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The Impact of Intercultural Healthcare on Indigenous Maternal Health and Access to Care in Ecuador

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THE IMPACT OF INTERCULTURAL HEALTHCARE ON INDIGENOUS MATERNAL HEALTH AND ACCESS TO CARE IN ECUADOR

By

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ABSTRACT

LEA M. DUDTE: The Impact of Intercultural Healthcare on Indigenous Maternal Health and Access to Care in Ecuador (Under the direction of Dr. Kate Centellas)

Article 32 of the 2008 Ecuadorian Constitution states that all citizens have the right to intercultural healthcare, which combines traditional and western medical practices. This thesis investigates the implementation of this policy and analyzes its impacts on Indigenous maternal health. I focus on Indigenous maternal health because there is a disproportionately high maternal mortality rate among this ethnic group. Moreover, medical racism and distrust of biomedical practices in public hospitals often deters Indigenous women from attending these facilities. This policy is highly tailored towards the needs of Indigenous mothers. In order to analyze the impacts of this policy on Indigenous maternal health I conduct quantitative analysis on the maternal mortality ratio and number of births attended by skilled birth attendants in Ecuador since the implementation of the intercultural health care policy. I accessed this information from the World Data Bank. I also conducted qualitative analysis using case studies on intercultural healthcare facilities such as Hospital San Luis de Otavalo and the Jambi Huasi clinic in order to understand how the intercultural healthcare policy functions on the ground. Through my research I found that intercultural healthcare has had little impact on overall Indigenous maternal health due to lack of standardization. On the small scale level, the policy is benefitting Indigenous women in clinics with developed intercultural healthcare programs; however, this can be difficult to recognize because the program has provided more qualitative rather than quantitative impacts. Moreover, I concluded that the extreme lack of data about intercultural healthcare is an indicator that the intercultural healthcare program is not a priority of the Ecuadorian government. I assert that in order for this program to have a national impact, better data collection and more standardization is necessary. However, I also argue that the program is a worthwhile investment at any level because it provides more respectful and dignified care for Indigenous mothers.

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Introduction

Historically, there have been large disparities in health outcomes among ethnic groups in Ecuador, which has caused concern for policy makers. Article 32 of the 2008 Ecuadorian Constitution attempts to address these disparities by stating that all citizens have the right to intercultural healthcare, which combines traditional and western forms of medicine in a hospital setting. The right to intercultural care was implemented in light of health outcome inequalities that accompany the differing views on medicine and the presence of discrimination in western medical facilities. Because of the history of conquest and colonization in Ecuador, there is a great deal of racism and discrimination in the country, which impacts the access to healthcare and health outcomes of ethnic minorities. Additionally, there are many varying beliefs regarding medicine among the different nationalities and ethnic groups that reside in Ecuador. For example, many Indigenous people consider birth to be a very sacred practice and prefer to give birth in a comfortable setting where they can deliver their baby in a sitting or squatting position rather than lying on their backs. This type of treatment is not always an option in western hospitals; therefore, some people are hesitant to access healthcare in these facilities. The intercultural healthcare policy was created to offer options for people who want to receive a different kind of care in a public hospital. The policy also focuses on racial and cultural sensitivity in order to

reduce discrimination in hospital settings and provide higher quality care for people regardless of race, ethnicity, or nationality.

The purpose of this thesis is to analyze the impact of intercultural health care on maternal access to care and maternal health outcomes. I chose to focus specifically on the impact on maternal health because throughout history, Ecuador has had a high maternal mortality ratio. According to the CIA World Factbook, Ecuador's maternal mortality rate is currently 59 deaths per 100,000 live births, which means that Ecuador has the 90th highest maternal mortality rate out of 184 countries ("Ecuador"). I also chose to focus on the impact on Indigenous women because there has been a disproportionately high maternal mortality ratio among this group. Moreover, because birth is such a sacred practice in many Indigenous cultures, some Indigenous women have been hesitant to attend western medical facilities that do not provide culturally sensitive care. Therefore, I attempt to answer the following research question: "Does the implementation of intercultural birthing practices in public hospitals increase Indigenous maternal health and access to care in Ecuador?" I answer this question using quantitative analysis of the maternal mortality ratio and number of births attended by skilled birth attendants in Ecuador, which I obtained from the World Data Bank. I also conduct qualitative analysis of case studies on intercultural healthcare facilities to demonstrate the true impacts of this policy on Indigenous mothers.

This is an important topic to investigate for several reasons. Due to Ecuador's history of systemic racism, ethnic minorities face a great deal of disrimination in their daily lives. This not only affects access to care but also the treatment that people receive in healthcare facilities. This limited and poor treatment can impact health outcomes across generations because health problems that are not addressed due to medical racism persist and are then passed on to younger

generations. This also increases the likelihood of chronic disease, which can be expensive and it can prevent people from opportunities in work and school. This contributes to the poverty cycle because chronic health issues are expensive but they also decrease the opportunities that people have to make money; therefore, it is a positive feedback loop.

Ecuador has attempted to address the monetary aspect of disparities in maternal health outcomes by providing free maternal care for mothers and infants in public hospitals through the Ley de Maternidad Gratuita y Atención a la infancia (LMGYAI) and the Política Nacional de Salud y Derechos Sexuales y Reproductivos (PSDSR) which were implemented in 1998 and 2005 respectively. However, these laws did not actively address the discrimiantion that often occurs in medical facilities which deters patients from attending despite access to free care. Therefore, it is encouraging that Ecuador has implemented an intercultural approach to healthcare nationwide because this demonstrates the commitment to creating more equity in the healthcare system.

However, it is also crucial that policy makers monitor the effects that this policy is having on the ground. Although the right to intercultural care is listed in the 2008 Constitution, this does not guarantee that women actually receive intercultural care on the ground. Moreover, it is important to ensure that the inclusion of traditional healthcare practices in public hospitals is actually benefiting maternal health. Without this analysis, it can be really easy to put a policy into place without actually ensuring that it is having any impact on citizens. This can cause complacency and it leads to the creation of performative policies in the future. Therefore, this research is important because it holds policy-makers accountable and it highlights areas of improvement.

Findings

This thesis argues that while intercultural healthcare is a key factor that can improve Indigenous maternal health outcomes in Ecuador, the lack of standardization in the implementation of the intercultural healthcare policy has limited the impact of intercultural care on a national level. By exploring different intercultural healthcare programs in Ecuador, and analyzing the demographics of the regions in which they are implemented, I found that regions with a large Indigenous population typically have more developed intercultural healthcare programs that have a greater impact on Indigenous maternal health. This is because the policy is actually implemented by a committee in each province of Ecuador rather than by a national organization. Therefore, communities with large Indigenous populations are typically more concerned about intercultural care and are more likely to form a strong committee that advocates for more developed intercultural healthcare policies. While this is helpful to the women that live in these areas, it means that Indigenous women who are the minority in a region likely don't have the support or the infrastructure to create developed intercultural healthcare systems for themselves, and they often go without. Moreover, there is an overall lack of documentation about the policy, which makes analysis and improvement of the program very difficult. This lack of information about intercultural care can also inhibit maternal access. It is difficult to find an intercultural hospital when there are only a few fully functioning facilities with little advertisement about their services. Therefore, I found that intercultural care is helpful on a very small scale in facilities that have actually implemented it; however, due to a lack of standardization and implementation, this policy has not had a profound impact on national Indigenous maternal health. This research is important because it can be easy to look at successful intercultural healthcare programs in specific regions and assume that the intercultural

healthcare policy is positively impacting Indigenous women on a nationwide scale. This assumption can lead to apathy in the struggle to reduce maternal mortality among Indigenous women. It is necessary to take a closer look at the intercultural healthcare policy in order to understand what is actually being accomplished by this policy and what can be improved.

Chapter Outlines

In Chapter One I focus on the ethnic makeup of the plurinational state of Ecuador and the way that this impacts health outcomes in a biomedical system. I first go into detail about the history of race and ethnicity in Ecuador and the implications on current-day race relations in Ecuador. I also demonstrate how racism and prejudice in biomedical settings negatively impacts maternal mortality ratio and maternal access to care. I further explain how this has resulted in the inequity of maternal mortality among different ethnic groups in Ecuador. I also discuss some of the attempts to provide higher quality maternal healthcare including two laws that were passed to address the financial factors that negatively impact maternal access to care. I use this chapter to demonstrate the reasons for lingering discrimination in modern-day Ecuador, and it shows why it is important to provide a healthcare policy that is concious

In Chapter Two, I outline the intercultural healthcare policy in Ecuador. First, I attempt to define intercultural healthcare despite the complicated discourse around the term, and I show how confusion about the term intercultural impacts mothers' access to care. I also discuss why this type of healthcare is important for minority populations in Ecuador, highlighting some of the key deterrents that keep people from giving birth in western medical facilitie including fear of discrimination, distrust of biomedical practices and differing cultural conceptions of birth. I go on to discuss some of the ways in which hospitals attempt to provide intercultural care including Kichwa lessons, cultural training, the implementation of traditional birth attendants in hospitals,

and the provision of culturally adequate births. This chapter helps me to demonstrate why intercultural health is necessary and some of the ways in which hospitals are attempting to provide it.

In Chapter Three, I present my quantitative data analysis of the maternal mortality ratio and number of births attended by skilled birth attendants in Ecuador since the implementation of the intercultural health care policy in Ecuador. I obtained this data from the World Data Bank. In this chapter, I demonstrate the lack of official data that is suitable for analysis and identify this as a symptom of the lack of investment and devotion to intercultural healthcare and a point of difficulty in its analysis. Moreover, I argue that in Ecuador and elsewhere, the overreliance on quantitative data obscures the true impact of a policy.

