹ Cristóbal de Molina El Cuzqueño writes about the *calparicuqui* as “those who see the luck, venture and events of the things they have been asked for; for this effect they killed birds, lambs and rams, and blow through some vein into their lungs, they find certain signals, by which they said what will be happen” (Molina 1916[1576]:f/044003, t. sp.).

In contrast to other animals traditionally used in the limpieas, the guinea pig can be utilised in all different phases of the treatment, including the ofrenda or *pago*. Like Sal y Rosas (1972a), my classification of guinea pig healing among the limpieas was corroborated by the fact that among the little specific Spanish scientific literature existing about guinea pig healing, the expressions “soba del cuy” (rubbing with the guinea pig) and “limpia con el cuy” (cleaning with the guinea pig) are often found used as synonyms (cf. Reyna 2002; Rimachi 2003; Arredondo 2006). Although the descriptions given are similar, they are not sought to mean the same, i.e. they attested either a diagnostic or a therapeutic function. Arredondo comments on this respect and mentions the *jubeo con cuy* as the diagnostic procedure, whereas the *limpia con cuy* implies the therapeutic process: “In the Andean context, the *jubeo con cuy* is widely disseminated. Sometimes it acquires a diagnostic character when it is used as a sort of x-ray to detect in its interior and exterior the causes of a patient’s disease. In other circumstances, it acquires a therapeutic character through the *limpia con cuy*” (2006:20, t.sp.). Alternatively, Molina asserts that the *limpia con cuy* is, at first, a diagnostic procedure: “Through the *cuy* the healer can determinate which are the evils of the sick and also, the etiology of them” (1984:381).

These distinctions are of particular importance, since among the Cronistas the sacrifice of the animal and the observation of its inner organs with divinatory purposes is described in detail, whereas the rubbing procedure itself –at least during the first years after the Conquista– is not mentioned. These observations could suggest a later inclusion of the rubbing procedure. Anyway, in the archives of the process of extirpation of idolatries there are enough testimonies of the use of the guinea pig with healing purposes²⁴⁰. Basto, based on historical documents and trials of the extirpation of idolatries, writes about those therapeutic methods in which the *cuy* was widely used among Peruvian Andean peasants from the 17th century, including the therapeutic friction or *soba* (1977:93-117).

²⁴⁰ See e.g. a short compilation offered by Reyna (2002:31-32).

4.4.2.2 An Afroperuvian Healer Using the Guinea Pig

The number of scientific studies about Afroperuvian medicine is extremely small²⁴¹. Anyhow, it is important to consider the role of Afroperuvians for the conservation and expansion of Andean healing traditions, and in particular, for the guinea pig healing. There is some historical evidence that supports this denied contribution.

Fig. 43: Jorge Hierro



Jorge Hierro by chewing coca (Photo Pribyl 2009)

In his book *Historia del Tribunal de la Inquisición de Lima: 1569-1820*, the Chilean Historian José Toribio Medina accounts the trial of *Manuel de Jesús* alias *Zaboga*, a seventy-year old African slave from Guinea living in Lima in the 18th century, who was condemned to a mild penitence because of his practices with the guinea pig healing (Medina 2000[1956]:2:258)²⁴². Also in the investigation process against the *cajamarquino* healer Juan Vázquez there is an interesting fact: The healer declares that he was taught on herbal knowledge from his grandfather (Millones 2002:41); anyway, the only mention of his use of the guinea pig rubbing came later, after his stay in Huacho (Chancay, Lima) and his establishment in the *calle Malambo*, in Lima downtown, a place inhabited mostly by black Africans by the 18th century (Millones 2002:25). It is plausible to think that Vázquez could have had contact with guinea pig

²⁴¹ A contribution on Afroperuvian ethnomedicine of southern Peru is delivered by Guevara and Cantoral (2008:50-74).

²⁴² “En cuyas operaciones mezclaba varias cosas y palabras sagradas a los conjuros y santiguos que hacía, valiéndose del sacrílego auxilio de nombrar a los santos, y haciendo señales de cruz con palma bendita, sobre las cuales mandaba que pasasen las personas referidas; a quienes fricaba los desnudos cuerpos, con cuyes (animales semejantes a los conejos)” (Medina 2000[1956]:2:258).

healing through Afroperuvians in this part of Lima, since around 1790, the African population in Lima increased to approximately 40,000 people, which was approximately 50% of the resident population to that time (DEFENSORÍA DEL PUEBLO 2011:36). Furthermore, the neighbourhoods of “blacks” in Lima were demographically heterogeneous, i.e. Afroperuvians, mestizos, indigenous, and members of other ethnic groups have been living together there, and the precinct was considered indeed “black”, because the meanings that characterised them were strongly impregnated by the Afroperuvian culture (Panfichi 2000).

As early as 1547, in the middle of the conflict between the *encomenderos* of Peru and the Spanish crown, a black slave of a Spanish surgeon in Lima was accused of having tried to murder his owner by witchcraft²⁴³ (Nowack 2004). During the investigations, a large network of indigenous residents in Lima practising various forms of “magic” to heal their clients, to solve problems and conflicts in their daily life, but also to damage their enemies was discovered (Nowack 2004:205-210). The lawsuit documents show how people of different backgrounds were able to participate in magical practices and share certain religious beliefs in spite of the different ethnical origin of the involved and their religious concepts.

Another similar case has been studied by Arrelucea (1997). Francisco Duran, known as the “*amantísimo*”, was a *cimarrón*²⁴⁴ born in Piura (northern Peru). He practised the curanderismo in Chilca and Calango (Province of *Cañete*, Lima). He underwent a judicial process (AGN 1778) in the village of Mala, near the city of Chilca, around 1788 due to possession of weapons (Arrelucea 1997:151). There are several interesting facts in his life. In Pisco (department of Ica) he served as an assistant for a Spanish doctor, making contact with biomedical medicine and secretly read medical books and learnt how to make medicinal drugs with herbs and fire water. In Chincha (department of Ica),

²⁴³ The terms witchcraft and sorcery are used almost as synonyms, but they could be differentiated according to their practice spheres and their connections with religion. Witchcraft surrounds more private and routine religious practices by invoking animistic beings or supernatural forces, whereas sorcery refers more to clandestine and hidden practices not always related to religion –or by abjuring it. Anyway, both have been applied to defend against or to eliminate (real or imagined) dangers. In the 16th century all practices –magical or not– associated to religious practices different from the Catholic were considered, and persecuted, as the same (cf. Millones 1998:87-96; Glass-Coffin 2002:129-131).

²⁴⁴ A black slave who escapes from his proprietor and lives clandestinely as a bandit.

he settled as a curandero, where an indigenous woman from there taught him to pray and to rub with the guinea pig, both built-in Andean ancestral practices. Afterwards, he moved from Chíncha to Mala. Francisco was an outstanding herbalist, a priest –he touched the patient with an iron crucifix– and devoted to cure illnesses like stomach-aches, rheumatism, wounds, and *juegos*²⁴⁵, as well. When he treated “witchcraft” he used the *misas de salud* (masses to recover health) as main therapeutic resource, and also the black guinea pig to extract physical pain (Arrelucea 1997:157). Arrelucea concludes that Francisco was a cultural agent due to his practical and effective knowledge; although it was something unusual in the Andean life, this knowledge allows him to be accepted among the indigenous people: “Both Francisco and the indigenous people of Calango and Chilca found a coexisting bond through the curative practice” (1997:156, t. sp.). In his analysis of this case, Guevara (2008:63-64) asserts that Duran did not maintain cordial relations with their Afro peers, still its clientele were mostly Andean, “perhaps due to his condition as a cimarrón, a quality that would compromise the positions and personal prospects of liberation of their counterparts”. It is also noteworthy, Guevara continues, that he was accepted by the Andeans, because “the so-called Indian peoples were distinguished by closing the doors to other castes, mainly to the enslaved Africans, with whom it was strictly forbidden to establish any kind of relationship” (Guevara 2008:64, t. sp.).

Although it would appear contradictory, black and indigenous people were the two ethnic groups who become more mixed in the coast of Peru. The historian Jesús Cosamalón shows that between 1795 and 1820, in the parishes in Lima with the highest concentration of black and indigenous population as San Lázaro (district of Rimac) and Santa Ana (Barrios Altos), the marriages between black and indigenous people were quite significant and, above all, a relationship easily accepted (Cosamalón 1999). Probably, the experience of everyday life in the same neighbourhood greatly facilitated this type of inter-ethnic unions. Anyhow, in the case of the *amantísimo* cited here, the fact is that his relationships with the indigenous people were special and meaningful, and he became a special trans-user of different medical traditions of his time.

²⁴⁵ This expression is used for ailments or misfortunes that are results of sorcery.

In their roles as slaves working in cotton and crop fields on the coast, and as domestic servants in the *casa haciendas*, the Africans have had a “privileged” ethno-medical position in accessing both the curative knowledge of Spaniards and indigenous people, as well (cf. Mariátegui 1995:46). The principal African ethnic groups introduced in Peru since 1526²⁴⁶ belonged to the Sudanese and Bantu linguistic groups. Until the 19th century, they were transferred to Peru principally from countries such as Senegal, Gambia, Senegambia, Guinea and Cape Verde (Cajavilca 2005:376). Interestingly, the contemporary Senegalese healers use the same diagnostic technique as guinea pig healers do. They rub the body of the patients with a hen to transfer the illness from the afflicted onto it, afterwards kill the animal, and then open it to observe the condition of the innards to give information about the patient’s health situation (Prinz 1994). Moreover, after this African *limpia* is completed, the patient should take a bath and offer the guts of the hen to the *pangool*, which are the Senegalese spiritual beings (Prinz 2001).

4.4.2.3 Hierro’s Conditions of Work

Hierro lives in a picturesque *quinta*²⁴⁷ in *Jesús María*, a popular district for lower middle class people in Lima downtown. He works in his home, in a small room specially conditioned for that in the second floor. Only patients with difficulties to go upstairs are attended to in his living room.

Hierro himself does not publicly advertise his work²⁴⁸. His patients came to him through recommendation from other people who had been attended to by Hierro mostly from the coast, specifically from Lima, southern and northern Peru. He attends to on average 12 people a day and, according to him, from all social classes and cultural backgrounds. The cost for a treatment by Hierro is 60 to 100 soles per session (between 23 and 39 US\$). Special treatments such as *paqapo* ceremonies or the removal of *daño* cost from 200 to 300 soles (about 77 and 117 US\$).

²⁴⁶ Del Busto (2001) states that the black presence in Peru is in 67 years previous to that of Spanish whites in 1532.

²⁴⁷ Lat. *quintus*. In the 16th century, a house located in the field for which the settlers used to pay a fifth (*quinta*) of the harvest. In Peru it is the set of houses built on lots of exclusive use, with access through a common area or directly from the public highway. When habited by poor people, such buildings are denominated “*quinta*”, whereas upper-class Peruvians live in “*condominios*”.

²⁴⁸ The only advertisement of Hierro is found online in a blog with conference posts (last update 2009) of the investigations of Victor Reyna on his work. See: <http://curacuy.blogspot.co.at/>.

Fig. 44: Hierro Attending to a Woman in a Wheelchair



(Photo Pribyl 2010)

In the past I had more patients. But now I'm working with appointment, more quietly. Now it's better. I feel more calm and restful. I say, come to me at such an hour, so I have your appointment separate; or when they say señor Jorge may I go within half an hour after, or one hour after? There's no problem with that, because I already have reserved the appointment. They do not need to wait long. I now attend to 10 to 15 people, from Monday to Saturday. I work sometimes on Sunday, but only in the morning, because I should rest in the afternoon (Hierro iw/2009)

Fig. 45: Hierro's House



*The healer's house is at the end of the quinta's entrance, on the right side. A Catholic altar consecrated to the Christ of Pachacamilla and the Virgin Mary stands in the middle of the quinta
(Photo Pribyl 2009)*

Hierro also works in coordination with MDs and chiropractors and he explains this good relationship with health professionals with his participation in conferences organised by MINSA. His most important connection to the academic world started with Dr. Víctor Reyna in 1995 up today (Reyna 2002:9).

There are also doctors who have sent me patients. I had a doctor who told the patient that she had a fluid in the back. Then the doctor said to her: there is a maestro who works with the cuy. That's because I've participated with Dr. Reyna in several events, in several hospitals, in several universities, at the national level. Another doctor saw me working and also told his patient: go to the maestro Hierro and let him work with the cuy, after that you'll come to me and tell me what he had said to you (Hierro iw/2009)

I have participated in various conferences. MINSA has invited me. Many doctors have already seen me. With Dr. Victor Reyna I joined a conference organised by MINSA and I made a demonstrative cuy. They brought me a patient, I rubbed him with the cuy and I made the diagnosis. That was in a hospital. They were all surprised. I said all that the patient had and how he could be cured (Hierro iw/2009)

I have also cured a doctor. I don't want to say his name²⁴⁹. He was a surgeon, but in a moment he was unable to operate. Somedoby made him a daño. It was a professional envy. But I didn't say who did that to him [laugh]. He was so anxious that he couldn't operate. His wife told me that during the treatment with the cuy, he felt that something went out of his body. He said that. That was because I was working on the daño. Now he has no more problems with that (Hierro iw/2009)

Fig. 46: Altar in Hierro's Practice



Virgin Mary, Angels, seguros²⁵⁰ and a copy of the cruz de motupe²⁵¹ (Photo Pribyl 2009)

²⁴⁹ In several passages of the interviews in which Hierro reported joint work with MDs or healthcare facilities, he did not want to mention the names. As I asked for his reasons in keeping the names secret, he says “they will probably don't want to see their names associated with the guinea pig” (fq/2009).

²⁵⁰ A composite made of special herbs, perfumes and stones, filled in a sealed glass, which is previously beseeched and afterwards given to the person to act as a special protection (fq/2009).

²⁵¹ Peruvian devotion originating in the district of Motupe (Lambayeque), dating back to approximately 1860. According to the tradition, the cross was made by a Franciscan priest, being subsequently found and venerated. The festivity held annually in August.

Hierro attends to patients of all ages and social status. In case of children, he commonly uses the egg instead the guinea pig –something common among guinea pig healers. According to Hierro, 70% of his patients' consultations are caused by *daño*, mostly trapped with a medical diagnosis. *Susto* is the second most common diagnosis among Hierro's clients.

I have had a patient, I do not want to say the name of the clinic, but she was there, also the husband and the daughter. I told the father, I'm going to go to the clinic and I'll check her there. I went as a visitor. Right there I rubbed her with the *cuy*, in that site. I checked that the nurse did not come over to us. I rubbed with the *cuy* and made the diagnosis there. I told him that I must see her in her home, because the work was not easy to do. In fact, I needed a month to cure her, because the doctors there didn't knew what she had. They were investigating the situation and they didn't know more. It was a *daño*.... Until today she is healthy and the doctors didn't know what she had, but they were surprised with her evolution. I needed more than a month to cure her (Hierro iw/2009)

This girl was a student, at the University of Lima. She was a good student. The doctor brought an x-ray in which the left kidney did not appear, and they were about to operate her. Then they said, "go to the maestro Hierro" to see how it really is. And, indeed, with the Guinea pig I saw that the left kidney was covered with the fat of the *cuy*; it did not come on the x-ray because it was clogged. Then I removed the fat over the kidney, and it came out. I told her that she should go to the doctor and make an x-ray to see the results. The doctor made the x-ray and there was the kidney. They could avoid surgery (Hierro iw/2009)

4.4.2.4 Method

4.4.2.4.1 Apprenticeship

"I come from Chíncha Alta²⁵². I studied at the School 563 of Chíncha. It was the Sotelo School. My aunt was a master healer. And she was, at the same time, a *partera*. She was a fat black woman. But her hands were very thin, very lank, despite the fact that she was fat... she was also from *chíncha alta*; her house was 7 blocks from the Plaza de Armas. She lived in the Chavin street. My aunt's name was Lidia Córdova. She was a big brown woman, but she had very lanky hands. She uses to smoke a cigar.

When I was in the elementary school, I observed my aunt by working. My cousins, her children, do not have had this ability to heal. They did not learn from her. They didn't like it; perhaps they had no specific preference for that. But I did. My aunt told me "I'm

²⁵² Capital of the Province of Chíncha, department of Ica, 210 km. south of Lima. See Fig. 1.

going to teach you this work”. She gave me guidelines. My aunt sent me to buy cigars, to buy the herbs to cure the patients. Well, I liked it. I started to watch what she did. She said that I have good prayers, and this eye to see, to see the spirit. If I didn’t have this interest, she probably wouldn’t have taught me all that.

When I was eight years old, I saw spirits. I said to her “aunt, see, I see here a little man with a brown suit and a hat”. She said, “That’s an elf”. Since that I started to work in this field. I can also see (read) in candles, but in white ones. I can see in it if the person is under daño; and as I see it, I make also a rastreo. I search with coca, I comb with the cigarettes, and I chew with the coca. That’s part of the ritual.

At that time my aunt was seventy five years old. She died at the age of 89. One day, she made me a test, as an exam. Look sobrino, she said, I want that you rub this time with a cuy. It was a woman there. Well, I rubbed her with the cuy, and due to my eye to see I said to her some things, but I was not at all qualified. Anyway, my aunt said to me: “sobrino, you can be a good healer!” Well, I began to work directly with her. During high school I continued working with her, until I finalized my fifth school grade. Then, once again many years after, she said “I want you to rub with a cuy here”. He was a man, and it was a male cuy. I rubbed him with the cuy, and this time I made the diagnosis absolutely perfect. I saw all his organs. In the cuy I saw an enfriamiento in the lungs, but that was not for a doctor or to make an x-ray at a hospital. It was just an enfriamiento on his back, and he should only go to the drugstore and buy parches de arnica²⁵³ to throw out this cold from his back. I worked with her for many years, and then I become an expert.

My aunt worked with many herbs. I have written down some recipes in books here. She gave them to women who had vaginal inflammation for example. I have recorded all here [he points to his head]. At that time we used a basin made of wood with edges of steel. There we prepared a bain-marie. From the field I brought *llantén*²⁵⁴, *hierba*

²⁵³ Popular free-of-recipe plasters covered with a film of arnica (3%). The *arnica montana* is native to Europe, and has been used since the 16th century against muscle aches, and rheumatic, lumbar and sciatic pains. Some evidence has found no effectiveness of it on muscle pains, however (cf. Adkison et al 2010).

²⁵⁴ *Plantago major* L., (*Plantaginaceae*). It is native to Europe and north-central Asia. The plant’s roots are used traditionally to treat fever, wounds and respiratory infections (Foster and Hobbs 2002:224).

*santa*²⁵⁵, *matico*²⁵⁶ and a plant called *qeto-qeto*²⁵⁷. I gave them all to my aunt, and she prepared with them the baths for the women... I dream of the herbs and plants, which herb is going to cure the person. That is, the dreams helped me also. I dreamed of the ruda, the children should be cured with the ruda.

My aunt died, because she was also a woman who was very tired, quite tired either, exhausted already, because of the amount of work she did. It was too many people, many, many people to attend to. Besides being a healer, she was also a partera. She saved the child as well as the mother. I learned a lot from her, very much, many things.

There are many people who heal, and also the people who make daño. In case that people come to me with daño, I treat them. It could happen that the opposite part attacks me. But they cannot knock me down, because I have been born standing²⁵⁸, and I drank from the blood of the bull. I have taken the blood of the *añaz*²⁵⁹; from it I ate also the heart, with a glass mixed with sugar cane liquor. I ate it all; I champ it with pisco²⁶⁰, to not bring it up. And the bull's blood in Chincha, I pricked the bull and held its blood in a glass, and I drank it, also with some pisco –to not spew it. Because with bull's blood it is difficult that someone can chop you down... Because my aunt told me: you're going to deal with a lot of bad, negative people. You are going to take this as a protection, for always.

²⁵⁵ *Artemisia absinthium*, commonly known as wormod, wormwood or wurmkraut is a medicinal herb native to regions of Europe, Asia and North Africa. Due to its multiple healing properties, this herb has been called the “mother of all herbs”. In European folk medicine, the wormwood is one of the main herbs used for abortion and gynaecological problems such as the induction of menstruation and childbirth (Rätsch 1998:52).

²⁵⁶ *Piper aduncum* L. (native Peruvian *piperaceae*), also called “hierba del Soldado” (Rätsch 1998:371) is traditionally used to treat fever, infections (urinary and genital areas), rheumatism and inflammations (CENSI 2010). A decoction of the fresh leaves is employed as antiseptic for sores and wounds (Arévalo 1994:288; De Feo 2003:247). I have observed its popular use in Northern Peru for the treatment of chronic asthma and bronchial infections.

²⁵⁷ *Gnaphalium spicatum* Lam, family *asteraceae*. Plant native to Peru used to treat bronchitis, abscesses, internal and kidney inflammations (CENSI 2010).

²⁵⁸ Breech birth.

²⁵⁹ The Andean skunk (*coneptatus chinga*) is a skunk species native from South America.

²⁶⁰ A Peruvian grape brandy produced in Peru since the 16th century. See e.g. Huertas, Lorenzo. 2004. “Historia de la producción de vinos y piscos en el Perú.” *Revista Universum* Vol. 2 (19): 44-61.

I stayed in Chincha until I was 19 years old. After that I went to Lima. I have already worked with the guinea pig and with distance healing for 25 years. And I have travelled a lot with my work. I was in Argentina, in Brazil, in Ecuador” (Hierro iw/2009).

4.4.2.4.2 The Soba con el Cuy

The whole process of the soba or limpia con cuy takes in average 15 to 25 minutes. Hierro works in a very systematic way, following the process described in table 8. I did not observe major variations in the sequence in the nine different cases registered during fieldwork²⁶¹.

According to Hierro, the guinea pig is an animal with special characteristics, fitting the best diagnostic and healing properties²⁶², and especially suitable for soba. Other animals, such as doves, red roosters, black hens or even piglets can be used as well²⁶³. The criterion in the use of the cuy or other animals instead is double mining: In the one side it is to consider the seriousness of patient’s condition and at the second, the probable elements intervening which have been used by *maleros* to turn persons sick through *daño*. This is established by Hierro after a first soba or during a preliminary examination during the preparation’s phase.

Some people sometimes need something stronger. Four years before, for example, in Huaral, I rubbed a person with a pig, a little pig. Why? The patient had a *daño*, and this *daño* was done with pig’s bristles and these are very hard. So, I had to use a piglet (Hierro iw/2009)

The sex of the patient should be the same as the sex of the cuy. Hierro selects mostly a young “criollo”²⁶⁴ cuy race, which is a small and rustic variation with low levels of production, acquired from his provider in a market in Lima. The colour of the cuy (white, brown or black) has no particular significance, except for the black cuy, which is considered to have efficacy to pull the illness or the *daño* from the patient. Oths also

²⁶¹ Because of time and disposition of the clients I have recorded only five cases.

²⁶² Some recent experimental research shows the suitability of guinea pigs as an experimental animal model that closely mimics the chronic manifestations and progression of some diseases in humans. It seems that by the chagras disease, the infection progress of guinea pigs recapitulates the human pathology of this disease (cf. Castro-Sesquen et al 2011).

²⁶³ According to De Feo (2003:250) in northern Peru the cuy is consider a cold element, as well as other animals used for limpieas such as dog, pigs and ducks.

²⁶⁴ Besides the pet variations (English or American, Peruvian or Angora, Abyssinian) the other four types are: Inti, Peru, criollo and andina (INIA 2008).

mentions that the black guinea pigs are highly sought after for giving the most effective diagnostic and therapeutic rubdowns (1992:78).

I became a patient through recommendation... she made a magnetic resonance in a private clinic. It cost her 450 dollars. But she felt very bad... Then I rubbed her with a cuy, made the diagnosis, and she had an old *daño*. It was a *daño*; she was four years with that; it has been almost passing on her. Thus, I used with her two cuyes. And here I used a black cuy, because when something is very special a black guinea pig must be used (Hierro iw/2009)

Table 8: Hierro's Method

Phase	Activities	Content/Topic	Elements/Substances
Preparation	cocachewing + invocations	preparation	Coca, incantations, conjurations, eventually prayers (e.g. paternoster)
	smoking / analysis of the ash	Preamble	Black tobacco, Aura, Intuition, Visions
	First Informations	Zodiac sign (personal background, personality)	Conversation
Soba	spray, aspirations breathing upon the guinea pig	Inhalation, expiration	<i>agua florida</i> ²⁶⁵ , guinea pig, breath
	rubbing	(1) head; (2) breast; (3) abdomen; (4) arms; (5) legs and feet; (6) neck; (7) back; (8) hands; (9) face	guinea pig; invocation and pray (<i>susto</i> , <i>daño</i> , God-diseases, stress, psychological states, social environment)
diagnosis	sacrifice, wash & slashing	Blood analysis	blade, guinea pig, water, blood
	peeling / general diagnosis	Back, spine, hip, sacrum, chest	guinea pig
	Entrail's examination	Liver, gall bladder, intestines, stomach, lungs, heart, kidney, head	guts, feedback, queries and explanations
outcome	offering / pago <i>paqopa</i>	removal / replacement	perfume, coca leaves, newsprint, plastic bag
	pleading and discharge, cast out <i>FloreCIMIENTO</i>	supplications, benedictions	prayer, bible, wooden cross, holy water, <i>agua florida</i> , <i>arte</i> (quince twig), eventually a white sword

²⁶⁵ Originally produced by the company Murray and Lanman since 1808, Florida water is a cologne scented water, which is used in Peru by healers for cleansing, healing and refreshment, for the opening of rituals and their termination, and as protection against evil spirits (fq/2010)

a) Preparation

In spite of the fact that the diagnosis is done through a careful and systematic observation of all the internal organs of the guinea pig, Hierro already gets an idea of the general situation of the clients during the first phase of the intervention (preparation). During this first phase, Hierro performs a brief contact with the client to collect first impressions about their general situation. Instead of talking about specific problems, while he tries to concentrate, sometimes accompanied by prayers or invocations, Hierro smokes white tobacco and chews coca, and asks for the zodiac sign and the cultural and social background of the client. He makes an intuitive observation and evaluation of the aura of the patient and asks seeking confirmation of his first impressions.

Fig. 47: Analysis of the Ash



(Photo Pribyl 2009)

b) Soba

In its diagnostic function, the cuy's body during the soba absorbs present affections of the person. As a procedure of healing (limpia) the body of the Guinea pig absorbs part of the condition that the patient has, and also absorbs impressions (susto) and negative energies (daño) that affect the patient (Reyna 2002:13).

Fig. 48: Previous to the Soba: Refreshing with Agua Florida



(Photo Pribyl 2009)

The whole process of the *soba del cuy* is always accompanied by an invocation and long prayer, in which Hierro invokes the support and presence of the spirits of prominent healers already passed by, ancestral spirits of the Incas, medical doctors, Catholic priests, spiritualists, angels and Andean deities (e.g. *pachamama*²⁶⁶, lagoons, hills, etc.) to take all the evil of the patient. The invocations are quite different according to the case, in which Hierro has already an idea what is going on with the person and what the person needs. Hierro holds the *cuy* by the head, holding at the same time its forefeet and hind. Starting the *soba*, he requests always the patient to exhale his breath on the face of the animal.

Fig. 49: Exhalation on the Cuy



(Photo Pribyl 2009)

²⁶⁶ One of the principal deities of the Andean pantheon representing the mother earth.

The rubbing with the cuy begins with the head. He proceeds then to rub the chest of the patient, the abdomen, arms, neck, legs and feet, sometimes returning to specific parts, but always in cephalous-caudal direction (from head to tail). The patient usually remains clothed during the procedure²⁶⁷. The following case quotation illustrates the process of the *soba con cuy*.

Fig. 50: Soba del Cuy: Rubbing the Head



(Photo Pribyl 2009)

[*Hierro begins with the soba, cuy is posed over the head*]: “I’m already cleaning you [*name*], I come and clean your *rastro* (trace). I clean your shadow. I’m cleaning you in these hours, in this moment, in the jungle, in the coast and in the highlands. Pretty mountainsides, beautiful hills, in this way I’m cleaning you, for your health, for your inner peace, so in this way I’m cleaning you with saint Michael, with saint Gabriel, with Uriel and Raphael;

Fig. 51: Soba del Cuy: Rubbing the Chest and the Abdomen



(Photo Pribyl 2009)

²⁶⁷ I could observe the guinea pig rubbing by another curandera in Lima, who performed the same procedure but with the patient lying on a bed and almost naked. This modality is more common among healers from the highlands. In Huancayo (central highlands of Peru) the healer observed the patient after the rubbing and staying with him all night long to confirm the diagnosis (cf. Rimachi 2003:289-290).

I come and I clean you in these hours, in this moment, for your health, for your projects, and for your family (bis), Jesus! [*Hierro prays the pater noster, patient spontaneously prays with him*]. So I'm cleaning you, in this way, I'm cleaning you, pachamama mother earth, good offerings, good pagos to the earth too, and for the health we're also asking for; we beg [*Hierro rubs the arms*], and we're also cleaning the soul, when the soul is a little depressed and bleak, we're cleaning the soul, Jesus, Jesus, we're cleaning also the aura; pulling; cleaning. Eternal lord, we're cleaning your path, for your health, and the part of the heart, I'm cleaning you, padrecito, clean this body, protect this body, purify this body, beautiful daddy, help us to clean [*rubs abdomen and pelvis*];

Fig. 52: Soba del Cuy: Rubbing Neck, Back and Legs



(Photo Pribyl 2009)

dear father, so we're cleaning, in this way we're cleaning, so we pull all the evil to the wind, all the evil, all the negative energy, every bad shadow, every contradiction, and so, beautiful father, in this way I'm working, for her health, for her inner peace [*rubs the arms*]; where I work with the ancestors, with the kings, with those of the time of Incas, from the ancient Peru [*rubs the legs*]; I'm working with all the nature, with the four elements, god of the air, god of the fire, god of the earth, and god of the water. So I'm cleaning you, father! clean! pull! Every bad shadow, every bad air, every bleak from a lazy mind, depressed, bleak [*rubs head and back*]... (Hs3-hierro 2009)

The status of the cuy after the soba is diverse. Sometimes it was exhausted, lost control of its sphincter, or died. In the opinion of Hierro, the cuy should be sacrificed by the healer, and it is not a good sign, i.e. a bad omen, when the cuy died during or at the end of the soba (hs1-hierro 2009).

c) **Diagnosis**

Fig. 53: Hierro Examines the Cuy



(Photo Pribyl 2009)

The diagnosis is made after the end of the soba. The observation of the cuy's organism after it was sacrificed is equivalent to a direct observation of the patient's organism. The animal is then sacrificed by cutting its neck with a razor blade, letting it bleed for a while, and afterwards washed. The quality, colour, and constitution of the blood give additional diagnostic information "to see if the blood is thick or if the patient suffers from diabetes. I see if the blood is thick or watery; when it's weak, this is because there is a strong anaemia" (hs4-hierro 2009).

Fig. 54: Peeling the Fur



(Photo Pribyl 2009)

Afterwards he examines the cuy with the presence of the patient, and observes in the guts the presence of morbid conditions.

Fig. 55: Examining the Entrails



(Photo Pribyl 2009)

Fig. 56: Diagnosis with the Cuy: Healthy Cuy (left) and Cuy with Daño (right)



(Photo Pribyl 2009)

d) Outcome

After the evaluation and feedback, the cuy should be prepared for the offering or *paqapo* phase. During this first stage of preparation of the cuy, the offering or pago, the cuy will be filled with coca leaves, sprayed with perfume and agua florida, and carefully packed in newspaper. Hierro disposed alone of this cuy-paqapo at noon on the same day.

When we make this pago in Lima it is different than in the field. Here in Lima we cannot do these things as there. I mean, there, in a field, is more open and even more mystical, in Trujillo or Chincha, or in a farm. But as we are here, the cuy makes a pago but not in a ceremony as it should be, because we're here in the capital (hs2-hierro 2009)

In the *floreCIMIENTO*, Hierro prays for the patient, similar to the first phase. He uses for that a bible, wooden cross, holy water, agua florida, an *arte* (quince twig), and eventually a white sword if the case is about *daño*.

By the Holy Bible, I enshrined you in these hours, cute father, eternal Father, heavenly, clean this body, padre lindo, eternal Father, by the 7 nails of Christ and the descendants of Christ, Jesus clean this body, san Vicente, my relative, puts the cross on your forehead, so that no evil enemy will tempt you, neither at night nor in the day, Jesus, my nice friend, Jesus, my powerful friend, clean this body, protect this body, purify this body, I come to clean you at these moments, Jesus, Jesus, Jesus, Mary and Joseph, holy spirit, amen, Jesus (hs2-hierro 2009)

Fig. 57: Florecimiento 1



(Photo Pribyl 2009)

Fig. 58: Florecimiento 2



(Photo Pribyl 2009)

4.4.2.5 Influence of Spiritism on the Work of Hierro

Besides the egg rubbing and prayers, Hierro applies other techniques such as *florecimientos* (flourishing), *santiguamientos* (to make the sign of the cross over a sick person with invocations), *saumerios* (cleaning with incense when the persons are e.g. depressed) and the cleaning with newsprint –also a technique he learnt from his aunt.

Some children have susto or ojeo. In these cases I use an egg, and I sanctify them, with an egg and a Christ, if there is not a Christ even with a wooden cross. I sanctify and spit holy water in a cross over them. The children can then eat and sleep... I also work with the newspaper, like the egg, I rub the patient with the newsprint and burn it. This technique is from Chincha (Hierro iw/2009)

There are some healing, philosophical, metaphysical, and spiritual traditions that could be recognised in Hierro's work. He profoundly identifies himself with the principles of spiritism or kardecism, like other THPs do (cf. e.g. Gushiken 1979; Dobkin de Rios 1992; Joralemon and Sharon 1993). The principal spiritual European philosophy approached by Hierro is the *kardecism* or spiritual lessons derived from the work of the French Hippolyte Léon Denizard Rivail (knowns as Allan Kardec), followed by other spiritualistic leaders from contemporary times and well known in the Latin American region

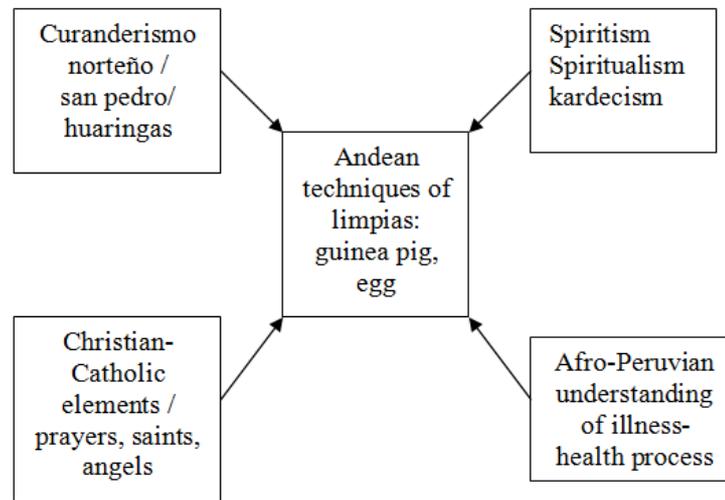
Distance healing is with the mind. You focalize and concentrate yourself, and than you'll be transported to other places. With your mind you can make many things! The mind works, it's the greatest. Nowadays there are many good books about it, about mind's power, for example, "the best prayers of the world", and others from Allan Kardec (Hierro iw/2009)

Whenever you go, you'll be flourished; you will shine, with the herb of the fortune and of the cabbala; Master José Gregorio Hernández, and San Ignacio de Loyola! And so, you will be elevated, roused up, well prized, well pleased to, and well appreciated. Nobody will hate you, nobody will abhor you... (hs4-hierro 2009)

...as I am working with that great Venezuelan doctor scientist José Gregorio Hernández, with your knowledge as doctor, as a doctor, as a doctor of the soul, in this way I'm cleaning you, San Juan de Dios, San Ignacio de Loyola clean this body, protect this body, purify this body, Jesus! San Pantaleon²⁶⁸, clean this body! (hs1-hierro 2009)

²⁶⁸ Born in Nicodemia (today in Turkey) ca 275AD, he studied medicine and was a doctor of the Emperor Galerio Maximianus. He apostatized of the Christian faith, and was persecuted by Diocletian by 303AD. According to the Christian tradition, his death took place under a dry fig tree, which bloomed to receive the blood of the martyr after being beheaded (Liguori 1888:308-311). The iconography represents him with a small cross and a scalpel, or at the foot of an olive or dry fig tree. It is invoked by those who suffer from headaches and tuberculosis (fq/2009).

Fig. 59: Hierro's Work Approach



Pollak-Eltz asserts that the *kardecism* was introduced in South America in Brazilian territories in the 19th century by middle-class European citizens. This philosophy is also inspired by other religions than Catholicism, such as Buddhism, and particularly by its conceptions of reincarnation (Pollak-Eltz ws/2011). According to this, a spirit remains on earth (with or without a physical body) because of its necessity to learn, to expiate its faults or to compensate them through gaining credits, in order to obtain redemption and reach the next spiritual development level (i.e. salvation, soul restitution or just reincarnation). Millones asserts that since the Conquest, or soon after, an assorted scale of popular healers coming from different traditions was born. Like other social processes occurring during the 16th century, healing traditions fed on the process of intense crossbreeding that was surrounding. The exercise of the “spiritualists” is a modern example of the coexistence of different forms of folk medicine (Millones and León 2004:60-61).

The central belief of spiritism is that humans continue to exist after death and that the communication with the living is possible through a medium, a person with special psychic characteristics able to receive the messages (e.g. in form of thoughts, vibrations or frequencies) that cannot be perceived by a common person. Although of a spiritual nature, this communication can be manifested in the physical world and be materialized

in form of “paranormal” activities, from automatic writing or speaking up to possession. This explains the possibility for Hierro to attend to clients that are not physically present, also from other countries, because in the spiritual world there are no limits in relation to time and space (distance healing). Hierro learnt this technique from his aunt, too.

I also have patients from the USA. Sometimes they want me to make a *rastreo*²⁶⁹ for them, to know how they are doing. So I make the *rastreo* from a distance. That’s distance healing. Then I can tell them, you’re in this way, you’re not ok, you have something for the doctor, you have *daño*, you’re blocked or crossed, right? Then I answer them from my computer (Hierro iw/2009)

I concentrate, I project myself, I go up to the stars. I can heal from a distance. I go also up to the stars. Of course, I have unfolded myself several times. Because there could be patients who are in Chincha, Pisco, Ica, here then I transported myself; I sleep and that is called distance healing. That’s a special power, because the mind cures all. My aunt also did that (Hierro iw/2009)

Visions. It is all about concentration. Distance healing is in the mind. As you concentrate, you can transport yourself everywhere. With your mind you can do many things. The mind is all that works. Now there are many books about the power of the mind. In the past there were not so much, now there are very good books, including “the best prayers of the world”, at that time the book cost 100 dollars. But to that time I have already recorded my own prayers, here [points out his chest]. My aunt said to me: When you cure somebody, use your prayers. And I pray! (Hierro iw/2009)

Fig. 60: Hierro in his Consultation Place



*San Expedito*²⁷⁰ is front and centre on the work desk of Hierro. Candles, perfumes, holy water, *agua florida*, a stone from the *Lagunas de Huancabamba*, and coca leaves (Photos Pribyl 2009.)

²⁶⁹ Sp. *rastrear*. Mental-spiritual-cognitive techniques to track down or trail the origin of a problem, and to identify the herbs that should be utilised to resolve it. It is a sort of differential diagnosis procedure, screening, and prescription at the same time (fq/2009). See also: Joralemon (1984a:401).

²⁷⁰ Although he is not readily accepted by the Catholic Church as a saint, the popular belief asserts that St. Expedite was a Roman centurion converted to Catholicism, for which he was killed in martyrdom. He is a folk-saint invoked to solve urgent causes without delay, to win lawsuits and to reach financial success. He is also often invoked in the African-American magical tradition of *Hoodoo* (cf. Anderson 2008).

Another working concept and important diagnostic instrument of Hierro is his apprehension of patient's "aura", which he sees and feels in form of an energetic field with specific colours, emotions and qualities, plenty of information about the client's personality and life history.

Like other healers²⁷¹, Hierro realises periodic visits to the *lagunas de las huaringas*²⁷² as a preventive health action, to clean him spiritually and psychically from work performed during the year, and to reinforce his abilities. Nevertheless, its connection to northern curanderismo does not end there. As he told me, he sometimes utilises the San Pedro cactus for "special clients", e.g. people whom he himself has known for a long time or for Peruvian migrants in the USA visiting him in Lima for a treatment, who need an "express" service. He also lifts his clients with tobacco (*singadas*) as well, and arranges special treatment trips with the guinea pig healing to northern Peru (Piura, Huancabamba) and Lima (Huacho).

The only thing I couldn't learn from my aunt was the technique to operate on the cuy. She operated on the guinea pig! But I didn't learn it, because at that time I was also learning *curación de casas* and to rub with the cuy, to make the diagnosis... so it was already too much for me. But I help people very much, I make the *pago* with the cuy, and the person feels well. The patient goes well. This is the most important thing (Hierro iw/2009).

²⁷¹ Two of my interviewed wachuma healers located in Lima, do it as well (Granados iw/2009, Levis iw/2009). See also Sharon (1993).

²⁷² A group of lagoons located in the province of Huancabamba (Piura) at the cordillera *Huamaní*, at 3,950 m.a.s.l. The most visited are the *laguna negra*, *laguna shimbe* and *laguna Del Inga*. According to the tradition, the encantos live in the huaringas, entities with divine and mythical character that intervene in daily life (Polia 1994:18). The huaringas are one of the most popular pilgrim shrine and natural treatment place both for THPs and brujos in the country (see also Glass-Coffin 2002).

5 Results

The discourses have been organised into five categories according to their content, which were identified and established after the inductive qualitative analysis: (1) Governance; (2) Health Policy Making; (3) Healer's Conditions of Work; (4) Intercultural Curricula; and (5) Integration of TM

5.1 Governance

The problem here is what we really mean with "nation". In Peru we couldn't build up a nation. Whereas in other countries they have already destroyed it [laugh], here we do not know until now where it is (Public Health Expert iw/2009)

Governance means the more or less typical political practices and administrative policy approaches in a given government by delivering decisions and establishing managed procedures to shelter national or populations' affairs. Nonetheless, governance refers not only the complex behaviour of governance actors, policy makers and political groups. As Benz points out, governance is a "steering for the aim of managing interdependencies", and stresses the capacity of governance theories to study in depth the complex relationships between state (formal institution) and society (informal institutions) (Benz 2004, cit by Schiller 2008:14). As a concept, governance also explains the relationships between society and government, amid public and private spheres and their social and political networks, as well as the modes they establish in cooperation pathways to build up political decisions among them, or not. In the same way, an analytical perspective of the discourses about governance can be additionally expanded by distinguishing between governance and bureaucracy. Although bureaucracy implies a style and disposition to repeat and delay activities not strictly pertaining to job instructions, bureaucratic behaviour in political charges can also be productive when it is driven principally to fill out key tasks, like in governmental administrative institutions, as it is the case in some industrialised countries.

Table 9: List of Codes, Subcategories and Categories: Grounded Data

CODES	SUBCATEGORIES	CATEGORIES
Attitudes People, Hopeless, Loneliness-Isolation, Media Influence, Peru Identity Nation, Psychologists, Status Quo	Psychosocial Factors	Governance
Attitudes Policy Makers, International Interests, Lack of Funding, Peruvian Politics, Pharmaceutical Industry, State & Government	Political Conditions	
Access to Official Healthcare, Mystical tourism, Peru Health Situation, Public Health	Health Situation	Health Policy Making
Hospitals & Health Centres, Peru Health System, Popular Medicine	Health System	
CENSI, INMETRA, Intercultural Health Policy, Intercultural Health Programmes, MINSA & INS	MINSA	
CAM Centres ESSALUD, TM vs. CAM	ESSALUD	
Alternative Health Practitioners, CAM	CAM	
WHO & PAHO	International Health Offices	
Economical & Social Situation, Family Situation, Health Condition, Social & Political Activism	Healers' Profile	
Ethic, Socio-Cultural Clues	Healers' Identities	
Benefits Integration, Healers' Intercultural Expertise	Healers' Competences	
Patients, Practice & Fees, Projects	Healers' Practic	
Commercialisation, Legal Situation	Legal Frame	
Medical Doctors & TM, Medical studies, Physicians, Training Intercultural Competences	Physician's (sub-) Culture	Intercultural Curricula
Plants & Phitotherapy, Publications, Research	Investigation and Studies	
Healer's Definitions, Healers Classifications, Healers' Initiation, New Healers, Sorcery, TM characteristics, TM Instruments, TM Techniques	Conceptions of TM and THPs	Integration of TM
Authorities' Attitudes, Attitudes to Linking, Healers' Attitudes, Healers Education & Training, Standardization TM	Implementation TM	
Academic Activities, Network Specialists, Scholars	Academic Approaches	
Committee TCAM, Explanation, CMP, Solutions	Advocacy	

The conceptualization of governance as a category used here establishes a central difference between the structure and process that is of special importance. Formally speaking, there is on the one hand a given executive and administrative structure, with specific political procedures to make governmental functions possible and visible for the society. On the other hand, the outcomes of political discussions and negotiations that are part of political decisions in a given governmental period are more related to culture and social conditions of the actors. Thus, the perspective of the discursive governance analysis in terms only of a process, could be insufficient to explain the position of knowledge in politics and society, which is certainly “far more complex than this analytical distinction suggests” (Schiller 2008:12).

There are three principal sources that are constantly evoked to explain the governance problems in the country and its specific impact on non-existing clear policies about TM.

- (a) An indolent and unresponsive attitude from policy makers driven by a colonialist mentality that shows disdain for the indigenous legacy.

The concept of nation approached by my informants alludes to the construct of national identity; a collusive emotional and rational attempt to assemble Peru’s different ethnical groups, also an identity search or identity-to-be. It enhances a hidden dream of a cultural commonplace, a longing to find the distinctiveness that could somehow bring all these cultural groups together. Peru is meant to be a still-working-out nation with several ethnical, cultural and social identities and disparities, either conflicted assumed or refused at all. The principal groups historically excluded from this social conglomerate are the indigenous communities, who are socially and culturally kept from the essential benefits and rights as Peruvian citizens.

Racism is a key topic. All from the inside, what is indigenous, is bad. It’s profoundly racist. There are some improvements in other fields, but this is still a country where the minorities have the power and don’t share it, and this theme is consubstantial to its development. I think there is also a political, cultural connotation to this (MD iw/2009)

In Peru nobody wants to be indigenous. All the people want to be “white”; hence it is so difficult that somebody accepts the postulates from others with the same criterion, for example, to use a plant with my same criterion as an indigenous person does... Everybody speaks for the indigenous people but, *who* works with them? (Anthropologist iw/2009)

In this concern, the inside, central, inner, surrounded are terms that appear constantly in the discourses. It could explain the position of the “indigenous” in the imaginary of the informants at the bottom of the historical and cultural origins of the country. In contrast, the explanations of an unproductive state, an indolent government and inoperative political institutions speak for a disposition of the indigenous people no longer in the middle, but at the edge of the country.

