"The wingka call it cancer; that is the difference"
Intercultural health and ethnic community relations among the Mapuche people in Chile

Report from a Minor Field Study
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Abstract

"The wingka call it cancer; that is the difference”. Intercultural health and ethnic community relations among the Mapuche people in Chile. Department of Cultural Anthropology and Ethnology, Uppsala University.

The aim of the thesis is to clarify the socio-political aspects of the concept of intercultural health, as state policy and an incitement in projects initiated by local Mapuche health associations. The thesis examines how Mapuche involved in projects connected to intercultural health relate to and assimilate the state concept, and how this is expressed at a discursive level. The thesis is the result of a three-month Minor Field Study conducted in Chile.

The present process of redefining the relation between the Chilean state and the indigenous people has created a socio-political space, which different agents with different strategies are struggling to define and control according to their own interests. The thesis suggests that the field of intercultural health corresponds with this process: Conflicting interests between the Mapuche and the Chilean state, related to aspects of economic development, modernity processes, integration, multicultural relations, and indigenous rights are reflected and acted out also in projects for an intercultural health system. In the thesis, it is shown how the Mapuche make use of the concept of intercultural health to manifest culturally defined aims. They dispute the legitimacy of the concept as defined by the state, and, in their own projects related to intercultural health, they argue for an integral valorisation of the Mapuche culture from a broader perspective. In this process, the Mapuche strengthen their community identity in the Chilean society.

Keywords: Mapuche, interculturality, health, ethnic boundaries, community relations, discourse, medical development.
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PART I: INTRODUCTION

All medical systems derive from, and are dependent on, social and cultural context. Nevertheless, western medicine, with its emphasis on science, is often perceived as self-evident and objective, detached from its history of practice and free from ideological interests. The practice of medicine entails more than curing and improving life. Imbedded in the field of government's concern; the fostering of life, the care, and ultimately the productivity of the population, contain also the notion of biopower or biopolitics, concepts coined by the philosopher Michel Foucault to explain the effective works of organisation, normalisation and control in the state’s production and management of human resources (see Rabinow 1987:17ff; Danaher, Schirato & Webb 2000:64, 90, 124ff). In an article published in the journal American Ethnologist, Shane Greene introduces the subject by placing medicine in this context, concluding that ever since the very beginning of European imperial expansion and worldwide colonialism, “medicine has played a complicit role” (Greene 1998:634). Part of colonial presence was the location of hospitals and care centres that facilitated the containment, control and the subjugation of the native population (ibid.:634). According to Greene, this complicity is historically present in Latin America through the continuing collusion between western neo-colonialism and capital interests, and the role that medicine today plays in development schemes. Schemes often coloured by the representation of western medicine as science/modern/progress as opposed to indigenous medicine as magic-religion/traditional/stasis (ibid.:635).

This thesis will show that the projects for an intercultural healthcare system – besides aiming at improving the access to and the quality of health among the Mapuche in the countryside – can be understood as involving deeper political meaning. By interpreting discourses of intercultural health and placing them in a larger socio-political context, it can be shown that intercultural healthcare is related to broader political ends connected to the process of redefining the relation between the Mapuche people and the Chilean nation-state. The process
reflects the interplay between multiculturalism and aspects of modernity processes in the country. With this broader socio-political perspective as framework, the question the thesis will examine is how the Mapuche involved in projects for an intercultural health system relate to and assimilate the concept.

The Mapuche are recognised as one of Chile’s indigenous groups, and as such they constitute a minority within the Chilean nation-state. According to the national census conducted in 1992, the Mapuche number around one million, corresponding to approximately ten per cent of the country’s population\(^1\) (CONADI 2000:15). The Mapuche represent a way of life that is in many aspects different from Chilean and western traditions: They have their own religion and language, their own cultural traditions and also their own medical system. The Mapuche have lived in a reality of intercultural relations with other groups ever since colonisation, but it is only in recent years that the issue of cultural diversity has become part of state concern and policy making. Intercultural health represents the latest contribution of such policy-making in Chile today.

Since the end of the Pinochet dictatorship in 1989, Chile has taken a number of actions towards the democratisation of the country, a process that mirrors Chile’s strife for modernisation of the state. According to the sociologist Sergio Cuadra, the new modernity in Chile is characterised mainly by the search for a new type of relationship between ethnic minorities and the modern nation-state (Cuadra 1994:52). Discourses concerning the rights of ethnic minorities, along with consequences of mismanaged conflicts, are factors that have influenced this new and active interplay between multiculturalism and modernity in the country (Cuadra 2001:28). The Chilean state has made efforts to redefine its relationship towards different social agents, the indigenous groups especially. An example of this is Chile’s legislation process, aiming at a ‘new relationship’ between the

\(^1\) The Mapuche population in Chile counted 928,060 people (9,6 %); based on people aged 14 years and over, auto-identified as indigenous Mapuche. The census was conducted by the National Institute of Statistics in Chile INE (Instituto Nacional de Estadísticas).
state and the indigenous people. There is a general agreement among the different political agents in the society as to the need for a redefinition of the relationship between the state and the indigenous people, but the opinions differ regarding its form and content (ibid.:29).

According to Cuadra, this process of redefinition has created a social and political space, a space that different political and social agents are struggling to define and control in accordance to their own specific interests (Cuadra 1994:16). This can, among the different indigenous movements, lead to strategies involving both the expression of essential traditionalism as well as essential modernism, positions that have bearing on different symbolic elements important for the groups’ identity in relation to the surrounding society (ibid.:52).

Previous laws and policies applied by the Chilean state in relation to the indigenous people have, with few exceptions, promoted their assimilation into the national society (Aylwin 1998:4). These assimilation policies reached their maximum expression during the military regime of Pinochet (1973–1989) when the imposed legalisation declared Chile an ethnically homogenous nation. Aiming at the definitive division of the Mapuche territory into private holdings, the Act 2.568 of 1979 declares that upon the division of collective property “both the land and the individual cease to be classified as indigenous” (Calbucura 1996:42). When the succeeding presidency set about the task of replacing this law, the new bill contained – for the first time in Chilean history – the recognition of Chile as a multiethnic country. The bill contained the recognition of the indigenous people of Chile in accordance with the main principles of the ILO convention number 169 (i.e. constitutional recognition, reinforcement of indigenous traditional organisations, protection of indigenous land and natural resources, etc). This recognition was politically perceived as a highly controversial matter, and the following statement reveals the need for rhetoric defending the compatibility of traditional values with modernity and progress:
It is not a question of returning to the past since history does not move backwards. It is about moving on towards the future with the help of one’s own roots and with an understanding of the human beings’ ability to profit from the best of progress of civilisation and culture. We believe that the world today is moving in this direction, and then one with power confirms an identity of one’s own, and at the same time open the doors to a prosperous and modern future. It is not incompatible to defend culture and at the same time strive for development. On the contrary, the two ambitions complement each other. (Chile’s [then] President Patricio Aylwin presenting the indigenous bill before the national congress in 1991. Quoted in Cuadra 2001:32.)

The bill was discussed for several years in the senate, and when the Indigenous Act of 1993 was finally passed, the proposed recognition of the indigenous people was changed into “ethnic groups”, and the ILO convention was not ratified. Nevertheless, the bill is seen as a step towards a constitutional recognition of Chile as a multiethnic nation, and with it followed a renewed political mobilisation among the indigenous people in Chile, a process that has continued and evolved in later years.

The urge of taking multicultural relations into consideration has influenced other areas of society, especially that of education. The implementation of intercultural education has been carried out to some extent, through special programmes introducing the teaching of indigenous languages in a number of schools. A state initiative towards interculturality in the field of health was first recognised by the Ministry of Health, through a special health programme that raised the question of cultural diversity. Discourses concerning intercultural health have from this starting-point evolved during the 1990s, and become part of a larger national process involving different agents and different interests. A general definition of intercultural health, referred to by the Government health agency, forms an introductory understanding of the concept. The definition establishes that:

Interculturality refers to the relation of at least two cultures. A proposal for an intercultural health refers to a primary programme of healthcare-model between two cultures that coexist in a geographical and clinical space. (Ibacache Burgos 1998:12.)
Margarita Sáez, co-ordinator of the project for health and the indigenous population at the Chilean Ministry of Health, states that:

> Interculturality is a fundamental change of values and attitudes about constructing new relations. Relations based on the themes of respect, on accepting diversity, founded on the contribution towards a future co-operation. There are two that contribute, two that know, two capable in the making. (Margarita Sáez, August 2000. Quoted in McFall & Ibacache Burgos 2001:51.)

