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BOLIVIAN PUBLIC HEALTH CARE:
INTERCULTURATION FOR INDIGENOUS RIGHTS

2014

By
Kendra Leigh Wright

A thesis presented in partial fulfillment of the requirements for completion
Of the Bachelor of Arts degree in International Studies
Croft Institute for International Studies
Sally McDonnell Barksdale Honors College
The University of Mississippi

University, MS

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ABSTRACT

KENDRA LEIGH WRIGHT: Bolivian Public Health Care:
Interculturation for Indigenous Rights
(Under the direction of Dr. Kate McGurn Centellas)

This thesis is concerned with Bolivian public health care, specifically how interculturation plays a part in bringing indigenous rights and representation. By examining indigenous traditional healing and Western medicine, this thesis attempts to answer the question of: is the role of pluralizing medical practices a mechanism that successfully gives more power toward the representation and inclusion of indigenous rights in Bolivia? If so, how exactly has interculturation taken place? This thesis hypothesizes that through projects of cultural sensitivity and the respecting of Aymara and Quechua languages, rituals, and traditions, indigenous representation is enhanced in the Bolivian public health care field, allowing for health care professional and traditional healers to work together in alleviating Bolivia's poor public health indicators. The theories of interculturation, medical enculturation and cultural sensitivity as it contributes to recognizing indigeneity are examined via a theoretical framework. Furthermore, to test the hypothesis, data was gathered from various international organizations, national programs and ministries, and the 2001 Bolivian census data. In all, through various analyses it is possible to determine that the act of interculturation in public health care is crucial for including the indigenous population into national representation.

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INTRODUCTION

Background and Research Questions

This thesis examines the co-existence and interculturalization of Bolivia's two medical philosophies: Western medicine and indigenous traditional healing. Specifically, my research focuses directly on public health and its influence in creating interculturalization, or a space in which the two differing medical practices are equally represented and respected. My overarching research questions are: is the role of pluralizing medical practices a mechanism that successfully gives more power toward the representation and inclusion of indigenous rights in Bolivia? If so, how exactly has interculturalization taken place? I hypothesize that by the government creating and recognizing an intercultural space where Western medicine and traditional healing can intermix and complement, the Bolivian indigenous population is better represented and included in Bolivian national society, both culturally and politically. Throughout, I measure the role of pluralizing medical practices by examining news articles, official governmental reports, and international programs to argue that compelling data proves the projected efficiency of an interculturality model. Furthermore, I examine how implementation models are being created, distributed, and if there have been any immediate conclusions drawn. I measure efficacy of the intercultural models by the ways in which program managers are teaching interculturality in a sufficient and reliable manner.

I chose this topic after taking my methodology course during June of 2012 in La Paz, Bolivia as part of Drs. Centellas Social Science Field School. While in La Paz, our professors assigned us an extensive final research project that examined some part of Bolivian society. One element of Bolivia that perked my curiosity was its official name, the Plurinational State of

Bolivia¹, and what exactly Bolivia's *plurinational* meant or made it different from other nation states. The idea of pluralizing has become important for the Bolivian society because by allowing for adequate diverse representation, it has the potential to give social power to vulnerable groups, such as Bolivia's indigenous population, who have been historically underrepresented throughout Bolivian national culture and society. I became interested in this topic when one cold La Paz morning, I walked into a pharmacy to receive something for a minor, but nagging cough, noticing what appeared to be natural medicinal remedies being sold at the same time and place as Western pharmaceuticals. The pharmacist offered both types as medicine, both natural and pharmaceutical, as she did not know which form I would prefer. This system was pluralistic, meaning that two or more systems of ideas, cultures or beliefs coexisted in the same space. When I saw the special cohesion of natural and Western medicines into one, I began to wonder if there was more to this in Bolivia. Thus began my investigation into pluralism present in the Bolivian health system.

When studying an upper-level anthropology course, I learned about the differences between medical enculturation, interculturalism and pluralism in representing various cultures. Interculturalism represents a middle ground between two differing cultural contexts, demonstrating an interplay and soft merging of the two cultures. Enculturation is the act or process of learning the social norms surrounding a culture or institution, and furthermore how one becomes a citizen to this process. Throughout my research, I developed a concentrated idea of medical enculturation that examines how people are learning to become citizens of Bolivia's pluralized medical practice system. This term will be seen primarily throughout the fourth chapter. Specifically, my research examines the process of learning, experiencing and becoming

¹ El Estado Plurinacional de Bolivia

a social actor (ie medical enculturation) in a pluralistic health care space, and how through the process of enculturation an intercultural space is developed. My research questions are not mutually exclusive and will act as my overall, guiding question. Interculturation in Bolivian public health care is a rather large topic, so to focus my topic in more, I look at two programs, PASS and FRONTIERS, specifically in Chapter 4 and examine if the success of new health programs is contingent upon the implementation and effectiveness of providing cultural competence and demonstrating cultural sensitivity in both training and education projects. This is vital in addressing if the Bolivian government is not only introducing and validating the idea of interculturality; it must also act upon it.

Argument

Many international organizations and researchers, such as World Health Organization (WHO), European Commission, Erika Silva and Ricardo Batista, documented how significantly high levels of poor Bolivian health indicators are a consequence of a health care system that is structurally unequal, in terms of geography and intercultural barriers (Silva 2010). By being structurally unequal, the government has historically not included indigenous beliefs and rituals in nationally recognized health care processes, furthermore not allowing for indigenous medicine to be accessed in Western medical processes. Intercultural barriers can include language and other social barriers that occur via productions of knowledge, attitudes, social relationships, and practices. Thus, by the Bolivian government lowering these barriers and creating an intercultural space where indigenous beliefs and rituals are respected and used in the medical field, the historically high health indicators, such as child and maternal mortality, have a higher chance of decreasing and alleviating the high risk for Bolivia's indigenous population.

My research specifically examines the pluralism present in Bolivia's public health model and what I argue to be medical enculturation of indigenous traditional healing and Western medicine². By implementing an intercultural space of Western medicine and traditional healing, Bolivian Western health practitioners are equipped on cultural sensitivity and also how to include an indigenous healer into the process of providing health care to an indigenous patient. As already expressed, Bolivian medical practices can adhere to only daily use and also depend upon varying cultural, linguistic, regional, spiritual and healing beliefs. Throughout my investigation, I conceptualize various topics such as indigenous identity, public health and interculturalization. To clarify terms that I have not yet grounded, I refer to public health as being the science of prolonging life and promoting health projects through sustainable efforts such as education and prevention. Indigenous identity will include more subjective interpretations, as it is self-identified and can vary. However, for my purposes I will characterize indigenous identity as the personhood in which a person of native Bolivian origins interprets and shapes his/her communal identity, deriving from traditional indigenous sources and as self-representing as being different than a Western model of citizenship. Indigenous identity refers to a communal self that envelops group dynamics to revolve around a collective personhood, where distinct markers mark persons as citizens belonging to an indigenous identity. For Bolivian indigenous peoples, communal identity links itself heavily to geographical regions, languages and healing beliefs.

² Throughout my research, I will maintain my previous definition of pluralism and define general enculturation as the social construction of the process of teaching an individual the norms and characteristics of a cultural sphere. To clarify, pluralism means that two or more cultural beliefs or practices are equally or similarly present in the same space. Interculturality specifically refers to the space in between the two cultural practices or beliefs, allowing this in-between space to add or take out some variables of each culture, while also creating a middle ground as being definitively neither the first nor the second.

Why is it important to care about the interculturalization of health ideas in Bolivia, or even what indigenous traditional health beliefs are? Since the formation of the country, indigenous peoples have not just been underrepresented in their own country's history and politics, they have been virtually non-existent regarding their rights to active citizenship and participation (Gotkowitz 2007). Interculturality in the public health field could become one answer to how the Bolivian government can both tackle its horrible health statistics and find a new way of representing indigenous identity in the national sphere.

Why should one care to learn about indigenous medicine and its specifics? Firstly, to talk of Bolivian indigenous medicine, one must recognize the importance that Andean cosmology and identity have in it. Indigenous medicine is about more than the personal, physical side of health care. It is rather embedded in and connected to other cultural practices. Consequently, using indigenous medicine is not just about becoming physically better, it's about practicing indigenous culture and treating the body by their communal beliefs, focusing in on the traditional community structure. While health affects all of society, traditional healing focuses in on curative techniques in a different way by focusing on ideas such as the locality of space, Pachamama (mother Earth of the Inca tradition), reciprocity, gender roles and family ties. These themes drive Andean communities by informing the kind of medical epistemology that they practice.

Carmen Beatriz Loza's research submitted to ISEAT³ gives insight into what she calls the "labyrinth of healing" that exists in the Bolivian public health sphere (Loza, 544). She describes it as a labyrinth because it has an intricate design that primarily relies upon cultural and historical

³ In Spanish: "Instituto Superior Ecueménico Andino de Teología" or the Upper Andean Ecumenical Institute of Theology

situations, which have usually not been recorded or reconciled in an academic sense. It is unattainable in words, playing upon local beliefs, language and rituals. In essence, the labyrinth is the interplay of traditional medicine and if and how “lo tradicional” is recognized, accepted and/or authorized. Beatriz Loza argues that health is a question weighted in ideological, symbolic, and political capital. Indigenous tradition encapsulates not only their language and physical aspects of the community; it fastens communal identity to traditional healing to mean much more than biomedical techniques. For indigenous Bolivians, it is following the guidelines of Andean cultures and traditions that make them indigenous. By taking a closer look at how traditional medicine is structured and functions in Andean societies once can see the importance of following indigenous rituals. This form of medicine does not have a rigid educational structure, but rather molds to its community’s needs. Furthermore, the nature(s) of traditional medicine alludes to its own plural nature due to the vast difference of personal experiences and knowledge that may exist from healer to healer.

Recalling my research questions: is the role of pluralizing medical practices a mechanism that successfully gives more power toward the representation and inclusion of indigenous rights? How exactly is interculturality playing into the dynamic of increasing indigenous rights? In all, to argue my hypothesis that interculturalization matters and is a valid process in creating a well-represented space for Bolivia’s indigenous population, I will first examine the intercultural barriers that contribute to my second area of study: poor health indicators. I explain why interculturalization is needed. Additionally, the investigation surrounding indigenous identity, rituals and beliefs in traditional healing furthermore prove that interculturalization of public health ideas will help give more power to indigenous citizens by the inclusion of their traditional health rituals and beliefs.

Methodology

I use two differing methods, the first that is more quantitative, operationalizing indigenous identity and health care by examining a number of socio-demographic indicators through statistical analyses of some departments, namely La Paz. These include infant mortality, place where women had their last child, level of poverty, ethnic indicators (via language and self-identification), and presence of basic services such as potable water, electrical energy (lights, gas, etc.) and sanitation services. For census data, Bolivia follows the same 10-year structure as the USA. The most recent census occurred in 2011, however I will mainly use census data collected in 2001, due to the controversial and virtually inaccessible nature of the 2011 census. Also, many discrepancies exist around Bolivian census data collecting process, specifically calling into question the validity of self-reporting. With Evo Morales taking office in 2006, more international organizations, such as the UN, are concerned with -Morales' desire to adjust the concluding census data to make Bolivia appear to have better statistics than in reality. However, neither the 2001 and 2011 census asked about interculturality, thus making the information in both years consistent. Through the use of socio-demographic data, I will use a regression analysis to look at the relation between certain statistical analyses to further point at the relationship between health indicators, language use and regional markers.

The second form of research methods takes a qualitative approach and uses several different research forms such as (1) content analyses of international organizations' data, (2) anthropological work that focus on specific practices and rituals of indigenous medicine, (3) my personally administered surveys and informal interviews with average *paceños*⁴ from my June 2012 trip, and (4) national health care programs implemented by various presidents throughout

⁴ Bolivian residents from La Paz

Bolivia's history. Mainly in Chapter 3, I regress census data analyses as well as survey responses to show how the intercultural model subconsciously already exists in many areas of the Bolivian society. I rely heavily upon secondary sources from different sociologists or anthropologists for explaining indigenous communal identity and their different health care practices. My archival data derives from various national and international academic journals, books and newspaper articles. Also, much of my literature comes from the World Bank, United Nations, and World Health Organization as well as various country-produced data such as the CIA Factbook produced by the United States of America. Closer to the end of this research, I examine international organizations' data and programs, namely those of UNICEF and FOCAL, which are the programs called PASS and FRONTIERS.

Chapter Layout

To restate my research question, is the role of pluralizing medical practices a mechanism that successfully gives more power toward the representation and inclusion of indigenous rights in Bolivia? If so, how exactly has interculturalism taken place? I will begin by explaining what makes Bolivian indigeneity different from Western ideas, how it differs in a health care sense and also examine how health reforms through Bolivian insurance plans and new international programs are incorporating pluralism and interculturalism. Chapter 1 serves as a historical analysis of indigenous identity by looking at rituals, language and geography. Chapter 2 links various socio-demographic data to the idea of Bolivian indigeneity, relating it further to the national notion of public health, as well as proving the importance of maternal, sexual and reproductive health in the interculturalism process. In both Chapters 1 and 2, I will discuss how my variables intertwine to further show how indigeneity statistically links to poverty. When discussing indigenous identity, I am also implying that indigenous beliefs and methodology are

different in various social spheres than those of the Western sphere, such as health care. Chapter 3 examines the ample evidence of the use of traditional natural remedies used by indigenous groups throughout Bolivia and how the concepts of public indigenous identity and interculturalism begin to intertwine by the mixture and presence of indigenous healing into La Paz's Western practiced medicine. Chapter 4 looks at two different case studies, FRONTIERS and PASS that have partnered international organizations with the Bolivian Ministry of Health to help provide ways in which individual communities are able to implement interculturalism to their region and patients. The concluding chapter will act as a quick review of my main arguments, encountered weaknesses, and also as an area to examine future possible research within the topic.