We work with indigenous communities. In the *Alto Amazonas*²⁷³ there are nine ethnic groups in a space as big as Switzerland. When you go to the other river side there are totally different cultures, at odds. The *mentalidad limeña*²⁷⁴ is a drama, because we cannot look inward. This is not only a problem; it is also a possibility, I mean, an opportunity to learn many things of people conserving traditions in their own culture, it's a big value. But it's a heavy burden this “sight from Lima” (PH Expert iw/2009)

It is a colonial mentality that our presidents still ratify. The medicine practised here is with resources from overseas; it has nothing to do with us. When Spaniards arrived in America they consulted the curanderos, because they acknowledged their better techniques and results as those of European physicians. The problem was the beliefs of these practitioners, the intolerance of the Catholic Church and the fact that the academia has served principally political forces. So, what has to do there a curandero? An indigenous person! (Psychologist iw/2009)

The national political class is essentially perceived as inactive and actually neglecting and part of a privileged group. The complained acquaintances are mainly established between local politicians in pool or strategically positions with direct responsibilities and mandates in healthcare administration, or on people's well-being. In the view of specialists, whenever economic growth in the country means for instance a better situation for the country, this financial improvement is not largely optimised and justly distributed among all of the different productive sectors and social groups, making emerging markets not an automatical solution against poverty and people's healthcare attention deficiencies. To overcome this situation, meaningful and strategic investments in health and education should have been made, and not only in some resorts as it was the case in the last decades. This apparently economic development benefited directly a group of people holding the production media, without redistribution for the large population sectors.

Political systems in Peru reproduce the fracture of the cultural diversity, which has been no longer solved at any time. Maybe in a legal sense, but that is fancied, and not real in

²⁷³ Alto Amazonas, province of the Loreto Region, located at the north-eastern Peruvian Amazonia.

²⁷⁴ Mentality of the people living in Lima, thinking and acting on Peru as a large-scale copy of Lima (e.g. urban, non-rural environment and life-style, Spanish speaking population, trade and services, etc).

the practice. Actuated decisions of the political party in turn use them according to its own interests... there is a certain primitivism in this governmental conduct, it is pre-relational and pre-positivist, because it is inconceivable that a government undoes what the previous government has done. They don't make plans in the long run, there is no vision of the country, and i.e. these worse matters are the same since a century. That causes repercussions in two simple and principal sectors: Education and health (Anthropologist iw/2009).

- (b) National policies dictated principally by international economic organisations and the pharmaceutical industry

In the discourses the collusion of politicians, including presidents of the nation, with international mafias serving and defending personal, private, international and/or corporative economical interests in the country (lobbies) are constantly suggested. This situation prevents in so far the development and implementation of a suitable and fair intercultural policy making, with inclusion of TM, in benefit of the majority of the population.

I understand now, maybe too late, projects like Takiwasi²⁷⁵...they must go to the province to make things like that. Now I understand them as well, because in Lima nobody would know about it... (In Lima) I could be still struggling against this. In contrast, they are there well known, they know what they do. The spaces are too different! Lima is a space of ignorance, to hid things, they don't want neither to know about TM nor to learn more about it (Sociologist iw/2009)

5.1.1 Corruption

The illegal and corrupt practices to maintain positions of power in the government or to improve personal enrichment or obtain political benefits of the promotion of TM is enunciated as a common practice in the country, not at least with fateful consequences on people's health or over the CH of the country.

There is no naivety. Last year I have worked in *Madre de Dios*²⁷⁶. The situation there is horrible due to the gold-panning sites; the contamination is extreme, the exploitation of children is ghastly; little girls are commercialised as prostitutes. And who are the owners? Are they informal people? Lies! All the city mayors are the proprietors of the centres. Here there are no innocents, it's a shame! (Anthropologist iw/2009)

²⁷⁵ Drug dependency treatment and TM research centre located in the city of Tarapoto (San Martin) in west-Amazonia. It was founded 1986 by the French MD Jacques Mabit. See: www.takiwasi.com

²⁷⁶ Department situated south-west of Peru, one of the richest in biosphere in the Amazonian with several ecological natural parks. Although the agriculture and cultivation of rice, rubber, maize, manioc, banana, wood and stock farming are important, the main current economical activity is the work in gold mines, with serious impact on popular health and environment. See e.g.: <http://www.scribd.com/doc/10947704/Diagnostico-Ambiental-Madre-de-Dios>.

There are also some politicians who want to use the project with the construction of temples to capture people for political purposes. Thus, I said NO. We won't permit that, I don't want their money for those things (Wachuma Apprentice iw/2010)

Within the discourses, the utilisation of TM by politicians towards the maintenance of political influence and power or to defend themselves from enemies is present - whenever they are considered political or personal opponents. The addressed persons were also presidents of the republic.

It is mainly accepted that sorcery is associated with people with low education, but this is not always the case. The best examples are the presidents... There are many reminiscences from the past that are nowadays still vivid. How can you explain that people with education or from the upper class visit sorcerers? An example: Alan Garcia with Coty²⁷⁷; Alberto Fujimori did it too. Another case was Toledo; he went to shamans and witches and made inclusive ritual sacrifices to the *apus* in the museum of archaeology, anthropology and history, with his wife Eliane Karp (Historian iw/2009)

President Toledo was in Cuzco, in the *huaringas*, in *pachacamac*²⁷⁸ and he believes in all these things. But it's not a real belief for him; it's rather a political interest. Anyway, he has promoted that, the ministry of tourism itself called to us to make ceremonies for the tourists. That is the problem too, sometimes it would turn a little into folklore or tourism, and we don't want it (Wachuma Apprentice iw/2009)

The contextualization of these dealing practices is identified not only by scholars and experts within a large network of international economic organisations and/or regional or foreign countries economies. The relationships are mostly identified between politicians or economic leading groups with multinational economic organisations, like the International Monetary Fund and the World Bank.

The problem is that the big interests of the American transnational corporations are against coca. And with coca we could resolve the problem of the hunger in only one day... The general politic in Peru is imposed from the International Monetary Fund and the World Bank. So, we can do nothing! And when you do not agree, there is no money! (Naturopath iw/2009)

The mass media in the country have had also played a key role in the political manipulation or disuse of traditional knowledge or information about TM, and especially in the character and role of the THPs. In the perspective of many of the

²⁷⁷ Coty Zapata is a psychologist working as clairvoyant and fortune-teller in Peru: <http://www.cotyzapata.com/>.

²⁷⁸ Qe. Pacha Kamaq (king of the world), a deity venerated before and during the Incas, which was afterwards called Wirakocha. Its archaeological cult-site is situated 40km. south-east from Lima, composed of 17 pyramids constructed between 200-1450 AC. It was most expanded during the Wari, Yshmac and Lima cultures (Eeckhout and Owens 2008:377).

informants, the media proprietors are also colluding with politicians or state-positioned economical and political groups, making the thematic of TM a psychosocial instrument to manipulate the population and confuse the public opinion in benefit of their interests.

Due to political interests during the nineties²⁷⁹ there was a dirty use of TM in the media. They presented and utilised “shamans” in a dizzy way, in some comedy series, generating over them discredit or loss of prestige among the population (Psychologist iw/2009)

The problem is: When the media want to talk about the project²⁸⁰, they invite only the witches and put them in the front of the discussion. I have seen a programme that showed a hospital in which “witches” were encouraged to spew perfumes to the people in a ridiculous way (THP iw/2009)

5.1.2 The Pharmaceutical Industry

In the discourses, the negative role and influence of the international pharmaceutical industry was discussed, and its influence on healthcare attention and of the related pharmacological research on health policies in the country. This is also mentioned among health policy makers, and it is not only an alleged point of view exclusively present in scholars, social scientists or social or political activists:

Research has a lucrative goal...There are thousand of examples of medicines that were produced (from pharmaceuticals) on the basis of medicinal plants used in traditional healing. But the interest here is not for the benefit of the people, it is instead to make a profitable business. The actual society is founded on profit, on personal economical enrichment, on the generation of capital, on utilities. It is not grounded in altruism. So, we are not talking about something that is not based in contemporary society... Therefore, interest in this field of TM will probably not exist until it generates revenue (PAHO Health Officer iw/2009)

The problem is that there is too much interest from the pharmaceutical consortiums. This centre could be a good alternative for people, good and cheap. I have seen patients who nobody wanted to treat any more, a hysteric one, another with brain haemorrhage, and another with chronicle tuberculosis. They come to us and they leave us better (MD, Head of CAM Centre in Lima iw/2010)

In forty years the situation has become atrocious. The basic traditional guidelines are lost, both in medicine as well as in beliefs and family structure in the communities. And there is nothing to compensate this... It is a direct aggression to the ethnic group... How can you respect traditional medicine if you don't recount their lives? The big laboratories did it. They put up some sort of fence, and take the plants for analysis without control. “Shaman” is a laboratory that has done it. The physicians from Shaman

²⁷⁹ During Alberto Fujimori's dictatorial regime (1990-2000) it came to massive proliferation of such contents in media, TV, and radio programmes. Social specialists and political analysts identified this as “psychosocial campaigns” to intimidate people and keep them away from social and political participation.

²⁸⁰ See Law Project for the recognition of the TCAM and its practitioners (CRP 2008).

take these plants and examine them without any care and respect to the community²⁸¹. When the pharmaceuticals plunder it, what kind of respect can I have for a community, for its culture, when I'm killing them? (Anthropologist iw/2009)

5.1.3 Politicians, Drug Trafficking, and National Lobbies

Some connections to international drug trafficking networks are also commonly used to explain the misuse of natural resources, including for instance medicinal plants with historical and cultural traditions that are widely used in popular health treatment. This is notably the case for coca leaves, not only in their ritual and traditional therapeutic uses, but also in their intrinsically potential as natural resource for industrialisation and commercialisation. According to my informants, the role of the state and its representatives of these important policy concerns are non-existent or responds only to the interests of well identified economic international lobbies.

They don't want to open the doors, they don't want to hear. Maybe it is fear, or interest. I think that behind all this stand the big laboratories, because whenever there are more sick people, they fill their pockets with more money (THP iw/2009)

That with the coca is a prejudice. Yesterday I say in television an angry parliamentarian who shouted out "they want to give us cocaine!" They don't understand! Who is behind the transnational companies buying the coca? That's what we must see! (Anthropologist iw/2009)

The developed countries are perceived at the same time as principal influential leaders in health policy making in Peru. In the view of many THPs, the prohibitions of coca or the practice of other healing traditions are in part a product of disinformation and well-established interpretative models on the basis of the scientific development and lifestyle of the industrialised world. Thus, the true problematic lies in their conceptions of human being and disease; about health, body, and curative recovering process, which are straightforwardly wrongly imposed or misunderstood.

There are thousands of professionals, millions of ecologists. What they do for the mother earth or for natural medicine? Why do they prohibit us to use it in the right way?

²⁸¹ I discovered some opposition to this opinion: "(Shaman Pharmaceuticals) was the only company that actually did pay upfront compensation when working with communities... Overall Shaman and its successors are in my point of view amongst the most honest companies in the field, and have always tried as much as possible to give benefits to communities before having sold a single flask of any product. Many colleagues I respect have early on helped to get the company going and to structure their PIC and IP policies. I don't know how NAPO works now, but the two Shaman incarnations were certainly at the forefront of fair research" (Bussmann ec/2011). Shaman Pharmaceuticals did get closed for the first time in 1999; for an economic analysis of this failure see: <http://www.economist.com/node/187192>.

I don't understand. Or, are there some interests of this plastic medicine? I can't find any solution for this idea, of a world managed by great professionals, and that these great professionals are destroying the world, something that our ancestors have not done. They have rather kept the mother earth healthy (THP iw/2009)

Since the Americans keep having more and more junkies, the USA said: We will send a lot of money to Peru and Bolivia to eradicate coca leaves. It's really stupid, they think that if there's no coca, than there's no cocaine and they could be healed. The most ignorant person knows that the solution is not the eradication of coca, because they will create another drug, and the problems go on. But they don't want to hear the things we say. With the same coca you can heal those persons. The problem is not coca, but the politicians (THP iw/2009)

For my informants, the difficulties are located originally in a political and economic superstructure beyond the geographical frontiers, directly accounting and yielding the whole state system in the country, and not only policies' drifts. The divorce between what "people want" and what the state or government's representatives de facto do is similarly exposed among all informants, regardless if they are MDs, authorities, scholars or healers. For many of them, there is a sort of new identity in progress, which they have already seen in people's choices while seeking alternative products and services instead of conventional healthcare.

Many centres have already got the information that physicians recommend natural remedies to the patients, and there is an increasing tendency on people to buy them. The media has experienced a revolution in this sense; RPP²⁸² actually has a space for this topic with an opportunity for people and professionals to share information about it. People are willing and demand more this type of service (Psychologist iw/2009)

Interestingly, some THPs and AHPs in the same situation in Peru invoke information, research findings or trends that are produced in other countries and regions, to reinforce their position and to highlight the importance to promote TM and its products and services.

I am working to raise the spirit of the Peruvians, because in the past when you talked about e.g. the consumption of *quinoa*, *kiwicha*, *máchica*, *habas*, *olluco*, *tarwi*²⁸³... that was for persons of a *low* level, right? But now the world is changing because in foreign countries they say that the guinea pig has a lot of proteins (Bonesetter iw/2009).

When adducing that stakeholders or national lobbies are behind neglectful and corrupt politicians in the states' institutions, the discourse stresses either the moral or ethical

²⁸² Radio Programas del Peru (RPP) is a famous Peruvian radio sender with national coverage.

²⁸³ Peruvian grain cereals, and root crops: *Quinoa*, *Amaranthus*, *máchica*, *Fava Bean*, *ullucus tuberosus* and *lupinus mutabilis* (*Andean lupis*) (cf. Bussmann and Sharon 2006).

dimension of the concerned parties, or the professional or technical abilities of the people in charge. The critical discourse elaborated for the majority of informants in the private sphere about governance problems in the country has insofar a moral countenance, whereas the public discourse addresses the governance problems due to technical handicaps, e.g. concerns about training of human resources, the setting of institutional instruments and programmes or administrative enhancements that should allow more functionality and efficacy in HC. The last discourse focus was on technical and technocratic issues and revealed a posture into the modern neo-liberalism philosophy applied into health, for which “in intercultural health challenges” –as they prefer to say– lay furthermore in the reinforcement of performance, accomplishment, productivity and administrative order in health centres and general institutions. In this sense, the human or personal aspects of the implied people in key positions are not so important. So defined, the corruption problems or malfunctions of politicians or policy makers could be resolved just as health centres achieve more efficiency and efficacy, and their directors and authorities count with more and better specialisation trainings.

5.2 Health Policy Making

One of the major difficulties was the absence of a common vision among health authorities, politicians, professionals, labour federations and civil society by defining what should be reformed in the health sector (European Expert, General Coordinator of Project AMARES ec/2011)

According to some public health experts, the people in Peru respond to at least two criteria by choosing healthcare attention: The availability of these services in geographical and infrastructural terms, and the perceived effectiveness of the treatment. Both conditions determine the use of conventional, traditional, or a combination of both medicines, among the population.

In a wide fraction of the population the only available alternative is traditional medicine, they have nothing more. The official medicine does not exist in their territory; they don't know it, and they will not come into contact with it. In regions like Cuzco, Puno and Cajamarca the people use both medicines indistinctively, they discriminate clearly between them and how they should be used. Some persons become disappointed in one of them and consequently begin to use the other. But in a country like Peru there are many places where the only existing option is the traditional medicine, and nothing else will be available in a long time (Health Officer iw/2009)

In most of the cases, MDs identify the “cultural factor” as a decisive indicator of why many people in rural regions do not want to be attended to in conventional health centres, despite the fact that they could be easily reached and are available to them. Moreover, the fact that these cultural preferences are associated to a greater extent with low health standards in some regions in the country –which remain alarming and uncontrollable– is throughout pointed.

We have done some research on this, and we could see that there were several reasons why the people don't come to the centre. Herewith we developed the concept of “barriers”. Some gaps have to do with the distance: There are places in Peru where you reach a health centre in two days and there is no other option; thus, we must improve the communication. The costs are already getting over because the *seguro integral de salud* covers the whole attention costs for maternity care. But, the other point is the reality with the offer-demand on the care giving relationship: the culture... There is racism, and also an idiomatic handicap. In Peru there are over 56 languages, a high maternity mortality ratio and the lowest health covertures. And we don't know that (UN Peru Health Officer iw/2009)

Whenever we are making social programmes to diminish the malnutrition and maternal mortality, but if the last continues to be too high among the indigenous population, it's logical that we have not worked for the indigenous population in itself. We should steer an opposite course to this (MD, Health Policy Maker iw/2009)

We try to inform the community about the problem and also the local researchers about the importance of intercultural care... There is 31% of malnutrition in La Libertad; and that's an official amount. What kind of health policy are we talking about then? It's a disaster! (MD iw/2010)

Nevertheless, the relation between the employment of popular local resources of the communities, i.e. THPs, to improve the populations' attendance and reliance on health centres is for many PH experts and MDs not self-evident. The discussions on this point during interviews and work-meetings among this group become more technically oriented, situating the problem in terms of the different strategies for the implementation of new specialised centres and/or about the training of health professionals in THS and CAM techniques –from this group I have not heard any statement on how THPs could be incorporated into HCS. This was not the same for discussions about the implementation of CAM in health centres, and its specialists.

5.2.1 Complementary and Alternative Medicine vs. Traditional Medicine?

Some scholars want to see in this positive reception of CAM instead of TM in public policies a predictable tendency. Hereby the role of tradition has, as interpretative

argument, a special position in policies development to this respect. This explanation asserts that Peruvian TM, in opposition to CAM, has a long tradition in the country; it could be used anywhere and by anyone, all the time. CAM inhabits a different status, and its implementation is even more necessary because their techniques and methods are not an established practice among the country's history and culture. Thus, the preference for CAM over TM in implementation attempts can be firstly explained in terms of the disadvantaged structural position of CAM in the populations' preferences by hospitals and health centres' authorities and health policy makers. Of course, so the official discourse, this not necessarily means a disaffirmation of the indigenous legacy; it is, instead, a historical, cultural and sociological circumstance. That is why TM does not need any further implementation.

(In CENSI) it was the time for the CAM-physicians to build up a space in health sector. Hence, they occupied themselves with this at the core. This has not occurred with TM, because they thought that it has, anyhow, the weight of "tradition", so you don't need to conquer it, as it is the case for CAM (Anthropologist iw/2009)

The ministry recognises the existence of *médicos tradicionales* and traditional systems; more important, it recognises that it would be impossible to obtain an adequate health for all our citizens without the harmonic coexistence of these different worldviews and medical systems... today we have invited a renowned practitioner of our TM for this conference, to follow a tradition that has begun with INMETRA, in order to continue with our articulation, to know more about each other as a first step for a dialogue between the different systems...we'll try to continue discussing how can we improve our health system (MD Health Officer t/2010)

Another important aspect of this notable preference is the adduced absence of scientific medical evidence of TM practices, i.e. in the field of evidence based medicine (EBM) and research production. On the contrary, there are numerous publications using medical research trials and EBM methodologies of CAM techniques that sustain the use of these techniques in physician attendance, as well the availability of scientific literature and ethno-historical writing documents. This position is strongly represented within MDs, academic medical authorities, and policy makers, and it is clearly associated with the positivist conventional scientific formation, which does not consider findings without evidence basis.

The difficulty lies in the frontiers. When is it serious and when not? When somebody begins to talk about the *chakras* I feel uncomfortable. Once I was with a Canadian colleague who had studied Ayurveda. I felt certainly cool: He measures the pulse, don't eat this, pay attention to your weight, etc, and it was so for me because I knew that he is a serious person, and that ayurvedic medicine has centuries of testified efficacy. But

when I stay in front of a stranger... I don't know. Probably, my reaction would be the anomie -but that is my case; maybe for the majority is different (MD, University Vice Chancellor iw/2009)

Policy experts and physicians demand more research on TM to evaluate the feasibility of the integration of TM techniques in HCS or for the implementation of special courses in the curricula of health professionals at universities. This should be made, however, thoroughly in terms of EBM.

From the perspective of health, there were some mistakes in intercultural issues, especially in TM. When speaking about TM, the speech is only about plants "The plants are good but the practices are wrong" [Grins]. Nothing about the curanderos, or the concepts...When the INS opens CENSI, the only aspect of TM incorporated was the research on plants. That was the vision. But now we are trying to integrate intercultural issues as well (Health Officer iw/2009)

According to Davidoff et al. (1995), EBM attempts to fill the chasm by helping doctors find the information that will ensure them to provide optimum management for their patients. The authors point out that EBM is in essence rooted in five linked ideas: (1) clinical decisions should be based on the best available scientific evidence; (2) the clinical problem –rather than habits or protocols– should determine the type of evidence to be sought; (3) identifying the best evidence means using epidemiological and bio-statistical ways of thinking; (4) conclusions derived from identifying and critically appraising evidence are useful only if put into action in managing patients or making healthcare decisions; and, (5) performance should be constantly evaluated (p. 1085). The practice of EBM aims to sustain clinical performance and provide safely certified medical practices on health attendance.

In the view of an MD, some policy makers and academic authorities, some aspects of the intended integration of THPs in HCS should be by all means well discussed, but more on the part of other social scientists and scholars involved, who "do not really know well the situation in healthcare centres" or the challenges to be faced up among HCS. Their observations and proposals are too "abstract" to deal properly with specific situations, e.g. the difficult position of MDs in administrative positions that should act quickly and effectively with not less than resources in case of an emergency.

The consultants have too much theory and less practice. One already knows what they will tell to us. From this side I think that this has not much to do with the idea that we "don't want to hear". I have rather the impression that the discourse of the social

sciences falls too much abstract, with too big categories for our daily handling. The community mayor will ask: Who pays? I don't need a phenomenological explanation of the matter to resolve that! (PH Specialist iw/2009)

5.2.2 The Museum Syndrome

For experts on TM and social scientists, this point of view has a long tradition among MDs and policy makers, and it is a central part of their critiques and complaints about their procrastination and negative attitude in implementing intercultural health policies. A concept that I have coined to explain this constantly reference is the “museum syndrome”. It means the undisturbed and interrupted posture of policy makers in focussing their work on TM and TM practices, in time and space, in the past (fq/2010).

The Amazonia and Andean medical systems are the same since many centuries. Like Cabieses, other physicians have seen only the idealistic part of the past, because it is easier to speak about history and not about the present. That position enhances no compromise; you don't need to make policies or take any actions, because when you recognise that this exists in the present, the next step is, therefore, to allow them into the official system (Sociologist iw/2009)

In contrast to social scientists and field researchers, who work mainly direct in the field, i.e. in and within the community, the prevalent health officers' platform-scenario here is a museum, a library or archive, a research institute or an institution with mandates on health policy making. The attracted time is not the present, but the past: their interests are not about what is going on among people and TM, or in how TM is been used at the moment, or the actual situation of THPs in relation to people's healthcare attendance. They situate the contexts of their research focus, publications and administrative activities in a previous time and preceding space, i.e. they occupied themselves with the ancient history of Peruvian TM: its old artefacts, instruments, techniques and the ethno-pharmacological use of local herbs by priests during the time of the domination of the Incas or the uses in other pre-Hispanic cultures. In this respect –and different from their establishment in their functions and charges as policy makers– they do not build, promote or support empirical or field-based research about TM's contemporary practices. Actually, they have neither interest in the current situation in HCS regarding the role of THPs, nor to find ways how these resources could be allocated in HCS. This style had concrete effects on health policies, because there are no relations between research and data collecting, and what they do with it to improve health access in

populations using TM. Within the discourses of scholars and experts on TM, this appears to be the typical perception of public health authorities.

For some international health officers working a long time in the country, the problem is also related to the discontinuity of policies due to the particular interests of political groups or the related state of knowledge about TM of governmental authorities in a specific period of time. In this sense, the actions of a courageous or committed health minister or health policy maker about TM could be imparted ineffective by the defiance of an opposite congress or parliament. And no one can do anything against this, or prevent what would be decided at the end.

Now exists CENSI and before we had INMETRA. But MINSA has not a proactive attitude to promote the legalization, documentation and integration of these practices in HCS. Unfortunately, Peru has something in common with other countries: The frequent rotation of ministries and officers. This causes that the policies do not have continuity. When today we have a ministry susceptible to this topic, tomorrow comes another with no sensibility and any knowledge about it, with no interest... in this way, when the government period finishes, the emphasis concludes too (PAHO Head Officer iw/2009)

Consequently, the in-advance policies of a given government administration may be abrogated by its followers. The personal or particular preferences of some authorities determine the course of policies and programmes without more foundation or direct relation to the country's health needs in a given period of time. This is principally true in case of programmes or agreements about the incorporation of TM, which have been stipulated in consensus with consultants and experts in the governmental period before

Although in some places there are experiences, they depend upon the interest of isolated functionaries. For example, in the hospital of *Yurimaguas*²⁸⁴ the bonesetters were admitted, that was like a fairy tale! But that was the director at that time; what is when a new one comes and she must go? That is a consequence of a state's policy lacking vision (Psychologist iw/2009)

For the majority of the scholars and social scientists interviewed, the sanctioned opinion is about the state's inefficacy in policy development. They gave very concrete examples about the dejectedness of Peruvian health authorities by including consultants' recommendations and suggestions in health policies, with negative long-term effects. The evaluations and reports submitted by them, or the personal communications shared

²⁸⁴ See interview with the former director of the Hospital in Eddowes and Sixto (2006:60-64).

during technical meetings, have been mostly archived, in most of the cases as part of bureaucratic transactions, and do not appear in the final official reports.

The interest now is to adapt the services by utilising those things that could be “rationalized”... working with parteras and sensitizing health personnel as the first strategy. But before the THPs come in, the physician should be prepared to work with them... They are physicians that are not working in the field, they sit down at the desk... and until now we are continuously trapped in this “sensitizing process”. Since the nineties (Anthropologist iw/2009)

This year I have elaborated a technical document on how to work the intercultural architecture in health establishments, especially how to build the *casas maternas*. That was in April. And until now there’s nothing... When will be this applied? (Anthropologist iw/2010)

One of the principal patterns observed in the discourses about policymaking is the incidence on the part of scientists, scholars, AHPs and THPs in signalling the persistence of policymakers decrying as utter failure everything that had been done before. During the seventies, Albert Hirschman has studied this phenomenon and coined a term for this suggested policymaking “pattern” in Latin America: the *fracasomania*. According to this concept, policy makers are immersing in a “failure complex”, produced by the impression that one had to start from scratch over and over again, without solutions for the country (1981:155). By looking for the possible hidden rationality of this fracasomania, Hirschman argues that “the alleged failure of past policymaking induces the expectation of renewed failure, and this expectation –for example, that a land reform will be not vigorously enforced– may make it easier to adopt reform legislation than if there were not a general conviction that such legislation will remain only on paper” (1981:155). For this author, the fracasomania is, in many respects, an “unfortunate trait” which means “to shut oneself off from newly emerging cues and insights as well as from the increased confidence in one’s capabilities which should otherwise arise” (1981:155). He became more concerned about a closely related but more general phenomenon, the pervasive “obstacles to the perception of changes” and found that “when there are special difficulties in perceiving ongoing change, many opportunities for accelerating that change and for taking advantage or newly arising opportunities for change will surely be dismissed” (1981:155-156). According to his reflections, a country with a prolonged relative backwardness, the general expectation is that one’s country will continue performing “poorly”, and that any evidence that the country may possibly be doing better or may be emerging from its backwardness, is

going to be dissonant with previous cognitions, and this is therefore likely to be suppressed; “the evidence that nothing at all has changed will be picked up, underlined, and even greeted” (Hirschman 1981:156). The explanation that Hirschman offers for this behaviour relies on the “self-esteem” and “intellectual dependence” of the country, i.e., an intrinsically cognitive and emotional disability among the Latin American political class: “The difficulty in perceiving change and any partial forward movement is thus related to the findings of social psychologists who have demonstrated with experiments that persons with a low self-concept feel some discomfort when they suddenly perform well ... The proclamation of failure is a terrain where those who are comfortably adjusted to protracted backwardness and dependence can unite with those who advocate total change” (1981:156-157).

Besides considering that the populations’ profile in Peru –and of my informants– is now different from here back to the time of Hirschman’s theory, it is important to make some additional reflections. It is difficult to support a theory that is based on focal observations without considering the enormous and certainly decisive influence of the global economic market and its institutions on policy-making decisions among Latin American politicians. To explain this by ascribing it to an “inferiority complex” –as a sort of genetic disposition– is largely scientifically arguable. This sort of explanation certainly shares some similarities with most of those given by my informants, who came mostly from the research tradition from the seventies, however. At that time, and still nowadays, the identification of the political class in the country, perceived quite automatically as white and traditional oligarch, is directly associated with corruption and inefficacy in governance issues. Similarly, the political class and the local and national government systems in the country are perceived by the majority of the population in Lima in a negative way. For example, 63% of the *limeños* think that there is corruption in the city’s municipal administration, and 48% consider that most projects and political decisions are made prior to favour only some privileged groups in the city (Lima Como Vamos 2010:20). Nevertheless, the increment of the powerful economic acquisition capacities from a mostly young puissant new bourgeoisie in the country, with its own cultural and social styles, has permitted the affluence of a new vision of the

country and its policy-making structures, nearly to a positive perception²⁸⁵. Accordingly, in the same cited survey, 43% of the people feel satisfied with living in Lima, and 31% think that the living conditions in the capital are much better than in previous years (2010:7). In the last decades, we could observe the increment of civil participation, civil organisations and social networks, and their increasing influence on policy discussions and political participation in Peru²⁸⁶. Moreover, the political class in the country is not anymore composed exclusively by traditional privileged economic groups in the country, and many policy makers, parliamentarians and political leaders have a new ethnic and social profile. For sure, there are problems that remain the same as forty years ago, and it could still need a couple of decades to observe and evaluate some specific changes in one or another sense.

5.2.3 International Health Offices

The perception of an unsupportive state with corrupt politicians and non-operative structures in health or in the promotion of alternative healthcare models, has as a consequence that most informants see in foreign help one of the viable alternatives to obtain financial resources for their projects or work.

I guess that foreign people have more interest than our local authorities to bring financial aid... They said, they could invest fifty percent and the rest we still have to find. I think rather that the state should participate in this, because there is a budget, they couldn't tell me that there is no money. I know that there is money (Wachuma Apprentice, Social Activist iw/2009)

Anyway, the endorsed responsibilities are also contextualized within an extended international health policy managed by international health agencies that also operate in the country. These policies principally do not work properly because they ignore the perspective of the target people and their specific cultural characteristics and needs. The principal effects are reflected in inoperative intercultural health programmes, which have not even been evaluated accordingly.

I have worked for the WHO and the PAHO... There lies the problem. For them, in a manner of speaking, there exists an "indigenous" and a "white" agenda. They don't resolve anything because, as Machiavelli says in *The Prince*, to make an agreement both parts should win. Therefore, they will not let an indigenous person win, because for them he is "ignorant" and "less". So, I should impose me over him, and he must give

²⁸⁵ See e.g. Urrunaga (2010).

²⁸⁶ See e.g. Burt and Youngers (2011).

me all. I come to him, I am good, I help him, and he gives me his plants to decorate my report. The years of experience allow me to say what I saw! (Anthropologist iw/2009)

In these testimonies, the discourses turned out to be dramatic in some occasions. This was the case for some scholars and social scientists that have spent many years working in health programmes or consultancies for governmental and national and international health policy institutions. They went sometimes demanding and questioning with this research proposal, seeking for instance effective help or even sympathy when talking about their failed purposes or frustrated experiences –e.g. fair-minded intercultural settings in PHC attention. This denouncing attitude was accompanied with feelings of hopelessness, mistrust, anger, worthlessness and isolation, building a complex psychosocial cluster that was profusely present among the group of consultants.

I don't know how it is in other countries, but here in the PAHO... I don't take part in it anymore. They have people that are not competent, they invent their own version, it's a verse, they don't believe themselves in that -or maybe they do it as well. It's a matter of great delicacy: They talk about the "incorporation of TM", but, what does it mean? They brought 4 indigenous people to Lima, took photos with them in a cocktail-reception in a five-star hotel, and that's it. At worst is that they promise them "the moon and the stars", and at the end, they did nothing. The indigenous people don't trust them anymore later, rightfully so... I don't believe that the integration is possible, and I have been working over 42 years with communities (Consultant iw/2009)

I have beaten the air so long...but now, I don't know what we can do (Anthropologist iw/2009)

This could find an explanation in their most negative experiences with governmental health policy programmes and the negative impact of these programmes on indigenous communities' health and social and cultural structures. Such criticism –directed towards a constant administration style in individual cases and concerning intercultural health policies– should not, however, cause the gulf to be widened. In fact, there is a high specificity by narrating their own failed experiences in meeting up with physicians in teamwork, in which making them understand and accept their recommendations, ideas and suggestions, seems to be impossible.

This firm position is not only about policy makers, institutions and the HCS. So many scholars I have interviewed worked little together or thought that a proper work-partner could be found, also with those people with the same professional background and concerns as theirs. There is in fact no common network to operate in; the loneliness or

isolation in the work on this field and in health anthropology seems to be typical for this group.

There is absolutely no aid. I have sought people to make an association with, and I didn't find anyone. In the end I stayed alone with the indigenous people, because they are still fighting – at least now. When the mine corporation comes and gives them money, then fifty would probably give up and fifty will stay (Ecologist and Consultant iw/2009)

I also found that this loneliness or isolation is not only part of the discourse of social scientists. Also physicians themselves feel “abandoned” by the state and its promises to give better legal and administrative frames to their implementation efforts, both in CAM and TM. Above all young physicians are also confronted with several difficulties by trying to do their work

There were settlements 5, 7, 9 hours away. We went once a month to each town; actually, we scheduled only one place in a month! Some of them should be reached only by walking, there was no direct transport to reach these towns, and there was only one car available every two weeks. The people are really far away... it was very difficult. I was responsible for the programme on mother-child health. There was no obstetrician; I had to do everything by myself. One nurse took care of the vaccines and together, or alone, we prepared the visits. I controlled the pregnant women, talked to the health promoters and oriented them towards the prevalent diseases: malaria, dengue and also to recognise risk signs to transfer the pregnant women to the centre. I stayed most of the time alone there (MD iw/2009)

A MD working as Director in a health centre also asserts:

We organised a training course with the INS and MINSA about CAM. At that time Dr. X became director of CENSI and wanted to close the course. I talked to him and said that he can't do it, there was a ministerial resolution for the course and that would be a violation of public trust. Finally he couldn't discharge the course, but the next year he fired all the professors, and only kept one of them, the “cheater” –precisely the one who had said that we did “sorcery” because we once invited a curandero to the lectures. This Dr. X knows absolutely nothing about alternative medicine, he's a medical historian. There's no help for this! (MD, Head of CAM Centre iw/2010)

In general, for public health experts working for governmental institutions with policy mandatory in health, the situation is encouraging in terms of intercultural issues. They recognised a certain reluctance or unwillingness; but for them, this should be for sure only for some MDs. They want to see in the institutional activities positive signals for the development of policies that include indigenous perspectives.

In the plan of the commission of intercultural health the statistical documentation of the ethnic adscription²⁸⁷ of the health user, their clinical records, etc. is foreseen... We have

²⁸⁷ Ethnic adscription is conceived to be self-determined by the users.

a specific proposal, and now after many years of conversations with the ministry (of health) they finally answered yesterday. They have the entire disposition to develop it (MD, Health Officer iw/2009)²⁸⁸

There are some advances, but I think it could be more rapidly done if the political willingness of the people that stay over us had been real... this diversity is something which we feel so proud of, but in the policies that remains only in discourses. But there are certain advances. The fact that just Peru has proposed the intercultural agenda to be one of the important points in the meeting of Lima²⁸⁹ speaks for itself (Public Health Specialist iw/2009)

For many of these experts, the health situation cannot improve for both poor and indigenous populations under these conditions. They do not trust effortlessly the health professional care system or its institutions, and this could be one of the weakest points of the whole healthcare attention system, including for instance social professionals working on it. Nonetheless, the consulted experts were expectant about results of ongoing projects, new programmes or research proposals to improve this situation. Despite this particular and sometimes contradictory breadth of view, they shared, for example, ever so much information with me and stood as principal referees for peer-reviewing during the whole research process and related activities. However, this situation conduces to a problematic one-way road in health policy, in which scholars do not take part in policy making decisions, either because they feel themselves not taken seriously or because they do not want to be part of it anymore.

5.2.4 The Neo-Indigenous Discourse

The explored discourses in this category also include an analysis of the principal role and responsibilities of international donors and their NGOs located in the country in these failed implementations. In the view of some social scientists, experts on development issues and health programme consultants, there is a predominant presence of a *discurso neo-indigenista* among these local agencies that postulate an advocacy and fundraising with the main idea that indigenous people and worldviews are *holistic* and invariably *autochthon*.

²⁸⁸ Two years after this interview this plan is still in a planning phase.

²⁸⁹ See: ORAS-CONHU (2006a).

The neo-indigenous-discourse adopted an indigenous aesthetics based on the idea that everything the indigenous people are and do is unexceptional, that they are people living exempt from external influences and in a purely harmonious and unspoiled relation with nature²⁹⁰. This discourse disregards on purpose the real situation of indigenous people and their cultural survival, people that are at the range of systematic exploitation affecting irremediably their environment, health standards and social and cultural beliefs systems, including the impact on and even threatening their THS. Consequently, the proposed health programmes and programmatic aid from international donors and their foundations stream over these ideas, provided from local owners and teams of NGOs located in the country. These proposals have little to do with the actual situation and demand of indigenous populations themselves; they do not fit the communities' perspectives, needs, health situation, and problems. The explanation given for this preconceived and standardized tendency is mostly found in the interest of these organisations teams to obtain financial aid and enable with these budgets the continuity and endurance of their organisations. A consultant with many years of experience in health issues in communities in the Amazonia depicted the situation as follows:

There is no group in Peru more attacked than the afro-descendants and the Amazonian nations. Since the beginning they have been wronged with the extractive cycles of rubber, epidemics, and now oil. All of that has generated many diseases in the population, reducing it from ten to one. The so-called "cosmologies" do not exist anymore; rather they turned into *cosmodenias*²⁹¹, a sick vision. So, that is an abstract indigenism only negotiable for some NGOs. To think that communities in the Amazonia with extreme poverty and an enormous biomedical disease schema, including acute respiratory infections, digestive diseases, and dysenteries, could have a "holistic relation with the nature" is ridiculous. Precisely it was the extreme aggression that fractured it! How can a society maintain itself holistically and autonomically in this way?! The NGOs have an interest: In that way they seek financial aid in Europe and the USA, countries that have an exotic and distorted vision of the indigenous people (Anthropologist iw/2009)

²⁹⁰ This naive idealization is shared by foreign medical, psychedelic or spiritual tourists, which come to Peru and other countries seeking wisdom, enlightenment, life sense and similar experiences. See to this respect section 4.3.

²⁹¹ When "cosmology" means the explanation of the origin of universe and the position of human beings or a specific group within it, *cosmodenias* would then explain the process of destruction, chaos and the end of it (fq/2009).

5.3 Healers' Conditions of Work

I have knocked on the door of many presidents and parliamentarians to give us the law, which is the basis for our work. But we always fell on deaf ears! (THP iw/2009)

Although there are no official scientific surveys about the amount and demand for THPs in the country, and as my informants have strongly argued, it can be assured that the use of TM in all its forms and variants is remarkably high in the country.

It's urgent to discuss this topic in an open way. It must be recognised that these traditional practices exist and are more commonly used than many people would think. They represent an important alternative for a big amount of Peruvians (MD, International Health Officer iw/2009)

How many *mesas* will be done in a year? In La Libertad 100, or 200; the same is in Lambayeque or Piura. A lot of people attend them and they are certainly effective, otherwise the people wouldn't attend them in that number... The same is the case with the guinea pig: Today, at least 500 *limpias con cuy* have been performed... It's a very common practice, and here we're not including the *limpia con huevo* (Ph D, TM Researcher iw/2009)

People from Ica, Arequipa, Ayacucho, Nazca, Huancavelica, also from Lima and Trujillo come here... I have many patients in one night, up to 140 patients or so²⁹² (wachumero iw/2009)

At least 99% of the people coming to my practice have used the egg, and I think that this percentage could be extended to the whole population in Peru (Psychologist iw/2009)

The traditional medicine is in use. It is present in all our behaviours. Although we could think that we are not Andeans, we believe in the concepts of cold and warm, wet and dry... We accompany our meals with plants, to give them a specific flavour, to make our digestion better. It is present around; we are immersed in it (Anthropologist iw/2009)

5.3.1 Healers' Identities: Maestros or Curanderos?

There is a wide and heterogenic range of services offered among AHPs and THPs in Lima. Most of them are considered among some experts as "pseudo-specialists", i.e. they are practitioners with questionable procedures or a mix of not easily identifiable

²⁹² In twelve sessions I have attended by this wachumero in two different cities, I observed in average the presence of 80 patients (besides family members and accompanying persons) and 15 cases indirectly consulted in each ritual session.

techniques that could bring along an unpredictable risk for popular health. On the one hand, some of them –if not most– are considered by my informants as *charlatanes* (swindlers) that take advantage without regret from the allegiance and the affliction of people who could not find solutions with the official medicine, or other health practitioners. Just as well, there are also many practitioners that are per se accredited by their own prestige, and are well known among the population. In their view, despite their diversity, the demand for these groups of specialists among people is significant, and it is increasing constantly without any form of control and guarantee. Anyway, historically seen, different belief systems expressed in popular medical practices in Peru are constantly socially and culturally building up, reconfigured and reproduced; they coexist in a sort of antagonistic dynamic, reciprocal tolerance or complementation, which are instead regulated through existing power relationships and market laws (Pedersen 2009:47).

All the people coming to me are recommended from my old patients, people whom I have healed. It is like a chain, I have never placed an ad in a newspaper or in the radio. All my patients are people coming in advice from other people (wachumero iw/2009)

But, who is a curandero? For instance, would it be appropriate to rename THPs, for example, as maestros instead of curanderos? In their own speeches and discourses, THPs prevalently use the term “maestro” to refer to themselves and their fellows, and less often the term “curandero”, which is more used among scholars and experts. This tendency could be associated to a healer’s comprehensive conception of what a THP should indeed do, and also with patient transfer and positioning of oneself within health-disease-recovering process, as their respect for other practitioners as well. By all means, no THP used “shaman” to refer to him- or herself²⁹³. According to Oths (2002:64), while healers in the pluralistic highland medical system are generally labelled according to their primary form of ministration –that is, as herbalist, soul caller, bonesetter, shaman, midwife, lay biomedical practitioner, doctor, etc.– in practice, they may freely mix and match the techniques of which they have acquired knowledge, facility and a reputation (Oths 2002:64).

²⁹³ Several studies question the appropriateness in the use of this category when referring to Latin American curanderos. See e.g. Atkinson (1992) and Martínez (2009: 203).

Within modern curanderismo, Polia describes the positive charismatic operators (“shamans”), such as augurs and therapists, who can be distinguished from the negative charismatic operators and specialists in *magia amorosa*²⁹⁴, and the non-charismatic therapists like hueseros and parteras (Polia and Chávez 1994:10). The distinction made by Polia between charismatic and non-charismatic healers is based on the possession of a *vista en virtud* (a shamanic capacity of vision), which entails the displacement of the double anima or *sombra* (shadow) from the person to other places and dimensions, in order to make the journey or *vuelo* (1994a:29). So defined, charisma in this context means a congenital or inherited endowment, characterised by the healer’s ability to see the past, present and future (clairvoyance), to make predictions, and to invoke entities from the mythical world –something that is not reserved for other type of operators.

The maestro does not only own accustomed or ancestral knowledge and specific skilled methods to treat illness and improve healing –something that is “traditional” in a historic perspective. Moreover, the maestro professes a specific wisdom that includes a basic humanistic philosophy and corresponding worldview that could be properly considered “holistic”. According to this, a human being is considered more than only the biological aspects of the human condition. The *maestros* provide information and counselling to their patients beyond the mere employment of physical interventions or botanical treatments. Besides the setting of mediations at the spiritual level, there are also recommendations with a specific psychosocial character; they should be carried out by patients themselves and/or by their relatives. On many occasions, the maestros also cannot decide to begin a treatment or to interrupt it when, in their perspective, the person cannot be healed –i.e. when he or she is close to dying or have still learnt something important about the disease or threatening situation. Whatever the specific outcomes expected, and the prescriptions assumed for them, they should also find something that benefits the spiritual development of the patient, their family or even the extended social group.

²⁹⁴ Magic rituals performed by brujos (or healers with this field of speciality) with the specific purpose to obtain the love or attention of a person, and the dominion and control over him/her. This can be obtained, for example, by magically handling objects of the target person (photos, strands of hair, clothes, etc), through the administration of a drench, or by putting specific elements in his/her meals. See e.g. Millones and León (2004).

5.3.2 Healers' Competences

THPs in Peru have always been used to working in intercultural contexts. They have developed long-life skills that could be qualified as intercultural competences. In dealing with *daño*, e.g. THPs should know how their opponents –the so-called *brujos* or *maleros*– work by making *daño*. For such assignments, a properly trans-cultural technical training is indeed needed; this affords at least a continuous process of knowledge exchange and transfer, the development of linguistic competences, healing procedures and protection techniques in order to fight and/or to protect against it.

Sometimes there are *cuentas*²⁹⁵ that have to be done in Quechua. How can you return that *cuenta* when you don't know Quechua? You should then know how the maestro from the Andes works, his customs, to give him the same, to turn him over, to roll him over and give him there... I went to different places to learn how to work. My maestro told me: You should go to different places to see how the maestro from the coast, the one from the mountains, and the one from the jungle work (wachumero iw/2009)

In facing *daño*, the *curandero* must know how sorcery works in other indigenous and popular traditions and regions, and how this can be ended or resolved. This knowledge includes not only the techniques and instruments utilised, but also the ways in which the problem operates and affects people according to their cultural particularities and social circumstances. Hence, the competences to achieve knowledge and expertise to deal with is characterised for a continuous exchange and knowledge transfer, which are essential to cure or extricate the person from the *daño*. It could be said, in this example, that they must be habituated to intercultural issues if they want to succeed. These proficiencies also include working with foreign patients:

I provided proof for a friend²⁹⁶, a French woman. She was always asking me to explain this work. I said, I will explain you, but you wouldn't understand me, up you drink this sacred medicine. I said, are you ready? Because, these things are easy to talk about, but you should feel it by yourself, so you can explain it to other friends. She said, she was still not prepared. After a week, she said: Now I'm ready. We went to our *maloca*²⁹⁷, and we drank. I open to her good visions, exactly there, where I wanted her to go. I opened it and she began to cry. Why do you cry? You should resist. To be a *curandero* is not easy, ok? And to understand is also not easy. I told her, as here in Peru there is the

²⁹⁵ Sp. In the *wachuma* healing tradition it means the process in which the *brujo* (sorcerer) conjures a person to make a *daño*. The reversal technique is *descontar* (reverting the *daño*) (fq/2009)

²⁹⁶ Amazonian and mestizo *Ayawaskeros* use to call foreign patients "friends" (fq/2009).