**Ethnicity: Boundaries and Relations**

A theoretical framework applicable to the context of interculturality is that of **ethnicity**, a term understood as “[…] aspects of relations between groups that perceive themselves – and are perceived by others – as culturally distinctive” (Eriksen 1998:12-13). At the same time as ethnicity establishes us/them-contrasts, “where group loyalties are confirmed and reinforced”, ethnicity also comprises a field for interaction between ethnic groups (ibid.:40). It is within this field that the concept of intercultural health can be placed.

Ethnic relations can be marked by mutual exchange and adaptability, but also by conflict and competition for resources. Indigenous people in particular are said to be in a potential conflict with the nation-state as an institution (ibid.:157). This latent conflict is activated when the nation-state wants to control resources (ecological, economical or human) situated within the indigenous territory (ibid.:161). These claims to resources by the state are often included in development plans. Eriksen points out that for an interethnic relation to take place, a mutual recognition must be an integral part of the process that communicates cultural difference (ibid.:39). Eriksen calls this recognition **complementation**. The term complementation has two-fold relevance to this thesis. Besides the perspective that Eriksen illustrates, a complementary approach constitutes one of the concepts that the Mapuche refer to in relation to
intercultural health. The field of complementation has in this perspective similarities to what Cuadra identifies as the socio-political space that result from the current processes of redefining the relation between the Chilean state and the indigenous people: It is an open space that different political and social agents struggle to define in accordance to their specific interests.

How then is a project for intercultural health affected by a possible conflict of interests? Is it possible to realise a project for interculturality in the field of health if one group is subjugated the other, or if the mutual recognition of cultural differences is asymmetric or fragmented? As previously pointed out, the Mapuche are not fully recognised by the state as an indigenous people and they experience a negative, discriminatory treatment in society. In this perspective, the prerequisite condition for realising a complementation is limited and likely to affect the interethnic relation and the possibilities for implementing an intercultural health. According to Eriksen, the lack of complementation is followed by tendencies towards identity change or assimilation among the members of the weaker group (Eriksen 1998:40). Even if the Mapuche in many aspects form an exposed group in the Chilean society, they have maintained their identity as an ethnic group. Their social mobilisation continues to grow in importance, and ethnicity plays a key role in their boundary deliberation and their struggle for recognition and control over resources.

In ethnic relations, differences can be accentuated and made socially relevant, but they can also be ignored or considered irrelevant. According to Eriksen, it is when differences are important and relevant, for example “in gains and losses in group interaction”, that they are stressed by the agents (ibid.:22). The quotation used in the title of this thesis represents to me such a two-edged possibility. The quotation comes from my interview with the machi (i.e. Mapuche medical authority) Victor Caniullan, when he described the illnesses that affect the Mapuche due to the expansion of forest industries into their ancestral territory. The quotation can be interpreted as the only difference that exists between us and them lies in how we choose to label our reality: We only use different
names for describing the same condition. However, the quotation also contains the word *wingka* (“thief”), which is a stereotype the Mapuche use, often in a derogatory way, for describing practices or habits conceived as non-Mapuche. The quotation can thereby also be interpreted as representing a stronger marking of symbolic difference between the Mapuche and the non-Mapuche than what lies in the simple labelling of things. The production of stereotypes is always the production of categories and difference.

**Fieldwork and Method**

This thesis is a result of a Minor Field Study, which I conducted in Chile between November 2001 and February 2002 thanks to a grant programme provided by the government agency Sida (Swedish International Development Cooperation Agency). The fieldwork was conducted at two principal settings: The Makewe Hospital for intercultural health and the present construction of a centre for intercultural medicine named Boroa-Filulawen, both located in the rural areas outside Temuco in the IX region of Chile. (See separate chapter for a closer description of the fields. A map of the region is found in appendix B.)

To pursue the aim and purpose of the thesis I planned to conduct a number of interviews with different agents involved in intercultural healthcare. The first natural choice of field for gathering data was the Makewe Hospital, since the hospital (as of March 1999) is run by a Mapuche association, declaring it to be the first hospital in Chile implementing an intercultural model of health (Holzapfel 2001:15). During the first weeks at the Makewe Hospital, I observed and participated in the interaction between patients and the physicians, nurses and auxiliaries, at the hospital’s premises. I also followed the staff on three medical rounds to different health-stations in the nearby rural communities, and participated in medical house calls in the area. At the Makewe Hospital, I interviewed the director Francisco Chureo, the chief physician Dr Jaime Ibacache Burgos, Dr Carlos Labraña and Margarita Trangol, member of the
auxiliary personnel. I had informal conversations with other members of staff and with patients and their families at the hospital and in the local communities.

Unfortunately, I had no opportunity to interview, or to visit the machi collaborating with the Makewe Hospital. I therefore decided to complement the information gathered at the hospital with relevant information from other sources. Through contacts, I had an interview arranged with the machi Victor Caniullan, active in the rural area outside the municipally of Carahue. Victor Caniullan practices Mapuche medicine and has also been an active participant in the national dialogue concerning intercultural health.

The other source of field data derives from the project of Boroa-Filulawen, a Mapuche medical centre presently under construction, that I was invited to visit. In relation to the project, I participated in different activities and meetings in the planning of the centre. I took part in the ‘Intercultural Congress’ on the 5 November 2001 in Boroa, when the proposal for the medical centre was officially presented before the Ministry of Health. At this event the (then) Minister of Health, Michelle Bachelet, the Health Ministry’s Seremi Carlos González, local Mapuche community directors, and many other political and medical authorities partook in a debate arranged by the Mapuche communities about intercultural health and the Mapuche’s situation in general. I arranged an interview with representatives of the Mapuche intercultural committee in Boroa-Filulawen; with the president Antonio Huircan Pichicón, secretary Abelino Pichicona Guimay, community director Omar Pichicona Guimay, treasurer Carlos Huircan Pichicón, community collaborators Gloria Ñancucheo Colihuinca and Carmen Pichicona Guimay. Besides the many informal conversations, I also conducted two formal interviews with Lucy and Carmen Pichicona Guimay. I also participated in two Mapuche religious ceremonies in the area (one being the nguillatun) and attended a health consultation at a machi.
During the field study, I lived together with different members of the Mapuche family Pichicona, mainly in the city of Temuco and the rural community Cumil Lizama in Boroa. My relationship with this family dates back to 1999 when I lived with them while attending an anthropology diploma course in Chile between August and December through the Universidad de Artes y Ciencias Sociales in Santiago. Most members of this family are local authorities and directors of different Mapuche organisations. They are also highly involved, among other commitments, in the implementation of intercultural health through the project of Boroa-Filulawen.

Besides being a method for collecting data, participant observations gave me a better understanding of the different activities, and they also led to more initiated questions during the formal interviews that I later conducted. In total I conducted ten formal (from which two were group discussions) and sixteen informal interviews. All interviews were semi-structured or unstructured with open-ended questions divided on different themes. The interviews were held in Spanish and most were tape recorded and later transcribed. All interviews and informal conversations have been useful for my general understanding of the Mapuche and their experiences, even if I have not used all information as quotations in the thesis. All English quotations (except the ones of Mariqueo and the “Integral Development Programme for Indigenous Communities”) are my own translations of interviews or written material.

The information from the field study has been complemented with several policy documents regarding intercultural health. Other references, consisting of literature about the Mapuche people and their medicine, are mainly written by non-Mapuche authors, but are based on extensive fieldwork and local collaboration. This applies for example to the anthropologist Ana Mariella Bacigalupo’s book on tradition and change among Mapuche machi (2001), and the book by Luca Citarella et al. about the Mapuche culture and medicine (2000).
For my broader understanding of intercultural health, valuable inspiration comes from Sergio Cuadra’s sociology dissertation on the Mapuche’s contemporary social movements (also based on fieldwork), from which I use parts of his model for discourse analysis in my thesis (2001). I have also taken the liberty of borrowing the term boundary deliberation from this dissertation, a concept Cuadra introduces for “the full process of defining, redefining, comparing and testing” of symbolic boundaries between different groups (Cuadra 2001:22). In the discussion, I also refer to Shane Greene’s article regarding shamanic agency, development, and the possibilities of implementing so called “intermedicality” in post-colonial Peru (1998), issues that in many ways are pertinent to that of intercultural health. The social anthropologist Thomas Hylland Eriksen’s book on ethnicity and nationalism has also been useful in the discussion (1998).

