



The Hegemony of the Biomedical Model from the representations of health care worker in the context of a health care model with an intercultural approach in Chugchilán, Ecuador

La hegemonía del modelo biomédico desde las representaciones del personal de salud en el contexto de un modelo de atención en salud con enfoque intercultural en Chugchilán, Ecuador¹


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Abstract

This article aims to discover the intercultural practical approach in the context of the Comprehensive Healthcare Model within family, community, and interculturality in Chugchilán, Ecuador, via the recognition of knowledge, perceptions, and practices applied by the health team in maternal and child care. In this ethnographic study 21 health professionals, both Indigenous and non-indigenous from Chugchilán Health Center have participated, among the Indigenous health care workers were the primary health care technicians. The techniques applied were participant observation and in-depth interviews. The observed scenarios were the Health Center and excursion with community to record their daily life experiences. The generated data were examined using thematic content analysis. It showed that the operating biomedical hegemonic model could constitute one of the main limitations in the development of the intercultural approach. Even though Indigenous healthcare team holds an ambiguous and sometimes contrary role to the biomedical model, it has emerged as a counter-hegemonic element and real conciliator between biomedical and indigenous knowledge in intercultural contexts of care-self-care.

Keywords: Ethnography; Interculturality; Health Care; Indigenous Populations.

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Resumen

Este artículo pretende conocer cómo se pone en práctica el enfoque intercultural en el contexto del Modelo de Atención Integral de Salud con enfoque Familiar, Comunitario e Intercultural en Chugchilán (Ecuador), mediante los conocimientos, percepciones y prácticas que aplica el equipo de salud en la atención materno-infantil. Estudio etnográfico, en que participaron 21 profesionales sanitarios entre profesionales indígenas -técnicos de atención primaria de salud- y no indígenas del Centro de Salud. Las técnicas llevadas a cabo fueron observación participante y entrevistas en profundidad. Los datos generados se analizaron mediante análisis del contenido temático. El análisis de los datos evidenció que la hegemonía del modelo biomédico operante podría constituir una limitación en el desarrollo del enfoque intercultural, sin embargo, el personal de salud indígena, desde su rol ambiguo y contrario al modelo biomédico, emerge como un elemento contrahegemónico y articulador real entre los saberes biomédicos e indígenas en contextos interculturales de atención-autoatención.

Palabras clave: Etnografía; Interculturalidad; Atención Sanitaria; Poblaciones Indígenas.

Introduction

Intercultural perspective was introduced in the political arena of Ecuador as a result of the indigenous mobilizations that took place in the 1990s, in which they demanded their right to land, water, and health, among others. The mobilizations led to the reform of the Constitution in 2008, from which Ecuador was established as a plurinational state, integrating *Sumak Kawsay* [in Quichua] or *Buen Vivir* [in Spanish], in the so-called National Development Plan (Ecuador, 2009). *Sumak Kawsay* is a concept inspired by Indigenous ancestral approaches that starts from a holistic cosmovision of Andean-Amazonian ways of life, intending to show a harmonious life model both in community relations and with the natural environment—“*Pacha Mama*” or “Mother Nature” (Acosta, 2015; Arteaga-Cruz, 2017).

Health was one of the core elements to achieve the objective of *Buen Vivir* (Good Living), since the Ecuadorian health system proved incapable of serving the existing ethnic and social diversity. This fact was manifest, for example, in the limitations of access to health services, high rates of malnutrition and maternal and infant mortality, especially among Indigenous peoples (López-Cevallos; Chi; Ortega, 2014). In this context, the Ministry of Public Health played a role of great importance, as its reforms enabled the right to health for the entire population by strengthening the first level of care and the implementation of strategies in Primary Health Care.

The necessary reforms in the health sector included transforming the health care model into a priority strategic axis (Naranjo, 2014). These reforms resulted in the Comprehensive Health Care Model with Family, Community, and Intercultural Approach (*Modelo de Atención Integral de Salud con enfoque Familiar, Comunitario e Intercultural - MAIS-FCI*), which according to Espinosa et al. (2017), unlike previous programs that operated in the country, was not focused on the disease or on the provision of curative services, but on individuals, their families, and their communities. In addition, the health authority presented the intercultural approach as a program in which the two health systems present in Ecuador can coexist. The first is that of traditional Indigenous medicine or ancestral medicine, terms

that, from the “etic” perspective, will be used to refer to the terms used by the State or official institutions; while, on the other hand, from the “emic” perspective, we have taken into consideration the term “traditional medicine” as that which is used by the community members and Primary Health Care Technicians (PHCT). The second is the biomedical system or Western medicine. The intercultural approach tried to formalize the coexistence between these two models with the fundamental pillars being: the creation and training of PHCT—professionals from the Indigenous communities; inclusion of midwives and traditional/ancestral physicians in the official health system; and, training health professionals in the intercultural approach (Ecuador, 2012).

