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Intercultural health: proposals, actions and failures

Eduardo Luiz Menéndez [1]

Abstract *During the 1980s, 1990s and early 2000s,various intercultural health proposals and actions emerged in most Latin American countries. These initiative saimed to integrate biomedicine with traditional medicine based on 'parallel' relationships, as opposed relationships based on exclusion, subordination and hegemony. These initiatives had two basic objectives:1) to contribute to the cultural rehabilitation of ethnic groups that made effective use of traditional medicine; and 2) to improve the quality of relationships between health professionals and indigenous patients. This paper analyzes the reasons for the limited impact and,in some cases, failure of such intercultural health initiatives.*

Key words *Intercultural health, Traditional medicine, Biomedicine, Ethnic movements, Ideology*

[1] Centro de Investigaciones y Estudios Superiores en Antropología Social. Calle Juárez 87, Col. Tlalpan, Del. Tlalpan. 14000. México DF México. emenendez1@yahoo.com.mx

Introduction

Concepts, processes and uses of interculturality emerged in Latin America in the 1970s and developed particularly throughout the 1980s and 1990s. The proponents of interculturality sought to defend and empower ethnic groups and question the dominant classes that excluded, subordinated and discriminated these social actors.

These concepts and objectives, which were driven by ethnic movements and, above all, their more or less organic intellectuals, were also promoted within the field of health by professionals working in programs designed to expand access to health care among these marginalized groups implemented by institutions such as the National Indigenous Institute (*Instituto Nacional Indigenista* – INI)[1-4]. It is important to stress however that these intercultural health initiatives were designed and organized by these institutions and intellectuals rather than the ethic movements themselves.

A number of different and sometimes divergent intercultural health initiatives emerged as a result of this process, some of which had a common objective: the possibility of integrating biomedicine with traditional medicine based on 'parallel' relationships, as opposed to domination and hegemony/subordination. Those concerned with promoting this integration sought to technically and culturally 'rehabilitate' traditional medicine, as part of a wider process of empowerment of Indigenous Peoples, and improve the quality of relationship between health professionals and indigenous patients; not only to achieve greater clinical efficacy, but also to reduce the rejection of biomedical care by Indigenous Peoples and increase the demand for health services among this population, particularly primary health care.

Based on these objectives, this article initially outlines some of the key factors that have limited or constrained the development of intercultural initiatives and then goes on to analyze some of the methodological orientations frequently used by purveyors of this approach. In this way, the article attempts to find an explanation for the limited success, or veritable failure, of several of the main intercultural health initiatives developed in Mexico.

Interculturality as a permanent social process

From the outset, it is important to stress that intercultural processes are permanent and have historical depth. That is to say, they are a normal part of everyday life, not a recent or occasional phenomenon or exceptional processes that needs to be constructed: intercultural processes exist whenever societies interact.

Therefore, if we want to incorporate interculturality into health/disease/care-prevention processes (hereafter h/d/c-p processes), first it is necessary to detect and analyze the intercultural processes that operate in everyday life and, based on these processes, and not only on our own assumptions, try to pursue and realize the goals of interculturality.

What has happened is that the government staff, health professionals and intellectuals responsible for promoting intercultural health did not take existing interculturality into account, but rather attempted to create spaces and organizations that they thought would encourage the use of traditional medicine. However, the lack of demand from the indigenous population for the services provided by hospitals and intercultural health centers shows that this did not happen, and traditional healer organizations have all but disappeared over a period of less than ten years[5-9].

This fact does not deny the legitimacy and frequent need to promote change processes from outside the community, be it through government staff, health professionals and intellectuals, or NGOs and political groups. However, for this to happen it is necessary to understand the main constraints to realizing these goals and the social forces that support and oppose these processes. It is also necessary to understand the level of acceptance, interest and rejection and, above all, agency of the respective individuals and groups upon which interculturalists want to push change and recognize that these groups have a range of resources at their disposal to pursue the objectives of change over time. However, despite years of efforts made by NGOs and other civil society organizations involved in h/d/c-p processes to promote the empowerment of these marginalized groups, it is still these same organizations that continue to direct and propose intercultural health initiatives, as opposed to the groups that they supposedly seek to empower.

Initiatives similar to those promoted by interculturalists in the 1980s and 1990shad already been developed in previous decades, above all

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by INI[4] and Mexico's Health Ministry. However, the results and experiences of these interventions were not taken into account by those who promoted the new intercultural initiatives. As with the policies implemented between 1940 and 1970, goals were defined and actions developed from outside the communities and not based on their specific demands: ethnic groups did not participate in the conception and development of programs and actions designed to assist them.