²⁹⁷ The *maloca* was in its origins a space for the social and familial group in a common house, a universe at the same time, in which knowledge and common-life rules were shared and departed. At the present it means the physical construction itself. For an interesting interpretation of the symbolic and cultural significance of a *maloca* see: Serje, Margarita. 2003. "Malocas and barracones. Tradition, biodiversity, and participation in the Colombian Amazon". *International Social Science Journal* 55 (4): 561-71.

first, second, third grade (in the school), so should you stay. At the end you go to the university, and make a master or whatever; well, this here is the same. See where you are now (ayawaskero iw/2009)

The difference between a healer and a brujo or *malero* is strongly emphasised among all my informants. Beyond the techniques or procedures employed, the central difference appears to be the specific orientation they make of their multiple competences such as divination, healing or protection. The type of consultations and demands of their clients are not a decisive factor in their positioning. All THPs know how sorcery works. The question about knowledge or information is not important here. It is instead a moral, personal, economic-motivated or social-oriented decision in which field THPs decide to work, in a manner of speaking, for the “good” or the “bad” side –a decision that is also not uncommonly felt as an unavoidable innate vocation.

Someone told me about a maestro from *chiclayo*²⁹⁸, because there are no more “good” ones, right? Only the ones that learn merely the technique, and work with the *cimoras*²⁹⁹, but they don’t really know... and there are also the *maleros*, they’re not good, they work with the hills and the rivers (wachumero iw/2009)

In case of some social scientists and AHPs, THPs are perceived as intrinsically positive. Although not so characteristic among the explored discourses, this basically affirmative perception could be explained with the reminiscence of an old idealisation process with roots in the “myth of the noble savage”. Resting upon on the written literature of European philosophers and traveller-ethnographers recalling their adventures and experiences in the “new world” before and during the 17th and 18th centuries, the indigenous people –because of their apparently non-profitable relationship to nature and their disinterest in gold– were above all perceived and portrayed as good and innocent beings. Since Jean Jacques Rousseau’s misinterpreted concept of the “intrinsically good nature” of human beings –which was indeed a critique of civilized man– and starting with Lescarbot’s *Histoire de la Nouvelle France* from 1609³⁰⁰, a renaissance-inspired contemporary interpretation of the noble savage, which has partially influenced

²⁹⁸ Capital of the province Lambayeque, in Northern Peru.

²⁹⁹ Also known as *timora* or *misha*, is a mixed psychoactive drink consisting primarily of solanaceae (*Brugmansia candida* and/or *Brugmansia arborea* or angel’s trumpet) and iresine species (Rätsch 1998:70-71). One or more of them are also added to the san Pedro cactus (*Trichocereus pachanoi*) to elaborate a cimora drink (Schultes et.al. 2001:168).

³⁰⁰ Cf. Lescarbot, Marc. 2007[1609]. *Histoire de la Nouvelle France Relation dernière de ce qui s'est passé au voyage du sieur de Poutrincourt en la Nouvelle France depuis 10 mois ença*. Project Gutenberg’s *Histoire de la Nouvelle France*. Retrieved April 22, 2011 (<http://www.gutenberg.org/files/21199/21199-h/21199-h.htm>).

scholarship throughout over two centuries, characterised natives –i.e. all non-Europeans– as intrinsically good, having a lifestyle exempt from occidental vicious and materialistic fights, as well depicted with values like courage, warfare skills and a special tenure of “nobility”. “Everything that determines their lifestyle, customs, practices and social structures is under the sign of the easygoingness of their daily life; this is, at the same time, a result of their (material) frugality... Léry³⁰¹ draws from this the context of justification between the physical health of the Brasiiliens and their lives that are nearly free of tribulation and fear” (Steinkohl 2000:37, t. g.). Whenever described also with conceded fear and suspicion, the conception of a noble savage disseminated in the anthropology of the last century about a specific “nobility”, in a sense of freedom and ruthlessness, of the savage’s activities and occupations was persistently emphasised (cf. Tessmann 1928:152-178).

Even though primeval colonisation-linked, some of these antiquated ascriptions and perceptions about the American natives remain in some aspects a central part of the new age reparative indigenous discourse. As Ellington argues, the myth of the Noble Savage, if we examine it closely, is constructed so as to assert the existence of what it purports to critique, the existence of a belief in the absurd juxtaposition of the incompatible attributes of nobility and savagery: “the myth operates by oblique and obfuscatory symbolic manipulations to attain its intended purpose, the creation of a self-authenticating, and self-perpetuating rhetorical program for the promotion of racial superiority and dominance” (Ellingson 2001: 297).

The disposition for a positive perception is a socio-cultural drift that has clearly a political sense for the groups of *mestizos* or non-indigenous in Peru trying to define themselves as part of the archetypal goals of the “autochthonous” population. Certainly, through their adscription to this “semiotic field of indigene”, and as Ellingson asserts, “it seems to be no accident that, just as the Noble Savage myth was propagated in a period of impending wars and the revolutionary “specter...haunting Europe”, so also its 20th century resurrection and escalation arises in an atmosphere of buildup to world war

³⁰¹ Jean de Léry (1536–1613), a French protestant pastor who integrated a mission in a French colony in Rio de Janeiro (Brazil) in the 16th century, wrote his experiences in 1578 in *Histoire d'un voyage fait en la terre du Brésil*.

and looming socialist revolution in which, as in the French revolution, subordinate classes or peoples might rise up to threaten the established order” (2001:384).

Although passing descriptions can be still found in the discourses of some AHPs and new-age adherents, it is basically not reproduced in the perceptions of THPs, MDs and experts interviewed. If anything, the conception about a “basically good” THP is questioned and explained in terms of a neo-colonialist mentality with specific political and economic interests.

The European vision was always the same, exotic. You can see it in the first travellers in the 17th century; they have already talked about the exotic... I work with the *aguarunas*³⁰², with the COFROC³⁰³, the supposed “enemy” number one of the state, because they defend the community and the land. An indigenous friend of mine told me, we should work together to obtain foreign financial aid. I said to him we should wait for the community and decide with them. He said no, we should do it now. He sent the documents overseas and received over hundred thousand dollars. He disappeared with the money until now. So, the indigenous people could also be corrupt. There are no angels (Anthropologist iw/2009)

Western medicine has flaws and is too market-oriented. Indigenous medicine also has flaws. I mean, no side is sacrosanct. There are good physicians, good healers and also bad ones. There are a lot of charlatans on both sides...I think, it’s a sort of cultural decomposition around the world, and we cannot subtract from it any ethnic group (Anthropologist iw/2009)

The natives have in the past offered their products for nothing. Now it’s different. When a stranger goes to the Amazon and asks them about their plants, they say *I don’t know*. That’s a sort of political education among the natives, to say nothing to the foreigners, excepting ‘how much can you pay me?’ According to the type of information the price could be high (Naturopath iw/2009)

Some text passages found mainly by foreigner scholars, in which the person could be downright seduced to imagine the idyllic situation that nothing could be more comfortable and enjoyable as to be attended to by a curandero, has also provided the academic discourse with a colonialist view on indigenous healing that has also contributed, paradoxically, to their stigmatization. Here an example: “The relationship between healer and patient are informal and cordial. There is no such hurry and the typical distance of a doctor’s office or clinic, areas in which, moreover, the indigenous

³⁰² Sp. Ethnic group of the awajun, belong to the linguistic family of the jivaroan, besides the shuar and wambisa. They live on the banks of the Marañon River and own land territories in four departments in northern Peru, at the border with Ecuador (Amazonas, Loreto, Cajamarca and San Martin).

³⁰³ COFROC and ODECOFROC are indigenous associations fighting against the ecological contamination and territorial expropriation through the mining activities of the companies AFRODITA (prior DODATO) in the district of Cenepa in Amazonas (cf. ODECOFROC and IWIGA 2009).

customers do not feel comfortable and sometimes are considered misunderstood and treated with little regard...the fact that the healer is part of their own culture and environment, and speaks the same language, is an advantage for the patient, something that he does not have in a clinical environment. The consultation takes place with composure, while penetrating from the outside noises of everyday life: a baby crying, loud conversations of passers-by, cars driving away, the visit of family members of the patient or the healer, children running around, or the visit of pets. The fact is that the environment is familiar” (Gubler 1996:13, t. sp.)

As is the case in biomedical or other non-official forms of official care and popular health attendance, it would also be right to assure that the attendance setting by a curandero –because of human being exposed to the demands of the economic life system with its ecological threat, among other social and political phenomena– can also have negative outcomes, or that the patients/clients do not always feel in hog heaven. When we assume that the curandero must cover such expectancies, than this specific aspect entails, in my opinion, more negative consequences, because of the idealization and propagation of such references that are settled upon him/her. As a matter of fact, there is no medical system, whether official, biomedical, allopathic, alternative or traditional, etc., which can assure such friction-free and promissory ambrosial encounter between sufferers and those who are supposed cure others.

In this context, the tendency to associate “indigenous” with “happiness” and “humility” or “needlessness” could be only found in the discourses among some professionals working in NGOs and international agencies. In this case the figure of a THP will be loaded principally with positive elements, supposed with this to contribute to their social inclusion or recognition. Nevertheless, it could consolidate its weakening social position, by maintaining them away from social, economical and political discussions, which are unavoidable to deal with. At the end it is a matter of choice who and how will be making the better use of this delusion about the noble savage, and with which purposes. Some THPs intentionally use this picture to receive recognition, prestige, and also money.

The NGOs arrived here fifty years ago. If they eliminate the poverty, in what should they then work? Worst of all is that there is no participation of the beneficiaries. They

(the NGO's staff) managed always the funds and get evermore advantage. These funds do not arrive to the indigenous, they stay at the road...the WHO, the OAS, and all the international organisations play up with them (anthropologist iw/2009)

With the ayawaska you can see the future, what will happen. That means, you go in visualising all that'll come true. That's why so many foreigners come to Peru; they see all their projects, if it would function or not. When it doesn't work, he can do another thing. I speak a lot with foreigners when they come and want to see these things (ayawaskero iw/2010)

During my second fieldwork stay, I could observe remarkable differences in the way some of my THPs presented and applied their work in comparison with the findings of the first period. At first glance, it suggested to me the creative adaption of my informants regarding the political and socio-economic and labour conditions in the country –which may change swiftly and sometimes unforeseen. This difference was the most notorious in the innovative settings performed by healers whom I had worked with less than a year ago, and with whom I maintained continuous contact.

The best example was in my encounter with the implementation of new techniques, such the *bioenergetic chiromagnetism* in the practice of a bonesetter or in the entrepreneurships of two ayawaskeros to improve their service networks to other circles of clients by conquering the European market. There is clearly a growing need in the area of business know-how and to promote themselves and their services in extended client networks. Almost sophisticated, this interest resides principally in the incorporation of new elements in their consultations places, in gathering information about their legal situation, their possibilities to work in foreign countries, to export herbal medicines made by them, and to connect with more potential clients overseas. I could also observe a special interest to come into direct contact with foreign key partners –without the conventional support of other professionals– to promote their work through their participation in the production of films or multimedia projects, which are thematically mostly associated to drug recovery treatments for foreigners with indigenous medicine³⁰⁴.

³⁰⁴ See e.g. the participation of one of my informants, an ayawaskero and his community, in Sabourin (2012).

But, in fact, and although they could principally participate in exchange meetings with colleagues³⁰⁵, THPs tend to work alone. Some experts argued that, historically seen, this tendency was always typical for healers. The continuity of this work-alone-tradition has different interpretations. It may be based, so my informants, on their individual character or personality, and on the fact that they have been special persons since their birth, far from the common cognitive and emotional structures of the “normal” individual people. Anyway, what I could observe in the interviewed THPs is a tendency to work alone with his/her patients, but to accept the association with other persons only in case they want to implement a project. Similar to many developing projects in Peru, it is certainly difficult to be exempt from problems

The curanderos are too atomized. During the last five hundred years a lot has done to make them dispute... (Therefore) there is too much mistrust between them (TM researcher iw/2009)

At the end nothing was constituted. We built up a *maloca*, they began to line out very much ayawaska, chacruna, and many medicinal plants and fruits in the communities' plough lands...we thought to built much more, but we would have needed more organisation, better distribution of the money, there were also problems among the people in the community, but I didn't know more about this. The gringos were aware of all of that! They were witnesses of this separation and they didn't understand why. I warned them to take care and they went back to the USA. They have many problems with the properties, because they donate also money and wanted to get it back. There was a lawyer in *Tarapoto*, he demanded, he threatened them with death, and they became scared. They could not return to Peru for six years, because an arrest warrant was out for them (Ayawaska Apprentice iw/2009)

The idea to build networks between healers is not present within THPs, but is a constant illusion or desire of some social activists, AHP, new age adherents and some scholars. Although the tendency in organising healers to promote and legalise their activities has direct consequences on the socio-medical and therapeutic level in the community, it is an aspect that has not yet been properly researched. In this respect, and as Menéndez also suggests, we need to analyse the consequences to promote organisations in communal life areas in which the activities of THPs operate within cultural structures that have not formerly include this type of organisation: “The conception to organise *medicos populares*³⁰⁶ is foreign for the ethnic group in the major cases that we know. It is an idea that was proposed from outside of these groups, by people who had worked in

³⁰⁵ These meetings or arrangements are in the last three decades principal offensively-minded organised by professionals, tourist agents and new-age adherents interested in their practices with commercial purposes. For recently activities like this see e.g. CIC (2011).

³⁰⁶ Sp. Popular healers, term used by Eduardo Menéndez referring THPs.

or closely to them (...) by creating such organisations it is supposed to assume that between them it would be generated, at least, a minimal process of work division, new organisational mechanisms that include the bureaucratisation of specific activities, and the construction of asymmetric relationships, which either have not existed before or were circumscribed to the therapeutic relationship. The creation of these types of organisations implies the development of micro-power processes affecting the groups and their functioning inside, and altering the sense of traditional health activities” (1997:98-99, t. sp.).

In this sense, and in many cases as far I could observe, it is very difficult to distinguish if the procedures they use at the present are either “traditional” or “alternative”, and the need to establish clear conceptual, historical, anthropological or social definitions and the “limits” between them, were not strong presently in the discussions. To date, specialists and experts interviewed seem to have a similar impression:

INMETRA has never developed a project to certify THPs. They didn’t do it, and now I understand why not. TM has seemed to be too mixed-up, right? It cannot be clearly recognised what is TM or not. And the lawyers, of course, want to be clear with these “details” (Anthropologist iw/2009).

Many of what are considered foreign techniques are plenty in use and accepted among different social groups in the city. A possible explanation for this soft incorporation is that they are traditional techniques of social groups and cultures that are part of the socio-cultural-ethnic conformation of the present inhabitants of Lima. The practice of acupuncture (a Chinese Cantonese tradition of one of the principal schools of TCM) and vibration techniques from the Japanese culture also followed a certain logic development due to the important social, historical and cultural influence of these Asiatic communities in Peru. In this sense, the use of these procedures in combination with more or less traditional techniques of healing –or its re-interpretation– is not surprising, and owes an incorporation tradition that is typical for the development of TM in Peru. In fact, since the times of the formation of different cultural periods before the Incas, the tendency was always to incorporate the (foreign) knowledge of the conquered folks. In this sense, the THPs’ community is neither only national, nor a uniform community, and for sure not always “traditional”. Their practice interests, perspectives of work and projections are far from being the same, and have, at the same

time, something in common. In this sense it is either a properly international network, does not exist in any recognisable organisational form or a local or regional community, and has little to do with social shared concerns, spatial intimacy, cultural specific characteristics or long term client-healer kin-relationships.

5.3.3 Healers' Profile and Postmodern Traditional Healing Practices

Social and political processes in the country since the establishment of the neoliberal economic political structures in the country in the 1990s and the introduction of a postmodern work philosophy in health service attention have enabled the appearance of specific arrangements among professional, alternative and health practitioners, with some differences between them in the application, immediate practice benefits and its inherently socio-medical implications for the population.

Table 10: Postmodern Practices Encountered Among Some Interviewed THPs

PROCEEDING	STRUCTURE	ORGANISATION
Duration, quality, use and amount of elements depend on type of patient	Acquisitive vs. non acquisitive patients / International vs. national service / Different fees / English as new work-language	Possibilities of the patient to make publicity determine also the way in which techniques and elements are employed (shorter/longer ritual, special versions or combination of techniques, etc.)
Activities should give prestige, notoriety or fame. Oriented to promote the own work/proposal/style	Increment of the utilisation of technical or biomedical and popular-accessible or new-age language (i.e. "neurotransmissions", "energy" etc.)	Participation in congresses, symposia or academic activities. Projects or initiatives to come closer to MD and health practitioners at institutional level (universities, congress attendance, etc.)
Work is developed in the context of a growing transnational network	Biomedicalization of the intervention. Patients could be used to prove the efficacy of new or revisited techniques. Relations between practitioner and client become increasingly impersonal and hierarchical	Accomplishment of new instruments and equipments, rebuilding or accommodation of special attendance places. Former house or familiar contexts been replaced by special consultations or ordination-like places.
Recuperative emphasis replaces formerly preventive approach of TM	Nomination or transportation of culture-specific syndromes or embodied Andean illness into international disease classifications (v.g. <i>kutichyi</i> , <i>cutipado</i> (stress), <i>debilidad</i> (burn-out), <i>susto</i> , <i>mancharisqa</i> (trauma), <i>tapia</i> (anxiety), etc. ³⁰⁷).	Problem-centred explanations within the consultation context replace outweighing psychosocial interventions

³⁰⁷ The multi-causality and complexity of many Andean syndromes make impossible a specific identification. Also in this respect the over-simplification of many of the syndromes might be seen as a consequence of this postmodernization process.

The aim for prestige and acquisition of new clients and markets are widely present in the discourses of THPs. At the present, there are some common postmodern factors in the practice structure by all practitioners working in the city, which are constantly mentioned by the interviewees. The table above lays out some of the principal characteristics of the postmodern practices that have been found, identified and categorised. The emphasis on the introduction of new elements in the formerly intimate and highly personal relationship between THP and patients, as well the economic orientation of type, quality and quantity of attention, are the most important establishments in the last decades.

Approaching the significance of postmodern practices among parteras studied during the nineties, Davis-Floyd et al. used for the first time the term “postmodern midwifery” in 1997 to refer to “midwives who are educated, articulate, organised, political, and highly conscious of both their cultural uniqueness and their global importance” (2001:110). Nevertheless, the term “postmodern” used here is principally in terms of the acquisition of work styles and readapted economic systems, which were traditionally used by groups-in-power in the country, and now by subaltern social and ethnical groups. “In Latin America the market forces and the liberalism were primary instruments to reinforce inequalities and not to attenuate them. Both the resources and influences were accumulated in the hands of the richest and europeanised, who monopolised all civil rights, excluding the alternative or subaltern actors” (Gootenberg 2009:401, t. sp.). Thus, the intrinsic socio-cultural dynamic of these “imagined communities”, i.e. subaltern groups, rejects the pre-colonial and post-independence values in developing countries in order to make a profit or to get products inserted into neoliberal economies.

Principal characteristics of these postmodern practices are the competition between them to obtain more clients, to get into contact with a wide range of potential – mounting foreign– customers and the establishment of national and international exchange networks with a particular set concept of marketing-application, in which the words “prestige” and “effectiveness” are common. I guess that many of them would like to see in this a social advancement, a sort of upward mobility dispositive, with strong conceptual and practical connections to psychedelic-spiritual tourism and the (foreigner)

academic and social movement around the “internationalization” of Latin American *curanderismo*, although the latter has, indeed, little to do with the Peruvian populations’ health needs.

The ethnomedical competition in Lima is massive. There is a need to win prestige because everything is concentrated in the capital; centralization turned it into a city flowing with offers in health. Although all of Peru is represented in Lima, healers’ services are different from what they give in their cities of origin. It will be given according to the customer’s appearance as well the perception and ideas they make of the people demanding their services. Sometimes they don’t want money, but they want prestige, to gain space in more exclusive circles (Anthropologist iw/2009)

I also travel to big cities, I have been sent there in dribs and drabs to become known for the people, following my maestro’s example, because my maestro is already well known (Ayawaskero iw/2009)

The socio-economical and professional consequences of becoming famous in case of some healers who have taken part in research projects and made a name for themselves through publications is another aspect that has been not paid attention in the academia. As it was the case with some famous healers in Peru, like Eduardo Calderón Palomino “*El Tuno*”³⁰⁸, the popularity increased, whereas the familiar and social problems seem to follow an identical pattern.

When I knew him, he was living in a one-room place on the soil. After we published the book he became well known and got a three-floor-house. In the top was his clinic. Imagine, he had 40 patients at a day! But the family condemned him; they became greedy and fired his assistant. They thought, my father is now famous, we come into more money now, and we don’t need this other one...five years later, he was dead (PhD University Professor iw/2009)

As a consequence of postmodernisation practices during the last decades, there is at the present the professionalization of an individualistic work style and at the same time an accelerated “deritualisation” process in line with the current supply and demand of these practices. These developments are principal to observe in their life style, social status, practice structure and organisation, knowledge and language acquisition, activities, and networking procedures. Different from the past, in which rituals were constantly modified by curanderos in a self-renewal dynamic due to the exchange with peers, postmodern rituals now change at the structural level –elements, techniques and dispositions- as a consequence of the direct expectations of clients, the media and the

³⁰⁸ A publication-row about Eduardo Calderón followed the first book about him published in 1978 (Sharon 1978). See e.g.: Gushiken (1979), Joralemon and Sharon (1993), González Viaña (2009), Sharon (2009a).

academia (cf. Brabec and Mori 2009). In rethinking these observed structures, Davis-Floyd notes: “Examples such as these ...confront us with novel combinations; unexpected juxtapositions, ironies, and reversals of what was once touted as medical “progress” ...They highlight the fact that exchanges of knowledge and technology across locals increasingly muddle our attempts to find “authentic”, culturally specific practices and monolithic value systems” (Davis-Floyd et al. 2001:107).

I: I have also drunk ayawaska

i: for yourself or to work with it?

I: no. when the patients want to drink ayawaska, I work also with ayawaska... with the ayawaska is only another form to work. I prepare my mesa to back me up and then perform the ritual in silence, because ayawaska likes the silence³⁰⁹ (Wachumero iw/2009)

I choose here additionally the expression “deritualisation” due to two reasons. I consider it important to challenge the common assumption that traditional healing rituals are an estrangement of historically stated sequences of procedures not allowing any intrinsic prescription of the structure before at a later time. The difference is that these never-ending changes are offhand and can be followed through a historical analysis in big periods of time and development. The second reason is to indicate that the rituals now are mostly enacted in an unconcerned allowance of induced-exogenesis and transactional instructions that are principally regulated through clients, market-rules and liberal economies’ tendencies.

That is what I ask for and what I already do –the “innovation”. Logically, we should turn out some things that are magic-religious, those sort of ideas that make our work not of quality. We should eliminate this; this has yet to be improved (Bonesetter iw/2010)

Many maestros prohibit patients sharply to have sex. But, by a good *maestro*, for drinking this medicine, if you have a wife, you can have sex with her the day before. Why? Because we are children of the sex, it’s not a problem! In the past the shamans, the *ayawaskeros* did not permit this. Also when the woman has her “month”, she shouldn’t join the ceremony. But with me, she can! (Ayawaskero t/2010)

In La Parada, there are many stands with these things. You say what you need, for example, I want a candle for fighting, or a candle to haul love...of all sorts. In La Parada you find everything. Do you want a powder to banish someone from your home? They also prepare that there. Do you need an herb to maintain your partner doom? It’s there too...they only sell the stuff, and you go to the maestro with it and he prepares that (Wachumero iw/2009)

³⁰⁹ In san Pedro rituals the wachumero afford the clients to talk, to dance and to sing with along the session (fq/2009).

In some aspects, the process of deritualization and the postmodern practices might bring near the figure of the THP to the conventional profile of an MD. The subaltern practices, which have been observed into the conventional HCS between physicians and patients, as well as their structures and institutions, tend to replace the structure consultation of THPs within the firm introduction of postmodern structures in this field. Accordingly, a process of bio-medicalization of the discourses about conceptions and corps of explanations existing among THPs suggested also a standardization tendency, an ideological alignment with the dominant discourse about health that is becoming taken-for-granted.

We're no more in the time in which our grandfathers sailed in boats. Now is other time! ...I wouldn't stop to talk as doctors do; otherwise, I could not be also in the health attention, and we could not be exercised in attending the population. I mean, we should understand the chemical, the traditional, technical and scientific aspects. Here we are right! (Ayawaskero t/2010)

In this line is also important to point out the influences and consequences that the power of the biomedical language has gained in the patient-practitioner relationship in our modern society. In face of the influence of a particular type of training and practice -the "medical practice"- language occupies a kind of differentiating role, in which neither THPs nor patients can participate directly. For some critical medical authors from the late 20th century, the biomedical language has created a selected space, a social and class fortress without the participation of anyone except for their group members. So Illich said in 1975 to this respect, that the language "is taken away from him [the patient] and made into the raw material for an institutional enterprise", i.e. a process in which a patient's condition is interpreted according to abstract rules, and in a language he does not understand: "Medical doctors take possession of the language: The sick man is deprived of all meaningful words for his torment, something caused by the propagation of a linguistic secretiveness...if the common language of society is increasingly becoming dependent on the technical language of an elite, then disease will finally lead to an instrument of class domination" (Illich 2007:123, t. g.).

As it has similarly been found among other scholars (Pedersen 1988:69-76; Menéndez 1994:81; Eyzaguirre 2005:33-46; Sharon 2009a:258-259), the ethnographic recompilation of THPs practices I have made provide evidence that their knowledge

does now not only include practices, but also representations of allopathic medicine in their curatives activities, and that this fact is, at the same time, not self-perceived as a conflictive area. This process of functional and cultural articulation of biomedicine within TM at the linguistic level of the practice comes to be an operational factor at the level of representations generated among domestic or short social groups. Anyway, in all the cases these representations exist and perform within a hegemonic-subaltern relationship structure that prevails in the system. To this respect, Menéndez argues: “Biomedicine continuously tends to expand itself indirectly over the popular practices and representations; in its expansion process it has become not only part of them, but also uses it to demand that other diseases attention and care forms assume a subaltern character, what supposes in some cases the appropriation of such care forms by including them in its technical and ideological rationality” (1994:80, t. sp.). Nonetheless, for some scholars, the tendency in using “pseudo scientific” medical expressions by curanderos is a form to protect and rescue traditional knowledge and themselves from social persecution, and is not conceived as an abdication to their own cosmologies or knowledge. At the same time, this appropriation is also identified as characteristic for the continuous trans-acculturation process in the country, surfacing related TM knowledge as well

It’s strategic. The language they utilise is in a certain way, we could say, “popular scientific”; it is a dissuasive, expectant language. Some of them talk about “energy”, words closer to that used by Western physicians. And they sound cute, like “quantum physics”. Someone could say “that’s scientific”. They use concepts to make it digestible and nice; when I say “spirit” or “soul” –a classical concept of TM– that could generate rejections, they compare instead soul and spirit with “energy”. For me, these spaces are *regiones de refugio*³¹⁰ in which traditional therapies could survive (Anthropologist iw/2009)

There is an enormous diversity and variability among diagnosis and treatment patterns; also among these patterns there is a high mobility, a media-related, social mobility. Logically, that’s all we can find in a society like the Peruvian one, so contradictory and conflicted with its self (Anthropologist iw/2009).

³¹⁰ sp. Regions of refuge. Originally referred by Aguirre Beltrán in 1967 as to geographical spaces (cf. Aguirre Beltrán 1991), these imaginary regions have the primary function to allocate indigenous communities’ knowledge at safe from extinction. Though, in these spheres, the urban dominates the rural, and the communities turn to be satellites, establishing asymmetric (subaltern) relationships with other populations’ segments.

Anyway, this tendency is not always accepted by some researchers, who want to hear, preferably, more of the connected conventional speaking of THPs, which include typically a spiritual or non-materialistic (idealised) speech:

This is the first time I hear you in a speech. I'm very glad for you, really! But I think, like all others here, we are coming to hear a *shipibo-conibo*. In this sense, please, all the chemical and pharmacological aspects should be left to the MD, anthropologists, etc. right? I appeal to you today, please, to explain to us the spiritual principle of the *ayawaska*. What is this spirit in the plant, how makes such connection with our inner being? Please, don't talk about biochemical principles. Tell us about the spirit of the *ayawaska*, which is conducted through your *icaros*³¹¹. I'd be very thankful if you speak with us ONLY about it (Biochemistry t/ 2010)

In many cases THPs want to study and learn more techniques from Western medicine and to be part of research projects. In a first moment, it could be understood as a sign of globalisation, but in a second analysis the disposition shows double-speech subaltern practices, in which THPs are willing to distance themselves from their conventional discourse to fit health-care mainstream structures in the country. In turn, many AHPs working in the capital and other big cities passionately incorporate in their practice indigenous elements of Inca and pre-Inca cultures. AHPs brought into the discourses a new or revisited message of their supposed ancestors as far often as THPs do.

A typical pattern for this group is the use of a neo-indigenous reparative discourse at the core. This particular form of vindicated ideology combines indigenous political populism with spiritual healing and well-being practices, and is a central part of their work and life philosophy. The discourse includes the protection and conservation of the environment, i.e. ecological concerns, a statement of solidarity with indigenous rights and aboriginal cultures wherever they come from, and the assumption and emulation of re-invented lifestyles evoking deep ties of clan solidarity and spirituality³¹². The general identification with all these elements are presented as, adduced for and supposed to be part of a pre-colonial traditional legacy that could survive through them. At the same

³¹¹ Brabec accounted *ikaro* as a “magical song that helps by healing”. *Icarear* refers to a “melody whistling” to “transfer a magical function to an object, to travel to the past, to accompany the work of the medicos, or to undercover enchantments” (Brabec de Mori 2002:9,59, t. g.). One of my informants defines *icaros* as “songs coming during ceremonies...gifts from the grandmother *ayawaska*, immerse in a pray” (Ayawaska apprentice iw/2009).

³¹² See also Centro Kukahampywasi: <http://www.kukahampywasi.blogspot.com/>

time, the rescue of ancient values and lifestyles are intended to be part of the projects and work activities of many AHPs.

I organise all sort of spiritual-ecological- type of events, about TM, about coca, or “the call of the condor” organised in 2003³¹³. But in general I now want to give more conferences and develop workshops and social projects (AHP iw/2009)

Fig. 61: The Pirámide Moche³¹⁴



(Photo Pribyl 2009)

5.3.4 Patients, Fees, and Projects

In respect of the target populations they are working with, there is an escalating tendency to work with foreign clients or patients from the upper or middle social class. The reasons are basically economic and are indeed related to post-industrialised, market globalised practices present along Latin American curanderismo

I don't work with people from here. I mean, I also work here but to collaborate, I give them medicines. But it is something I do at less, more in order to see the effects. My interest was that. Once I obtained what I sought, I left it... My clients are to 90% foreigners, only 10% from here (Wachumero iw/2009)³¹⁵

³¹³ “El Llamado Del Cóndor: Consejo De Visiones Para La Acción Biorregional”, September 22 – 29, 2003, Valle Sagrado de los Incas, Peru. A video report can be found at: <http://video.google.com/videoplay?docid=-7531366971201031508>.

³¹⁴ This mystic-touristic place located in the Moche valley (Trujillo, La Libertad) is inspired by a postmodernist philosophy of entrepreneurship and combines architectural-archaeological style inspirations of the Moche Culture (and Egypt) with the realisation of “mesas de san pedro”, andino-muchik ceremonies, as well Asiatic and Indian healing traditions during the day.

³¹⁵ This THP is one of the most active organisers of “shamanic encounters” in the country.

Here come all sorts of people. Sometimes there come people, like to say, from ‘high hierarchy’, people from *La Molina, San Borja*³¹⁶, but also people from Comas³¹⁷. People from all places...I have a lot of clients also from the USA (Guinea Pig Healer, iw/2009)

At noon a woman from England is arriving. She wants to know me, she wants to work with me, but I don’t know yet much about it... It seems that she has a place there, in London, like a clinic, with therapies. She has worked before with maestros from here, but now she wants to work with women. We’ll see. If it’s my luck, I’ll go there to work, but I should look at my labour contract. I am determined, and I hope it’s not like the last attempt to go to Norway...When she wants to bring me there, I go for sure, I’m decided...If it is London or Norway or whatever, I don’t care, I will go. I will go. I wouldn’t stay here (Ayawaskera iw/2009)

In fact, it is reported that at least until the 17th and 18th centuries healers did not use to charge and receive money for their work as such. Larco mentions that the main occupation of the indigenous peoples in the Peruvian north was agriculture; they earned their living by caring for taller and the flocks of goats belonging to the Spaniards, and did not charge for their ritual activities, which were instead rewarded for with food, drink or objects (2008:35-36). Although postmodern practices are signed for an increment –or the wish– to improve the economic status of the healers, there are many THPs that are in acute danger of extreme poverty, with health and social problems, sometimes abandoned by their relatives and trying to survive with very few resources. Despite of the fact, that they are consulted by herbal and natural products companies and academic authorities due to their expertise in the preparation and knowledge of herbal remedies, the negligence on the part of their colleagues and authorities makes an improvement of their situation doubtful.

We hope only for one thing: That you don’t forget how I live. This house is 300 years old. When I came it was all black, black. I have made my work that God gave me, and nobody helped me. These rooms are falling down...from many countries people have come to me, and they didn’t come back anymore...I have had 700 students, from Germany, Bolivia, Ecuador, Colombia, they came and made videos...with my three years in prison...I asked to offer training courses in 1985, 1986 and 1987 in San Martin de Porras, in Jose Faustino Sanchez Carrion in *Huacho*, but they didn’t want me, they want me dead. Vergara is dead! (Naturopath and Herbalist iw/2009)

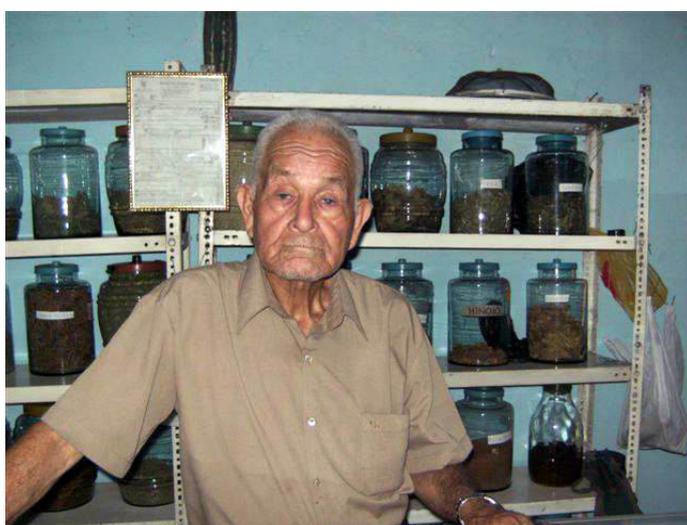
Some THPs do not have certain exclusive preferences in choosing their clients; in some cases they would like to work more for and with Peruvian clients, but do not find labour or economic support from the state or any institution in doing it. In these cases, they

³¹⁶ Middle-class districts located at the east and central Lima respectively. See Fig. 2.

³¹⁷ One of the most densely populated districts in northern Lima. See Fig. 2.

“have to” work more with foreign partners and clients to obtain money. The perspectives about money and fees are quite different among health practitioners. For THPs money is a consequence of good living and a logical service benefit, but it is indeed perceived primarily as a resource that should not be crucial to attend somebody. At the same time, some THPs make other colleagues aware of the implicit dangers of money, avarice, prestige and sway implicit in the modern practice of the profession.

Fig. 62: Valeriano Vergara Giraldo



*Peruvian naturopath, prestigious expert in healing plants in Peru. Although his knowledge is recognised by the most important academic experts, he lives and works in poverty
(Photo Pribyl 2009)*

I lived here 34 years ago. I don't live for me; I attend to each person that has no money. We should take care of them; when we pray you see a light with life-force for them, with the solutions for them, because many people have too many problems with the partner or they are alone, or they have nothing to eat (Herbalist iw/2009)

All my life I was here...when they came to me, crying to be healed, they don't have money to pay...but I attended to them. That made me happy. They come to be healed and they stayed here by me for several days, like a family, and then they went wholesome (Naturopath iw/2009)

We are devoted to cure, and sometimes people come without money, so we cured them because we can help. Those having money, they pay, and the ones that don't have it, don't pay, and ready! So we're always helping people, always (Wachumero iw/2009)

Sometimes you can distract yourself and then you went astray from your good life road, isn't it so? Just when you realise it, 10 or 15 years have already passed, and if you're not spiritually prepared for the fortune goodness, what do you do? Alcohol, women,

children here and there, and there's no comeback. But when you are spiritually strong you make a company, you work, and you help people, and you keep growing. Off course! Money is energy, but it will be learned to be shared (Wachumero iw/2009)

There are also some concerns about service fees and honoraries that are not at least throughout deliberate in the mind of the interviewed THPs in case of their integration in HCS as health workers. But some of them have already reflected on it

Something serious could be when they give you, for example, a salary, so you can work all-round. But here, we must work in other things and in the free-time make that we really love...MINSA will not make it (Wachumero, Coca Specialist iw/2009)

It's a great idea...but, does it mean I should pay also income taxes? (Wachumero iw/2009)

In case of MDs the position to this respect is not very clear, because it is yet very difficult for them to imagine a THP as a colleague working in the same health centre. Similarly, in a market-oriented economy the corresponding social lifestyle among people means lower monetary incomes for most of the population and at the same time more consumer stress, a situation that is also found among health professionals working in health and wellness sectors. The angst-inducing occupational perspectives and the uncertain future in the system demand from health practitioners looking for patients principally with more and better-paid-capacity and to see in colleagues potential antagonists. In the opinion of some experts and social scientists, the rejection of THPs in the part of health professionals could be explained in economic terms: In the amount of effort and investment on their own formation and career, something that a THP has not done. Besides the cultural differences, this socio-economic distance –and the threatening idea to lose status through this articulation– appears to be one of the principal obstacles in accepting a curandero as part of the staff

There is some tolerance with alternative therapies, but with TM there are for sure more problems and prejudices among professionals and the population itself... In this health centre there was an MD, she was over sixty, she believed in sorcery and those sorts of things. Once she asked me for a maestro because her son has “something”. So, she has the beliefs, but the conflict in her was always in relation to the money. The maestro told her how much it would cost, and that hurts her! I felt in her rejection something like “how can this ignorant, who has not studied as long and hard as me earn more money than me!”. The topic here is the studies and not the racism: *I have studied and he doesn't*. I feel this is at strongest (Psychologist iw/2009)

It is mostly negative. There is a missed encounter between the ones practising biomedicine and the ethnomedicals. Probably 90% do not accept it, and 10% of them do it well. But those accepting it have made their SERUMS³¹⁸ in zones in which the traditional medical practices are in average, and the reality compels them to compare and to inform themselves about this reality that somehow found solutions for health complaints (Anthropologist iw/2009)

5.3.5 Healers and Medical Doctors

Several healers accept and practice the inter-consultation of patients with MDs, health professionals or AHPs. As they declared, for healers there is neither reject nor objections in working with MDs or other health professionals indeed. In many cases they do not demand specific conditions, but in other cases they are difficult-to-be-pleased and require the establishment of precise contexts for joint work. Many THPs have already worked with MDs for many years, but always in an informal and mostly secret way, performing in most of the cases cooperation as a sort of clandestine submission.

Thanks God, now MDs understand more. They have realised that we could do more things together and not separate, something called “synergism”. They refer patients to me and if I saw a case in which there something must be done that I can’t, I said to the patient to go to the hospital and not to any other place, that they shouldn’t let anybody touch them. Maybe a surgery or something is needed, or it’s a major problem, it’s a fracture or so, or it is an elderly person...the medical association, the physicians self, are far more receptive (Bonesetter iw/2009)

I have found some patterns in the discourses about this hidden transaction process. It is common to find within THPs the derivation of a patient or client first to an MD, second to an AHP and only in rare cases to another THP. For MDs, the transference goes in the contrary way: They prefer to send patients first to other physicians or to MDs with CAM training, then to AHPs and only in last case to a THP. If these discourses fit the reality, why are there so many patients arguing to be referred to THPs by MDs? And why do so many THPs assure to become patients from MDs? The answer might lie in the specialisation field of each practitioner. It seems that there are some specialities of TM that makes the decision of some MDs easier for a patient’s remittance to a THP. In

³¹⁸ SERUMS (sp. Servicio Rural y Urbano Marginal de Salud). This official programme for health professionals foresees one year work in PHC level in rural and semi-urban zones of the country. It is *conditio sine qua non* to make specialisations, to obtain scholarships, labour benefits and to work at state’s institutions. See: <http://www.minsa.gob.pe/servicios/serums/2011/default.asp>.

the interviews it is more common to find this secret transfer in case of guinea pig healers, herbalists, naturopaths, and in the last case, bonesetters. Nevertheless, in case of ayawaska and san Pedro, there are more reservations to send a patient. Anyway, in all the cases there are heavy inhibitions on the part of MDs to recognise that they were the patient themselves. The following quotations can illustrate this paradoxical situation

i: Are there also MDs sending patients to you?

I: No, they send me no patients. No.

i: What about when they are themselves sick? Have you had MDs as patients?

I: Yes, they come, they hear. If they go as persons, they do it.

i: Why? If this is good for them, why do they not recommend you to their patients?

I: Because they don't want to be appear in a bad light.

i: You mean, they don't want to fall out of fashion with them?

I: Yes. They don't want to show off that their medicine does not work (Ayawaskero iw/2009)

I have doctors as patients also. They come to me to be cured (Wachumero iw/2009)

The child was very sick; he had terrible headaches, just like a brain haemorrhage. It wasn't easy but I cured him. Thus, the doctor wanted to know more about it. She said: When could I have the honour to drink with you? We are eight doctors and we want to drink today friday...she worked at the *Hospital del Niño*³¹⁹, the other doctors wanted to maintain the secret...she said she wanted to know about the child, because with her machines, with her science, she couldn't find out what he actually has...I was a little bit scared, I saw the doctors, with their ties, they were super! And I...I was only me, as I am (Ayawaskero iw/2010)

Also Ramírez asserts that the proposals of the THPs whom she worked with offered to join both medicines, and to share the attendance office with the MD at the PHC centre. The traditional therapist would attend popular diseases, while the doctor treats diseases of biomedicine. "Other desires of the traditional therapists are the exchange of knowledge with physicians. They proposed training courses for them conducted by medical doctors, and training courses between "médicos tradicionales" for the exchange of experiences" (2010:265).

For AHPs and THPs the idea to be incorporated in HCS is received with cautious compliance. For THPs there is for sure a clear disposition to join HCS, but at the same time they appraise few but clear requirements and conditions. According to them, they want to be let to guide the healing process, to prepare and use the instruments and

³¹⁹ Sp. Children's Hospital, today *Instituto de Salud del Niño*. The oldest and most important hospital specialised in paediatrics in Lima. See: <http://www.isn.gob.pe/>.

medicines under only their supervision and, most important of all, to not allow “false” THPs to be “erroneously” incorporated.

I have no problem in building up a team with physicians, psychiatrists or psychologists. But they may only see what I do. The point is that they should drink first. When they see, when they have experienced it, then we can talk. The patients are here, I’ll give them the medicine and they (the researchers) should only observe. I am the one in charge. I know what I do with the people and the others may only watch. When they know it better, more or less, only then they could work with the patients. So directly they can’t do it, because it’s not so easy. That’s what I want (Wachumero iw/2009)

There are so many people now that are really maestros and other maestros that are only cheating. The charlatans charge more. I don’t know, they have a ready tongue, they use to convince people that they are sick, and bring them to the mesa and charge more bills (Wachumero and Coca Specialist iw/2009)

Nonetheless, there is a critical but tolerant position on the side of THPs about “neo-healers”, i.e. psychologists or health professionals that have made a free integration of eclectic techniques learned at the university or alternative centres, and the use of plant ingestion and “shamanic” techniques in their practice. In the opinion of many THPs, their enterprises are profit-oriented and not a hundred percent authentic:

In the beginning I helped him. He was in Cuzco and afterwards he went to Spain. I told him, that’s ok. But he charged a lot for a therapy. He said, you should diet for three days, four days, two thousand dollars, three thousand dollars. And the people go to him; he guided them and gave them counselling. And he goes so on. He has not evolved at all, right? His body has changed, but he remains the same person: Less certificates but the same marriage. He went “metalyzed”, *ahi grita el cuero*³²⁰ (Wachumero iw/2009)

Among the interviewed THPs, the possibilities of Western medical techniques to the benefit of the population’s health are in general questioned. The main critique of MDs lies instead in the predominance of biological aspects in their treatments and the body-oriented medical curricula at universities.

Similarly, I found that the THPs interviewed identified themselves per definition closer to Western trained physicians as it is the case for AHPs. In their discourses, they perceived themselves –as it is also the case for MDs– more advocated to see and evaluate the patient’s situation in terms of the health impact of their own or anyone’s interventions with compromise, and a high sense of responsibility as well an according set of priorities and responsibilities in these concerns. This identification with

³²⁰ sp. The buff shouts there. Local jargon: The money bag (made from leather) is in charge.

established and accredited professionals applying their knowledge after many years of training and preparation within an institutional frame and regulated work conditions means for instance a positive identification in case of the integration of these practitioners into biomedical institutional work contexts.

That was the first what the maestros wanted, a recognition, something that INMETRA could give us...second, we wanted to do more research with our plants, for the people, so they can use them with confidence (Naturopath iw/2009)

Anyway, I guess that these positive attitudes of THPs working with MDs could also be explained as a part of a social advancement strategy of THPs. In this context, certain elements like prestige and being well known become interchangeable and will be assigned to a plan of action in order to climb the social pyramid and the rigid social structures in the country. Based on the discourses explored in this part, the aimed social improvement of THPs could be at this point also conceptualised as a frame on living better (including the social and legal recognition) with according economic advantage. Such wishes and expectancies are of imperative character among social groups traditionally excluded.

The concept of “education” in this sense is placed in the front of these considerations. The idea that “education is vital for economic success” means for instance only the occidental or Western oriented knowledge or formal education, which includes a specific (official) language and profitable social connections. Historically seen, THPs do not fulfil the occidental scale of training or formal education, e.g. long years of studying, investment in official or institutional training or conditioning their work place in a Western acceptable attention style. The maybe most distinguished attributed and recognised “vocation” of THPs and insofar their initiation processes become in this context an insufficient ability or in-going condition that must be now worked up to make its credibility enough marketable and creditable.

When I travelled to El Salvador and gave many conferences at the university they asked me where in Peru I learnt everything I know. I answered: nowhere. Because there is no legislation, no universities that could give a diploma or grade for our TM, which is, as it's generally known, priceless, because many people make use of it (Bonesetter iw/2009)

5.4 Intercultural Curricula

*The brujo was the most hesitant to come to our health centre
(Physician iw/2009)*

In understanding the key problem about intercultural issues in health, and as my informants strongly argued, the principal difficulty in dealing with Peru lies on the field of the university studies, more specifically, in the formation and training of MDs and health professionals. A large group of AHPs and social scientists interviewed scope the inherent problem basically in terms of the MDs' mentalities reinforced through the education, training and work of MDs at universities, academic and research institutions

The problems are the persons and their educational backgrounds. We need more health professionals with studies and bias in social sciences, or more anthropologists in the field of healthcare, but within a space of power and decision, because it is an assumed idea that MINSA belongs only to the physicians (Anthropologist iw/2009)

I thought that my team have understood and followed me, but I see that they prefer their conventional medicine; they felt themselves tied to it. On the other hand, there are health professionals that know a lot about TM, but they are ashamed themselves, or prefer to be white-dressed, and be the nurse or technical. Only the obstetrician understands the proposal a little and supports me, but the others didn't (Ms Public Health iw/2009)

Another handicap is that conventional professionals are not susceptible to the importance of these or other health systems. More than merely information, i.e. training, what they need is life experiences (Psychologist AHP iw/2009)

A profound limitation to the studies about explicative social accounts in health systems research is the barely presence of critical approaches questioning theories, significances and practices in and around biomedical knowledge. Biomedicine, with its instruments, institutionalized beliefs, values and procedures, also constitutes a sub-culture, which obeys the unquestionable statement that it owns exclusively the authentic and properly scientific evidence, and that this should be enough by establishing its universal validity and pre-eminence in health attention.