However, according to various authors, the MAIS-FCI model does not respond to an intercultural approach in which the beliefs of Indigenous peoples and nationalities, either as a group or individually, are incorporated into the health system (Gallegos; Waters; Kuhlmann, 2017; Torres; López-Cevallos, 2017; Herrera et al., 2019). Herrera et al. (2019) assert that the Indigenous path to healing may be “chaotic” and “amorphous,” contrary to linear model posed from the State, and based on essentialist notions of what Indigenous culture means. On the one hand, this is because the State ignores the Indigenous path to healing and, on the other, because it is proposed that there are only two interacting health models the biomedical and the ancestral medicine. In this line Menéndez (2016) points out that current models of care in Latin America maintain an uncritical and reductionist vision of interculturality, relying on the existence of only two models, leaving aside the different ways of understanding health and disease. On the other hand, the change of focus from curative to preventive and the incorporation of the different approaches in the MAIS-FCI, including interculturality, influenced not only the structural modifications of the Ecuadorian health system, but also the profile of the professionals who provide health care, making effective what was established in the MAIS-FCI. The State made a significant investment in human talent toward strengthening the teams for the first level of care. Thus, Primary Health Care Technicians (PHCT) were created and trained with technical profile geared to prevention and promotion

work and not to curative care (Naranjo Ferregut et al., 2014; Espinosa et al., 2017). The PHCT belong to the communities and therefore act as a link between the people of the community and the health care workers. Their duties include: extramural visits, outside the health center; education and guidance on health care; informing about the health system and how it works, including special health programs such as vaccinations; and completing forms, such as family records, promoting the services and programs established by the health authority. On the other hand, this investment was also focused on the better management of the “Rural Health Service Year Strategy” (Estrategia del año de Servicio de Salud Rural) in line with the MAIS-FCI principles. This is how recently graduated professionals should comply with the rural health year, i.e., a mandatory work period mainly in rural areas prior to their professional qualification. For Pulido-Fuentes et al. (2017), during their academic the training health professionals do not acquire sufficient cultural competencies since, on many occasions, it is the first and only period in their professional path in which they will be with the Indigenous population. For this reason, Álvarez Romo et al. (2020) affirms that the insufficient time spent in these communities, added to the scarce time available with the community—once already working in them—means that these professionals do not develop cultural competencies.

This article aims to answer the question of how the intercultural approach is put into practice in the context of MAIS-FCI in Chugchilán (Ecuador) with the knowledge, perceptions, and practices applied by the health team in maternal and child care.

Methodology

The article presents part of the results of a broader ethnographic research carried out in Chugchilán (Ecuador) within the framework of a Doctoral thesis entitled “Consideración de la interculturalidad en las acciones de prevención y promoción de la salud materno infantil en las comunidades indígenas del Subcentro de Salud de Chugchilan, Cotopaxi-Ecuador”. Fieldwork was conducted between September 16, 2020, and April 30, 2021, with the researcher living in the community. The techniques used were participant

observation and in-depth interviews. Thematic analysis was carried out with the data generated. This article presents the results of the observations and interviews with health professionals. The sample consisted of 21 health professionals from the Chugchilán Health Center, who were followed up in their extramural actions—conducted outside the health center to provide care to the different communities—and intramural, within the health center (Table 1).

The scenarios of participant observation were varied both in extra- and intramural actions: home visits to families with some risk factor, such as incomplete vaccination schedule, pregnant or postpartum mothers, etc.; at the health center, during medical, nursing, or dental visits; also in

meetings with traditional healers and the local health committee.

The first observations were descriptive, and then focused and selective (Spradley, 1979) on specific aspects of the study phenomenon. Interviews were conducted at the health center, in a framework of trust and openness. At first, as the main researcher was a nurse and a teacher, the participants' reports were conditioned at times. This initial obstacle, which could have had repercussions on data, was overcome over time as the participants gained confidence with the researcher, and their speeches became more spontaneous. Additionally, the information provided could be constantly contrasted and validated during the observations and in-depth interviews.