Possibly one of the longest-running and most interesting intercultural health initiatives is the training and control of *parteras* (traditional midwives)which aimed to reduce maternal and infant mortality rates and, it should be stressed, particularly birth rates. During the 1970s,*parteras*were trained to sterilize traditional birthing instruments and keep the birth environment clean, refer more complicated cases to official health services, and promote the use of birth control and certain allopathic drugs. These elements became part of the core knowledge of *parteras*[10,11].

Therefore, to a certain extent, the intercultural health initiatives developed during the 1980s and 1990s could be said to be a continuation of previously developed actions, although with slightly different objectives: while the initiatives developed between 1920 and 1970 aimed to reduce morbidity and mortality through the expansion of biomedicine- through traditional healers or nonmedical personnel–the new actions sought to improve the quality of relationship and generate mutual respect between health professionals and indigenous people. The new intercultural health initiatives focused on the second aspect, seeking especially to validate, legitimize and promote traditional medicine and, in particular, traditional healers. However, they did this based on certain assumptions and theoretical/ideological orientations that failed to consider a series of processes and social actors that hindered the achievement of their goals.

The intercultural approach adopted by these initiatives was based almost exclusively on recognizing and working with cultural aspects, focusing on the 'differences' associated with Indigenous Peoples' customs and traditions, cosmovisions and ways of life. Although correct, this approach failed to consider, or only named, the processes that act not only 'together with' but also 'within' cultural differences, and intercultural initiatives associated with h/d/c-p processes disregarded the socioeconomic inequalities that characterize Mexican society as a whole and ethnic groups in particular.

Moreover, they failed to consider these socioeconomic inequalities exactly at a time when they were deepening worldwide and especially in México. While the interculturalists – and also the ethnic movements and most of the organic intellectuals – underlined the role of 'cultural differences', they were also recognized in neoliberal policies, together with gender differences and the gay movement, as socioeconomic inequalities, poverty and concentration of wealth deepened in the 1970s and, particularly during the 1980s and 1990s.

A second limitation of this approach was the assumption that social actors are homogeneous and in certain cases monolithic. Ethnic groups were seen as a separate entity from the rest of society, which in turn is viewed as a separate entity associated with a particular country, in an ethnic group/western society relationship. Thus, indigenous peoples are regarded by authors such as Bonfill[12] as a single civilization, without considering the major differences that exist between them. A case in point is that of the Maya people of Yucatán and the highlands of Chiapas who are extremely different in various aspects, including health. Moreover, the interculturalists did not take into account the increasing differences within ethnic communities associated with religion, gender, political orientation, level of education, power and age groups.

Some of the interculturalists considered Indigenous Peoples' cosmovisions not only monolithic, but also contrary to and incompatible with the 'western' cosmovision, which was also viewed as a monolithic block; a concept that, although it had its ideological uses and experienced momentary achievements, was increasingly losing its meaning. These concepts had little to do with the daily lives of the majority of Indigenous Peoples, and failed to explain a series of changes or confront the real processes that were taking place that showed not only the crucial differences between ethnic groups, but also that the terms 'West' and 'East' were ideological constructions that did not reflect the diversity, opposition and conflict between the social actors they were attempting to integrate. This statement does not deny that they were, and continue to be, utilized; rather it recognizes that they are used both to promote intercultural negotiation and incompatibilities between Indigenous Peoples and the dominant society.

Furthermore, the interculturalists forget that social groups, including ethnic groups, are characterized by change and not by permanence. An example is generational change, whereby young

members of indigenous groups develop habits and customs that have little to do with those practiced by their parents' or grandparents' generation. Indigenous youth are no longer interested in being traditional healers, although they are interested in being health agents. In other words, the interculturalists disregarded not only the various types of differences and inequalities that exist between indigenous groups, but also the changes occurring within them.

Another process that they failed to consider was the gradual, or in certain contexts rapid, reduction in the number of traditional healers, which for example would later lead to the disappearance of shamans in a large area of Chiapas and Yucatán[13,14]. This happened despite evidence that this process had been occurring in several indigenous communities across the country since the 1960s. A case in point is the Mayan community of Ticul in Yucatán, where the number of herbal healers decreased from around 30 in 1950to only 15 in 1970[11,15,16].