In Chapter Four, I present my qualitative data. In this section, I use secondary sources that have analyzed intercultural healthcare programs throughout Ecuador in an attempt to provide a better picture of the state of intercultural healthcare in Ecuador. I highlight some of the major shortcomings of the intercultural healthcare program including lack of standarrdization, persisting discrimination, lack of cultural understanding and improper training and implementation of care. I end the chapter by discussing the benefits of well-developed intercultural healthcare programs. This chapter is important because it shows that while the intercultural healthcare policy can have positive impacts on Indigenous mothers and their level of comfort and safety while giving birth, this is only possible when the policy is implemented in an effective way. It is important that policy makers pay attention to the way that this policy is being carried out in all areas of Ecuador, not just the areas where there are successful intercultural healthcare programs. In this chapter, I show that there is a need for more monitoring and analysis of the policy.

In Chapter Five, I present my overall analysis and conclusions. I discuss the strengths and weaknesses of the concept of intercultural healthcare in general, but also its implementation in Ecuador. I also discuss some of the implications of this policy on the racial stratification and gender roles of Ecuador and propose possible improvements for this policy in the future. In this section, I come to the conclusion that intercultural healthcare has had a limited impact on Indigenous maternal health and access to care on a national level; however, it has had profound effects in clinics with well-implemented programs. Finally, I assert that increased standardization on a national level and better data collection are necessary in order to increase the impact of the intercultural healthcare policy on Indigenous maternal health.

Chapter 1: Ethnicity and Healthcare in Ecuador

Ethnic Discrimination in Ecuador

In order to understand why intercultural healthcare is important in Ecuador, it is necessary to discuss the ethnic makeup[1] of the country and the way that this impacts access to care and health outcomes. Ecuador is a diverse country that is made up of many different ethnicities, nationalities, and cultures. According to Article 6 of the 2008 Constitution, "Ecuadorian nationality is a political and legal bond between individuals and the State, without detriment to their belonging to any of the other Indigenous nations that coexist in plurinational Ecuador." This demonstrates the complexity of Ecuadorian nationality because while all citizens are part of the Ecuadorian nation, they do not belong exclusively to it. Because of this, it is often difficult to establish a sense of unity among citizens. While there has been a movement to embrace the diversity of the Ecuadorian population, there is still a great deal of racism -both systemic and overt- that results in inequalities in access to healthcare and health outcomes.

Currently, there are about 1.1 million self-identified Indigenous people in Ecuador and 14 different Indigenous nationalities. Many Indigenous people live in rural areas, occupying some parts of the Amazon and some mountainous regions. Some of the biggest problems facing Indigenous people today are territory degradation and weak protections of Indigenous rights

[1] Because many of my secondary sources use race and ethnicity interchangeably, I do as well. However, I want to acknowledge that "Race includes phenotypic characteristics such as skin color, whereas ethnicity also encompasses cultural factors such as nationality, tribal affiliation, religion, language and traditions of a particular group," (Santos et al. 121). Therefore, when speaking about Indigenous groups, ethnicity is often a more suitable choice.

("Indigenous World"). Additionally, because of the history of conquest and colonization in Ecuador, racial discrimination has been prominent in the country for centuries. When colonists first arrived in the region now known as Ecuador in the 16th century, Indigenous people, who Europeans referred to as Indians, were considered to be backwards and of the past while modernity and progress were associated with whiteness. These feelings persisted when Ecuador was named a republic in 1830 (Hernández Valencia). When enslaved people were brought from Africa into what is now known as Ecuador in 1526, similar racist views were placed upon them and they remained long after the abolition of slavery in 1822 ("Afro-Ecuadorians").

During the Liberal Revolution of 1895, the period that followed the abolition of slavery, social Darwinism heavily impacted conceptions of race. Europeans considered themselves to be superior to Indigenous people and Afro-Ecuadorians, so they attempted to create a more unified mestizo race. According to Foote, "It was assumed that immigration would bring white Europeans who would help 'dilute' the disadvantageous strains of Indigenous and negro blood, and thus help to transform and 'civilise' the population as a whole" (263). This attempt to whiten Ecuadorian society was a process known as blanqueamiento, and it shaped the way that people understood race in the country (Beck et al. 106). Due to these social Darwinist views, a racial hierarchy was created in Ecuador, and Indigenous people and Afro-Ecuadorians were at the bottom, which negatively impacted their socioeconomic standing and overall sense of well-being. The discrimination associated with racism made it more difficult to access opportunities such as education and employment, which increased poverty, and this was often exacerbated by structural issues such as lack of infrastructure in areas that were highly populated

by ethnic minorities (Foote 270). Although perceptions of race have changed greatly since the colonial period, the history of racism has made lasting impacts on Ecuadorian society.

One impact of the history of racism in Ecuador is the way in which Ecuadorians perceive their national identity. In an article entitled “Que es racismo” which focuses on conceptions of race in Ecuador in the 20th century, the idea of “todos somos mestizos" is explained. The authors state that when thinking about the national identity of Ecuador, many citizens think of mestizos, who are people of mixed race. This concept is called mestizaje and it refers to the common idea that “to be Ecuadorian is to be mestizo” (Beck et al. 106). However, in actuality, Ecuador is very ethnically diverse. Mestizaje is inherently exclusionary because it was never meant to include people of color such as Indigenous people (Indians) or Afro-Ecuadorians (Beck et al. 103). These people were at the bottom of the racial hierarchy during colonial times, and they still face a lot of discrimination and exclusion becuase of this. The fact that the 2008 Ecuadorian Constitution recognized the country as a plurinational state was important because it acknowledged the racism and discrimination throughout Ecuadorian history while highlighting that there is value in the diversity of Ecuador. It was a way to change the “todos somos mestizos" narrative and it pushes back on the mestizaje that has been prevalent throughout Ecuadorian history.

This racism also transferred to the education system, and it influenced social conceptions of knowledge. This is very notable in the education system during the Liberal Revolution, which lasted from 1895 until 1944. During this time period there was a heavy focus on the creation of a more productive workforce and participation in the global economy. One method that was used to create this more productive workforce was the expansion of secular education, which focused

particularly on citizens who were considered to be inferior due to social Darwinist beliefs (Foote 261-262). The 1906 version of the Ecuadorian Constitution states that everyone has the right to free education; however, this was actually an attempt to transform the population into a more desirable one through means of education (Foote 269). In fact, schools actively tried to undermine Indigenous knowledge through their curriculums in order to increase productivity and create uniformity in the Ecuadorian population. As Foote explains, "It was hoped that instruction would 'remake' the Indigenous peasantry, expanding their loyalty beyond the local community to the Ecuadorian nation, bringing them away from their imagined fatalism and superstition and into the realm of science, and allowing the introduction of their produce into the national marketplace. This integration would transform and renovate the nation, massively increasing the number of 'productive citizens" (Foote 269). This type of discrimination transferred to the medical system as well. As demonstrated in the quote above, the object of schooling during the Liberal period was to bring Indigenous pupils into the world of science. In European eyes, the Indigenous forms of knowledge and healing methods were not included in the term science. Moreover, once biomedicine became more prevalent, this divide between traditional and western medical knowledge increased. As Lock and Nguyen explain, "Biomedicine became explicitly hitched to imperial ambitions when it gained institutional credibility through mounting evidence of successes in disease control once hygienic measures were implemented in the capital of nineteenth-century Europe," (81). Therefore, Indigenous forms of knowledge were excluded from the medical curriculum and Indigenous perspectives were ignored in medical settings, which has caused many Indigenous people to feel uncomfortable attending biomedical facilities. The dismissal of this knowledge as well as the outward racism that has been present in Ecuador

since the colonial period has had a negative impact on maternal mortality ratios of Indigenous women in the country, and this highlights the need for a program that addresses these issues.

As previously mentioned, Afro-Ecuadorians have also faced a great deal of racial discrimination throughout history. As Rahier explains "'An African origin, which is not seen as positive in main- stream Ecuadorian society, and the highly negative value ascribed to coming from a lineage linked to the experiences of enslavement sustain the many expressions of Ecuadorian anti- Black racism and the construction of Afro-Ecuadorians as "ultimate Others'" (Rahier 2003, 2011, 2014)," (S248) This othering has had a great impact on perceptions of Afro-Ecuadorians and their place in society. However, it is interesting that in present-day Ecuador, there seems to be a greater movement for Indigenous rights in Ecuador rather than Afro-Ecuadorian ones despite the history of racial discrimination and its lasting impacts on both ethnic groups. According to the World Directory of Minorities and Indigenous Peoples, Afro-Ecuadorians still have many social disadvantages. For example, the organization states that "Afro-Ecuadorians have the highest unemployment level and are among the poorest of Ecuadorian social groups," ("Afro-Ecuadorians"). However, they also state that "...Afro-Ecuadorians fare considerably better than Indigenous people on nearly every socio-economic indicator…" Moreover, Afro-Ecuadorians make up a smaller portion of Ecuadorian society. According to the CIA World Factbook, 7% of Ecuador's population is Amerindian, while only 4.3% is Afro-Ecuadorian ("Ecuador"). These factors help to explain the seemingly greater efforts to support the Indigenous population of Ecuador, especially in the healthcare system.

Impacts of Discrimination in Ecuador on Health Outcomes

The history of ethnic discrimination in Ecuador heavily impacts present day health outcomes of ethnic minorities. It is no coincidence that Indigenous mothers have the highest maternal mortality rate in Ecuador. There are clear links between racial and gender discrimination and poor health outcomes. One example of this is the alteration of local biologies. According to Lock and Nguyen, "...the concept of local biologies refers to the manner in which biological and social processes- nature and nurture - are everywhere entangled, ensuring a degree of biological difference amongst humans that typically has little or no significance, but which at times bears profoundly on well-being," (319). In this case, racism heavily impacts the local biologies of racial minorities for several reasons. First, when someone faces racism throughout their lifetime, it causes a stress response, which has a profound and prolonged impact on their nervous system that negatively impacts health outcomes. Additionally, because racial minorities have been historically excluded from biomedical care, there are greater risks for chronic illness and complication.