Table 1 – Participants and settings of the observations

Participants	Interviews	Focused observations	Setting
21	20	12	<p>Extramural (community visits)</p> <ul style="list-style-type: none"> - In people's homes, while health teams visits mothers and children - During vaccination campaigns. - During medical brigade. <p>Intramural (within health centers)</p> <ul style="list-style-type: none"> - In clinics during health care

Ethical aspects

The study was approved by the Bioethics Commission of Universitat de Barcelona (Ref. IRB00003099) and by the Ethics Committee of Human Studies of Universidad San Francisco de Quito (Ref. IE3-EXP164-2019-CEISH-USFQ). Before starting the fieldwork, community consent (authorization from the Indigenous community to carry out the research) was obtained at the general assembly. All participants were informed of the objectives of the study and received guarantees of confidentiality. They were asked for written informed consent to participate, and any doubts they might have been clarified. Participants' privacy was maintained during the transcription and handling of the data by assigning them a fictitious name. Likewise, the security and protection measures adopted during the fieldwork were of vital importance, considering that fieldwork was carried out during the COVID-19 pandemic.

Community Context

The communities served by the Chugchilán Health Center are located in the high mountainous area of the Andes, and are characterized by a dispersed population within a large and rugged geographic area. Of the 7,811 inhabitants of the region, 85% (6,619) are Indigenous. The most remote communities are composed mainly of "Kichwa" Panzaleo people and are mainly extended families, whose form of social and political organization is the commune—they cover and regulate common needs and their highest authority is the community assembly. In terms of economic activity, the Indigenous communities are mainly engaged in agriculture, livestock raising, and family poultry farming. The products are for their own consumption, but part of it is commercialized, especially to acquire other products that the land does not offer. regarding health care, the villagers can choose between accessing the Chugchilán health center or one of the two neighborhood hospitals.

The population uses public transportation to access the health center; and since it only runs twice a day, they have to walk long distances on dirt paths for approximately 2 hours. The causes of general morbidity are mainly acute respiratory infections (39.6%), parasitism (14.5%), urinary tract infections (8.9%), acute diarrheal diseases (4.4%) (Ecuador, 2017). The first cause of infant morbidity is acute respiratory failure (59.2%), followed by acute diarrheal disease (15.7%). In the case of mortality, 45.28% of deaths in the canton are due to unspecified causes in those over 65 years old and under 5 years old. The main factor is the lack of immediate care in cases of illness or lack of preventive control (Ecuador, 2017).

Health care centers appear as components of the MAIS-FCI. These are classified according to levels of care, i.e., organization of services according to their capacity to solve problems (Ecuador, 2012). The Chugchilán health center is located at the first level of care, which is the gateway to the health system. The first level of care is characterized by its direct contact with the community and must cover the entire population, meeting the basic and/or most frequent needs of the community. These centers provide comprehensive care aimed at the family, individual, and community levels (Ecuador, 2012).

In the health center, most of the health care workers were recent graduates completing their “rural health year,” a mandatory period after graduation

and prior to officially practicing their profession. Among the staff there are Indigenous health care workers (Primary Health Care Technicians - PHCT) and non-Indigenous health care workers (nIHCW); and all of them make up the Comprehensive Health Care Teams. Those who were not present in the care teams were the representatives of Indigenous traditional medicine—despite being contemplated in the MAIS-FCI model. These include: the Midwives, women who are in charge of pregnancy control, diagnosis of pregnancy problems, assistance and company during labor, accommodating the newborn baby, and also providing the first care to the newborn; the *sobadores*, people who attend to everything related to blows, sprains, and fractures; the *yachaks*, people with multiple functions and knowledge, they know the ancestral medicine, diagnose and attend different affections either of the body or spiritual; and the *kuypitchak*, people who perform diagnosis of diseases by rubbing a “guinea pig” on the body, which they later dissect. The study participants of the health care teams were as follows: One physician specializing in Family and Community Medicine attending the health center on an itinerant basis; 5 general practitioners; 3 dentists; 3 nurses; 3 obstetricians; 7 PHCT. The permanent staff at the health center were the PHCT and the specialist physician, the rest of the staff were recent graduates in their “rural year,” from two different periods (Table 2).

Table 2 – Relay periods of the rural year

YEAR		2020													
Fieldwork												Sept	Oct	Nov	Dec
Group 1	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec			
Group 2							July	Aug	Sept	Oct	Nov	Dec			

YEAR		2021			
Fieldwork	Jan	Feb	March	April	
Group 1	Jan	Feb	March	April	
Group 2	Jan	Feb	March	April	

Period 1: from January 2020 – December 2020; Period 2: from July 2020 – June 2021.

Results and Discussion

To answer the research question, the results are presented based on two thematic axes and the

categories emerging from them related to the integration of care practice in the HC: non-indigenous health professionals; and Primary Health Care Technicians (PHCT) as indigenous professionals (Table 3).