CHAPTER ONE: THE INDIGENOUS, RURAL STATE

1.1 Indigenous Rights and Struggle for Representation

“Indigenous peoples remain on the margins of society: they are poorer, less educated, die at a younger age, are much more likely to commit suicide, and are generally in worse health than the rest of the population.”—The Indigenous World 2006

Currently in Bolivia, there are over ten million people, with over fifty percent self-identifying as indigenous (CIA Factbook 2012). Bolivia is one of the few Latin American countries that have a majority indigenous population. While the majority of Bolivians self-identify as indigenous, indigeneity is split into over twenty individual groups. A few examples include the Aymara and Quechua populations in the *altiplano* (or high plateaus) and mountain regions, and the Guaraníes, Botocudos, Tucanos and Panos in the lower regions (BBC 2012). For example, of the entire indigenous population living specifically in the city La Paz, only 68.4% are of Aymara descent, while the remaining thirty percent of La Paz indigenous population is Quechua. Indigenous diversity can also be shown through the diversity of national languages. Bolivia officially recognizes thirty-seven national languages, including Spanish and different indigenous languages (BBC 2012). Most of the different indigenous languages refer to geographical differences. Seeing the differences of indigeneity in identity, language, and regions, one is able to see that the indigenous population does not work as a single static unit. Due to this, indigenous social rights have been harder to implement due to the large and diverse group of indigenous peoples. Something that might be beneficial for the Aymaras might not be in the best interest of the Tucanos. For example, national legislation surrounding the legitimacy of cultivating and using coca leaves affects most Aymaras and Quechuas who farm coca in the *altiplano* and use coca to curb drowsiness due to altitude, while the Tucanos live in the Amazon

region where coca is essentially useless because it does not render the same benefits for altitude as it does for the Aymaras.

The concept of indigenous peoples is hard to concretely define because, as Bjoren-Soren Gigler describes, it inherently “rejects to be defined by external agencies,” encompassing their communal identity as “ancestral property, languages, cultures, and forms of government” (Gigler 2009, 4). “External agencies” can furthermore be seen as those of dominant Spanish descent. Indigenous groups define themselves by self-identification and unification within the group, calling upon social responsibility to adhere to the traditional beliefs and rituals surrounding language, property, religion, health, etc. (The Indigenous World 2006). When referring to indigenous persons or ideas, I define indigeneity to be a mixture of the two ideas, (1) involving self-identification as an element of rejecting external agencies as well as (2) contributing to communal identity by fully becoming enculturated into the community’s beliefs and rituals. When specifically referring to the Bolivian indigenous, I focus on the most populous ethnic group, being the Aymaras and Quechuas, who make up approximately twenty-five and thirty percent respectively of the entire Bolivian population, while the other indigenous groups comprise approximately six percent (CIA Factbook). I look at the two groups as being more similar than other indigenous groups based on their shared geography and Inca heritage, both traditions stemming from the vast presence of beliefs deriving from the Andean highlands.

Historically, the poorest and most excluded demographic group throughout Latin America has been people of direct indigenous descent. The level of discrimination is very high, causing an impediment in access to basic social services such as health, sanitation, housing, education, and political representation. In Laura Gotkowitz’s book, *A Revolution for Our Rights*, she explains that the “long-lasting struggle” for indigenous persons refers to a struggle in the

“power of representation” (Gotkowitz 2007, 41). An example of the struggle in the power of representation is the politics of land reform and land ownership by indigenous Bolivians. While most have lived in the same region and worked on the same areas of land for generations, it was not until the early 1990’s that land reform allowed indigenous communities to protect their lands from commercial enterprises (MRGI). However, it was not until 2006 with the National Land Reform that land was dispersed into the indigenous ownership by the state (MRGI). Furthermore, language differences and the urban/rural divide perpetuate a larger lack of representation. By giving “power of representation” via land or public health reform, the Bolivian government is able to give equal rights to all of its citizens and fully recognize all of its population as active and participatory members of Bolivian society.

While indigeneity can encompass many things such as language, religion, geography, politics and culture, I specifically focus my thesis on the public health side, showing how indigenous traditional medicine involves both a physical and cultural approach to health care. However, I will use language, gender, and the urban-rural divide to explain what elements contribute to creating an indigenous health care. In the past, many non-indigenous Bolivians and outsiders believed indigenous traditional techniques of medicine to be “practices of ignorance” or moreover a form of witchcraft, due to its ritualistic and traditional nature. Most of the rituals do not adhere to Western standards, as it existed before Western influence was introduced into the country. For example, many indigenous groups believe in serving certain liquid mixtures and presenting Pachamama (the Andean Mother of Nature) with sacrifices of llama fetuses or pure cane alcohol. Due to this stigma surrounding indigenous healing, the interactions between Western and traditional medicine practitioners have historically been conflict-ridden and/or non-existent. In many social contexts, indigenous medicine was regarded as being the “other” culture,

stigmatizing it as “practices of ignorance” that were not studied nor proven effective (Beatriz Loza 2008). Throughout the early and mid-twentieth century, there is evidence that Western-trained physicians took indigenous healers to trial, blaming them for carrying out illegal practices on patients (Gonzalez Salguero et al, 2005). The usual court result would lean in the Western-trained physician’s favor because the indigenous healer either lacked legal representation, or his/her rituals were not understood for its traditional, cultural context. However, while the use of indigenous medicine might have diminished as a result of those controversies, it did not disintegrate entirely, and researchers even argue that these cases drove some indigenous people to seek out indigenous medicine more actively (Beatriz Loza 2008).

1.2 Why Plurinational and Why Now?

In 1995, Evo Morales, a cocalero⁵ from the altiplano, began his fight to bring the indigenous population away from the “margins of society” and into the Bolivian social and governmental spheres (Gigler 2009). He rose through the political ranks as an adamant representative for the indigenous community and ran for the Bolivian presidency in 2004. He was elected in 2005 as the front candidate from the MAS⁶ party, which had organized itself around creating and giving more political power to the Bolivian indigenous people. Morales’ popularity skyrocketed among the indigenous peoples because he appeared to be like them and he supported issues that appealed to them. His campaign specifically ran on expressing how Bolivia was a plurinational state, by recognizing an “interculturalidad”⁷ that would help merge representations of many different cultures into a united Bolivian model (Gigler 2009). Morales

⁵ Meaning a leader in the Union for Coca Growers, being highly influential in many areas where coca is the predominant cash crop

⁶ Or Movement towards Socialism, the reigning Presidential party today

⁷ Interculturality in English

took office in 2006 after winning the democratic election. The Nationalia⁸ as well as researchers such as Annie Murphy argue that Morales delivered his promises of giving indigenous political representation by implementing the new Bolivian Constitution in 2009 (Nationalia 2009, Murphy 2008).

The plurinational state “recognizes and encourages the socio-cultural diversity of the population” via cultural practices such as language, ritual, religion, and health practices (Nationalia 2009). Also, it also has a culturally heterogeneous governmental system that recognizes the authority and autonomy of individual nationalities present in the state. The constitution describes the plurinational state as “independent, democratic, intercultural, decentralized, and autonomous⁹” (Constitution of Bolivia, 2009). The new constitution of 2009 was legitimized through the government and the people by a two-thirds majority vote of Congress and the majority vote of the Bolivian people.

Evo Morales is an effective political leader in gaining support because he had an important political tool: his personal indigenous identity. Morales self-identifies as Aymara. Through Morales’ identity, he is able to share in the same group struggles and fights for representation that most indigenous groups have in common. Morales used his identity to rally supporters because he was the first Bolivian president to self-identify directly with the ethnic majority of Bolivian people. He represented his identity through image politics of dress, speech, and image showing that he had the same look as indigenous Bolivians. The photo below shows how he uses identity politics throughout political engagements. By dressing in traditional Bolivian colors of red, yellow and green and choosing to wear a typical Andean striped jumper

⁸ A Bolivian Newspaper

⁹ “Independiente, democrático, intercultural, descentralizado y con autonomías”

instead of a traditional Western suit, Morales becomes personable, linking himself to the audience and his constituents.



Photo 1. President Evo Morales. Gigler 2009.

Morales broke the status quo of having a white Bolivian president by addressing and fighting for representative rights for all Bolivians. His self-identification of being indigenous gives him greater political economy and power because he is able to better represent the majority of the population. Additionally, he also promoted policies disguised to address the needs and concerns of the indigenous population.

How does this relate to public health practices? In regards to the health care field, various laws and insurance plans, such as the Universal Maternal and Child Insurance Law, have been decisively designed before Morales was president to be “adapted and institutionalized through traditional Bolivian medicine, whenever the uses and customs of indigenous populations, farmers or natives of the area choose to” (SUMI 2002). Health reforms are important because it allows for more citizens to access health care and increase their longevity by fighting, preventing, curing and/or treating diseases and illnesses. The reforms that Evo Morales introduced include

those of “interculturality” or mixing the two predominant beliefs, Western and indigenous medicines, and creating a more gray, in-between space in which both methods interact and work in a mutual space. In allowing more medical beliefs to be represented in public health, Bolivia is giving better representation to groups by creating a dialogue between health care provider and patient to serve and respect both the patient’s needs and his/her cultural beliefs. An example of this (that I will expand upon in Chapter 4) is the creation of a mutual space birthing room, or one in which an indigenous woman can choose to have present both her Western-trained medical doctor and her indigenous healer or midwife helping her through the birthing process.

1.3 Language Barriers to Health Care

Bolivia has approximately a population size of 10 million people with over fifty percent self-identifying as indigenous. The majority of those identifying as indigenous also speak an indigenous language. Language use is a key marker in indigenous identity, by providing pride in the usage throughout the community group. The native languages that I focused on throughout my research include Quechua primarily spoken in the Andes and Aymara spoken in the Altiplano and surrounding areas of Lake Titicaca. The latter, Tupí Guaraní, I used to show the sheer importance and force of both Aymara and Quechua in comparison. In looking at Table 1 below, one can see that only thirty percent of the Bolivian population speaks both a native language and Spanish.

Table 1. Language Demographical Information from the ECHI 2012.

	Spanish	Quechua	Aymara	Tupí Guaraní	Native and Spanish
Speaking Population	6,821,626	2,281,198	1,525,321	62,575	2,739,407
Percent of Bolivian Population	75.01%	25.08%	16.77%	.069%	30.12%

Through these numbers, it is evident how language barriers create barriers to health care. Although there is an overlap of 30 percent due to native language and Spanish bilingualism, over forty percent are monolingual in only their native language (de Varennes 2012, 54). If Western-trained, Spanish monolingual health care providers and Aymara or Quechua patients are not able to communicate about individual needs or illnesses, the health care system cannot adequately respond to the patient's problems. Furthermore, without adequate bilingualism, representative rights do not fully become recognized and the government is unable to reduce poor statistical health indicators.

A specific way in which Morales legitimized indigenous culture was through the introduction and institutionalization of language representation. Morales emphasized that the nation's language barriers needed to be overcome in order to help create a more representative government. Among his primary goals, he created a new constitution specifically stating "the official languages of the state are Spanish and all of the languages of the original indigenous 'campesino' nations and communities"¹⁰ (Bolivian Constitution, Article 5-1). While the 2009 Bolivian Constitution officially recognizes thirty-seven official languages, the national and departmental governments are only required to use at least two languages in their operations and affairs. Consequently, Spanish is usually one of the languages while the next majority native language in a given area is the second. While the governmental requirement is to have two operational languages, many critics have expressed that only Spanish is fully functional and indigenous languages are pushed to the side and not used (Nationalia 2009).

¹⁰ In Spanish: "son idiomas oficiales del Estado el castellano y todos los idiomas de las naciones y pueblos indígena originario campesinos"

Imagine that you are a young, monolingual Aymara woman living in the rural provinces of the La Paz department. You are in your third trimester of your pregnancy, and you begin to feel sharp pains. You think you need to go to the doctor, but where do you go? There is only one rural health care clinic and the resident doctor only speaks Spanish. When you finally arrive to the clinic, you learn that there are no government-funded translators available at this time or currently in your region; thus, you are not able to understand what the doctor is telling you. He tries to show you through gestures or pamphlets, but you still do not understand. You are unable to communicate adequately with your doctor, causing your level of health care access to decrease because you and the doctor cannot understand each other. While this example may be a more serious one, this is what many monolingual indigenous speakers go through daily.

Dr. Fernand de Varennes, a human rights lawyer, examines in the way inclusion and/or exclusion of indigenous peoples in social and political spheres occurs via the access of language use throughout their society. Specifically, he argues that language issues are a “significant barrier for minorities to the use of health services and that as a result those not fluent in the national language tend not to receive timely health care and be sicker” (de Varennes 2012, 37). Through his argument, de Varennes discusses linguistic politics, showing how the inclusion of indigenous languages can improve public health care. The use of language in health care is important because it can hinder and/or enhance the patient’s experience. The language barriers that de Varennes discusses include poor communication on the part of both or either the provider and the patient, inadequate translation or lack of language representation in pamphlets, documents or prescription plans, and lack of active translators that can provide patients with the knowledge given by a doctor. De Varennes argues that “they (indigenous patients) are seriously disadvantaged if they do not have access to health care in an appropriate and accessible language

when compared to those people who do” (de Varennes 2012, 38). Many scholars such as Gigler and De Varennes have debated how to reduce or alleviate language barriers in Bolivia, with some general consensus being to recruit staff that better represents culture and language, improving cultural awareness via staff training, and translating vital written documents to be usable by indigenous people.

The urban-rural divide is related to the language divide, due to a larger ratio number of indigenous people living in rural settings. Rural areas are more predominately inhabited by indigenous peoples, with an average percent of indigenous-identifying people to be at 78% (Gigler, 2009). On the other hand, urban areas have a higher percentage of non-indigenous or mestizo peoples, rounding out around 66% (Gigler, 2009). However, indigenous identity is a fluid concept, as mestizos¹¹ may manipulate each side of either being indigenous or not to have social capital in certain situations. Since indigeneity is self-reported and identified, it is hard to express a clear-cut distinction of the Bolivian population as being indigenous or not. Since the indigenous population has a majority population in rural areas, one can infer that the predominant language used is a native language while urban areas have a strong Spanish language presence, thus urban/rural divisions also reflect linguistic ones, meaning that rural areas are less likely to be multilingual and are instead more likely to be monolingual in an indigenous language. Through this assertion, urban-rural barriers, perpetuated by language barriers, enforce a continual national history in which the national government fails to recognize and well-represent its indigenous counterparts. This separation shows more examples of the need for Bolivian systems, such as public health to include indigenous communities, alleviate barriers and create an intercultural space where both indigenous and western ideas are used and respected.