Outline

The thesis consists of six parts. The first part contains the introduction and a presentation of the fieldwork conducted. The second part is a presentation of the Mapuche people, their organisation, cosmology and religion and the Mapuche medicine. The third part consists of three chapters presenting a socio-political background to the thesis subject: The first chapter describes the development of the indigenismo as state strategy in Chile, followed by the indigenous social movements of indianismo. The second chapter describes the political project developing in the late 1980s, aiming at what has been called a ‘new relationship’ between the Chilean state and the indigenous people. The final chapter in this segment describes the processes of implementing an intercultural health in Chile.

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2 Discourse is generally understood as the certain way in which we speak of and understand the world (Jørgensen & Phillips 2000:7). A discourse analysis aims at understanding the processes within the discourse and how different discourses interrelate.
Part four contains a description of the two settings that I visited during the study in Chile: the Makewe Hospital for intercultural health and the project for an intercultural and integral medicine centre called Boroa-Filulawen. After the presentation, there follows a chapter that describes some of the ambitions behind the two projects. Part five presents some of the difficulties and obstacles facing intercultural health in the view of the Mapuche, followed by a broader discussion. The sixth part contains the conclusions. The appendix comprises a map over Chile and Mapuche ancestral territory, a map over the IX Region of Chile (the Araucania), the classification scheme of illnesses according to the Mapuche medicine and a glossary of Mapuche words cited in the thesis translated into English.
PART II: THE MAPUCHE PEOPLE

Mapuche: ‘mapu’ (land) + ‘che’ (people), i.e. ‘men of the land’.
Chaf mapuche ngueín: We share the same culture.
Quiñe nullfiñ ngueín: We are of the same blood.
Quiñe ath ngueín: We have our own distinctive features.
(Mariqueo 1979:7)

The quotation above is how the Mapuche define their community. The word mapu is of central reference in the Mapuche’s symbolic community. Besides forming the name Mapuche, concepts such as the Mapuche’s law-code (Ad mapu), the explanation of their cosmology and origin (Meli witran mapu) and the name of their indigenous language (Mapudungun) all derive from this word, representing the Mapuche’s relation to nature as fundamental to their existence and beliefs.

When the Spanish colonists first arrived in the territory in the sixteenth century, the Mapuche numbered around one million, subsisting on an economy based on a combination of hunting, gathering and horticulture (Bengoa 2000:21, 23). Despite the many military attempts to defeat the Mapuche, the Spaniards never managed to conquer them. The Mapuche retained their autonomy and their territory throughout the entire colonial period, and continued to do so during the liberation war that led to the declaration of Chile as an independent state in 1818. It was not until the 1880s, when Chilean military forces occupied their territory, that the Mapuche were finally defeated, loosing the last battle 1883 (ibid.:325-326). Directly after the military conquest, the Chilean state claimed ownership of the territory and created the ‘Commission for the Relocation of Indians’, thereby establishing the process of moving the Mapuche people into limited “reservations”.

Mapuche's loss of territory brought about extensive economic and social changes, which, in turn, caused massive migration from rural areas to urban

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3 Ad-mapu is also the name of a Mapuche political organisation formed in 1978.
conglomerations. Today, a majority of the Mapuche live in Chile’s larger cities like Santiago, Valparaíso, Concepción, Temuco and Valdivia. Among the Mapuche population in the IX region (see map in appendix B), 44 per cent remain in rural areas (Cuadra 2001:75). The Mapuche who live in rural areas are organised in family-based communities, where they subsist on farming with very scarce resources.

Socio-political Organisation

The Mapuche’s traditional social organisation is based on the extended family, called lof. The lof is ultimately led by the longko, that literally means “head”. Every lof was previously autonomous and obeyed only to a limited extent or temporarily, for example during times of war, under any central political authority. The fact that the lofs were autonomous did not mean that they lived in isolation: Social, economical and cultural contacts between the lofs were extensive (Gumucio 1999:47). Councils consisting of authorities from different lofs were called together for mutual affairs, and during times of war the council elected a temporary toki as military leader.

The Mapuche’s traditional organisation contains a number of religious and political authorities. The machi, which is the authority on medicine and religion, is part of the religious hierarchy and holds an important position in the social structure. Through the possession of holy knowledge, the machi has the particular responsibility of guarding the relation between spiritual forces, nature and the people. The dungunmachife, also part of the religious hierarchy, is the mediator between the machi and the people during ceremonies, while the ŋgenpin is the ”master of the words” (Marileo Lefio 2000:105). Furthermore, the social hierarchy contains the weipife, who administrates the historical knowledge, and the werken, who is the Mapuche’s messenger or spokesman. Apart from the machi, the authorities are either elected or claimed through descent. However, to become a machi is said to be the choice of nature. The
machi experience this vocation through dreams and/or by being inflicted with specific illnesses.

Historically, the Mapuche’s socio-political organisation has been characterised by change and flexibility (Cuadra 2001:118-121). The development tended towards a more institutionalised and hierarchical system during the peace negotiations with the Spaniards, to its almost definitive dissolution during the Chilean state’s relocation of the Mapuche into the limited “reservations” in the late nineteenth century (ibid.:119). Moreover, the roles of traditional leaders have continuously changed over time and not all of the positions in the hierarchies exist today. In today’s socio-political organisation, the longko, the machi and the werken constitute the most important authorities (ibid.:118). The social and political organisation is today very much connected to the different communities the Mapuche inhabit. The rural communities represent the fundamental expression of the Mapuche’s symbolic community, also for the many urban Mapuche. Ever since the Mapuche lost their autonomy, it is from the base of these community units that they have struggled to maintain their traditional economy, customs, religion and language.

Cosmology and Religion

The Mapuche’s cultural and socio-political relations have references to their cosmology and religion. According to the Mapuche’s cosmology, the world is conformed by the dualistic relation between different elements and spiritual forces. Equilibrium is the steering principle. The linked relation between man, nature and territory reflects, and is part of, the condition of the cosmos.

The cosmos has different dimensions. The Wenu mapu is a supernatural space, associated with the positive forces and the spirits of the ancestral family, and the Mińche mapu is the underground, associated with the negative spiritual forces.
(Marileo Lefio 2000:102ff). The binary spiritual forces, the *Wenu mapu* and the *Miñche mapu*, are manifested in the dimension *Nag mapu*; the concrete and material space that is the earthly home of all the living, including man and nature. The cosmology also includes the calendar, following the circulation of the seasons.

The four cardinal points form and unite the world, all following the path of the sun. The cardinal points also connect the Mapuche with the territory. This vision of origin is represented by the different territorial identities which constitute the Mapuche community: The *Pewenche* are the people from the area where the pewen tree grow (towards the east, by the mountains), the *Lafkenche* the people from the sea or the coast (*lafken mapu* = western territory), the *Pikunche* the people from the north (*piku mapu* = northern territory) the *WIlliche* the people from the south (*willi mapu* = southern territory) and the *Puelche* the people from the east, a territory now belonging to Argentina (*puel mapu* = eastern territory). In addition, the *Muluche* are the people from the humid area, the *Nagche* the people from the valley, and, finally, the *Wenteche* are the people from the central region. (The territorial identities of the *Pikunche* and the *Muluche* are said to have ceased to exist today.)

The most solemn expression of the Mapuche religion is the *nguillatun*, a grand ceremony that takes place during two or three days each year, celebrated together by many different communities. With the *nguillatun*, the gathered Mapuche community relates to the powerful spiritual force of *ngenechen*. The objective is to renew the past of the ancestors and to understand the needs for the future, a collective action that unites and strengthens the Mapuche’s community relations (Nesti 1999:38).

Influences from Catholicism have affected the Mapuche’s religious beliefs. In time, the syncretism between the two religions has become extensive and today there are many Mapuche who confess solely to the Catholic Church. This is not
necessarily a reason against participating in the nguillatun and other religious activities: New elements of belief are commonly interpreted within the traditional structures.

Mapuche Medicine

The authority on medicine within the Mapuche culture is the machi. The following quotation explains the machi’s role in the Mapuche culture:

The machi are the mediators between the Mapuche and the spiritual [---] Their protective spirits provide them with the powers they use to combat the malign spirits and to propitiate the positive spirits and divinities. The machi see to the physical, mental and spiritual well-being of the patients and operate to benefit the community and her/his clientele. [...] they practice physical and empirical medicine [...] they have knowledge of and use medical herbs to cure. (Bacigalupo 2001:29.)