Beyond its impacts on biology, racism can also affect access to care. Many patients face overt racism in biomedical facilities while others deal with microaggressions. This creates a very hostile environment, and patients often do not feel comfortable expressing their needs in these circumstances. For example, in an interview on the conditions of hospitals in Ecuador, one father named Widman Jimenez stated "'If you don't know anybody, the doctors may not even want to help you. If you are from the countryside they look at you differently,'" (Olfarnes). In many cases, patients don't return to biomedical facilities after experiencing this kind of treatment, and

they discourage their family members and friends from doing so as well. This fear of discrimination in medical facilities is often deeply rooted dating back to colonial times when Europeans would test medicines on racial minorities in Asia, Latin America, and Africa (Lock and Nguyen 86). Therefore, it can be incredibly difficult to combat these ingrained negative associations with biomedicine, especially when racism still remains in present-day society. Additionally, because of this persistent racism, patients who choose to seek care at a biomedical facility still might not receive the proper care because the doctors are often dismissive of their needs or concerns. Therefore, there is a great need for reform of medical facilities in order to encourage better health outcomes among ethnic minorities.

It is also important to recognize the role that intersectionality plays in health outcomes. According to Kimberlé Williams Crenshaw, who founded this concept, "Intersectionality is a conceptualization of the problem that attempts to capture both the structural and dynamic consequences of the interaction between two or more axes of subordination" (Crenshaw 17). In this case, women of color in Ecuador have two axes of subordination because they are discriminated against on the basis of their gender and ethnicity. For this reason, many policies that focus specifically on Indigenous maternal health have been implemented in an attempt to account for these two axes of subordination. The right to intercultural healthcare which was stated in the 2008 Ecuadorian Constitution is an intersectional approach to the very concerning issue of disproportionately high maternal mortality ratio of Indigenous women in Ecuador.

Finally, it is important to acknowledge that the history of racism and discrimination against ethnic groups has resulted in systemic issues such as lack of infrastructure and poverty,

which negatively impact maternal health outcomes. For example, many Indigenous people live in rural areas where access to medical facilities is limited. It can be difficult and expensive to reach a hospital, so many people opt not to give birth there. Because of this, the United Nations states that "...women face high risks of dying from childbirth simply because they recieve help too late ("Ecuador provides birth choices to save lives"). Poverty also impacts access to care. According to a study done in Latacunga, which is a rural area that is heavily populated by Indigenous people, "Sixty-eight percent of the people live on less than two dollars a day" (Jacobson). When people do not even have enough income to pay for their daily needs, it is difficult to justify attending a medical facility in order to give birth. These systemic barriers to care have a significant impact on the maternal health of ethnic minorities.

Efforts to Decrease Maternal Mortality Ratio

In years past, Ecuador attempted to address the disproportionately high maternal mortality among Indigenous and Afro-Ecuadorian women by creating laws and policies that provided financial support for women. These laws recognized that cost is often a barrier to medical care, and they were helpful in some regards; however, policy makers realized that even when services were free, many women were still hesitant to give birth in a western medical facility and still opted to give birth in a home setting. Therefore, they recognized the need for other adjustments to the healthcare model.

In light of the relatively high maternal mortality ratio and the growing poverty in Ecuador during the 90s due to falling oil prices, lawmakers proposed the Ley de Maternidad Gratuita y Atención a la infancia (LMGYAI) in 1994. This law was amended and officially put into effect in

1998 (Hermida et al. iii). The LMGYAI was the first attempt in Latin America to provide free healthcare for mothers (Goicolea et al.). The LMGYAI was created to reduce maternal and child mortality by providing free health care for mothers and their children while improving the quality of healthcare in the region. Lawmakers identified key pre- and post-natal issues that threatened maternal and child health and funded treatment for them through the Solidarity Fund for Human Development (Hermida et al. iv). A study of the law states that the LMGYAI, "...aims to contribute to the reduction of maternal and infant mortality, the improvement of women and children's access to quality health care, and the reinforcement of society's participation in decision-making processes and control over the quality of services." (Hermida et al. iii).

This law also attempted to ensure that Indigenous people benefitted from and participated in the LMGYAI by creating multiple management committees, which worked on the local level to provide information about the right to free healthcare and funding for medical procedures that were necessary in these areas (Hinrichsen). As Andrea Quijije, who is the President of the Users committee in Sucre states, "'We are proactive in that we inform women of their rights under the law and also educate medical staff on its implication for reproductive health care,'" (Hinrichsen). In theory, this law was a very effective way to increase maternal access to care by eliminating concerns about cost; however, there were still many shortcomings of the law in practice. For example, there were issues with timely funding, transportation to and from medical facilities, and overall accountability for providing services and funding since the law was interpreted by individual counties (Goicolea et al. 94). Moreover, the law did not actively address factors such as medical racism and Indigenous women's fear of medical facilities, which meant that many women still chose not to access free care in public hospitals.

In an effort to provide better care for women, Ecuador implemented the Política Nacional de Salud y Derechos Sexuales y Reproductivos (PSDSR) in 2005. (Goicolea et al.). This policy acknowledged the needs of Indigenous and Afro-Ecuadorian women and recognized some of the key problems with the LMGYAI, including the lack of attention to the social factors that impact maternal access to care and the lack of accountability in the implementation of the law (Goicolea et al. 94). According to section 3.1 of the PSDSR, "El Ecuador es un país multiétnico y pluricultural de mayoría mestiza y, con un grupo indígena estimado en 10 %, y un 5% de afrodescendientes, en consecuencia existe una diversidad de estilos de vida, modernos y tradicionales, con comportamientos diferenciados frente a la salud sexual y salud reproductiva[2]" (25). This statement is important because it acknowledges that women have different sexual and reproductive health needs, and this article attempts to address those by providing more personalized care. Many scholars have discussed the impacts of outside factors on health. For example Camacho explains, "In almost all societies, perceptions of health and disease are related to broader cultural and social influences and relations" (Camacho et al. 2). The fact that this article recognizes the diversity of the Ecuadorian population and the varying needs that comes along with it is a very important step in creating equitable healthcare for people with health outcomes that are disproportionately affected by social factors.

Section 3.1 goes on to state that "Las características socioeconómicas y culturales determinan la calidad de vida y el estado de salud individual y colectivo de los ecuatorianos. A final del siglo pasado, el Ecuador sufrió una crisis económica sin precedentes. El desempleo, la

[2] Ecuador is a multiethnic and multicultural country with a mestizo majority and, with an estimated 10% Indigenous group and 5% Afro-descendants, consequently there is a diversity of lifestyles, modern and traditional, with differentiated behaviors towards sexual health and reproductive health.

caída de la oferta alimentaria, la inflación, la contracción del gasto social, el deterioro salarial real, afectaron a las familias en general y particularmente a las mujeres y niños de las poblaciones en situación de pobreza, disminuyendo en forma ostensible su capacidad de lucha contra la enfermedad y la muerte[3]" (*Política Nacional de Salud* 25). This is another important statement because it demonstrates the multiple factors that could affect the health outcomes of women and their children. This statement demonstrates the negative impacts of the economic crisis on the whole Ecuadorian population while also highlighting that women and children were left more vulnerable to this because of their role in society. This intersectional perspective demonstrates the need for more specialized healthcare that addresses not only the impact of poverty on the country as a whole but also the socioeconomic disadvantages that affect certain communities more heavily.

Another important aspect of the PSDSR is that it acknowledges the need for intercultural care unlike the LMGYAI. The PSDSR states that "Los servicios de salud sexual y salud reproductiva requieren mejoras en los aspectos médicos, técnicos, de seguridad y sistemas de referencia así como la humanización de los servicios,desarrollando habilidades en el recurso humano para la comunicación y trato con perspectivade género, generacional; respeto intercultural y confidencialidad que permitan a los usuariosla toma de decisiones informadas y el acceso a servicios de calidad[4]." (32) This is important because it demonstrates that there are

[3] Socio-economic and cultural characteristics determine the quality of life and the individual and collective health status of Ecuadorians. At the end of the last century, Ecuador suffered an unprecedented economic crisis. Unemployment, the fall in the food supply, inflation, the contraction of social spending, the deterioration of real wages, affected families in general and particularly women and children of populations living in poverty, significantly reducing their income. ability to fight disease and death.

[4] Sexual health and reproductive health services require improvements in medical, technical, safety and referral systems, as well as the humanization of services, developing human resource skills for communication and treatment

other factors that impact access to care besides cost. This is the first step in providing intercultural care which focuses on the alternative needs of patients. It demonstrates the crisis that was occurring in Ecuador due to maternal hesitancy to attend biomedical facilities, which shows the need for a new model of care.

These policies were important steps in the process of providing more equitable healthcare because they addressed the issue of cost; however, they were not very effective. Many women were unaware of the fact that they could access free healthcare because there was poor advertisement of the new law in rural communities. Policy makers tried to combat this by implementing User's Committees to inform women of their rights and encourage them to access free healthcare at public hospitals; however, this was a tedious process (Hinrichsen). Moreover, even though these policies did include some intercultural ideas, they did not actively attempt to provide intercultural care. Without this, many Indigenous women were unwilling to attend biomedical facilities for their needs throughout pregnancy and birth because of distrust of the biomedical system. The next step in the effort to provide more equitable care for Indigenous women was the implementation of an intercultural healthcare policy nationwide in the 2008 Ecuadorian Constitution.

with a gender, generational perspective; intercultural respect and confidentiality that allow users to make informed decisions and access quality services.