¹¹ Mestizo meaning of mixed indigenous and Spanish race.

I want to conclude by relating this chapter back to my research question, or is the role of pluralizing medical practices a mechanism that successfully gives more power toward the representation and inclusion of indigenous rights in Bolivia? Chapter 1 acts to exhibit the current framework of Bolivian indigenous rights and how such actors like Evo Morales play into helping implement interculturalism. By showing the necessity to implement a plurinational model in which all citizens are recognized, the struggle of indigenous rights has become a national concern, creating political parties and activists that fight for indigeneity. Language barriers have acted as hindrances in many different spheres (political, health, economical, and cultural) to slow down interculturalism. Overall, interculturalism is needed to help Bolivia's main public health concerns.

CHAPTER TWO: GENERAL OVERVIEW OF BOLIVIA PUBLIC HEALTH

2.1 Barriers to Public Health Care

Bolivia ranks second to last among health indicators in the Western hemisphere, falling slightly behind Haiti. These health indicators include life expectancy, infant mortality, vaccinations, and communicable diseases (ECHI 2012). Poverty is more severe among indigenous groups and rural areas where conditions have either stayed the same (and not increased with national standards) or worsened due to the lack of governmental aid or regional disparity that furthermore creates a lack of access to services (PAHO). FOCAL, a Canadian organization that focuses on the Americas, argues that there are two types of factors that exclude rural and indigenous populations from adequate health care: exogenous and endogenous, relating to external and internal factors respectively.

Exogenous factors make up around sixty percent and are factors such as “illiteracy, poverty, geographic barriers, gender inequality, historic discrimination against the Indigenous People and inadequate housing” (Silva and Batista 2010, 1). The National Bureau of Economic Research also discusses that there is a strong correlation between education and health care, arguing “the more educated report having lower morbidity from the most common acute and chronic diseases” (Picker 2013). As seen in Table 2 below, while literacy increases, child mortality decreases. I believe that this correlation infers that the more accessible literacy and education is, better knowledge is produced surrounding developmental health care techniques and ideas that could prevent Bolivia’s high mortality rates and shocking health indicators (Silva and Batista 2010). Throughout Table 2, while child literacy rates increased, child mortality decreased, showing how exogenous factors do contribute to health indicators.

Table 2. Calculated and Estimated Child Mortality for Bolivia.

Year	Child Literacy Rates	Child Mortality (Per 1,000 births)	
1990	90.4%	116	
2003	98.32%*	75*	*Calculated by the National Survey of Demographic and Health
2015*	99.8%**	40**	**Estimated by WHO

While the European Commission and José Antonio Pagés have examined the validity of these literacy rates, Bolivia has had a strong history of focusing on literacy in schools (where literacy was measured upon students), drastically increasing literacy throughout the nation (European Commission 2012, Pagés 2004). On the other hand, endogenous factors look more at the internal barriers, such as cultural rituals or beliefs, which may affect exogenous factors. Endogenous, or internal, factors relate more to communicative differences that exist within the geographical and educational barriers. Chapter 4 will serve to better relate communication differences by running through the programs of PASS and FRONTIERS.

2.2 Health Care Sectors and Levels

Bolivia's health care field divides itself into many sectors and levels. First, there are two main sectors: public and private. The public sector is funded by the government and mainly focuses on providing free health care to mothers, children and the elderly. It also includes social security benefits¹² and provides coverage for diseases, pre- and neonatal care, childhood care and occupational hazards. Health care policies and systems implemented by the Bolivian government fall under the public sector. However, the Bolivian public sector suffers from a lack of resources,

¹² Only provided to those who work in the public formal sector, a relatively small percentage of the Bolivian population

both human and operational, in providing health care. An example of this is the shortage of public sector doctors, with only 3.6 doctors for every 10,000 urban residents and 1.3 per 10,000 rural residents (Silva 2010).

On the other hand, the private sector includes private clinics and practitioners, and leans heavily upon church and non-profit based charitable organizations. As of 2010, the majority use of traditional medicine still is in the private sector, due to many of its practitioners not using public hospitals or clinics to reach their patients, instead using personal stores, homes and buildings. With Morales coming into office in 2005, he set up various programs with the Ministry of Health and Sports to certify traditional healers to practice in public hospitals and clinics (MSD 2009). This process is more difficult and more expensive because it requires healers to complete government training and exams. While the difficulty of attaining a license still exists, the offering of public health care licenses to traditional healers has significantly increased the use of traditional medicine in the public sector, further providing another opportunity to implement interculturality.

Within the public and private sectors exist three different official levels of health care facilities, each referring to the type, use, and “complexity of care provided” from the center (Silva 2010). The first level is called the “entry-level” and makes up around 93% of the health care field. Entry-level has two types: basic facilities and health centers. Basic facilities are the most prevalent in Bolivia, making up over 54% of the entry-level centers; it is described as having “nurse-assistants [giving] health promotion programs, preventative care and basic health services” (Silva 2010, 6). Additionally, the other type of entry-level care includes health centers, or centers in which both a doctor and/or a nurse promote and offer preventative and outpatient medical care. The second level is mainly found in urban settings, and only makes up around

5.2% of health care facilities. This level includes basic hospitals and clinics that include at least one of the following four specialties: pediatrics, gynecology, general surgery and trauma. On the second level, the care becomes more advanced and specified.

The third level of health care makes up only 1.9% of the medical field and encompasses general and specialized hospitals that cover cardiological, neurological, urological and psychiatric health. The more specialized hospitals are only readily available in the capital city of each department. Given that levels two and three are mostly concentrated in urban settings, rural communities are without access to higher levels of health care (specialists, surgical teams, supplies) that could help treat the serious threat communicable illnesses. The urban/rural disparity exists throughout all three levels and becomes a large reason as to why urban residents have more access and thus have better overall health indicators. Moreover, rural areas are more vulnerable to communicable diseases because they do not have the infrastructure to prevent the precarious cycle of diseases. Recognizing that a large hospital would not have the infrastructure nor the necessity in rural areas, these areas are still in need of a smaller form of infrastructure, such as a clinical setting in which there would be enough physical demand for the clinic size. In summary, I conclude that the three differing levels of health care exacerbate the urban-rural disparity by further providing a barrier that prevents rural populations (remembering that rural populations generally refer by majority to indigenous populations) from helping to stop the spread and suffering of preventative and/or serious illnesses that only the second and third levels can provide better services to.

In researching Bolivian public health interculturalization, the Erika Silva and Ricardo Batista's FOCAL (Canadian Foundation for the Americas) report examines if "insurance" plans introduced by the Bolivian government truly helped the poorest and/or indigenous population of

the country. I use the quotations around insurance because, later in their argument, they refer to this idea of “insurance” as not defined in the Western sense, but rather a type of free care that does not require buying into the governmental system via taxes¹³. These free care programs were used instead of traditional insurance to help scale down economic barriers. For example, the government offers various *bono* programs; the most common used being the Bono Juana Azurduy, which pays mothers to attend prenatal, natal and postnatal appointments in order to receive a cash payment.

Insurance plans¹⁴ began in the mid 1980s, have changed rather drastically with the creation of three main programs during different times, and continue to be in use till today. Silva and Batista’s research focus on the three main plans that had the most development and government influence from 1994 till 2010, the year the report was published. Furthermore, the official goal of the insurance plans was “reducing the gaps between the urban and rural population with respect to health” (Silva 2010). Silva and Batista mention that this goal does not take into account all of the barriers in making policies and intervening in public health, such as language, culture, education and geographic. They go on to say that in order for insurance to be provided universally, the government must build and solidify a strong infrastructure that “provides the necessary equipment and human capital to increase the level and access of primary care in rural settings,” signifying a necessity of investment financially and physically across all levels and regions to help reduce mortality rates and provide better access specifically to rural communities (Silva 2010).

¹³ All Bolivian citizens pay taxes, but it is harder to record whether or not every individual in rural areas have paid his/her taxes or not due to the geographic isolation of these areas. Therefore, a non-tax based insurance system would allow for citizens to access health care without having to wait for a Bolivian official to confirm if the individual had paid his/her taxes.

¹⁴ For the sake of clarity, I use the term *insurance* to refer to the free care plans, due to the coined use of *insurance* in Bolivian health care policies.

Furthermore, Silva and Batista argue that education strategies need to be a part of insurance plans and need to be targeted to all women of childbearing age. Moreover, these barriers have specifically caused disparities in the delivery and/or birthing process due to differing languages or cultural rituals performed during the processes. To specify further, delivery refers to the birth of the baby, while the birthing process signifies the start of contractions until the birth of the baby and the placenta. Since to access health care facilities is more limited in rural setting, rural women are more likely to give birth to their child in their home, further perpetuating the urban-rural divide.

In 1994, infant mortality in rural communities was 106 deaths per 1,000 live births, and in urban communities, mortality rates were drastically lower, being only 69 infant deaths per 1,000 live births, averaging the Bolivian national index to 87 (DHS 1994). Due to the more encompassing coverage for mothers and children, infant mortality indicators heavily dropped throughout the years, with a 42.8% decrease from 1994 to 2008. In 2008, rural communities experienced 75 deaths per 1,000 live births while urban populations had only 43. Silva and Batista state, “in general, in rural areas, all the rates are almost twice as high as those in urban areas” (Silva 2010). Specifically, these rates are experienced in indigenous-majority rural departments: Chiquisaca, Cochabamba, La Paz, Oruro, and Potosí. Through these statistics, it is becomes evident how the urban-rural divide is a barrier made via differing language, geography or culture. Mortality rates are important to my research because these indicators show an inability of the Bolivian public health care system in providing adequate care to its citizens. Morales uses these indicators to show that there is need for immediate change. Through Morales’ proposal, he addresses bettering indicators by becoming more culturally sensitive to its citizens’

needs, especially in rural areas where health indicators have been historically worse than urban areas.

I created the next two tables (Tables 3 and 4) to show public health statistics are affected by independent variables, such as race and place of birth. The Table 3 acts as the groundwork to show the basic analysis of the female Bolivian population to various socio-demographic data. Furthermore, it shows the percentage of women who are: (1) over the age of fifteen with at least one child, (2) the percentages of the female population that had their last child in a health facility/establishment, (3) the percentages of the female population that had their last child in a home/place, and (4) percentage of indigenous identifying women in the total population (INE 2002). In Table 3, I used census data from 2001, as the most recent 2011 data was more controversial and inaccessible¹⁵.

¹⁵ The reason for the controversy of Bolivia's national census data surrounds how the information is collected. The national Bolivian census works in the form of a national holiday, prohibiting citizens from working (unless in a government fashion) and requiring all to remain at his/her home while census officials make rounds throughout the neighborhoods, collecting adequate data. The process of self-reporting has come into question even at its most basic level. Essentially what occurs during the process is that a Bolivian government official, someone more educated with what is seen as "more" political power in the government, enters the families home and conducts the census survey. While the Bolivian government is supposed to offer the census in all indigenous languages, many of the officials are little to not fluent, thus already creating a communication barrier. Furthermore, most respondents respond with what they believe the officials want to hear so that they answer the census in the "right" way, or essentially in a way that is making the government look better. In all, the process of self-reporting allows for influence, unconsciously or consciously, that can change the results allowing Bolivia to appear to have better indicators than it does in reality.

Table 3. Socio-demographic Data for La Paz¹⁶.

	Percentage of female population over 15 that have at least 1 child	Female population over 15 that had last child in a health establishment	Female population over 15 that had last child in a “domicilio” (home delivery)	Percentage of indigenous-identifying women in population*
High	84.92%	71.49%	89.36%	48.65%
Low	60.77%	02.56%	25.63%	01.35%
Mean	72.51%	12.55%	78.51%	32.42%
Median	72.89%	07.24%	81.68	33.41%
Standard Deviation	00.0445	00.1171	00.1275	00.0822

*The percentage of women in the La Paz department make up 50.52% of the population total, both urban and rural. --Based on data from the Instituto Nacional de Estadísticas (INE 2002)

I used Table 3’s data from Bolivia’s National Statistical Institute (INE) to run regression analyses for Table 4, which looks at the relationships between various dependent (where women have their children) and independent variables (indigenous and rural population). By using the regression data, public health is a dependent variable of other independent variables, such as race and place. For example, the high of the population of indigenous-identifying women was in rural municipalities of La Paz, which have much higher rates of not having basic services. This in turn causes higher rates of women to have their children in the home versus a health establishment. The independent variables affect public health care.

¹⁶ Created by the author, Kendra Wright, using information from INE 2008.

Table 4. Regression Estimates (for population of rural, urban and indigenous-identifying and female population with child statistics in La Paz department)¹⁷.

	Female population that had last child in a health establishment	Female population that had last child in a home
Female population over 15 that have at least one child	0.2974	-0.1318
Indigenous identifying women in population	-0.5454**	0.5038**
Rural Population	-0.2555**	0.1900**
Constant	0.3201	0.5438*
R-Squared	0.5516	0.2991
N	75	75

*p < 0.05; **p<0.01

All of the statistical information is relevant when comparing my study to that of Laura Gotkowitz. Gotkowitz explains that the region of Cochabamba in the past “conjured up powerful relationships between concepts of race and place” (Gotkowitz 2007, 11). My research took this notion a step farther by showing in Table 4 how the indigenous-identifying, rural population is much more likely to have had their last child in a home and not a health facility. I took the individual regressors¹⁸ and examined against where female population had their last child. The double asterisks show that the p-value is less than 0.01 (p<0.01**), meaning that the data is statistically significant, or strongly correlated. The significance can be negative, meaning that it is highly unlikely to happen, or positive meaning that it is highly likely. This shows that women that were indigenous identifying and in a rural population were negatively related to having their last child in a health facility, meaning that it was less likely for this to occur. On the other hand, both the indigenous identifying women and the rural population were more likely to have their

¹⁷ Created by the author, Kendra Wright, using information from INE 2008.

