

We need to “*ikarar the kutipados*”: intercultural understanding and health care in the Peruvian Amazon

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Abstract *The scope of this qualitative research was to describe and analyze how the Kukamas Kukamirias indigenous population from the Peruvian Amazon perceives and evaluates the healthcare offered by health workers at the local San Regis health post. An ethnographic-based study was conducted among the San Regis community on the Marañon River in the Loreto district of Peru, including interviews and participative observations with female and male patients as well as with traditional healers and professional health workers. An intercultural perspective is adopted to discuss the evaluations made by the Kukamas Kukamirias about the healthcare offered by professionals at their local health post. Issues examined include the intercultural matches and mismatches that affect vulnerable groups of the population in their interactions with the health services. The frequent preference shown for traditional treatment implies a close relationship between the healer and the person who is sick. This means that conventional forms of healthcare should be seen from an intercultural perspective and taken into account when organizing and articulating health services.*

Key words *Traditional knowledge and practices, Maternal health, Intercultural perspective, Professional health workers, Peruvian Amazon*

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Introduction

Although Peru is a multicultural country, the official health system (Ministry of Health) is directed towards a homogenous population, and does not consider that different cultures retain their own traditional knowledge and practices. Intercultural healthcare can be understood as the capacity to move between different concepts of health and sickness, life and death, different notions of the biological, social and relational body¹. An intercultural view implies enhancing common elements and respecting and understanding the differences that exist between cultures. However, it is necessary to recognize the limitations or the challenges that this perspective involves.

Disease, suffering, illness, physical, moral, mental, spiritual, psychological and other disorders are in some way defined by all societies and social groups, which develop different responses to deal with the suffering that constitutes illness, different ways to treat people who are sick². Each healing system represents a body of knowledge, formed within each society. In contemporary modern Western society, the benchmark in terms of health/illness is centered on the modern medical rationale, the essence of its knowledge and practices being found within the natural sciences model. According to several authors who take Western biomedicine as the focus of their anthropological investigations^{3,4} this hegemonic model tends to establish a working practice which individualizes the process of illness and its decontextualization from socio-cultural realities.

Interculturalism implies a relationship of respect and understanding the way that reality is interpreted, in a process that involves information, education and training. During recent decades, health interculturalism or intercultural health have been concepts used indiscriminately to describe a series of actions and policies that seek to understand and incorporate the culture of a patient within a health care process⁵. Developing inter-cultural processes in various Latin American countries, be this for historical, socio-political or epidemiological reasons, was required to ensure that a person's ethnic and cultural identity would not become a barrier that would prevent them from gaining access to better healthcare. However, a divide still undoubtedly exists between the cultures of many societies around the world. According to Geertz⁶, "culture is a web of significances" and "man is an animal suspended in webs of significance he himself has spun,"

(...) [I take] culture to be those webs, and the analysis of it to be therefore not an experimental science in search of laws, but an interpretive one in search of meaning". This conception immediately announces the multiple possible meanings and interpretations about a phenomenon, if we adopt an intercultural perspective.

Another aspect present in this intercultural dynamic is the process whereby certain concepts belonging to one culture are assimilated by another. For example, the way indigenous groups use biomedical resources and practices is different from the way these are used by Western science itself; similarly, biomedicine interprets the elements that conform to other healing systems based on its own theories about the world. In much the same way that elements of indigenous cultures undergo a process of "scientification" by biomedicine, which incorporate these elements without considering the local logic⁷, a process of assimilation of biomedical elements also takes place among indigenous groups, who incorporate these in their own system of reasoning, a process that Greene calls "the shamanification" of biomedicine⁸.

Furthermore, it is important to observe that public organs themselves make use of the local elements of a certain culture as a way to minimize investments made in the health care provided to local populations. This issue is examined in an exemplary manner in the work of Cardoso⁹, when he discusses the main problems of incompatibility that exist between public policies involving indigenous peoples and the specific ways that these societies are organized. The author argues that the involvement of these communities and of their local leaders is essential when drawing up and accompanying healthcare projects, so as to ensure that the rights and the individual characteristics of these communities are respected.