Table 3 – Emerging categories based on the thematic axis

Thematic axis	Categories
Non-Indigenous Health Care Workers (nIHCW)	Linguistic-cultural relation
	Transmission of health-disease information
	Maternal care practice
PHCT	Intercultural competence and training
	The role of PHCT
	Training and capacity-building
	Medical practice

Non-Indigenous health care workers (nIHCW)

Linguistic-cultural relationship

Intra/extramural care reflects the relationship of the health care staff and the community, based fundamentally on the ability to communicate and relate to each other. In Chugchilán, there was evidence of difficulties on the part of the non-Indigenous health care workers in communicating with the communities. On the one hand, the non-Indigenous health care workers do not speak “Kichwa” (Quechua in Spanish), and on the Indigenous side there is a group that does not speak Spanish, another that speaks it, but does not master it, despite the fact that most of them are bilingual; and a last group with difficulties in understanding and interpreting information due to different levels of schooling.

I don't know Quichua, I don't know, some few words that they have taught us, [...]. Sometimes it is difficult to understand them, even when they speak Spanish to us, it seems that they do not say some words well and we do not understand them, so we have to call the PHCT. (nIHCW _1)

[...] there are some inconveniences here in terms of medical visit when dealing with the population, [...] the problem is that there is no, there is a lack of education [...]. (NIHCW _2)

These situations evidence the frustration of the non-Indigenous health care worker, due to the fact

that they are not autonomous in patient care, since they depend on the PHCT to communicate, give information about prescriptions and other treatment indications. The narratives note that linguistic differences generate communicative difficulties in diverse cultural contexts (Fernández Juárez, 2008; Belintxon; López-Dicastillo, 2014) and support the need to use interpreters or mediators (Carrasquilla Baza; Pérez Quintero, 2018; Pulido-Fuentes et al., 2017), a function that in this case is exercised by the PHCT.

At the same time, two new situations appear making communication even more difficult. First: the non-Indigenous health workers uses biomedical technical language, making it difficult for Indigenous people to understand. And second: the health workers do not seek to deepen the explanations about treatment or educational orientations, because they consider that patients will not understand them—Observation Note (ON)—and this is again attributed to the educational level of the patient.

[...] then the mothers, who are illiterate, almost do not know [...] Since the initiated doctors [young and novice physicians] speak in Spanish, they almost don't take it into account, they almost don't explain, so when we explain in our language then they again, they reconsider and understand. (PHCT_1)

The findings make it clear that, as in other studies, the communicative process is complex (Belintxon;

López-Dicastillo, 2014), and accounts for prejudices and stereotypes based on cultural differences, built from the spheres of power. Because of this, the community is placed in a position of inferiority, by qualifying its knowledge as non-knowledge compared to the location of the non-Indigenous health workers as subjects of knowledge, falling into a cognitive racism based on “knowledge-power” (Rocha-Buelvas, 2017). Additionally, as Fernández Juárez (2008) points out, the lack of knowledge of the language, culture, and Indigenous medical systems will also produce certain responses in care “alien to any kind of intercultural criteria” (Fernandez, 2008:31).

Transmission of health-disease information

In addition to the linguistic aspect, we consider how the biomedical model has permeated the activity of health promotion and disease prevention in relation to how information is transmitted to the community members, especially mothers, to promote the activities of the health center.

The observations and narratives disclose how information is not provided in a direct way, as the non-Indigenous health care worker shy away from prolonged social contact and extensive explanations. Non-Indigenous health care workers prefer to delegate to PHCT the delivery of indications and instructions to patients. For example, a physician (NIHCW _2) who, after a physical assessment of Laura (patient), tells her she has a sore and very red throat. The physician then explains to PHCT how Laura should take the medication while he completes a form and leaves the house. In this context Laura explains her doubts to the PHCT: what it is and why she should take it (observation note - ON).

In another observation, on family planning programs, it was evidenced that mothers were informed in a partial and unidirectional way, informing only about the methods that were in the service portfolio (hormonal implant, oral contraceptives) and emphasizing those that were close to expiration (ON). the information provided, thus, does not seek to explain the method nor does it seek to solve doubts. For example, an obstetrician (NIHCW _13) visited Maria—a puerperal woman—and mentioned to her that she had to take contraceptive pills, and that on Wednesday she should go down

to the health center to have the intrauterine device inserted. That said, the obstetrician left the house without giving her any further information. The PHCT, who is familiar with the procedure prior to the implantation of the intrauterine device, and in view of the mother’s uncertainty, gave her explanations on how to take the pills prior to the intrauterine device implantation. Maria, in response to the explanations, expressed that she could not attend because she had to take care of her children, and showed doubts about the treatment questioning “won’t the pills do any harm?” (ON). These doubts were based on maternal representations that the patent drugs would cause discomfort in the body, in line with what is shown in other studies (Fernández, 2008).