¹⁸ Or the first three regressors listed vertically

child in their home, as seen in the positive statistically significant relationship. By showing that rural and indigenous communities were less likely to have women give birth in health centers and with the previous knowledge of the lack of health centers in rural settings, I strongly conclude that these groups of females experience a lack of access to public health in terms of maternal health. However, such insurance policies, such as SNMN, SBS and SUMI discussed below, were strategically created to alleviate the female's lack of maternal health plans or outlets by offering programs to teach and advocate for better maternal health.

2.3 Insurance Policies: SNMN, SBS, and SUMI

A majority of Silva and Batista's research surrounds the three implemented insurance plans introduced by the Bolivian government starting in 1994. The three insurance plans are crucial in looking at what strides the Bolivian government has made historically, while also examining structural successes and failures. First, the National Maternal and Child Insurance (SNMN¹⁹) was created and used from 1996 to 1998, with the goal of reducing maternal deaths and child deaths due to pneumonia or diarrhea by fifty percent. It specifically targeted pregnant women and children under five years in providing throughout the first and second levels of public health care facilities approximately 32 basic interventions, including prenatal care, labor, delivery and postpartum care, newborn care to treat pneumonia and diarrhea, along with other emergencies.

While SNMN was effective in somewhat alleviating mortality rates, it is more often seen as a tool for the government to determine or assess the needs of most mothers and children. As a

¹⁹ In Spanish: "Seguro Nacional de Maternidad y Niñez"

result, Basic Health Insurance (SBS²⁰) was created in 1998 and was active until 2003. It built upon the goals of SNMN and further expanded the realm, including a goal to “reduce the morbidity and mortality of the most vulnerable groups of the population [and] improve the quality and efficiency of care with cultural adaptation” (UDAPE 2006). The “most vulnerable groups” referred to all women of reproductive age, pregnant women, and children under the age of five as well as including care for the general population in respect to the reduction of endemic diseases. “Maternal health” starts with the pregnancy of a woman and ends six months after childbirth. Consistent with global standards of measurement, the female reproductive age ranges from 15 to 44 years. Child mortality is assessed until the age of five. An endemic disease is a term that I use throughout my research and I define it as a regularly found disease among a certain group of people or restricted to a certain area. Examples of endemic diseases in Bolivia include malaria, Chagas disease, tuberculosis, and diarrhea. It can be communicable, is generally heightened by poverty, and stems from a lack of sanitation and/or a lack of preventative education. Since rural areas statistically have less running water, electricity, education and government support, they are more prone to contract these communicable diseases.

SBS offered over one hundred basic interventions that could be accessed in the first and second levels of care. The coverage built upon that of SNMN and offered more assistance in complications, birth control methods, sexual reproductive health, sexually transmitted diseases, endemic diseases, and the providing of health practitioners via visits to rural communities. While SNMN only was accessible through public health facilities, SBS leaned both on the public and private sectors, increasing coverage and accessibility. SBS was the most effective statistically because of its vast inclusiveness, offering insurance to all women of childbearing age as well as

²⁰ In Spanish: “Seguro Básico de Salud”

offering free family planning services. During the time of SBS, neonatal mortality dropped by the largest amount of the three insurance plans, 20.6%, and was argued to improve health care the most in rural areas, causing the urban-rural divide to lessen (UDAPE 2006). Silva and Batista express that the reason was due to the increased coverage in prenatal care, health care during delivery, post-natal living conditions, and home care. SBS also improved basic health services at the entry-level facilities, further administrating better access and coverage to more citizens as well as providing more health education.

The final insurance plan that was implemented in 2003 and is still in use today is the Universal Maternal and Child Insurance, or SUMI²¹. The primary reason for going from SBS to SUMI was to reduce the cost of insurance burden on the government. This plan was to reduce child and maternal mortality by primarily focusing on neonatal mortality. The population receiving SUMI includes pregnant women until six months after childbirth and children under the age of five. SUMI allowed women to reach all three levels of health care facilities if necessary by providing both basic and higher complexity coverage of care for mothers, allowing services in surgery, trauma, ambulance, and hospitalization to be usable, with services provided from both the public and private sectors. The principal change between SBS and SUMI was that SUMI removed coverage of women of childbearing age and of the general public, consequently restricting coverage of endemic diseases and sexual reproductive health. Silva and Batista argue that SUMI was not as successful because it removed the effective elements of SBS, replacing necessary preventative techniques with therapeutic services that advanced urban populations to access the second and third levels, but disadvantaged rural populations because there was no previous, strong rural infrastructure of the second and third levels in rural areas. By enhancing

²¹ In Spanish: “Seguro Universal Materno Infantil”

regional disparity in health care, it “reversed the gains made” by Bolivia (Silva 2010). The level of institutional deliveries again began to recede and Silva and Batista have even described public health indicators as becoming stagnant once again.

SUMI was implemented in 2003 in conjunction with funding of the World Health Organization (WHO) with the continuing main purpose of decreasing maternal and child mortality. On one hand, the prevalence of institutional deliveries has increased since the inception of SUMI, going from 57.1% to 67.5% (WHO). On the other hand, however, from 2003 to 2008, maternal and child mortality rates actually increased and contraceptive prevalence remained stagnant, causing the government to look further into how to adapt the program better to reach more childbearing women. While SUMI was created and implemented before Evo Morales took the presidential office in 2006, SUMI was not removed or replaced and is still in affect today, even after the increasing rates of child and maternal mortality. Many believe that it was not replaced due to the cost efficiency, implying that it would be more expensive to replace the program than to add to it since it is mainly nationally funded (Global Health Initiative 2012). Morales kept this program because it was one of the remaining parts of the Law of Popular Participation, a law that was designed to decentralize the government and give more power in social services to municipalities. Because Morales kept this law as an active part of his MAS campaign, he was able to give more health care maintenance power to municipality, justifying that the municipalities would know better what its citizens need.

In 2009, the Bolivian government introduced a new element, called Bono Juana Azurduy, which would enhance the SUMI insurance by creating a conditional cash transfer program for maternal, newborn and child health. The use of Juana Azurduy’s name was a deliberate political move to gain social support. Juana Azurduy de Padilla was a revolutionary guerrilla leader in the

independence wars and she is continually portrayed carrying a rifle while nursing her young baby. This model of militant motherhood expresses a strong image of a Bolivian woman who can take care of her family and protect them simultaneously. Interestingly, Aymara and Quechua tradition call for women to guard the house and take care of their children for long periods of time while the father figure goes off to herd livestock or work in the fields.

Through the clear expression of the importance of a strong mother figure via the representation of Juana Azurduy de Padilla, the Bolivian government is utilizing her character to show the power and agency that women traditionally have in the family setting. With Bono Juana Azurduy, a pregnant woman receives US\$260 for attending regular prenatal visits, having skilled birth attendance and going to postnatal appointments until their child is two years old (Global Health Initiative 2012). This program exists to support more women to access and use adequate care during and after their pregnancy, while also helping provide educational opportunities to teach women about proper nutrition and health during pregnancy. Additionally, Bono Juana Azurduy was intended to build more health care facilities and provide trained staff that could adequately give health care and disburse the stipends to qualifying women on a micro-level (WHO 2013). However, many have complained that the government has failed to build facilities and equip health care providers with stipends, staff and supplies, as the Bono Juana Azurduy had initially promised (Silva and Batista 2010).

2.4 Policy Recommendations

I classify the seven policy recommendations into two categories: (1) providing resources and education and (2) adaptation of cultural rituals, ideas or traditions into public health. The first category includes giving more resource priority to the indigenous departments, which

statistically have worse indicators and also are without necessary supplies. Also, it includes listening to women of childbearing age in helping see what needs to be provided in education to teach women about adequate sexual and reproductive health.

Bolivians are not shy when it comes to showing their affection. In fact, sexual activities are not culturally and traditionally seen as defined within marriage like it might be in the Western sense. Many Quechua and Aymara partners will live with each other for a “trial period” where they will see how compatible they are together (Rostworowski de Diez Canseco 1988). In this time, most women become pregnant and will bear more than one child. Some men and women will have multiple partners that take on a trial period, have kids, and end up not marrying each other. After a certain length of time that the woman’s parents or elders think has expired in showing the compatibility of the couple and how they treat one another and each other’s families, the couple is then allowed to marry.

Marriage in Bolivia is celebrated with festival-like crowds, decorations, food and drinking. It becomes a party for the entire community. The importance on marriage is strong for Bolivian indigenous communities, but the importance in showing that the couple will work together due to their compatibility is greater. Also, a large reproductive family is highly valued in Andean tradition, showing how difficult it is to implement practices of abstinence. With this information, Bolivian sexual and reproductive health should not focus on abstinence but rather birth control via contraceptive forms such as condoms and oral medicine as a more viable solution because it does not degrade the value of having a large, reproductive family as abstinence would. For clarification, condoms and oral medicine are not recognized by indigenous tradition as an acceptable form because it prevents women from bearing children, something that is ideal and essential to creating and continuing the large family structure of Andean tradition.

However, with more women having more children, maternal and infant mortality rates do not decrease because the women continue having children in the home setting, outside of a doctor's guidance in a health setting. Thus, the government has recognized that the most effective way to help control for infant and maternal mortality is for the education system to teach safe sex and to help provide youth culture with ways to practice it (Global Health Initiative 2012).

Further expanding the realm of sexual reproductive health education, Silva and Batista's recommendation for the government is to return to providing birth control and teaching women how to access health services. The Bolivian government has in fact been providing condoms with photographic instructions, detailing the use of the condom for citizens who cannot read. These three recommendations expand upon previous plans to create adequate services to all of Bolivia, in particular rural communities, while keeping the focus on women. Silva and Batista argue that with the return of sexual reproductive health education via birth control and access to maternal health services, the Bolivian government will be returning to the model of SBS that may have been more costly, but was also very effective in reaching a greater number of Bolivians. This category remains very important in the Bolivian health discussion, as seen through programs such as the Bono Juana Azurduy, which helps women financially via direct cash payments in their pregnancy while also promoting women to use maternal health services.

The second category, which has the majority of the policy recommendations containing four of the seven spots, is what I call adapting indigenous culture to health care by creating an equal space. Below are the four recommendations:

- (1) "It is necessary to design and implement policies and interventions adapted to the needs of rural areas and the indigenous population and to focus on the reduction of the inequities affecting these groups.

- (2) Since infectious diseases are still prevalent in rural and indigenous populations, any insurance plan needs to focus on the delivery of curative, preventative and health-promotion services geared to these problems.
- (3) Other barriers that limit access to health services such as cultural differences, lack of education, gender inequalities and geographic distances could also be considered and addressed in health policies.
- (4) Before any insurance plan is implemented, in whole or in part, there is a need to increase health service facilities in rural areas and improve their problem-solving capacities, which involves assigning more doctors and improving the cultural sensitivity of providers. “ (Silva and Batista 2010)

The first recommendation of Silva and Batista of the second category specifically calls for a necessary adaptation to rural and indigenous populations that would create a more representative space, reducing inequality between differing groups such as rural and urban, mestizo and indigenous. They express that it is essential to have “interventions adapted to the needs,” calling upon number 4 where they propose a “cultural sensitivity of providers” (Silva and Batista 2010). These four continually work hand-in-hand by creating a space where a health care provider learns and becomes aware of cultural differences and inequality (e.g. number 3). By becoming culturally aware, the need of curative medicine is emphasized to show respect towards indigenous culture, while at the same time working to create an adaptive medical plan that can treat indigenous populations within the realms of their culture. This adaptive measure represents an in-between, intercultural space, where the medical treatment plans are neither fully one nor the other. This in-between space relates directly to my concept of medical enculturation (or the process of learning and becoming a member of a given culture) in that it calls upon interculturalization (the in-between space of culture) of Western medicine and traditional healing. Further, by medically enculturating both the health care providers and community, public health is able to become a social sphere of dualistic identity and is able to represent, respect and give power to both techniques.

The third cultural adaptive policy recommendation asserts specific barriers that hinder health care coverage to all, including cultural, gender, geographic and educational differences. This recommendation is a form of expressed interculturalism, in which the Ministry of Health (MOH), in conjunction with PROSIN²², or the Integral Health Project, pointedly partner in the creation and analyzing of various approaches in making health care more “culturally appropriate” (Gonzalez Salguero 2005). By this, respecting traditional rituals or methods and incorporating the traditional ways into health care recognizes the social power that it has in the community context. Furthermore, by recognizing and respecting cultural traditions, which is their legal obligation per the 2009 Bolivian Constitution, health care professionals give agency to the patient by helping create a better level of equality between the patient and the doctor, using a reciprocal and cooperative system, i.e. an intercultural system. While the 2009 Constitution and Morales’ various programs work towards creating an intercultural system, its rhetoric does not always imply a verifiable and concrete implementation.

The concept of enculturation is a perfect explanation for this process. Recalling upon my definition in the introduction, medical enculturation is the social construction of the process of teaching an individual the norms and characteristics of a cultural sphere. This definition is not only limited in the formal pedagogical sense. Instead, it adheres to the every-day interactions of cultural practices. Enculturation uses interculturated spaces to create a new way of viewing Bolivia as a society. For example, in this specific context, Silva and Batista are calling for the Western-trained medical doctors to adhere and listen to the cultural boundaries of the indigenous populations. They are essentially signaling a necessary medical enculturation of Western doctors to see and understand the indigenous cultural view of healing. It values both the indigenous side

²² In Spanish: “Proyecto de Salud Integral”

and the Western side. Thus, they are able to actively examine cultural differences while also promoting health services in a manner that makes health care more accessible to indigenous populations because it is including them in the process of health care. In essence, western practitioners need to learn about indigenous culture to adequately help and include indigenous patients in the treatment process.

Characterizing cultural sensitivity comes from the key project points, including increasing the education and knowledge about “other” cultures, improving communication via learning and promoting the Quechua or Aymara language to become usable in health facilities, and establishing systematic mechanisms to educate patients to use self-assessments while also being adequately screened in the facilities (Gonzalez Salguero 2005). One of the main cultural differences that I would like to stress is the difference in the use of communication. For many indigenous languages, non-verbal communication via hand signals or body language affects the socio-emotional content of the sentence or phrase (De Varennes 2012). Most Bolivian indigenous cultures prize community cooperation, reciprocity and interdependency. Through respect in communication, two different people are able to feel more linked while also having a reciprocal exchange of information. For example, using a more culturally sensitive model, a doctor respects and recognizes the traditions of an indigenous patient and therefore is able to create a space in communicating to the patient that he/she is respected and is a part of the doctor-patient relationship, designing a care plan together. While the program proposed by the MOH and PROSIN served as an “initial diagnosis” to the system, it was a first clear sign that the Bolivian government (even before Evo Morales took office) recognized a necessary change needed to happen in its current system in order to give more access for maternal and reproductive health services.