The Mapuche medicine has a well-developed system for classifying illnesses (see appendix C). Depending on its origin, an illness can be classified as a Wingka kutran or a Mapuche kutran. Wingka kutran are the new, previously unknown illnesses that enter the community, while the Mapuche kutran are familiar illnesses considered proper to the community. Illnesses with different origins can show the same symptoms. For example, tuberculosis can in one case be a Wingka kutran (of foreign origin), but can also derive from another origin, then classified as a Mapuche kutran (Citarella 2000:131). The Mapuche kutran can be divided into three sub groups: re kutran, wenu kutran, and weda kutran (ibid.:132f). The re kutran are the “pure” and natural illnesses, involving no agency of spiritual forces. The wenu kutran have supernatural origins and are triggered by a person’s careless conduct. The weda kutran are illnesses of supernatural origin, caused by negative spiritual forces. The machi can operate within all these medical fields.
Commonly, the machi diagnoses the illness by looking at the person’s urine. Furthermore, clothes and other objects frequently used by the patient can be used to diagnose the illness. This is a quick process, by which the machi can determine the origin of the illness, and also diagnose the physiological symptoms. More complicated and spiritual illnesses demand more effort from the machi. For this, there are a number of different ceremonies, the most important one being the machitun. During machitun, the machi enters a trance to communicate with the spirits and to receive knowledge about the illness. A machitun is a ceremony that involves specific religious elements and the assistance from several people. The ceremony is performed around a rewe (a sacred wooden ”ladder”), accompanied by singing, dancing and the constant sound of the kultrun, the sacred drum painted with symbols representing the Mapuche cosmology. The machitun is completed with the administration of medical plants, required to cure the illness.
PART III: BOUNDARY DELIBERATION AND THE EMERGENCE OF NEW DISCOURSES

The following part contains three chapters, which together describe the socio-political background and development of the relationship between the Chilean nation-state and the indigenous people. Aspects of this relation, expressed in ideology and policy making, as well as in social practice, represent different discussions regarding the indigenous people’s role and status in relation to the society. These different discussions can be understood through the two dominant discourses - *indigenismo* and *indianismo* - influential in the continuing debate for a ‘new relationship’ between the Chilean state and the indigenous people, and, in my understanding, also in the development of an intercultural healthcare system.

**Indigenismo Versus Indianismo**

After the liberation from the Spanish crown, the political and ideological project of the Chilean state was to create a new unifying identity for its people. The concept of citizen was modelled on the ideas of the North American and French Revolutions. The Chilean inhabitants were for the first time seen as citizens with rights and obligations to the state. During the creation of the new nation, the representation of a strong and resistant Indian was commonly applied, but this was a symbol used to strengthen the Chilean self-image. This idealised representation was very distant from the perception of the contemporary “Indian”, more commonly perceived as uncivilised, degenerated and in need of improvement. Becoming citizens, the Mapuche saw their special status as a people abolished, and, in reality, they came to constitute the poor and often exploited lower class of the society, commonly as labour for the Chilean and foreign landowners. The continuous aim of the state has been to encourage and promote a homogenous society: a Chilean national identity deriving foremost
from European origin. Yet the state’s assimilation strategy was not fully realised; in practice the Mapuche were not treated as equal citizens and they partly kept their distinctiveness in relation to the surrounding society.

Throughout the history of the relationship between the Chilean state and the Mapuche, the state has always seen the “Indian” as a political or a social problem to be solved. From the 1940s, the indigenismo in Chile and in other Latin American states has evolved as the state policy to define how the relation between the indigenous people and the society should function. The ideology of the indigenismo has its roots in the colonial era, but it is in the last 60 years that it has taken on an official status and become a persuasive force as state strategy in Chile (Cuadra 2001:59). The indigenismo’s solution to the marginalisation of the indigenous societies lies in their incorporation into the dominating society. The indigenismo strategy puts priority on the socio-economic sphere, and its focus has foremost lied on language programmes and on projects for a general modernisation of the indigenous societies (ibid.:60). Within the indigenismo there are different strategies, ranging from experts advocating total assimilation of the indigenous cultures to those more considerate of indigenous identity. What they have in common is the strategy of including the indigenous problem in modernity projects. Even if the indigenismo evolved as a state strategy, it is also a discourse that has been, to a large extent, adopted among the Mapuche themselves. The Mapuche’s exposed situation, combined with the call for their assimilation and integration into the Chilean national society has made many Mapuche deny or conceal their ethnic origin.

From the 1980s, the Mapuche movements, as well as other indigenous movements, entered a new phase. The background to this change was connected with the new social movements that emerged at that time. The development took place during the period around 1978-1985, coinciding with a brake down of a number of military regimes in Latin America subsequently allowing most countries on the continent the possibility of a return to pluralistic democracy. Another main cause behind the change was the crises of many established
nation-states in the world. Identity had become an important factor globally in political discourses, and issues like human rights and multi-ethnicity were discussed. There was a shift from seeing problems as class-related to focusing on problems based on ethnicity, sex, etc, as being more important.

It is in context to these changes that, from the 1990s onwards, a new era of indigenous political struggle evolves, known as *indianismo*. For the indianismo movement, the indigenous ethnic identity is the fundamental base of political struggle. According to Cuadra, the movement evolves among the Mapuche as a protest against the indigenismo strategy, for having failed in solving the problem of their marginalized and discriminated position in the society. The indianismo movement struggles for alternate solutions, created by the Mapuche themselves. They stress the importance of deciding over their own development and future, using concepts such as self-determination and autonomy. The ideology and discourse of the indianismo movement has given priority to the cultural values of the indigenous civilisation (Cuadra 2001:62). The marginalized position of the Mapuche people is explained through historic and current injustices, where they as a group have been oppressed by the Chilean state and society. In their view, state policies have restrained and hindered their proper development. They argue for fundamental and collective rights for indigenous groups and call for a revalorisation of their history and culture. A characteristic for the indianismo movement is the ambition to revalorise their own traditional elements and, particularly, to reinforce traditional hierarchies.

Even if the Mapuche have their own solutions to their problematic situation, the frame of indianismo has partly come about through the influence from western ideas. During the 1960s-70s, many Mapuche leaders were politically active in organisations, popular groups, trade unions etc, at the time more as Chileans than as Mapuche. During this period, they were trained to speak in public and “learned to be leaders” in a western political environment. In this political arena, they were trained to organise and to act politically in the western sense. These skills proved useful later, in the indianismo movement. With indianismo, the
Mapuche movements have become better organised and more politically active. They frequently use political tools and concepts known to the western politics. Ironically, this has resulted in the representatives of the movement being both incorporated into and rewarded by the very processes of modernisation they oppose.

In this development, the role of the machi occupies an interesting position. The function of the machi has outlasted many other Mapuche traditional authorities. This has been explained by the machi’s ability to adjust to new and shifting demands in society (Bacigalupo 2001; Cuadra 2001:128-133). The machi’s function has for example adjusted to the situation of an expanded urbanisation among the Mapuche, and the treating of non-Mapuche patients has also expanded the machi’s field of expertise. In this development, the role and the services of the machi has continually adjusted to meet the demands deriving from shifting cultural and identity crises within the Mapuche community, as well as new demands resulting from the modernisation processes in the society (Cuadra 2001:131). Part of the modernisation process in Chile has been the development of extreme privatisation, affecting also the health sector. This situation has created a growing need for alternative services supplied by the machi. Moreover, the role of the machi has developed an ability to complement medical systems (ibid.:131). The adaptability of the medical role of the machi can consist, for example, of specialising in the operative field of illnesses considered supernatural or spiritual, where the western medicine provides no answers (ibid.:130). This flexibility is built within the Mapuche classification of illnesses (see appendix C), in which western medicine can be considered for treating physical symptoms and non-spiritual illnesses.

Even if the role of the machi is characterised by flexibility and change, its position has traditionally remained in the medical-religious or social sphere. Lately, and especially following the development of the indianismo movement, the role of the machi has gradually become incorporated further into the political sphere (ibid.:129). Many machi participate in different internal discussions in
the Mapuche social and political organisations as well as in official political activities and meetings. This is a development much supported by the indianismo political leaders, since the machi, in their movement, represents a fighter and a “synthesis of the Mapuche culture and traditions” (ibid.:129).

From the traditional role as the mediator for the patient and the local Mapuche community, the machi now assume a role resembling the mediator between Mapuche community and Chilean society (ibid.:132). Due to this, the new and strengthened role that the machi occupy helps the Mapuche in marking their borders in relation to the Chilean society along the lines of ethnicity. They can reorganise parts of their social life and find new points of reference for their community (ibid.:132). Yet the development of the new roles and functions of the machi is also questioned by some fractions of the Mapuche movements, especially those more conservative (ibid.:129).