As method it could gain some level of knowledge, but there are profound answers that are still not resolved within the scientific method. Science is very deft in this sense; everything that cannot be confirmed with its methods, is not scientific. Science makes no efforts in developing methods that could delve in this type of knowledge (PH Expert iw/2009)

Science determines what is scientific and what not, what is certifiable and what not, what is researchable and what not. And there is always an economic interest. I study the basis of a profoundly profitable interest: I'm agreeing to examine some diseases, but in order to produce some medicines, because that's advantageous... Sadly, people interested in topics like TM are persons getting out of the norm, and of the system (MD iw/2009)

5.4.1 A Special Physicians' (Sub-) Culture

The physicians' culture in the country enhances specific characteristics that are essentially enunciated in the discourses in two principal aspects. The first is the social position conveyed to MDs and the second the Western-oriented curricula's contents in medical studies and training at universities. The first dimension includes important conceptual clusters like the physicians' identity, self-and social perception, self-definition, culture boundaries and racism. In relation to TM, as with other altered kinds of knowledge and systems, MDs own the absolute prerogative to address it or not, regardless of the cultural environment in which he or she works, i.e. patients' beliefs and different (culture-bounded) notions about body, health and disease. And the legal and institutional structures of the medical professional practice in the country reinforce these positions

In Peru the academic degrees are given by the state. It is a sort of license, because the state is directly involved. In addition, some professions must count with the approval of professional associations through a specialists register...but we physicians can do here all what we want, no matter if we are specialists or not. It is enough to be a MD (MD iw/2009)

All these aspects are immerse and interrelated in a particular epistemology, a doctrine of knowledge and life, in which the unquestionable and average privileged role of MDs in HCS and medical decision-making is extended also to their social and political status in the Peruvian society. In the imaginaries as well as in the actual facts, this role is situated in a setting of central political power and personal and social advantage, which is not only circumscribed to health attention. According to this image, MDs are health professionals with outstanding cognitive capabilities and surpassing intelligence. Consequently, MDs own high self-esteem, self-confidence and relish on prestige, because they are appraised and highly valued as health professionals with unrivalled social importance. Central to this portrait is the association of a MD with the ability to

have or maintain a high life standard, which means at the first an above-average financial income. Among my informants, Peruvian MDs are perceived as some of the most competent of the world (sic) but at the same time are described also as too “acquisitiveness-tinted”, “deceitful” and/or “insensitive”

The physician in Peru has on average three jobs, because on the basis of psychological reasons, it is supposed that the physician is too intelligent, and should earn a lot of money; consequently, he works in a hospital, at a university and a private clinic, and has no time to make scientific research. Or when he does it, it is only to prove the effects of certain medicaments because there is money in that; the pharmaceuticals pay for that (Ph D, University Professor iw/2009)

An MD considers himself at the top of all existing. We should rather make him put the feet on the earth. Whereas many have already accepted that a more “horizontal” view is needed, precisely those physicians are not in key positions. The physician in a hospital diminishes the others working in rural areas. He maintains still a little respect over him - maybe because he’s also a physician- but when he stays there more of 2, 3 or 5 years, “he’s not a physician anymore, he has forgotten all” (PH Expert iw/2009)

In Western medicine everything is about money. When you have money, I can attend to you, if don’t, I will not take care of you -regardless if you’re dying. There is no love and compassion in the relationship. All haggle over sending you here and there, to inject you, to draw blood, to make X-rays (AHP iw/2009)

In the view of many of my informants, the case of Peruvian physicians is a very special one. A principal problem is identified as an iterated behaviour with roots in the still present and practised colonialist ideology, which promotes an undervaluation of all that implies, or has to do, with indigenous religion and native cultural legacies

I have the privilege to dictate a course about TM in MINSA during two months. I invited two maestros curanderos to explain how they cure and make the diagnosis. We have had a guinea pig healer, a bonesetter, and many others. The same course was carried out in *Huancabamba* and the trainers of the health personnel were the curanderos themselves. It was a marvellous experience, everyone was delighted with it. But that was all. There were no more courses. We have never had a politic that assumes the compromise to work and involucrate in the formation other medical systems (Anthropologist iw/2009)

We have always used both things, a sort of mixture of Western and popular medicine. Vis a Vis the establishment, the physician discourse was managed around the harmful effects, because the patient use to ask us if they may drink *chancapiedra*³²¹ or matico. Of course they can! If it’s inoffensive for you, go ahead. It is few and far to find a physician not doing the same, because we keep in mind the placebo effect: when the patient thinks that the plant could help, it’s ok. Maybe he or she will be cured by using

³²¹ *Phyllanthus Niruri*. Native plant of the Amazonian rainforest. The Spanish name, *chanca piedra*, means stone breaker or shatter stone. The *Macantohue* is used to eliminate gallstones, kidney stones, and by colic (Arévalo 1994:175-176).

the plants and not because of my medicine, but *I* will always have the credit for the success (MD, University Head iw/2009)

Medical studies in Peru are essentially technology-pertained, characterised by a hyper-specialisation curricula and a career philosophy that promotes an adduced profit-oriented professional development with the promise for “unlimited” social fancies and the preference to work in an urban and not rural environment. Direct consequences of this abnegation are constantly cited among the interviewed. Medical authorities also reject initiatives from colleagues working with CAM, perpetuating in so far also with them the subaltern condition of alternative and indigenous popular medicine in health attention, and denying with it the way in which it is practised at the present.

The biggest problem is physicians’ attitudes. They don’t see it; they don’t realise that when this will be developed, this could benefit their own prestige. I have talked to the hospital’s director and I told him exactly that (MD, Head of CAM centre iw/2010)

In fact, and at least at the discursive level, there is among MDs an increasing interest in exploring alternative schemes of medical formation and healthcare interventions, including also a proper information and training in TM in the medical curricula. Nonetheless, in trying to find alternative holistic approaches and different practice options, these MDs collide permanently with strict structural conditions that overwhelm them. And this is not only on the part of the state, the academic institutions or within the legal regulations of the medical practice in the country. In this respect, THPs may be antagonistic to professional health workers because they see them as a threat to their power and livelihood. “Customs and taboos often militate against primary health workers, and problems arising from the traditional division of activities and prerogatives between the sexes also complicate the establishment of a new system. So, although basically they may be willing to stay in the villages, primary health workers may be discouraged by the problems they face and prefer to move to the cities and better-paid jobs” (Djukanovic and Mach 1975:20). According to some speeches, patients, customers and the public should also offer a great resistance to change this situation.

There are some MDs in my course. They have already worked with some alternative therapies and are truly interested in my herbal essences. Traumatologists for example, I have essences for the bones, they do trials with it... there are an increasing number of physicians willing to try other things, because, if you see how the medicine is being practised in Peru, the state trains you to be dependent on pharmaceutical providers, to

have the exclusive status to write prescriptions...and they want to do something different (AHP Psychologist iw/2009)

It is not easy. It is not possible to do serious work until legislation is passed allowing us to practise TM. Because if I use an egg to clean a child right now, I would lose my physician's certificate (MD iw/2009)

An MD speaks very little about this. There is something there, and it has to do with the physician's formation that induces them to adopt a specific attitude, certain behaviour. It also has to do with prestige. The patients are also very special. When a physician comes and begins to rub you with an egg or a guinea pig, they would say, "this is not a doctor!" The physicians are also at risk. What happens then? I mean, patients go to the doctor, because they want a pill, and not other things (Anthropologist iw/2009)

5.4.2 Traditional Medicine in Physicians' Curricula

Although there have been several official board resolutions, strategies, and mandates of the Peruvian government over the last forty years in order to articulate TM in the medical curricula, there are no obligatory courses at universities to date. If there is a course, it is about CAM and not about Peruvian TM. The systematisation and teaching methodologies are also perceived by students as confusing and without practical implications.

There were some courses on TM, but they were cancelled. This course was not properly carried out, because the contents were not clear. Supposedly it was about medicinal plants. But some things were also about holistic medicine, alternative therapies, and acupuncture. We saw this as upsetting, what is this? Because we had at the same time biochemistry, pharmacology, and it was very confusing (MD iw/2009)

In the course (of TM), doctors came and performed acupuncture or similar therapies for the lectures...but they were inspired by India, by other countries. Not by Peruvian traditional medicine (MD iw/2010)

The problem with the course was that it was very chaotic. The lectures were boring and long. He could talk about acupuncture and suddenly turn to the *uña de gato*³²² and then to the Vedas...It was interesting but...and when he talked about the mesas, yawaska, it was always muddled. We couldn't draw any lessons from it (MD iw/2009)

It is important because when we have a patient he could say that someone has rubbed him with the egg or the guinea pig, and we should understand that (MD ic/2010)

Sometimes it is the foreign doctors who have more insight, field experience, and methodological and technical skills in dealing with intercultural differences among

³²² Sp. Cat's claw (*uncaria tomentosa*).

health programmes. This aspect is of vital importance for medical students, which see in these transactions and personal reports a suitable procedure for their practice

There was an Italian doctor working in a health programme in Amazonia. He talked about his experience near Loreto. They wanted to apply a medicine and the family refused because their gods would be angry with it –or something like that. Thus, he spoke to the community's *apu*³²³ and they made a deal. They attended a religious ceremony, the doctor was also there, and they danced and he purified himself or something. Only after that he could inject the patient. Honestly, that was gripping! (MD iw/2009)

Many reasons are alleged to explain this situation, but central issues are enunciated in terms of a veiled rejection of indigenous knowledge in which TM and its practitioners are considered accepted protagonists in popular health attention, therefore making its insertion unnecessary. Nevertheless, the importance of an interculturally competent curricula in a country like Peru is shown by testimonies like this, in which many MDs not only should take care of losing benefits and job positions, but, also, to protect their own lives:

I have sent numerous proposals saying that a physician needs training on TM, because in the faculty of medicine there are no courses on TM. Once there was a curricular meeting in *San Fernando*³²⁴ and they invited me. A young physician asked about the course on TM, saying that it is important. I said that I could send a course proposal. Suddenly, an old physician professor of the faculty stood up and said: “doctors, only over my cadaver will there be opened a course on traditional medicine here!” They are very intransigent. Nurses and obstetricians could do a course; there is no problem, but “do not touch the physicians!” And what to do when the doctors go to communities and have misconceptions there? (Master PH iw/2009)

A colleague offered good money to work in special health brigades after the SERUMS was completed. I was thinking about it, but then I read in the newspaper that a group of them were killed by the peasants. One of the colleagues wanted to do a gynaecological examination on a patient, and they killed them because of this....yes, they were murdered, young doctors, the whole brigade, all of them... There are villages with too much closed people and we must understand them before doing something. But, I mean, how? (MD iw/2009)

Additionally, the labour situation of health professionals in general centres has been operating as a structural debilitating factor in accepting changes, in being more receptive to necessary intercultural attendance strategies, and to combine traditional and

³²³ Qe. Leader of a community. Apu has several meanings. It could be also a god (Wiraqocha), spirits of sacred mountains (Macchu Picchu, Pachatusan, etc.) or those ones living around them, as well a spiritual or political leader (fq/2009).

³²⁴ Faculty of Medicine at the Universidad Nacional Mayor de San Marcos.

occidental methods as well. Because of the labour conditions in the country, which are inspired by a liberal economic model, many health professionals working in state institutions are afraid of losing their employment, and live with constant insecurity of their actual positions. The pressure put by health authorities on MDs, nurses, obstetrics and healthcare takers to cover a certain minimum of attentions a day, and for the application of obligated medical proceedings are the principal reasons for this situation. The perceived potential danger of being discharged operates as a big stress factor, converting the health attention setting into a battle field in which the patients must be dissuaded –or forced– to shape into fixed attention conditions, whether they want it or not. These exigencies make the caretaker-patient relationship a struggle in which suspicions, impatience, intolerance and annoyance are the principal characteristics. Another argument enhanced with these economical motivated rejection could be easily identified in the fear of some MDs in losing privileges, and also the business or professional competition with THPs. In contrast, and as a MD pointed out, the competitive relation of a Peruvian MD with a specialist in TCM is still negotiable, because the competition is not on the next street

The problem with the own medicine is maybe due to the proximity of the antagonist. If I accept that Peruvian traditional medicine is good, I have my competitor right here. We have here herbalists on each corner. But if I say the same about TCM, there is no problem (MD PH Expert iw/2009)

5.4.3 Research and Publications

Although the need is enormous, there are no clear political guidelines or an academic niche among institutions to give support and frameworks for carrying out specific research on TM. Neither the national institutions nor the universities see it in their responsibility. Most of the researchers on TM I interviewed undertake personal and individual efforts to develop research projects, and the possibilities to obtain funding for publications are certainly scarce.

There is not enough research...I wanted to do research, I edited a book many years ago and I couldn't publish it. You don't find support. MINSA doesn't support, they don't understand. And the universities organise at least a course about TM, nothing more. I have searched in MINSA, at the university, in public institutions that could help. But it is like a vacuum, there is no academic discussion, no politics, nothing (Sociologist iw/2009)

In 1989, I presented my project to the CONCYTEC³²⁵. And they rejected it arguing nonsense. They said that I had not made an exhaustive bibliographic investigation and that I had to eliminate all the magic-religious aspects –that because I was interested only in the empirical aspects...I tell you, the extirpation of idolatries goes on (TM Researcher and University Professor iw/2009)

Most publications in the country have been done by individuals, they themselves put up the money for that...in FOROSALUD I knew from people that have made efforts to publish their professional experiences and systematizations, like a nurse in Ayacucho (Master PH iw/2009)

In general, research activities in the country are seen as privileged endeavours of certain academic groups, or just a marginal occupation of health professionals. Among academic specialists on TM there are more concerns about the position and attitudes of the people responsible working at high positions in institutions as with MDs in PHC sector. The latter do not have the chance, time and resources to systematize their activities; on the other hand, the urgent research, systematisation and documentary work on TM are one of the principle assignments of MINSA. But, in the opinion of experts, MINSA has no interest to promote research in TM, and the universities do not assume this deficiency.

How much has MINSA invested to date in studies about the cuy? Not one sol. How much money has MINSA spent to study the mesas de san Pedro? Nothing. How many limpieas con cuy have been done in Peru today, this morning? Not fewer than five hundred. MINSA doesn't care, however. How many lives are saved, how much health has the *limpia con cuy* in Peru brought up to date? All the contributions to medicine that has been done through the traditional medicine and what does it mean for MINSA? "We have nothing to do with it". No, that's a grave negligence! (Ph D, TM Researcher iw/2009)

If there is some interest in TM among MDs, then it is in medicinal plants and their possible uses as complementary herbal and nutritional supplements. The conception of some MDs and policy makers scope TM exclusively in medicinal plants, which are the essential item of discussion and concern in official research and policies about TM. The main focus among them rests exclusively on the research of the pharmacokinetics of medical plants, and the composition of monographs and essays and double blind studies of particular herbal species. The results are mostly not shared among other specialists or

³²⁵ Sp. *Consejo Nacional de Ciencia, Tecnología e Investigación Tecnológica* (National Council Board for Science and Technological Innovation) is an institute part of the Peruvian Ministry of Education. See: <http://www.concytec.gob.pe/>.

remain unpublished for a wider public due to particular career expectancies. Ritual aspects or intervention techniques are simply out of interest.

We are too much trained in an academic way. When we see a study we accept it. But when there is something that still requires research, or it is not sure, we don't use it. Maybe that is needed: To investigate them! (MD iw/2009)

I've talked with the botanist X, from the museum X. I wanted to know something new about the *paulownia tomentosa*³²⁶ (it's the tree with the most amazing growth rate, 5m per year!) and she told me that X was here looking for some registers about medicinal plants. She has already more of 700, and that since many years. It seems that Cabieses didn't want to publish them (maybe he didn't want to stay in the shadow)...Anyway, it's sad that they have so much research like this, and many years before could pass anyone learns about it or to has the conditions to publish them...to date she didn't say why they don't disseminate them... I know that there are other publications...but nothing is known, and they don't want to share them; the same is with X, they show it only in the *cumbres*³²⁷ (MD ec/2011)

Although the responsible national institutions in researching TM have for decades concentrated their academic activities exclusively in terms of botanical investigation as the principal focus, there is to date no traditional medicinal plant or derivatives from them that became to be used in any HCS in the whole national territory. The prescription of nutritional supplements or medicinal herbs that could be obtained on the market is in charge of the individuals and the MDs, and is not regulated or coordinated by any institution³²⁸. THPs, AHPs and some young MDs see in this avoidance the economic interest of the pharmaceutical industry promoting mainly events or research projects that include plants and botanical research which could be use to make profit

During the twelve years of INMETRA, with Cabieses at the front, can you mention please, at least, one plant that is used by now in public health centres?... None! (Psychologist, former worker in INMETRA iw/2009)

Pharmacy laboratories wouldn't promote this. You go to them and say that you want to make a congress about pain therapy, and they finance it quickly. But, in case I propose a congress to discuss traditional medicine, which is willing to finance it? It's very difficult (MD iw/200)

There are also other factors involved in choosing a research project in TM to get funding by national institutions. These reasons could be the personal relationship

³²⁶ Tree native from China and disseminated in America since the 16th century. Results of recently reports revealed that ethanol extracts of the *P. tomentosa* (var. *tomentosa bark*) possessed significant anti-inflammatory activity (cf. Si et al 2011).

³²⁷ World Summit of Harmonization on Traditional Alternative and Complementary Medicine released in Lima, Peru, in 2005, 2007, 2009 and 2010. See chapter 3.3.3.4.

³²⁸ See chapter 4.2.2.2

between fund-giver and researcher, and the need or wish to make funding suitable to obtain more money through the presentation of more projects. Nevertheless, at the top of factors are the personal and not the technical aspects (i.e. sympathy, personal identification, personal help, willingness, etc.)

I showed my book to a physician, and he said, “this book is about *folclóricos*³²⁹, do you think you can publish it?” Just the Peruvian physicians close the doors! By now, as Dr. Cabieses has passed by, maybe they wouldn’t demand anymore his signature or a letter from him to approve the publications, because without his *padrinazgo*³³⁰ nothing was possible to be published (TM researcher iw/2009)

Less research in big a format has been undertaken by foreign scholars working in this field and coming with financial resources from overseas for a specific period of time. During these periods, some official or institutional agreements could be established, but they neither found continuity within the institutional frames nor become part of research mainstream in the country.

329 sp. Pejorative term mostly used by physicians when referring THPs.

330 sp. Godfathership or patronage.

5.5 Integration of Traditional Medicine

MINSA does not accept traditional medicine because health is one of the major profitable businesses. Take into account the fight of Obama in the USA to create the universal health system. The lobbyists make too much pressure, and no physician wants to be isolated from their benefactors (THP iw/2009)

5.5.1 What Are We Talking About?

An interesting situation that arose during the interviews was the fact that I was intentionally did not explain to my informants, at first, what I exactly meant with the expression “traditional medicine”. Surprisingly, no one asked for it. Without exception, this seems to be a relatively clear construct among my informants, not offering any conceptual rejection in the use of this term in the embodying discourses. This non-first-reaction on the side of my informants suggested me that TM was a sensitizing concept that should be considered as a key explanation about the position of TM and THPs at the academic, scientific and institutional level.

Too often it has been mentioned in the discourses that TM constitutes a deeply rooted and non-achieved-informal institution in the country, which is also widely required by the population. Its historical development, the instruments and techniques that have been used during the last 5,000 years, and more importantly, the practitioners of the different THSs are throughout recognised and conceived as part of Peruvian’s CH and factual actors covering important people’s health attention needs. Although there is at the present some lack of confidence about the “authenticity” of their work –and many concerns about surrounding socio-medical problems– they are still considered as unquestionable important healthcare practitioners, whose practice must be appropriately regulated and capitalized on. This imponderable situation does not affect its adjudicated effectiveness and an appraised, mostly idealized, “humanistic” character of the prototypical healer-patient interaction.

TM is a common practice and a very concrete reality in the country. Sometimes it remains hidden because of the fear of a social sanction if it’s practised in an open way. At the present we could observe a deformation of these practices in command of many merchants (Anthropologist and Consultant ei/2011)

One of the reasons why TM still exists in the country is generally explained in the populations' difficulty to access modern or conventional medicine, either geographically or culturally conditioned. These reasons have been affirmed by some scholars suggesting that the principal reason in the maintenance of the practice of TM in the country and its prevalence in specific regions (northern, Amazonian and south-Andean) are by means of the populations' need in dealing with *daño*, for whom no other specialist than a *curandero* could be helpful (cf. Glass-Coffin 1992; Dragunsky 2009). For the experts interviewed, the reasons go far beyond specific historical and economical inferences, such as cultural preferences of communities and antithetical illness-health-recovering concepts. Many want to see in the absence of the state with its health institutions in wide regions of the country an indirect contribution to the maintenance of the different medical traditions.

Which medicine are we talking about? Oficial medicine has not reached the Amazonia or the Andes, and that is the reason why in these regions TM remains alive to date (Sociologist iw/2009)

Accordingly, the benefits of a possible integration of these medical traditions in the official HCS is considered by most of the interviewed as at least advantageous for popular health, regardless if the question is about specific THSs or techniques, the promotion of Andean products into suggested new popular nutritional patterns (i.e. neo-Andean trophotherapy) or the medical prescription of coca derivates and other herbal compositions in health centres

Optimal is that the medicine would be wholesome. A medicine with a unique knowledge but with different techniques of diagnosis and treatment, and that the medical students would be trained to manage industrialised medicines as well other therapy methods like bioenergetics, etc. and that he or she is also able to prescribe either an antibiotic or herbal medicine. In doing this it must be accomplished that all prejudices and barriers disappear, that the science accepts these different methods and the academia assumes a different attitude and wants to teach this.... But I see this maybe possible in the 30th century, I don't know when (PH Expert iw/2009)

TM is part of the people. At the present, here as in the whole world, the people are completely brownd off with the oficial medicine. They are seeking for alternatives, and anything that implies phytotherapy is perceived as an alternative (Psychologist, Coca Researcher iw/2009)

It's a technique that promotes health, it's effective, with a simple procedure, and improves a patient's quality of life. It's already done in Ecuador and in other countries, why not in Peru? (Chiropractic and Bonesetter apprentice iw/2009)

The government will gain a lot with this. First of all, the medical treatment in Peru could be improved as it is in Cuba, and there has nothing to do politics, but they took their traditional medicine and put it into the people's service... people at the hospital are exclusively because of pain. These people lose their jobs, family, whatever. But when we unclog the nerve or correct something damaged producing the pain, the patient returns to his normal life. Thus, I think it would be much better if the medicines joined each other like in other countries (Bonesetter iw/2009)

It's throughout beneficial. For example, we can apply both things in a unique situation. I can have my oxytocin to avoid a haemorrhage in the third period of childbirth, and also use traditional vertical delivery. I use the latter at childbirth and the horizontal position in the after-birth stage with microoxytocin to prevent bleeding. It's a combination of the technology of the oxytocin –which is wonderful and modern– with the traditional technique to reduce complications and maternal death (MD Health Officer iw/2009)

For example, the women violated during the dirty war³³¹. They went to psychologists, and it was a waste of time! If these women had undergone traditional treatment it would have been more effective. This sorrow could not be relieved so easily; it can only work in part with the guinea pig and in the other with mesas de san pedro (Ph D, University Professor iw/2009)

Among my informants, the protection and preservation of these medical traditions are urgent burdens. THS are constantly defined to be at high risk of disappearance. One of the principal causes mentioned for TM's process of devitalisation and commoditization is the so called "mystical tourism", which is repeatedly identified as an uncontrolled pernicious phenomenon.

I know the case of a maestro. I asked him to come to Lima to cure a patient; at that time he said, "No, this is my place, I don't want to go to Lima". He worked at his *chacra* and he didn't want to abandon it. But now, ten years after, he brings 10-30 people from Europe to make treatments here. He also travels to the USA and Europe. He has changed a lot, and I don't know if he's still as good as in the past. He was a maestro from San Martin. I saw many cases like this (Ms. PH iw/2009)

The richness of TM is vast and it's still throughout in force. The problem is what has happened during the last 8-10 years. It was a sort of external manipulation, the tourists, the mestizo people, scholars or researchers, and many psychologists, which have tried to join a curandero to make such things like business deals (Sociologist iw/2009)

Do you know X? He is the non-plus-ultra curandero among the *shipibos*. He came to Lima and up there has been paid by the rich people. He's an astonishingly good curandero, but he became corrupt. He learned to manage both worlds. His father was a great curandero also, a *shipibo* from the Ucayali, they lived in *San Francisco*. But there they all do that for money, all the people there. X has no scruples, but he's very smart and knows a lot of medicine. The *shipibos* are a community that have been too much touched up (Anthropologist iw/2009)

³³¹ See chapter 3.2.1.

According to my informants, the second place responsible for the bereavement of TM is occupied by the proliferation of evangelic religious communities and other Christian and non-Christian spiritual cults in the country. The gradual growth of these groups in the last decades has been playing a role as an additional progressive exterminating factor for TM and its practitioners. Some scholars want to see in the insertion of these religious communities and their preference by rural and indigenous peoples also an unpredictable problem with serious consequences for the preservation of cultural medical traditions. De La Torre says that the most visible aspect of this phenomenon is the mostly North American origin of a great part of evangelical groups in the country: “This circumstance, and the spectacular use of technical and economic resources they made, gives this process the impression of an externally controlled acculturation... The new churches promote the rupture with traditional social forms, and reduce in this way the “social combativeness” of oppressed groups” (1992:66, t. sp.)

I travelled often into the communities in whole Peru. I'm realising that there is a big movement of religious sects that are occupying the communities... basically evangelists, and others like the “prosperity” sects that takes away the money of the members... in one district you can't find a Catholic church, but instead two or three evangelic churches. The people there don't celebrate anymore according to their ancient traditions or are rejecting their own culture or identity, because they were told that it's diabolic, and that only through this abjuring they would be saved. I saw in this a cross-cultural manifestation, and alienation, a bad intention with the communities. They have already taken away our land, our identity, and now they want to destroy also our spirituality (Wachuma apprentice iw/2009)

These evangelic groups are the worst for traditional medicine at the present in Amazonia, because they fight against it (Ph D TM Researcher iw/2009)

This neo-Indigenism promotes the idea that the indigenous medicine is holistic...that's a joke! The Amazonian communities have experienced a constantly ailed external aggression that has broken down this holistic worldview. Since the time of the insertion of the Catholic Church and its persecution of indigenous religion, and now the demonization by the evangelicals... how can a society remain holistic in this way? (Anthropologist iw/2009)

According to the 2007 national census, 81.3% of the population in Peru is Catholic; 12.5% Protestant (mainly evangelical); and 3.3% includes other confessions like Seventh-day Adventists, Mormons, Jehovah's Witnesses, and Israelites of the New Universal Pact (INEI 2008:138). Alongside Jews –residing primarily in Lima and Cuzco– there are small Muslim communities in Lima (of Palestinian origin) and in Tacna (of Pakistani origin). Although the National Evangelical Council (CONEP)

estimates that evangelicals represent at least 15% of the population, official comparative statistics between the census 1993 and 2007 show an increment of the mostly evangelical Protestant community from approximately 2% to 12.5% (INEI 2008:139). Traditionally, most evangelicals reside in smaller rural communities outside of big cities in the country, but in recent years their presence in urban areas has increased significantly (USA DEPARTMENT OF STATE 2011).

Certainly, for both Evangelicals and Pentecostals the practice of TM and the work of THPs with spirits –from plants, deaths and natural or sacred places– are conceived as the devil’s influence that should be eliminated³³². Nonetheless, there are some exceptions.

The *Asociación Evangélica de la Misión Israelita del Nuevo Pacto Universal* AEMINPU (Israelites of the New Universal Pact) is a local religious group founded in the mid-1960s by Ezequiel Ataucusi Gamonal, a mine and railroad hireling born in Arequipa³³³. Their doctrine is inspired by the indigenous chronicler Guaman Poma de Ayala and an indigenous rebellion leader from the 18th century, Juan Santos Atahualpa. Ataucusi asserts that Peru has been chosen by God to be the New Jerusalem on earth and promote the vindication of the indigenous culture, which includes language, costumes, and also the practice of TM. According to their doctrine, the nutritionists “should give instructions about the nutritional regimen, especially with the use of vegetables, fruits and meat. Pharmaceutical medicines are for those with low faith; natural plants and spiritual cure are instead for those with more spiritual development... (In the forest) they are building medical clinics, in which they offer natural and spiritual cures” (Scott 1987:31,41, t. sp.). Subsequently, THPs who are members of this community could practise some type of THS³³⁴ if they advocate this service in the name of God, preach the gospel to their patients and exhort them to convert to their doctrine.

³³² In the Amazonian part of San Martín, a region in northern Peru, the “Guardia Celestial” of Pentecostals persecutes the curanderos because of their medical practice (Giove et/2011).

³³³ For an anthropological study on this community see, e.g. Ossio, Juan. 2005. “El Mesianismo Andino” Pp. 201-230 in *Religiones Andinas*, edited by Manuel Marzal. Madrid, Spain: Editorial Trotta, Enciclopedia Iberoamericana de Religiones, Vol. 4.

³³⁴ Excluded here are commonly the wachumeros, ayawaskeros and other THPs using artefacts like skulls, ruins’ stones, ceramics and figures of other religions (fq/2009).

Naturism teaches that we're all natural beings, children of the earth, and that we live according to this earth's spirit. When a person does not believe in God, then we are living in sin...someone said that the sin is death-like; but we're not dead, rather dirty, because we don't believe. But, when we begin to believe, we will certainly eat in a natural and healthier way. We have the nature to overcome each other, in front of God, with his aid [prays]... we should predict the ten commandments, the divine law; talking, and bringing it, and loving each other...we are trying to return to the time of the Incas (Naturopath, Member of the AEMINPU, iw/2009)

And this exception is not exclusive among *israelitas*. Also some evangelicals can practise some sort of TM:

She's evangelical. Actually, she shouldn't work with the *cuy* because the evangelicals prohibit it. But she had dreams before; an old man told her "you should use it to cure your brothers". She thought, "I can't do it, I'm evangelical". But the dream comes repeatedly. She told a friend about it and she said that she should ask permission from the pastor of the community. She went to him –certainly afraid– and told him this story with the dreams. He finally said "then you should do it". Up to this moment she works with the *cuy*, and she's very effective (University Professor iw/2009)³³⁵

5.5.2 Traditional Medicine and Curanderos: A Merged Concept

Two questions appear to be the most important among the discourses when talking about the integration possibilities by including THPs in HCS and their related mechanisms: What is traditional medicine? And, who is a curandero?

Far different from many scholars, for whom the conceptual delineations and theoretical exclusionary criteria about the terms used for TM are at the first place of importance, for THPs and AHPs this is a diffuse area that should be carefully evaluated in terms of "safe" techniques. They stress recognisable proceedings with a regulated and controlled functionality that should be defined in relation to specific observable results and measurable outcomes –something that is not necessarily traceable from a pre-determined theoretical or historical perspective. Among most practitioners, secure and positive outcomes superseded –and thereupon disguised– the "origin question".

It is like a brainwash, but this brainwash is done by the plant. It goes directly: this could serve and this one not, what doesn't help, you should give up, and go ahead. It helps you to bring hidden things over and that cannot be cured with an operation or pills or with conversations (Wachumero iw/2009)

³³⁵ A similar case was about an herbalist in Comas (Lima), who cured one of my informants from prostatitis. This THP is also an evangelical working on permission of his religious community (Hurtado iw/2009).

She has already worked with me for over 20 years; I know *who* she is. One time, I wanted to teach my techniques to other persons very close to me...but NO, it didn't work. Once for all: not everyone can do this. Because you can also put persons off balance if there are negative effects and I take too much care over this (Bonesetter iw/2010)

After attending to many people I must believe in this medicine. People that couldn't see and recovered their vision, or others that were considered incurable, with cancer, and were healed, or persons sitting in a wheelchair and afterwards stood up and go. I have had a patient that couldn't talk and began to speak. Do you know what I mean? (Wachumero iw/2009)

In all these years I have observed that most illnesses are of a psychosomatic nature; it has a meaning. TM is a preventive medicine; she allows us to understand, and she enables us to see what is in ourselves, the matter of trance, which is looking inwards, to have visions... Drinking this medicine is like putting the finger on the wound... It is not just for sick people, also the healthy ones could find help (Wachumero iw/2009)

Anyway, at least for my study's sample, an eventual integration process of THPs should be discussed by considering clear conceptual definitions, characteristics and determinations of who is a THP and which are their characteristics. Among the interviewed there are different conceptions on how a curandero should be identified, but in all the cases it is enunciated as a passionate and delicate task that must be overcome in order to promote a serious public health discussion about it.

There is a great diversity of specialists in Lima. They have increased dramatically due to the immigration from the provinces into the capital during the last ten years. Unfortunately, swarms of charlatans are to the detriment of those maestros working seriously. An interesting question would be, how could a specialist/maestro be distinguished from a simple charlatan? (Ethnomusicologist ei/2011)

How could a good maestro be classified? That is the detail. Because of a lack of occupation many present themselves as "shamans", and the limeño world, that doesn't know it well, recognise him as a shaman. And he's not (Ayawaskero t/2010)

By recognising a curandero you should see his work; when you go to his mesa and you feel better, if there's a progress. In this exact moment you can know it (Wachumero iw/2010)

The services offered by practitioners of the traditional or alternative medicine are wide and heterogenic. Most of them are pseudo-specialists, whose behaviour could be very hazardous for customers. In other cases they could be swindlers using people's naivety or affliction, because they are confronting health problems and did not find solutions through formal medical services. Nevertheless, there are also practitioners accredited by their prestige that also promote themselves in the mass media... Irrefutable is that the demand of this type of medicine is very significant, and grows constantly (Ph D Anthropology, University Professor ec/2011)

In addition to detailed descriptions of personal and cognitive characteristics, the dominion and expertise in applying specific –and knowledgeable– intervention techniques and the necessary attitudes in relation to the patients and the work situation self, the explanations have been consistently attached to affirmations about what must be part of the repertoire of a “good” and “real” curandero. In identifying such characteristics there are five principal dimensions that have been often mentioned:

a) An Indigenous Origin

The attributed ethnical or cultural characteristics of a curandero are considered important among scholars to determinate the “authenticity” of a THP. Above all other considerations, like specific technical knowledge, effectiveness or patients’ demand, however, the prevailing distinction mentioned among scholars and researchers is done by means of a sort of racial or ethnical/cultural identification. It is instead of great meaning an identifiable linguistic knowledge –i.e. the use or dominion of indigenous languages, which includes a “poor” Spanish. Likewise, the utilisation of a modest outfit and associated life style (*real* curanderos are basically poor people), as well as specific elements of their physiognomy (skin colour, facial features) allegedly make it possible to recognise their indigenous ethnical adscription. Opposed to these are the narratives of THPs and AHPs to this respect, in which the racial, socioeconomically attributed status or ethnical considerations are not crucial by defining a curandero –whenever mentioned.

Within some scholars’ discourses of this point, there are some diffused or isolated reflections questioning the pertinence of this peasant-fixed-imaginary or racial essentialism when talking about curanderos.

But in doing this we must consider also the “hybrid” specialists, those reflecting our high mixed culture and having a profound connection to our *mestizo* culture (Ethnomusicologist ei/2011)

Although assuredly unassertive, these perspectives slightly challenge the enforced concept of *mestizo* and *mestizaje* in Peruvian society. The term *mestizo* refers to a broad swath of racially “mixed” or hybrid identities in Latin America connoting primarily “a mixture of European and indigenous ancestry” (Hill 2008:252). Among the scholarship of post-colonialism and cultural studies in Latin America, the construct of *mestizo* has been extendedly examined under different aspects. It has been addressed in the context

of acculturation and interculturality (Walsh 2002), euro-centrism (Quijano 1997), the biologization or biological determinism (Menéndez 2001), among others. As a mainstream concept for Latin America, the plain ideological identification of Latin American inhabitants as mestizos will operate as a discontinuity in the unrelenting re-colonialist discourse³³⁶. One of its functions is to uplift the indigenous population by draining their backwardness, in which the term mestizo represents the condition of possibility of Latin America as a future par of its northern neighbour, while accepting the inferiority of the region in its current stage of evolution (De La Cadena 2005:16).

Anyhow, mestizo curanderos are principally identified by most experts and academics as legitimate ones by pointing out their moral/ethical behaviour or intended expectancies in applying traditional techniques. According to these imaginaries, and despite the proper application of procedures, work style and/or effectiveness, mestizo curanderos are usually set apart from “real” or “authentic” healers. This conceptualization could also be verified by contrasting this aspect within the empirical findings on their counterparts’ discourses. In fact, THPs used to present themselves identifying and describing first their curandero origin, which is mostly declared as indigenous. All of them agree in defining themselves as predestined to be maestros, establishing at the time of inception commonly around their birth, with specific and mostly just inexplicable magical events surrounding it that might be also present during childhood and adolescence. At the same time, it is prevalently asserted that being a curandero was not a proper “free” decision in terms of self-determination choices for them, commonly based upon mere allegiance, or an ulterior occupational option among many others. In turn, this vocation is described reverently by the THPs as a process in which the curanderos themselves have had no chance to reject it or, in other words, it is by all means destiny-decided.

A *willakoq* is a priest, *mamacona* if a woman. They must have been trained in all the fields. He should know how to cure, he must be able to diagnose, and above all he should know the plants very well: Which is for fever, for a stomachache, etc. The word “priest” means eternity. One is born for this; we have been born for this. There is no other path we can choose (THP iw/2009)

³³⁶ Some studies using “embodiment” or “bio-cultural” approaches in Andean ethnography could be interpreted as a non-disruptive continuity of this ideological tradition. See e.g. the analysis presented by Oths (1999).

Becoming a maestro cannot be learned, it comes at birth...it's not just if you will it or not, or if you want money, because you have seen the work (Wachumero iw/2009)

I feel, and this is real, it's just like a painter that has been born with this feeling that he can paint well. I feel that I can cure since I was a child. I was born with it, it's genetic. And I thank God for having been born with this condition, to cure with my hands (Bonesetter iw/2009)

I dreamed of the guinea pig, I was rubbing persons with it...I dreamed of the herbs, which herb will cure some persons, the children; the dreams helped me (Guinea Pig Healer iw/2009)

I know that I was born to heal. When I was seven years old I used to dream often of demons, and that I went down to the people, and cure them. I saw myself in the middle, they told me that I should not eat any meal, that it must be a special one. The time went on, and I didn't understand what was going on with me... And I finally cured people (Wachumero iw/2009)

A review on the ethnographic records existing about curanderos' backgrounds confirms the information provided by my informants. In case of wachuma healers, for example, the tradition supposed a sort of transmission that has, in most cases, an initiatory character (Giese 1989:29-28). According to some authors, this initiation could be announced through dreams and visions with a specific and most symbolic message about their vocation (Chiappe, Lemlij and Millones 1985; Polia 1988, 1994; Camino 1992), through the *levantamiento de las artes o encantos* (Gushiken 1979:49), as well the personal experience fighting against a serious illness (Joralemon and Sharon 1993:89,114; Sharon 1978).

The initiation with the *arte* for the new curandero typically follows in an inter-generational transmission from father to son/daughter (Feldman 2006:19; Sharon, Glass-Coffin and Bussmann 2009:251-253) or from other family members like uncles, aunts and grandfathers (Pérez 2009:30-31). Also among "Andean shamans" –spiritual leaders with visionary and healing capabilities– and other THPs like herbalists, naturopaths or coca healers, the initiation begins frequently with the experience to be directly exposed to an extreme climate phenomenon, i.e. being targeted by a thunderbolt (qe. *libiac*, thunderbolt's children), with the spectacular emprise of dying and being reborn afterwards (Cabieses 1993a:71-72; Gareis 1999:134-135; Cáceres 2002). In Bolivia, the "gloria" is a culture bound syndrome appearing when the thunderbolt falls and its reek enters the person. The rumbling thunder frightens the person, and causes

coughing, temperature and weakness, up to death (Ramírez 2010:96). If the person survives this attack, it is possible that he is considered a special one, with divinatory and/or healing capacities (fq/2010).

Cristóbal de Molina reported that “there were others named *camascas*, who said they got this ability or virtue from the thunder, saying also that when a thunderbolt falls down and somebody is frightened, after recovering, they said that the thunder has shown him that art, either to cure with herbs or to give answers in things they were asked for. Similarly, when someone escaped from a river or a big danger, they said that the demon comes around, and those who he has chosen will teach on the herbs. From here many indigenous come that are great herbalists; to others he showed poisonous herbs to kill, and these were the *camascas*” (1916[1576]:f/045013, t. sp.).

For Polia (1994a), in a chapter written in collaboration with Chávez, the shamanic tradition of northern Peru unfolds a transmission that could be undertaken in six cases: (1) from the shaman father to his son; (2) from shaman to disciple; (3) through “direct call” by means of dreams or precocious states accompanying certain sicknesses; (4) as consequence of an event with sacred value, i.e. to be targeted by a thunderbolt without dying; (5) due to the selection by spirits of the lagoons or hills that carry off the future shaman for a while to teach him the secrets of the “arte”; and (6) by the presence of certain talents or characteristics, such as the clairvoyance, which are interpreted to be signs for the future vocation (p. 19).

Pedersen and Coloma (1983) also found that in the Ecuadorian Sierra, the father’s influence is decisive in the initiation and training of the healer, and although evidence is only partial, dreams and oneiric experiences also play an important role in the initiation, training and practice of healing. Because of the non-formal nature of the teaching and learning process, the training of a healer continues through his life and daily practice. There is no fixed time-span, and apart from the main initiator, apprenticeship is completed with other healers or witchdoctors from remote areas. This teaching-apprenticeship process takes place on two levels: the first level is one of *oficiales* or assistants to the master in direct practice; and, on a second, non-empirical, supernatural

level, through dreams and initiation rituals, such as visits to powerful places or revelations (1983:1253). The initiations process is different in the same country depending on the region. In the same study it is reported that the practice of attending to births on the coast is usually inherited from the mother or grandmother; in some cases, however, the community chooses a certain woman to take up this profession (Pedersen and Coloma 1983:1254). Very few cases were initiated through dreams with the apparition of spirits who not only invited the woman to the profession, but also taught her how to attend to deliveries. Whereas in the sierra the partera works only in her own community, and since women generally have their preference for a particular partera, the latter attends all births within a given family, parteras on the coast frequently establish symbolic kinship relationships (*comadre*) which reaffirms their bonds with their clientele and assigns them a definite role in the upbringing of the children they deliver (Pedersen and Coloma 1983:1254). The specialist on traditional health is a “chosen” one, a person who can become a vehicle for the achievement of a special knowledge that can discover hidden things and performs revelations through dreams or trance, sought by ingestion of hallucinogenic concoctions. “Finding symbolic elements of power (Illas) are different ways to access the role of priest and/or healer” (Sánchez Garrafa 2011).

The explored discourses about curanderos in Peru indicate, notwithstanding, a sort of final-state-reliance upon a largely peasant-derived stereotype. Anyway, the emergence and establishment of an “urban curing complex” among scholars and practitioners is present, a curandero-model that was proposed by Press forty years ago, as an example on what has occurred in Colombia in similar issues at that time (1971:741-743). This approach counts, however, with a short range of ethnographic accounts and scientific studies outlining the relation of the practice of these urban healers within the country’s health attention system, as well as with the legal conditions in which these practices have been done. On the other side, and according to the current situation in the country, in which the number of mestizo healers has ostensibly increased during the last decades, the demand on the ethnic-based “purity” was not considered a primary requisite among my informants, but noticeably expected for many of them. Anyhow, THPs are more emotionally preoccupied on how they use their migration experience in the city and to

what extent they have been transformed through this acculturation process and, moreover, if they maintain themselves “authentic” to their vocation. Accordingly, THPs present themselves as self-assertive, establishing in the discourses a diligent cultural, social and spiritual distance between them and the demands of the modern society, also relying on essentialist notions, whether they identified themselves as indigenous or mestizos.

In fact, making a name here in Lima was a battle against racists. Even being my own brothers, they said “what does this cholo know?” Well, maybe I don’t know a lot of things of the city, but I could learn. And you also don’t know what I know (THP iw/2009)

When I came to Lima I suffered too much, because I come from the Andes, where the man lives in connection with the mother nature from the sunrise up to the sunset, your plough, your field, your animals, your home; we don’t even have electric light...I arrived at Lima with my sandals and my peasant suit, I could neither read nor write, and I saw a cement jungle, and the cars, and so many things. There must have passed too many years to inform myself about all that, and my wife has helped me in coping with, to enter in this world of technology, computer and cell phones. And now you can see me with this t-shirt, and these jeans... As my wife says, “you should be according to the time, an Inca of the year 2009” [laugh] (THP iw/2009)

In turn, they must demonstrate an apprenticeship in a large and identifiable healing tradition in the family, in the social and ethnical community of origin or by a famous curandero. Independent of the type of THS and region, THPs have constantly approached the possibility and opportunity to learn in this long road of knowledge from a high positioned maestro³³⁷, as a key issue in becoming curanderos. Although the initiation process is mostly conceived as an atavist spiritual subject, in which this supernatural selection confers to the elected certain powers –as by the *Altumisayuc*³³⁸–, this does not exclude the necessary culmination of an apprenticeship process by a veteran maestro. Also in this sense, Cáceres points out: “although his selection is supernatural, and his knowledge imbued, he also acquires it by experiencing with the *materia*, the practice, and supervised learning by a maestro, who is also a sort of godfather for him” (Cáceres 2002, t. sp.). At this point it is crucial for many of my

³³⁷ In case of naturopaths, herbalists and ayawaskeros the role of this maestro is also transferred to a “master” plant, from whom they could also directly learn and been instructed (fq/2010). Even so, in those cases the learn-process is conceived quite as different as with a “human” maestro.

³³⁸ Qe. Also known as *Paqu*, *Yatiri*, *Pampamisayuc* or *waynillu*. An Andean specialist with the highest hierarchy who possesses the power to convene the Apus (mountain deities) and the Pachamama (mother earth), among others entities, to cure and solve cosmic imbalances in Andean consciousness (Cáceres 2002, t. sp.).

informants that a curandero can prove not only a strong background in the learning process of techniques, and counts with the consensual approval from the master to work independently, but also a special personal relation/identification to the tutor maestro/a. After the apprenticeship, it is also important by determining the authenticity of a curandero a state of enduring long practice, in average at least a couple of decades of experience, in dealing with patients.