In all, Chapter 2 further develops my research questions examining the role of pluralizing medical practices and including indigenous rights, demonstrating how historical barriers have hindered intercultural. The communicative, urban-rural, gender and cultural barriers still exist, but are being shaken due to different policy recommendations that have helped spark the debate on how to include intercultural. Also, insurance policies such as SNMN, SBS and SUMI that focused on maternal health became a basis for future programs to examine what problems exist on maternal health and how to develop culturally sensitive programs that work with insurance plans to reach more indigenous women.

CHAPTER THREE: INDIGENOUS MEDICINE

3.1 The Nature(s) of Traditional Medicine

In Andean belief, the spaces where one lives are extensions of the family, fully encompassing the areas where the family cultivates or raises food and animals, providing them with a sustainable livelihood. Their love and respect for nature is personified through the naming of “Pachamama” as Mother Nature, whom they worship and respect. Andean belief surrounds notions that nature provides for the body not only through physical necessities, but also through spiritual and healing processes. Andean cosmology places similar, if not equal, importance upon humans and non-humans. Thus, a traditional medicine links illness of humans to the curative remedies of plants and animals, valorizing non-human entities (animals and plants) to be, in essence, an extension of the necessities of humans (Álvarez Quispe et al 2007). The corresponding nature of the two has been taught and used by Andean indigenous Bolivians since the time of the Incas, rooting hundreds of years of history into the practice of traditional medicine. However, extensive history was not enough to convince more modern political leaders to accept and use the practice (Coupal et al 2009).

The very use of traditional medicine did not start as a concrete, institutionalized and studied mean to cure the body. It was an oral tradition, passed down generationally that focused on experience-based knowledge. It was a type of “biomedical performance that only responded to criteria of functionality and efficacy²³,” explaining the lack of a fortified and structured learning system (Beatriz Loza 18). Traditional healers do not go to schools or have formal training, but rather become healers via an informal apprenticeship where they study and learn from their elders. Moreover, healing techniques rely upon a “transmission of knowledge and

²³ In Spanish: “La actuación de la biomedicina responde solo a criterios de funcionalidad y eficacia”

social processes of acquisition” that are dependent and differ on regional and community lines (Mathez-Stiefel 2011). Usually, the most community-wide practiced and respected healers come from long lines of traditional healers, learning from their parents’ and grandparents’ experiences. For more rural communities, healers travel from town to town helping treat various sicknesses. Because of this, healers carry much social weight in a society and are very revered throughout many communities.

Understanding how knowledge is produced via generational and/or community lines is paramount in realizing the deep-rooted, reciprocal nature of Andean indigenous tradition, in that tradition must be taught and preserved by carrying down through generations and equipping younger community members what it means to be indigenous. Researcher Mathez-Stiefel has looked at many different forms of dispersing local knowledge, concluding that there are most common four ways: (1) vertical (parent-to-child), (2) horizontal (unrelated individuals), (3) one-to-many, and lastly (4) concerted/many-to-one (Mathez-Stiefel 2011). In Bolivian traditional healing, all four ways are present, and usually can unite different areas in how traditional medicine is learned. Additionally, most of the approaches work simultaneously to provide a traditional healer apprentice with a complete knowledge and understanding of the trade. First, vertical dispersion valorizes family history and tradition and marks specific, well-known families in the community as healers. With this, families can be stratified in the social system as being wise and respected. Most Bolivian indigenous families follow this structure, preparing their oldest sons and/or daughters to continue the family tradition of healing.

Secondly, horizontal distribution links unrelated individuals and allows different families to join the social sphere of being healers (Mathez-Stiefel 2011). Specifically, in this case there can exist more intracultural variation (or variety within a culture) due to the different experiences

and knowledge of various people being brought together. Horizontal distribution takes place in more communities that have experienced expatriation away from their communities via migration to larger cities. In turn, the horizontal displacement of large groups to urban settings creates a necessity for more community members to remain at-home so that they can create and learn traditional healing as their own trade and continue their community line of supplying traditional healers.

The third approach, “one-to-many,” allows for a teacher-student type of knowledge dispersion and is able to control specifically what healing practices are transferred and taught (Mathez-Stiefel 2011). However, this method is not as formalized in the sense of a classroom or instructional setting with examinations and/or research and is rather primarily driven by experimentation and informal apprenticeships. This method is believed to make for the most effective Bolivian model because the knowledge production is controlled and works to progressively assimilate practices into representing a larger and broader indigenous conglomerate. The last approach, “many-to-one,” integrates a large population of elders into pulling their resources and teachings into one or a few apprentices. While this approach can provide the apprentice with alternating opinions or practices, it has been shown to help provide a more general analysis of the human body. This approach also goes hand-in-hand with the first two approaches in that families are able to pull multi-generational traditional healers into helping teach an apprentice the trade.

While indigenous healing has various ways of knowledge production, it has not changed nearly as rapidly as Western medicine, with heavier influences of globalization. For example, many healers use the older, more traditional form of Quechua or Aymara to locate and discuss specific forms of illnesses and cures, words and thoughts that do not have an adequate Spanish

translation. By the strong continuance of language, they are marking themselves and their practice as their own, not influenced or taken over by Western forces. However, this is not to say that globalization has had no impact on the state of indigenous healing. Instead, forces such as the broad institution of a Western state-run education system, migration to urban centers, the market economy, and the presence of primary health care services have made it a harder environment to adapt indigenous healing to more modern medicine. Currently, the Bolivian government is finding that global forces and their own Spanish-dominated culture have created an environment of exclusion for indigenous healing in current medical practices. While the government is working hard to make health care “interculturated,” Bolivian history has already done its damage. Thus, due to traditional medicine taking form in non-institutionalized Western ways, it becomes harder for the government to legitimize it as a competitive and adequate form of medicine to the Western model.

Many Bolivians that use traditional healing are indigenous and speak their native language in most day-to-day interactions. Because of this, their Spanish is not at a level of comprehension with regards to medical knowledge. Traditional healers typically communicate in the native language of the people that they are treating, showing their patients their own respect and admiration for the indigenous culture (Murphy 2008). Additionally, indigenous healers work in a mobile nature, explaining both the informality of their healing and approachability to their customers. Most healers visit their patients in their patients’ homes, adding a substantial amount to the level of informality (Gonzales Salguero 2005). The home space is a very intimate, family setting, and when the healer enters to help treat a patient, he/she is becoming part of the symbolic mold of the family, respecting and following their ways. Therefore, the nature of home visits makes healing process feel approachable and non-authoritative. In contrast, the building and use

of a formal Western hospital or clinic is cornered off from the community, and becomes authoritative by the coldness of the doctor-patient relation, allowing the doctor to control and the patient to succumb to the doctor's ways (Silva and Batista 2010). The doctor was not invited in to the intimate space of a patient's home, rather the opposite. In essence, for traditional healers, their main identity is indigenous thus making them perform medicine in their traditional, more intimate ways, while Western-trained doctors have been educated to leave their identity and community ways behind them to apply a very rigid form of medicine to their patients. Through this, one can see how an indigenous Bolivian might feel, react, and desire more the relationship of a healer and patient than that of the doctor-patient relation.

However, a traditional healer's mobile nature can also create problems. While the healer is able to move from town to town and become important to various communities via his/her level of informality, they are also unable to become a larger authoritative figure in the Western sense. In contrast to the Andean cosmological structure of communality and exchange, the Bolivian government was formed and operates around a Western form of government, valuing education, knowledge, individualism and social power. While traditional healers may have prestige in their community, they are not following the rigid political structure of the government. Therefore, while they have communal power, they inadvertently exclude themselves from state political power, a sphere in which national change must be institutionalized and supported by the national government in order to adequately be funded and represented throughout all of Bolivia. Hence, it is made harder for indigenous healers to become recognized in political spheres, an area in which they could have more easily induced a positive change in the way of thinking about traditional medicine. While traditional healers might be seen as knowledgeable and have power in their indigenous communities, this power does not

transfer into a more rigid government system because the healers have not been educated or licensed via Western-accepted colleges or institutions. Thus, by the government or society not bringing in indigenous healers to educate the government about their beliefs, they miss out on fully understanding and positively changing social spheres to be more inclusive. Rodríguez Márquez Rosario looks at this concept in his research of the urban Andean space, demonstrating how difficult and complicated it can be for indigenous leaders to enter the public political sphere where white, non-indigenous males have dominated for the majority of Bolivia's history. This concept stems from how Bolivia, a country that has always had a majority population from indigenous descent, has an unrepresentative nature of its government (Rodríguez Márquez Rosario 2007).

3.2 Gendered Spaces

In the fifties and sixties, while traditional medicine was not fully prohibited, it was almost impossible to practice due to strict laws and regulations. During this time, in open parts of urban areas the police controlled most common areas and would not allow traditional healing sessions to take place. This did not take place in rural settings due to the weak presence of police in rural areas. During the fifties and sixties, the majority of traditional healers were men²⁴. However, with the increased presence of police restricting where and when traditional healers could practice in common areas, most of the male traditional healers had to find another way to sustain their families and, in consequence, they turned to jobs in other trades. While men began to work in trade, women took up the lost positions of home and private traditional healing for their children, gradually learning how their gardens' crops were able to provide natural medicine and

²⁴ A reason for this could be that they were more able to easily travel away from the family while leaving the woman to fulfill her duty of keeping the house and children in order.

healing for when a member of their family was ill. While historically men were seen as “experts” in traditional medicine due to their longer generational line and exposure via other male healers, women became foundational in looking at the body in a different way. Child-bearing women are bound to use a healer or midwife with much more frequency than their male partners, thus the woman knows more about the process induced in pregnancy: the emotional, physical and spiritual parts. Women first-handedly experienced how to carry and deliver children, understanding better the feelings, emotions and illnesses that could occur and, in turn, how and what it took to help to alleviate pain. While men began to gradually move farther and farther from the house or the “body of the family” to do other trades of work, the women were exposed to the intimate, relational space of the nature of the body and how to cure it with what “Pachamama” provides.

While for decades, a woman’s role in traditional healing was omitted from history book and ethnographic analyses; Beatriz Loza argues that their importance was crucial in understanding a more complete nature of the body. Beatriz Loza hypothesizes that due to the heavy male absence throughout these twenty years women were able to become significant social actors in the traditional healing realms and would in later generations be able to own and operate shops that would focus on natural remedies and healings. They are able to experience not only through their own body, but also from their continued long hours teaching and taking care of their children. While today the population of healers might technically be male (by 60%), there is still a large population of women healers, surging from the twenty plus years in which they began to take the reigns in the field of traditional medicine.

In examining more specifically the role of women in indigenous traditional societies, it is essential to look at the role of both male and female in the “mirror theory,” or idea created by

Rostworowski in explaining Andean cosmology (1988). The “mirror theory” applies to the gender norms in a Bolivian Andean group, focusing on the necessity of a complementary nature to the man and woman. Within the mirror theory, gender relations are structured in so that both the man and the woman are able to adequately provide for a family and work with Pachamama in differing ways. For example, the male is the herder, traveling with animals while protecting and bringing in necessities from farther away, while the woman takes care of the house, the surrounding agriculture and the children. The mirror theory works to create this ideal couple in order that they may procreate and guarantee the viable continuance of their family and community. By complementing each other, they are able to take part in a unique form of reciprocal exchange (Rostworowski 1988). By examining the complementary nature of gender roles, it can be inferred that gendered roles would be evident in traditional healing beliefs.

The strong-ordered gender roles have many different historic and societal contexts that they follow. In her research, Beatriz Loza argues that women healers were more common in Inca times alongside men than what has been noted. However, with the arrival of the Spanish conquistadors came a dramatic change in how gender roles were defined and augmented in society. Instead of women being looked at as healers or even having the ability to heal, the Spanish believed that it was only a male’s place to examine and treat the human body (Álvarez Quispe et al 2007). The Spanish began to think of women healers as “brujas,” or witches, borrowing from the strong superstitious European history and relation with the idea (de Varennes 2012). Instead of helping the community, the title of witches made women be seen as diabolical and undermining Christianity. Thus, they were not allowed to practice traditional healing openly. With this spark of women healers being named “brujas” starting as early as Spanish settlement, the idea is still in place in today’s Bolivian society, notably occurring in La Paz where the main

traditional healing market off of “El Prado” (or the main street in the heart of the city) is named “El Mercado de las Brujas,” or “The Witches’ Market.” Moreover, the notion of witchcraft also demonstrates how indigenous healing has had a rougher experience in becoming accepted and valued in society.

While the influence of Spanish vocabulary may still impact the name of the ‘Witches’ Market,’ in current Bolivia society there are more women becoming healers or owning small stores that sell natural medicine and remedies. Nicolasa Saravia explains in her interview to APCBL²⁵ that

“[As women] we understand and explain more, men do not understand, and for this reason they do other work. The mother teaches the child. If the man does not know, what will he teach? While the woman sells medicines, she is able to teach [...]”²⁶ (Álvarez Quispe, 2007).”

By signifying the important role of a woman to teach, she is turning the question as to why she is a healer on its head, implying she has any more reason to be a healer than an equal male opposite. Saravia alludes to an inherent quality in women that help them better understand and teach elements of traditional healing and treatment. Looking back upon important elements of Andean cosmology, a person’s role is to serve their family and community. Thus, traditional healers must also best serve their community.

3.3 Traditional Healing and/or Natural Medicine

Comparing and contrasting traditional healing and natural medicine is a more difficult concept to explain. Traditional healing has more inclusive elements, in the sense that it incorporates religion, tradition, culture, and language into its fold. It draws almost all of its physical plant elements from natural products that adhere to certain curative techniques, but it

²⁵ APCBL: Archivo Privado Carmen Beatriz Loza

²⁶ In Spanish, “Entendemos más y explicamos más, los hombres no entienden por esa razón tienen otro trabajo. La madre enseña a la hija. Si el hombre no sabe ¿qué

also attaches indigenous identity and beliefs to the natural product. Therefore, traditional healing usually pertains more to a certain ethnic population, primarily indigenous, that believe and practice the varying ideals within the healing process.