When comparing different countries, it should be noted that no governmental organ exists in Peru, such as the National Indian Foundation – Funai, in Brazil, that specifically defines and administers policies related to indigenous populations. The Peruvian State defines itself as a democracy that represents the plurality of its cultures and accepts the cultural rights and equality of all Peruvians before the law. However, hegemonic guidelines still exist that are directed towards relationships of power, social and economic asymmetries and cultural intolerance within the "national culture." The government has not yet developed differential policies, which

means that indigenous peoples are still included in the Peruvian Ministry of Health's mainstream national health policy.

In Latin America, many countries have a significant representation of indigenous peoples among their population, as is the case in Peru. Including indigenous populations in healthcare coverage presents specific challenges, which should be analyzed to ensure that the universalization of the healthcare system is a success.

According to the Peruvian National Institute of Statistics and Computer Science (INEI)¹⁰, indigenous peoples represent at least a third of the Peruvian population and, more specifically, the region of the Peruvian Amazon has the widest diversity of indigenous people in the country, with their own culturally different music, architecture, ancient customs, mythology and traditional expertise related to healing practices. This context means that professional health workers are required to understand not only modern Western biomedicine, but also to see cultural and social issues as important factors when providing healthcare services, and in all procedures related to health and illness. The literature has indicated several limitations from the point of view of intercultural responsibility, either from the perspective of individual practices or from a micro-political-institutional context, in understanding traditional health practices, which reduces the quality of care given to these populations^{9,11}.

The original proposal for this research was to investigate the treatment provided to women during pregnancy, childbirth and during the postpartum period. During the period spent living alongside the people in San Regis, other questions also began to emerge, such as family violence, the use of contraceptives and interaction with professional health workers. They also include the evaluation of the treatment received at the local health service, differences of opinion about biomedical health care and the community's traditional knowledge and healing practices.

As a result of these discussions about intercultural health, this study sought to analyze the views expressed by the *Kukamas kukamirias* people of the San Regis community in Peru about the healthcare treatment provided by professional health workers at their local health service. This should be done in an attempt to understand more about the intercultural matches and mismatches that affect their relationship with healthcare services.

Context of the study

The region of Loreto has 355 healthcare services, which are distributed as follows: three hospitals, fifty-one health centers and 301 health posts¹². The healthcare structure is developed on the basis of the level of complexity of demands, which are classified into three levels of healthcare.

The first level is formed by health posts and health centers, where healthcare is considered to be of low complexity. This is where preventive and specific defensive measures are developed and early diagnosis and timely treatment provided for the most common health problems. These health services are found in suburban and riverside areas, and in some Indian villages with limited infrastructures. The way these services are distributed in the first level is designed to provide treatment for the whole population living in more isolated areas, which also means dealing with ethnic diversity, different cultures and dialects. The second and third levels consist of category I, II and III hospitals and the Specialist Institute, respectively. These are reference centers for outpatients and for more complex treatment¹³.

Some of the most important indicators of health problems in the Loreto region include maternal mortality, malnutrition (especially among infants), infant mortality, which are mainly associated with respiratory infections, the quality of water and acute diarrheal diseases. Other diseases that affect the poorer sections of the population, who have limited access to health services, are malaria, dengue, Leishmaniasis, yellow fever, Bartonellosis and human rabies.

The population in focus: the *Kukamas kukamirias*

The *Kukamas kukamirias* are considered the largest indigenous group in the region of Loreto. The "official" language in the region is Spanish. The *Kukamas kukamirias* dialect has been relegated to the private sphere. The younger members of the population only have a passive use of this language: they listen and understand, but do not speak the language. It can be said that this language is in danger of becoming extinct, since it is used in very restricted communicative situations and, in most cases, only by adults.

According to their cosmovision, there are two categories of the conceptual universe that are used to characterize issues of health and illness: *kutipa* and *ikaro*¹⁴. These two words refer to the

concepts of good and evil, respectively. *Kutipá* represents the influence that the spirits of animals, plants and individuals have on people who are weakest; it is something that penetrates the body, which alienates, causing harm and disease. Those who are said to be *kutipadas* present signs of debility, immobility and melancholy, in such a way that the concept of health contemplates the idea of purification and the need to expel that which is causing harm. This is achieved by means of *ikaros* (chants, prayer and/or protection, to cleanse the body, soul and mind), which make it possible to remove and expel that which is causing harm by means of rituals.