Chapter 2: Interculturalism Explained

Interculturalism Definition

In order to analyze intercultural healthcare and its impacts in Ecuador, it is important to first explain the meaning of the term intercultural. The 2008 Ecuadorian Constitution, which was written and passed during the Correa Administration, states that Ecuador is a plurinational and intercultural country with 14 different Indigenous nationalities. The Constitution was written in an attempt to combat the neoliberal policies of Ecuador's past, and it was approved with little opposition on September 28, 2008 (Becker 47). While the 2008 Constitution was easily passed, Indigenous groups had been demanding that the country be named a plurinational one for many years. The most notable push for this was with the formation of the Confederation of Indigenous Nationalities (CONAIE) in 1986, which was a group of Indigenous leaders who stated that the different Indigenous groups in the country formed different nations (Jameson 65). This group worked tirelessly to advocate for a plurinational state, and their goal was finally achieved in the 2008 Ecuadorian Constitution. The new Constitution recognizes that Ecuador is an incredibly diverse country, and many articles in the constitution - including the one addressing intercultural healthcare- attempt to protect the rights of ethnic minorities, their beliefs, their practices, and their lands.

Because of the great cultural and ethnic diversity in Ecuador, and a history of discrimination that comes along with that, the 2008 Constitution places heavy emphasis on the

need for mutual respect for all nationalities. One way in which the new Constitution tries to address this issue is through the concept of "interculturalism." This term appears in multiple places throughout the Constitution, but for the purpose of this thesis, I am analyzing it in regards to healthcare. According to Article 32 of the 2008 Ecuadorian constitution, "The State shall guarantee this right by means of economic, social, cultural, educational, and environmental policies; and the permanent, timely and non-exclusive access to programs, actions and services promoting and providing integral healthcare, sexual health, and reproductive health. The provision of healthcare services shall be governed by the principles of equity, universality, solidarity, interculturalism, quality, efficiency, effectiveness, prevention, and bioethics, with a gender and generational approach." This article is important because it acknowledges the need for a healthcare approach that recognizes social inequality. However, while the constitution states that healthcare should be governed by interculturalism, there are no real guidelines that explain how to do this or what interculturalism really means as listed in the constitution.

After this constitution was rewritten, the Ecuadorian Ministry of Public Health released a mission statement on their website regarding their role in Ecuador's pursuit of intercultural health: "Formular y coordinar la implementación de políticas, planes, programas y demás herramientas de salud intercultural en el Sistema Nacional de Salud y la gestión del Ministerio de Salud Pública, que garanticen el reconocimiento y respeto de la diversidad de pueblos y nacionalidades, y la articulación de los conocimientos, saberes y prácticas ancestrales de salud[5]" ("Dirección Nacional de Salud Intercultural"). They have also released 20 points of focus for

[5] To formulate and coordinate the implementation of policies, plans, programs and other intercultural health tools in the National Health System and the management of the Ministry of Public Health, which guarantee the recognition and respect of the diversity of peoples and nationalities, and the articulation of the knowledge, knowledge and ancestral health practices

their intercultural care provision efforts in their direction statement. For example, according to article C of their mission statement, the national director of intercultural health, Miguel Angel Quijije Santos is required to, "Planificar e impulsar en el Sistema Nacional de Salud acciones estratégicas, procesos de reforma y fortalecimiento de capacidades, para la institucionalización de la interculturalidad[6]" This article, along with the 19 others listed on the direction statement demonstrate that the Ministry of Health holds a great deal of responsibility in relation to the implementation of intercultural healthcare throughout the nation. However, these statements are also rather vague, which shows the lack of direction in the implementation of intercultural care.

Another useful source to help provide a clear understanding of what interculturalism means in Ecuador is a series of videos that the Ministry of Public Health released in 2016 on Youtube to help inform the public about the meaning and importance of intercultural healthcare. At the beginning of a video entitled "2. Introducción Salud Intercultural," an intercultural health analyst named Luis Enrique Cachiguano explained, "Nosotros interpretamos a la interculturalidad como la relación respetuosa entre dos personas, entre dos culturas, y entre dos sociedades con igual nivel de prestigio pero con visiones diferentes de una realidad."[7] In the video, Cachiguano starkly contrasts multiculturalism with interculturalism, explaining that interculturalism places high value on the mutual respect between different forms of knowledge while multiculturalism only offers the opportunity to share other forms of knowledge without giving those knowledge forms equal respect. In a multicultural healthcare system one would only be able to access biomedicine in a western hospital or traditional medicine in an Indigenous

[6] To plan and promote strategic actions in the National Health System, reform processes and capacity building for the institutionalization of interculturality.

[7] "We interpret interculturality as the respectful relationship between two people, between two cultures, and between two societies with the same level of prestige but with different views of a reality"

setting. However, because the Ecuadorian Constitution of 2008 states that Ecuador is an intercultural country, it is important that the practices of different ethnic groups are respected and shared. This is what an intercultural healthcare system provides because it combines biomedicine with traditional knowledge, and it respects and values both practices and forms of knowledge.

The Need for Intercultural Healthcare

There are many factors that prevent Indigenous women from feeling safe and comfortable in western medical facilities where they can access biomedicine. While biomedicine is not necessary for a safe and healthy birth, it can be helpful in the event of an emergency. Because many women feel uncomfortable in biomedical facilities, they do not have access to biomedicine while giving birth, which increases the risk of maternal and infant mortality. I want to stress that emphasizing and focusing on maternal access to biomedicine is not meant to undermine the value of traditional medicine and forms of knowledge. Instead it is meant to maximize the resources that women have and to give equitable opportunities to all women. As Darly Quninonez, the president of a private intercultural clinic in Ecuador states, "There is no reason why we cannot have both: if our client needs an emergency operation, she can have one; if she wants to give birth according to her cultural needs and preferences, she can do so," (Vivar 1302). This demonstrates the coexistence of biomedicine and traditional medicine in an intercultural facility. Some reasons why equitable access to healthcare does not exist in Ecuador without intercultural healthcare are discrimination, fear of western practices, and a desire to have culturally significant births. Intercultural healthcare attempts to meet these needs while also giving women access to biomedicine in a way that is comfortable for them.

One key reason why many Indigenous women do not want to attend western healthcare facilities is the fear of mistreatment and discrimination based on their ethnicity. Many Indigenous women have complained that medical personnel do not treat them fairly because they are Indigenous. According to the head of the User's Committee, Giovanna Alvarez, "Before, the doctors would treat us badly. When we were giving birth they would shout, 'you dirty Indian, you opened your legs when you felt like it and now you're screaming! Shut up now!'" (Jacobson). This is just one example of the kind of discrimination that Indigenous women face in western healthcare facilities that do not prioritize mutual respect and intercultural healthcare provision. Because of this discrimination, many women are deterred from attending biomedical facilities, which means that they might not have access to the care that they need. One of the goals of intercultural healthcare is to eradicate racial discrimination and to provide more inclusive care.

Another reason why women are hesitant to give birth in western medical facilities is because of distrust of biomedical practices. There is a long history of mistreatment of people of color in the biomedical system because it is directly related to colonialism. When colonists started implementing biomedicine in Asia, Africa, and Latin America, they did not explain their seemingly violent and inhumane practices to patients in the region. Instead they often conducted experiments on people in the region, which caused fear and instilled a hatred of Europeans and the biomedicine was associated with them. According to Lock and Nguyen, "...in many parts of the world the deployment of biomedicine was thought of as a part of an oppressive colonial apparatus, and was often met with incomprehension, suspicion or even outright resistance," (86). This fear and mistrust is very evident in Ecuador. For example, in an interview about the

implementation of intercultural healthcare in Ecuador, Dr. Alfredo Almarez discussed a conversation about mistrust of medicine that he had with a patient. He explained that he asked, "'Why don't you go to the hospital? And she said 'Because we are violated'" ("Ecuador Provides Birth Choice to Save Lives"). In the same video, a mother expressed her fear of cesarean sections in biomedical facilities saying, "I am scared to go to the hospital because I know that sometimes when women cannot give birth the normal way they open you up." This demonstrates an overall fear and mistrust of the practices that occur in biomedical facilities, which deters Indigenous women from seeking care there.

Moreover, many Indigenous women are hesitant to give birth in biomedical facilities because of cultural conceptions of birth. In many Indigenous cosmologies birth is a very sacred practice. In an article about the cultural conceptions of birth in Latin America, it is stated, "Among Indigenous women, reproductive cycles are strongly linked to the sacred dimensions of nature and space," (Camacho et al. 359). However, biomedical facilities typically do not approach birth in a way that honors that. Because many Indigenous women prefer to have a private and intimate birth setting, these women often find the clinical environment of a doctor's office to be very unappealing and uncomfortable ("Ecuador Provides Birth Choice to Save Lives"). According to Indigenous beliefs, warmth -in both the physical and metaphorical sense- is necessary when giving birth to protect a mother and her baby from sickness. As Camacho et al. explain, "It is believed that when the baby is born, the uterus opens, allowing cold air to enter, cooling the blood," (359). Because of this belief, women find it necessary to keep warm under blankets and in a heated room. This starkly contrasts with the typical atmosphere of a western hospital (Camacho et al. 359). Many Indigenous women complain about giving birth in western

medical facilities because they are uncomfortable with the cold and harsh setting of a hospital. Another example of cultural differences regarding birth is women's choice of birthing position. Some Indigenous women feel extremely exposed when giving birth while lying flat on their backs. One Indigenous midwife equated this birthing position with the crucifixion of Jesus, saying, "The hospitals sacrifice the women like God was sacrificed with nails in the legs and in the hands" ("Cañar, Ecuador: Birth and Indigenous Identity in the 21st Century"). This intense opposition to western birthing positions demonstrates the fact that intercultural medicine is crucial in order to increase Indigenous mothers' attendance of western medical facilities.

It is important to understand that many factors influence people's healthcare needs. Health is not only influenced by what is physically taking place in the body, but also by society, history, and cultural beliefs. According to Lock and Nguyen, "Biomedicine is a socio technological system, akin to a power grid, railway network, or the Internet; an arrangement cobbled together steadily since the end of the nineteenth century. The biological sciences on which biomedicine is based provide a set of standards, protocols and algorithms that enable the production of knowledge and practices to treat ailing individuals and improve the health of populations around the globe. Biomedicine, in theory then, is based on an assumption of the universality of human bodies that everywhere are biologically equivalent," (1). As this definition demonstrates, biomedicine does not take into account these other factors that impact the biology of a person. The failure of biomedicine to acknowledge this is one of the major reasons why many Indigenous people are deterred from attending biomedical facilities to give birth.