Precisely, continuing with the explanations about contraceptive methods and other devices, it was seen that they are superficial as they do not consider the social and cultural aspects of women’s lives and how these remedies can affect the health-disease-care-prevention process. All this shows the absence of an intercultural dialogue where biomedical and Indigenous popular knowledge and practices converge. This is how prevention and health promotion is literally based on the indirect “delivery of information” via the PHCT, partial information as it does not deepen or broaden the information, unidirectional information, as it does not seek dialogue with the other, imposed and as a transversal axis to the curative approach that prioritizes diagnosis, disease, and treatment. All this shows an asymmetrical, conflictive relationship with reductionist vision of the person’s experience from the hegemonic position of biomedicine (Menéndez, 2016; Ávila; Alves, 2022). Similar cases are repeated during the research and evidence that, as in the studies of Carrasquilla Baza and Pérez Quintero (2018) and Pulido-Fuentes et al. (2017), health care workers “[are] not aware of the importance of the cultural domain in the way they carry out their work, and this hinders cultural consonance” (Pulido-Fuentes et al., 2017, p.369), falling into “cultural impositions” (Leininger, 1999).

Maternal practices of care

To understand how the biomedical model is presented in the health center, it is important to take a tour of the knowledge and perceptions of non-Indigenous health care workers regarding certain maternal practices.

Regarding perceptions, the health care workers consider that many of the Indigenous women perform risky practices such as home birth, putting the life of the mother and baby at risk, as opposed to hospital birth, which is the only one considered safe: “Home birth is not safe, it puts the mother and baby at risk, why deliver at home if they can deliver in the hospital?” [...]” (NIHCW _2).

Other risky practices are maternal decisions regarding their own or their children’s health that, according to biomedical knowledge, are made with no scientific basis:

The other time the mother came with her son who was crying from toothache, to have me pull out her son’s tooth. I told her that we could heal him and that it was no good to take it out because his teeth would move. She didn’t understand, she insisted that we take out the tooth, she got angry [...], the PHCT explained to her, but she said that taking out the tooth is only one pain, and so it should not come back; in the end we took it out, but I don’t understand [...] (NIHCW _7)

Likewise, in relation to vaccines, the non-Indigenous health care worker consider that women have erroneous theories, such as that vaccines are harmful. In order to convince parents to vaccinate their children, the workers use various forms of persuasion (Fernandez, 2008). For example, commenting to them that if they do not do so they may “die” or lose “the bonus,” an economic benefit from the State (ON). However, the non-Indigenous health care workers are unaware that some mothers avoid vaccines because, in their rationalities system, vaccines have iatrogenic effects such as general malaise, fever, and irritability in their children.

[...] I have heard a lot of theories that parents have about why they don’t want to vaccinate, so we convince them. See, if you don’t get the vaccine and they catch the disease, your child could die [...], they are going to take away your bonus. Because we have to comply, and we know that the vaccine is right, and that the child will not get sick if we give the vaccine. So, then they think a little bit. (NIHCW _1)

They also perceive that mothers do not do enough in terms of feeding and hygiene:

[...] I think there is a lack of care because, for example, I don’t know if in feeding, for example, there are quite a few children who are [underweight for their age], they don’t go for their check-ups. They come when they already have vomiting, diarrhea, when they are already sick. That is when they come [...] I am preparing the patients, I have not seen them come when the child is healthy, they always come when they are already sick [...] If the children are not well cared for, if they get sick with diarrhea, then there is a lack of hygiene and care. (NIHCW _11)

Therefore, perceptions about Indigenous knowledge are supported by social representations that are based on generalizations and colonial imaginary linked to historical prejudices (Walsh, 2009), from which they end up seeing these behaviors as wrong (Ávila; Alves, 2022). These perceptions do not recognize that Indigenous women develop different and individual representations regarding health-disease-care-prevention processes (Menéndez, 2016), or as Fernández Juárez (2008:41) mentions “Indigenous versions of signs, symptoms, diseases, and therapeutic processes are not equivalent to those of biomedicine and its protocols of action.” Dias-Scopel and Scopel (2019) also show that self-care practices are prioritized and central in indigenous communities, but that knowledge is not recognized by health professionals in the daily routine of biomedical care.

Intercultural competence and training

In university training, despite having restructured the university curriculum based on the objectives of Ecuador’s National Plan for Good Living (*Plan Nacional del Buen Vivir*) 2009-2013 (Ecuador, 2009), little is actually applied (Cedeño Tapia et al., 2021; Meneses; Icaza; Albán, 2020) showing a low or almost nonexistent level of training in intercultural competence. Therefore, the training level still needs to incorporate inter- and multidisciplinary approaches to interculturality, as well as traditional medicine in the undergraduate teaching plans (Fernandez Juárez, 2008; Herrera et al., 2018). The non-Indigenous health care workers interviewed

consider this theoretical and practical training, as well as that received from local health administrations, as insufficient. With this background, the notion of interculturality for non-Indigenous health care workers is limited to its literal definition of “between-cultures” (Carrasquilla Baza; Pérez Quintero, 2018), hiding the existing power relations between the dominant and the subaltern culture (Walsh, 2012).