Methodological framework: seeking to see, to understand and to comprehend

This is an ethnographic-based qualitative study that seeks to understand the daily life experiences of the population living in San Regis on the Marañón River, which has approximately 1,200 inhabitants, in an area that is part of the region of Loreto.

This ethnographical work was essential to fine-tune our perception and understanding so as to be better equipped *to look, to hear and to write*¹⁵. Spending four months living within the community made it possible to describe the cultural scenarios, beliefs, experiences, attitudes, thoughts and reflections of the San Regis community.

San Regis was chosen because: a) it is one of the most populated riverside communities located on the Marañón River; b) this community has a health post and professional health workers; and c) it also has midwives, health promoters and healers within the community.

The techniques used to collect empirical material included participative observations and notes in field diaries and interviews. The participative observations were helpful in mapping various issues related to the community and made it possible to approximate the narratives with the meaning of actions, and the dimension of these practices and their significance in daily life.

The interviews added greater scope and detail to information provided from the perspective of members of the San Regis community: their knowledge, views, thoughts, language, actions, opinions, and evaluations in respect of the health care they receive from professional health workers. The interviews and photographic images were obtained with the prior and informed consent of each participant. A total of twenty-five

individual interviews were conducted which included pregnant women (six), mothers who had recently given birth (six), midwives (four), herbal practitioners (two), the husbands of these women (four), and professional healthcare workers (three). All the women had received elementary education, except for one who had never studied. The professional healthcare workers interviewed included nursing technicians and nurses with a university education.

Interviews with the health workers were conducted at night at the health post, at a time when these professionals were more easily available for this type of dialogue. This arrangement also made it possible to accompany several women who arrived at the post in labor.

The interviews with the local inhabitants were conducted in their own homes. Several small children usually accompanied the women. Each conversation lasted an average of one hour; however, some interviews were interrupted and took longer, since the informant had to visit their small country holding (located at least one hour's distance by canoe from the informant's home), to cook or to go to the river to wash their clothes. In general, informants showed more trust in relation to the research during subsequent conversations, when conversations tended to last longer and were on a more personal level and when family problems were shared. In the case of the men, the interviews were more lively and unhurried, even though these took place in their own homes at the weekend.

The interviews were transcribed, and every effort was made to transmit faithfully the exact meanings of the particular terms used by this group. Extracts from some of these interviews are presented as part of the conclusions of this article, so as to illustrate certain arguments. The names of the interviewees were replaced with fictitious names to maintain their anonymity and conceal their true identities.

A thematic analysis of the empirical material was conducted, articulating records made of the observations and narratives provided by the informants. This made it possible to understand the meanings that the subjects of this study attribute to the form of healthcare they receive from professional health workers in that location.

This study fulfilled the requirements outlined in Resolution 196/96¹⁶ and was approved by the Committee for Ethics in Research of the School of Public Health at the University of São Paulo (FSP/USP). This study was also submitted to the Ethics Committee at the National Health Insti-

tute of Peru and to the Ethics Committee of the Regional Health Directorate of Loreto, receiving approval from both institutions.

Different interpretations for the same phenomenon?

Studies in health anthropology are notable for the fact that these seek to understand experiences involving affliction, disease, injury, death, etc. and the ways people cope with these, according to different socio-cultural and historical situations. In all societies, illness is interpreted in a certain way, and healing systems/therapeutic procedures are formulated to comprehend that which disrupts the natural order of things. An intercultural perspective makes it possible to highlight this multiplicity without attempting to claim that one has primacy over another; on the contrary, it advocates the need to incorporate local knowledge into the healthcare process in order to achieve greater permeability and comprehensibility on both parts. This examination of the *Kukamas kukamirias* represents an effort in this field of study to seek to understand the way that different perspectives, related to the health-disease process, are (or are not) juxtaposed in healthcare practices in the San Regis community.

The devaluation of local knowledge

For the *Kukamas kukamirias* population, health depends on harmonious co-existence with the forces of nature, both as an individual and in conjunction with other people. Health care consists of a way of life where knowledge of traditional medicine is preserved, practiced and passed on. Nevertheless, outside the local environment, little is known of the great wealth of traditional healing methods. There is a wealth of knowledge, formed over thousands of years, about plants and herbal remedies, practices and concepts about pregnancy, childbirth and the postpartum period, among others. A cure involves a close relationship between the healer and the person who is sick and an emotional bond is essential for this to occur. This feature goes against the official healthcare system, which presupposes a distance between the two parties, and represents a point of conflict between the local expertise and that of the professional health workers.