I was 8 years old when I began to cure, with plants and with my hands, because in my family and my town they have practised all that (Bonesetter iw/2009)

We have had also in my family a very good maestro: Santos Vera Sandoval³³⁹, who was internationally renowned. I and 3 other cousins have worked and learned with him. I have begun with him and step by step I could gain experience on this (Wachumero iw/2009)

My aunt was a maestra curandera; but she was also a partera. I was in primary school when I began to learn with her, but at first I only saw how she worked... she sent me to buy cigars, herbs, to cure the patients. Since that day I began to work directly with her (Guinea pig healer iw/2009)

When I ask a curandero or brujo where they learn such abilities, they said: I was born to do that, my father procured me, because of tradition; my children are curanderos (PhD TM researcher iw/2009)

A healer is born. It's a great conceptual mistake of some people thinking that curanderismo can be learned such as in a school. It can't be... How do you become a healer? It's natural. What does it mean? His mother, aunt or grandfather is a healer and he begins to see, to bring things to the healer such as water, etc. and therefore they were always more involved than others in such things. The little boy begins to see, to ask "grandma, what is it?" But the really disposition is natural. At one point the child, who has seen his grandmother, or whoever, says: I can do it. If for some reason the grandmother is sick, he says "grandma, I will spend you the guinea pig" (University Professor iw/2009)

I come from *Túcume*, Lambayeque. My great father was Pedro Vera Vilela, and the other one from my mother side was Victor Granados Lopez. Both of them were maestros. The former was an herbalist, he had a *mesa curandera* and worked with *san pedro*, he was a healer. My great father Victor was more a "mentalíst", as we say, you came to him and he could tell you your name and what you had. Thus, I have this tradition from both sides (Wachumero iw/2009)

³³⁹ Don Santos Vera Sandoval, famous healer born and died in Túcume (Chiclayo, Lambayeque). There are several testimonies about his abilities and efficacy as wachuma-healer. In his honour was composed a celebrated marinera norteña, the Peruvian national folkloric dance. There are no ethnographic publications about him, only an apprentice's reference from the wachumero Marcos Mosquera Huatay in Pérez (2009:32-38).

b) The Curandero Must Use “Autochthonous” Techniques

Interestingly, and according to the explanations giving by some of my informants, the adscription process to this category is based upon not necessarily unequivocal identification of “endemic” or “native” techniques, but rather on a restricted identification of possible “foreign” procedures that healers have used in defiance. Once this “intrusion” has been identified, it automatically questions the authenticity and the serious character of a healer. The proclivity to find a mostly “purist” tradition among healers –and an appropriately conceptual/historical statement– is among my informants, without exception, certainly high.

With the support of the INC in Ayacucho I have travelled a lot, I gave conferences and sought the “good ones”, that have not yet been contaminated, that are in possession of knowledge about a lot of things, who have lived in the town and never left it (Bonesetter iw/2009)

It must be autochthonous, it must have all the elements of the past, which were granted from the ancestors, and without being contaminated with other techniques or whatever things. The materials used should proceed from this time, or at least, by trying to make a copy of that what has been made done in that time (THP iw/2010)

When we try to explain TM in terms of the traditional Chinese medicine than it turns into a great *sancochado*³⁴⁰... others talk about the egg and argue that this has no “energy”, and it’s only through the reiki or the hands... you know what? We speak about the paradigm of the *sancochado*, and that’s right, because here comes out a soup made with all possible ingredients (Anthropologist iw/2009)

With the arrival of the Europeans not only new diseases were introduced into the Indo-American populations –conforming throughout new mortality and morbidity profiles–, but also compelled an encounter of different medical systems. At the beginning of the 16th century indigenous traditional healing in Peru came across with those medical practices brought by Europeans, which due to the medieval Catholic religion were throughout mystical and sought as counterpart of witchcraft (Delgado 1999d:4). In the course of the following four centuries there were added in Peru other curative cults from the complex spiritual and religious cosmology of the Caribbean region –including Haiti, Dominican Republic, Surinam and the coastal areas of north-eastern Brazil– which conformed a group of intricate manifestations of Indo-American, African and European traditions (Pedersen and Baruffati 1985:6). Besides the Catholic religion, with its

³⁴⁰ Sp. a popular soup and traditional Peruvian dish, consisted on a combination of several vegetables, tubers, roots and herbs.

belief's doctrine, rituals and instruments, the modern conception of this animistic-spiritual dimension expresses the syncretism that is typical for Peruvian curanderismo that is widely documented (Valdizán and Maldonado 1922; Chiappe, Lemlij and Millones 1985; Giese 1989; Camino 1992; Glass-Coffin 1992; Joralemon and Sharon 1993; Sharon 1993; Cabieses 1993, 1993a; Andritzky 1999; Gushiken, Shattuck and Douglas 2002; Eyzaguirre 2005; etc.).

Fig. 63: Mercado de Curanderos



The exchange with médicos bolivianos and healers from Ecuador³⁴¹ can be observed in the mercados de curanderos. Detail of a stand in a witch market located vis-à-vis a hospital in Jesus Maria District, Lima (Photo Pribyl 2009)

Accordingly, traditions, beliefs and techniques delivered directly from the European spiritualism or spiritism, i.e., the idea that the dead communicate with the living and the practices or doctrines of those holding such beliefs, are common among THP's practices and rituals, moreover in northern coastal and Andean traditions (Delgado 1984:5-6; Pedersen 1989:69-70). During field research I have found these characteristics averagely present among THPs, in particular among san pedro healers or wachumeros (cf. also Gushiken 1979; Joralemon and Sharon 1993:89,114; Polia 1994a; González Viaña 2009) and other curanderos working in the city, such as guinea pig healers or herbalists (cf. Andritzky 1999:64-87).

³⁴¹ See e.g. Valdizán and Maldonado (1922:193-195) and Wörrle (2003:28-31) respectively.

Certainly, in the Andean world, illness and disease³⁴² are comparatively considered as persons. They have similar characteristics as people: “They can see, hear, eat and walk; come alone or with company, are in transit, seat, stand up, go away or escape; they rise or descend, or do not come back any more” (Delgado 1999c:5, t. sp.). By interviewing wachuma-healers and “non-charismatic operators” in Huancabamba (department of Piura), Polia writes: “With the arriving of the Spaniards, the old world of the ancestors disappeared in the maternal sacred waters as part of an enchantment. It has returned in that way to the chaos, in which it has been born. However, it doesn’t die. All what from this world goes to the enchantment’s world turns to the status of being in a visible-way to the condition of being in an invisible-form; that is the reason why it takes unending force, and has influence on all the life cycles. The Invisible in the Andean World does not mean not-to-be, but rather a latent power. And abeyance is not the same as death; it is waiting, seed, *malqui*: cadaver-springs’ cocoon” (1994:75, t. sp.).

According to the Amerindian cosmogony, all the things have a spiritual counterpart, an anima (*kamasqa*) that bears both life and power, which could be positive or negative. In the past, this spiritual and live condition of things was principally attributed to all sacred elements and places such as wakas, persons and shamans (Polia 1994a:17). This is the case, i.e., by *chacho* or *chapla* which is produced by the magical power of natural agents like hills, stones, trees, *puquios*³⁴³, caves and ancient constructions or archaeological rests (Arredondo 2006:96). Similarly, the *japisqa*, a set of different symptoms’ complex, which has in common the situation to be trapped by the earth (*pacha japisqa*), by stones (*rumi japisqa*) or the gentiles (*gentipaq japisqa*) (Delgado Súmar 1999c:8-10). In more recent times and due to the extensive use of Western explanations about health –as well as the direct involvement of the population in psychosocial and ecological problems they are confronted with– this animistic view is now also related to certain life periods and specific social situations. Correspondingly,

³⁴² Disease represents a concerted objective physical reality of distress, whereas illness describes the culture-bounded specifically individual experience of disease (complaints, afflictions). This dichotomy demonstrates bio-medicine’s hegemony on the discourses about health, in which illness represents “culture and diversity” and complements disease, “which is the natural, genuine and universal one” (Hadolt 2004:13, t. g.).

³⁴³ Qe. *Pukyu*: spring of water. It means also streams or water points alongside a road, a field or around a house.

this “modern anima” has the additional competence to produce, reflect or alleviate distress and illness, and includes other types of social and political situations.

The wide presence of cause-explanations for different culture-specific illnesses, delivered under the influence of this *kamasqa*-concept, could be found repeatedly in the ethnographic literature, strengthening the animistic vein of the cosmogonies undergoing the modern spiritualistic practices. In Peru this principal European pole of “exogenous” influence in autochthonous techniques overlaps, in some semantic and symbolic way, the animistic axioms of the ancient Amerindian religious thinking. Among my informants, the greatest spiritualistic European philosophy is approached to the *kardecism*³⁴⁴.

I knew a person that has read Allan Kardec as well. He told me, if you read him, he will lead you to the good things, to help others...and then I had begun to read more books, and to invoke Allan Kardec for my work. He’s the father of Spiritism; I read many books from him and began to get more profound insight in my work (Wachumero iw/2009)

Fig. 64: Influence of Spiritism in Peruvian Curanderismo



Figure of Dr. José Gregorio Hernández³⁴⁵ in the banco curandero³⁴⁶ of a wachumero’s mesa in Chíncha (Ica) (Photos Pribyl 2009)

³⁴⁴ see chapter 4.4.3

³⁴⁵ José Gregorio Hernández (1864-1919) was a Venezuelan MD who reaches legendary status among popular health cults in Latin America. His presence in this banco curandero constitutes an example of the process of “exchange of magical powers” (cf. Pollak-Eltz 1987:82-93; Ferrándiz 2004:216-217) between TM, popular Catholicism and spiritism.

³⁴⁶ Left side of a mesa, also known as “campo justiciero” (Sharon 1978: 62-65) or “field of divine justice” (Joralemon 1984:2-6). It is associated to forces of good and positive powers.

Similarly, in the north-Peruvian healing tradition of the wachuma, the spirit of the *pacto* or *compacto* is encouraged through invocations to make contributions to a patient's assistance. A *compacto* is a contract between the curandero and the auxiliary spirits or mythical entities such as an *apu*, *encanto*, an ancestor or an older passed-by maestro in order to guide, help and protect the *curandero*, and to contribute to patients' rehabilitation or luck (cf. Molina 1984:339; Polia 1994:42). Some authors, such as Reagan (2001) and Kato (2004) have also described the pactos from curanderos with the evil. The conception of the demon in the northern of Peru obeys, however, a more complex and variable significance than the Catholic stereotype of Satan. The first includes the conception of the evil as an elf or the representation of a successful or rich person (Regan 2001:131-139), or a spirit who inhabits a cave or an isolated place (Kato 2004:136-137). Meanwhile, the compacto can support the maestro by giving him power and effectiveness, as well as useful answers, explanations or advice, or even prescribing specific herbs, methods or proceedings.

And he goes himself to the field and looked for his herbs. He cropped and cooked them. And he could be at two places at once; he has his spirits that told him what's going on and helped him by curing others. He puts from time to time a *mesa*, but he worked more with his mind (Wachumero iw/2009)

It means, when you have the virtue, you call a pacto, a spirit, right? Then you make a deal with that spirit, which is on another level, and you begin to work with him, and he calls you. (But in his case) the spirit brought him there, wherever he wanted, and he could make his choices. But afterwards he picked up something from him, for example, his son (Wachumero iw/2009)³⁴⁷

As well as in other Latin American spiritual and healing traditions with this spiritualistic influence (i.e. *Maria Lionza*, *candomblé*, *santería*, *umbanda*, etc.) the wachumero settled rituals –or went into trance or altered states of consciousness– to establish a communication with his/her compactos. Although the ingestion of san Pedro, coca and tobacco is present, and the consultation is taken upon within a ritual séance, the dialogue or assessment by the spirit compactado is part of a long-term relationship with mutual prescriptions and obligations, which in some cases could also be inherited. Similarly, in other traditions like among the Shipibos, the *Arkaneo* transaction constitutes a similar process as the compactado; here the curandero shipibo (*cushi*

³⁴⁷ A couple of years before of our first interview in 2009, this wachumero lost at the same time two young daughters in a terrible car accident at the Panamericana highway. During the interviews, he did not want to talk about it.

onanya) receives special instruments and spirits that will stay forever with the *Onanua*, which help and protect him in his work (Arévalo 1986:158-160).

For many researchers and experts the difference between sorcery, spiritism and curanderismo, and between a brujo³⁴⁸, a spiritist and a curandero respectively, resides basically on the own decision of a THP in choosing to work on one or the other side, and not necessarily according to the degree of knowledge or dominion of both dimensions.

They invoke you, but you continue with your normal life. Maybe you become tired, most affected is your brain, you have headaches, get nervous and get *estómago flojo*³⁴⁹. Those are the signs in case of a work with spiritism. But if you've been knocked by a malero, you have heavy body aches; they can say "I want that this person has an accident", or a painful wrist ache, or you sit up and can't stand up, or they want you to turn crazy. They send then a spirit, and the person goes badly. All these things exist, there are different *trabajos*³⁵⁰. There are persons coming to maleros, giving them 1000 soles³⁵¹ and say "I want that this person dies". They made the *trabajos*, and *te dan vuelta*³⁵² (Wachumero iw/2009)

Witchcraft is for me just trying intentionally and consciously to do harm to others. The damage is something concrete, that is, when I talk with some people about whether there's damage or witchcraft, and they said I don't believe in those things, I say something very simple: sorcery is not a cloud to be seen and not touched; in witchcraft you have something to eat, you get something concrete. If they put black chicken feathers at your door, that's a suggestion, but the real witchcraft enters through the mouth. If you take a poison it will hurt you. Here there's not anything like "I'm strong, I don't believe in it", because there are only superstitious beliefs of the people: If I don't believe in witchcraft, it's not going to hurt me (Psychologist iw/2009)

Naturopaths, herbalists, and chiropractors quoted repeatedly that "sorcery" –coupled extensively with the spiritistic practices– has nothing to do with real curanderismo. In some THPs and a few scholars' narratives the strengthening of this differentiation is, indeed, the most important.

It takes all sorts. When I drink ayawaska people could say "maybe he is a brujo". Wait a minute, I said, I'm not a brujo. If I am one, I could harm you, do something bad to you. Of course, because the brujos make *daño*, they can turn you one-legged, or blind. But I don't (Ayawaskero iw/2009)

³⁴⁸ Also known as malero (from mal=evil, someone that makes bad things and practices sorcery). The expression is quite informal as brujo; otherwise, if it is mean a powerful or special bad one, it is emphasised with the expression "brujo malero". (fq/2010).

³⁴⁹ Popular expression for diarrhoea.

³⁵⁰ Sp. works. When speaking of "trabajos" it is mean always sorcery.

³⁵¹ Around 400 US\$.

³⁵² Peruvian jargon. To be killed.

We're fighting for this. People called you brujo, charlatan, or such things. Sure, it was a tiff: the medicine and the sorcery and charlatanism, all were tar with the same brush. But it's not the same! (Wachumero iw/2009)

But, rather, I ask me, why spiritists? Why the *brujos*? Why the skulls? Because there is no authority, they leave them to win space. For example, when we go to *La Parada*, there are crushed herbs to buy, and when you open it, there is instead only powder. And nobody does anything against it... I don't like the use of skulls and that sort of things (Naturopath iw/2009)

Fig. 65: La Parada - Mercado Mayorista



In the Mercado Mayorista (for fruits and vegetables) there are up to three big malls offer among herbs, remedies, perfumes, and nutritional supplements all sort of instruments for popular health practices (Photo Pribyl 2009)

Nonetheless, sorcery was not an exclusively European tradition. Among the Incas, witchcraft was clearly and directly associated to healing. As the back and reverse of the same object, sorcery and healing were, in practice and in a conceptual sense, not too all different. The Quechua word *hanpipakuy* (sp. curanderismo) is commonly coupled with *lluq'ichiy*, which means, “to make exactly the contrary of what it is intended to be fighting against” (Calvo 2009:355, t. sp. qe.). Accordingly, in northern-Quechua, *hampikuq* and *hampiq* (curandero and brujo), as well the reflexive verb *hampikuy* and *hampinakuy* (to be healing, to heal or to make sorcery) have been extendedly used as synonyms (Carranza 2003:67, t. sp. qe.). In chapter XIV of the “*Comentarios reales de los Incas*”, Garcilaso de la Vega also asserts: “There were also some men and women

that gave poison to kill, quickly or slowly, or to drive crazy or daze whoever they wanted; to turn them ugly in their faces and bodies, leaving them in convalescence on white and black, and as lepers, or cripples in the limbs” (Garcilaso de la Vega and Aranibar 1991:38, t. sp.). Furthermore, according to Cabieses, it should be certainly common that the priests were, at the same time, confessors, curanderos and sorcerers: “whilst we should occupy with several denominations, as if all these were different ones, we do not suppose that the professionals performing these activities were necessarily different persons” (1993a:68, t. sp.). Also Gareis argues that the cause for diseases mostly originated in maledictions or sorcery: “In those cases, the sorcery had to be reverted in order to heal the patient. That is because healing proceedings, and the ones to damage a person, were both very similar... only the same person could be qualified to perform these two functions” (1999:134, t. gv.).

I distinguish between the healer who heals and the brujo, who is the one most prone to do evil. But, in the traditional domain –of what I’ve seen, in my experience– this difference is very ambiguous. It could be divided only for Western comprehension and for didactic questions (Psychologist iw/2009)

In opposition to what can be found among existing scientific and historical literature, most THPs interviewed defended the position that sorcery was not practised by natives in Peru in pre-Hispanic times. THPs conferred to sorcery a foreign status (Europe), asserting that this has not existed in pre-colonial times. This statement could be elucidating in terms of the social condemnation of those practising sorcery as principal agitators of the established social order, and the unlimited disadvantages, as the social, emotional and legal ones, in belonging to a high-rejected social group, and in to be identified as a sorcerer.

I’m very clear in this point. Sorcery is not part of TM. Ancestral TM -exactly what we want to rescue- was inherited from the pre-Incas and the Incas...Sorcery is originally from Europe, it was delivered to us by the people coming from Europe. In that time people were persecuted, there was a big religious crisis there, a schism, and they began to follow people, and a form was to accuse them of sorcery (Bonesetter iw/2009)

Some people named them brujos or shamans and confuse them. I told them that in our Andean culture there were neither brujos nor shamans. We have begun to educate, to explain, and in the end they understand the difference (Wachuma Apprentice iw/2009)

In society’s collective the brujo is for some superstitious, diabolic or oaf people. It has always had a negative connotation. And the ones who go to them are mostly desperate people, because of love, money, drugs, whatever, but always hopeless (Psychologist iw/2009)

“To have the gift of healing” and “to be righteous” are strong factors legitimizing the practice of curanderos. The popular healer would legitimize its symbolic capital drawing on elements of religious rationality and moral order (cf. Oliszewski 2010:12-13) to obtain recognition, something that is most appropriated to offset their lack of legal and institutionalized status. The use of moral or religious strategies constituted an act that involves the whole of the needs of the position held within the field, and which would guide the actions of social partners in terms of keeping and/or defending that position.

Local and indigenous knowledge is frequently represented as an ancient wisdom that has been passed down through generations without essential changes, and this seems to be the position of many discourses adopted by the majority of my informants. Regarding TM, the conceptualization of tradition and heritage suggested here reveals a tendency to conceive knowledge as an immutable wisdom. In fact, TK is subject to a “continuous process of reassessment, renewal and expansion; each generation forges the cognitive tools and understandings required to live in a rapidly evolving world by tempering the knowledge of its forefathers with personal experience and opportunities” (UNESCO 2002:77). Certainly, one indication of the inherent dynamism of local knowledge is the accuracy of local peoples adopting modern technologies and ingeniously adapting them to their needs, as it can be observed in modern Peruvian THPs.

c) Theories About Their Efficacy

Another assertion adopted to identify a curandero refers to theories about their efficacy as healers. These concepts are neighbored to deserving theories and the biomedical paradigm, in which the conducting approach responds to an expectation on the evaluation of outcomes, a willingness to find secure measurement schemes, and the need to map in a positive way the type of interventions in relation to the ongoing results.

The doctors say that it was her spinal cord that was damaged, supposedly, but they didn't have a real diagnosis. They said that after some time, she would not be able to walk anymore, never again. But what she really had was a severe compression in the spinal cord because of a discopathy. We depressurised it and the woman could walk again. I have a video of it, and I will upload it on *youtube* (Bonesetter iw/2009)

I don't want to disdain psychology, but this medicinal plant arrives where it doesn't. In a conventional psychotherapy we need too much time, because it's only the word. The patient can do it if he wants, or not. But in this medicine it's quite different. It is by hook or by crook. Here there's no machismo, it takes you down, whether you want it or not (Ayawaskero t/2010)

The patient should go with 90 percent less pain, if possible with 100. We have made the technique as least traumatic as possible, and it's applicable to all ages...the difference is also that we don't need too many sessions (Bonesetter iw/2010)

I know naturopaths that really heal. I witnessed that, because I have referred to them some of my patients. They cure cancer, cirrhosis, all demonstrated with exams (Herbalist iw/2009)

Among my informants, the distribution of a specialisation field for curanderos and specialists of the Western medicine is present. This depends principally on the etiology of diseases that should be treated. Most THPs classify illnesses and diseases not by their symptomatic manifestations, rather fundamentally by the identification of their origin. In the academic literature they have been principally reported in terms of *enfermedades de dios* (or natural illness) and *enfermedades de daño* (provoked through sorcery, envy or maledictions) (cf. Chiappe 1993:191-198). Some MDs interviewed also considered the nature of complaints as an indication to transfer patients to a THP. Therefore, the efficacy on one field can only be acquired if the treatment corresponds to the appropriate specialist, who can specifically deal with the attributed problem.

When you come to me I should make first a *rastreo* over you, to see what you have, if the sickness comes from God, or if it's from the evil. If it's a *daño* you need to go to the mesa to cure yourself (Wachumero iw/2009)

Several times we have had there snake bites, and I didn't have an *antivenom*³⁵³... I told the family to bring the person to the *curandero*, to make prayers and use plants. They brought him to the *curandero* and he treated him, all night. We both have broken down with it the idea that I gave him something traditional, and thus you don't need to bring him to the doctor. No. We talked each other about that: "hey, you're right, I don't tamper with it, and I can't give him these medicaments". The *curandero* himself told me "I don't know" (MD Public Health Expert iw/2009)

There are some illnesses that come from God. They could be also cured with herbs to resist the disease. But there are some illness that are from the evil, made by wicked hands to make you fall, or to turn you crazy and have problems (Wachumero iw/2009)

In the clinic I rubbed her with the *cuy*; I saw that the nurse didn't come and make the diagnosis. I told her that she should go to her home and I'll cure her there. I needed a month because the doctor examined her and didn't know what she had. And that because it was a *daño* (Guinea Pig Healer iw/2009)

³⁵³ A blood serum (antiserum) specific for the treatment of venomous (snake) bites or stings.

The science cannot yet explain some diseases. Finally they said “cancer” because they cannot see the evil on the person. There are people with scientific treatments and they did not get better, because the microbe is yet in your body, in your blood, and it continues killing you, no matter if you get injections or medicaments. This is even worst! The medicine can shock you when you have daño, you won’t get better (Wachumero iw/2009)

Related to THPs’ efficacy, there are commonly mentioned two aspects that are perceived, at the same time, as precondition and consequence of their work. The first aspect considers the sacrifices implied in the training process of being a curandero, and in the continuous personal preparation to be able to attend to people.

It’s also a sacrifice; you must fasten the day after. You cannot eat chilli or condiments, or you should stay alone one or two days. You cannot go to parties, nothing...that’s why I say that the person who wants to learn with me should make a sacrifice (Wachumero iw/2009)

Once I complained to Felicita Moscoso, my curandera in Cuzco. I’ve felt tired of everything! Every time I drink the plant I should look at the people, their problems, and sometimes I just want to see nothing; maybe only lay down and have pretty visions. She said to me, “Ah my son, sometimes it’s so, because medicine men have that mission. I would like also just to lay flat and see only cute things. But we can’t. One day I saw a cricket playing its violin; its music relaxed me and brought me to a paradise, but afterwards I continued curing. That’s our destiny!” (Ayawaska Apprentice iw/2009)

The second diet is very strict. You eat very few portions without salt, nothing, only rice, and your water. Only then you can drink the *chiricsanango*³⁵⁴, you’ll see the effects. It makes the strongest man sit down, because it’s a powerful plant, more than the ayawaska, and the dizziness remains longer. It could remain all night long. But it cleans you up, it heals all sickness that you can have, by pressing you over there where is something bad. It hurts! But at the same time it gives you a clear mind, it opens you up to a special intelligence (Ayawaskera iw/2009)

It’s not easy to learn all this. It’s very difficult. Among all is the preparation, the diet. You need too many years to be a curandero, to know the secrets of the plants. That’s why I say, it’s too heavy...The diet is very strong, because you should not take sugar, eat meat or seasoned meals, no liquor, no beer, no sex; only fish and banana, and nothing more. And you become really tired, you cannot sleep...sometimes we diet ninety days, or a month, or three months. These are the processes of the plants (Ayawaskero iw/2009)

³⁵⁴ *Chiricsanango* or *Chiricaspi* (*Brunfelsia grandiflora* ssp. *schultesii*), is a psychotropic plant used by several Amazonians to treat fever, rheumatism and arthritis. It constitutes with ayawaska an important teacher-plant (Schultes et al 2001:134-135). According to Luna, 30 days of diet are compulsory for its use (Luna 1986:68).

Fig. 66: Ayahuma³⁵⁵: One of the Several Plant-Teachers of an Ayawaskero



(Photo Pribyl 2009)

The second mention is about the risks content on the curanderos' work itself. It seems that there have been identified *internal* (from the ritual immanent) and *external* (enemies, authorities) hazards. In this respect, THPs feel themselves most of the times at high risk by attending to their patients. In their own conceptions, the work they make would turn them sick after the treatment –because of attacks of the opponents, the *brujos*–, including also the possibility to die after especially complicated and difficult sessions.

It's a slaughter, a cruelty one. The *malero* who has made the evil work will not permit that you take away the spirit from there where he has been invocated, because he has gained money in doing this. You should be strong and fight against...there are cases of maestros that have died in their mesas. I was twice almost killed...that left me frail and I had to go north, to cure myself. In the second one I got labyrinthitis (Wachumero iw/2009)

Here in Lima I've heard too many things...when you cure someone, they can follow you, and then, they kill you... I was afraid of it, not for me, rather for my friends (Ayawaskero iw/2009)

We've worked in *Huancabamba*, in the lagoon, at night. The maestros of Huancabamba have no fear to work there, although people die. There are several experiences of maestros working there, whose patients died at the mesa. They die because it's cold,

³⁵⁵ The *ayahuma* or *ayahuman* (*Couroupita guianensis*) is a tree with round fruits used for the enhancement of the body (Schultes et al. 2001:134). According to Luna, it is usually added to ayahuasca, "so that one becomes as strong as these trees" (Luna 1986:67). I could observe its use during the second diet period of an ayawaskera apprentice, and for her patients as a bath with vigorous massages. Its use requires at least 20 days of strict dieting (fq/2009).

they get numb. The lagoon is an *encanto*, so it could drag you, and you die (Wachumero iw/2009)

When you cure someone, they follow you and make you forget everything, and then they could kill you. That is why we should protect us, you must take care. I have had many problems, but it doesn't brush me...for sure, in *grande mareación*³⁵⁶ it could disturb me, that is why we should be well prepared to beat them down...when you cure some persons they awe you: "if you cure this person, you'll die"...they come during the drunkenness -the spirit- and tells you "do you want to die? Will you go up here? Knock it up, if you can!" (Ayawaskero iw/2009)

An intense concern of THPs constitutes the emotional and physical wellbeing of their patients within and after treatment. This remarkable fretfulness about the life of the patients they care for, hoping intensively that they do not die or get complications after a ritual treatment, suggested to me that this fear is intrinsically based not only on the nature of their *materia*, but also on the social and legal situation surrounding a THP's work. A subsequent complication would lead, inexorably, to at least one penal process, in which their chances to win are as good as inexistent³⁵⁷.

He didn't want to hear, although the *rambas*³⁵⁸ told him that repeatedly. And when they took the taxi and wanted to bring her in the hospital, she was already dead! Whose was the failure? When you have experience and you get visions, you should attend it. We should be very cautious, it's a very seriously thing, and you must know to handle, and have character (Wachumero iw/2009)

The *hueseros* are afraid of the lack of opportunities to study anatomy and physiology. It's possible that he can exceed with a manoeuvre, or it's too strong, and that can cause an iatrogenic problem in some patients (Bonesetter iw/2009)

There were many problems with patients. When the maestro Ramon Sanchez went to Lima for the first time a patient died in an ayawaska session. He gave him too much ayawaska, and the man had a hearth attack (Wachumero iw/2009)

In this context, the necessary distinction in being perceived either as healers or *maleros* is of vital importance, and far away from only theoretical or moral abstract disquisitions. In this point I give weight to the position and forms in which the image of healers have been perceived and managed through the media and the local and national health authorities in the imaginary of the people. They could also be considered –or induced to– among the population as directly responsible for health complications, fraudulence, and inclusive murder, something that is broadcast by the yellow press in an

³⁵⁶ Sp. heavy dizziness state.

³⁵⁷ During whole research process and assessment, this was the principal requests that THPs made to me, asking for legal support (fq/2010).

³⁵⁸ Sp. Assistants helping the wachumero by working (fq/2009).

irresponsible and sensationalistic way³⁵⁹. The constant situation to live near-to-death and the heartless competition or fight against other counterparts and health authorities make their attitude in declining a cooperative work typical, or to apply a definitive closed defence against. In this sense, and as San Román writes, it is throughout comprehensible that they try to defend themselves and, at the same time, attack others (San Román 1979:29).

No curandero in the coast and the mountains mistakes these expressions. In the jungle could be, because they were always told that, and don't want more problems...A brujo works with the devil, to do bad things to somebody, but a curandero works with God and with prayers. Many physicians and professionals confuse the terms and say that they are not in charge of this confusion -but for me, it's deliberate. There are people practising sorcery and they want to mix it together, intentionally, in order to make people disconcerted about... Perhaps that was the reason why Cabieses didn't involve himself with the legalization of curanderos, because the first ones lying about and come in will be the brujos; and then, how can you get rid of them? It's a serious problem! (PhD researcher TM iw/2009)

In the discourses, the poor control of the state in this concern is constantly mentioned. At the official-institutional side the figure of the THP is not represented; they are not considered serious or important, and are not visible and recognised as key agents in the health-illness-recovery process of the population.

The most impressive finding is that the ethno-medicals want to be instructed, they want to organise themselves, to learn, and want to be recognised among people as *médicos*. They don't want to be confounded with *maleros*. They fill an important social function, and accordingly, they want to be socially accepted and distinguished. That's an exigency (Anthropologist iw/2009)

5.5.3 The Integration Inquiry: Mechanisms, Approaches and Advocacy

The accessory articulation of traditional knowledge among governmental health centres in Latin America has turned out in practice to be an intricate endeavour. Several reports addressed the deficiencies or work-in-progress status among these initiatives (cf. Campos 1997, 2006; Abad 2004; Fernández 2004), and only few cases are arguably considered as best-practices due to the positive evaluation in terms of impact, sustainability, responsiveness, health policy identification, potential for replication, among other PH mainstream criteria (cf. Mignone et al. 2007:8-11).

359 See e.g. such news in the gutter press in Peru: <http://trome.pe/buscar/curanderos>

Based on the analysis of all categories and dimensions along the study, I have elaborated five different approaches stressing different aspects to accomplish the integration of TM and the regulation of the work of THPs. Each of these models elucidates the proposed mechanisms, the evaluation of its reliability and sustainability, as well the principal difficulties in order to be adequately applied. Agreeably, informants' social and professional backgrounds –as well their personal experiences– have played a significant role in the construction of these narratives' contents. These explain the priorities focused on and the emphasis given to specific selected issues. Although the thematic choice by the interviewed in each model might be seen as a cross-linked conceptual frame between the different approaches –which have been also accompanied by extensive information–, there are notable variations regarding explanations about its plausible applicability. In contrast to the focused detailed reasons and analysis about the problems surrounding the integration quest, the ongoing proposed solutions –e.g. how specific mechanisms should be implemented– are throughout underrepresented. The discourses are, on average, highly elaborated in terms of historical and sociological descriptions, including at least the development and course of past and present articulations' initiatives, the enunciation of theoretical, conceptual and practical consequences on customers' health, and the populations' health standards. Nevertheless, there are still unclear proposals related to specific guidelines and strategies to accomplish this integration, i.e. categorical content and methodological procedures enabling TM to come into medical academic formation, and as part of the national agenda in health research programmes. This is also the case for most of the empirical questions attained to the articulation process, which is how a decisive national official register of THPs could be achieved and the identification of directly responsible institutions or governmental dependencies adopting these specific regulations' tasks. The explanation to this inquiry given by a health officer illustrates the situation dramatically

I'm worried with the idea that the wrong people could come into the system. I mean, all these charlatans working on the streets...We have elaborated an instrument to make possible a proper identification of the agents, an attention register. We have completed this instrument already and it is also proofed. Though, there are still some questions that should be answered first before we apply it -and not because of the instrument itself. The point is which institution can nominate them? Who assumes the selection process? (Health Policy Officer iw/2009)

The technical document mentioned by this expert –that includes 8 pages overall– describes only some conceptual definitions and characteristics of the *agentes de medicina tradicional* (THPs) based on a short bibliography. The purpose of this document was to give health personnel working at the DIRESAS (Regional Health Departments) some criteria to choose THPs in order to invite them to future conventions (“encuentros de medicina tradicional”) (cf. Quispe, Córdova and Sánchez 2005:3). Although this document cannot be considered a register proposal, I wanted to follow it up due to its declared importance for this public health officer. After constant requests to him and other experts working in these institutions, I have not received up to today any information if the mentioned Jour fixes were ever taken up.

5.5.3.1 The Harmonization or Standardization Approach

This approach gives priority to existing international agreements on TCAM’s implementation in the health sector. These refer to technical drafts, ongoing executive suggestions submitted by international health organisations that have been signed by Peru and other member states (PAHO 2002:11-12). The advocates of the harmonization approach conceive the international health community organisations (WHO, PAHO, UNICEF, etc) as an extended and decisive interlocution partner and reference for the implementation of TM in national health programmes. They recognise, thereby, its structural and decisive influence on the elaboration of national health policies. The articulation of TM and the integration of THPs in HCS are therefore theoretically possible in the context of the implementation of these international agreements at the national level in PHC.

The WHO and its regional office for the Americas (PAHO) have made decisive steps in this field. They put the topic on the discussion’s agenda of health ministers in the world assembly; since this moment radical resolutions have come. Another important step was the global study of TCAM...it has shown the real panorama, for example, when some states have a law policy for TM, but have not yet recognised their traditional practitioners... This atlas is an excellent documentation and provides a basis for policy decisions ³⁶⁰ (MD PH Specialist iw/2009)

³⁶⁰ The two-part book provides a worldwide visual and textual representation of topics such as herbal/traditional medicine, Unani, TCM, Ayurveda, homeopathy, acupuncture, Siddha, chiropractic, bone setting, etc. as well as information about national legislation, policies, education and fundraising on TM, among other aspects. Peru has participated in responding surveys to this study report and is briefly mentioned on pages 42-47 in the text volume. See: ONG et al (2005).

First of all, they established the conceptualization of TM as an alternative medicine, similarly conceived like other alternative and complementary methods that are part of CAM (cf. Padilla et al. 2001; Smith et al. 2008; Gonzales et al. 2010). The process of development and establishment of institutionally specialised CAM Centres (CAMES) in Peruvian territory through ESSALUD since 1998³⁶¹ (Luyando 2003; Fernández 2009; Villar iw/2009) illustrates this disposition to the core (cf. ESSALUD/PAHO 2000; Villar 2009).

The conceptualization of TM as an alternative medicine in Latin America has been, to a marked degree, conceptually, historically, anthropologically, epidemiologically and methodologically questioned by diverse social science experts in different times and contexts (Duarte 2003:638-640; Menéndez 2003; Bejarano 2004; Delgado 2009:23-27; 1994; Zuluaga 2009). Also within the biomedical scholarship (Peña and Paco 2007:88-90), far beyond the focus only on TM, researchers questioned the whole concept of CAM by analysing models of “integrative medicine” (Johnson 2009:704-706; Robinson and Zhang 2011:3-5) and the possibilities for an integrative HCS. Nevertheless, this conceptualization has come across in the academic and public discourse in Peru, imposing a conceptual trend not only among health practitioners and health officers in public institutions, but also within AHPs and THPs. However, for some academic and practicing circles, the use of the term “alternative medicine” to refer to TM within the Peruvian context is an argumentative question, and has practical consequences that are not free from conflicts between them.

Like some other people, he and Dr. X consider traditional medicine as an alternative medicine. That means, they see it not as a medical system, which it really is, rather as an alternative therapy, and that’s not correct... acupuncture, being part of the Chinese traditional medicine, it’s of course an “alternative” for us, but the Peruvian traditional medicine has its own therapists here, and is traditional here, it’s not an alternative. But they handle it in the integral medical system as an alternative one (Ms PH iw/2009)

As the society’s development succeeded, the use of natural products turned traditional, because each culture achieved knowledge from those experiences, and these experiences became part of their own culture; that means, the information on how they cured themselves and the way they transmitted this information over the time. This tradition is what remains up to our days... this traditional medicine turns into alternative when it is transferred from one context to another. In our Andean culture the alternative for us is the allopathic, and not the other way around (Psychologist, University Coordinator CAM iw/2009)

³⁶¹ See chapter 3.3.1.3

MD1: I have my concerns regarding this, because only the complementary aspect would be seen and not the traditional one...why do you say “alternative”? You must take it out.

MD2: You see?! That’s a topic that we’ve already discussed, please!

MD1: But, why do you insist on putting it that way? Take it out!

MD2: Ok, ok. May I write “integrative medicine”?

MD1, MD3, and MD4: yes, yes, that’s better, of course!

MD1: It’s different from the complementary techniques. The term “alternative medicine” is a name that we shouldn’t use, never, because that means that is either one or the other. In the practice is so, but that’s not the right way, because it means that there’s something complementary, that one of them has the priority, and that means subordination...

MD3: But the universities use the term alternative medicines!

MD1: Well, even the Pope can say that, but it’s wrong! (CMTAC-CM gi/2009)

In a recent article, the director of the department of TM of the Ministry of Health of Mozambique brought the discussion about the common confusion between TM and CAM, to the point: “The fact is that the two forms of medicine are considered as competitors: allopathic (which is seen as the official and scientific) and traditional (non-scientific). So it’s easy to think that where a health service, mainly allopathic, is institutionalized, the other must be an alternative. To think in this way is not correct, because there are regions in Africa where allopathic medicine does not exist. Incredibly, in Africa there are still people who are born, grow up and die on traditional medicine despite all the technological developments with which we are living. So why traditional medicine should be treated as an alternative when more than 50% of the population depends on it? More to the point, it is allopathic medicine that is the alternative, imported medicine. Their medications, diagnostic systems and treatment are not known by communities. In fact, it is so expensive and inaccessible to the majority of the population” (Bela Agostinho 2011).

Although not directly mentioned among my informants’ discourses, a key concept here is the mechanism of standardization, which means, in theory and practice, the adaptation of traditional techniques to fit healthcare attention mainstream standards, as well as to facilitate the commercialisation of derivate medical products. Accordingly, a globally conceived standardization procedure is defined to be necessary in order to harmonize both medical systems, and to enable the application of TM services and products into the official HCS (WHO and WPRO 2000). Hereby there are three important reasons that have been enunciated in several interviews that appear also in

official national documents reinforcing this harmonization standpoint: (1) The claim to safe and quality-controlled use of traditional remedies (cf. WHO 2005, 2011:8-9); (2) the request of MDs and scientists for research evidence about the effectiveness of many traditional practices (cf. WHO 2000); and (3) the government's need to establish and update mechanisms for the regulation of TM and its practitioners (cf. WHO and WPRO 2000:14).

What should be done is to take a traditional therapeutic method for a specific pathology and compare it with other scientific therapeutic methods for the same pathology to make a feasibility analysis of it, and determine in that way its effectiveness. At the same time, its efficacy in terms of costs for the costumers should be identified (MD PH Expert iw/2009)

The standardization also entails the translation of specific concepts and health treatment procedures from TM into a scientific community accessible mainstream language – which means not only the language, but also the comprehensive technical accessibility. This mechanism is broadly proposed in official international agencies' documents: “To enable global knowledge exchange and facilitate efficient and effective use of TM, it is essential to produce international health information standards on TM terminologies and classifications. Such standards will allow various stakeholders to gather data on form, frequency, and outcomes of traditional medicine and to meaningfully exchange information globally” (WHO 2010:2-5). In May 2009, the WHO headquarter invited various countries dealing with TM from all over the world and explained the WHO's plan to incorporate TM into ICD-11³⁶² and asked them whether they are interested in (Gao and Watanabe 2011:1163). Among TM in the world, the candidates for ICD-11 should be internationally used and should have systematic diagnostic ways. Because in China, Korea and Japan, “TM has an inter-country experience and experience of harmonization, it met the criteria and was considered by WHO at the beginning” (Gao and Watanabe 2011:1163). During the following meetings of the WHO in Hong Kong (25-29 May 2010) and Geneva (22-24 March 2010) an organisation to promote the project was conformed, whose major goal is to develop a standardized TM terminology and classification system for regular data collection and comparisons with conventional

³⁶² The International Classification of Diseases (ICD) is the WHO's standard tool to capture mortality and morbidity data, used for statistics and epidemiology, healthcare management, allocation of resources, monitoring and evaluation, research, PHC, prevention and treatment. The 11th version is now being developed and due by 2015 (WHO 2012).

health information systems (Gao and Watanabe 2011:1163). According to what has been proposed and implemented in the WHO family of international classifications' releases (WHO-FIC) and meetings during the last decade³⁶³, this schema on international health information standards should also be implemented at the national level in Peru (WHO 2006:5-8, 2010:2-3).

The time would come when Peruvians will open their minds. There are clearly outcomes with TCAM, everybody could see that it really works; I see it in the diplomas, by professionals, not only in ESSALUD but also in MINSA, and at the private practice. This expands very quickly, including hospitals of the police and the armed forces...but for this it's crucially a political decision. For sure, it was certainly considered in the governmental plan of the APRA³⁶⁴, but they haven't yet put decisive force on this, it still remains a second interest matter. If they would support us now, we could have more possibilities. But we're still trying hard, alone (MD, CAM Manager's Office Head in ESSALUD iw/2009)

One of the standardization's requisites effectively mentioned throughout this group is the accuracy of solid data on the extent and safe use of TM in the country. According to this, in order to consider TM as a valid therapeutic approach, it is urgent to gather more research information, clinical and pre-clinical studies, and randomised controlled trials to determine the effects of using TM's services and products on the population (Cañedo et al. 2003; Viergever 2010). In fact, and as some of my informants have argued, the strongest resistance against the use of Peruvian TM in HCS resides on the limited scientific data available about the effectiveness of such treatments, as well the absence of written original documentation.

In this point we have an academic burden. And it would be defined, probably, at the corporate level, depending on the strength of the organisation. In my experience, the medical association has not yet accepted it as part of the medicine, and it will remain so, as long as the famous evidence based medicine comes into discredit. Because TM must be accredited, and there is not much evidence, if any! (MD, PH Specialist iw/2009)

We can say that the tragedy for the traditional medicine is that the medicine was created in the West. But, what would have happened if the science had been invented in the East? Moreover, much of our knowledge comes from the East. It's an ideological matter (Psychologist iw/2009)

³⁶³ The last Interventions Meeting (Manila, Philippines, February 7-11, 2011) counts with input suggestions also for a standardization of TM's classifications for Australia and the USA (WHO and WPRO 2000).

³⁶⁴ Sp. Alianza Popular Revolucionaria Americana is a left-middle-oriented political party in Peru. Alan García, the Peruvian President at the time of the interview (2009) is member of this party.

This position seems to be the same among the international scientific medical community addressing the standardization approach. Grundmann asserts that this “resistance” can be remedied by using preclinical and clinical study protocols that are rigid, reproducible, and provide sufficient statistical power to support the observed health effects (2011:54). Effectively, the principal purpose by the standardization of TM is to create an EBM to allow conventional medical practitioners to directly apply techniques and products derived from TM. According to the harmonization approach, it is essential that these data collection, monitoring, and evaluation systems for TM be unified with those used in conventional medical services, in order to ensure the efficiency of data collection. This is inspired in the standardization process that has been applied during the last forty years in China (Zheng, Acupuncture, Moxibustion), Japan (Kampo), the Republic of Korea (KCDOM) and more recently, in India (Ayurveda) (Chaudhury and Muchtar 2001).

In the opinion of some of my informants Peru, as a member state of international health agencies, is under pressure to assume this articulation approach. They have invested in infrastructure, research, building and health professionals training, and they want to see tangible results and police outcomes. The creation and use of specific attention protocols for CAM in ESSALUD since 1998 is concrete evidence that this incorporation tendency has already begun (cf. Luyando 2003).

A serious problem that confronts the WHO is the divisional line between the formal and serious practice of the TM from the charlatanism. That’s a very complicated topic, because the strategic tools are in the hands of the governments, they should separate them and persecute and penalize the charlatanism. The WHO can’t do anything about this! (PAHO Officer iw/2009)

We physicians should begin to discard our former vision and consider a new one. We should be more scientific. A scientist is someone who accepts, or not, something that is or not yet verified. During the last ten years we have attested that the alternative and complementary medicine is a great option for healthcare system in Peru...we have worked out the recuperative side, but there’s another part that has yet to be taken into account, and that is public health. For us the principal interest is the patient, the person begins to take care of their own health, because this is part also of the philosophy of the complementary medicine (MD, CAM Health Officer iw/2009)

Interestingly, this approach has not only notable preference among THPs but also among some scholars, who perceive the institutionalization and internationalization

process of TM in China as a paradigmatic and absolute exemplary model that should be emulated in Peru³⁶⁵.

Peruvian TM has an exceptional richness due to the natural pharmacy that we have in the Andes and the Amazonia. If we had a vision of what we could build up with traditional knowledge in health, economy and the positioning of ancestral knowledge, I'm sure that Peru would be one of the principal countries exporting medicinal plants, as is the case for China or India (Social Communication Specialist, Wachuma researcher ec/2011)

According to governmental statistics, there are one million people with mental problems. Who will heal the victims of terrorism? Who cures those shell-shocked by earthquakes? Which support do these people receive? Can the healers refine their art? In China they can, they have a basis and support from the state, they have universities, and the better ones go to study (Psychologist, Coca Specialist iw/2009)

It is supposed that official medicine has a scientific basis and others not; therefore, what is not scientific, is despicable. Nonetheless, official medicine is different in each country. In most European and American countries the official medicine is the allopathic and Hippocratic and the Chinese medicine is the alternative; but, for some people, it has the same level as the allopathic or conventional medicine. It is more than 5,000 years old, older than Hippocratic medicine; Western medicine arrived to the Chinese as an alternative. This relativism turns this conceitedness, at least, to a matter of curiosity. What is the foundation to infer that Chinese medicine does not have a scientific level? It has been well documented; every Chinese knows a meridian map, which has been constructed over thousand of years. If that's not scientific, what is it then? (MD, PAHO Officer iw/2009)

We're not only talking about a technique like acupuncture, tai-chi or Qi Gong; there are also the massages, the herbals, their diagnostic procedures, it was a holistic health approach. That is what confers reliability and conviction to it, that it's their authenticity, a culture that has lived alone with those treatments since its beginning up to the 1950s. Their knowledge was not "scientific" only because it was not used by science, but the Western model couldn't colonize them (Psychologist iw/2009)

Some critics argue that as traditional healing was incorporated into PH it was evaluated not on its own terms but on the terms of biomedicine. Consequently, knowledge of pharmacopoeia was privileged over the social, symbolic and cultural aspects of healing (cf. Van Wolputte 2002:18-20). In case of THPs, the focus on medicinal plants research and training in specific techniques preceding all other aspects involved in ritual and traditional therapies could mean a secure way or *via regia* to obtain acceptance and

³⁶⁵ This is also due to cultural, social and historical reasons. Chinese (as well as Japanese) immigrants and their descendants in Peru are perceived among the population as prosperous and diligent. Furthermore, Chinese doctors and herbalists, who are integrated part of Peruvian nations since the last century, own a proper tradition in being consulted by the population for healthcare (cf. Fukumoto 1994:314).

recognition among Western trained health practitioners. This would also allow the introduction of the thematic around TM in HCS in a gentle form.