How come intercultural health? That is, of cultures? Well, I think that neither the Ministry nor the university prepared us. Maybe they should have explained it to us [...]. We are different, we think differently. They told us that we had to be extroverted. [...] Here they throw you out of the community at once. (NIHCW _1)

In the “rural year” period, the non-Indigenous health care workers come from different regions of the country. Some of them have never left their areas of residence, others have not had previous contact with Indigenous communities, nor have they undergone training—neither theoretical nor practical—so they do not know the lifestyles and customs of the communities.

The truth is that I have never gone out, I was trained in [...], there are no Indigenous people there. [...] besides, sometimes you hear things, but that's all. At the university, we have never done internships in Indigenous communities. (NIHCW _10)

All this, finally, leads to the fact that the care applied by non-Indigenous health care worker to Indigenous populations is marked by a clear biomedical influence.

[...] because in the end the care, no matter if it is to someone rural or to someone who lives in the city, in the end the real thing is the participation of the pathology, the treatment, the diagnosis remains the same. (NIHCW _2)

Despite all this, during the “rural year” and after the first encounters with the “strange” or the “different”, the non-Indigenous health care workers become more attentive to cultural issues, i.e., they manage to develop some *cultural awareness* (Campinha-Bacote,

2002). This cultural awareness allows professionals—especially nurses—to adapt at the practical level, such as positive differentiations (person-based explanations) or language adaptations (using popular language); in short, being more *sensitive* to the needs of the culture.

[...] I've had to change, I think it's a little bit the language, expressing myself carefully from there I haven't had to do anything (laughs). I don't think I know how to speak, I don't know how to speak with very technical words to the point of, to explain something, I think that in that sense, that's it, that's all, no more. If it's like saying “sputum” or you don't understand me, you have to say “drool,” “gargle” or something like that [...]. (NIHCW _11)

Indigenous health personnel (PHCT)

In the comprehensive health care teams, the PHCT stand for an important pillar in the deployment of the MAIS-FCI model (Ecuador, 2012). Their attributions include extramural visits with the rest of the team, they are always present; education and guidance on health care; providing information about the health system and its functioning, including special health programs such as vaccinations; and completing forms, such as family records.

The role of the PHCT

The PHCT, in the health centers perform a series of activities in which their main role within the health teams is evident. This role is fundamentally that of a mediating agent or bridge in health care, that is, mediating between the community and the biomedical system: “[...] it allows you that approach, at a certain point they translate to you, they make you understand what you want to say to the patient and what the patient wants to say to you [...]” (NIHCW _1).

The observations and interviews displayed a whole series of activities developed based on the attributions set by the health authority. The PHCT are thus shown as agents of promotion, education, and guidance of health programs:

[...] Health promotion activities, we carry out according to the norms of the Ministry of Health, for example,

we carry out vaccination campaigns, first we promote before the practice and also another would be about what we are currently living, about coronavirus (PHCT_1)

They also promote the services provided by the health centers: “Today, on the subject of planning and we have fostered with contraceptive methods [...]”. (PHCT_1). Related to this promotion of services, they also manage the access to patent medicines, especially those that do not require a prescription, such as paracetamol. For example, in the middle of a conversation, Maria commented that she had been suffering from a headache and other cold symptoms for days, and that her neighbor called one of the PHCT and they agreed that in the afternoon he would bring her paracetamol to relieve her symptoms (ON). These activities also include those of a census-administrative nature:

[...] we prepared reports of the activities, update of vaccine card holders, and also update in the talking map of pregnant women, and also general map of priority groups and update of situational room. [...] update of family cards. (PHCT_1)

All these functions described are in line with those shown in other studies (Pontes; Rego; Garnelo, 2018; Langdon; Diehl; Dias-Scopel, 2014), being also related to what MAIS-FCI establishes, so they do not generate conflict with the biomedical model. The relevance of the role of mediation—or bridge—in the PHCT, is due to the mastery of the Kichwa language and knowing the community with whom they create bonds of trust and even share kinship ties.