The San Regis population says that their traditional health system (midwives, health promot-

ers, healers) is of enormous importance to them in their daily lives. It is a place where treatments are offered at an unhurried pace and where trust exists on both sides. The population receives advice that makes sense according to their cosmovision and makes them feel they have been treated well during their care.

Camilla (twenty-five years old, pregnant mother of her second child) provides the following comparison: *The people at the health post know that my mother is a midwife and they [the professional health workers] do not like the fact that women are treated by them [the midwives]. I have already decided to have my child here at home. The health post does not treat people well, I feel more confident in my own home, and I feel better here.*

The view that people have about the health workers is that they do not value local knowledge, and that their task is to persuade the *Kukamas kukamirias* peoples of San Regis that their knowledge is primitive, outdated, impedes the advance of modernization and that this should be discarded. According to the statement of one nurse:

Here at the post there are none of the traditions that they want and which interfere with our work, obviously this would hamper our work; but if I see that a newborn baby is still at home, I imagine the child could kutiparse, this is something I discovered here and it seems pretty strange to me, right? I don't believe in all these lies, on the contrary they [the fathers] have to be taught to take a bath because it is obvious that after working the land, fishing, they are all sweaty and dirty and if they pick up the baby, it [the baby] will become sick (Claudia, twenty-eight years old, nurse).

On one hand, this type of relationship can be interpreted as an example of ethnocentrism on the part of the health workers, since indigenous populations are treated like children, and seen as ignorant. The concept prevails that the indigenous population has to be educated, and shown how to live according to values or perspectives considered to be "more correct." On the other hand, this view must be taken on an individual basis since health practices are not totally disconnected from the macro-structural contexts for which these were created. This involves recognizing the fact that routine life is imbued with certain shortcomings, especially with regard to public policies, in the sense of making efforts to provide a differential healthcare service for indigenous populations. Thus, intercultural misunderstandings cannot be seen just from the perspective of personal limitations on the part of

healthcare workers. The situation is much more complex: such attitudes are often the result of inadequate government policies too.

***Ikararse* to find oneself: relationships between users and healthcare workers**

A norm exists within the Peruvian Ministry of Health stipulating that all professional health workers must serve in the Rural and Urban-marginal Health Service (SERUMS), when they complete their formal training. This is a form of internship (no longer supervised), aimed at offering healthcare services to the more isolated (rural areas) populations, for a period of one year. The ‘*serumista*’ healthcare professionals, when arriving at a village or community, are faced with a particular reality, communities that have internal structures, organization, political relationships, value systems, collective sanctions, their own language and cultural rules. Other non-*serumista* healthcare workers also work among these rural populations, that is to say, those who have exceeded this complementary period of training.

According to the views expressed by the local population, *serumistas* offer a low-quality healthcare service or are still in the process of “learning,” which is an aspect that is also noted in the literature¹⁷. Their assessment also extends to those who are not *serumistas*, who are also considered to have few of the abilities required to deal with the local population: *Here we can choose to go to the post when there are good workers there, good people, who treat us well. But, when they are very intransigent, it's impossible to go there. People working at our post are stubborn; they even scold us* (Andrés, twenty-eight years old, one of the husbands interviewed).

In general, when they arrive in the community, all health professionals are seen as showing a sense of superiority, since they reject most of the important aspects of local culture and knowledge. This lack of connection makes it more complicated to create an understanding and establish a good relationship between the users and the healthcare workers. The users hope to understand the guidance they receive, but also want to be understood and respected for their own traditions and, more importantly, that a relationship of “healing communication” be established, which is essential for them to evaluate if they have received proper treatment, and which transcends a physiochemical or anatomical-biological dimension involved in the healing process.