If hospitals accept TM, as it is the case for China, they would not be so overcrowded with patients and, through this, both time and money would be saved (Wachumero iw/2009)

Some critical positions to this approach assert that the standardization idea is not motivated to benefit the countries in which TM is widely still in use. According to them, it is instead due to the growing interest in TM shown by consumers, scientists and regulators from other countries, especially those from developed countries, in which the Western medical paradigm is. Similarly, and addressing the specific case of China, Churchill suggests that the “biomedicine is scientific” argument has been used continuously and mainly successfully in last century to suppress competition, and that “one can suspect that the call for evidence based medicine is the latest manifestation of this” (Churchill 1999:33). But, although the randomized controlled trials as standardized method for Chinese medicine is attentive to power in the sense of tracing the history of biomedical science’s rise to dominance (Shea 2006:258), it is arguably unrealistic and historically incorrect to assure the “Western-Dominance-Theory” as a lone explanation for this standardization tendency. The standardization process of TM in China has not come as a direct influence from overseas, and it is not of recent date³⁶⁶. Aside from the intensive exchange over centuries and the resulting acculturation and assimilation processes occurred between rural communities in Southwest China with traditional Chinese herbal medicine, Tibetan medicine and local and indigenous medicinal systems, the establishment of a unified Chinese pharmacopeia began during Mao Zedong’s Cultural Revolution (1966 to 1976).

When was the moment in which acupuncture began to be widely used and famous in China? It was at the time of Mao. When he was in the provinces during the red revolution, he observed that the peasants used the acupuncture to treat illnesses. And since there were no more resources available, he disseminated it actively in other regions of China (CAM Specialist iw/2009)

Certainly, during Mao’s Regime, traditional and cultural elements from the Chinese society, as well as market capitalism, were tried to be removed in order to enforce socialism and Maoist orthodoxy. Although during the last years China’s government

³⁶⁶ See e.g. selected milestones in the history of TCM of Li Jingwei et al (2000) in Qi et al (2011).

has made sustainable efforts to rationalize and publish about the traditional medical knowledge of the minor nationalities in the country, from which fifty-five are recognised by the state, the modern established TCM entails only the traditional knowledge of the majority Han population culture in China (Farquhar 2011). Thus, the knowledge about medicinal plants and illness was strongly influenced by information provided and distributed in herbal books from the 1970s such as the *Yunnan Zhongcaoyaoxuan* (1970) and the *Yunnan Zhongcaoyao* (1971), distributed respectively under Mao Zedong's directive to improve rural healthcare (Weckerle et al. 2009:226).

Stakeholders and medical practitioners in Peru following this model consistently demand more clinical studies on TM as a principal argumentative reason. Actually, the common position in stressing the lack of TM's research in terms of a positivist philosophy of science, and reframed within the EBM model, can explain in part the constant reference to these issues in national and international congresses, submissions, official events and institutional policies that have been made in the country during the last 34 years. In these meetings ongoing agreements and academic contributions were almost exclusively retrieved on contributions from the pharmacology, research and evaluation reports on safety and effectiveness of herbal remedies and products for Western illnesses³⁶⁷. Meanwhile, in order to promote its standardization on a large scale as it was the case for China, it should locate other intrinsic aspects of traditional medical knowledge (i.e. rituals, beliefs and religious elements) far away from institutional research interest and priority. To this respect Lo had argued that it is certainly ironic that just these "abstract astrological calculations" of early Chinese culture are one of the biggest growth areas in research in China, and suggested that researchers and policy makers "ignored the broader culture of divinatory and magical techniques, the core of medical theory, in favour of selecting out those elements that demonstrate how scientific Chinese knowledge equalled and in many respects developed in advance of Western equivalents". Ethnic knowledge, Lo continues, "would ultimately offer up its treasures to the common universal pool of knowledge,

³⁶⁷ As it is known through paleopathology, medical history and modern socio-epidemiological research, some diseases, such as chronic complaints or muscle-skeletal disorders are mostly free of differences among countries and populations. That is not the case for infectious diseases, which are mostly culturally pertained. See e.g. Cabieses (1984:39-43,52-72).

like all other ethnic cultural rivers...flow...into the sea of modern science” (Lo 2009:287).

The harmonization model provides an international frame to bring together TM into the existing competitive markets of HCS, following the structure of the modernization and internationalization policies that have been evidenced by in China during the last sixty years. Incidentally, this approach makes the study of local cultural meanings of TM, religious accounts and its ontological and philological structures unnecessary.

5.5.3.2 The Intercultural Approach Revisited or the *Intercambio de Saberes*

The perspective encompasses the focus on the critical and contrastive analysis of the discourses about interculturality, as well as its latent conceptualizations, to encourage the academic and political discussion about healthcare models and approaches that have been oriented public policies to meet the cultural diversity in the country.

The *intercambio* or *diálogo de saberes* (knowledge exchange or dialogue of knowledge systems) is an epistemological, educational and social intervention model that has been used and applied since the 1980's in Latin America, preferentially by social activists, community-based leaders and educational advisors. In contrast with the subaltern studies approach emphasising the study of the historiography of post colonialism (Mallón 2009:160-166) the theoretical and epistemological development of this model derived from the so-called *Estudios Interculturales*, a cognitive, research and educational movement connected to the study of multiculturalism, social movements and its present historical and political conditions. Dietz argues that the scope of the *Estudios Interculturales* is closely related with the re-emergence and re-definition of indigenous ethnical identities in the context of the Latin American post-indigenism and the migration processes south-north occurred in the last decades (Dietz et al. 2009:58-59). It focuses the different aspects of the cultural and social life from different disciplines such as the jurisprudence, history, sociology, anthropology and pedagogy, and contributes directly to the discussion about multiculturalism and interculturality in specific intervention contexts.

Among this approximation, the access to fair healthcare is intrinsically connected to the possibilities of the population to obtain education and information. In this regard, the principal statement is the enhancement of ancestral knowledge and the establishment of dialogue channels among cultures, achieving the cultural and ethnical diversity in the territories, and reinforcing the suzerainty and autonomy of the population (cf. GESTS 2006, Espinoza and Ysunza 2009:294-297).

The model pursues the development of specific actions or health programmes enabling economically, socially and culturally excluded communities to access and acquire information and training to improve their health and social life conditions, and to participate directly in decision making about intercultural educational and health policies.

The integration of those practicing TM would be a cultural and historical vindication, because in many communities they are still the most demanded and consulted by the population, and are not visible for the official system...we need to incorporate a *diálogo con otros saberes* and to not restrict this to the academic dialogue, because this is based, in the most cases, in a bibliography that was developed in different contexts and they are not suitable to work with populations in our society (Psychologist, Ms. As. Community Psychology ec/2010)

The idea is to construct a knowledge fitting our reality, and not to locate TM as an alternative or complementary one. It must assume a central place in professional training and academic discussion (Psychologist ec/2010)

The exclusionary systems in the country have a historical character, with a long record of difficulties and conflicts in coming closer to a dialogue with the official one. The different valued nominations have reinforced the exclusion and rejection of TM as part of these systems of exclusion. In some cases the inclusion would be maintained in the discourse, but not in practice, turning this inclusion into an adverse, not into a proactive option that could generate changes. Therefore, the “dialogue of knowledge” implies inter-cultural, inter-linguistic and inter-sectoral dimensions challenging the social conditions in which interculturality is constructed (FONDO INDIGENA 2009:8-11). The dialogue of knowledge unfolds the diversity of positions and views among inter-subjective relationships. This inter-subjectivity proposes the possibility for a relational collective thinking; there are the contributions of the subjects and their transversal explorations what will foster a complex cognition that enables the proposition of

questions conducting to open-mindedness for the inclusion, and for a rupture with the determinacy. This ensues to a compromise with knowledge, the disruption with closed doctrines and, in consequence, a conscious broad-mindedness (cf. Pérez and Alfonzo 2008:457). But, in doing this, it is necessary to elucidate the interpretative frames from which the interculturality is perceived, conceived and discussed. According to this perspective, these analytical spaces should be enclosed and promoted, principally, through academic and governmental health institutions in the country, to enable not only a fair process of knowledge sharing among health providers, patients and authorities, but also to derivate in specific agreements in intercultural health attendance that reflect the interests of the groups addressed.

I consider that the integration of the THPs is a possibility, but we don't count, at the present, on a model that could make it viable. If we want to achieve this, it should be given a context with certain socio-political conditions, like, for example, the task to think on an articulation between different world visions, and, at the same time, to meet this challenge with an intercultural education and the construction of a society with equity for all cultures. Meanwhile, we can just promote the dialogue and intercultural understanding, as well as the awareness of the whole society of these concerns; in particular, health administrators of the official medical system (Ph D Anthropology, University Professor ec/2010)

It's not about to integrate, rather to articulate medical systems, but with an intercultural focus. In doing this, mechanisms should be created in which the community agents could have a space in the official system. They must be recognised as health workers; in that way they could become strategic allies in the promotion of health, especially in rural areas. In Lima the hospitals should also count on community advisors that could have access to the population that feels, speaks and thinks differently (Anthropologist iw/2009)

A principal assertion underlying this model is the establishment of new approaches in the information technologies on health, asserting essentially the perspective of the significance and validity of a collective construction of knowledge. Furthermore, the *diálogo de saberes* implies a method that promotes the convergence of cognitive discourses with pluralistic origins and dialectics, referred to the same epistemological objects, and creates a productive interlocution with specific contributions to the universe of knowledge (cf. Tengana 2010:6). Accordingly, this method makes visible different types of medical knowledge, despite their origin and/or tradition.

We should create some sort of intercultural universities, in which the *curanderos* would come to the city and the MDs should go to the hills. They should come and organise an intercultural clinic. The doctors should come; then we can work together, in dialogue, to learn from each other (Psychologist, Coca specialist iw/2009)

The time has come in which we should do something for popular health attendance in this times of interculturality. We should shake hands, and not only wait for a president to do something. We're good enough in achieving that, we have intelligence and the ability to develop what we have in the country (Ayawaskero t/2010)

The exponents of this approach find an important difficulty in what we understand as the concept of "interculturality", and of which worldviews are evocated, because this implies important programmatic and practical dangers. As Dietz also argues, there is a risk of the contingency going into a postmodern "anything goes", and the rise of a new hegemonic ideology that covers with its conceptual ambiguity the import and mimetism of apparently intercultural solutions that, in other contexts, are inoperable, counter-productive or openly prejudicial for those pretending to be "interculturalizing", "integrating" or "empowering" (2009:57). Anyway, for a representative number of my informants, the principal difficulty in accessing this model relies on the structural absence of egalitarian spaces for intercultural exchange. Former integration initiatives in the country to date were always substantiated in an attitude of advantage and an appropriation tendency of TK, and not necessarily inspired by an altruist and social-oriented paradigm of medical knowledge exchange, for both beneficial and suitable.

The integration of different medical knowledge connotes the assumption of the position and view of the other, and not the mere application of techniques without considering the constructions of otherness and different conceptions about the health-disease-recovering process. Thus, to apply in a proper way the concept of interculturality in health programmes it is necessary to consider the conceptions about nature and human beings operating in different forms in each cultural and ethnic group. This includes, for instance, the different socio-environmental, nutritional, educative and medical disease index conditions of a given population group. Interculturality resides and occurs, indeed, in what is not a common property, in a reciprocal constructed space, which is grounded on the balance between one's own self and one's non-own self (Pribyl and Villar 2010:15).

It must be possible to develop the local knowledge and promote the exchange. The talent of the Inca Empire was, in big part, due to this knowledge network, to make the initiatives come together. What could happen when we join these people, we give them a little support and a place? I would ask them how could be the future of TM in Peru, and they can give a direction, suggest, stimulate. That must be done! (Psychologist iw/2009)

Overall it's important to afford an honest dialogue between traditional specialists and academic physicians in order to eventually find common points, but with an open mentality and without prejudice. I believe in something that grows step by step, based in the communication and the wish to serve the patients (Wachuma Researcher ei/2011)

5.5.3.3 Grassroots and Community-Based Approach

Related in some way to the social-oriented concerns appealed in the approach above, this position focuses basically in a regional and local perspective to promote the inclusion of THPs in HCS. This proposal asserts principally, with some variations among the interviewed, the creation of health centres or special integrated community health institutions for each region, as an attainable and legitimate solution.

Right now I'm working in a rural community. I see all this from the perspective of interculturality, in trying to bring together TM with official medicine in a health centre... sometimes the motivation, the energy is waning, but I think that only making such an experience, at a local level, would make it possible (Sociologist iw/2009)

The major goal of these healthcare centres is that health professionals, centres' health personnel, patients, relatives and community health agents should build up a partnership, in which all the involved persons can work together, under fair labour and social conditions, with the same right to make suggestions about persons' and the community's health route and, accordingly, to make on their own health decisions.

The solution should go through the establishment of an alliance with the parteras and curanderos along the whole existing community health network. Exactly here is the handicap, because the ministry doesn't succeed in giving confidence to these agents (Ph D Anthropology iw/2009)

It is difficult to imagine the integration when there are not studies about who practises them, or which medical systems there are, or what are the diagnosis or therapeutic procedures in use, or what are their contributions to Peruvian healthcare...Nonetheless, it is for sure necessary to open the national health system to different practices of the traditional medicine. Maybe in a first stage it could be organised some spaces for local agents educating the patients about it and letting them choose the treatment (Wachuma Researcher ei/2011)

The recognition of local indigenous knowledge transforms the position of indigenous from patients to managers for the own local communities. Rather than mere resource users whose practices must be managed, local people are recognised as "knowledge holders in their own right with their own ecological understandings, conservation practices and visions of how resource management goals should be defined and

attained” (UNESCO 2002:78). Thus, the context in which the articulation should be implemented must essentially consider the participation of grassroots fellowships such as community-based organisations, community health promoters, healers’ and popular health associations, as well as civil initiatives. These actors could bring not only crucial information about the specific regional and local particularities with its own cultural, language and geographical characteristics, but also contribute to the allowance of implementation arrangements that fit the cultural and social reality of a population group or ethnic community. The posture promotes indeed a questioning process about medical knowledge and its mechanisms of circulation, appropriation, dissemination and resistance, identifying specific agents that either inhibit or promote one of these different forms of democratization of knowledge in health.

My position is that we cannot assume another culture, because it’s not mine. I can only understand and accept it. For example, X³⁶⁸. I have known him more than thirty years, and since that time he repeats the same. Is that true? It can’t be real. He’s here and all the communities are over there, thus, what are they talking about? When someone has already understood Peru, it can’t function in that way (Ecologist, Consultant iw/2009)

I said to all my colleagues that stayed in Cuzco or Lambayeque that nothing behind them to develop a specific health plan for the region. They should create an independent institute, apart from MINSA, because the physicians don’t want the traditional medicine...the only way to promote it is taking it away from MINSA, but with financial support from the state, because it’s their responsibility to preserve popular health (Ph D, University Professor iw/2009)

We don’t need here a general model. We need clear guidelines allowing us the construction of specific models according to each region (Anthropologist iw/2010)

The general context of the main proposal is for a democratic decentralization of the health system as a whole. The health, social and environmental situations of some communities make centralist efforts unsuitable; therefore, they appeal for a restructuration of health attendance services with the incorporation of local knowledge in the programmes and services, and the implementation of human local resources in the centres. Nevertheless, these stations should also be regulated, supervised and organised through a central institution that designs and promotes the creation of local specific health programmes, in accordance to the information they receive from each region, which also must be throughout discussed with social and civil organisations and representatives of the communities.

³⁶⁸ Director of an International Health Agency in Lima.

First of all we should determine the spaces. And they must be done with municipal or communal policies; they can't be organised in a centralist way. We can't have a health ministry for the whole country, because it is always managed by a doctor or an economist, and they are only interested in building hospitals (Psychologist, Coca Specialist iw/2009)

It corresponds to the society, the patients themselves, and the people itself. I don't think that the curanderos can join that, because they're too much disintegrated and there are too many suspicions among them...Just as it has been created a ministry of health, there should be also given an institution to see this. And they must be supervised by the civil population that knows best how it should be made. Otherwise, this knowledge will disappear (Ph D, University Professor iw/2009)

The practical importance of this model could be located in the recognition and use of self-care attention systems and popular medical practices in healthcare centres, which have been proven to be beneficial and also effective in affronting public health problems. In approaching the case of alcoholism, for example, Menéndez argues that for such forms of alcoholism, in which biomedicine has proved limited efficacy, the social groups themselves have development self help groups –such as alcoholics anonymous– an attention model that, in comparison with other types of specific attention to this problem, has demonstrated the most efficacy, at least in certain contexts (2005:39). Similarly, the use of sorcery in Mexico has shown efficacy in the control of pathological consumption of alcohol and in the reduction of its damages (cf. Menéndez and Di Pardo 1996). In Puerto Rico, “spirit-healing” –religious spiritual popular medical practices– are now recognised and used in community mental healthcare, although thirty years after the beginning of an interesting project called the Therapist-Spiritist Training Project (Koss 1980). Koss, director of the project, says that these centres have been pressured by national health interests in the United States and Europe to facilitate utilisation and availability of health and mental healthcare services for minority and immigrant communities (Koss-Chioino 2008:222). These kinds of projects are also part of the proposal of my informants, as an anthropologist said

Never mind that the profession, the intelligence or the capabilities would bring efforts: it's only about the human quality...we need a type of “intermediate-professional”, someone that could deal with emotional problems at this stage, in the field of community mental health...in each district there would be created one up to two health community centres, i.e., an instance between the specialised level of health attention, and the daily popular demand. That would work! (Anthropologist iw/2009)

5.5.3.4 The Educational Approach

This model stresses the attributes, nature and structure of the patient-doctor relationship in intercultural contexts. Here the attention is drawn to the prevailed, mostly negative defined, attitudes of health professionals and health managers with patients of ethnic minorities, as well as the role of academic authorities, universities, research and governmental departments in allowing and reinforcing these unfavourable beliefs and dispositions in HCS.

Once I had an interview with a physician in the ministry of health. She was a candidate to be minister. She said that she was in Huancavelica³⁶⁹, and told me: “Did you know that the women there are different from us? They don’t take care of their hands, they work with the earth, and the children wear clothes with mends!”... I wondered how is it possible that she doesn’t know that rural people don’t polish their nails and work with the earth?! What kind of policies can such a person give?! It’s impossible! (Anthropologist iw/2009)

The discussion was about a sheep skin. They said that it should be first sterilised in order to be used. At the time a gynaecologist came to evaluate this, but she didn’t know what to say, because she had never seen a traditional childbirth. She was the inspector sent from MINSA to evaluate this intercultural approach, and based on her opinion should be done the whole suitability of the project! (MD PH Expert iw/2009)

Like other health professionals enrolled at MINSA in peasant communities and special rural programs such as the SERUMS, MDs do not perceive patients fundamentally as persons but as *cholos*³⁷⁰ with disinformation and ignorance, inappropriate lifestyles, improper hygiene and nutritional patterns, and a “wrong” and “superstitious” perspective about their body and healthcare³⁷¹.

The Amazonia’s settler, the native, is in general someone that does not want to evolve. They only want to live the day. They crop bananas or whatever and sleep all day. We see the men sleeping in the afternoon, all the time. And the women cooking the *masato*³⁷² (MD iw/2009)

Here we *choleamos entre cholos*³⁷³ (Anthropologist iw/2009)

³⁶⁹ A department situated at the central Peruvian mountains, with majority Quechua speaking communities. After Puno, is the second department with more children mortality-ratio, by the year 2007 with 29% (MINSA 2010a:16-17).

³⁷⁰ Sp. cholo is a dismissive expression for indigenous people.

³⁷¹ See e.g.: Camino et al (2003), Pesantes (2004), and Huayhua (2006).

³⁷² An Amazonian local traditional drink made with yucca (*manihot esculenta crantz*). The fermentation traditionally begins with women or children chewing mouthfuls of mashed yucca and spitting it back into a vat, as an amylase resource in converting starch into fermentable sugar (Arias et al 2009).

³⁷³ Sp. A figure of speech meaning the paradoxical situation to finger out the other as indigenous, in spite of the fact that one self is also an indigenous.

I: I didn't know where I should go until I saw the map. I looked at it, and it was all green [laugh]. I went there because I needed the highest score for my speciality.

I: Have you ever been interested to know about the techniques they used, or their beliefs...?

I: No. My goal was to obtain the score and make my speciality. Nothing else (MD iw/2009)

According to this perspective, the “particularities” of rural people complicate the MD’s consultation and intervention, and are seen as obstacles that should be eliminated rather than understood and accepted. This perception about health professionals attending indigenous communities’ health centres or assuming policy making decisions is often narrated in the discourses, making these attitudes manifest

I have had an experience that was very unsettling for me. One of my former PH students, a physician who was responsible for the decentralisation of MINSA, sought an appointment with me. He had a meeting with the mayors of several districts in *Huánuco*. He complained, “I talked and they didn’t understand me”. I said to him that that’s a common phenomenon when we speak in a very technical way, but he said, “No, I come to you because I need your advice for something different. I did it neither, I couldn’t understand them. I really wanted to hear them, I was attentive, but I was not able to understand. And that is not a technical problem. *We don’t have ears to listen to them*” (MD, PH Expert iw/2009)

Culture should not be a barrier. Because, which culture do we mean? Is it my culture or the patient’s culture? Maybe *our* culture is the problem, because we see always what the other does wrong, and consider it as the disadvantage. That’s why we talk about “disagreements”, because we haven’t yet found a same sense with the user. And this is quite discouraging for physicians. Trying to change the culture of the other could not be the solution (MD, Health Officer iw/2009)

The approximation also stresses the direct association between the attitudes of health professionals in relation to the worldview and cultural particularities of the patients and the predominantly unsuccessful experiences observed by the functioning or implementation of representative health programmes in the country. Though, specific training programmes for health professionals conventionally offered by government institutions are widely discussed and most often evaluated as unsuitable. In the opinion of some social scientists, experts and consultants on communities’ health, these training programmes approach international policies, misaddress the real characteristics and needs of the population, and are not properly carried out. Although there are some initiatives on the way reflecting local needs that are mainly supported by international private organisations and carried out by communities and indigenous associations in

Peru³⁷⁴, informants have argued strongly for the release of clear intercultural educational policies from the state, in accordance with the regional and local particularities in the country.

The most dangerous thing is that a strange element in the community has been introduced, and they don't know the risks about and how to manage that...the traditional minorities lose the most, because there's no medical and technical preparation to defend themselves. They're losing their territories, water, and a healthy environment. The training of health promoters could be something that could be useful (Anthropologist iw/2009)

Health must be seen as a set of medical systems living together in a complex reality. Health should not be grounded only on an official system; rather it must be understood within a diversity of systems and cultural complexities. More anthropological research on health must be done, in order to take decisions and build policies responding the needs and expectancies of the population (Anthropologist iw/2009)

In order to overcome this situation, the principal solution proposed here resides in the elaboration of educational policies that not only consider the inclusion of TMS in the curricula, but also draw on the promotion and training of specific intercultural abilities among health professionals. Universities and formal educational institutions are considered instead as the primarily responsible in providing such adequate educational and intercultural frame to enable students and health administration specialists the accomplishment of key abilities in dealing with intercultural issues. This approach has been called “cultural competence training” for medical sciences.

The state should propitiate a re-valorisation process of these medical cultures. It is urgent to develop an intercultural health culture, with emphasis on the promotion and prevention...we still have unsuitable curricula...it is important to establish an intercultural dialogue between the university and the traditional medical systems (Aliaga t/2009)

It depends a lot on the possibility to change the academic structures in the country, because if the universities continue to promote professionals with a conventional view, it would be very difficult. We can't impose something new (Psychologist iw/2009)

According to this perspective, health professionals and policy authorities should assume the position to hear, encompass and follow people's representations, conceptions and needs: health providers should displace their prejudices and accept patients' perspectives –including the use of TM– as a matter of fact. By any means, such key

³⁷⁴ There are some programmes approaching the training of indigenous people as community health practitioners such as the Programme for Indigenous Health from AIDESEP (see chapter 3.3.3.2).

cultural competences can only be achieved through the inclusion of an intercultural training during the first years of medical formation. The abilities include the respect of diversity (gendered, ethnical); tolerance towards different points of view and personal/cultural explanations about body, health and care; a working perspective inspired by equity and social inclusion and an enlarged acceptance of persons coming from different cultural environments, even with opposed worldviews. These intercultural skills should be put across and imparted on the students during medical studies. In the opinion of some specialists, the major problem in this implementation is the absence of a human rights perspective inspiring the medical studies curricula. From this point of view health attendance is a basic human right, not a commodity, and it should be done in a friendly cultural environment, with respect for the socio-cultural specificities of the people. Even without learning these intercultural skills, if such a perspective exists, it could instead help to overcome the ethical, ideological and socio-technical defaults of the formation.

When we work according to the demand of the people, we should change our offer...when the request is about the formation; we should assume that, no matter what. We've already seen that (MD, Health Officer iw/2009)

An important dimension is the hindrance of academic authorities and Peruvian education politics in granting medicine students to come into direct contact and exchange with surrounding social and culture realities in which the use of TM is at the front. Existing medical and healthcare training offered by universities is not suitable with Peru's cultural particularities. The result of this unyielding restriction is a medical training without cultural competences and social bias in the country.

As first we proposed the introduction of a course on intercultural health in the medical curricula. But our chef cancelled it. And by the present they continue to say that the principal problem is the lack of a formation that enables the understanding of our multiculturalism! (Anthropologist, former member of CENSI iw/2009)

First of all I would change the medical curricula and put courses on cultural, social and medical anthropology. I would send the students each month, during the first year, to know the reality, and to make a thesis of each culture they visited. If they don't know it, they should learn and write about it. We couldn't hide ourselves behind a mask. If I don't recognise myself, with a supposed name, with a false identity, what can I do? Whom this will benefit? I would make that all the health personnel should make research pursuing these types of topics. Otherwise it is only the same story. In all the professional formation they should first recognise themselves, and know who they are, where they come from (Anthropologist iw/2009)

It was an obstetrician, with an Master in Health, and Ph. D, expert in maternal care and research who questioned my work. She alleged that I had not planned a model about the *casas maternas* and how these could minimize maternal death. I only asked her if she knows how many ethnic groups are in Peru. She didn't know. She's an example of health professionals here; she asks for a model - and maybe she want it only to make a picture of it and hang it behind her desk. Since colonial time they have been always acting in that matter, rather than trying to understand popular diversity in Peru (Anthropologist and Consultant iw/2010)

Among some social scholars and THPs the necessary training of THPs and community health workers is also central part of this educational approach. This training should be given from the state, principally through the universities. Accordingly, some THPs and popular healers want to be trained at universities or specialised health centres in order to obtain a legal and social framework for their activities –and also recognition as popular healthcaregivers. In their opinion, although these activities are not necessarily tied to research or investigation activities and not properly academic, it is important for them to have biomedical information in order to ensure, at least, an integrated treatment for communities in rural and urbanized popular sectors.

A person makes mistakes when he doesn't have enough information. A doctor with many years of studies can also make a false move, thus, you can imagine a person without any notion, who has made this in empirical form, because he has learned in that way. But if this person is identified and can give his knowledge at a university for traumatologists or neurologists, whoever, consider what we could make in Peru with this! (THP iw/2009)

In Peru, like in many other countries, professional health education has not been developed according to the challenges of a complex and adapting society. Among other factors, this is due to a fragmented, outdated and static curriculum that produces “ill-equipped graduates” (Frenk et al. 2010:1923). As it has been often mentioned, there are existing structural conditions in the educational system in the country entrenching this undesirable status quo and thus preventing important changes in the formation of human resources in intercultural health. According to an official report about universities in Peru it is asserted that in the academic tradition a “fetishist vision of power” has been consolidated (CNSRU 2002:86). This, combined with corporative practices, accomplished a management style that serves only as an instrument for the distribution of complaisances and the compensation of loyalties. “Such a system is profoundly divorced from a perspective inspired by the public interest and the reinforcement of communal wealth” (CNSRU 2002:86, t. sp.)

It is urgent to offer training to the university professors at state and private universities. Only in this way they can achieve adequate knowledge to assess governmental dependencies. The parliamentarians here are mostly only nobodies interested in profit and not in protecting the citizens. They invest in their own campaign and get a place in the parliament. There is no interest in popular health. And they don't have professional consultants working with them...the government policies should begin with the educational sector (Pharmacologist, Naturopath iw/2010)

Another important aspect addresses the accessibility for medical students to obtain quality information about TM. The access to scientific information about TM, actors, methods and techniques is not provided for health professionals or researchers in a comprehensive way, including medical trials and controlled research (e.g. double blind methodologies) that are not always disposed in data banks of libraries or universities. As a consequence, the reception to these contents depends alone on students' individual interest or necessity to research topics related to TM.

As far as I know, it can function if it comes from above. From the ground there are many experiences that cannot succeed because the super-structure doesn't allow it. I worked in a complementary medicine service in a hospital of ESSALUD in *San Juan de Lurigancho*. The service held out three years and it didn't grow, in part because of us, and on the other side the doctors didn't account this. And they didn't do so due to ignorance...I perceive more ignorance on their side than other reasons, because the medical and psychology faculties don't give courses that could show other things (Psychologist iw/2009)

As it is the case for other fields in science, knowledge transfer among different medical systems requires the establishment of bidirectional communication channels. A fluent, free and egalitarian accessibility to different information sources avoids the emergence of academic lobbyist practices that occur when the manipulation or avoidance of information related to specific medical systems is applied. Similarly, academic lobbying has been done by professionals whose activities are trying to influence legislation and administration in health on behalf of special interests who hire them. That is the case for people or groups-in-charge at the academic level, who are individuals pursuing a chair or academic positions at universities and that are working concurrently as pharmaceutical agents or researchers, fellow legislators and government officials, or are part of advocacy groups in professional federations that have become a strong influence on the country. According to my informants, that seems to be the standard situation in many universities and educational medical centres in the country.

Since they handle the topic of traditional medicine from the perspective of the social development, I think that they should be sought for partners for a constant and wide effort, but in several fronts at the same time. One of these fronts is the academic, but it can't go alone, it needs also the social communication sphere. They should go together, because if this can't go from the academia to the daily life, it would remain as an esoteric question, maybe not as amateur, but always as a "professional" esoteric. Research must be accompanied with some sort of action in order to disseminate it (MD, University Head iw/2009)

I'm worry with the universities, with the formation and training of human resources. I think that the public institutions are more sensible than the universities...but I don't know the solution for that, I'm not a professor (MD, International Health Officer iw/2009)

The access to information about TM for non-social academics resides in two qualitative aspects that are not guaranteed by universities: The first one is the absence of clear criteria for medical students and bioscience researchers to select adequately scientific literature about TM. The second aspect refers to the attitude of academic authorities in locating research and information about TM only in the area of the history of medicine (as an old-fashioned and rescinded topic), in pharmacology lessons (e.g. medicinal plants) or elective courses that are a not central part of the basic formation for medical students.

I work at the X University. When I ask if they have already had courses on medical anthropology or health anthropology they said "of course, we have learnt something about medicinal plants". Thus, they change the pill for the plant. That's the tendency, and that's what their authorities are expecting of them (Anthropologist iw/2009)

Although adequate information about TM would be available, there are indeed no cognitive structures among medical students to assimilate and embody such kind of knowledge into the basic set of their medical competences. Despite the implemented reforms including intercultural approaches in the health sector since the 1990s, clinical teaching at universities in Peru grasps medicine as MDs' exclusive knowledge terrain, and the components of human disease are conceived as apportioned dimensions of a unique biological reality that should be understand, analysed and repaired as such. This paradigm rests upon a hegemonic pragmatic-instrumentalist view of health fitting the national sanitary model, as well as on "physicians' trust and admiration of foreign technology" (Zárate 2001:12, t. sp.). Consistently, TM and its popular medical practices constitute a too "abstract" topic agreeing historical, anthropological or sociological

issues without any scientific and practical significance for biomedical practitioners. Social or cultural factors “surrounding” disease and illness have, therefore, only a peripheral or anecdotic role, and are not conceived as part of medical training. Health science educators and all the agents in mainstream HCS such as policy makers, practitioners and also patients support and reinforce this conception.

We should think also about this: Why do they need the rest? I mean, it’s a little bit problematic, why should they learn about a ritual if it’s something that isn’t expected? (Anthropologist iw/2009)

The afforded changes in medical curricula addressing the achievement of intercultural competences by MDs reflect an intention bias that would be probably difficult to assess. Whereas worldwide there is a call for curricular reforms among medical studies regarding cultural competences (cf. Homedes and Ugalde 2005; Murray et al. 2005; Drain et al. 2007; Jenks 2011), the hierarchical and highly specialised structure among global HCS expects and reinforces people and health resources to behave consistently. It is also important to take into account that what we perceive as success, is mostly constructed to some extent by upside-down processes that shape our experience to discard or accept ideas and assumptions. As Preston says, naive theories of behaviour holding that actions are caused by an agent’s intentions, and the subsequent success of an action is measured by the satisfaction of those intentions (Preston et al. 2011:233). In the evaluation of new educational settings, this perception of outcomes and success plays an exceptional role.

Additionally, in systems in which the flow of information and the challenges presented among multicultural situations are quite large, the incorporation of new and defiant information can produce a “social noise” that moves the group or system from an open to a closed status. In fact, when students perceived the ideal of the activity as congruent with their own ideals, they did not experience cognitive or emotional *dissonance*, a psychological state of tension within an individual when he or she holds two conflicting cognitions. But, “when internal and external ideals were not congruent, students found themselves in a state of cognitive and/or emotional dissonance, or tension created by two opposing ideals” (Thompson et al. 2010:904). Evidently, and as Zárte also asserts, if in medical schools there was no training provided to consider Peru as a medical pluralistic country, it is difficult to afford from MDs a different behaviour; because this

is not the responsibility of an individual MD, “everyone acts according to how he grew up and how he/she was educated” (Zárate 2001:17, t. sp.). Also in this sense Cabieses admits that in bicultural situations MDs have “something hindering them to see”, and that the reasons lie in the adherence with the principles of the dominant class, or the excessive focalization on the causality of illness, or the distortion produced during the academic formation (1985:4). For sure, this “something” is not a situation that an intercultural training would overcome effortlessly. As Albó excerpts, interculturality can function in both directions over time, but it must be given some form of mutual reciprocity and some symmetrical relationships: “if not, sooner or later, the relationship deteriorates and it turns into some deviations such as fundamentalism and chronic conflicts, alienation, or assimilation” (2004:67, t. sp.). Subsequently, the achievement of this symmetry is only possible after a long, patient and sometimes painful process.

No matter how legitimate and theoretic relevant the provided information is –or how necessary new behavioural patterns are to be assumed in– the system rejects the information as a first reaction in order to maintain the security bind to a knowing and predictable social structure. It would be said, therefore, that the introduction of intercultural curricula or specific courses about TM into the medical formation should be done after a specific cognitive preparation for medical students to be receptive for new information. This would enable them to assimilate the material that will be presented and endorse the cognitive challenges involved in that. It would consist, possibly, in a sort of training before training.

5.5.3.5 The Cultural Heritage Approach

Although not strongly elaborated among the explored interviews’ narratives, the cultural heritage approach is important because it locates the discussion about the integration, commercialisation and use of TK in HCS into the extended frame of the protective and regulative national and international legislation on indigenous rights, biodiversity, intellectual property rights and CH.

TK encompasses a wide construct with many conceptual areas, in which only a part includes medicinal plants and the traditional medical practices of indigenous

communities. The UN World Intellectual Property Organization (WIPO) defines TK as tradition-based human creations and innovations resulting from intellectual activity in the industrial, scientific, literary or artistic fields (WIPO 2002). This tradition-based knowledge includes systems, creations, innovations and cultural expressions which have generally been transmitted from generation to generation, generally regarded as pertaining to a particular people or its territory, held collectively, and are constantly evolving in response to a changing environment (WIPO 2002). The pertained local and indigenous knowledge includes not only sophisticated inventions and individual creations pursued by individuals or communities, but also understandings, interpretations and meanings that are accumulated and developed by peoples having extended histories of interaction with the natural environment: “they are part of a cultural complex that encompasses language, resource use, naming and classification systems, ritual, spirituality and worldview” (UNESCO 2002:74).

The Convention for the Safeguarding of the Intangible Cultural Heritage, adopted by the General Conference of UNESCO in 2003, was the first international agreement to provide a legal, administrative and financial framework to safeguard CH. This convention ensures respect for the intangible CH of the communities, groups and individuals concerned, and seek to raise awareness of the importance of intangible CH at the local, national and international level (UNESCO 2003:4). The Peruvian Government and the Ministry of Culture in Peru are responsible in providing information and to propose to this assembly the recognition of affected Peruvian intangible CH³⁷⁵. The Convention defines intangible CH as the practices, representations, expressions, knowledge, skills –as well as the instruments, objects, artefacts and cultural spaces associated therewith– that communities, groups and, in some cases, individuals recognise as part of their CH. It is, therefore, “transmitted from generation to generation, is constantly recreated by communities and groups in response to their environment, their interaction with nature and their history, and provides them with a sense of identity and continuity” (UNESCO 2003:4). The fundamental aspects of these definitions draw to attention that TK is “traditional” only to the extent that its

³⁷⁵ Between 2008 and 2011 Peru presented 7 records that were approved by the commission. None refers to medicinal plants or TM. See intangible heritage list at: <http://www.unesco.org/culture/ich/index.php?lg=en&pg=00011#tabs>.

creations and usages are part of the cultural traditions of communities, which does not automatically mean that this kind of knowledge is entirely ancient. TK is also contemporary, and is being created every day as individuals and communities respond to a changing social environment. Additionally, and because most (but not all) TK is transmitted orally from generation to generation, it remains largely undocumented (WIPO 2002).

In respect thereof, intangible CH is not merely valued as a cultural good –on a comparative basis– for its exclusivity, individual or its exceptional value. Intangible CH “thrives on its basis in communities and depends on those whose knowledge of traditions, skills and customs are passed on to the rest of the community, from generation to generation, or to other communities” (UNESCO 2003a:5). Besides oral traditions and expressions, intangible CH refers also TMS since they include the social practices and rituals based on communal knowledge, as well as practices concerning biological resources, nature and the universe. The genetic resources in the country, such as plants, animals and other organic and inorganic elements that have been used by the indigenous communities during centuries, are part of the intangible CH. TK of communities about medicinal plants represents the collective wealth of their experience and constitutes their intellectual property. Thus, the commercialisation of genetic species and TK underlies the international special legislation on indigenous rights, intellectual property rights and CH submitted by Peru, as well the Peruvian national legislation on these issues.

In The *Ley General del Patrimonio Cultural de la Nación* (National General Law on Cultural Heritage) 28296 and its Regulation, TM is expressly included as part of Peruvian intangible CH: “Integrate the intangible heritage of the nation the creations of a cultural community based on traditions, expressed by individuals in single or group way, and admittedly respond to the expectations of the community, as an expression of cultural and social identity, as well as the values transmitted orally, such as languages and native dialects, knowledge and traditional knowledge whether artistic, culinary, medicinal, technological, folkloric or religious, the collective knowledge of peoples and other expressions or cultural events that together make up our cultural diversity” (CRP

2004a: art. 1, nr. 2). These manifestations of the intangible cultural heritage can be: knowledge, know-how and practices associated with traditional medicine and gastronomy (CRP 2004b: art. 86, par. 8).

Fig. 67: Popular Uses of Animals and Plants



*Sale of frog juice³⁷⁶ at a market in Puente Piedra District, Lima
(Photo Pribyl 2009)*

In accordance with the ILO Convention 169 (ILO 1989) and the UN Declaration on the Rights of Indigenous Peoples (UN 2007), the Peruvian state should guarantee the protection, safeguarding and conservation of this biodiversity in respect, trust and coordination with the indigenous communities, who are the principal custodians and owners of this biological diversity. The United Nations Declaration on the Rights of Indigenous Peoples, which was adopted by the General Assembly, on September 7 2007 established in art. 5 that “indigenous peoples have the right to maintain and strengthen their own political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State”. More precisely, art. 12 of the same statement provides that “indigenous peoples have the right to manifest, practice, develop and teach their spiritual and religious traditions, customs and ceremonies; to maintain and protect their religious and cultural sites and access to them privately; to use and monitor their objects of worship and to obtaining the return of their human remains”. Further, the art. 24 of the same Declaration states that indigenous peoples have the right to their own

³⁷⁶ Cocktail consisting of a peeled frog without innards mixed with maca (*Lepidium peruvianum Chacon*), pollen, honey, milk, powder jelly, sugar beet, fruits, eggs, aloe Vera, among other combinations. The brew is said to increase virility and cure fatigue, especially for elder and children.

traditional medicines and to maintain their health practices, including the conservation of plants, animals and minerals of vital interest from the medical point of view. Indigenous people also have the right to access, without any discrimination, to all the health and social services. The indigenous people are entitled to equally enjoy the highest possible level of physical and mental health. The States shall take the necessary measures to achieve progressively the full realisation of this right (UN 2008).

The importance of safeguarding and protecting indigenous intellectual property of biological species and TK is expressed in the fact that the knowledge about the characteristics of a particular plant and its properties for healing is what gives medicinal plants their social and economic value: “As a result of this technology of use, which has been acquired through thousands of years of experience, trial and error and incremental refinement, communities have developed their knowledge of the plant, animal and mineral world to a technology that exists in old traditions of healing” (Sahai, Pavithran and Barpujari 2007:5-6). Accordingly, a technical invention such as the use of a plant to heal specific affections cannot be seen as an isolated one, rather than as an element that integrates a vast and mostly coherent complex of beliefs and knowledge, which control is not in the hands of individuals who use isolated pieces of such knowledge that are vested in the community or collective (WIPO 2002).

Although Peru was on the vanguard in Latin America with the implementation of a protectionist and juristic innovative legislation about indigenous rights and intellectual property rights (cf. UNU-IAS 2004:24; Gassenbauer 2008) this exemplary legislation does not guarantee the protection of indigenous rights over territories and biological and genetic resources.

The industrialisation, commercialisation and transfer of biological species and TK are not absolved from juristic contradictions and legal and dramatic socio-ecological problems. The loss of control and/or access to traditional territories, and their sacred sites, traditional foods and medicinal plants attacks the very existence of indigenous peoples and local communities as distinct cultural groups (Tobin and Taylor 2009:4-5).

Table 11: International Regime for the Protection and Regulation of Traditional Knowledge

	Law, Declaration, Covenant, Agreement, Assembly	Principal Statements
Protection	United Nations Declaration on the Rights of Indigenous Peoples (2007)	Self-determination of indigenous peoples as a basis for protection on human rights
	ILO Convention 169, (1989, ratified by Peru on 2004)	Parties to the Convention are obliged to respect and protect the social, cultural, religious and spiritual values and practices of indigenous and tribal peoples (ILO Convention 169, art. 5)
	UNESCO Intergovernmental Committee for the Safeguarding of Intangible Cultural Heritage, Convention for the Safeguarding of Intangible Cultural Heritage (2003)	Provides a legal, administrative and financial framework to safeguard CH; ensures respect for the intangible CH of the communities, groups and individuals concerned, and seek to raise awareness of the importance of intangible CH at the local, national and international level
	Convention on Biological Diversity (CBD), (adopted 5 June 1992, entered into force 29 December 1993)	Recognises sovereign rights of member states over genetic resources and the right of indigenous peoples and local communities to be consulted and to share in benefits associated with access to, and use of, their TK
	UN Covenants and self – determination: International Covenant on Civil and Political Rights (CCPR); International Covenant on Economic, Social and Cultural Rights (CESCR) (1976)	All peoples may freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law (CCPR Part 1, art. 2). The States Parties shall promote the realisation of the right of self-determination, and shall respect that right (CESCR Part 1, art. 1)
Regulation	UN World Intellectual Property Organization (WIPO): Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore (IGC), (2000)	international forum for examination of the interplay between intellectual property, TK, genetic resources, and traditional cultural expressions (WIPO, 2008)
	World Trade Organization (WTO) Agreement on Trade Related Intellectual Property (TRIPS) (15 April 1994)	The protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations (TRIPS, art. 7, objectives) ³⁷⁷

³⁷⁷ Peru has argued that protection of their rights over TK should be secured by modification of TRIPS to prevent biopiracy (cf. Tobin and Taylor 2009).

The principal threats to TK are the extractive industries such as mining, oil and gas and forestry, as well as colonization by large-scale farming interests displaced peasant communities and undermining their traditional lifestyles. The Human Rights Watch ombudsman reported in June 2011 more than 200 ongoing social conflicts in Peru, many related to new mining ventures (HRW 2012:2). The dramatic events occurred in the country in the last three years, like the Massacre in Bagua in June 2009³⁷⁸; and more recently, the increasing protests against the Conga Project³⁷⁹ demonstrate the deep roots of the chronic conflict between the interests of indigenous peoples and those of the Peruvian state. Furthermore, the implementation of the *Ley del Derecho a la Consulta Previa a los Pueblos Indígenas u Originarios* (Law on Prior Consultation of Indigenous Peoples) (CRP 2010b) has been criticized because of several legislative and administrative measures relating to mining and forestry affecting Indigenous rights (cf. CAAP 2008; AI 2011:12).

Nevertheless, the Peruvian state has declared its own strong expectations that the access to its resources and to TK is based on fairness and equity, with due compliance with existing legal norms and regulatory frameworks. The Law of Protection of Indigenous Peoples' Collective Knowledge 27811, in force since August 2002, establishes a system of protection of the collective knowledge of the indigenous peoples that is connected to the use of biological resources (CRP 2002). The law defines collective knowledge as the “accumulated and transgenerational knowledge developed by the indigenous peoples and communities with respect to the properties, uses and characteristics of biodiversity” (CRP 2002:art. 2, par. b). The Peruvian state, in this same standard legal merit, has arranged INDECOPI (Peruvian National Institute for the Defence of Competition and Intellectual Property) the body that manages and protects this

³⁷⁸ Alan Garcia's Government signed a number of free trade agreements with the United States and Canada, seeking to change domestic laws and encourage unrestricted foreign investment in the Amazon. Awajún communities blocked the principal highway in northern Peru, demanding dialogue with the state and the abolition of these agreements affecting their territories. The conflict resulted in the killing of an estimated of 40 people among police forces and natives.

³⁷⁹ The owner is Minera Yanacocha, the largest gold producer in Latin America, property of the US Newmont Mining Corporation. The Project, located 73 km northeast of the city of Cajamarca, aims mining of two copper porphyry deposits –which are supposed to contain gold. The protestors are concerned about plans to dry up four lakes in order to extract the gold under the water, in a zone where economy depends on agriculture and livestock. Environmental impact studies of this project are under discussion. See: <http://www.newmont.com/>.

knowledge, either by registration in the confidential national register of collective indigenous knowledge.