Despite the importance of the PHCT, this role may be considered ambiguous and contradictory when observed in practice. It is contradictory regarding the MAIS-FCI and, above all, as Langdon and Garnelo (2017) point out, it generates bad relationships and tensions in the core health teams. Observations evidenced that the PHCT are often consulted by the mothers about ailments looking for answers. The PHCT, based on their knowledge system, determine and treat/cure the condition, but this is done away from the process of diagnosis and medical care. In other words, it is carried out without the intervention of the non-Indigenous

health care workers, similarly to how mothers seek solution to the ailment, in what Menéndez calls “self-care” (Menéndez, 2018). One PHCT mentioned: “Yes, yes,, we know, always saying and collaborating something, for a patient who needs some little thing. Yes, we are collaborating the same if we are there, field remedies, like native plants” (PHCT_2). When mothers opt for Western medicine, they prefer to consult the PHCT for reasons of trust and familiarity (ON). Therefore, the PHCT ends up playing an important role in the patient’s health-disease-care-prevention process, although it is undervalued by the rest of the health team.

[...] as you mentioned that everyone thinks that everyone here, we are, we are doctors, yes. So sometimes they also kind of take on that role. So sometimes they, they are the first contact with the patients. So sometimes they decide who you see, who you don’t see, they spoil patients by always taking their medication to them. So, in, at that point, no, they don’t really help, they become more and even a problem. (NIHCW _3)

At this point it is evident that PHCT are also articulators between different medicines: western medicine, Indigenous traditional medicine, or popular medicine:

[...] well, we connect and in some communities on the subject of ancestral medicine, if they are working, strengthening, we as health personnel have also worked with them as well. [...] both with midwives, yachak, kuypichak, herb maker and sobador, so they work helping each other. (PHCT_1)

These examples show how the PHCT both recommend ancestral medicine and accompany the biomedical system according to the person’s condition, but these situations generate tensions within the health teams. For example, it is seen that the non-Indigenous personnel believe that the PHCT seek to lead and impose themselves on their decisions when they determine which patients to visit and which activities to carry out. On the other hand, the PHCT also assume that the non-Indigenous health care workers will have difficulties in understanding the

community, as they do not share the language and cultural aspects, and therefore they are of the opinion that *“without us they cannot enter the communities, we do not let them.”* (PHCT_1). Despite these situations and tensions, the health team does not establish strategies to overcome them, accepting that this is how the physician/nurse-patient contact and relationship is. On the other hand, this situation does not favor the establishment of a relationship of trust with the non-Indigenous health care worker, contrary to what happens in the relationship with the PHCT.

All this shows interference in the cultural encounter, which does not allow the development of social contact and the physician/nurse-patient/community relationship, which would be contrary to a critical intercultural perspective (Walsh, 2009). In addition, it also favors the creation of stereotypes about communities, since direct interaction with people from diverse cultures is avoided, an aspect that does not help to refine or modify existing beliefs about a cultural group (Campinha-Bacote, 2002; Leininger, 1999).

Other situations that have to do with the translations that PHCT perform is that, on many occasions, words are translated without connecting them to the Indigenous cosmovision. This cosmovision is necessary to establish approaches to understand culture. In the intercultural context, health care faces the problem of cultural translation, which not only limits the replacement of a word but also the replacement of the worldview, as well as the vision and conception of health and disease (Carrasquilla Baza; Pérez Quintero, 2018).

Training and Capacity-building

PHCT are health care workers accredited by the health authority, with baccalaureate degree. To become accredited, they are trained for 2 years not receiving specific content in intercultural care, but content based on the biomedical approach, just like the non-Indigenous health care workers.

There, they talked about vital signs, everything is morphofunctional, they gave mathematics as statistics, a subject that they had to learn, calculations, all those things, then, you know, psychology and some subjects that TICS will be for that subject, for what it is called, for the platforms that they can handle and to enter the Internet and do some activity [...].(PHCT_2)

Regarding continuing education, the PHCT are very interested in enrolling in courses offered by the Pan American Health Organization through the health authority. These courses, however, are biomedicine-oriented, such as for example the detection of patients with cardiac conditions, or on specialized biomedical techniques (ON). These trainings reinforce the biomedical model (Diehl; Follmann, 2014; Langdon; Diehl; Dias-Scopel, 2014), hindering the articulation between local knowledge, Indigenous health practices, platform of the comprehensive health care model, and the intercultural approach, as established by the regulations (Ecuador, 2012). This situation brings about contradiction, since those who should be mediators and liaison with the community—emerging from the community, as a way of representing “the dialogue of knowledge” according to the MAIS-FCI (Ecuador, 2012)—end up being one more representative of the biomedical model. This situation also poses a risk, since the knowledge of PHCT as Indigenous somehow begins to be colonized (Rocha-Buelvas, 2017; Quijano, 2000) and, through them, the Indigenous women as well.