Failure to listen to or understand the local population is an issue noted by other authors in relation to certain ethnic communities¹⁸. The possibility of establishing a more dialogic posture that is sympathetic to the uncertainties, concerns and concepts of the local people, would make it possible to establish closer proximity and a relationship of trust between the population and the healthcare services provided by outside professionals. This is an attitude desired by the local inhabitants and could make all the differences as regards the *Ikararse* process: *It's important to feel we are being treated with respect, because we are human beings, right? We should be well looked after, so that we feel good, so that there is no ill-feeling, to continue using the services we have here, and which represent our people's ancient knowledge* (Elva, forty-two years old, a recent mother).

The people of San Regis feel that the reason that they are not well looked after by health professionals may be because they are *poor and of humble origins*. They say that when some healthcare workers arrive in the community, they assume a position of superiority, which makes local people question: *is this because they have a better education than we do? It's difficult to speak to them, as they don't appear to be very friendly* (Diana, thirty years old, a recent mother). Berlin and Fowkes¹⁹ point out that intercultural communication is achieved through a process that involves five elements: *listen, explain, recognize, recommend and negotiate*. Intercultural communication implies accepting that people have different positions, recognizing these and attempting to redress the balance as much as possible. Communication and information about health issues are ineffective when intercultural issues are ignored, a context where technical language is primarily used and where a total lack of consideration is shown for local knowledge/traditions. In San Regis, the attitude that normally marks the relationship between healthcare professions versus the local population is based on something that is lacking, on negativity. They use phrases such as: *you don't know, there is none, no, it isn't*, which places the former in a position of holding absolute knowledge and, at best, employs a form of pseudo-dialogue. As a result, the views of the specialists do not bring about changes in the health conditions of the local people, nor do they make social relations between both parties any easier.

In short, *Kutipa* manifested through a hierarchy of relationships negatively affects the *Kukamas kukamirias* population, contributing towards a perception of inferiority in relation

to other cultures. According to local opinion, it would be beneficial if health professionals could *Ikarar* a relationship of care with the indigenous population, ensuring that healing is provided through conscious communication. This should be provided without preconceived notions or impositions, and where local knowledge and expertise are valued, in an attempt to establish sincere articulation about health issues from an intercultural perspective.

Kukamas kukamirias: conflicting views about pregnancy, childbirth, the postpartum period and assistance received

Local lore includes several rather singular concepts about the process of pregnancy, childbirth and the postpartum period. Pregnancy is the most important stage in life, which means a woman has fulfilled her role and *is blessed*. Up until the eighth month of pregnancy, women carry out their normal daily tasks, which are seen as a form of exercise that will help them at the time of delivery; otherwise their bones will become hardened²⁰. Women only stop doing heavy work, such as carrying water or working on the land, toward the end of their pregnancy. During this period, they should avoid certain foods, such as game, which through the intermediary of the spirits can *kutipar* the unborn child. Certain fruits are also avoided (including, for example, watermelon, because this increases the size of the baby's head) and industrialized medicine.

The *ligadas* (bathing with the leaves of different plants) is a form of treatment that makes it possible for women to avoid feeling the cold, which can occur when they are caught in the rain or when they have spent too long in the water, washing clothes in the river, or have caught a cold. These precautions will prevent colic, and help women to prepare for the moment of delivery, when their bodies should achieve a perfect balance: neither too cold nor too warm, to ensure optimal dilation.

As from the seventh month of pregnancy, the *sobadas* (therapeutic massages of the womb) are frequently used as being synonymous with the safety of the mother and child, the purpose of which is to *acomodar* (correctly position – in the cephalic presentation) as well as to maintain a flexible womb *sem marcas* (without stretch marks). In general, pork, chicken or stingray fat, as well as ointments or odorless Vaseline, are used for these massages.