Based on these previous legislations expedited in 2002, Peru released in April 2004 the *Ley de Protección al Acceso a la Diversidad Biológica Peruana y los Conocimientos Colectivos de los Pueblos Indígenas* (Law 28216) for the protection and regulated access to Peruvian biodiversity and collective knowledge of indigenous people (CRP 2004). The law proscribes and interdicts the “non-authorized and non-compensated use and access to biological resources of traditional knowledge of indigenous people by third persons without the correspondent authorization and against the principles established in the Convention on Biological Diversity (CBD) and the prevalent national norms about this matter”. This appropriation would be done “through physical control, property rights over products including illegally accessed elements or, in some cases, through the invocation of these” (CRP 2004:final disposition 3, t. sp.). To address these issues, the law established a National Commission for the Prevention of Biopiracy³⁸⁰ which is conformed of different academic, governmental and social representatives of institutions and organisations in the country, such as the ANR (National University Colloquium), CENSI (National Centre for Intercultural Health), CIP (International Potato Centre), CONAM (National Environmental Council, currently the Ministry of the Environment), INDECOPI (Peruvian National Institute for the Defence of Competition and Intellectual Property), INDEPA (National Institute for the Development of Andean, Amazonian and Afroperuvian Populations), among others.

Some authors argue that biopiracy takes place in countries that are rich in biodiversity, on behalf of the scientific, commercial or industrial interests of developed countries (Ruiz 2005:1-2). During the past two decades, resources like *ñuña* (*Phaseolus vulgaris*), *kiwicha* (*Amaranthus caudatus*), *uña de gato* (*Uncaria tomentosa*), *camu camu* (*Myrciaria dubia*), *yacón* (*Smallanthus sonchifolus*) and *maca*³⁸¹ (*Lepidium Meyenii*, *Lepidium Peruvianum chacon*) are just a few of 32 other Peruvian botanicals that have

³⁸⁰ Sp. *Comisión Nacional contra la Piratería*. See: <http://www.biopirateria.gob.pe/index2.htm>

³⁸¹ The process began in 2002, two years before the establishment of the National Anti-Biopiracy Commission, and after discovering the patents have been granted in the USA for inventions related to the maca root (cf. Bazán 2006).

been prioritized in a list for protection against biopiracy (Bazán 2006:19). All these plants have one or more patents related to them that were given, or are in procedure, to private proprietors of the USA³⁸², Japan or Europe (Ruiz 2005:3).

This *albahaca*³⁸³ that we produce is a hundred percent organic. Everything that we produce is a hundred percent organic. We're working against transgenic products; we don't want that Monsanto³⁸⁴ comes into the country and steals the genetic and nutritional suzerainty in Peru. In principle, they don't want to sell transgenic crops, they want to creep into the country and take out the seeds of the *kiwicha* [amaranth], Quinoa and maize, all the Andean cereals. What for? They want to patent them, and sell... but our movement against is very strong (Ayawaska Apprentice iw/2009)

Transnational companies stick the nose even in universities' curricula, in education and nutritional policies, so we're ruined. Only a radical revolution avoiding and destroying all that could be a solution, otherwise we're prowling in desert... policies should be given by the state, but it's impossible with a government defeated by transnational companies (Naturopath iw/2009)

Part of this knowledge was picked up from a group of gringos from the University of Berkeley. A gringa married an aguaruna [awajún] to take away all his secrets. Though even in bed, she couldn't pull out his secrets, and he didn't give them to her! But they've obtained it through other forms: they paid money and identified the plant, and took it finally to the USA (Geographer iw/2009)

Some THPs are indeed aware of the legal and practical implications for their work due to the existing trademark laws, complicated intellectual property registration procedures, increasing biopiracy and the unprotected situation of TK and related healing techniques in the country.

But here in the country we don't make that. Our plants are not registered as it has been done by the Mexicans with the peyote. Here there is a total ignorance! The other day I saw somebody taking ayawaska to the airport and the police arrested them because "it's a drug, a hallucinogenic". People are dolts! Ok, the San Pedro is also a drug, but it heals you! And which medicine is not a drug? Tell me, isn't it? (Wachumero iw/2009)

Certainly, and as some studies and reports have shown (Correa 2002; Ruiz 2006; CAAP 2008; Wessendorf 2011:159-171), existing neoliberal economic systems are in strong opposition to the establishment, enhancement and implementation of intellectual property rights and the protection and safeguarding of the intangible CH of ethnic

³⁸² A startling case in Latin America was the grant of US patent 5,304,718 to two professors of the Colorado State University on *Apelawa quinoa* (*chenopodium quinoa*). The patent was cancelled in part due to international public protest and of organised Bolivian farmers (RAFI 1998).

³⁸³ Sp. Saint Joseph's Worth, Basil, or Sweet Basil, common names for *Ocimum basilicum* (Bussmann, Sharon and López 2007:188).

³⁸⁴ A US multinational agricultural and biotechnological corporation, leading producer of genetically engineered (modified) seeds worldwide. See: www.monsanto.com.

minorities. As Correa asserts, Western intellectual property systems have regarded TM as freely available for use by anybody. This has meant that TM and other TK “have been exploited in Western contexts without any recognition, moral or economic, to those who originated or held the relevant knowledge... diverse components of TM have been appropriated under intellectual property rights by researchers and commercial enterprises, without any compensation to the knowledge’s creators or holders” (2002:9-10). Regarding the particular aspect of the pharmaceutical industry patent process, and the use of plant-based TK of indigenous communities, it must be considered that while knowledge created in laboratories is certified in terms of patents, those created in fields and forests are not always recognised as the property of indigenous communities. Biotechnological procedures of the food industries and pharmaceutical corporations afford the research and study of plants, crop-grains and animals for industrialisation and commercialisation goals and for granting patents, and make use of the international intellectual property rights system for trading purposes.

Besides ecological and international corporations’ interests, indigenous peoples are confronted by additional difficulties regarding the legal recognition of their property rights. First, the international law protection regime faces the constant encounter with the customary legal system of indigenous peoples and their worldview regarding control and production mechanisms. Second, the complex system of intellectual property laws requires a high degree of legal and technical expertise to understand and apply these regulatory mechanisms in a proper way (cf. Kiene 2009). In Peru there is a lack of accessible and clear information about implementation mechanisms for indigenous peoples, and the poor coordination among the different sectors implicated (MINSA, Ministry of Agriculture, Ministry of Culture or even the Ministry of Environment). Another handicap lays in the unfeasibility to determinate and identify the big spectrum of the Peruvian legislation system on the part of social scientists and consultants assessing these issues. For example, besides the framework conditions consist of some complicated and unwieldy legislation standards, an interested non-law-specialist should be informed on at least four different legislative regimes addressing biological diversity, intellectual property rights, indigenous rights and CH (Quevedo ec/2012).

Several studies and conference meetings carried out by intergovernmental UN organisations such as the Convention on Biological Diversity (CBD), World Intellectual Property Organization (WIPO) and World Trade Organization (WTO) have evaluated in periodical form the status of countries' experiences and national laws regarding the protection of TK since their establishment, and are extensively documented³⁸⁵ (cf. WIPO and IGC 2003, 2008; Kiene 2009). Nevertheless, some evaluations of the pertinence of procedures in applying patents of TK and biological resources (e.g. medicinal plants) as intellectual property by indigenous communities has shown that although legal protective regimes are available, their implementation faces technical requirements that are not easy to cope with by indigenous peoples (Ruiz 2006; Reyes 2011).

Addressing the question of how TK documentation on databases and registers –as INDECOPI– could protect TK and share indigenous peoples' demands to control their knowledge and raise benefits from its use, Reyes concludes that the national and international law do not reflect indigenous peoples' demand for a holistic approach to the protection of their rights over TK; “the legislation tends to separate genetic resources and TK and treat them as divisible. The protection of traditional knowledge goes beyond the mere protection of knowledge itself as a separate issue, and this requires a holistic approach to protect not only traditional knowledge itself but also the communities who hold the knowledge” (2011:322). Similarly, an official UNESCO document asserts that although local communities are calling for the protection of TK from outside exploitation without prior consent or shared benefits (i.e. bio-piracy), existing regimes for protecting intellectual property are “ill-adapted” to the needs of indigenous knowledge and indigenous societies (UNESCO 2002:79). Berglund properly illustrates this discursive situation, arguing that “a shaman will be aware of the medicinal qualities of certain plants, but may not be in the position to provide the chemical structure of the active compounds and the scientific specification required to satisfy a patent examiner” (Berglund 2005:208). Thus, we are always confronted with the paradoxical situation to have a protective law system that cannot be properly used by the people it attempts to protect.

³⁸⁵ These research settings have been criticised as non-pertinent to indigenous self-determination and autonomy (cf. SOUTH CENTRE-CIEL 2007).

The importance of the protection and regulation of indigenous medical TK can be emphasised by mentioning the *ayawaska* patent case, known among patent legislators as the “De vine case”. In 1999, the Centre for International Environmental Law (CIEL), on behalf of the Coordinating Body of Indigenous Organizations of the Amazon Basin (COICA) and the Coalition for Amazonian Peoples and Their Environment (Amazon Coalition), filed a legal request for re-examination of the US Patent and Trademark Office (PTO) of the patent given to the US American Loren Miller to the *ayawaska vine*. Although the arguments presented by COICA and the Amazon Coalition addressed principally the inapplicability of the purpose of a US Citizen to appropriate a plant that is sacred to many indigenous peoples of the Amazon, used by them in religious and healing ceremonies, the CIEL filed this request for re-examination of the patent based only on the “lack of novelty” criteria (CIEL 1999). According to this, a requested invention is not patentable if the claimed subject matter was disclosed before: “A document will only destroy the novelty of any invention claimed if the subject matter is explicitly contained in the document...Lack of novelty can only be found if the publication by itself contains all the characteristics of that claim, that is, if it anticipates the subject matter of the claim” (WIPO 2004:5). Consequently, in November 1999 the PTO issued a decision rejecting the patent only because the invention had been previously described. As detailed in an analysis made by the CIEL’s attorney Glenn Wisner (CIEL 1999), the PTO accepted the petitioners’ arguments that the claimed plant variety was not distinctive or novel, but did not acknowledge the argument that the plant’s religious value warranted an exception from patenting, and did not consider that traditional indigenous knowledge of a plant or its uses should be considered prior art (Tupper 2009:128). Under the law, a patent applied for before 1995 expires 17 years from the date of its original issuance. The *ayawaska* patent expired on 17th June 2003 and cannot be renewed.

By mentioning this case, Tupper asserts that the *ayahuasca* brew is a “complex decoction that evidences an advanced form of pharmacognosy among the indigenous peoples of the Amazon”; “an example *par excellence* of cultural intellectual property” (Tupper 2009:127). Nevertheless, cases like the granting of intellectual property rights over specific TK like *ayawaska* should be carefully analysed. In such a case, in which

there exists a common possession of TK, i.e. the same knowledge may be held by more than one community³⁸⁶, a big issue on historical or geographical priority would arise, since intellectual property rights systems does not grant rights to communities as such (Correa 2002:17).

A possible outlet to this situation could be the recognition of specific TK as national cultural heritage, in order to create a previously existing register of the knowledge. Besides discussions around its supposed millenary origin, it is necessary here to give weight to the fact that the *banisteriopsis caapi* is a plant native from the Amazonian region, and that the uses of the ayawaska brew (the combination from *banisteriopsis caapi* and *chacrana viridis*, among other plants) with healing, ritual and religious purposes by local indigenous and mestizo communities are part of the TK and intangible CH in Peru: The knowledge and traditional uses of ayawaska practised by the native Amazon communities were declared as Peruvian CH on 24th June 2008 (INC 2008). By all means, the De Vine case illustrates the way in which patents on TK and biological resources threaten the autonomy of indigenous communities and shows, at the same time, the perspective of international trademark courts regarding indigenous rights over their biological species.

Peru is considered as the country in the world with the third most biodiversity. It has provided important bio species due to its diverse altitudinal ecological zones and microclimates. From the 103 biospheres niches that are known worldwide, Peru houses 84 with 50,000 vegetable species, which constitute 20% all existing worldwide (Li 2009:3). Furthermore, Peru occupies the first place worldwide in population use of medicinal plants, with an estimate of 4,400 species (MINSa 2010:5-6). The utilisation of these plants is of traditional and popular character, however, and most of these plants are only available through a healer, and are not industrialised.

³⁸⁶ Ayawaska has been used by indigenous and mestizo communities in north-west South America, including Peru, Ecuador, Brazil and Colombia.

Fig. 68: Passion Fruit (*passiflora ligularis*)



*The ethnopharmacologist Orlando Rosas shows a fruit of the *passiflora ligularis* (sp. *granadilla*³⁸⁷) in the botanic garden of his centre located at the Moche Valley, in La Libertad. (Photo Pribyl 2010)*

The legal and procedural conditions under which different products of TM (services, techniques and elements) should be distributed, purchased and utilised by the population in the country are addressed throughout the discourses. For THPs the commercialisation of such products is necessary and welcome, though the government should develop fair and clear mechanisms of production, distribution and commercialisation, as well as guarantee the preservation of the botanical resources in the country and the protection of customers' health

Here grows the *diente de leon*³⁸⁸, or *malva*³⁸⁹ or you find everywhere the *matico*. They grow on their own, nobody in the country needs to plant them; they don't need anything. Are they important? No, they're waiting for foreigners coming and saying that these plants are worthy and only then they give them attention. But we already know about that since centuries (Bonesetter iw/2009)

³⁸⁷ In the middle and northern coastal zone of Peru the fruit's juice is given to babies to equilibrate the intestinal flora. Rosas argues positive outcomes in the treatment of gallstones in adults (Rosas iw/2010).

³⁸⁸ *Taraxacum officinale* Wiggers (fam. Asteraceae), known as *amargón* or *hierba del león* (lion's herb). Used in case of internal inflammations (liver, stomach, ovaries), against *mal de aire* (bad air) or protection from evil (Bussmann and Sharon 2006:16).

³⁸⁹ Different species of the family of the *Malvaceae* (*alcea rosea*, *gossypium barbadense*, m. *paviflora*, m. *sylvestris*, etc.) with adduced anti-inflammatory and restorative properties are used against mal de aire, epilepsy, "nerves" or ojeo (Arévalo 1994:184; Bussmann and Sharon 2006:12; 49-50).

There are many companies using TM as a business. It's a boom and it has become to be a strong commercial empire³⁹⁰... By the way, one of them wanted to purchase my idea, but I can't sell it because it's not only mine...it was a respectable institution. But I told them that they should be careful; for sure they can take it over but a very different thing is to make it function in a fair way...we didn't want a business, although you can make a lot of money with that (Wachuma Apprentice iw/2009)

Although the adduced lack of government regulations and open control mechanisms to this respect are throughout discussed and cited in a range of examples, trading processes are principally approached in terms of export and commercialisation difficulties over the specific quotation of existing legal dispositions about biological patents and indigenous intellectual property rights. For some THPs and AHPs the commercialisation of botanicals and herbal remedies should be possible in an easier way. They do not think in terms of control and security at the first level, because, as they say, they proved these products long time ago, and they do not need or should stand continuously under evaluation. For them there is only one requisite: The products should be manufactured and prepared under their supervision, and the industrialisation process should be implemented in consent with them.

I said some time ago that we should share our traditional medicine...clinically studied. But for a proper use of this plant there should be maestros that are well trained. I don't know if I'm wrong on this, but I don't think that the dosage could be given by anyone; it must be a good trained medico with a spiritual formation (Ayawaskero t/2010)

Another important aspect is the foreign population that consumes these species and services in non-traditional contexts: Bringing TM products and derivatives into an international market, with carefully qualified proof criteria of the production, competitive marketing strategies and trademark guarantee is often addressed within this approach. This knowledge transfer of products and services in international markets corresponds to a internationalization process –as it has been conceived and mentioned by my informants– and is even not regulated, presenting different circuits and characteristics that are not yet properly researched in terms of public health impact. Again, it is the state, the government and its biomedical institutions who are syndicated by my informants as the principal responsible for the “progressive extinction of TM”, because they do neither assume the compromise to preserve these traditions –underlying

³⁹⁰ Inspired in international companies like Omnilife, Prolife or Herbalife, some Peruvian companies such as *Bio Salud*, *Fitosana*, *Santa Natura*, etc. show increasingly profit accuracy, but not recognised production standards. Whereas the informal market has been increased, the official certified export has declined in the last four years, at least for *yacón*, *maca* and *tara* (UNIDO 2008:8-11).

the impact of this on the Peruvian populations' health– nor to protect and promote its conservation as part of the national CH.

And now, that you are talking about this integration, it makes sense! Because here what the physicians want to do is to destroy TM. They don't say that openly, but they do it in practice...for them the best curandero is one who has passed by; only so he can be honoured! (TM Researcher iw/2009)

The principal governmental agency responsible for the control and monitoring of the medicaments in the country is DIGEMID, an office administrated by MINSA. It supervises, inscribes, modifies, suspends and revokes the sanitary register of companies, and executes sanitary monitoring and control. Each year, an average of 150 natural products will be inscribed at DIGEMID. Between 1999 and 2007 a higher proportion of foreign natural products (54%) compared to nationals (46%) was approved for nutritional and medicinal use (Camacho 2010:11). Despite the biodiversity in the country, there is a predominance of foreign natural products for sale, a situation possibly attributable to the lack of research and information regarding therapeutic properties of national species. For my informants the principal problems in the non-existence of standard norms to prove the sanitary guarantee of herbal, nutritional and natural products, as well as operative institutions regulating these tasks (cf. Li 2009:27-30). A topic that is still not guaranteed in the country is the concomitant institutional responsibilities for health impact supervision in the use of traditional remedies, with an according monitoring process and evaluation at each level, from farmers, manufacturers and investors up to costumers.

Here there are no natural medicines to sell. They're only nutritional supplements. In preparing medicines the cellulose must be first isolated, as well as the agents that we can't metabolize. A bird, a cow, a bear, they eat a seed and they can't assimilate it. Then, imagine a human being, who is carnivore!... These false medicines in Peru remain in the oesophagus, and go to the appendix or colon. The bacterial flora is altered; it must combat exogenous agents we can't metabolize, because we don't have the enzymes for this. That's a problem in our country that conducts to a population that can't think, because they don't eat properly and take false medicines (Naturopath iw/2010)

It belongs to a sector in which physicians and pharmacologists have nothing to do. These natural products do not go through a proper quality control with methods of the phytochemistry... they are products that go across with any quality proof control: the agricultural engineers give the permission with a simple copy and only a microbiological test, and then they sell the pulverized plants with all the bacteria and fungus. That's what they sell in the markets (Pharmacologist iw/2010)

In fact, for the application of a sanitary register for the commercialisation of herbal resources in the country it is required to present an analysis protocol including technical specifications, results, analytical methods, and a physical-chemical and microbiological control report subscribed by a chemical-pharmacologist (Camacho 2010:12). The procedure includes also the presentation of a scientific monograph about the herbal substance, which must include the taxonomic identification, botanical description and information related to the dosage, harmful secondary effects and references on clinical trials conducted for. Anyhow, many of my informants argued that most of the herbal resources with traditional healing use in the country do not count with scientific monographs. Although the sanitary register dispositions contemplate this exceptional situation, and assure that products without clinical trials should consign the expression “traditionally used for...” (Camacho 2010:12), most of the problems suggested reside in the absence of such monographs and an official national pharmacopeia (Zevallos 2002:84-85). Due to this declared situation the criteria used by DIGEMID to differentiate between natural medicines with specifically therapeutic use from a nutritional supplement is problematic. In those cases they consult the *Comité Especializado del Ministerio de Salud CEMIS* (Special Committee of MINSAs) composed by health professionals and pharmacologists, without social scientists and experts on TM. Therefore, many natural products remain with such ambiguity, their registers are either cancelled or not awarded, or are erroneously catalogued as nutritional rather than medicinal products (Camacho 2010:13).

Admittedly, one of the principal problems for the sanitary register and proper commercialisation and control of medicinal plants is the absence of information and/or share of existing monographs of medicinal plants, and the necessary coordination among neighbored health institutions on existing databases. Similarly, there is no protection of the Peruvian germ-plasma (Zevallos 2002:84-85). The Unit of Complementary Medicine of ESSALUD, based on two project covenants between the Korea Research Institute of Bioscience and Biotechnology (KRIBB) and the CONCYTEC, has elaborated a register of 450 medicinal plants of the Amazonia and 100 monographs since 2005, which are said to be in a medicinal plants database at the Information Centre of Complementary Medicine CIMEC (Matos 2001:7). In case of CIMEC, there is not yet available an electronic version of this database, and I did not

find out if this database has been incorporated and in which amount in the correspondent information retrieval system of CENSI, or not.

An exceptional case that overcomes the difficulties present by regulations policies is the coca (*Erythroxylum coca* fa. *Erythroxylaceae*), one if not the most important native plants in Peru. Besides its religious, ritual and communal value, coca chewing or coca leaves as tea beverage have been used also as a homeopathic medicine among indigenous peoples in Peru for centuries. A study asserts that chewing coca as a communal activity began in Peru 8,000 years ago³⁹¹.

One of the most comprehensive chronics about Peru is offered by Pedro Cieza de León in his “Crónica del Perú”, written around 1544-1552. His Crónica was the first that sought a comprehensive conception of the history of Peru, written in an alluring literary style and compounded with sifting information from the most remote origins he could reach. In prior documents written before Cieza, organised on the second voyage of Pizarro (1527), there were no mentions of the word “Incas”. Indeed, the most elaborated concepts and tighter descriptions about the Incas’ political and social organisation were depicted and organised for the first time by Cieza de Leon. The ethno-medical value of his work is also present. In chapter 96, Cieza offers one of the richest descriptions about the coca consumption and its economic and social value in Peru (Cieza de León 2005:247).

Garcilaso de La Vega, quoting Father Blas Valera referring to the benefits of coca among the indigenous people, notices: “coca preserves the body against many diseases, and also our doctors use it as powders to stop and placate swelling ulcers; to strengthen broken bones; to take away the cold from the body, or to prevent it from entering; to heal corrupted sores filled with worms. When coca benefits so much the diseases of the outside, with such singular virtue, would it not have more virtue and force in the entrails of those eating it?” (1609:180-181).

³⁹¹ The authors found and identified coca leaves in house floors in the Nanchoc Valley, in northern Peru. There were also pieces of calcite, which is used by chewers to bring out the alkaloids from the leaves (Dillehay et al. 2010: 939).

Several European physicians from the 16th to the 19th century –such as Nicolás de Monardes (Millones 1998)³⁹²; Paolo Mantegazza (Mantegazza 1858)³⁹³ and Sigmund Freud (Freud 1884)³⁹⁴– were fascinated with its properties, and have proposed the therapeutic use of coca as a medicine for different complaints and medical interventions. Mantegazza, for example, who thought of coca as a datura species, writes about using coca leaves as an illuminating experience: “...I sneered at the poor mortals condemned to live in this valley of tears while I, carried on the wings of two leaves of coca, went flying through the spaces of 77,438 words, each more splendid than the one before...An hour later, I was sufficiently calm to write these words in a steady hand: God is unjust because he made man incapable of sustaining the effect of coca all life long” (Mantegazza 1859). Around the 1880’s the consumption of wine containing coca (the Mariani wine) was widespread in Europe. The excitement was almost general with this wonderful remedy that strengthens the nervous system, helps digestion, stimulates fatigued bodies, and calms the pain and release of drug for those entangled in it. In 1884, with only three years in the medical profession, Sigmund Freud began to experiment, on himself, on his wife and some of his patients, with coca. Having read Aschenbrandt’s experiments³⁹⁵ (Aschenbrandt 1883) on the administration of drugs to soldiers as stabilising manoeuvres in order to combat fatigue, he tried to find out the mechanisms of cocaine in alleviating anxiety and depression (Jones 1953:78-81).

Since the middle of the last century, indigenous use of coca has been reported as a treatment for malaria, ulcers, asthma, to improve digestion, and to guard against bowel laxity (cf. Cabieses 1996:161-162). It has also been mentioned as a therapeutic source against cephalalgia and as natural anaesthetic for rheumatism, sores and wounds (Bussmann and Sharon 2006:31). Modern studies about its pharmacological and behavioral effects have partially supported a number of these medical applications. It has shown effectiveness for digestive complaints (Gil 2008) and also to diminish the

³⁹² After graduating and gaining experience as surgeon in Sevilla, Monardes joined a company for trade exchange with American products. His medical history based also on references of travellers with sicknesses and constitutes a detailed account about the healing and nutritional properties of multiple barks as *tacamahaca*, snuff, *mechoacán* (a purgative pineapple), sunflower, cassava, etc. (Monardes 1580).

³⁹³ See also: Mantegazza, Paolo. 1859. “Sull'introduzione in Europa della coca, nuovo alimento nervosa.” *Annali de Chimie y Applicazione Medica* Vol. 29 (3): 18-21.

³⁹⁴ “Über Coca” was the best European study about coca to this time.

³⁹⁵ Aschenbrandt, Theodor. 1883. “Die physiologische Wirkung und die Bedeutung des Cocains.” *Deutsche medizinische Wochenschrift*, December 12.

negative effects of the high-altitude illness or mountain sickness. It has been keenly suggested that *coqueo*³⁹⁶ increases muscle activity of the basal metabolism and peripheral vasoconstriction causes certain changes in the economy of heat (Hanna 1971a) and body exercise (Hanna 1971, Spielvogel et al. 1997). There is also information about the positive influence of the *coqueo* on the inner process of oxygenation and the decrease in oxygen consumption (Favier et al. 1996). In this regard, prior studies indicate a positive effect specifically on the stress associated to high altitude syndrome (Hanna and Hornick 1977, Torchetti 1994) and no significant differences on control groups in relation to muscle metabolic effects (Bolton 1976) and other physiological symptoms such as chronic hypoxia (Brutsaert et al. 1995). Anyway, recent experimental findings reported that chewing coca leaves induces biochemical changes that enhance physical performance at high altitude (Casikar et al. 2010). Ethnomedical and archaeological evidence indicates, however, that coca use was widespread at all altitudes before the European conquest, far from being purely a high-altitude phenomenon (Warwick and Dollery 1983:269-271). Although the mechanisms by which all these effects are realised have been not clearly explained on an experimental basis, evidence suggests, however, that the indigenous assertion that chewing coca warms them, quells hunger, and reduces fatigue may be valid.

But something that remains far more interesting for our topic than the relationships between coca and mountain sickness are the bitter altercations in the country about coca and nutrition. The association of coca chewing, malnutrition and underdevelopment also has its own history, beginning with the establishment of academic psychiatry in Peru (Valdizán 1913)³⁹⁷. Cáceres (1990) and Cabieses (1992) criticised these development above all because of the absence of definitive scientific evidence to support the negative affirmations about *coqueo*. They attributed to this speculations racism and prejudice against indigenous people (Cabieses 1996), as well other political and ideological interests of governments and institutions in and outside of the country (Cáceres 2003).

³⁹⁶ Sp. Traditional chewing of coca leaves, also known as *hallpay* (Cabieses 1992:31) and *cacchado*, *acullico*, *pichado* and *mambeado* (Hurtado 2008:25). For a comprehensive description of its varieties and uses, see e.g. Henman, Anthony. 2005. *Mama Coca*. Lima, Peru: Juan Gutemberg Editores.

³⁹⁷ Hermilio Valdizán (1885-1929) was the first psychiatrist in Peru. He studied psychoanalyse in Rome and Paris, wrote his doctoral thesis about the mental alienation in “primitives” of Peru (1915). He founded the chair on psychiatry, the first mental health hospital (Victor Larco Herrera) and the first nervous and mental diseases departments in the country.

I discovered a big prejudice against the coca that was spread through Peruvian psychiatrists. Hermilio Valdizán brought to us the idea that the coqueo was a cocaine addiction... He read a psychiatry text from Emil Kraepelin, in which the use of coca leaves was “chronical intoxication”. Thus, Valdizán said “oh dear, that’s why the race is degenerated”, and began with this fable³⁹⁸. Through the Peruvian psychiatry chair he combated the coqueo as a race-degenerating addiction (Cáceres iw/2009)

The problem is not about the coca. The real thing is the international fight against drug trafficking that involves a national natural resource. The state’s dereliction about its industrialisation has induced that only the narcotic traffickers use this resource. Which alternative has the coca farmer? For whom can this be sold? How could this be regulated? Of course, it is a very complex problem, but there are for instance too many people in Peru wanting to restrain this development because they receive a lot of money from the USA to say that we have a “drug consumption problem” –something we don’t have. They export a health problem of the Americans to us (Psychologist iw/2009)

Fig. 69: Coca Market at Centro Histórico de Lima³⁹⁹



(Photo Pribyl 2009)

³⁹⁸ Kraepelin reported labour pharmacological measures by injecting cocaine on rats and the observation of European people with intravenous, oral and inhalation cocaine dependence. He assumed similar effects on traditional coca chewing among Peruvians: “The cocainism is one of the most modern chronically intoxications...Observations of pure cocainism are very uncommon here, whereas in Peru, the home of the coca, the consequences of this chronically intoxication are obviously known as the opium’s addiction in China...Unfortunately, psychological trials with this substance afford too many risks; thus, we know very few about its psychological effects“ (Kraepelin 1887:117, t. g.). In fact, no empirical studies have been ever done with Peruvian indigenous coqueros supporting Kraepelin’s findings.

³⁹⁹ APEHCOCA (*Asociación Peruana de la Hoja de Coca*) was the first big Peruvian civil association in organising forums, outreach work and public activities defending and promoting the free production and commercialisation of coca meal products and coca leaves (fq/2009).

Today there exists an increasingly academic and activist lobby which promotes and defends the use of coca not so much as a stimulant, but as a food supplement, appealing to all types of sources of information in underlying coca's dietary benefits. This movement promotes the free consumption of coca leaves among non-Andean indigenous populations and the industrialisation and commercialisation of coca leaves derivatives for therapeutic and nutritional purposes.

However, the therapeutic and nutritional use of coca leaves and coca derivatives –most of all because of the alkaloid cocaine⁴⁰⁰– remains arguable. Some experts and health professionals have a sceptical position about the terms and conditions of commercialisation of products derived from coca leaves, such as the coca flour and its adduced medicinal and nutritional properties. The principal concerns are in relation to the questioned nutritional adequacy of the coca, and the absence of clinical trials regarding health impact. It has been purported, for example, that coca leaves might be a useful therapeutic substance to treat drug abuse (Llosa 2010), or as a friable source of dietary protein (Ramos 2005, Barrio 2008:29-32, Hurtado 2008:73-107). On the other hand, some studies assert that eating coca leaves or adding them as a nutrient fortificant does not contribute to improving the nutritional quality of the diet (Cordero 2002, Castro de la Mata 2004), introduces an appetite suppressant that is counterproductive (Bedford et al. 1981), and exposes the population to toxic substances that are associated with short- (Castro de la Mata 1991) and long-term health risks (Penny et al. 2009).

Since 1975, the results of the so-called “Harvard study” have been turned into the principal scientific argument that is cited among pro-legalization adherents. The cited report presents the results of a chemical analysis of the coca leaf in Bolivia, in which the presence of numerous proteins, vitamins, and minerals is argued as proof of its nutritional value (Duke, Aulik and Plowman 1975:114-115). The study compares, indeed, coca leaves' nutritional parameters with fifty foods, among ten nuts and ten oil

⁴⁰⁰ Cocaine is only one of the fourteen alkaloids in coca leaves. A leaf contains altogether from 0.5 to 1.5% of alkaloids -although there are several factors influence the amount of these, such as atmospheric conditions, age and condition of the plant, soil quality, time of growing, harvesting, etc. To obtain 1 Kg cocaine –through several chemical processes using acetone, ether, sulphuric acid, caustic soda, kerosene, among others– it is needed at least 250 kg of coca leaves (Gil 2008). It has been also demonstrated that it is not economically viable to extract cocaine from coca leaves that are sun-dried, such as coca tea or coca flour (Henman and Metaal 2009:9-10).

seeds, ten pulses, ten vegetables and ten fruits consumed in the Andean Region, such as *Amaranthus Caudatus*, *Oriza sativa*, *avena sativo*, *chemopodium Pallidicaule*, *quinoa del chenopodium*, *Hordeum Vulgare*, *Sccale Cereale*, *Coix Lachrima Jobi*, *Zea mayos*, *triticum Aesticum*, *Canna edulis*, *Caapsicum, spp.*, *allium Saticum*, *arracacha Xanthorriza*, *batatas de Ipomoca*, *Musa Sapientum*, *Cocos Nucifera*, *passiflora Mollissima*, *Annona Cherimolia*, *Prunus Persica*, *Fregaria spp.*, *Annona muricata*, *Ficus Carica*, among others. In contrast to the way in which this report has been cited by the Peruvian Pro-Coca Movement, the findings here suggest only the nutritional use of Bolivian coca leaves, but preventing also that “although coca leaves contain relatively high levels of certain nutrients, the presence of alkaloids and the possible presence of insecticide residues suggest caution in coca chewing” (1975:117).

Fig. 70: “¡Hace bien y es legal!” Nutritional Products Made with Coca Flour



(Photo de Pribyl 2009)

Despite everything, the use of coca leaves expanded from the Andean villages to the cities and industrial products from coca leaves like coca meal, syrups, tea, salves, capsules, etc. have found medical popular use also in the middle and upper class in Peru:

Now there is more openness and information about the benefits of the coca, it is perceived by the people both as food and medicine, and it is largely consumed in naturist stores...Nobody dares today to say that the coqueo is an addiction... There are companies that work with coca (flour)⁴⁰¹. Andean products have come vigorously into

⁴⁰¹ In Peru the purchase of coca leaves, *mate de coca* (herbal coca tea) and coca flour is legal and without restrictions for consumers. The variability of coca-products offered today by private companies is steadily growing.

the city. In the past neither the *quinoa* nor the *maca* were consumed in Lima, the coca likewise. The reason lies in this “Andean feeling”...this *renacer andino*... I see in all this the development of an Andean identity reaffirmation movement (Cáceres iw/2009)

What remains indisputable about coca is its principal position and presence in most of the different ritual and religious ceremonies among indigenous and mestizo communities⁴⁰². Some forms of the therapeutic rituals, like the *K'antu* or *Hallpay*, to preserve or re-establish good and harmonic relationships between human beings, between people and the mother earth, with the *apus* or the ancestors, are still being practised in all of Peru. The ritual use of coca leaves is inspired by a specific conception of living, the *allin kawsay*. Interestingly, the Quechua adverb *allin* means good and excellent; *kawsay*, as noun, denotes life. Thus, *Allin Kawsay* announces a conception of a better life, a good life, a life in harmony. Even so, according to González Holguín, *allin* means also noble and healthy; *allipi* or *allinpi caucani* (“biuir a gusto”) suggests “living with pleasure”, which is corresponding to *allparicuypim caugani* (“vida muy trabajosa”), a life plenty of work (2007 [1608]:63, t. qe. sp.). Accordingly, through sharing, offering and chewing together the coca leaves, the social, personal and commercial relationships among the people of the community would be stronger and renewed, and conflicts tend to disappear: “In the coca leaves rituals gratefulness and acknowledgement are important social attitudes that strengthen social ties and improve health, wellbeing and progress in the group” (Wamankanki iw/2009).

Considering what an MD asserts below, it would be probably difficult to find practicable solutions for the integration inquiry at the short time, because of the social structures supporting the medical care in the country, among other reasons previously throughout discussed.

The local discussion is still too hard. Probably, this could be one of the principal problems of traditional medicine in being incorporated and dealt with. It must yet go through the corporative discussion. And the physicians will be the first again; although debilitated, our council is still very strong in Peru. But I think that the discourse about TM will be accepted *if* it's only applicable to the preventive aspects, and not the curative ones. When an intervention does not go through physician's hands, nothing works (PH Expert iw/2009)

⁴⁰² Except for chilli and egg rubbing, and bonesetting, I have observed the use of coca (as leaves in baths, tea or offertory; as seasoning or chewing) in all the healing sessions I have attended during fieldwork (fq/2009, 2010).

But still, these discussions should be reclaimed on a new, different basis. Besides political and economical analysis and technical considerations, it is important to take a profound revision of the principal aspects enunciated up to this point, agreeing principally through the lenses of the rationality, but also with attention on people's right for healthcare with a culturally and socially friendly environment. This attempt could be attained as fair and necessary in the light of the right of Peruvians to live a good life. An *allin kawsay* revisited.

6 Conclusions

As is characteristic of qualitative research, this dissertation sought to describe a long-term process in relation to the integration of indigenous medicines in HCS, and not the evaluation of this process in terms of specific quantitative results. The ground-based exploration accomplished to answer three major questions: Which historical and social characteristics does the development of this specific health policy in Peru show? How have public health policies in relation to this topic been conceived? Which social and cultural factors are important to explain and understand this development? An analysis of the field materials in the light of research contributions, policy development at the international, regional, and local levels, the systematic observation of the work of THPs, and the comparative review of classic and modern scientific literature was periodically achieved within a period of five years, allowing the construction of specific thematic fields of exploration. The analysis and description of pertinent discourses fit best for the analysis, arriving at the categorisation of five specific integration models. The methodological approach used provided an insightful perspective on the “quest for integration” by proposing a comprehensive readiness on the topic, and by identifying specific thematic guidelines that are important to follow up in specific subsequent research. Anyway, the principal limitation of the research lies in the generalisation of the results due to its regional focus and its significance for the construction of national policies.

As a concrete advanced public health measure, the articulation process constitutes a long-term, complex, and also disputable undertaking. The articulation’s proposal is especially crucial for developing countries largely composed of indigenous peoples, with a scarcity of allopathic medical doctors or regions with low coverage resources for health, and where the emulation of health attention models of industrialised nations is neither culturally nor economically affordable. According to the empirical findings, it is of general accord that THPs should be recognised and integrated as part of the healthcare system. For healers among the various indigenous and mestizo groups this process opens, for sure, interesting professional perspectives. However, more than twenty years after the first policy proposals in Peru, the articulation has not been

implemented, and there are no signs favouring a long-run utilisation of THPs. This attempt turned into a chronic issue, and there are some structural factors explaining this tendency:

01. A prior task that has not yet been resolved in Peru is the lack of social recognition of its different nations. Peru, as a country, is still working out several ethnical, cultural, and social identities and disparities, either assumed conflicted or refused at all. The principal groups historically excluded from social participation are the indigenous communities, which are socially and culturally kept from the essential benefits and rights as Peruvian citizens. The ideological dominance based on racial categories and rigid social structures –remnants of Spanish colonial politics– have been utilised in the defence of the economic interests of corporate and pharmaceutical lobbies and anti-national public policies. The continuing destruction of the environment and the ecosystem of indigenous groups in favour of transnational mining and oil companies, as well as politically and religiously motivated persecution, homicide, and stigmatisation of specific groups in the country turn the proposal of inclusion of indigenous knowledge in official healthcare into a halting matter.

02. The state is perceived as ineffective for the development of a congruent health policy, characterised by poor governance and accountability, with an indolent and unresponsive attitude from policy makers driven by a colonialist mentality disregarding the indigenous legacy, as well as an inactive, negligent, corrupted, and non-responsive national political class. National health policies follow stipulations of international economic organisations and the pharmaceutical industry without considering national priorities. The in-advance integration policies of a given government administration will be continually abrogated by its followers, principally due to the political interests of specific groups, and the knowledge status of governmental authorities about TM.

03. Although there is a wide and heterogenic variety of services offered among healers in Lima and there are no official scientific surveys about the amount and demand for healers in the country, it can be assured that the use of TM in all its forms and variations is remarkably high in the country, increasing constantly without any form of control and

guarantee. The protection and preservation of these medical traditions are considered urgent burdens. For specialists, the principal causes for the devitalisation and commoditisation of TM is the so-called “mystical tourism”, and the proliferation of evangelic religious communities and other Christian and non-Christian spiritual cults in the country. At the same time, the prevalent use of TM in some regions of Peru cannot be only explained in terms of the availability of health services of biomedicine, cultural identification or ethnic membership. It has been largely documented that people in Peru respond to at least two simultaneous criteria in choosing healthcare attention: The availability of these services in geographical and infrastructural terms, and the perceived effectiveness of the treatment. Both conditions will determinate the use of conventional or traditional medicine, a combination of both or other forms of self-care, which are predetermined due to personal or group experiences, and not only as a direct result of the cultural or ethnic affiliation of the customers.

04. The position of MINSA, the primary institution that regulates health policies in the country, remains unclear apropos THPs. While MINSA accepts the prevalence of TM in the country, this acceptance has not been translated into recognition of THPs’ work, whether it considers their inclusion in health centres or not. Health experts state the importance, expertise, and support of THPs for the maintenance of popular healthcare in their official speeches, but do not provide concrete policies for formal recognition. Thus, the social and legal situations of healers continue to be precarious, since they can be easily made responsible for health complications, fraudulence or even murders. This status quo entails a double bind situation, where despite their practice being commonly praised and recognised, they continue to border on illegal practice. The work of authorities and functionaries from institutions founded in the 1990s in Peru such as INMETRA insist on situating their research focus, publications, and administrative activities in the history of TM and the ethno-pharmacological use of local herbs. Contrary to its stipulated functions, they neither show interest in the current situation of healers in relation to popular healthcare, nor in finding concrete ways to allocate them in health centres. As a result, specific emic healing-competences, the construction or identification of categorical profiles, or the quantity and quality of popular demand for healers were not considered as tasks to be achieved. Although PH experts and policy

makers recognise certain reluctance or unwillingness in some MDs, they want to see in their achieved institutional activities positive signals for the development of policies including indigenous perspectives. Anyway, communities' cultural values are still not considered in the planning of disease control programmes at the PHC level.

05. Conventional and established conceptions of policy makers, but also among some scholars, have had an impact on the research focus and academic development in this area. In relation to the concept of TM, it is necessary to review the concepts of “tradition” and “authenticity” in the light of the research findings. Local and indigenous knowledge is frequently associated with an ancient wisdom that has been passed down through generations without essential changes. The general perspective on evaluating authentic traditional healing practices outweighs a passionate search for what remains “traditional” as a fundamentally differentiating criterion. Accordingly, TM has been defined as a cultural substructure on the basis of an essential opposition between the present and the past, and as an antagonism of modernity and cultural dominance. This antagonism extrapolates “traditional-modern”, “Andean-Western”, and “magic-rational” as principal conflicting categories, which, paradoxically, have become amalgamated in the practices of healers as a sort of cultural resistance process. In addition, the official discourses tend to overestimate the diagnostic and therapeutic procedures employed, the degree of influence of Western religiosity and its symbiotic manifestations rather than to study TM in terms of a comprehensive cultural analysis. This conceptual decomposition gets stuck in a nominative taxonomy, in which the “real” or “natural” level, which includes the use of animals, plants, minerals, and their therapeutic properties, and the “cultural” and “magic-religious” have disaggregated. The mindset derived in considering these poles as historically fixed realities, and not merely as methodological constructions, thus simplifies the complex relationships between the dynamic of the social and individual behaviour regarding sickness and health. This means, for instance, a tendency to conceive healing systems only as historical products with specific socio-cultural functions –which they are not.

06. Thus defined, as “authentic” TM are considered all the practices with minimal use of non-authentic artefacts, rituals or concepts, i.e., all the instruments that existed before

the Spaniards' arrival. Furthermore, if a healer migrates to the capital, or attends to non-community members, he or she would not be considered as "authentic" by some scholars. However, in terms of public policy, the inspection of the "purity" or "authenticity" of healers' practices could lead to a blind alley since healers have conventionally resorted to "non-traditional" technologies for a long time. The use and incorporation of foreign knowledge and techniques has always been typical for healers in Peru, and does not constitute a modern phenomenon. In discussing the transformations of healers' practices in the last decades, a rural MD and expert in TM asserted that, despite the enforced changes, "we remain the same, but we don't do the same as before". Healers in Peru have developed intercultural skills and competences to achieve knowledge and expertise within a continuous historical exchange with peers from other regions, and through contemporary knowledge transfer flows. The existence of such purist expectancies, and also statements such as to consider as "autochthonous" the non-existence of foreign techniques, or that healers typically do not charge money from the patients, or that they began to be persecuted only since the Spanish Conquista have, in part, no historical foundation. Concerning the tendency to establish the primacy of certain knowledge over others, it is necessary to question the reasons for establishing a hierarchical order. Do we know enough about the variety of techniques used by Peruvian healers? Why could the knowledge of a partera in Huaraz or a guinea pig healer in the Andes be considered as legitimate, but not the activities of a wachumero in Lima or an ayawaskero who travels periodically across the country? Why do some scholars legitimise the practices of rural healers, but reject the study of those used by urban healers? What is the reason that some specific knowledge could be accredited and others not?

07. Due to the stereotype about migrants as acculturated persons that are no longer "authentic", research continues to be focused primarily on the rural areas. In Andean ethnology, populations have been studied in a static way, emphasising tradition over change, and focusing on religious and rituals aspects of isolated communities. In the 1970s, ethnographic research conducted with healers in rural areas did not typically register or explore their connections to urban areas or their circulation and networks outside of their communities. Medical practices, healthcare networks, and self-care

strategies used by numerous migrants in the proximities of urban cities –the so-called *pueblos jóvenes* or *asentamientos humanos* (slums)– continue to be poorly documented. It should be carefully noted here, however, that this type of mobile curanderismo is not the same as the enterprises organised by national or international alternative practitioners or new age activists with some *ayawaskeros*. Mobile curanderismo is performed and coordinated between healers and clients within close face-to-face social networks. Considering the inexorable expansion of urban models of living, also in rural areas, the introduction of research settings including these physical and socio-cultural spaces is necessary, as well as the reformulation of ideas about identity, migration and mestizaje to processes with socio-medical importance for the construction of new paradigms in intercultural healthcare.

08. The impact of this perspective on public policies is of extreme importance when we consider that, according to the discourses, a healer should demonstrate “integrity” in order to be included in the HCS. This moral dimension means a decorous and modest behaviour, which is mostly associated with low monetary expectations and humble living conditions. Similar to the stereotype of the noble savage, a product of a neo-colonialist mentality with social and economic determinants, this image implies a basically “good” indigenous person, who is intrinsically spiritual, joyful, righteous, austere, and needless. The aesthetic is based on the idea that indigenous peoples’ worldview is holistic, living apart from external influences and in a purely harmonious relation with nature. This vision contrasts the real situation of indigenous peoples and their threatened cultural survival, their systematic exploitation affecting their environment, health standards, and social and cultural belief systems. Many health programmes financed by international donors are inspired by these ideas, not matching actual communities’ socio-cultural characteristics. However, some healers intentionally exploit this picture to obtain recognition, prestige, and also money.

09. The liberal economic system introduced in Peru since the 1990s has not shown sustainable signs of improvement of the quality of life, economic development, and health standards for the large majorities in the country. The enormous inequality access to health services in the population indicates that many of the health problems in Peru

are inextricably linked to poverty and discrimination. Health does not constitute a priority in public policies, and the PH system is grossly underfunded. In addition to the shortage of infrastructure and properly trained human resources, Peru's fragmented and segmented healthcare sector operates as an obstacle for the modernisation and better access to customers, from which only one third of the population –mostly indigenous or peasant communities– have access to health insurance. Healthcare attention is not considered a human right, but rather constitutes an enormously profitable product for many healthcare practitioners nowadays. Social forms of dominant interaction, such as competitiveness, the reduction of the mechanisms of solidarity, and the promotion of individualism, have nowadays become hegemonic within both the official and the informal healthcare system. This is basically characterised by a process of professionalisation and medicalisation of the practice, an individualistic and competitive work style, and the deritualisation of their practice in accordance to market laws. The postmodern enterprises of many healers could be understood as renouncing their historical condition associated to poverty, vulnerability, and underdevelopment. These characteristics can be observed in their lifestyle, social status, practice structure and organisation, knowledge and language acquisition, activities, and networking procedures. Healers' demand for assessment, legal advice, and business know-how to promote themselves and their services in extended client networks is also present. Despite the profitable orientation of enforced postmodernism, healers perceive money as a resource that should not determine patient care. Most of the healers working with well-off clients want to work preferably with less prosperous clients, but do not find labour or economic support from the state's institutions in doing this.