Medical practice

As previously mentioned, between the PHCT and the rest of the comprehensive health care team, there are different appreciations that are mainly born from the experiences shared in both intra- and extramural work. The vision of the PHCT, due to their experience and permanence in the health centers, is important when it comes to describing medical practice in the intercultural context. The PHCT, based on their own system of Indigenous representations, perceive that non-Indigenous health care workers are seen as strange and distrusted by the community, especially at the beginning, *“the people do not trust us at first”* (PHCT_6). For this reason, they are the link with the community to enable the non-Indigenous health care worker to be integrated and accepted. In addition to this fact, the PHCT believe that the itinerancy of these workers, especially those in their “rural year,” provides little experience and therefore insufficient skills in practice and in relations with their culture, often witnessing situations of rejection and cultural discrimination toward the community.

Well, yes, they have a little difference [a term that expresses unequal and discriminatory treatment] because every time they go out to the community, then they as professionals, then some things, so they are like that they see, for example, they observe, they diagnose the patients. So, they don't just explain, for example, by dispensing medication. Then they say that you have to take it, like this, like this. Then they leave a prescription [...]. (PHCT_1)

The PHCT are also concerned about everyday aspects in the physician/nurse-patient relationship: the tone of voice; the words used; and even the body movement on the part of the non-Indigenous health care worker (NO). All of these are aspects that, according to the Indigenous social representation system, determine “good or bad treatment.” People in the community are wary and fearful of talking to strangers and more so with the “*doctorcito*” (little doctor), a term used to refer to all non-Indigenous personnel, using a low tone of voice in contrast to the loud and fast tone of voice of people from the coastal region, a warm climate zone, closer to the Pacific. The accent and tone when speaking make them sometimes assume that they are “*talking*” [treating them badly] (ON).

Everyday life, in short, is what determines the level of bonding that can exist between the community and the non-Indigenous health care worker. This daily routine is affected by aspects of bureaucratic work: “[...] they tell us that we must visit the communities, integrate, organize activities, but they also ask us for reports all the time” (NIHCW _2). And also because of personal aspects, such as social and family commitments. Thus, the non-Indigenous health care workers are rarely included and participate in community activities such as *mingas* (community work), religious acts or festivities. When the non-Indigenous health care workers are invited to community activities, they send the PHCT in their place. The workers themselves sometimes mention this: “*I believe that one never finishes integrating one hundred percent into the community*” (NIHCW _11).

In this sense, Langdon et al. (2014) mention that the relevant information generated in the communicative interaction during home visits

is disregarded when the activities are reduced to the production of “reports.” Therefore, non-Indigenous health care worker is not integrated into community processes that involve sociability and that take place among kinship networks, political and trust relationships.

Final Considerations

This article shows aspects related to the intercultural approach in health that previous studies have already mentioned, such as the problems of linguistic and cultural competence of health professionals, due to lack of previous training, high turnover of health care workers, and the lack of participation in community life. All this continues to contribute to the creation of stereotypes regarding Indigenous communities and to the non-recognition of their ancestral knowledge.

On the other hand, the biomedical model continues to be very present in the actions of health care workers, despite the MAIS-FCI, showing that the dialogue of knowledge promulgated is almost non-existent, except for the figure of the PHCT. The intercultural approach of the MAIS-FCI, besides creating the figure of the PHCT as Indigenous workers, considers the inclusion of ancestral knowledge as pillars of the model. Ethnography, however, has shown that in Chugchilán the figures of traditional medicine are not contractually included in the health center.

The hegemony of the biomedical model in Chugchilán is “strong,” but there are other opposing forces that act as a counter-power. This counter-power is carried out by the PHCT who, with their daily practices spontaneously oppose the hegemonic power, for example: prioritization of extramural visits, influencing the decision on maternal care, etc. They are in a privileged position, as they are part of the community, and play a prominent role as mediators or bridges between the biomedical model and traditional medicine. This fact positions them in an ambiguous way since they are part of a hierarchical institution and a biomedical model permeated by knowledge-power relations. In a way, they have managed to exercise counter-hegemony in the face of a biomedical model that ignores the interactions that take place

within the communities. In addition, the PHCT, as experts in biomedicine and traditional medicine, are articulators of this knowledge in intercultural contexts of care-self-care, applying treatments of one or the other knowledge according to the mothers' ailments. The attention and care provided by the PHCT in Indigenous communities clearly becomes a construction of intercultural attention and care, deconstructing the hegemonic biologist biomedical model. Through their actions, they seek to achieve the objective of *Buen Vivir* (Good Living) of *Sumak Kawsay*.

Finally, it should also be noted that the narratives of non-Indigenous health care workers differ depending on whether they are medical, dental, obstetric, or nursing staff. In nursing, there is greater empathy toward the Indigenous reality, perhaps due to their own training and the fact that it is a profession based on a humanistic and holistic vision of the person.

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