Intercultural healthcare attempts to address these other needs. It acknowledges that there is more than one way to provide healthcare and it respects different systems of knowledge

regarding health. Therefore, this method of healthcare provision can be very effective in providing the most inclusive and expansive healthcare options for patients. However, healthcare does not exist in a vacuum. Obviously, there are other factors at play, one of which is the lack of standardization in the regulations for healthcare provision. Therefore, it is important to look critically at the intercultural healthcare system and analyze the difference between the policy and its implementation.

It is important to note that individual choice and the availability of intercultural care are not the only factors that impact Indigenous access to and use of public healthcare. As previously mentioned, there are also structural barriers to care such as distance from medical facilities and poor infrastructure which prevent women in rural areas from reaching public biomedical services. Moreover, even though two laws were put into place to provide free maternal healthcare in public hospitals, this is not always available because the budget is not big enough to provide all of the materials and supplies necessary for treatment (Hermida et al. 15) While the focus of my thesis is the impact of intercultural care on Indigenous maternal health outcomes, I want to acknowledge that these structural issues also affect health outcomes, and the provision of intercultural care does not resolve the need for better infrastructure and a more comprehensive free maternal healthcare program.

Intercultural Care in Practice

As previously mentioned, there are many sources that reference the term interculturality and provide a slightly different definition. Therefore, it is very difficult to understand exactly what the term means. Likewise, even though there is much discussion and information about intercultural care, there is little standardization in its provision. Policy makers and healthcare

providers are still developing an effective way to put intercultural health into practice. While each hospital is constitutionally required to provide intercultural care to those who seek it, hospitals attempt to provide it in many different ways because there are no clear national requirements for hospitals. According to one study of intercultural care provision nationwide, "legal and regulatory framework is ambiguous" (Gallegos et al. 108). Therefore, there is a lot of variation in intercultural care provision across the country because of the discrepancies between hospitals' interpretations of intercultural care.

One example of an effort to provide intercultural healthcare is Kichwa lessons for healthcare workers. Kichwa is one of the most common Indigenous languages in Ecuador, and it was named as one of the country's official languages; however, it is uncommon for mestizo or Afro-Ecuadorian people to speak the language. Kichwa lessons help doctors to speak with Indigenous patients in their preferred language, which often makes experiences in biomedical facilities more comfortable for Indigenous people (Llamas and Mayhew 2). A misunderstanding in a medical setting due to a language barrier can cause fear, distrust, and even danger for the patient, which would deter them from attending a biomedical facility; therefore, Kichwa lessons reduce the chance of this happening and increase the likelihood that Indigenous patients receive respectful care in a biomedical facility.

Another common intercultural healthcare practice is cultural training conducted by hospital managers in an attempt to instill more respect and understanding for indigneous practices among healthcare professionals (Llamas and Mayhew 2). While there is a wide range of ethnicities and cultural groups with various cultural beliefs in Ecuador, there is an overall lack of mutual understanding between these groups. Many people do not know much about the

cultural practices of other ethnic groups in Ecuador. These practices extend to the medical field too, and a lack of understanding of the cultural significance of these practices can lead to discrimination and disrespect for the patient's needs and preferences. Therefore, cultural training, which is typically provided by members of the Ministry of Public Health is meant to provide more inclusive and equitable care for all in biomedical facilities (Gallegos et al. 109).

Another common attempt to provide intercultural care is the implementation of traditional birth attendants (TBAs) into government funded biomedical facilities (Soguel 1). Traditional birth attendants are people who are trained in traditional Indigenous birthing practices. They are typically -but not always- Indigenous women who have learned these techniques from family and community members. TBAs help Indigenous women to feel more comfortable in the hospital by providing comfort and a sense of familiarity. Moreover, they often help to advocate for women in the face of medical racism or discrimination. The presence of TBAs in biomedical facilities usually results in the provision of culturally sensitive care because TBAs have knowledge of Indigenous birthing practices, but they provide care in a western medical facility where patients have access to biomedicine (Llamas and Mayhew 2). Therefore, this provides a mix of Indigenous and western practices in the medical system, which allows patients to choose the type of care that they want to receive.

Finally, there has been a great focus on the provision of culturally adequate births, which provide a more comfortable environment and emulate the experience of a home birth while still giving mothers access to biomedicine if they need it. There are many ways to perform a culturally adequate birth, but most of them usually involve the practice of vertical birthing which is common in Indigenous communities. According to Hospital San Luis De Otavalo's

intercultural healthcare model, a culturally adequate birth is "...la expulsión del producto en una posición cómoda para la madre, posición vertical (de pie, sentada, semisentada, de rodillas o cuclillas) mientras es atendida por el personal de salud y la partera"[8] ("Hacia la Construcción 11). Vertical birth not only has cultural significance, but it also has some physiological benefits. For example, the vertical position, whether squatting or standing is helpful during the birthing process because it increases dilation, and it allows gravity to help mothers give birth (Soguel 2). Moreover, this position often feels more comfortable for mothers who find giving birth on their backs to be immodest. While this practice is very common in Indigenous communities, many biomedical practitioners are not trained in helping women deliver their babies in this way, which means that it can be difficult for Indigenous women to give birth in the way that they prefer in a biomedical setting. Therefore, offering facilities where women can give birth in a way that is culturally sensitive while also being able to access biomedicine is a way that many hospitals are attempting to provide intercultural care.

As previously mentioned, there is little standardization about what constitutes interculturalism in a medical system. Therefore, hospitals implement a wide variety and combination of these measures. Some hospitals with underdeveloped intercultural health programs only provide one of the intercultural elements, while others such as Hospital San Luis de Otavalo and the Jambi Huasi Clinic provide all of them. The development of a hospital's intercultural healthcare program depends on the staff of the hospital and the demand for intercultural care by patients and community groups. According to Vivar, "...only with the

[8] "...the ejection of the product in a position comfortable for the mother, vertical position (standing, sitting, half-seated, kneeling or squatting) while being attended by health personnel and midwife"

effective participation of Indigenous communities will there be a sustainable effect on the lives of women and children," (1302). Therefore, it is very difficult to understand the state of intercultural healthcare on a national level because there is so much variation in intercultural health care programs. Moreover, the fact that there is little published information makes it not only difficult to study the intercultural health care efforts in each hospital but it also makes it difficult for mothers to know where they can access intercultural healthcare that is sufficient for their wants and needs. There is a wide range in the quality and respect that women might receive in biomedical facilities depending on the region that they are in. The lack of standardization demonstrates a lack of dedication to the implementation of intercultural care. This is a major area of improvement in the effort to provide intercultural care.

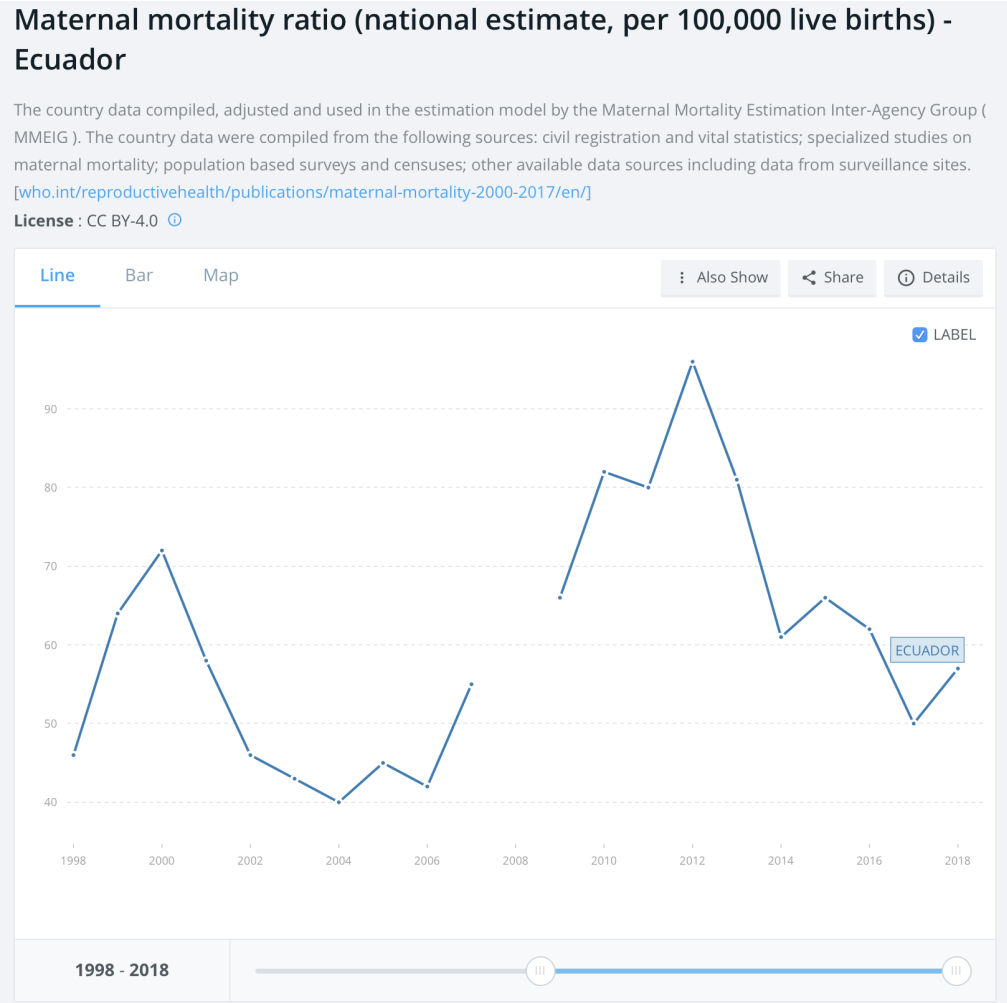
Chapter 3: Quantitative Data Analysis

Research Method

To help me understand the impact of the intercultural healthcare policy in Ecuador on maternal health, I analyzed two different quantitative indicators: the number of births attended by skilled health staff and the maternal mortality ratio. I chose to use the number of births attended by skilled health staff to show the direct impact of the right to intercultural health on maternal access to care. I used the maternal mortality ratio to show the impact of the right to intercultural care on maternal health outcomes, which helped me determine if this policy actually increased the quality of healthcare provided to mothers. These metrics are commonly used by policy makers and government officials to determine issues that need to be addressed; therefore, I thought it was important to analyze the change in these determinants in order to see what policy makers commonly see when they are attempting to analyze the impact of this policy on maternal health. I accessed this information from the World Data Bank because it was the source that had the most consistent and available data. I analyzed data from 10 years before the implementation of the policy until 2018, which was the most recent year with available data. I chose to use this interval because I wanted to have a good understanding of the trend before the implementation of the policy. Therefore, I analyzed the data 10 years before the implementation of the policy and 10 years after so that I could understand maternal mortality and the number of births attended by

skilled staff both before and after the implementation of the intercultural healthcare policy in order to understand the impact hat intercultural healthcare has had on these factors.