On the other hand, natural medicine when spoken of more broadly does not *have* to relate to traditional healing. It has more freedom to focus on techniques of biomedicine and natural products. Globalization definitely influences the linguistic use of “natural medicine” instead of “traditional healing” by the vast increase of communities all around the world expanding and valorizing the local and/or natural market. This occurs as well in the United States with the increasing commercialization of the benefits of natural foods, products and medicinal supplements. The popularization of natural medicine throughout the world has created a “craze,” in which the naturalness of a product is determined more pure and better for the body. This craze is also heavily taking place in the urban city commerce market of Bolivia, allowing for vendors to detach the indigenous identity beliefs that are with traditional healing and instead allow the products to be seen as only “natural” and furthermore a source of national, not indigenous, pride. Simply put, the distinctions between indigenous healing and natural medicine is used to separate indigenous cultural and community identity from using natural, homeopathic medicine.

3.4 Current Evidence of Interculturality

My historical context came from reading and examining various documents, articles, and books that better explain the terms of traditional healing practices (such as the different words for a traditional healer, like *curandero*, *yatiris*, and/or *kallawayaya*). For example, there was a book that I used in my research from the Fundación Flavio Machicado Viscarra (FFMV) library entitled, *Mitos, Supersticiones, y Supervivencias Populares de Bolivia* (Paredes 1936). This

book, from the 1930s, explained some of the popular Aymara traditions that surrounded many aspects of life, not only health. When I compared some of the traditions to more recent traditions, I realized that many of the traditions and views were still very similar. For example, the book discussed the necessity of protection via certain ornamental objects. This compares to my experience interviewing a market woman in Sagarnaga²⁷, where she kept repeating how important the ornamental objects sold were for protection, protection for everything. The two practices are still very similar, even though they are separated by over seventy years.

For this thesis, I conducted twelve interviews (six each) at pharmacies and vendors at the Mercado del Brujas (the Witches' Market in Sagarnaga). I also conducted thirty-five random surveys with pedestrians in Plaza Avaroa and the Prado. My survey, which is outlined in the appendix, asked both pharmacists and market women that sold traditional healing medicine a number of questions such as:

- (1) What type of medications did they sell most frequently?
- (2) Is it common for people to consult either the pharmacist or market vendors about illnesses before a doctor? If so, what were the common illnesses addressed?
- (3) In their opinion, what were the top 3 illnesses most common in La Paz?
- (4) In their opinion, how would they rate the doctors, pharmacists and market women?

Below in Table 5 I outline the results of this survey. Throughout the process, I found how cohesive many of the surveys were. For example, out of the six pharmacies surveyed, five indicated that the top three most common illnesses for La Paz were altitude sickness, stomach aches/illnesses, and cough/flu-like symptoms. The sixth pharmacy respondent indicated cough and flu to be two different illnesses, and did not list altitude sickness²⁸. Most survey respondents also stated that the constant use of natural medicine, such as vitamins and teas, were the best

²⁷ A popular market in La Paz, Bolivia where customers are able to find various souvenirs, traditional medicines, and healers available to help.

²⁸ One can assume that pharmacists ranked altitude sickness higher because it is more likely that tourists would see a pharmacist for altitude sickness than a yatis or market woman in Sopocachi.

remedies for many of the common illnesses. By expressing natural medicine, the interviewees where taking out indigenous cultural contexts, maybe due from their integration into a city life style, rather than indigenous community epistemology. A visual representation of pharmacies showed the importance of natural medicines. If you look at most pharmacies medical display shelves, many places have the vitamins and natural medicines in the center, with antibiotics and common Western modern medicine on the two sides. This was interesting because it seems to promote a central focus on natural remedies.

Table 5. Healer Survey Data from Pharmacists and Market Women²⁹.

Survey Respondents	Average Rank of Doctor*	Average Rank of Yatiris*	Average Rank of Pharmacist*	Flu/Cough as Most Common	Altitude Sickness as Most Common	Stomach Illnesses as Most Common
Pharmacists	3.83	2.33		33.33%	50%	16.67%
Market Women	3.66	--	4.33	16.67%	16.67%	66.67%

*Average Rank on scale of 1 to 5 (1 being the worst, 5 being the best); respondents were not allowed to rate themselves due to sample bias.

Most pharmacists explained that many customers trusted a pharmacist more than a doctor, which was very striking. When I proceeded to ask why, they explained that doctors had the same training without much specification in certain medical fields of study. Pharmacists, on the other hand, were more likely to know a little bit more about many different medicines because they have many more daily consultations in which they prescribe medicine (without a doctor’s prescription). For example, many pharmacies have started to offer consultations with pharmacists about common illnesses offering both natural and pharmaceutical medicine. In my case while in Bolivia, when I had a cough, we went to the pharmacy with a recommendation from a doctor, but once we got there, the pharmacist recommended another type of medicine for my illness. This is not to underestimate or under state the importance of a doctor. However, the pharmacists expressed how regular and frequent many of the top three illnesses were, concluding

²⁹ My sample surveys are located in the Appendix section of my thesis.

that many customers did not even feel obligated to go to a doctor. Typically, pharmacists ranked doctors higher than traditional healers (3.83 to 2.33), but they also ranked the continued use of natural medicines higher than antibiotics (Table 5). Through analysis, I conclude that there is a distinct enculturation in pharmaceutical practices in the city of La Paz, consisting of a strong advocacy for natural medicines.

While I was interviewing pharmacists, several of them expressed the belief that indigenous natural methods and medicines help many customers feel more comfortable with taking medications because it is more natural for the body. Over seventy percent of my random survey respondents told me that they take vitamins and other natural remedies because it showed how the body could heal through natural resources. Also, with over seventy percent of the respondents taking vitamins, only twenty-eight percent bought them from a yatisis or market woman. This indicates the possibility that pharmacies also have a rather large responsibility in selling natural medicine and remedies.

The results from the health users' survey respondents around the Prado and Plaza Avaroa were a little bit different. Most of the results were mixed, but that could have been due to a wide number of factors, such as: age, gender, geographical, and historical differences³⁰. Through the surveys, over seventy percent of the respondents admitted to using some form of natural medicine (such as vitamins, powders, and/or teas) to stay healthy and strong. While many survey respondents did not express very strong belief in traditional healers (with an average number of visits limited to 0.5 times in a year), they expressed belief in natural medical practices, such as vitamins, foods, and drinks (Table 6). When they were asked if they saw any type of traditional

³⁰ If the project permitted more time, I would have again looked at a wide variety of random survey samples, controlling for basic factors, so that information would have been more statistically significant.

healer, they hinted at a familial responsibility. For example, the people that saw a yatiris were concentrated in factors of age (usually older), and indigenous-identifying persons with a familial history of using a yatiris. Many answers were “yes, with my mother” or “yes, with my aunt”. This shows that traditional remedies have been self-identified and confined by the people that believe in the power of the practice, or that it is very much a cultural practice, more than a “healing” practice.

Table 6. Information from Survey Respondents (35) on the Prado and in Plaza Avaroa.

	Average Age	Visits to a Doctor a Year*	Visits to a Pharmacists a Year*	Visits to a Yatiris a Year*	Percentage of Vitamin Users	Percentage of Medicine Bought from a Yatiris/Market Woman
Survey Respondents	31.62	2.02	3.82	0.45	71.42%	28.57%

*Average number of visits a year.

Many survey respondents admitted to using natural medicines and remedies, but said that they did not use a traditional healer because it was just that: traditional. An interesting point to include here is the differences between natural and traditional remedies. While many traditional remedies are natural remedies, traditional remedies are self-identified by the consumer. For example, if one believes that a natural remedy of tea, powders, or vitamins has personal traditional significance, than it can be considered a traditional remedy. Throughout my surveys, I found a larger acceptance to natural medicines and remedies, without the traditional significance of a kallawaya or yatiris. Also, in my surveys, I found how many different social construction systems were present, by seeing the different names used for a traditional healer, such as “curandero,” “kallawaya,” or “yatiris”. When researching the differences between the distinct names of kallawaya, yatiris and curandero, there was little information about differing distinctions, but much information about similar traits. Many of these traits consist of the persons

being deeply in tune with nature and Aymara tradition. An interesting survey respondent was respondent #15 who stated: “We live in nature, and nature provides for us.” This was an explicit link between the body and nature, one that other survey respondents did not express.

For much of Bolivia, the economic market relies on its agriculture production. The explicit reliance on nature shows how most Bolivians are able to agree with and use natural medicine without necessarily having indigenous rituals or beliefs attached. When I interviewed market women in Sagarnaga, they told me how many people do not come for blessing and healing by a yatiris³¹ as much as they come to buy vitamins, teas, powders, and remedies. When I asked why, the women stated that more “traditional” persons and families would come for healing, hinting at a center amount of “regulars”, or persons that frequent a yatiris, while many people just believe in the importance of nature for one’s health.

When I surveyed people concerning the interculturalization of Bolivia’s public health system, I asked some respondents if they believed there to be a hierarchal difference between Western medicine and traditional healing. In this, some admitted to believing that Western medicine is more advanced than indigenous traditions of healing (Table 6). When comparing this to the average of respondents would visit a doctor (2.02) or pharmacist (3.82) more times a year than they would visit a traditional healer (0.45), I conclude that the “advancement” of Western medicine had a strong correlation to using a doctor or pharmacist over a traditional healer. Respondents were almost twice as likely to visit a pharmacist more than a doctor, and four times as likely to visit a doctor than a yatiris. However, while the education of a doctor or a pharmacist might have been more advanced, one respondent (Respondent #15) noted that indigenous

³¹ Meaning indigenous healer

methods of healing complement and “should work side by side with Western methods of medicine”.

Chapter 3 introduced the nature of traditional and natural medicine, gendered spaces and current evidence of interculturality. Specifically, this chapter supported my research question of “is the role of pluralizing medical practices a successful form of giving representation and inclusion?” by affirming how pluralizing medical practices is a mechanism to give indigenous rights by creating spaces where they are recognized in the public health field. By showing that many city dwellers were using traditional medicine, a small form of interculturalization exists, a form that borrows indigenous healing medicines and remedies, but takes out the ritualized aspect. This is important in showing the general acceptance to the curative techniques that traditional healing knowledge has. This is very important in moving to Chapter 4 where intercultural programs are discussed, programs that are to help include indigenous language, rituals and beliefs into the Western medical process.

CHAPTER FOUR: INTERCULTURATION IN PRACTICE

"Indigenous medicine doesn't exist just because these communities can't afford hospitals. Many of these remedies work, and Western medicine often borrows from indigenous tradition."— Eduardo Moreno³² (Murphy 2008)

4.1 Differences in Medical Practices

Differences in medical practices between Western and indigenous cultures primarily involve differences in rituals and the categorical social relations that relate to society. To further understand where the differences stem from, one must understand the origin of indigenous culture: the community. An individual is simply a part of the larger group; consequently when a member is ill, their part affects the entire community unit. Therefore, rituals to heal illnesses involve the entire family or community unit, valorizing the healer as an essential, authoritative unit that is able to realign the community once more. This chapter serves to answer my subordinate research question of: is the success of new health programs contingent upon the implementation and effectiveness of providing cultural competence and demonstrating cultural sensitivity in both training and educational projects?

This section is not designed to point out which system is right or wrong, but rather allow the reader to understand what thought processes might transpire while deciding which method to use. While neither disputing nor choosing a certain method, it has been shown through Bolivia's history that Western medicine has been productive and efficacious in relieving the severity of diseases. However, the efficacy of Western medicine does not mean that indigenous medicine should be discarded as it has in the past because history has also shown that given the choice to either choose Western medicine or traditional healing, an indigenous person is more inclined to choose traditional healing due to their strong generational line of living their cultural beliefs. While there are many different practices and beliefs between indigenous healing and Western

³² General practitioner in La Paz

medicine, differences in reproductive health beliefs are the most striking and affect more people. The importance placed upon reproductive health also stems from the government's tries to strategically better the nation's horrendous health indicators surrounding child and maternal mortality.

Imagine you are a pregnant indigenous women and the tradition surrounding childbirth that all of the women in your entire family have followed consists of you giving birth in your own home, an intimate and warm place. Your husband is to be the only one with you besides perhaps a midwife, and he is to clothe and feed you before giving birth and after he is to remove the placenta per your traditional cultural rituals. However, you are not allowed that same experience in the hospital. Instead, you are placed in a cold hospital room, dressed in a simple sheet, given some generic type of food, and many nurses and doctors come in and out of your room, looking at and examining you. You do not feel the intimateness of your own home. Your husband may or may not be allowed by your side. Your placenta is not disposed of in ritual fashion and is instead only handled by a nurse or doctor. Which experience would you choose to have? Understanding the safety and warmth that is provided in the home setting, indigenous women typically choose their own home instead of a hospital, which is seen as cold, both physically and communicatively.

Another difference that frequently occurs is the treatment of a puerperal period, or the period following childbirth in connection to returning to the woman's normal menstrual tract. For indigenous women, the treatment does not involve medicine, but rather treats through a series of rituals and uses of warm water (Gwatkin and Victora 2004). On the other hand, Western medicine practitioners primarily use antibiotics. For the rejection of medicinal antibiotic

treatments in this case, many indigenous women choose not to seek or accept Western medicine because the process goes against what they believe.

If the patient does not feel comfortable or respected in the hospital/clinic situation, he/she will be less likely to take the recommendations of a doctor or nurse. Their traditional beliefs are not a form of living that they were taught to perform at a certain age or even gradually develop stronger throughout the years. They have been enculturated by their healing beliefs, with years of rituals, engrossing their lives and their communities. Historically, the health care field did not accept the differences and incorporate their beliefs into Western medical practices. Instead, it was a choice: to either pick Western medicine or traditional healing. Through the lack of past understanding and mixture (or interculturalization) of the two ideas, poor health indicators have remained stagnant or even worsened. It becomes even more important and valid that interculturalization take place and become fully integrated into the health care field.