It is worth remembering that the actual government institutions responsible for promoting intercultural health directly contributed to the reduction in the number of traditional healers, especially in the 1980sand1990s. For example, both the INI and health sector organizations trained traditional healers exclusively to use herbal therapies, excluding all mention of witchcraft and magic[17].

The proponents of intercultural health also failed to consider that relations of solidarity and cooperation interact simultaneously with relations of conflict and violence in ethnic groups. Numerous rituals and cooperation organizations exist in these groups together with relationships characterized by envy, blood feuds and witchcraft. The interculturalists tended to emphasize relations of cooperation, failing to mention relations of conflict and division, including those between traditional healers who tried to organize associations that, however, were later dissolved.

One key aspect that they did not consider as a constraint to achieving the goals of harmony and respect that they promoted between indigenous and nonindigenous people was violence at macro and micro level that continues to the present day in Mexico. They disregarded structural violence, violence generated by organized crime, and gender violence. These omissions are almost incomprehensible given that Mexico has the highest homicide rate in the world. Furthermore, much of the territory inhabited by Mexican ethnic groups are marijuana and poppy producing regions and settings for fighting between organized crime factions and the police/army in a process which often leads to the recruitment of indigenous youth by criminal groups.

Possibly one of the main omissions of the interculturalists was, and continues to be, the issue of racism. Most importantly, they omitted or made only minimal references to this issue, knowing the role it played in the relationships between health service providers and the indigenous population. This omission is in fact a characteristic of our anthropology, which ignores racism in all the fields that it studies. For example, ethnographic studies do not describe racism or the relationships between health professionals and indigenous patients[18]. Although federal and certain state intercultural health programs do address racism, it is generally dealt with at a superficial level.

Finally, interculturalists fail to fully acknowledge the role of biomedicine and the health sector as one of the main constraints on intercultural initiatives, despite its continual expansion and tendency toward growing monopolization of health care. This can be observed in the application of official norms that directly affect the work of traditional healers. In the case of *parteras*, these regulations exclude them from labor, limiting their activities to *sobadas* (massages), health education focusing on birth control and referral of pregnant women to medical services, meaning that in 2013 only 1.51% of births were delivered by *parteras* in Mexico[19].

In this respect, one of the main omissions was, and continues to be, the failure to register and analyze the increasing penetration of biomedical products and concepts into everyday life, including the work of traditional healers. This penetration and appropriation involves intercultural processes that are ignored, meaning that organizations and proponents of intercultural health disregard some of the main aspects of this penetration because they have nothing to do with their own goals. But these aspects influence how groups, particularly women, deal with their illnesses, and it would be interesting to observe how these groups integrate traditional medicine with biomedical products in treating, alleviating and resolving their health problems[20-24].

It is also important to recognize the growing medicalisation of traditional healers, managed by themselves as a professional survival strategy. This is something that we have found since beginning our work in Yucatán in 1977 where we observed the tendency of traditional healers-in-

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cluding shamans and *parteras* –to use allopathic medicines. Recent studies have also documented the practically exclusive use of allopathic drugs and ownership of pharmacies by traditional healers in their own communities[25]. However, the medicalisation of traditional healers dates back further than this. For example, training programs for *parteras* and people who know how to administer injections (*inyectadoras*) have been developed in some states since the 1940s[15,16,26].

This process has involved a number of developments, including the implementation of government and NGO training programs since the 1970s for health promoters, many of whom became local *curadores* who treated all kinds of illnesses with allopathic drugs. For these and other reasons, it can be said that the interculturalists did not adopt the pragmatism of Health Ministry that includes and excludes traditional healers according to its needs and objectives or the human resources at its disposal: when it needed them, it did not hesitate to turn traditional healers into health promoters or train *parteras* to promote its family planning program and later exclude them when it was possible to expand the coverage of medical services.

The recognition of the constraints imposed by the set of processes outlined above, particularly those involving biomedicine and the health sector, should have led the interculturalists to question the national and international groups and social forces that favored, facilitated, distorted, hindered or opposed intercultural health initiatives. Furthermore, they should have observed the real interests and powers behind the different social forces and their interest in intercultural health and the sectors they look to support.

However, this does not mean that the interculturalists were unaware of the path and direction that the Mexican health sector was taking, the destruction caused by extractive companies operating in Indigenous Peoples' territories, or the ambiguities and contradictions of government discourse on Indigenous Peoples. Despite this, they did not see these factors as constraints on intercultural health or take into account the complementary use of biomedicine and traditional medicine among the indigenous population or the penetration of biomedicine products and concepts into indigenous customs and traditions and practices of traditional healers.