The ‘New Relationship’ Between the Chilean State and the Indigenous People

Since the national plebiscite on the 5 October 1988 was to put an end to the Pinochet dictatorship, the call for a new relationship between the Chilean state and the indigenous people was politically acknowledged first by the Agreement of Nueva Imperial of 1989. The agreement, signed by the coalition of democratic parties (CPD) and a majority of the Mapuche movements, contained demands for legal and constitutional recognition of the indigenous people with ensuing territorial and development rights consistent with their cultures, and the initiative for the ratification of the Convention 169 of the ILO. As described in the introduction, when the Congress finally approved the Indigenous Act of 1993 for the “protection, promotion and development of indigenous people”, its intentions and content had been changed. The constitutional amendment was not approved, and the ILO Convention granting legal right to territory was not ratified. The Indigenous Act of 1993 acknowledges the Mapuche as one of
Chile’s eight “ethnic groups” and declares the relationship and responsibility of the state towards the Mapuche:

[...] The state value their existence as being an important part of the roots of the Chilean Nation, in that sense that their integrity and development correspond to their customs and values. It is the duty of the society in general and the state in particular to by its institutions respect, protect and promote the development of the ethnic groups, their cultures, families and communities, to take adequate measures for these aims and to protect indigenous lands, see to their adequate exploitation, ecological equilibrium and contribute to their expansion. (The Indigenous Act 1993.)

With the Indigenous Act of 1993, a National Corporation for Indigenous Peoples (CONADI) was created in 1994, with the objective to implement and see to the observance of the law. A land and water fund was also established for the purpose of acquiring lands and water rights, as was a development fund, aimed at providing indigenous people and communities with financial support for economic and cultural initiatives compatible with their cultures (Aylwin 1998:8).

The Mapuche people have been much affected during the last decade by the economic policy of the government aiming at liberalisation of the economy and at opening the country to the global market (ibid.:10). Land, water, forests and other natural resources, that are essential to Mapuche subsistence and culture, have been subject to exploitation, and the Indigenous Act of 1993 has failed to provide sufficient protection for the indigenous peoples’ rights (ibid.:11). Among the governments so-called mega-projects are the construction of the hydro dams in the river of Bio-Bio, the expansion of the forest industries into Mapuche territory, the construction of a coastal highway in the same area, and the Temuco By-pass. These development projects emanate primarily from the private sector but involve also state participation (ibid.:11). Voices have been raised from the indigenous communities that the government, through CONADI (the National Corporation for Indigenous Peoples), acquires territory through the land fund. Due to lack of funds, most of these demands have not been met, something that has caused frustration among the inflicted people. In the region
several occupations and incendiaries directed against forest companies and landowners have occurred, and tensions have escalated (ibid.:13).

The current government of Ricardo Lagos has as one of three stated priorities to “[...] supply equal opportunities for all Chileans, regardless of ethnic social or geographical origin.” (Lagos 2001:XIII). Under the parole of “protection from helplessness and discrimination” the aim of “recognising the indigenous people in all their dignity, opening new opportunities for development” is stated (ibid.:XIII). The ‘new relation’ between the Chilean state and the indigenous people is referred to in the recent creation of the ‘Commission for Truth and New Agreement’, led by the former president Patricio Aylwin with the cooperation of indigenous leaders, academic and industrial representatives. The Commission has been given the mandate to “[...] propose, with total autonomy, a new relation between the Chilean state and the indigenous people.” (ibid.:XIII).

What can be concluded is that the ‘new relationship’ for the indigenous people is based on the demand for legal recognition and collective rights according to the ILO convention. This demand, first acknowledged by the Agreement of Nueva Imperial in 1989 has not been enforced and the ‘new relationship’ still awaits further implementation. The main opponents to acknowledging the principles of the ILO convention have been the political forces from the right and the free market agents. The state’s contribution to the new relationship has so far consisted of development projects in a few key areas identified by the state, mainly infrastructure, productivity, culture and identity, health and education (Parra-Jerez 1996:2).
Towards an Implementation of Intercultural Healthcare

Established in the year 1992, the Government health agency of Araucania set about the task of working with the Mapuche on the basis of a special health programme. The objective was to:

[…] improve the care of the Mapuche people through promoting community participation in the identification and solution of their problems and to stimulate intersecting co-ordination in the execution of local development plans together with the concerned population. (Citarella 2000:567.)

The Government health agency put together a multidisciplinary team including physicians, anthropologists and ‘intercultural facilitators’ (i.e. representatives of the indigenous population) in order to develop suggestions for joint directions and investigations in the area of health among the indigenous people in Chile (Berg Kroll 2001:18). In 1992 and 1993, this resulted in a special pilot project situated at a number of public hospitals in the region, the Temuco Hospital among others (ibid.:18; Citarella 2000:567). The programme, called Amuldungun, consisted of setting up intercultural offices at the hospitals, and employment of bilingual Mapuche facilitators, with the main function to orient and support Mapuche patients in the hospital and to facilitate intercultural communication (Citarella 2000:567).

As a result of the first years’ experiences, the Government health agency of Araucania, together with the Ministry of Health, set up a series of national conferences, which took place in 1996, 1997 and 1999. Among those invited to participate and to debate were leaders and representatives of the different indigenous peoples of Chile, official functionaries from different health-institutions, social workers, academics as well as experts and people with a special interest in the field.

The first conference, called ‘National Conference of Health and Indigenous people’, was held in Puerto Saavedra in 1996. The main objective of the
conference was to present the basis for a national policy of intercultural health (Berg Kroll 2001:18). The conference concluded that an intercultural health policy was both possible and necessary in order to contribute to an improvement of the quality of health in the country (ibid.:15). The following year, 1997, the second national conference called ‘Health, Culture and Territory’, was held in Lican Ray, focusing mainly on the possibility of forming a basis for an intercultural epidemiology (ibid.:18). In 1999, the third and latest conference was held in Puerto Saavedra, and, for the first time, the documentation from this conference contains a presentation of obstacles and benefits of intercultural health. The different groups present agreed that the lack of political will and the lack of economical resources were major obstacles to intercultural health. The indigenous representatives concluded in general that the benefits of the programme were very few (Servicio de Salud Araucanía Sur 2001:144).

The incitement for an implementation of intercultural health comes from the Integral Development Program for Indigenous Communities (through the Ministry of Planning and Co-operation), with a budget of 133.4 million US dollars loaned by the Inter-American Development Bank. The general objectives of the programme is to improve living conditions, to promote economic, social, cultural and environment development, and to promote indigenous peoples identity, especially in rural areas. Intercultural health forms one of the components in the development programme:

This component will finance specific technical assistance, awareness and training activities, meetings and seminars, dissemination and social marketing, and investments in works and equipment under its four subcomponents: (i) designing reference models for intercultural health care, based on experience with existing intercultural health activities in Chile; (ii) improving the quality, sensitivity and cultural relevance of health services, through awareness, information and training activities of the 10 health services; (iii) strengthening indigenous medicine, as part of a model intercultural health care, with funding for meetings among indigenous medicine practitioners, and support for formulating proposals; and (iv) improving access to intercultural health services, with financing for projects originating in indigenous communities. (Integral Development Program for Indigenous Communities CH-0164.)
PART IV: PRESENTATION OF THE TWO PROJECTS

The following three chapters present the two local Mapuche projects on which my Minor Field Study is based: The Makewe Hospital for intercultural health and the Boroa-Filulawen centre for intercultural medicine. The introductory presentation of the two settings is followed by the chapter on “Intercultural Health in Local Context”, describing the main concepts that the Mapuche themselves – in interviews and in policy documents – stress as meaningful in their projects for an intercultural healthcare.

The Makewe Hospital

The rural Makewe Hospital is situated in the territory of Makewe-Pelale, outside Temuco, in the municipalities of Padre las Casas and Freire. The 200 square kilometres territory of Makewe-Pelale is originally wenteche territory; today it is inhabited by a Mapuche majority of 90 per cent containing 80 Mapuche communities (about 10.000 individuals) (Chureo Zuñiga 2001a:9). In the communities, the vast majority are small-scale farmers, cultivating wheat, vegetables and, in recent years, also lupines for exportation, all on an average of 1,5 hectares of land per capita (ibid.:9).