Maternal Mortality Ratio



I was surprised to find that there has been a great deal of fluctuation in maternal mortality since the implementation of the intercultural health care policy. I was expecting to find a decrease in maternal mortality after the implementation of the policy because many news articles and ethnographies reported positive experiences among Indigenous mothers who had intercultural births. However, by looking at this data, there is no clear correlation between the

implementation of the intercultural healthcare plan and decreasing maternal mortality ratio; therefore, it is very difficult to understand the impact of this policy on maternal mortality ratio.

I came across several problems during my analysis of the maternal mortality ratio. First, I recognize that the use of the maternal mortality ratio for the country as a whole is not the most effective way to analyze the impact of the intercultural healthcare policy on the maternal health of ethnic minorities in Ecuador because there are only a few well established intercultural healthcare facilities that have provided mothers with intercultural birth. I wanted to get an idea of the impact that this has had on the mothers that have received this care, but because the plan is relatively new with little standardization, it is hard for it to have an impact on a national level. Moreover, I really wanted to get an understanding of the impact that this policy has had on ethnic minorities since many of the intercultural healthcare practices were directed at Indigenous women specifically. I initially wanted to examine the maternal health outcomes of each ethnicity in Ecuador in order to get a better understanding of how this policy has impacted minorities; however, this data was not available. While I found several studies conducted by individual scholars that showed maternal mortality ratios of ethnic groups in Ecuador for one specific year, I could not find this data for a range of years, so the data was not suitable for statistical analysis. I also tried to find the maternal mortality ratio and number of births attended by skilled birth attendants in each province. I wanted to use this in combination with the demographics of each province to help me get a rough understanding of how intercultural healthcare provision has impacted each ethnic group in the country. I found a few scholarly articles that had this information for specific years, but because I could not find this information for multiple years, it was very difficult to analyze and make any statements about the impact of intercultural care on

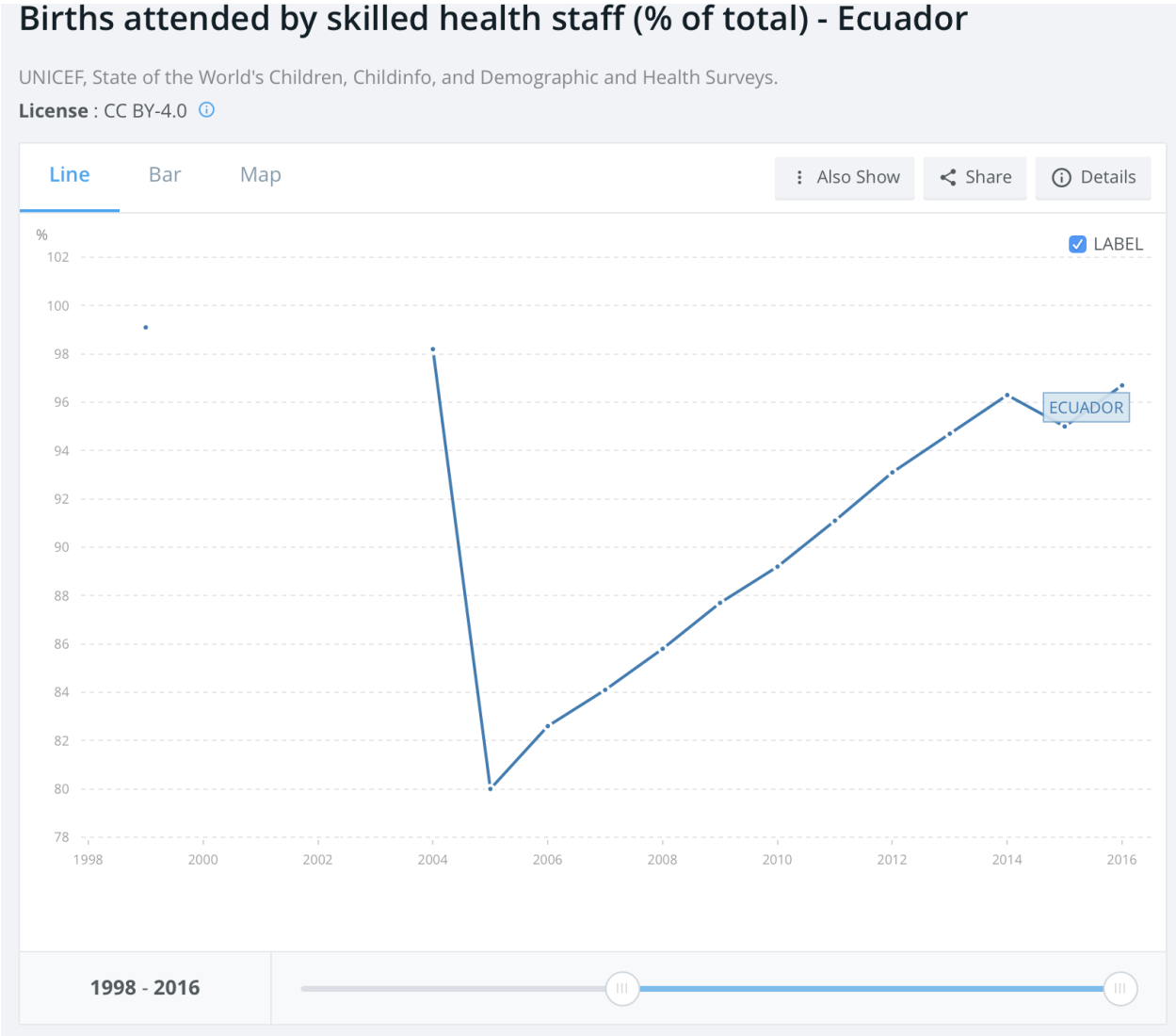
the health of Indigenous laboring parents. Therefore, because of a lack of detailed data, I had to resort to using the maternal mortality ratio even though this was not the most reliable indicator for the impact that the intercultural healthcare policy has had on maternal health outcomes.

Another difficulty that I had while analyzing the maternal mortality ratio is that this is not the most accurate representation of maternal health in Ecuador because it does not demonstrate the nuances of maternal health outcomes. It is important to reduce maternal mortality ratio, but this should not be the only goal of maternal healthcare provision. It is also necessary to address other pre- and post-natal health issues that can be detrimental to the mother's quality of life, even if they are not life threatening. The analysis of these health indicators would provide a more nuanced assessment of the intercultural healthcare policy on maternal health. However, it was incredibly difficult to find this data, especially over an extended period of time. Moreover, while a major goal of intercultural maternal healthcare is reducing maternal mortality, it is also focused on creating a positive birth experience for Indigenous mothers, and this is a worthwhile goal that cannot be accurately measured through quantitative data analysis. Oni-Orisan talks about this problem explaining that many doctors feel pressured to "prove their success" so they focus more on quantitative results rather than the quality of care because there are no quantitative measures for high quality care (93). This can be difficult because there is a political need for quantitative proof of the success of the program, but there is little data to actually meet this need. Because there was no available data for these other indicators, I had to rely on the maternal mortality ratio as a rough indicator of the impact that intercultural healthcare has had on maternal health.

Finally, many maternal deaths happen outside of biomedical clinics, when women give birth at home, which often means that they are not recorded. This policy was created to help

prevent these deaths outside of hospitals from happening by encouraging mothers to give birth in biomedical facilities; however, the maternal mortality ratio is not the best indicator of this because the maternal deaths that happen outside of hospitals are still unlikely to be recorded. Therefore, it is difficult to account for a decrease in maternal mortality that was never being recorded in the first place.

Births Attended by Skilled Health Staff



As I predicted, the number of births attended by skilled health staff in Ecuador has had an overall increase, which might demonstrate the positive impact of this policy on maternal access to care. However, there is one major issue with this: lack of data. I initially wanted to analyze data from 1998 to 2018, which would allow me to analyze the number of births attended by skilled health staff 10 years before and after the 2008 Constitution was passed. However, data was not available until 2004 (which explains the large gap in the graph) and the most recent available data was from 2016. The small range of data makes analysis very difficult. Moreover, I had difficulty with the meaning of the term "skilled health staff." According to the World Data bank, "Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns." However, this definition is incredibly vague, especially in this context. For the purpose of this thesis, it is important to understand if Indigenous birth attendants are considered to be skilled health staff. It is also important to understand if these Indigenous birth attendants are considered to be skilled health staff if they are working in a biomedical facility and, or outside of a biomedical facility. If traditional birth attendants outside of a biomedical facility are still considered to be skilled health staff, then this indicator does not give me much insight into the impact of the intercultural health care policy because it does not show if there has been an increase in women attending biomedical facilities, and this policy has not extended funding to private Indigenous clinics. This greatly impacts the analysis of women's access to maternal care after the implementation of the intercultural healthcare policy; however, this information is not available, so it makes analysis less trustworthy.