Furthermore, they did not evaluate intercultural health initiatives associated with h/d/c-p processes that affect the daily lives of ethnic groups, or those previously developed by the government and civil society organizations that directly or indirectly promoted biomedicine products and concepts. To the contrary, they treated interculturality as if it was a recent process and something that should be induced in communities, as if they it did not develop from their own activities and needs.

The ahistorical perspective of the interculturalists was influenced by various processes that are both ideological and theoretical. One of these was the expectation placed on the constitutional recognition of indigenous 'difference' by Latin American governments and on the power of ethnic movements. It was largely down to this expectation that they promoted traditional healer organizations and mixed care centers as part of the indigenous 'difference' and power, and as the core of the cosmovision and identity of Indigenous Peoples, thus excluding the growing use of biomedicine. This was in accord with a general tendency among anthropologists who studied h/d/c-p processes to investigate only traditional medicine practiced by ethnic groups and traditional healers, such that the interculturalists investigated what persists rather than what changes. The former allows one to think in terms of identity, cosmovision and difference, particularly for who were seeking to legitimize the rights of Indigenous Peoples. However, it should be stressed that, beyond these attempts to legitimize, a significant portion of intercultural health interventions, as well as ethnographic studies conducted by anthropologists, tended to exclude the growing use of biomedicine by ethnic groups because of these objectives. As a result, they generated an image that did not reflect reality. Furthermore, they excluded mortality – although in contrast they sometimes talked a lot about death – providing detailed descriptions of the work of *parteras*, shamans and herbal healers, but without presenting data and statistics about the causes of death in communities.

I would like to stress that the fact that I am outlying these processes does not mean that I do not recognize the effort, good intentions and the huge amount of work done by various interculturalists, as well as the partial achievements made by these interventions. However, in addition to not considering the various social and economic forces outlined above, the interculturalists disregarded numerous aspects of the daily lives of Indigenous Peoples when designing and implementing intercultural policies.

There are two particular aspects that I observed in various small and medium-sized com-

munities in different contexts throughout Mexico between 1976 and 1990, and that should have been incorporated into intercultural health initiatives. Firstly, traditional healers not only used allopathic medicines, but also preferred to work autonomously in their home or their patients' homes rather than in health centers, unless they were paid or received some kind of material compensation. Many also seemed to be more interested in the diplomas and certificates they received from the workshops than in the learning itself. Furthermore, there was competition and conflict between traditional healers that was reflected in appointment and treatment prices and traditional healers tended to be more critical of other traditional healers than biomedicine[6,11,14].

The second aspect regards one of the most decisive factors in terms of interculturality at the microsocial level: self-care processes, particularly among family groups, which lead to the coordination and integration of traditional and biomedical knowledge and the simultaneous use of traditional and western methods of care and cure, apart from the possible epistemological and cultural differences that may exist.

Self-care processes can serve as an important guide to understanding interculturality in a health context and to design possible interventions in this field, particularly since self-care among these groups is a necessary part of social and biological reproduction processes. Furthermore, this practice depends on the agency of individuals and microgroups, which goes beyond the existence of actors who promoteinterculturality[20,23,27].

Self-care shows us that interculturality is a standard process in the behaviors and daily lives of the different micro groups, particularly among families. That is why we propose that intercultural health initiatives should focus on self-care processes, rather than traditional healers and their cosmovisions as promoted by the government staff, professionals and intellectuals who have promoted interculturality in Mexico; not only because self-care practices promote interculturality as a standard routine process or due to its possible efficacy, but because, while traditional healers may be declining or disappearing, traditional knowledge will remain, at least for sometime, through self-care. Furthermore, self-care shows the inconsistencies of certain theoretical orientations, since although the cosmovisions of ethnic groups may be different and even incompatible with the "Western" cosmovision, their practices show that they adopt, sometimes simultaneously, the conceptions and products of knowledge that is considered incompatible.

The inclusion of these and other aspects of interculturality is necessary because, despite their importance, they are generally excluded from the objectives, theoretical and ideological frameworks and, above all, from the institutional, professional and academic interventions aimed at the harmonious, symmetric and tolerant promotion of intercultural health based on traditional healers.