The hospital itself dates back to 1895, when it was founded as a small health dispensary run by an Anglican Church missionary; the institution also in charge of the local church and school in the area. Despite financial contribution from the Chilean national agency for health, the hospital later came to suffer economic difficulties, a situation that culminated in economic crises in 1993. To prevent the hospital from closing down, the surrounding Mapuche communities together took over the administration of the hospital and formed the local Mapuche organisation ‘Indigenous Health Association Makewe-Pelale’. This association has run the hospital since March 1999, with the director Francisco
Chureo Zuñiga as president, and Dr Jaime Ibacache Burgos as chief physician of
the hospital. When the direction of the hospital was taken over by the Mapuche
association, a model of intercultural healthcare was implemented for the first
time, with the objective to complement the hospital’s western medicine with the
Mapuche medicine (Holzapfel 2001:15).

The hospital attends on average approximately 70 Mapuche and non-Mapuche
patients per day (ibid.:15). The most frequent diseases diagnosed are respiratory
and digestive complications such as bronchitis, diarrhoea and biliary colic, as
well as occupational injuries and injuries related to accidents and physical
violence, along with cases of cancer and depression (C. Labraña, personal
interview January 2002). The list can be complemented by many cases of
hypertension and vascular (blood vessel-related) diseases (Holzapfel 2001:15).
The hospital also offers a special programme for treating patients suffering from
alcoholism, a widespread social problem in the region. Besides medical attention
offered at the hospital, frequent medical rounds are made to the rural
communities nearby.

The hospital holds a medical ward with 35 beds, a separate polyclinic, and a
waiting room with a reception for registration. It has its own pharmacy with a
basic supply of pharmaceutical and herb medicine, and an ambulance at its
disposal, used for emergency calls to the communities, or for transporting
patients to the hospital in Temuco. Since the administration was taken over by
the Mapuche association, a modernised ruka (the Mapuche traditional wooden
house) has been constructed in the vicinity of the hospital. The ruka is used by
the hospital as an assembly-hall for meetings and lectures. Next to the hospital
lies an Anglican Church funded by the missionaries, which is still in use.

The hospital is financed by a contribution of the Governmental agency for health
in the south of Araucania and through contributions of the local communities of
Makewe-Pelale (Holzapfel 2001:15). By 2001, 32 people were working at the
hospital, including two general physicians, one physiotherapist, a dentist, two nurses, two midwives, six paramedical auxiliaries and service auxiliaries (ibid.:15). Among the hospital workers, approximately 50 per cent are Mapuche and 50 per cent are non-Mapuche (Chureo Zuñiga 2001a:10).

The physicians attend the hospital’s polyclinic twice a week. Their salaries are paid directly by the Governmental agency for health in the south of Araucania. The remaining hospital workers are divided between a stationary team (consisting of the midwives, nurses, auxiliaries, secretaries, etc) and an advisory team comprised of agents of the Mapuche medicine: the machi, the Mapuche herbalist and the gutamchefe, specialist in treating fractures and dislocated joints (Asociación Indigena para la Salud Makewe-Pelale 1999:4).

The intercultural health model implemented at the hospital is based on the idea of the complementation of medical systems. The physicians and other non-Mapuche working at that Makewe Hospital are educated in the areas of Mapuche medicine, cosmology, culture and history. The complementation of the medical systems is, in practical terms, carried out through mutual referral of patients between the hospital and the machi (Holzapfel 2001:15). There are no elaborate criteria for the referral to the machi and, ultimately, it is the decision of the patient.

The Makewe Hospital is often put forward as a successful example of the implementation of intercultural health, both by representatives of the government and among the Mapuche themselves. This does not mean that the project is unquestioned or runs without difficulties. The economic support from the Governmental health agency is insufficient leaving the hospital to suffer severe financial difficulties. As it stands today, the Makewe Hospital is a private hospital run by the local Mapuche association. Even if the state’s intercultural development programme has received funding for intercultural healthcare, the hospital will have to accept government administration in order to receive any
extended economic support, a solution the Mapuche association would want to avoid.

The Project of Boroa-Filulawen

The access to healthcare in the rural areas of Araucania is limited. Additionally, the existing health stations and care centres run by the municipalities have insufficient resources and no stationed medical personal. The hospitals are situated far away and the roads are of poor quality. Apart from busses that pass on occasion, the means of transportation in the area are restricted to travelling by horse or on foot. This is also the situation in the area of Boroa-Filulawen that I hosted as part of my field study. Boroa-Filulawen is located in the rural part of the municipality of Nueva Imperial. The demographics, the conditions of living, and the health situation in the area are similar to those described in Makewe-Pelale.

In the late 1980s, a neighbouring community of Boroa-Filulawen initiated the possibility for the construction of a care centre in the community. The plan was discussed for many years, but neither the municipally nor the community took any formal action and the care centre was never constructed. Convinced by the need for better healthcare in the area, the initiative was in the late 1990s taken over by the communities of Boroa-Filulawen. The communities organised the ‘Intercultural Health Committee of Boroa-Filulawen’ consisting of 360 Mapuche families, natives of 16 communities in the area. The committee though, did not choose to push for a care centre, partly because of the poor service such centres can offer, and partly because they are run without much local influence. Instead, the committee decided to propose a community-run medical centre, presented before the Government agency of health in the region.
Under the direction of the president, Antonio Huircan Pichicón, and the secretary, Abelino Pichicona Guimay, the committee in 2002 presented a complete proposal for the construction of the Intercultural and Integral Medical Centre of Boroa-Filulawen. Governmental officials have visited the community, and the final result of the proposal is presently under negotiation with the Chilean Ministry of Health.

The inspiration for the centre derives from the Makewe Hospital, and its intercultural health model. The Boroa-Filulawen centre is proposed to have an ‘intercultural and integral health-model’, that complements and integrates the biomedical medicine and the Mapuche medicine. The committee advocates a specific policy for the integral health, stating that:

These health policies aim at not understanding the biomedical model as the uniquely valid health-system, but to integrate the understandings that the process of health – illness presents among the proper people. (Comité de Salud Intercultural Boroa-Filulawen 2002:4.)

The intercultural health aspect is said to signify:

[… to know and to valorise the local culture as a tool in the betterment of health and the treatment of illnesses and to consider beliefs, practices, values and proper language in the construction of sanitary programmes with the active participation of the individuals involved. (ibid.:6.)

The property for the future centre was donated by the community, and, in 2002, the first building constructed there was a ruka. The proposal contains a full plan for the other buildings: three rooms for medical treatment divided between the machi, the physician and the nurse; a waiting room, administration offices and a conference hall. In addition, the hospital will house a pharmacy and will provide accommodation facilities. The architecture reflects the Mapuche cosmology with consideration for the cardinal points and the path of the sun. A rewe (the sacred "ladder") will be located in the centre area. A medical herb plantation is presently being constructed in the community in order to supply the centre with medicinal herbs.
The Mapuche intercultural health committee propose that two representatives of the committee, assisted by an advisory consul consisting of local community authorities, direct the centre. The medical personnel will include a general physician, a pediatrician, a dentist, a midwife, a social assistant, two paramedical auxiliaries and three representatives of the Mapuche medicine: a *machi*, a *gutamchefe* and a Mapuche herbalist. In the proposal, there is an expressed demand that the medical personnel shall have a general attitude of respect and understanding towards the Mapuche people and their culture. The permanent personnel shall preferably be of Mapuche origin and live in the area.

The above plans are currently under negotiation with the Government health agency and the Ministry of Health. Even if the representatives of the state have been very positive to the initiative taken by the local Intercultural Health Committee, no economic support has so far been agreed on, and the realisation of the project is thereby presently without economic guarantees.

**Intercultural Health in Local Context**

During the field study, a number of concepts were in discourses on interculturality and health, especially emphasised by the people at the Makewe Hospital and the Boroa-Filulawen project. The main concepts, which will be presented in the following paragraphs, are: *complementary, integral, participation, local communities, the mapudungun language, environment and territory, and self-determination and autonomy*. These concepts are referred to by both the Makewe Hospital and the Boroa-Filulawen project, representing what the Mapuche themselves stress as meaningful in the projects. Even if, in the thesis, the concepts are presented separately, they are better understood as interconnected.
A Complementary Approach
The objective of the complementary approach is to complement Mapuche medicine with western biomedicine. The complementation of medical systems holds that “[...] different medical systems are considered, valorised and interacting, and that the best of each one can be extracted with respect and reciprocity” (Chureo Zuñiga 2001b:40). The western medicine is, in general, considered effective in several ways, especially in curing physiological symptoms, where its developed technology and pharmaceutics have an immediate effect. Health for the Mapuche is not just the lack of illness, but involves a more holistic and social approach, which apart from the individual also takes into consideration family, community, territory and environment. A proper health system for the Mapuche considers their cosmology and the notion of equilibrium. The Mapuche medicine is considered better in diagnosing illnesses (offering a faster and more holistic diagnose), being more developed therapeutically, and being better in detecting and curing the cause of illness (J. Ibacache, personal interview January 2002; C. Pichicona, personal interview January 2002). This understanding may explain the expression that “the Mapuche medicine treats a person’s health while the western medicine treats a person’s illness” (V. Caniullan, personal interview January 2002). Combining the two systems’ different strengths is seen as the best method (F. Chureo, personal interview January 2002; A. Pichicona, interview January 2002). The combination of the two medical systems also reflects the reality of the Mapuche in the area, with widespread use and influence of western medication, in many ways competing with the faith in Mapuche medicine. Complementation is seen as an instrument for the state to valorise Mapuche medicine and also to re-valorise it within the Mapuche community.