4.2 Interculturalized Programs

More recently, many international government and non-profit affiliate organizations have begun projects in conjunction with Bolivia's government, with the most notable partnerships being with USAID, a Canadian organization, and non-profits such as the Population Council. Throughout these partnerships, many projects have been developed and executed. However, since the projects are fairly recent, taking place within the last ten years, most research conducted about projects' long-term efficacy and sustainability only show short-term results with hypotheses as to what researchers expect to find in the future. In this section, I examine two programs, FRONTIERS and PASS as case studies that use international organization support in helping implement interculturality. First, FRONTIERS focused on maternal health, teaching

cultural sensitivity via diverse communication, use of Quechua or Aymara and workshops to teach both health care professional and indigenous healers. On the other hand, PASS focused on child nutrition and maternal health, supporting the government's plan of interculturality to help implement family planning and nutritional monitoring.

4.3 Resolving Differences in Communication

Most of the communication differences involve how to phrase certain questions or sentences and, if explaining reproductive health, how to involve the woman's husband in as much of the process as possible so that he will reaffirm the woman's decision. Of the two projects that I use as smaller case studies, both emphasize how health care professionals and students must be aware of their patients' cultural differences. The immersion of the Aymara or Quechua language into their vocabulary was integral in using both verbal and nonverbal communication to understand how their culture is expressed through their language. Nonverbal transmission refers to the socio-emotional and experiential content that a word or phrase may mean to a specific community or culture. FRONTIERS focused more on verbal communication, while PASS focused more on program structure.

4.4 Case Study 1: FRONTIERS

In 2003, the Ministry of Health and Sports created their Integral Health Project, or PROSIN³³, that works to adapt health services to the patients' culture, most notably indigenous culture. The Ministry of Health and Sports asked the Population Council for specific assistance in researching how and through what means their Integral Health Project could be carried out, thus creating the FRONTIERS project. PROSIN, the Bolivian government's project, was

³³ In Spanish: Proyecto de Salud Integral

enveloped into FRONTIERS, the internationally funded project. The FRONTIERS project specifically focused on women's access and use of health services, with a special look at reproductive services and if health services were becoming culturally appropriate. While this program started before Evo Morales took office in 2005, Morales has significantly expanded the project to more areas and encompassed more initiatives. This particular project was designed and mostly carried out by international forces, therefore allowing the government to take a more hands-off approach to charging its potential of providing equity. However, the Population Council required that the Ministry of Health and Sports provide on-site coordinators that would perform instructional seminars to help health care providers (Ministerio de Salud y Deportes 2006).

FRONTIERS defines cultural appropriateness or sensitivity as a four-fold method: (1) to provide interpersonal and intercultural communication in “enhancing their understanding and acceptance of the ‘other’ culture” by promoting the use of certain Quechua vocabulary, (2) to advance a monitoring mechanism, allowing health care professionals to examine their efficacy in the first goal of providing cultural acceptance and understanding, (3) to acknowledge and foster a more sensitive environment that screens for desired services that may be challenging to communicate between patient and doctor, and (4) to create partnerships with the community via advisory committees in order that the health care professionals cultivate better interactions between the two groups (Ministerio de Salud y Deportes 2009). This program was not designed to build up the physical and economic infrastructure of health care, but rather introduce different areas into ways that the two health practices are able to be interculturated.

The training materials of FRONTIERS included specific educational items that taught Andean beliefs, reproductive health, the Quechua or Aymara³⁴ language and how to use specific words and/or phrases in order to elicit certain responses. In order to achieve its goals, the FRONTIERS project created five different types of workshops, designed to adequately explain cultural differences and how to demonstrate cultural sensitivity. The first category pinpointed how the idea of community was interrelated to Andean health and sickness concepts. Secondly, coordinators tied in “ethno-anatomy” or how the body directly relates to nature. The notion of “ethno-physiology” was introduced or how specific gender connects to nature and the relevance of reproductive health. In understanding the above concepts, coordinators began to introduce basic traditional rituals that surround ideas of health and how to interculturate these rituals into Western medicine. One of the most predominant examples was the use of the birthing blanket given to the indigenous women to help her feel more safe and warm throughout the process. The last of the workshop information tied the four above themes together by expressing the necessity of a relationship between the doctor and the traditional healer.

While many of FRONTIERS materials stressed to health care professionals how they could become more culturally sensitive, they also demonstrated ways in which they could more easily and efficiently introduce and implement their health care practices into the community, namely concerning reproductive health. First, to introduce varying forms of birth control such as condoms and oral pills, the program started focus groups consisting only of women. Through these groups, the Ministry of Health coordinators handed out pamphlets in Quechua and Aymara that described different forms of sexually transmitted diseases. However, the pamphlets

³⁴ It is important to note that since the latest research the FRONTIERS program material has only been produced in Quechua and Aymara and not in smaller indigenous languages because it has not branched out to reach all of the country’s indigenous population due to financial restrictions.

purposefully did not discuss unwanted pregnancies, as the concept does not exist in the Andean community sphere³⁵. Also, if the focus groups seemed to be interested and receptive to the material, the coordinators would then choose to venture more into discussing other diseases that affect communities. The reason being that they first chose to discuss reproductive health is that it was the project's main focus, with more general health information filling the gaps. The FRONTIERS researchers took data from before the focus groups and after, examining the women's knowledge surrounding the information discussed. They found that statistically forty percent of women became more receptive to ideas of birth control, but less than half were actually secretly using forms of birth control (Salguero et al, 20). While this program seemed effective with the women chosen, it was not the quickest form in teaching all community women. Thus, FRONTIERS changed its plan to recruit more people into harnessing the Western medical information that the Population Council and Ministry of Health wanted to stress.

An important element to the FRONTIERS research plan included interviews and informational sessions with traditional healers. The purpose of the interactions with the healers was not to tell them how to implement Western medicine, but rather to emulate a symbiotic relationship. Throughout the process, the interviews served as opportunities for the coordinators to learn about specific community feelings relating to Western medicine. A recurring theme was how Western-trained doctors “cannot cure when the soul is scared [because] there are no medicines for those illnesses, [instead] they care for illnesses of the body” (Salguero et al, 20). From the study, the program realized how beneficial the ideas of the healers were in helping realize the importance of the sickness-taking place in the soul of the person, and furthermore

³⁵ The reason for this is that the concept of unwanted pregnancies is foreign to many Andean indigenous communities, being that the concept undermines the basic family structure of reproducing and creating a large, inclusive family and community.

how knowing this both parties can work together “by analyzing, these patients are for you and these are for me” (Salguero et al 25). Through this, FRONTIERS acknowledged the importance of cultural authorities, such as traditional healers, in the community and how channeling information through well-respected authority figures was more likely to reach more patients of the community. Intervening by the use of traditional healers has become the most effective-to-date process for FRONTIERS, significantly increasing the levels of prenatal and post-partum check-ups, knowledge surrounding birth control and general disease-control medicine.

One of the most successful elements to the program has been the inclusion of health care professionals in homebirths. This is an example of intercultural adaptation, in which health care professionals have taken into account the rituals that surround the birthing process and take part of the ritual as an active participant. They have followed the cultural rules that have been emplaced, such as the proper way to feed and dress the woman, the woman’s partner’s involvement, and the process of removing the placenta. This example fulfills most of the considerations brought about by the four goals of the FRONTIERS program, combining respect, communication and acceptance to rituals surround indigenous health.

To test the use of cultural appropriateness, researchers Fernando Gonzales Salguero, Maria Antonieta Martín, Rosario Pérez Mendoza and Ricardo Vernon were hired by the Population Council to conduct patient and provider “exit interviews.” These interviews were designed to help determine whether the three different types of communication (medical, socio-emotional and non-verbal) were expressed in a manner that improved health care practices. In all, the researchers found that the above four goals were being used and were successful in helping increase communication, including medical, socio-emotional and non-verbal communication. To briefly explain, medical communication is that which is used to encourage a

patient to ask questions, responding in simple terms that are understandable and personal while informative of a treatment regimen. Socio-emotional communication refers to creating a space where health care providers express positive reinforcement and take the time to prove to the patient that they are interested and care so that the patient feels respected and understood. Lastly, non-verbal communication includes kind gestures, looking into the patient's eyes, and his/her tone of voice. However, the researchers expressed hesitation in the ability for the communicative steps lasting after international organizations' help expired.

In conclusion, while the FRONTIERS program has only been initiated in a few regions for a relatively short period of time, it has proven to be successful by researchers Gonzales Salguero et al (2005). However, the Population Council has determined that for the program to be successful in more of Bolivia, the government will have to pour more time, money, and workforce into the program. The interventions with women focus groups and discussions with healers proved to be the most effective way in increasing the quality of care and changing processes of knowledge to include Western medicine. However, a main impediment that both groups interviewed indicated related to the lack of health care facilities, access to pharmacies carrying medications, and the cost of services, problems referring to a lack of infrastructure. All of these obstacles were not heavily judged in the formation of FRONTIERS and I hypothesize that even while FRONTIERS has the potential of being widely successful, economic and geographic barriers will continually remain in the way.

4.5 Case Study 2: PASS

The second program that I focused on was PASS, or Bolivian Health Support Program³⁶. The main reasons for creating PASS stem from 57% of the Bolivian population from years 6 to 59 not having access to health care services and while 87% have access, they are excluded from the upper-levels of care (UDAPE and UNICEF 2006). Also, the health system, as proven throughout, is segmented and fragmented, mainly due to insufficient financial resources and inadequate training exercises for health care professionals. PASS joined both UNICEF,³⁷ the Canadian government, and different entities of the Bolivian government in a five-year program that sought to improve maternal and child health by “strengthening (the) public health sector management capacities at the central department and local levels” (Coupal 2009). Moreover, PASS was designed to bring “greater interaction and exchange” between all acting parts of the community interface (Coupal 2011). In its conception, UNICEF, through its program PRICCAS, gave over ten million dollars to help strengthen local networks and services (Coupal 2011). The Ministry of Health, SEDES and FLASS combined gave around seven million dollars. Due to financial restraints, from the beginning, the coordinators decided to only focus on the three poorest and least health care developed departments: Oruro, Beni, and Pando. For research purposes, this does not have much significance as the majority populations in these three departments are still indigenous and identify Quechua or Aymara.

UNICEF’s involvement has been crucial since it was one of the first international organizations, along with the Canadian International Development Agency, to support the Bolivian Ministry of Health’s adaptation to the intercultural model set afield by President Evo

³⁶ In Spanish: “Programa de Apoyo al Sector Salud (PASS)”

³⁷ United Nation’s Children Fund

Morales. As stated earlier, Bolivia has the worst indicators in both areas for the Western hemisphere, falling only behind Haiti, which has the worst indicators. Thus, UNICEF helped create and implement PASS in order for Bolivia to improve in both of these fields. Furthermore, in Latin America, UNICEF has individually created PRICCAS³⁸, or the Project to Improve Coverage and Quality of Health Care, for Latin American countries and has used this program in specific contexts to help set a standard and orientation for governments to use after UNICEF leaves.

PASS focused on 4 of the Millennium Development Goals (MDG) of the United Nations: eradicate extreme poverty (MDG 1), reduce child mortality (MDG 4), improve maternal health (MDG 5), and combat HIV/AIDS, malaria and other diseases (MDG 6) (UDAPE and UNICEF 2006). To do this, PASS has four main goals expressed from its start in 2006 including (1) integrating fixed and mobile health services to regularly deliver to marginalized towns and communities, (2) support the government's plan of cultural diversity and gender equity, (3) help indigenous communities realize their "right to participate" in health forums and (4) improving human resources to better combat maternal and child care as well as implement child nutrition and immunization programs (Bâcle and Pooley 2012). The main part that supports my research is the second goal, supporting the government's plan of cultural sensitivity and interculturalization.

Specifically, PASS focused on more than maternal health and used workshops and focus groups to look at what indigenous communities viewed as the most pressing problems relating to child nutrition. Through this, PASS researchers focused on the Andean diet and creating a balanced meal that used more vegetables, milk, and meat for children. While this focus was more expensive, the Canadian government as well as the Bolivian Ministry of Health helped support

³⁸ In Spanish: "Proyecto de Incremento de Coberturas y de Calidad en Atención en Salud (PRICCAS)"

the program by creating a National Fund for Production and Social Investment (Bâcle and Pooley 2012). In 2011, the Canadian Government concluded that 65.3% more children from ages six months to six years were using nutritional supplements that helped communities avoid child malnutrition. Also, Bolivian health care professionals were able to teach family planning and nutritional monitoring, surrounding ideas of learning a woman's menstrual cycle and her fertility peaks as well as adequate feeding plans for children (Bâcle and Pooley 2012).

The program began in 2006 and lasted until 2011, producing mid-term and final evaluations, both of which had relatively the same results. The program was introduced to evaluate and capture the relevance, sustainability, efficiency, risks and equity involved with interculturated medical practices at a more pragmatic, local level. Specifically, PASS is different from FRONTIERS due to a few different factors: (1) PASS relied more heavily upon the Bolivian government's support, both financially and for human resources, and (2) individual communities where PASS was implemented were charged with deciding where and how they needed help.

However, especially in the case of Bolivia, international health critics, expressing the concern that the Bolivian government may be unable to properly and adequately continue the PASS program after UNICEF and coordinators leave, have criticized the heavy influence of UNICEF. The last research published and accessible for PASS was done in November of 2011, consequently I do not know if the concerns have become more prevalent.

The presence of Bolivian government entities stresses the importance of multiple components of the government, such as the involvement of the Ministry of Health, Departmental

Health Secretariats (or SEDES³⁹), and the Local Funds for Health Sector Support (FLASS⁴⁰). By this involvement, PASS is able to more successfully bring in all components of the plurinational Bolivian state or the autonomous government, departments (such as the state structure of the US) and municipalities to become active participants in the program. By creating a more active participation by local communities, PASS has been able to implement the Social and Productive Investment Fund, working like grant processes where communities can apply for aid in certain areas that they as a community self-identity as being more pressing. Through this, communities are able to identify their resource necessities so that money used is more efficient. With this idea, PASS is systematically relating the importance of the Andean cosmological community back to health care, furthermore involving underrepresented communities into taking claims and pride in government work. This element has proven PASS to be more effective in finding a level of interculturality that works for individual communities, by giving government resources to individual needs, and listening to community concerns. For example, the communities of Beni focused more on maternal health and clinic deliveries, due to Beni's higher risks and greater percentage of maternal mortality (Coupal 2009). In contrast, Oruro focused more on training health care professionals how to properly interculturate in-home birthing practices, allowing for both a clinical nurse and traditional healer to be present in the process. The department of Pando held more workshops on sexual and reproductive health practices, focusing on the younger generations in schools. In conclusion, the Social and Productive Investment Fund helped organized communities to actively participate in the execution of their health care rights (UDAPE and UNICEF 2011).