Setbacks

I came across many setbacks in my quantitative data analysis process. First, it is very difficult to find accurate data. On the Ecuadorian database, there is very little clear information. In fact on the Ecuador en Cifras website, which is the official Ecuadorian database, there is no information about maternal mortality. There is only limited information about infant mortality. This is very telling about the true importance of intercultural healthcare to policy makers because it is difficult to monitor the impact of the efforts to reduce maternal mortality when accurate records of maternal mortality are not kept by official sources. Because of this, I tried to look for information in other areas. More specifically, I was trying to find data on the health outcomes of specific ethnic groups in Ecuador, in an effort to determine the impact that this policy had on different groups. I found a few individual studies done by scholars that recorded maternal mortality ratio by province, and then stated the ethnic makeup of that province; however, these studies only had a few years worth of data; therefore, it is very difficult to actually conduct analysis with that information. Moreover, it is important to acknowledge who is recording the data. Because the majority of this more specific data has been collected by individual scholars rather than government organizations, it is less likely that government funding will be devoted toward addressing the results. A lack of government data allows government officials to neglect serious issues because there is not proof to hold them accountable.

Another issue that I came across while doing this quantitative research is that each province has its own intercultural health care protocols. Therefore, it is extremely difficult to gauge the overall impact of intercultural care on any one ethnic group because there is so much variation in health outcomes and access to care across the country, and the national data does not

reflect these differences. Therefore, through my research, I found that the lack of data collection and the lack of standardization around intercultural care provision makes quantitative data analysis very difficult and rather useless. However, I still wanted to provide some numerical understanding of the issue, especially because I know that this is important to policy makers who use data to help them decide on the policies that they need to implement and improve on. Therefore, I turned to the World Data Bank because it had the most consistent data that allowed for some analysis.

Conclusions

Through my research for this section, I ultimately found that there was not sufficient data to critically analyze the impact of this policy on maternal health and access to care among ethnic minorities in a quantitative way. There were two reasons for this. First, the policy was implemented rather recently, and it has not been completely developed; therefore, it is very difficult to understand its impact. Second, the data that I could find lacked very little nuance, and this is not very suitable for analyzing a policy that is focused on nuanced elements of healthcare such as respectful and empowering healthcare service. However, I understand that numbers are important when attempting to make changes in the field of global health; therefore, I attempted to do some analysis. This was somewhat useful for my research because a major goal of the universal access to intercultural care was the improvement of overall maternal health and access to care. However, the lack of data on specific ethnic groups demonstrates that there is a lack of focus and attention on the health outcomes of ethnic minorities despite the fact that this policy is focused on improving health care for these minorities. Without specific data on the health outcomes and access to care of different ethnic groups, it is virtually impossible to critically

analyze the impact of this policy on different minority groups, which is problematic because many policy makers use quantitative data as a motivator for policy creation. It is difficult to create better policies when a need for change is not numerically evident.

Even though I did not gain much quantitative evidence for the impacts of the intercultural healthcare policy on ethnic minorities in Ecuador, I did gain evidence of a different kind. Quantitative data is important because it is used to make policies, and the effort that a government devotes to data collection demonstrates the investment that they have in that issue. As Oni-Orisan explains, "The entanglements of politics and metrics productivity result from a push for numerical proof of effectiveness that determines not only who is counted but also how healthcare is delivered -- in other words, determining which women are metrically seen and which are not," (85). Because of the lack of detailed data on this particular issue, it is evident that equity in maternal health outcomes and access to care is not a true priority. It seems that this policy is a quick fix for an issue that deserves more attention and effort. Through my quantitative research process, I found that in order to really create a more equitable healthcare experience for Indigenous mothers, it is necessary to maintain more comprehensive data. Without this attention to detail, it is easy to have skewed assumptions about the impact of the policy. Therefore, policy makers might not notice a need for improvement in order to provide better care for those who are still being left out of the system.

Chapter 4: Qualitative Data Analysis

Research Method

As demonstrated by the quantitative analysis, it is necessary to analyze the intercultural healthcare policy in 2008 from a qualitative lens to really understand its impact on maternal health outcomes and access to care. I analyzed several secondary sources such as case studies in hospitals that implemented an intercultural healthcare program including the Jambi Huasi Clinic and Hospital San Luis de Otavalo. I also utilized more generalized commentary about the state of intercultural healthcare in Ecuador as a whole to help me understand the impacts of this amendment to the 2008 Constitution. Through my research, I found that although there are many positive aspects related to this policy, there are some major setbacks that could be improved upon in order to provide a better healthcare experience in biomedical facilities in Ecuador.

Lack of Standardization

One major issue with the universal right to intercultural healthcare in the 2008 Constitution is the gap between the goal of policy makers and the actual practices that have been implemented in hospitals. While the Ministry of Health released official statements on the implementation of intercultural health and created an Intercultural Health Office that is meant to implement the intercultural health programs and provide regulation, there is little standardization of intercultural healthcare practices throughout the country. Hospitals are required to have

"culturally appropriate services and installations" (Gallegos et al. 3); however, there is not much specification about what these terms constitute. Moreover, there is little information about the availability of intercultural care in hospitals around the country. There is no national directory for intercultural clinics, which makes it difficult for mothers to know how or where to access intercultural care in a biomedical facility. While there are few hospitals in the Andean region such as the Jambi Huasi clinic that have facilities that are specifically dedicated to intercultural birth, this is not standardized throughout the country (Mignone et al. 5). This makes it difficult for women to determine if an intercultural healthcare experience is even possible at a clinic near them.

Moreover, the framework for intercultural health implementation is very unclear, so there are many issues that are left up to personal interpretation within each hospital. One example of this is the role that traditional birth attendants (TBAs) should have in the hospital. One study of intercultural healthcare stated, "Ecuador constitutionally protects traditional healers, but lacks clear regulations as how the public health system can interact with them," (Mignone et al. 2). This quote demonstrates the confusion that comes with lack of standardization. Without clear guidelines about the role that traditional healthcare should play in a biomedical facility, it is very easy to dismiss its importance. This confusion is exacerbated by the fact that the Ministry of Public Health does not hold much power, which makes it difficult to hold hospitals accountable. According to a public health nurse working in an intercultural facility in the region of Cotopaxi, "...the Office of Intercultural Health is very weak...the Office has no power to make things happen and to institutionalize what it has proposed. It only has a good intercultural and political discourse," (Gallegos et al. 108). Because of these informational gaps and the lack of

enforcement by the Office of Intercultural Health, it is difficult to provide consistently high quality healthcare, which means that inequality still persists.

Another major issue is that some hospitals do not provide a proper environment to facilitate a comfortable vertical birth, which is what many women who choose to have a home birth are seeking. Many of the clinics that provide vertical birth have built separate birthing facilities which have the tools necessary for vertical birth such as a kitchen where teas and food can be prepared, space and furniture for the family members who want to be involved in the birth process, and a chakana which is a ladder-like tool that women often hold onto while giving birth in a vertical position (Soguel 1). Some hospitals have implemented very successful vertical birth facilities. For example, the San Luis Clinic in Otavalo facilitated 128 vertical deliveries from April to December of 2008 (Soguel 2). This clinic is located in an area with a large Indigenous population; therefore, there was a high need for intercultural healthcare, and this clinic quickly met that need. However, many other hospitals do not even have the capacity or training to help carry out a vertical birth. The different interpretations of what it means to provide intercultural care make it hard for women to receive the same quality of care around the country. Moreover, even the highest quality facilities might not be appropriate for an Indigenous mother who is seeking a culturally sensitive birth because they might focus more on the medical side and forget the cultural importance of birth and its sacred nature in Indigenous cosmologies.

Racial Discrimination and Lack of Cultural Understanding

Another major setback to intercultural healthcare is that discrimination is still prominent in Ecuadorian hospitals. Even though one of the main goals of intercultural healthcare is to reduce racism, discrimination still happens, especially because there are no specific

consequences for racism that hold health practicioners accountable. As previously mentioned the Office of Intercultural Health has little power, which allows discrimination to persist (Gallegos et al. 108). In an interview about intercultural healthcare implementation, a mestizo policy-maker stated "'You can easily make cultural adaptations in hospitals but if HW attitudes don't change then you have the same discriminationin [hospitals] with vertical birth rooms'" (Llamas and Mayhew 7). If patients cannot be sure that they will be respected in a hospital setting, it is very unlikely that they will choose to give birth there. This means that they might choose to give birth in a more dangerous setting; therefore, it is crucial that hospitals provide the most welcoming environment possible. However, this policy cannot ensure that this happens despite its ultimate goal of reducing racism in the hospital setting.

The racism can also be seen among healthcare practitioners, which impacts the quality of care that patients receive. As previously mentioned, one major way in which hospitals have attempted to implement intercultural healthcare is through the presence of TBAs in western hospitals. This is meant to make Indigenous women feel more comfortable and to give equal importance to both traditional and western methods of care. However, the implementation of TBAs into western hospitals has not been an easy process for several reasons. Many doctors have been reluctant to accept the presence of traditional birth attendants in the hospital. For example, in a case study conducted in Cotopaxi, it was found that "TBAs face institutionalized intolerance, being barred from entering public health facilities and delivery rooms on the orders of attending physicians or even guards at hospital entrances" (Gallegos et al. 110). Healthcare workers often complain that they have worked too hard in medical school to allow traditional birth attendants to work in hospitals; therefore, they often undermine the advice of traditional birth attendants

and ignore their expertise during the birthing process (Llamas and Mayhew 4). Although doctors have been educated on the importance of traditional practices and the value of intercultural care, many still have a hard time respecting traditional medicine. As Mingnone et al. explain, there is "little support for Indigenous medicine among western health professionals in general" (7). Medical practitioners often feel that their years of studying biomedicine have given them more prestige and expertise than traditional birth attendants. These ideas, combined with prejudiced stereotypes about Indigenous people and their practices can cause a hostile environment in healthcare facilities. Tensions between healthcare workers and traditional birth attendants can cause discomfort and confusion for birthing mothers (Llamas and Mayhew 5). Moreover, the tension can also lead to racist outlashes against Indigenous mothers, which might deter them from returning to a western medical facility to give birth in the future. Therefore, even though one of the major goals of intercultural healthcare is the reduction of racism in medical facilities, it can actually increase racial tensions among personnel, which can create a more uncomfortable and possibly dangerous situation for mothers.