It could be argued with respect to the majority of the points raised against the intercultural approach up till now that, while traditional healer organizations have almost disappeared and mixed hospitals are underused, it is possible that these interventions have led to learning, empowerment and management processes among the traditional healers and population as a whole that at some point may be recuperated by these individuals and groups. It is not only necessary to demonstrate this, but also admit that several of these processes may have reinforced the exclusion, subordination or hegemony that Indigenous Peoples experience, as we have highlighted in other works[28].

Interculturality: some methodological problems

As noted above, for some researchers and government staff who study or promote interculturality the relationship between Indigenous Peoples and the dominant society is seen as an encounter of different and, for many, incompatible, 'cosmovisions', whereby indigenous cosmovisions exclude the biomedical cosmovision.

The concepts of cosmovision, identity and difference have affected our understanding of intercultural processes, since they drive a search for congruence, coherence and balance that tend to eliminate certain conflicts, ambiguities and contradictions that permeate social groups, including ethnic groups, rather than for information that shows these conflicts exist. They are concepts that, whether from a reflexive or non-reflexive perspective, encourage an ahistorical perspective of the groups and relationships being studied.

It is due to the use of these concepts and certain ways of obtaining information that a large part of the intercultural studies and interventions are biased from the outset. For example, the tendency to look for only the differences in 'others', leads one to disregard the similarities that

exist between different 'others' and between the different social actors and the researcher. The exclusive search for differences has almost become a norm in anthropology, which contradicts that which is called common sense, given that, if I am going to study or intervene in a health professional/indigenous patient personal relationship, I should understand not only all the differences that exist between the social actors involved in the relationship, but also the similarities, both in their representations and behaviors. The unilateral search for differences leads us to underline incompatibilities, which is important to be able to understand the difficulties involved in constructing interculturality. However, this emphasis often leads us to ignore the existence of similarities, which help us to think of the best ways of developing approximation processes.

There is something that occurs in both ethnic and non ethnic groups that has always drawn my attention ever since I started working with h/d/c-p processes: the majority of healers of higher social status, regardless of whether they are traditional healers or medical doctors, are male, while those of low social status are women. Furthermore, the charismatic relationship is generally associated with male figures in both types of healers. This hierarchization of healing contrasts with the fact that in both ethnic groups and the rest of Mexican society disease, prevention and healthcare are in the hands of women. That is to say, the control of hierarchical knowledge is exercised by men, while traditional knowledge is a female task.

Similarities of this type are more frequent than we think. However, they are not documented by ethnographic studies because anthropologists do not investigate them, often because they deny or inhibit their own socialization process. And this is partly why we insist that anthropologists should contrast not only their differences, but also their similarities with the social actors who they study/co-study/self-study. The exclusive search for differences can lead one to deny his/her own process of cultural formation as an individual, given that it is highly likely that not only anthropologists, but also doctors and nurses, received a cure for indigestion or protection from evil eye during their childhood and as adults have participated in *limpias* ("purification" rituals) and resorted to a more or less traditional or new age healer to solve a problem, or have treated colds or gastroenteritis simultaneously or sequentially with allopathic drugs and traditional infusions. Thus, one of the theoretical and ethnographic contributions consists of detecting not only the differences, but also the similarities within the differences.

One of the main methodological limitations of intercultural studies and interventions is that they prioritize information gathering or work with only one social actor who is considered "key", at the cost of excluding a relational focus that includes all the main actors related to the processes and problems that are the focus of the study or intervention. For example, studies should not be limited to presenting only the views of traditional healers or medical doctors on patient diagnosis and treatment, but also include the patients' point of view. However, despite the quality of anthropological texts on healers, the majority of studies look at the subject through the eyes of the curers[29].

Traditional healers – like medical doctors – will always present the ideal standard for diagnosis, treatment and healing. However, it is likely that they omit aspects that show that their knowledge is being modified or demonstrate their ineffectiveness and malpractices, and almost certainly talk only about "traditional" ailments, despite the fact that they are increasingly working with allopathic medicines.

We need to listen not only to the traditional healers' patients' point of view, but also the opinions of non-patients to understand why they do not seek this type of treatment. Reduce information to the point of view of just one actor can lead to biased and incorrect conclusions, both in qualitative and statistical terms, which has particularly serious implications for intercultural health interventions.

While this approach to research is common in many contexts and fields, it is particularly prevalent in gender studies, which have reduced investigation and reflection exclusively to the point of view of women, even for processes that by definition are relational, such as inter-gender and intra-gender violence. In general, these studies only describe and analyze male violence against women, while omitting violence committed by women against their children and other family members, or homicidal violence involving only men; in Mexico over 90% of homicides involve only males. This does not mean that we must not continue to denounce and make efforts to end male violence against women, quite the contrary; however, we must also denounce and make efforts to end male violence against men, since the majority of homicides are intracultural.