10. The effect of an economy that diversifies and shows wide consumption opportunities has placed the power to self-configuration on the individual. In short, economic development has intensified the individual constitution of identity through consumption, becoming the supreme value of civil society. In this sense, cultural identity is now perceived as something that can be built on, and consumption plays an outstanding role in that constitution with different companies producing goods that meet increasingly more rapidly the wishes of consumers with greater specificity. This hyper-specialisation corroborates the fact that some THS suit the collaboration between MDs

and THPs more than others such as herbalists, naturopaths, guinea pig healers, and bonesetters. In case of ayawaska and san pedro healers, however, there are more objections –probably due to the major use of magical rituals and elements. TM shall be adapted and become “liberated” from their non-instructional characteristics and particularities like cultural beliefs, ritual frames and settings, and disease interpretations and meanings, which could be identified as “magic-religious”. Anyway, the nature and origin of complaints could operate also as an indicator for MDs in transferring patients to a THP, and vice versa. In both cases, the efficacy of one field can only be acquired if the treatment corresponds to the appropriate specialist, who can deal with the attributed problem (e.g. a healer for daño, and a MD for a ruptured appendix).

11. Medical studies in Peru are essentially technology-related, characterised by a hyper-specialised curricula, the promotion of a career philosophy oriented towards profit, and the preference to work in urban instead of rural areas. The distribution of MDs is centralist and inequitable. Because of the labour conditions in the country, many health professionals working in HCS are afraid of losing their employment. Thus, the labour situation of health professionals in health centres has been operating as a structural debilitating factor in accepting changes, and in being more receptive to necessary intercultural attendance strategies. Besides the cultural differences, the idea to lose status through this articulation appears to be one of the principal obstacles in accepting a curandero as part of the staff: In this context, THPs might be seen as antagonistic to professional health workers because they could threaten their already uncertain position as state-funded workers. In the other hand, as healers depend for their subsistence on the private practice, and considering the labour situation of health workers in HCS, their assignments in the formal system would certainly raise the additional question of appropriate remuneration scales or incentives. Additionally, and although sporadically conducted, there are no courses integrated in curricula about TM in PH centres and medical universities in the country. More comprehensive medical research on TM is undertaken by personal and individual efforts, and the possibilities to obtain funding for publications are certainly low. Neither MINSA nor the universities want to assume responsibility for this. In addition, a national pharmacopeia, an official register of medicinal plants and a programme of control of the production, marketing, and sale of

traditional products and services are still under construction. However, institutional changes and the observation and reflection of professional tendencies among MDs in the last decades show the prospective emergence of new tendencies among MDs' education worldwide. In this sense, it is probably that new tendencies in the medical formation will decidedly contribute to this topic in an unexpected way.

12. The perception of THPs and MDs as antagonists is stressed widely in the discourses of social researchers and AHPs. Assertions about were placed out in consultancies and reports of health programmes with some grade of participation of healers or partial adaption of their techniques, such as the inclusion of parteras in special establishments. In light of the findings, this standard-statement should be accurately followed up, however. Much of these disparities or differences should be evaluated through the direct observation of practices, because it is through these that we can testify the existence of differences, and the probable current existence (or potential use) of similarities and links between them. Studies and reports about integration projects carried out in Latin America addressed the deficiencies or work-in-progress status among these initiatives, and only few cases are arguably considered as best-practices due to the positive evaluation in terms of impact, sustainability, responsiveness, health policy, and potential for replication, among other PH criteria. Anyway, published reports and long-term interdisciplinary scientific evaluations of existing officially integrated health centres, where healers work on the basis of legal and official recognition as health practitioners, are not available in Peru because of the simple fact that such centres do not exist. Consequently, the articulation proposal constitutes a prototype mechanism that has not overcome the first level of evaluation. In theory, the inclusion of THPs in biomedical institutions could contribute to the reduction of the stigmatisation and subaltern position of the popular/traditional knowledge among the health staff of professionals, also reinforcing the promotion of the community's active participation in health decisions. Just as well, such integration could also reduce the demand and effectiveness of such knowledge, or even result in its extinction. Due to the duality produced by a mixed model of medical services, opposition and dichotomy rise among these medical systems, in which the scientific and official is contrary or complementary positioned to the traditional or illegitimate one.

13. The approval of a specific law recognising the work of THPs or allowing them to work in the HCS is not the end of a process of struggles and social vindications, as many would like to see. It would be only the start of a process with a still unknown prognosis. If the state finally includes TM in the HCS –somehow and in some way– the construction of scientific evidence of this process is essential, but in terms of the cultural characteristics of the country. The elaboration of legal devices that allow for their official exercise in a safe and reliable way for all those involved in healthcare process requires, at least, the formulation of a study at the national level of analysis of prior impact (health impact assessment) or an estimate thereof based on specific field studies. Scientific information, based on studies of behaviour of consumption of services and healthcare for the population at regional and local levels should also be imperative. Meanwhile, it should be possible to think in a system of practices' regulation outside the HCS with inter-ministerial work between the health, culture, and agricultural departments, and with community and civil participation. However, at the present stage and level of knowledge in the field it is not possible to discuss the topic of the integration of THPs in HCS in terms of cost-effectiveness approaches, public health competencies or health-economy analysis, because there are no studies and research accounts supporting a serious analysis.

14. In the meantime, five different approaches stressing different aspects to accomplish the articulation of TM in healthcare have been identified:

a) *The Harmonisation or Standardisation Approach* emulates the standardisation process that has been applied in China, Japan, and Korea and considers the international health organisations (WHO, PAHO) as decisive partners for the integration process. The model considers TM as part of CAM, giving priority to international agreements signed by Peru for its implementation at the PHC level. The reasons supporting the harmonisation approach adduce the claim on safe and quality-controlled use of traditional remedies; the request of MDs and scientists for research evidence of traditional practices; and the government's need to establish and update mechanisms for its practitioners. One of the standardisation's requisites is the accuracy of solid data on the extent and safety of usage of TM in the country and the transportation of specific

concepts and techniques of Andean medicines into a scientifically accessible language. Effectively, for policy makers, the absence of scientific evidence of the effectiveness of TM as well as the absence of written original documentation constitutes a handicap to sustain its use in medical services. Policy experts and MDs demand more evidence-based research in this respect to evaluate the feasibility of techniques of TM and for the implementation of special courses in the curricula of health professionals at universities. At the same time they do not build, promote or support empirical or field-based research about traditional medical practices, however. Some critics argue that this model has arisen from the interest of developed countries in the national pharmacopeia of others, and that TM is evaluated in terms of biomedicine. As a result, studies on the pharmacopoeia were privileged over the social, symbolic, and cultural aspects of healing, producing conflicts in the mechanism of standardisation in terms of the adaptation of traditional techniques to fit Western healthcare attention standards.

b) *The Intercultural approach revisited or the intercambio de saberes* focuses on a critical analysis of the discourses on interculturality and encourages the academic and political discussion of healthcare models and approaches that have been oriented towards public policy to meet the cultural diversity in the country. The principal statement is the establishment of dialogue channels among cultures, but thereby reinforcing the suzerainty and autonomy of the population. The model pursues the enhancement of ancestral knowledge; the development of specific actions or health programmes enabling economically, socially, and culturally excluded communities to access and acquire information and training to improve their health and social life conditions; and to participate directly in the elaboration of intercultural educational and health policies. A principal assertion underlying this model is the establishment of new approaches in the information technologies on health, asserting essentially the perspective of the significance and validity of a collective construction of knowledge. The integration of diverse medical knowledge connotes the assumption of the position and view of the other, and not the mere application of techniques without considering the construction of otherness and different conceptions about health. Thus, to apply the concept of interculturality in health programmes in a proper way, it is necessary to consider the conceptions of nature and human being operating in different forms in each

cultural and ethnic group. The principal difficulty lies in the structural absence of egalitarian spaces for intercultural exchange in the country.

c) *The Grassroots and Community-Based Approach* advocates a regional and local perspective to promote the inclusion of THPs through the creation of health centres or special integrated community health institutions in each region. The major goal of these healthcare centres is that centres' health personnel, patients, relatives, and community health agents should build a partnership, in which all of the involved can work together, under fair labour and social conditions, and with the same rights to make suggestions. The recognition of local indigenous knowledge transforms the position of indigenous from patients to managers of the own communal centres, and allows the participation of grassroots fellowships such as community-based organisations, community health promoters, healers' and health popular associations, as well as civil initiatives. These actors could not only bring crucial information about the specific regional and local particularities with their own cultural, linguistic and geographical characteristics, but also contribute to the allowance of implementation arrangements that fit the cultural and social reality of a population group or ethnic community. The posture indeed promotes a questioning process about medical knowledge and its mechanisms of circulation, appropriation, dissemination and resistance, identifying specific agents that either inhibit or promote one of these different forms of democratisation of knowledge in health. The general context of the main proposal is for a democratic decentralisation of health system. The health, social, and environmental situations of some communities make centralist efforts unsuitable; therefore, they appeal for a restructuration of health attendance services with the incorporation of local knowledge in the programmes and services, and the implementation of human local resources in the centres. Nevertheless, these stations should also be regulated, supervised, and organised through a central institution that designs and promotes the creation of local specific health programmes, in accordance with the information they receive from each region, which must also be discussed throughout with social and civil organisations and representatives of the communities. The practical importance of this model could be located in the recognition and use of self-care attention systems and popular medical practices in healthcare

centres, which have proven to be beneficial and also effective in affronting public health problems.

d) *The Educational Approach* stresses the attributes, nature, and structure of the patient-doctor relationship in intercultural contexts. Here, the attention is drawn to the prevailing, mostly negative, attitudes of health professionals and health managers towards patients who are members of ethnic minorities, as well as the role of academic authorities, universities, research, and governmental departments in allowing and reinforcing these prejudices. It occurs that the “particularities” of rural people complicate the physical consultation and intervention, and are seen as obstacles that should be eliminated rather than understood and accepted. From this point of view, health attendance is a basic human right, not a commodity, and it should be done in a friendly cultural environment, with respect for the socio-cultural specificities of people. Existing medical and healthcare training offered by universities are not suitable for Peru’s cultural particularities, resulting in a medical training without cultural competences and social bias. Although there are some initiatives on the road reflecting local needs that are mainly supported by private international organisations and carried out by communities and indigenous associations in Peru, informants argue strongly for the release of clear intercultural educational policies by the state. The solution hereby resides in the elaboration of educational policies that not only consider the inclusion of TM in the curricula, but also draw on the promotion and training of specific intercultural skills among health professionals, which can only be achieved through the inclusion of an intercultural training during the first years of medical formation. In the opinion of some specialists, the major problem in this implementation approach is the absence of a human rights perspective inspiring the medical studies curricula. Similarly, the enumeration of categorical content and methodological procedures enabling TM to come into medical academic formation, and as part of the national agenda in health research programmes are not elaborated throughout. For some social scholars and THPs this educational approach is also a central part of the necessary training of THPs and community health workers. This training should be provided by the state, principally through the universities. Accordingly, some THPs and popular healers want to be trained at universities or specialised health centres in order to obtain a legal and social

framework for their activities –and also recognition as popular healthcaregivers. In their opinion, it is important for them to have biomedical information in order to ensure an integrated treatment for communities in rural and urbanised popular sectors.

e) *The Cultural Heritage Approach* locates the discussion in the extended frame of the protective and regulative national and international legislation on indigenous rights, biodiversity, intellectual property rights, and CH. Indigenous peoples have the right to their own TMs and to maintain their health practices, including the conservation of plants, animals, and minerals, and to access all health and social services. The Peruvian state should guarantee the protection, safeguarding, and conservation of this biodiversity in respect, trust and coordination with the indigenous communities, who are the principal owners of this biological diversity. Thus, the commercialisation of genetic species and TK is subject to the special international legislation on indigenous rights, intellectual property rights, and CH ratified by Peru, as well as the Peruvian national legislation on these issues. Although Peru was in the vanguard of Latin America with the implementation of a protectionist and juristic innovative legislation about indigenous rights and intellectual property rights, this exemplary legislation does not guarantee the protection of indigenous rights to territories and biological and genetic resources. Existing neoliberal economic systems are in strong opposition to the establishment, enhancement, and implementation of intellectual property rights and the protection and safeguarding of the intangible CH of ethnic minorities. The principal threats to TK are extractive industries such as mining, oil, gas, and forestry, as well as colonisation by large-scale farming interests displacing peasant communities and undermining their traditional lifestyles. Besides the interests of ecological and international corporations, indigenous peoples confront additional difficulties regarding the legal recognition of their property rights; even though legal protective regimes are available, their implementation calls for technical requirements that are not easily attained by indigenous peoples. An additional problem is the non-existence of standard norms to prove the sanitary guarantee of herbal, nutritional, and natural products, as well as operative institutions regulating these tasks. Nevertheless, the Peruvian state has declared its own strong expectations that the access to its resources and to TK is based

on fairness and equity, with due compliance with existing legal norms and regulatory frameworks.

Among these approaches it is still fairly unclear how specific guidelines and strategies should accomplish the proposed articulation modalities, e.g. how a national official register of healers might be achieved, or the identification of directly responsible institutions or governmental dependencies adopting these specific regulation tasks. Anyway, some prior essential questions remain unanswered. What kind of consequences would this articulation have for the conservation and preservation of the cultural heritage of the country? Is it possible to rescue traditional knowledge per se when the life and survival of indigenous peoples is not guaranteed by the state? Is it possible to revisit and question essential assumptions regarding what constitutes TM, what are the characteristics of a curandero, or the identification and valuation of their activities in popular healthcare? And finally, is the articulation of THPs in HCS even required?

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7.2 Informants⁴⁰³

Interviews

Anderson, Jeanine: Lima (Peru), 31/03/2009 [Ph D Anthropology, Lecturer Anthropology of Health, Professor at the PUCP] *PhA D 8137 - 8138*

Anonymous: Ascope, La Libertad (Peru), 03/04/2009 [Watchman of the Cao Museum] *PhA D 8147-8148, V 3427-3429*

Ayllón, Fernando: Lima (Peru), 22/04/2009 [Historian, Principal of the Museum of the Inquisition and Congress] *PhA D 8147-8148, V 3440 - 3441*

Aliaga, Mérida: Lima (Peru), 26/03/2009 [Sociologist, Ms. PH, National Coordinator for the area of TM at FORO SALUD, Professor at the Universidad Nacional Mayor de San Marcos] *PhA D 8132*

Berrú, Theo: Lima (Peru), 10/03/2009 [Actor, Wachuma Apprentice, Social Activist] *PhA D 8110 – 8112, V 3432*

Cáceres, Baldomero: Lima (Peru), 23/03/2009 [Ms. As. Psychology, Coca Specialist & Coca Activist] *PhA D 8126 - 8127*

Camino, Lupe: Lima (Peru), 13/03/2009, 10/01/2011 [Painter, Ecologist, Consultant for Indigenous Communities] *PhA D 8116 - 8119*

Crisólogo, Mariela: Lima (Peru), 25/07/2009 [Medical Technologist, Ayawaska-Apprentice] *PhA D 8128-8130*

Cueva, Neptalí: Lima (Peru), 21/05/2009 [MD, PhD Public Health, Executive Director of the department of Traditional Medicine of CENSI] *PhA V 3465*

Eddowes, John: Lima (Peru), 23/03/2009 [Psychologist, Alternative therapist, Flower Essences KINDE] *PhA D 8125*

Eddowes, Mary Ann: Lima (Peru), 27/02/2009 and 06/03/2009 [Alternative Healer, Coca Activist] *PhA D 8120 – 8121, V 3419, 3420, 3421-3423*

Eyzaguirre, Carlos: Lima (Peru), 11/01/2009 and 09/03/2009 [Anthropologist, Consultant] *PhA D 8107*

Francini, José: Lima (Peru), 07/04/2009 [Shipibo-Conibo Ayawaskero from Santa Rosa de Dinamarca/Masisea, Ucayali] *PhA D 8141, V 3431*

⁴⁰³ Signature numbers (PhA) refer to audio and video recordings (healing sessions included) archived at the Vienna Phonogrammarchiv, and can be found at: <http://catalog.pha.oeaw.ac.at/ui/miha/sessions.php>.

Giove, Rosa: Lima (Peru), 27/03/2009 [MD, Founder of TAKIWASI, Dean of the Medical Association of San Martín, Peru]

González, Tina: Lima (Peru), 24/04/2009 [Egg und Chili Abrasion specialist] *PhA V 3442 - 3445*

Granados Vera, Ángel: Lima (Peru), 01/04/2009 [Wachuma Healer from Túcume, Lambayaque, cousin of *Don Santos Vera* famous Wachuma Healer from northern Peru] *PhA V 3426*

Guevara, José Guillermo: Lima (Peru), 11/03/2009 [Anthropologist, Consultant PAHO, MINSA] *PhA D 8115*

Guzmán, Agustín: Lima (Peru), 28/02/2009 and 05/07/2010 [Wachuma Healer, Coca Specialist, Social Activist] *PhA V 3418*

Heraud, María Helena: Lima (Peru), 22/07/2010 [MD, Neurologist, CAM specialist, Head of Centro de Medicina Alternativa del Hospital María Auxiliadora] *PhA V 3469*

Hierro, Jorge: Lima (Peru), 17/04/2009, 04/05/2009 & 07/05/2009 [Guinea Pig Healer from Chincha, Ica] *PhA V 3433, V 3436 – 3439, V 3448 - 3451*

Hurtado, Ciro: Lima (Peru), 09/03/2009 [Geographer, Naturopath, Coca Specialist] *PhA D 8105 - 8106*

Lip Licham, César: Lima (Peru), 20/05/2009 [MD, PH Specialist, Vice Chancellor of the Universidad Norbert Wiener] *PhA D 8153-8154*

Medina Ibañez, Armando: Lima (Peru), ei/27/04/2010 [Anthropologist, Consultant MINSA / INS, Interamerican Development Bank (BID), UNICEF, UNFPA]

Montibeller, Morayma: Lima (Peru), 30/03/2009 [Anthropologist and Ms As. Archaeology, Consultant] *PhA D 8136*

Moscoso, Ana: Lima (Perú), 31/03/2009 [MD, Otorhinolaryngologist] *PhA D 8144*

Muñoz Burgas, Antonio (“Senen Pani”): Lima (Peru), 08/07/2010 [Shipibo-Conibo Ayawaskero from San Francisco de Yarinacocha, Ucayali] *PhA V 3466*

Ojeda, Walter: Lima (Peru), 11/03/2009 [Transpersonal Psychologist, Alternative Therapeut, Bach Flower Essences, Ayawaska] *PhA D 8113 - 8114*

Pajares, Jorge: Lima (Peru), 28/02/2009 [Psychologist, Coordinator Diploma in Natural Medicine and Alternative and Complementary Medicine, Universidad Norbert Wiener] *PhA D 8098*

Perdomo, Germán: Lima (Peru), 25/02/2009 [MD, PH Expert, Health Systems & Service Assessment PAHO-Peru, Member of the WHO Regional Working Group on PHC] *PhA 8096 - 8097*

Piazza, Marina: Lima (Perú), 15/07/2010 [PhD Public Health, Professor at the FASPA, Universidad Peruana Cayetano Heredia]

Picón Saguma, José Levis: Lima and Ica (Peru), 17/04/2009, 24/04/2009 and 05/05/2009 [Wachumero from Ferreñafe, Chiclayo, Lambayeque] *PhA D 8149, V 3446-3447, V 3452 - 3453, V 3454, V 3457, V 3458*

Ramos, José: Lima (Peru), 10/03/2009 [Graphic Designer, Andean Music Healer, Ayawaska Apprentice] *PhA D 8108 - 8109*

Reátegui, Rogelio: Lima (Peru), 20/04/2009 and 05/07/2010 [Shipibo-Conibo Ayawaskero from Nuevo Ceilán/Pucallpa, Ucayali] *PhA D 8146, V 3462*

Reyna Mercado, Iván: Lima (Peru), 27/03/2009, 16/04/09, 11/05/2009, 18/05/2009, 12/07/2010 & 13/07/2010 [Componedor from Santiago de Chuco, La Libertad] *PhA D 3425, V 3434 - 3435, V 3455 - 3456, V 3459 - 3461, V 3467*

Reyna Pinedo, Víctor: Lima (Peru), 26/03/2009 and 14/05/2009 [Ph D in organic Chemistry, Professor at Universidad Nacional de Ingeniería, Researcher Ritual Use of Guinea Pig and Wachuma] *PhA D 8131*

Rosado Acha, Regulo: Lima (Peru), 22/07/2010 [Andean Healing Music, Coca Specialist] *PhA V 3470*

Rosas Durand, Orlando: Moche/La Libertad (Peru), 27/07/2010 [Pharmacologist and Naturopath, Centro de Medicina Alternativa Peru-Cuba] *PhA V 3471 - 3472*

Sifuentes, César: Moche, Trujillo/La Libertad (Peru), 04/04/2009 [Independent Entrepreneur, New-Age/Alternative Healer, Founder of the Moche Pyramid] *PhA V 3430*

Tavera, Mario: Lima (Peru), 17/03/2009 [MD, PH Expert, UNICEF-Peru Health Officer] *PhA D 8123*

Vecco, Roberto: Lima (Peru), 11/04/2009 [MD, Project Nimairama] *PhA D 8142*

Vela, Juan: Lima (Peru), 16/04/2009 [Chiropractor, Componedor Apprentice] *PhA D 8143*

Vergara Giraldo, Valeriano: Lima (Perú), 14/05/2009 & 20/05/2009 [Naturopath, Herbalist] *PhA D 8152, V 3463 - 3464*

Villar, Martha: Lima (Peru), 05/03/2009; 19/07/2010; 04/08/2010; ec/26/05/2011 [MD, PhD Public Health, CAM Manager's Office Head in ESSALUD, President of the CMTAC-CM] *PhA D 8099, D 8100 D 8101 - 8104*

Wamankanki Collque, Tahuiro: Lima (Peru), 31/03/2009 [*Amauta*, Inca Priest] *PhA D 8139*

Group Interviews

Cotrina, Dona, Mariela Crisólogo and Rosario De Pribyl: Lima (Peru), 24/03/2009 [Shawi Ayawaskera from Loreto, Ayawaska Apprentice and author] *PhA D 8128-8130*

Cotrina, Dona, 3 Patients and Rosario De Pribyl: Lima (Peru), 29/03/2009 [Ayawaskera Shawi from Loreto, Patients and author] *PhA 8133 - 8135*

Vergara Giraldo, Valeriano, Carlos Sánchez Mayurí, Mercedes Infante Flores, Antonio Lip and Rosario De Pribyl: Lima (Peru), 20/05/2009 [Naturopath-Herbalist, Roommates, assistant and author] *PhA V 3464*

Villar, Martha, Hugo Rengifo, Pablo Pacompea, Hugo Malaspina, Carlos Corbacho and Rosario De Pribyl: Lima (Peru), 17/03/2009 [MDs Members of the CMTAC-CM and author] *PhA D 8124, v 3424*

Questionnaires and Communications

Bussmann, Rainer: St. Louis/Missouri (USA), 13/04/2009; 05/10/2011 [Ph D Ethnobotanic, Director William L. Brown Centre and William L. Brown Curator of Economic Botany Missouri Botanical Garden, specialist on Peruvian and Bolivian botanicals]

Franco, Régulo: Trujillo/La Libertad (Peru), 25/12/2010 [Archaeologist Wiese Foundation, Director of the Archaeological Complex *El Brujo* and Museum of Cao]

Giove, Rosa: Lima (Peru), 07/10/2011 [MD, Founder of TAKIWASI, Dean of the Medical Association of San Martín, Peru]

Larco, Laura: Maryland (USA), 25/01/2011 [Ph D Anthropology and Ethnomusicology, Researcher on Music and Ritual]

Loo, Luz: Lima (Peru), 19/10/2010 [MD, Ms. As. Health Administration, President *Federación Peruana de Administradores de Salud FEPAS*]

Nederveen, Leendert Maarten: London (United Kingdom), 07/02/2011 [Ph D Social Sciences, Nutrition, Communication Studies, Psychology. European Expert, Project for Assistance to the Modernization of Health Sector in Peru (AMARES) 2003-2007, Lima, Peru]

Ochavano, Teovaldo: (Peru), 10/01/2011 [Shipibo-Conibo Ayawaskero]

Pérez, Ana Maria: Lima (Peru), 14/01/2011 [Social Communication Specialist, Wachuma Researcher]

Pino, David: Lima (Peru), 08/03/2011 [Historician]

Quevedo, Zoila: Lima (Peru), 10/05/2009, 15/07/2010, [Attorney, Specialist in History of Art, Ms. As. Peruvian and Latin American Art, Culture and Development Management, Professor at Universidad Científica del Sur UCS and Universidad Norbert Wiener]

Rengifo, Hugo: Lima (Peru), several communications 2009/2010/2011/2012 [MD, Ms. Sc. Policies and Planning in Health, Specialist in Immunology, President of the Sub-Committee of Traditional Medicine of the CMTAC-CM]

Revilla, Carla: Lima (Peru), 08/07/2010 [Attorney of Instituto del Peru, Universidad San Martin de Porras, Researcher on CAM]

Sánchez, Rodolfo: Lima (Peru), 31/12/2010 [Ph D Anthropology, Professor at Universidad Nacional Mayor de San Marcos]

Vásquez, Luis: Lima (Peru), 08/06/2012 [Linguist, Member of the Project *Alfabetización y educación básica de adultos* (PAEBA) of the Agencia Española de Cooperación Internacional (AECI)].

Velásquez, Tezania: Lima (Peru), 07/12/2010 [Ms. As. Psychology, Coordinator of the Master Studies on Community Psychology, Pontificia Universidad Católica del Perú PUCP]

8 Appendices

8.1 Questionnaire

CUESTIONARIO DE REFERENCIA

Muchas gracias por su interés y aceptación en participar en mi proyecto de investigación.

En la medida de sus posibilidades, conteste por favor a todas las preguntas.

El llenar el cuestionario sólo le llevará unos minutos. Si desea, puede contestar sólo con palabras clave. Toda información proporcionada aquí permanecerá sólo en mis archivos personales y no será divulgada. Siéntase libre de hacer todas las anotaciones y comentarios que considere pertinentes.

Reenvíe este cuestionario a mi dirección electrónica: rosario.pribyl@chello.at. Puede adjuntar aquí también cualquier otro documento/s que considere importante.

Muchas gracias por su colaboración!

Rosario de Pribyl

NOMBRES Y APELLIDOS					
Edad, sexo					
Estado civil					
Nacionalidad					
Lugar de nacimiento					
Religión					
Dirección postal					
Dirección electrónica					
Teléfono/s					
Estudios/Especialidad					
Ocupación actual principal (<i>actividades que realiza</i>)					
Lugar de trabajo (posición y fecha de inicio)					
Ocupación anterior					
Proyectos en los que ha participado (incluido el actual)	Nombre del proyecto	Lugar	Institución	Financiamiento	Duración
Temas de interés actual					
Actividad/Proyecto que desea realizar					
Ensayos, escritos, publicaciones, participación en congresos, etc.	1.				
	2.				
	3.				

¿A qué tipo de población se dirige principalmente su trabajo?

¿Trabaja usted interdisciplinariamente? ¿Con qué especialistas?

¿Qué temas considera prioritarios al hablar sobre el sistema de salud en Perú?

¿Qué temas/áreas de investigación o proyectos le parecen más importantes para el Perú actualmente?

¿Con qué métodos o sistemas médicos tradicionales y/o alternativos ha tenido/tiene usted contacto?

¿Qué opina sobre los practicantes de medicina tradicional y/o alternativos en Lima?

¿Qué le parece la idea de integrar a los practicantes de medicina tradicional y/o alternativa en el Sistema oficial de salud? Mencione las dificultades y/o los beneficios principales que usted ve en esa integración

¿Piensa usted que se deberían incluir temas relacionados a la medicina tradicional y los conocimientos indígenas en la currícula universitaria? ¿O quizá en otro tipo de centro de formación alternativo?

¿Qué planes profesionales tiene para un futuro próximo?

Comentarios

¡Muchas gracias!

8.2 Interview Guideline Form

Information about interviewees

1. Which is your main occupation activity?
2. For which population is/was your work related to?
3. Do your work alone or with other specialists? Which ones?

Perceptions about TM and THPs

4. Which methods or THS are most frequently used in Peru?
5. Which THS do you know or have become in touch?
6. What are your perceptions about TM and its practitioners?
7. Who practices TM in Peru? Who is a curandero?
8. How learn a curandero? How long is this training or learning process?
9. Which is your opinion about THPs working in Lima?
10. Are you agreeing with a national accreditation for THPs?

Linking TM to HCS

11. Which topics are urgent to be discussed when speaking about health care in Peru?
12. Is TM linked somehow to Healthcare System? Are there specific policies about?
13. Have the international agreements on TM already been incorporated in the national legislation? How has been Peru responding to this?
14. Are there specific norms or proposals for regulating the practice of TM? (e.g. training and formation, accreditation, quality control of products & services, etc.)
15. Are there in Peru any successful and/or sustained experiences regarding the incorporation of THPs into healthcare system? Which ones?
16. What are the difficulties encountered towards the recognition of TM?
17. Which would be the impact or benefit of this incorporation?
18. Strategies proposed by you for linking these medical systems
19. Training and Research on TM
20. How is the current situation of research on TM? Which institutions perform them?
21. Are there surveys on population's use of TM and other CAM systems?
22. Are there studies addressing the inclusion of TM in health system?
23. Do educational and research institutions offer courses, workshops or training programmes on TM for health professionals? Do you think there should be included at the universities topics related to TM in the curricula?

8.3 Protocol

Angaben zur Protokollierung von Audio- und Videoaufnahmen im Phonogrammarchiv

Urheber	<i>für die Aufnahme verantwortlich, Aufnehmender</i>
Projekt	<i>Projekttitel (sofern vorhanden)</i>
Titel	<i>Inhalt/Thema der Aufnahme (kurz)</i>
Aufnahmegeräte	
Ort, Land	<i>Entstehungsort der Aufnahme</i>
Zeit	<i>Datum, Uhrzeit</i>
Ethnie / Wir-Gruppe	
Sprache(n)	
Ensemble	<i>z.B. Namen von aufgenommenen Musikgruppen</i>
Anmerkungen	<i>Allgemeines zum aufgenommenen Ereignis, zu Aufnahmesituation, soziokulturellem Hintergrund, musikalischen / sprachlichen Besonderheiten etc.</i>
Materialien	<i>zusätzliche Unterlagen, Photos, Prospekte etc., die (in Kopie) im PhA vorhanden sind</i>
Publikationen	<i>nur solche, die konkret die vorliegende Aufnahme zum Inhalt haben</i>
Gewährspersonen	<i>Namen und Daten der aufgenommenen Personen (sofern vorhanden) (= Phonographierte)</i>
Protokollinhalt:	<i>Dokumentation des Inhalts des Audio-Bandes mit Zeitangaben</i>

8.4 Ethic Statement

From: Rosario de Pribyl <rosario.pribyl@chello.at>
Subject: invitación - proyecto de investigación sobre sistema de atención en salud
To: noname@yahoo.com
Date: Tuesday, 16 December, 2008, 10:49 PM

Estimado --XX--,

Estoy realizando un estudio doctoral en la Universidad de Viena (Austria) en la especialidad de antropología. El tema de mi proyecto de investigación es:

“La Integración de la Medicina Tradicional en el Sistema de Salud en el Perú”.

El proyecto ha recibido ya dos reconocimientos institucionales a nivel internacional. El primero es de la *International Federation of University Women* (IFUW) con un pequeño subsidio y el segundo de el Archivo Fonográfico de la Academia de Ciencias de Austria (*Österreichische Akademie der Wissenschaften*) con el apoyo logístico para el audio y video en el estudio de campo. Estoy muy contenta por ello pues constituyen un aliciente para la importancia del tema y la calidad del proyecto.

Parte esencial del estudio es la realización de entrevistas a expertos en el área y grupos de discusión con profesionales de salud en Lima.

La investigación está enmarcada dentro de un profundo espíritu ético, de manera que para toda información que me sea proporcionada directa o indirectamente rige el principio de total confidencialidad. De igual modo, se asegura en forma automática el anonimato de los participantes. Esta información no será divulgada bajo ningún medio electrónico o escrito y permanecerá sólo en mi poder. Una copia original permanecerá guardada en el archivo fonográfico. Si alguno de los participantes desea copias de las entrevistas en algún formato a coordinar, estos están naturalmente contenidos en mi ofrecimiento.

Le invito entonces muy especialmente a participar de las entrevistas. Adjunto aquí un resumen brevísimo del proyecto, para su consideración.

Estaré en Lima entre el 21 de Febrero y el 21 de Mayo del próximo año para realizar el estudio. Desde ahora coordino con la debida anticipación mi agenda de trabajo en Lima.

A la espera de su positiva respuesta, quedo atentamente a sus órdenes.

Cordialmente,

Rosario de Pribyl

8.5 Observational Protocol

PROTOCOLO NRO.: <i>number of observational register</i>
Fecha y lugar de documentación: <i>geographical situation, date</i>
Informantes principales: <i>name of principal informants</i>
Sesión Nro.: <i>number of session</i>
Palabras clave/Tema: <i>key words, what was typical for this session</i>

DESCRIPCIÓN	ABSTRACT ABOUT THE PRINCIPAL HIGHLIGHTS DURING THE SESSION.
Contexto	Where is the session carrying out? How is it? Description of the situation of the healer during the session. Personal, familiar, economic or professional dimensions.
Participantes	number of participants, ways in accessing the session (invited, cited, spontaneous, etc.), age, sex
Material (Fotos, grabaciones, instrumentos, etc.)	Additional information obtained during the session (photos, records, list and description of instruments, etc.)
Procedimientos / técnicas	Techniques and procedures used during the session. It includes commands, arrangements or specific directions
Usos	Ways of the healer in applying procedures and making prescriptions
Efectos / reacciones	Participants' effects and reactions. Outcomes.
Indicadores sociales, económicos, antropológicos	Social and cultural background of participants, service fees, payment settlements, attitudes to the healer and the treatment situation

8.6 Curriculum Vitae

Personal Information

Name: Rosario Jessica Quevedo Pereyra de Pribyl

Date of Birth: 29th August 1970 (Lima, Peru)

Address: Apostelgasse 35/1 A-1030 Vienna - Austria

Cell Phone: +43 (0) 676 9236901

Email: rosario.pribyl@chello.at

Education

2007 – 2012: Ph. D. Studies, Faculty of Human and Social Sciences, Department of Social and Cultural Anthropology, University of Vienna, Austria.

2007 – 2008: Training Course Intercultural Coach, Diploma European Association for Supervision EAS, Vienna, Austria

1999 – 2000: Postgraduate Studies in Psychoneuroimmunology, Universidad Nacional Mayor de San Marcos, Lima, Peru (Graduation with Distinction)

1994 – 1996: Degree Studies (M. S.), Faculty of Psychology, Universidad Ricardo Palma, Lima, Peru

1994 – 1996: Specialization Training in Systemic Family Therapy, Institute for Couple and Family Therapy, Lima, Peru

1993 – 1994: Specialization in Clinical and Health Psychology, Hospital Victor Larco Herrera, Lima, Peru

1993: Specialization Training International Standard Classification of Mental Diseases ICE-10, Ministry of Health of Peru, World Health Organization

1993: National Health Information System Training (HIS), Lima, Peru

1991: Training Seminar in Sexual Transmission Diseases, Universidad del Valle, Cali, Colombia

1988 – 1993: Psychology Studies (B. S.) Faculty of Psychology, Universidad Ricardo Palma, Lima , Peru (Graduation with Distinction)

1976 – 1987: Academic High School Hans Christian Andersen, Lima, Peru:
Baccalaureate

Grants and Awards

- 2012: University of Vienna, Office for Research Service and International Relations, Dissemination Program. Conference Participation 54th ICA International Congress of Americanists “Building Dialogues in the Americas”. Vienna, Austria
- 2010: Austrian Research Foundation (ÖFG), International Communication Program. Grant for international conference organisation at the International Congress of the Latin American Network of Legal Anthropology (RELAJU) Lima, Peru
- 2010: University of Vienna, Office for Research Service and International Relations. Research Scholarship for Doctoral Students at the University of Vienna
- 2009: Austrian Academy of Sciences (ÖAW), Austrian Audiovisual Research Archive. Video graphic Research Documents Found for Dissertation Fieldwork
- 2009: International Federation of University Women (IFUW). International Fellowship for Doctoral Studies, Geneva, Switzerland
- 2008: University of Vienna, Center for Gender Equality. Mentoring Program for Women Academics and Scientists (Muv). Vienna, Austria
- 2008: Austrian Integration Fund (ÖIF) and Austrian Chamber of Commerce (WKÖ). Mentoring Program for Migrant Scientists

Academic Positions

- 2011 - to date: Consultant. International Center for Ethnobotanical Education, Research & Service ICEERS, Halsteren, the Netherlands
- 2011 - to date: Research collaborator for Peru. Trauma and Global Health Program, University McGill. Montréal, Quebec, Canada
- 2009 - to date: Consultant. Peruvian Association for Medical Doctors, Committee of Traditional, Alternative and Complementary Medicine, Lima, Peru
- 2006 - to date: Research Associate for the Program of Indigenous and Traditional Knowledge. Chan Chan Peru, Institute of Research and Conservation of the Peruvian and Latin American Cultural Heritage, Lima, Peru
- 2001: Short Term Consultant Assessor, Training Program for Graduates in Psychological Evaluation. Professional Society of Psychologists of Peru, Lima, Peru

- 1999 - 2001: Consultant, Peruvian Society of Psychoneuroimmunology, Lima, Peru
- 1999 – 2001: Postgraduate Lecturer Gender Studies, Health Psychology, Psychoneuroimmunology. Faculty of Psychology, Universidad San Martín de Porras, Lima, Peru.
- 1999 – 2001: Postgraduate Lecturer Family Therapy, Training Program for health Professionals in Child Sexual Abuse and Family Violence. Universidad César Vallejo, Post Graduate Studies Program of the Faculty of Humanities and Social Sciences, Trujillo, La Libertad, Peru.
- 1990 – 1991: Undergraduate Teaching Assistant, Faculty of Psychology, University Ricardo Palma, Lima, Peru
- 1989 – 1990: Member of the Human Rights Department. Episcopal Commission for Social Action CEAS, Lima, Peru

Publications in Journals and Book Chapters

- Pribyl, Rosario de. 2011. *Documento de Trabajo: Derecho a la Salud desde la Perspectiva Intercultural*. Memorias del VII Congreso internacional de Antropología Jurídica RELAJU. Lima: Instituto Internacional de Derecho y Sociedad IIDS (unpublished).
- Pribyl, Rosario de. 2011a. *La Medicina Tradicional en el Sistema Oficial de Salud en el Perú*. Lima: Instituto Internacional de Derecho y Sociedad IIDS (unpublished).
- Pribyl, Rosario de. 2010. “Evidencias Médico Antropológicas sobre el Origen del Pishtaco.” *Revista Peruana de Medicina Experimental y Salud Pública* vol. 27 (1): 123-37.
- Quevedo Pereyra de Pribyl, Rosario. 2006. “Epistemología Psiconeuroinmunológica: Relación entre los Estados Psicológicos, las Enfermedades Médicas y los Procesos de Curación.” in *Psiconeuroinmunología en Sudamérica*, edited by Jorge Santiago, Rosario Quevedo Pereyra de Pribyl and Ninoshka Fasce. (unpublished).
- Quevedo Pereyra, Rosario. 2001. “Sexualidad y Discapacidad.” *Liberabit Revista de Psicología de la Universidad de San Martín de Porras* Vol. 7 (7): 107-110.

- Quevedo Pereyra, Rosario. 2000. "Actitudes Hacia la Infidelidad en Miembros de Parejas Conyugales en Lima Metropolitana." *Liberabit Revista de Psicología de la Universidad de San Martin de Porras* Vol. 6 (6): 11-27.
- Quevedo Pereyra, Rosario. 2001. "Evaluación, Diagnóstico e Intervención Psicológica en el abuso sexual infantil." Pp. 20-45 in: *Manual de Evaluación para Expertos Edición Especial: Programa de Postgrado y Especialización para Psicólogos en el Perú*. Lima: Colegio de Psicólogos del Perú.
- Quevedo Pereyra, Rosario. 2001. "Cómo proporcionar Educación Sexual a un Niño con algún Grado de Discapacidad: Guía Psicoeducativa para Padres con Niños con Necesidades Educativas Especiales." Pp. 7-18 in *Sexualidad y Discapacidad*. Lima: Instituto de Investigación de la Facultad de Psicología, Universidad de San Martin de Porras.
- Quevedo Pereyra, R. 1999. "Contribuciones recientes al Estudio de la Sexualidad Extramarital." *Revista Profesional de la Facultad de Humanidades de la Universidad Cesar Vallejo*. Trujillo, La Libertad, Peru
- Quevedo Pereyra, Rosario. 1997. "Attitudes Toward Infidelity in Marriage Couple Members in Lima City." *Archivos Hispanoamericanos de Sexologia* Vol. 3 (1): 93-114 (International Editorial Committee: Dr. William Masters, Dr. John Money)
- Quevedo Pereyra, Rosario. 1996. "Hacer el Amor con Otro: la Infidelidad como asunto Sistémico." *Actualidad Psicológica*, Lima, 3 (2), 14-18.

Articles in Magazines

- Pribyl, Rosario de. 2010. "El Culto de María Lionza." *Latinos Magazin*, Vienna, Vol. 1 (2): 24-26.
- Pribyl, Rosario de. 2010. "La Maldición de Malinche o los Enigmas de la Identidad Latinoamericana." *Latinos Magazin*, Vienna, Vol. 1 (1): 22-23.
- Pribyl, Rosario de. 2010. "Mitos sobre el origen del Cactus "San Pedro" (Wachuma) en el Norte del Perú." *Latinos Magazin*, Vienna, Vol. 1 (0): 10-11.

Professional Experience

- 2008 : Research and Project Assistant. Hundred of Original Projects for Employment HOPE'87, Vienna, Austria

- 2007 – 2009: Counsellor and Project Assistant. Platform of Latin American Associations in Austria, Vienna
- 2005 – 2007: Coach and Consultant. Association for Peruvian Indigenous Peoples and Application of Traditional Medicine MIPAMT, Ucayali, Peru
- 2000 – 2001: Director Program of Training and Research in Psychological Intervention. Warmikuna Non Profit Professional Psychosocial Association, Lima, Peru
- 2000 – 2001: Consultant for Organisational Development and Project Management. Psychological Organisation Motiva, Lima, Peru
- 1999 – 2000: Psychologist of the Children Development Program; Family Therapy; Pyschoneuroimmunology (Tuberculosis, Asthma and Stress); and Program of Sexual transmitted Diseases VIH – AIDS. San Luis Community Health Centre, Ministry of Health, Lima, Peru
- 1998 – 2000: Head of the Department of Psychology. Centre of Pre-school and Special Education Personitas, Lima, Peru
- 1997 – 2001: Clinical and Therapeutic Private Professional Practice, Lima, Peru
- 1993 – 1994: Clinical Practice in the Crisis Intervention Team, Psychiatric Hospital Victor Larco Herrera, Ministry of Health, Lima, Peru
- 1993 – 1994: Psychologist at the Program for Children victims of Terrorism “La Casa del Niño” in El Agustino District, Lima. Centre for Psychosocial Development CEDAPP, Lima, Peru
- 1993 – 1994: Member of the Prevention Program of Drug and Alcohol abuse. School 072 San Martin de Porres, Lima, Peru
- 1992 – 1993: Counselling for school students. Elvira García y García School, Lima, Peru

Internet-based Initiatives

Peruvian Traditional Medicine Policy Making Outreach Site (in Cooperation with the Sub-Committee of Traditional Medicine of the Peruvian Medical Association):
<http://www.facebook.com/pages/Sub-Comite-de-Medicina-Tradicional-del-Colegio-Medico-del-Peru/150490171667256>.

Organization and participation in Scientific Conferences

- 2012: Invited Speaker. “Evolución de los saberes médicos y sistemas de curación desde la conquista a la actualidad y la importancia de la aculturación en los mismos“. 54th ICA International Congress of Americanists “Building Dialogues in the Americas”, 15-20 July 2012, Vienna, Austria.
- 2011: Invited Speaker. “Visuelle Ethnographie über die Arbeit eines afroperuanischen Heilers“. 24th AGEM Symposium Ethnomedicine “Healing Imaginaries: Medial and Visual in the Context of the Interdisciplinary Field of Ethnology and Medicine”, 17 - 18 September 2011, Vienna, Austria.
- 2011: Invited Speaker. “Zur Stellung der traditionellen Medizin im peruanischen Gesundheitssystem“. Summer Conference Series of EMLAAK, Latin American Ethnomedicine Research Network, 17th May 2011, Vienna, Austria.
- 2010: Coordinator of the Symposia. “The Right to Health from an Intercultural Perspective“. International Congress of the Latin American Network of Legal Anthropology (RELAJU), 2nd – 6th August 2010, Lima, Peru.
- 2010: Paper Presentation. “Traditional Medicine in Peruvian Health System“. International Congress of the Latin American Network of Legal Anthropology (RELAJU), 4th August 2010, Lima, Peru.
- 2009: Invited Speaker. “Interaction between the official and traditional medical systems: Preliminary results of a medical anthropological study in Lima“. Scientific Symposia in Anthropology of Health, Peruvian Medical Association, 28th April 2009, Lima, Peru.
- 1999: Coordination Committee. “1st International Scientific Symposia on Psychoneuroimmunology“, Peruvian Society of Psychoneuroimmunology & Foundation for the development of Psychoneuroimmunology in Venezuela FUNDASINEIN, 2nd - 3rd December 1999, Lima, Peru.
- 1996: Public Relations, Translations and Coordination. “7th Peruvian Congress of Sexology and Sexual Education and 1st International Congress Sexuality and Life: Challenges and Hopes for the Third Millennium“, 3rd - 7th June 1996, Lima, Peru.

Professional Memberships

Trauma and Global Health Program (University McGill, Canada)

The Austrian Society for Ethnomedicine (ÖGV, Vienna, Austria)

Latin American Ethnomedicine Research Network (EMLAAK, Vienna, Austria)

Peruvian Association for Integrative Medicine (ASPESIN, Lima, Peru)

Peruvian Society of Psychotherapy (SPP, Lima, Peru)

Committee on Traditional, Alternative and Complementary Medicine of the Peruvian Medical Society (CMTAC, Lima, Peru)

International Federation of University Women (IFUW, Switzerland)

Peruvian Society of Psychoneuroimmunology (PNI, Lima, Peru)

Professional Society of Psychologists of Peru (CPP, Lima, Peru)

Language Proficiency

Spanish: Native

German: Fluent (reading, writing, speaking)

English: Fluent (reading, writing), Proficient (speaking)

Italian, French, Portuguese: Fluent (reading)

Quechua: Beginner (reading)