Improper Training and Implementation of Care

Misunderstandings among medical professionals about vertical birth also make the intercultural health policy less effective. Even though there has been a nationwide effort to provide vertical birth for patients, there is not always proper training to ensure that healthcare workers feel comfortable facilitating an intercultural birth. Many medical practitioners have complained that vertical birth is more dangerous, and they have reported higher fatalities among patients who chose to have a vertical birth. Part of this issue is that medical practitioners, who are used to facilitating horizontal births, have not been properly taught how to perform a vertical

birth. Therefore, they are less likely to do it in a safe way. According to a study conducted in an unnamed intercultural hospital in Ecuador in 2018, "Complications included post-partum haemorrhage resulting from an increase in vaginal tears and incomplete delivery of the placenta; an increase of dilatation and curettage (D&C) procedures; lack of asepsia, as HWs could not keep a sterile field because women constantly moved and contaminated the fields with excrements when they pushed, and the impossibility to perform episiotomies which they used to expedite or facilitate delivery and avoid vaginal tears, particularly in first-time mothers (primiparous)" (Llamas and Mayhew 4). This demonstrates that vertical birth in intercultural settings can actually be more risky if personnel are not properly trained, and this highlights a need for more intensive training programs in these facilities.

Additionally, medical practitioners often complain that they do not have the time or the resources to devote to learning about vertical birth; therefore, they do not have the understanding to respect the process of vertical birth or the skills to properly perform one (Llamas and Mayhew 4). One mestizo heath worker expressed his frustration with vertical birth saying, "'How would we, as health professionals, be involved in something that we thought was bad for patients?'" (Llamas and Mayhew 4). Because of the lack of understanding about vertical birth, many doctors discourage women from receiving vertical births even if that is the method that they are most comfortable with. Even if a woman goes to a western medical facility to have a vertical birth, she might actually be discouraged to have one. Therefore, the presence of vertical birth in western hospitals as a form of intercultural healthcare might actually be deterring women from giving birth in the ways that they want to. While this may be increasing women's access to biomedicine and increasing birth outcomes of women, it does not provide the most comfortable care for

women, and it can even lead to a more dangerous birth experience if the medical professionals do not have proper training. Therefore, it is necessary to have more comprehensive vertical birth training before it is actually put into practice in order to ensure that both the doctor and the patient feel comfortable during the birth process to ensure the safety of the mother.

Benefits of Intercultural Care

Even though there are many shortcomings of the implementation of intercultural care, it still provides great benefits to those who have access to it. As mentioned in the previous chapter, intercultural healthcare helps many women feel more comfortable and respected in biomedical facilities, and I found evidence for this throughout my qualitative research. One key example of the benefits of intercultural healthcare is Hospital San Luis de Otavalo, which is a clinic that implemented a vertical birth center in 2008. The article that I analyzed was written in 2009, and it discussed the progress of the intercultural healthcare program that was implemented the year prior. According to this article, intercultural healthcare brought many patients to the clinic. "Lily Rodriguez, an assistant representative at the United Nations Population Fund in Ecuador, says the introduction of the ward increased deliveries in hospitals by 8.3 percent" (Soguel 3). This demonstrates the positive impacts that a program of this nature can have on maternal trust of biomedical facilities. Moreover even though intercultural birth is tailored towards the needs of Indigenous women, mestiza women are also benefiting from the intercultural healthcare program. According to Pedro Luna, a chief gynecologist at the hospital "When the hospital opened the intercultural maternity ward, says Luna, indigenous women accounted for 95 percent of vertical deliveries. Most mestizas– women of mixed racial heritage–preferred horizontal, occidental delivery. The ratio is now 56 percent indigenous and 44 percent mestiza," (Soguel 2).

This demonstrates that intercultural care can be beneficial to all members of society, and it shows the value of mutual sharing and respect that is highlighted in the concept of interculturalism.

Conclusions

Throughout my research I found that there are many flaws in the implementation of the intercultural healthcare policy. Despite all of the shortcomings of the policy, it still has improved the experiences of many women in biomedical facilities, especially in areas such as Otavalo where the intercultural healthcare programs have been well-developed. Additionally, even though there are many facilities that have yet to implement vertical birth facilities, the efforts of speaking Kichwa or bringing TBAs into the hospital do help to create a more welcoming environment. Therefore, highlighting these shortcomings is in no way an attempt to criticize the intercultural model of healthcare. Rather it is an effort to demonstrate the areas of improvement in the implementation of intercultural healthcare. This research is conducted in an effort to help close the gap between policy and practice. There is still a great deal of work to be done in order to create a strong national intercultural health care program; however, it is clear from the success of local clinics that intercultural programs are worth the effort.

Chapter 5: Conclusion

Findings

I entered this project expecting to find a clear correlation between the implementation of intercultural healthcare and lower maternal mortality and higher maternal access to care. However, through my research process, I found that it is much more difficult to understand the progress of this project for several reasons. First, it is a relatively new policy, so there is not enough data to thoroughly analyze the impact that this program has had at a national level. Moreover, the type of data that is collected is not sufficient for detailed analysis of its impacts on Indigenous women. There may not be visible national impacts for a very long time; however, this does not mean that the project is not worthwhile or that efforts should not be put towards improving and expanding the program.

I also found that this policy is not as effective as it could be due to a lack of standardization. This was the major conclusion of both my qualitative and quantitative research. It is extremely difficult to have an effective policy when it does not function in the same way nationwide. While intercultural healthcare has had seemingly profound impacts in certain regions with a large indigneous population, there are other areas where I found no information about intercultural care at all. Moreover, after searching the Ministry of Public Health Website and the websites of individual hospitals, I ultimately had to resort to case studies conducted in intercultural hospitals to understand how interculturalism functions. This demonstrates a lack of clarity in national expectations for intercultural care. While there is a great deal of information

about the theory of intercultural care, there is very little information about how it is implemented nationwide, and it is very difficult for women to access intercultural care if they don't know how or where to get it. This is a major hindrance of the policy.

Moreover, through my quantitative research process, I found that there is very little clear and consistent data about maternal healthcare, especially health outcomes of different ethnic groups in Ecuador. Without this information, it is incredibly difficult to properly evaluate the effectiveness of the policy. Therefore, the lack of data is in some ways, an indicator of the possible ineffectiveness of the policy as well. It is very difficult for policy makers to create an effective policy if they do not have a clear understanding of what is actually happening within the country. Through my research, I found that in order for this policy to be truly helpful, it is important to have better data.

Areas for Further Research

Upon completing this project, I am still left with many questions that I would like to address if I had more time to develop my research. One key question is about healthcare for other ethnic minorities. I was really hoping to find information about Afro-Ecuadorian women because they are a major ethnic group in Ecuador that has faced discrimination and poor health outcomes throughout history. While I understand that much of the intercultural healthcare efforts have been focused on the needs of Indigenous mothers because of their specific beliefs regarding birth, I expected for some attention to be directed towards the needs of other ethnic minorities since they also have disproportionately high maternal mortality ratios. However, I was unable to find anything about efforts to address medical racism among Afro-Ecuadorians. I was very

disappointed by this, but I think that this is a gap in the literature that would be very interesting to explore if I had more time to conduct ethnographic research.

Similarly, I found it very interesting that the implementation of intercultural healthcare is so closely focused on the needs of Indigenous mothers. While the definition of intercultural care is the provision of respectful healthcare for all people of all ethnic groups, this is not the reality of intercultural healthcare in the country even though there are other ethnic groups who face discrimination in Ecuadorian hospitals. Moreover, I think it is important to think critically about why so much emphasis has been placed on birth. This is not the only healthcare issue that women face. Some scholars have even claimed that this approach to intercultural care is actually reinforcing the stereotypical role of women in society by focusing on their value as mothers (Camacho et al. 359). I would like to do more research into the implications of the focus on vertical birth and the reasons why this has been the key focus during the implementation of this policy.

I would also like to explore other policies that could be used in combination with the intercultural healthcare policy in order to increase Indigenous maternal health outcomes and access to care. Because this policy attempts to address racism within the medical setting, it could be useful in decreasing embodied racism over time; however, there are many other aspects of embodied racism that impact the health of ethnic minorities in Ecuador that are not directly related to the healthcare system. For example, the stress of racial discrimination in society or the poor infrastructure in rural Indigenous communities. These issues are not addressed by the intercultural healthcare policy. Without efforts to decrease racism in Ecuadorian society, discrepancies in health outcomes will remain. Obviously, no one policy can address years of

systemic racism within the medical system, much less in society as a whole. However, I think it is important to address the fact that there are so many other factors that impact maternal health outcomes; therefore, this policy will always have a limited impact on ethnic minorities if those other factors are remaining constant. In the future, I would like to do further research into ways to address medical racism and systemic racism that could be used in combination with this policy to help create better access to higher quality care and better health outcomes.

Conclusion

I came to the conclusion that this policy is a small step in the right direction, but there is still so much work to be done. The right to intercultural healthcare is benefitting some women, especially those in areas with a large Indigenous population where there are developed intercultural healthcare programs. However, there are many women who still do not have access to intercultural healthcare services even though they have the right to them; therefore, the intercultural healthcare policy has had virtually no impact on them. Because of this, the policy has not had much impact on national maternal access to care and mortality ratio. It is important to do this work of critically analyzing the policy in order to highlight areas of improvement and continue the work of creating policies that actually provide equality and equity.

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