During childbirth it is important to take an infusion made from the leaves of the cotton plant, *sharamasho*, *malva* and *albacabranca* (local herbs), and always be accompanied by the midwife. Once the baby is born, the midwife uses warm water to clean the mother, who will remain resting for eight days, making sure not to expose herself to drafts or cold environments. A piece of cloth is tied around the mother's head; she wears socks on her feet and stuffs cotton into her ears. During this period, she and her baby may receive visits from family members; visits from those considered to have *good spirits* (to avoid *kutipas*) are also acceptable. It is forbidden to receive the visit of women who are menstruating, to prevent colic in the newborn child. Their meals are based on chicken soups and porridge made from cassava, tapioca or green bananas. Later, the mothers can eat grilled fish or fish soup, provided these do not contain mucus, teeth and a lot of blood. After eight days, the new mother and her baby take a bath, which is prepared by the midwife by boiling the leaves of plants. Only then can the mother and her child leave the room (which is a divided area within the house, prepared specifically for the moment of birth and postpartum period) to integrate with all members of her family. To help boost their health, during the postpartum period, women usually undergo a treatment, which is made from the bark of certain trees (maiteno, acapurana, the yellow mombin tree, the resin of the muiratinga tree, cat's claw – *uncaria tomentosa*). Their husbands are responsible for obtaining these tree barks, and prepare a drink from these using sugarcane juice or boiling water (similar to the idea of the "*garrafada*" – so-called 'bottled beverages' – found in several regions of Brazil). This is bottled and the new mother begins to take a daily dose of this liquid for a month, so as to clean her womb and help eliminate the blood that remains after giving birth.

The recommendations and procedures related to the pregnant and puerperal period, as approved by professional health workers, are very different from those just described. Professional health workers do not offer these women clear information or ask them about any doubts they may have at this stage. See the following statement from a recent mother about her childbirth experience:

When my first child was born, my sister took me to the health post, I couldn't bear the pain any longer and finally the nurse said to me: 'Let's go' [in harsh tones]. She took me to the delivery room and asked me to push, I had nothing to hold onto, and I

was lying down. I was tired, I started seeing different colors and was not reacting well, and my sister told the nurse I was dying, 'she's not going to die,' this woman [the nurse] said [in a cross voice], if the fetus dies in the womb, we can still save the mother. That's when I felt I was being cut [episiotomy]. When I was pregnant with my boy, this suture opened up [episiorrhaphy], and now this leg of mine is useless, I'm always in pain... that is why, when I had my second son, I decided to have him at home (Diana, thirty years old, recent mother).

Most of the women in San Regis choose to give birth at home. During this field research, the following were noted: seventeen deliveries at home accompanied by a midwife and nine deliveries at the health post. In general, the population expresses its disapproval as regards the treatment it receives from the healthcare services. For example, the husband of one recent mother complained about the lack of dialogue and the way some health professionals lost their patience while his wife was giving birth. His immediate reaction was related to the attitude that these midwives usually have at the post:

They don't tell us anything. I think they only do something when the baby is about to be born, nothing more. The care we receive here at the post is not always good. This is really unfortunate, because they don't have any patience. In my wife's case, they even argued with us. They told us, I am tired; they said this and then left the room. We were left on our own. I think midwives know more than they [healthcare professionals] do. (Andrés, twenty-eight years old, husband).

For their part, professional healthcare workers describe in jocular tones cases involving traditional post-natal care given to the women, which shows that they have no knowledge of and denigrate traditional practices that are still important to the local people. One of these nurses described her feelings as follows:

I have seen here how women, after giving birth, immediately stuff their noses and ears with cotton, so that the air [gestures] can't enter or leave, I really don't know how... they can use so much cotton and I don't know where else they put this cotton [laughter]...they also put cotton in the baby's ears, so that air cannot enter (Claudia, twenty-eight years old, nurse).

Among the many different situations witnessed, I would like to cite the case of a father who took his ten-year-old daughter who had been stung by a stingray to the health post. After a four-hour journey by canoe, they managed to reach the health post. No prior diagnosis was

made: they gave her an injection (supposedly to reduce the pain), while the girl's father was not given the name of the medication, nor the reasons why it was used. The pain did not go away completely. The father was surprised because he was not even asked how this accident had happened. He was worried as he thought his daughter might lose her life. Indignant with the care they had received, he requested the help of someone living in the community, who gave him a match and then, right in front of the health post, he set fire to "some sticks" and placed the affected area of the foot that had been stung in the heat and smoke he had prepared. It was clear that both became calmer as the girl's pain appeared to abate.

The professional healthcare workers said that all this was *totally ridiculous* and that they could not believe what the father did to his daughter. The girl's father regretted the fact that he had undertaken a very long journey, but had not received competent services or *adequate care*. Similar attitudes that disrespect traditional knowledge exemplify the difficulties that the population faces in developing a relationship of trust in healthcare services and with the professional healthcare workers themselves²¹ (Figure 1).