Integral Health
The call for integral health confirms the Mapuche’s view of health as holistic - social, spiritual as well as physiological. The term is not limited to the field of health but emphasises also aspects of Mapuche cultural knowledge, cosmology and history. Support for educational programmes containing these aspects, are
thereby vital according to spokesmen connected to the Makewe Hospital and the Boroa-Filulawen project.

*Participation and Local Communities*

The Makewe Hospital stresses participation as an important concept in their intercultural healthcare model (Chureo Zuñiga 2001a:40). Participation is said to mean “to answer to the true necessities of the people and to create a room for the involvement of all people in the implementation of [the healthcare] model.” (ibid.:40).

The organisations behind the Makewe Hospital and the Boroa-Filulawen project are both based on local community involvement. The communities contribute financially to the work. Regular meetings are held to inform, enable and stimulate suggestions and participation in planning. The local communities are also very much involved in the frequent medical rounds made by the Makewe Hospital.

Policy proposals at the Makewe Hospital presuppose the participation of traditional authorities (for example machi, longko, werken, weipife, gutamchefe) along with western healthcare officials and intercultural facilitators. Representatives of the different Mapuche territorial identities (in this case the Nagche, the Wenteche, the Pewenche and the Lafkenche) participate in the meetings as well (Propuesta para una Política de Salud en Territorios Mapuche 2001:3).

*The Mapudungun Language*

The native language of the Mapuche, *mapudungun*, is made a salient and essential component, both at the Makewe Hospital and the Boroa-Filulawen project. *Mapudungun* is said to be the key to understanding the essence of being Mapuche, of understanding their cosmology and concepts of health and illness. The importance of speaking *mapudungun* with patients and families is stressed.
At the hospital and in the proposals, keywords are written in mapudungun and customs in mapudungun are taken into use. At the Makewe Hospital, the chief physician speaks mapudungun. It is also an explicit demand from the Intercultural health committee of Boroa-Filulawen that all future medical personnel speak mapudungun.

**Environment and Territory**
The environment and the territory are important in multiple ways. Firstly, the territory provides the subsistence for the Mapuche in the area, and environment and territory condition the state of health. However, the principles of equilibrium mean that the environment and the territory can also cause both spiritual and natural illnesses through the overexploitation of the natural resources or the local environment. The Mapuche medicine is dependent on the land to provide medical herbs to cure illnesses, something that is threatened by the worsening environmental condition.

**Self-determination and Autonomy**
The informants I interviewed, used and referred in different ways to the concept of self-determination or autonomy, stating that people in local communities can understand best of all, the proper solution to the problems in the area. The importance of self-determination is stressed, calling for local participation. The director at the Makewe Hospital has coined the term *internal autonomy* as representing the hospital’s position. Internal autonomy signifies the hospital's ability to decide and choose without state control or external interference what it considers the best solution for the people concerned. This implies local development in terms of “recuperation of cultural control” and “strengthening of the organisation for territorial autonomy” (Propuesta para una Política de Salud en Territorios Mapuche 2001:5).
PART V: INTERCULTURALITY IN A BROADER PERSPECTIVE

The following part contains three chapters, that each views the local experiences and the concept of intercultural health in a wider perspective. The first chapter, “Disputing Interculturality”, presents the interviewees understanding of interculturality, with related obstacles and prospects. The following chapters discuss these issues and the concept of intercultural health, the first in a context of medical development and community relations, the second in context of ethnicity and symbolic boundaries.

Disputing Interculturality

Despite the fact that the people I interviewed were active in political discussions on intercultural health and/or directly working within this field, they expressed strong negative views about the concept itself. The reason for this is a mistrust based on historic and current experiences of the relation between the Mapuche and the Chilean state and society. They feel the Mapuche have “done their part” and more, and now expect a change of attitude among Chileans for interculturality to be legitimate and real.

The machi, Victor Caniullan argued for example that there were no examples of intercultural health existing in Chile. Asked about the significance of the concept of intercultural health, he explained:

It exists in two different and opposite versions. Since the Mapuche medicine is religious it takes into consideration all religious aspects, the western medicine does not. I do not think there will ever be an intercultural healthcare system; personally I do not think it should exist. […] Intercultural health does not yet exist and it will not exist as long as there are unequal conditions for the individual. For example we, the machi, are not recognised. The day someone dies in our hands we will be considered guilty and possibly be put to prison because the Mapuche
medicine is not authorised. The Mapuche religion is not recognised either, despite the fact that a law exists stating freedom of cultural expressions. The Mapuche people and other indigenous people are not recognised. […] What might occur within the healthcare sector is the referral [of patients to the Mapuche medicine], this can happen, but this calls for education of the people who work with western healthcare, in hospitals the staff will need education and this costs money, time and will. (*Machi* Victor Caniullan, personal interview, February 2002.)

He also expressed that, even if there are Mapuche working for an intercultural platform, the concept is perceived as foreign and imposed:

[Interculturality] is not a Mapuche concept. It is not compatible with our thoughts, our values. It is not compatible because it does not exist. […] We do not have the power to say that the intercultural theme should be carried through this way or that way. To exist, the intercultural must be fifty-fifty. 50 per cent our way and 50 per cent western way. […] We Mapuche are already intercultural; we speak a language that is not ours and do many other things that are not ours, therefore the only thing lacking is that the *wingka* becomes intercultural. They should meet the level we are at, and from there at best begin working for the intercultural. (*Machi* Victor Caniullan, personal interview, February 2002.)

The chief physician at the Makewe Hospital, Dr Jaime Ibacache Burgos, expressed a similar view when discussing what intercultural health signifies:

It was a long time ago that I stopped using the concept of interculturality. Suddenly the day-by-day activities signalled that it is a matter of an imposed concept: An invented western concept to justify a lot of objections of socio-political character. They speak of interculturality in the everyday life, in the education, but I think it remained in the subconsciousness.

[Intercultural medicine] means absolutely nothing. It means that someone, with a *wingka*-perspective, thought of naming something the Mapuche already have been doing for years. […] The intercultural concept will not mean anything since the intercultural does not exist. Interculturality will exist when the indigenous people are legally recognised, when we have the same opportunities; that is interculturality. What does exist today, in some aspects, is complementation. […] the intercultural medicine is something someone invented that today has no correspondence or support. (Dr. Jaime Ibacache Burgos, personal interview, January 2002.)

The negative views became especially clear when asked if there is a conceptual difference between intercultural health and intercultural medicine. The director of the Makewe Hospital, Francisco Chureo, expressed:
I think the concepts have been used wrongfully in this march towards intercultural medicine and health. I think that the state’s programme for intercultural health is mistaken when it comes to the intercultural aspect of health. It calls for a change of attitudes; no magic word alone can do the work. I believe we must change the attitude to accomplish both things. To bring about an intercultural health model I should change my attitude towards you, towards your medicine, to really respect it […] We should respect the western medicine, valorise it, but also the Mapuche’s or any other indigenous’ medicine should be respected. This is why it concerns a change of attitudes among the people. I for instance, to be able to demand that you change, I myself must change first. This is why the government cannot tell me what intercultural health or medicine is. The concept is one thing, but we cannot talk about intercultural medicine or intercultural health because it does not yet exist in Chile. It does not exist. We [the Makewe Hospital] prefer talking about a complementary medicine and this is more practical because I share with you what I know and you share what you know; this is complementary. The intercultural medicine is a lie, the intercultural health is a lie; it does not exist. (Director Francisco Chureo Zuñiga, personal interview, January 2002.)