³⁹ In Spanish: "Servicio Departamental de Salud SEDES"

⁴⁰ In Spanish: "Fondos Locales de Apoyo al Sector Salud (FLASS)"

The main way in which PASS determined the validity of its program was through a tri-level sustainability marker (low, moderate and high) that looks at future potential. The low sustainability potential was more seen throughout all three departments, helping bring mobile brigades, higher percentage of women using clinics for the birthing process, training municipal health care leaders around indigenous beliefs, and teaching of sexual and reproductive health. The higher sustainability levels included joining municipal and community government officials in helping to set the standards for the region (moderate sustainability) and formulating national plans to continue intercultural health care programs after the international organizations leave (high sustainability level). In all, PASS researchers concluded that the program would see much more low level sustainability projects followed through with, since the higher levels required more government input and stable infrastructure. The lower level projects were already implemented with UNICEF and could better be continued through municipal powers.

Both programs told professionals to be aware of traditional rituals that must be taken into consideration by asking the patient if the recommended treatment follows the boundaries of their values and rituals. Furthermore, the doctor and/or nurse should ask whether the patient would like the treatment plan relayed and further advised by their community healer. However, this element has proven problematic, as many of the health care professionals have not the resources of time, money, language preparation, or manpower to adequately follow through with this suggestion. More generally relating to reproductive health, suggestions have been to be sure to ask the women if she wants her partner involved and to what extent she wants her partner to be aware of the information being shared to her and also to be discreet and cautious when talking about the couple's sexual life by not explicitly use words or phrases such as "sex" or "intercourse" but rather "sleeping together" or "being together". Specific instances relating to

reproductive health include taking special precautions to not refer to a woman's partner as her *compañero*, literally meaning partner in Spanish, which can have a pejorative and discriminatory double meaning for many indigenous women instead directly referring to her partner's penis. In order to reduce this, the practitioner must ask the name of her partner or use Aymara or Quechua vocabulary to avoid the misunderstood use of *compañero* to mean penis. By understanding these verbal communicative differences, health care professionals are able to better convey their message in a clear, respectable way.

In all, both case studies FRONTIERS and PASS were effective in implementing new ways for community health care to function. PASS took a more participatory approach, involving the community both through financial resources and examining the individual necessities needed across regional and ethnic lines. In contrast, FRONTIERS looked at how to better teach health care professionals about indigenous beliefs and rituals necessary to help link the two medicines. After international funding and coordination leaves the country, researchers such as Coupal and Gonzales Salguero are concerned that the Bolivian government is not equipped or invested enough in each of these projects to continue the individual successes. Their concern relies heavily upon financial restrictions of the Bolivian state. Both programs held the same basic purpose: to help improve Bolivia's health care system and implement manageable elements of interculturality. While both have made strides in the area, it is now up to the Bolivian government to continue the programs.

In all, Chapter 4 concludes my thesis by continuing to answer my overarching research questions affirmatively. Yes, pluralizing medical practices does successfully give more representation and inclusion to indigenous rights in Bolivia, and yes, interculturalism is taking place. Also, it answered my subordinate question, or "is the success of new health programs

contingent upon the implementation and effectiveness of providing cultural competence and demonstrating cultural sensitivity in both training and education?” By looking at PASS and FRONTIERS, the government is creating programs with international help that look at either maternal health or child nutrition, or both, and seeing how creating and demonstrating a culturally sensitive model will help alleviate child and maternal mortality, communicative diseases and child malnutrition. By focusing on enhancing communication, the success of health programs is dependent upon creating a sustainable, culturally sensitive health care system.

CONCLUSION

The examination that I have completed throughout my thesis has been a guide to the current, accessible state of interculturalism in Bolivian medical practices. Interculturalism is a rather recent phenomenon in Bolivia, especially in the public health care arena, thus creating it to be more difficult to provide a comprehensive report. In all, my research showed how interculturalism functions in Bolivia, providing an area in which professionals are trained about indigenous rituals, language use and health care practices. I envisioned my thesis research to show as an example as to how interculturalism is working in Bolivia and how it gives representation to indigenous Bolivians. I conclude by positively answering my research question, arguing that by implementing an intercultural public health space, the Bolivian government does give representation to indigenous and works to better include them into the Bolivian public sphere.

Bolivian public health care programs and insurance plans are crucial in including indigenous rights, with plans for indigenous inclusion to be continued to other elements of the Bolivian society. Further, by medically enculturating both the health care providers and community, public health is able to become a social sphere of dualistic identity and is able to represent, respect and give power to both techniques. The use of traditional medicine in urban settings was demonstrated to show the important element of natural medicine that was already present in Bolivian society. However, this model was not extensive enough, as it did not recognize the rituals and beliefs that are included in traditional healing. Thus, the programs of PASS and FRONTIERS contributed new elements to the public health care debate, sparking conversations concerning cultural sensitivity in communication and practices.

By completing informal interviews and surveys, discussed in Chapter 3, with pharmacists, market women, and average La Paz resident, I was able to see first hand how interculturality already exists via the major use and acceptance of natural medicine all across the board. In promoting natural medicine in the three sectors (pharmacists, market women and average citizens), one can see that the idea of interculturality was nothing new. However, this system only borrowed the “natural medicine” aspect of traditional healing and clearly left out the traditional Andean customs and rituals. Through my surveys and interviews, I was able to more clearly define how natural medicine was already important to the Bolivian society, but the acceptance and use of indigenous medicine was the aspect that needed more attention, via programs such as FRONTIERS and PASS.

Why did I research interculturality in Bolivian public health and why do I still find it important? By finding that the Bolivian government is making strides in providing interculturality in public health, it demonstrates the government’s promising future of representing the vulnerable group of indigenous Bolivians. The Bolivian indigenous experience being a vulnerable group in health measures by having the highest levels of mortality or disease penetration to their community. One of the most important aspects of interculturality in the two health care philosophies surrounded the role of women. Maternal health was a cornerstone in the creation of interculturality. To help prevent the high maternal and child mortality, the Bolivian government has adopted ways to treat women and children in an interculturated matter, whether it is through previous insurance policies or programs such as PASS and FRONTIERS.

By changing national processes to adhere to indigenous women’s wishes in areas such as the birthing process, the Bolivian government is successfully reducing child and maternal mortality while legitimizing indigenous women as social actors that are important to determining

what constitutes public health in Bolivia. Throughout a good portion of my thesis, I discuss barriers to health care, whether it is the urban-rural divide, gender, lingual, social, or cultural. Intercultural programs such as FRONTIERS and PASS, outlined in Chapter 4, work to eliminate barriers as much as possible. While multiple barriers exist, interculturality is slowly removing barriers via training exercises, cultural sensitivity and expanding the production of knowledge available. All were designed to teach women about reproductive health, while also including their traditional rituals into public health practices. By including women actively into the interculturalization process, the government was valorizing women as community leaders and cornerstones of community reproduction, both physically and culturally. At first I found this more surprising due to the higher mortality rates and the lack of bilingual indigenous women. However, when researching, I found that women traditionally play the pivotal role in Andean society. Thus, interculturalization in essence acted as a way for women to become represented and also to represent their own community or family structure. I am still passionate about this topic because it has shown me how the Bolivian government cares about its people and wants to better include more vulnerable groups into becoming full social actors.

Weaknesses

My more major weaknesses of researching interculturalization in Bolivia's public health were based on the actual research itself and were two-fold: (1) there was a definite lack of previous research conducted and (2) the question of validity of the research. On the lack of research, I had a tough time finding internationally published research surrounding the subject of public health interculturality in Bolivia. This could be a consequence of the concept of interculturality becoming introduced and adopted within the past 10 years and also the lack of research of this concept on the field of Bolivia. The main problem was with research validity, or

examining and synthesizing census or other socio-demographic data given by the Bolivian state. Many researchers have discredited the validity of the process of how Bolivia collects their information, citing that most Bolivian citizens feel pressured to recite more politically acceptable answers to Bolivian official surveyors. The validity of an entire census may be called into question. While I discussed this throughout my thesis when using census data, there are not many controls that I can or could have done to watch for this. Also, the most recent census data for 2011 is not fully available. In conclusion, most of the weaknesses presented throughout this research come from uncontrollable variables that may only be fixed by completing on-site data throughout rural and urban Bolivia. However, while this problem usually took place when I was analyzing census data, I also conducted my own data by surveying three different groups, pharmacists, average paceños and market women. Throughout my collection, I offered the surveyed to either fill out or answer the questions aloud, whichever way they preferred. I do not feel that I added any pressure as the questions were open-ended and had no clear, desired result.

While financial and institutional barriers exist in the way of research and implementing medical intercultural, the basis of pluralizing the medical sphere gives more representation to Bolivia's large indigenous population. Consequently, another weakness that I ran into many times in my research was determining how to examine different indigenous cultures and rituals, but address it as a more static identity unit. Through explaining the FRONTIERS and PASS programs in Chapter 4, I was able to better show how indigenous tradition differs from region to region and how the programs adapted to this diversity. In all, both programs acted as mechanisms to create "cultural sensitivity" a concept that is fundamental to building an intercultural public health environment. I tried to be very transparent throughout my introduction to express indigenous diversity.

Future Research

This thesis was to serve as an introduction into what is occurring in Bolivia, while hoping to spark both interest and future curiosity in the region. I believe that I have accomplished this personal goal because I am still very interested in its development throughout Bolivia. If time and resources permitted, I would focus on more than two case study programs, researching different ways in which the Bolivian Ministry of Health organism could improve. I would like to travel back to Bolivia and conduct more interviews with health professionals, Ministry of Health officials, and rural traditional healers that have used either FRONTIERS or PASS programs in the past. I am very interested to see the development of new programs and continuance of existing programs, quantitatively examining a cost-benefit scenario and the efficiency of differing programs' aspects. Another aspect that I would like to watch in the future is seeing if the Bolivian model of interculturality spreads to neighboring Latin American countries. It would be interesting to see if countries adopt a similar model and how they use concepts such as interculturality in their own indigenous or vulnerable communities.

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APPENDIX

- Note on Translation
 - The author, Kendra Wright, completed all of the translations in the research. In specific, her translations consist of Spanish reports, census data, and articles being translated into English.
- Survey Questionnaires

For Market Women in Sagarnaga

1. ¿Qué tipos de medicamentos se venden con mas frecuencia?
2. ¿Es común que personas les consulten sin primero ir a un doctor por alguna enfermedad?
¿Qué tipos de enfermedades son las mas frecuentes en que son consultados?
3. En su opinión, ¿cuales son las tres enfermedades mas comunes en La Paz? (¿Y lo mejor remedio?)
4. En su opinión, y usando un escala de 5 para mejor y 0 peor, ¿qué opina Ud. de los doctores en Bolivia?

5	
4	
3	
2	
1	
0	

5. En su opinión, y usando un escala de 5 para mejor y 0 peor, ¿qué opina Ud. de los farmacistas en Bolivia?

5	
4	
3	
2	
1	
0	

For Pharmacists

1. ¿Qué tipos de medicamentos se venden con mas frecuencia? Por ejemplo: antibióticos, vitaminas, otros.
2. ¿Es común que personas les consulten sin primero ir a un doctor por alguna enfermedad?
 - a. Sí

i. ¿Qué tipos de enfermedades son las mas frecuentes en que son consultados?

b. No

3. En su opinión, ¿cuales son las tres enfermedades mas comunes en La Paz? (¿Y lo mejor remedio?)
4. En su opinión, y usando un escala de 5 para mejor y 0 peor, ¿qué opina Ud. de los doctores en Bolivia?

5	
4	
3	
2	
1	
0	

5. En su opinión, y usando un escala de 5 para mejor y 0 peor, ¿qué opina Ud. de los yatiris o curanderos tradicionales en Bolivia?

5	
4	
3	
2	
1	
0	

For Random Survey Respondents

1. ¿Cuántos años tiene?
2. Genero
 - a. La Mujer
 - b. El Hombre
3. ¿Cuántas veces el año pasado busco tratamiento para una enfermedad?
4. ¿Tiene un doctor o algún medico en La Paz en particular que busca para consultar cuando Ud. o algún miembro de su familia esta enfermo?
 - a. Sí
 - b. No
5. El año pasado, ¿ha consultado con algún doctor?
 - a. Sí
 - b. No
6. El año pasado, ¿ha consultado con algún farmacista?
 - a. Sí
 - b. No
7. El año pasado, ¿ha consultado con algún yatiri, curandero, u otro medico tradicional?
 - a. Sí
 - b. No
8. ¿Usa vitaminas naturales o remedios naturales? ¿Con que frecuencia?

- a. Sí
 - i. ¿Con que frecuencia? _____
 - ii. ¿De donde los consigue: una farmacia, una tienda de medicamentos naturales, una yatiri, etc.?
 - b. No
9. ¿Alguna vez ha comprado algún medicamento de un yatiri, curandero, u otro medico tradicional?
- a. Sí
 - b. No
 - c. Comentas

¿Hay mas tiempo? Yo tengo unas preguntas mas. ¿Está bien?

- 10. Si tuviese una tos o dolor de garganta, pero no pareciera grave, ¿a quien consultaría primero y/o que tipos de medicamentos usaría?
- 11. Si tuviese un dolor de la espalda, pero no pareciera grave, ¿a quien consultaría primero y/o que tipos de medicamentos usaría?
- 12. Si tuviese un dolor en las manos, pero no pareciera grave, ¿a quien consultaría primero y/o que tipos de medicamentos usaría?
- 13. Si tuviese un dolor de estomago, pero no pareciera grave, ¿a quien consultaría primero y/o que tipos de medicamentos usaría?