Final Considerations

An ethnographic approach made it possible to gain some first-hand experience of some aspects of traditional knowledge and practices used by the population of San Regis in a social and cultural context, which are still used within the community and confer meaning and significance to everyday events. Intercultural dialogue, based



Figure 1. Belief in magic: father "ikarando" the pain of his daughter by smoke.

on a respect for differences, would be most beneficial to ensure good professional healthcare services and a less ethnocentric and imposed form of care, which would make it possible for the local population to gain greater confidence in the professional healthcare workers and, hopefully, result in a greater belief in specialist traditional knowledge. However, certain structural and institutional issues, that transcend the possibility of taking action from an individual perspective, should also be taken into account. For instance, there is the problem related to the way healthcare professionals are trained as regards adapting practices to other cultural realities, which in Peru begins from the time they undertake their graduation studies. There are few activities that involve the theme of rural and, more specifically, indigenous communities, especially regarding cultural adjustments and an intercultural understanding, which calls for greater reflection about the needs and awareness required in respect of the true realities involved in providing a more horizontal system of healthcare. This underscores the need for intercultural dialogues that cover the human rights dimension and thereby recognize the differences that exist between vulnerable groups who are excluded or victimized by the States, due to either economic practices that exclude certain groups or because of discriminatory political or cultural practices²².

In spite of the macro-structural and political limitations involved, it would be most constructive if healthcare services began to treat individuals from an integrative and integrating perspective, as well as taking into account their specific socio-cultural characteristics. Consideration should also be given to existing tensions between the way public policies are organized in each location, as well as how health and disease are viewed from a patient's point of view, since these cause friction that affect professional practices when applied to the population in question.

In the case of indigenous areas, there is a need to provide differentiated healthcare and one that, concomitantly, guarantees access to health services while respecting and valuing traditional knowledge⁹. In other words, and as proposed by Lévi-Strauss²³, in relation to a psychological-physiological approach, it is possible to achieve the desired cure within a ritual context, which is accepted and believed by the community. After all, the success of magic is a belief in magic. Few questions should be asked about the use of potions, chants and other shamanic prac-

tices. The witchdoctor cures when he becomes an object of consensus: society knows (and desires) that he cures, the sick person believes in the cure and, finally, the witchdoctor himself believes in his own magic.

As can be seen, there exist several challenges from an intercultural perspective. Health activities are established on the basis of different models of illness and cure. When it became dominant, modern Western biomedicine superseded other healing knowledge systems, bringing discredit to other practices in the process; traditional expertise is seen as being of less value than the "official" knowledge and as an obstacle to development. Cultural barriers can lead to conflict, especially when there is no consensus about the meaning attributed to certain elements. The moment that one viewpoint is imposed upon another, interaction breaks down and intercultural understanding is jeopardized. In fact, it is not the differences that taint the process of interchange, but the imposition of one viewpoint over another.

Finally, it is necessary to *ikarar* the *kutipados* to create better areas between the two health systems (the official health system and the traditional system used by the local population) to find spaces for the production of meaning which will enable these two cosmovisions to meet or communicate. Among the *Kukamas kukamirias*, it may be said that their notions of health do not only refer to the physical state, but also to a series of social, emotional, environmental, spiritual and natural factors that establish internal and external, individual and communal harmony, as well as a relationship of empathy, of communicative cure, between professional healthcare workers and users. This scenario, where such elements are reconciled, is vital to the *Kukamas kukamirias* in this process of *ikararse*, that is to say, their desire to be purified through the elimination of the *kutipas*, and, thereby, to be *cured*.

It is necessary to recognize and to take into account the diversity of values and methods of learning as elements that are central to policies and programs, and which can promote more equitable conditions for mutual respect between the actors involved. Thus, adopting an intercultural perspective in relation to healthcare activities can help to overcome the lack of quality and equality in the way socially excluded populations are treated, as is the case with the Andean indigenous communities in Peru, and thereby remove the cloak of invisibility that exists in relation to indigenous healthcare.

Collaborations

RA Yajahuanca was responsible for proposing and planning this study; for gathering, analyzing and interpreting data and for writing this article. CS Cabral participated in the relevant critical revisions of the intellectual content, editing and making suggestions for bibliographic references. CSG Diniz was responsible for tutoring the project, revising the article and initial version and for making suggestions for the final version.

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