Another tendency of intercultural studies and interventions is to compare the customs and

traditions and cosmovision of ethnic individuals and groups associated with h/d/c-p processes with those of biomedicine, or at least with those of medical doctors, without considering that they are comparing the knowledge of laymen with specialized knowledge. Therefore, if we really want to understand what happens, we need to compare the customs and traditions and cosmovision of indigenous individuals and groups with those of the nonindigenous population that live in the same type of setting, be it rural or urban, and the relationship of these individuals with health professionals in terms of cosmovisions associated with h/d/c-p processes.

Within the dominant approach, it is assumed that there are differences, and even conflicts of interest, between ethnic groups and biomedicine and, conversely, similarities and compatibility between the nonindigenous population and biomedical knowledge. Although this is possible, it is necessary to show these differences and similarities, since, while it is almost certain that differences will be found, it is also certain that there are similarities between the indigenous population and other segments of society and that both differ from biomedical knowledge.

For example, the mind-body rift and priority of physical elements of health over psychological and sociocultural aspects, which is a key feature of biomedical knowledge, is not part of the cosmovision of indigenous communities and a large part of the nonindigenous population. Furthermore, several studies have questioned the extent of penetration of biomedical concepts into the everyday life of indigenous communities, highlighting that ethnic groups had not adopted the germ theory of disease despite the fact that health centers had existed for years in certain communities. Although this is almost certainly the case, the researchers who conducted these studies did not ask themselves whether other segments of society in rural and urban areas–and not just ethnic groups-adopt this theory of disease transmission.

It is important to recognize that, like Indigenous Peoples, the majority of the Latin-American population, including the middle and upper classes, use allopathic drugs because they are effective and not because they are aware of their biochemical composition or how they act in the body. It is these substantive, rather than secondary, aspects to which I refer when I propose the need to look for similarities and not just differences, which also assumes working with various social actors rather than just one key informant.

Intercultural health studies and interventions should establish who are the key social actors who participate in intercultural relationships and work with two, three or more individuals rather than reducing interculturality to what a single actor has to say. I do not deny the possibility and even the need to work with the trajectory or life story of a single actor; however, researchers should define the objective of such an approach and evaluate the gains and losses in terms of achieving strategic information, since the fact that a large part of studies and interventions associated with processes that are by definition relational are conducted based on one social actor, excluding others that are part of the relationship as non-relational methodological approaches do, is a paradox.

Furthermore, the dominant perspective in intercultural initiatives does not consider change processes or generational differences, and thus implicitly, and to a certain extent explicitly, supposes that individuals from ethnic communities who seek help from a shaman or herbal healer think in the same way as traditional healers and, in contrast, these same individuals think differently to health professionals. Some researchers and ethnic leaders explain these differences in terms of incompatibility. Incompatibility exists without doubt; however, this does not explain, for example, why indigenous people sometimes simultaneously use traditional healers and medical professionals and the treatments prescribed by both types of healers. This in turn raises questions about the relationships between representations and practices, since I believe that a large part of intercultural studies and interventions are conducted based on what individuals say they do rather than what they do.

According to a large number of anthropological and historical studies, the cosmovisions of indigenous individuals and groups associated with h/d/c-p processes may manifest radical differences when it comes to the practices of these individuals and groups, since they can be biomedical or at least mixed. Therefore, one of the priorities of any intercultural intervention is to describe and try to explain why the indigenous cosmovisions described by ethnographic and historical studies do not correspond, at least in part, with the current practices of ethnic groups, and work with what these individuals and groups say and do; since it is through these practices that we can observe the real processes of interculturality.

I believe that much of the failure of intercultural projects is down to prejudice and ideological orientations that have been imposed on reality. While any approach towards change that seeks to involve individuals and groups needs to intentionally manage the ideological dimension, reduce reality to the same extent can lead not only to failure, but also strengthen the processes and social actors under question.

This text outlined and analyzed the limitations of intercultural initiatives associated with h/d/c-p processes. However, I have raised the possibility of creating and implementing intercultural actions that overcome such limitations. Those that conduct intercultural health programs have the necessary and pending task of undertaking a critical analysis of targeted interventions, their academic, political and ideological goals, and the sense in continuing to promote intercultural health initiatives in the present context given the failure of the majority of interventions up to date.

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