Medical Development and Community Relations

The interviewees argue that the concept of intercultural health is not legitimate without the fundaments of interculturality being considered from a broader perspective. This involves the questions of social and political equality, legal recognition, and the valorisation of Mapuche medicine and culture in development programmes. As long as the problems of inequality and discrimination remain unchallenged, a “relation based on respect” is not valid. These fundamental issues remain unsolved and are not recognised or part of the health policies. The focus of governmental planning has so far been on the betterment of the communication and interaction between the individual Mapuche patient and health workers. Due to this, some Mapuche explain that the projects of interculturality can work quite in reverse: When investments on intercultural programmes are controlled by the government agencies and reach the ‘intercultural offices’ in established hospitals, it can – at the expense of the Mapuche medicine – facilitate the integration of the Mapuche patients into the western biomedical system.
At a discursive level, the Makewe Hospital and the Boroa-Filulawen project represent the Mapuche’s contribution to an understanding of intercultural health: The state initiative towards the implementation of the concept has opened a field of opportunities that the Mapuche make use of and define according to their own needs. Using the framework of the intercultural health system, they have created elaborated locally based projects offering both Mapuche and western medicine in the area. Within these projects, the Mapuche strive for re-valorisation of their medicine as a acknowledged medical system. Simultaneously, they, as a people, express their culturally defined needs in a broader socio-political perspective, stressing a wider holistic view within these projects.

As pointed out above, for the Mapuche, the issues of health and medicine are not separated from other aspects of life. An illustrative example is found in the scheme of factors explaining illnesses that has been elaborated by the Makewe Hospital and also referred to within the Boroa-Filulawen project (Ibacache Burgos & McFall 2001:27-28; Comité de Salud Intercultural Boroa-Filulawen 2002:8). This scheme contains a total of seventeen factors causing illnesses among the Mapuche in the region. These factors can be arranged into three main categories: (1) the condition of the territory and the environment, (2) external social influences, and (3) changes in their way of life. The first category contains factors such as “scarce land and poor quality of soil”, “use of chemical products in agriculture” and “expansion of cultivated forest” [for commercial use]. The second group contains factors such as “no valorisation of Mapuche culture in education system”, “no valorisation of Mapuche culture in the different religions within the area”, “difficulties in economic, geographic and cultural accessibility” and “invasion of mass media”. The third category contains factors such as “loss of cultural identity” and “division and loss of community organisation”. The third group can also be seen as a consequence of the second category: Due to external pressure, the Mapuche have experienced a loss of cultural life, which affects their state of health. Together, these three categories form the culturally conceived cause of illness among the Mapuche in the region, with “external social influences” as a major explanatory factor.
The factors used in explaining illness in the region can easily be viewed as originating from negative effects of historic and current development projects enforced through government support on indigenous territory. (See the chapter about the ‘new relationship’ between the Chilean state and the indigenous people, Part III). They also form a background for understanding the dispute regarding the legitimacy of the concept of intercultural health among the Mapuche.

The governmental economic support for an intercultural health programme is only one component of a larger development scheme. The component receiving the largest economic support through this programme is “Development of productive activities”, which refers to:

(i) development of rural production activities, through financing for projects design to improve agricultural yields and diversify sources of family income, by promoting nonagricultural activities and improving the management of natural resources; (ii) support for communities, in order to improve the quality of investment projects and enhance their access to economic and production support services, as a guarantee of greater effectiveness and sustainability; (iii) support for project generation and investment promotion in indigenous areas, for identifying projects and public and private financing; and (iv) support for state agencies that promote production-oriented activities, to ensure that they are in a position to follow up on and continue program activities in the area of productive development. (Integral Development Program for Indigenous Communities CH-0164.)

Under this plan, the state is the agent imposing and assuring productivity and development among the Mapuche, with the aim to integrate them into the country’s economic system. It is interesting that the term “cultural relevance” found in other components of the programme is left out of the above quotation. Most of the suggestions quoted above are, in my understanding, not compatible with the Mapuche culture and view of development, and the plan does not suggest local participation in the planning. In fact, some of the aspects suggested by the quotation above may very well fit in among the causes of illness according to the Mapuche.
A “risk” foreseen in the Integral Development Program for Indigenous Communities lies in the failure to achieve effective co-ordination between the state apparatus and the “fragmented” social organisation of the Mapuche. This risk motivates the state to support a strengthening of the Mapuche’s traditional form of social organisation:

To minimize this risk, the program will provide training and strengthening for indigenous organizations and will stress the creation of an effective institutional structure for the ADIs [Indigenous Development Areas]. (Integral Development Program for Indigenous Communities CH-0164.)

At this stage, some of the concerns regarding medical development, labelled “the myth of collaboration”, brought forward by Shane Greene (1998) become apparent. Greene argues for an understanding of medicine in an ideological perspective. He pays attention to how political economy intersects with medicine, concluding that economic and capital interests often motivate development (Greene 1998:636). In this case, the state policy for an intercultural health system shows similarities to the older strategy of indigenismo, as the health situation among the Mapuche is to be solved by integrating them into a programme of modernisation and development.

Greene concludes that at best, medical collaboration may lead to the recognition of ethnomedicine, but it may also become a way of circumventing the problem of providing more extensive biomedical resources. This is connected to the cost of development according to Greene. If the aim of earlier development policies was to replace the ethnomedicine with the biomedicine, it is clear now that this is economically impossible without major redistribution of resources. Linking ethnomedicine and biomedicine might, in this perspective, prove more economic. Persisting asymmetric distribution of resources give way for collaboration through the utilisation of all health care resources available, thereby leaving a space for continuing economic development in other areas. This is illustrated by the fact that the state programme for an intercultural health
system is included as one component in a more extensive development programme. The development projects in the region are likely to continue, while intercultural health is perceived as a separate issue.

Even if medical pluralism is acknowledged, and integration is preferred to replacement, Greene also points out that development plans often continue to embrace an old and misguided set of conceptions about ethnomedicines and, by implication, about indigenous cultures and people (ibid.:637). As previously pointed out, the Mapuche are frequently perceived as the “opposite pole” to development and modernisation. In my opinion, this representation is nourished by the fact that the term ‘indigenous’, by definition, links present legal rights to ancient customs and time honoured prescriptive rights with a strong connotation of authenticity (see Nesti 1999:5ff). When struggling for the recognition as indigenous people, as are the Mapuche, it is, by all means, relevant to communicate traditional values and customs, something that can be misconceived as contra-modern. Even if the indigenous people do not oppose the modernity process per se, but rather the violation of their territory or threats on their ability to self-determination, the representation of “modern versus tradition” often constitutes a source for a prescribed binary opposition in ethnic relations. When conflicts are acted out, this dichotomy is embraced by both sides to communicate and justify their position. This is relevant also in the field of health. Traditional values and elements are communicated by the Mapuche as a way to achieve a re-valorisation of the Mapuche culture in modern society. However, representatives of the Chilean state continually view the Mapuche as traditional and static and sometimes even as the opposite of a civilised society: When discussing intercultural health, Seremi Carlos González of the Government Health Department in Araucania states:

> It has to be evaluated what the Mapuche want, and if they intend to continue to maintain their ancestral form of live. My impression is that that is not the case, that they instead are making a tremendous personal effort to integrate themselves in what we call civilisation. By this we believe, that they are losing the peace and calmness they could have had, but it is part of the modernity that we can not deny. (Seremi Carlos González, August 2000. Quoted in Ibacache Burgos and McFall 2001:53.)
As pointed out by Cuadra, in the process of redefining the relation between the Mapuche and the Chilean society, the agents have to adjust to the modernist perspective (Cuadra 1994:16). The strategies can involve expressing both essential traditionalism and modernism. Simultaneously, as the Mapuche may work for a re-valorisation of their traditional values, they can confirm the idea of modernisation and see their position in such a context. The notion of Mapuche medicine as static and anti-modern can be challenged, and instead the Makewe Hospital recognised as the active agent of modernisation:

The principal contribution that the Makewe Hospital can offer, is to demonstrate the way towards modernisation of health, to show the way in which western medicine system can be modernised, the way in which western medicine system can be more humanistic and return to hold the characteristics it had many years ago, but has lost step by step. (Ibacache Burgos 2001:42)

The director Francisco Chureo states that the intercultural and complementary health model at the Makewe Hospital represents the most modern of health systems. In his opinion, no medical system alone will be sufficient to challenge present and future illnesses and a complementary health model is therefore the answer. He views traditional knowledge as a resource for modernity and progress. When elaborating this issue he explained:

Most indigenous medicines are on the edge of disappearing but in the IX region, where we are, the medicine has prevailed because it exists as a local medicine. I can consider this medicine modern because it is spiritual and views the human being as a whole. It does not exclude anything in order to treat the illness. It is a modern medicine because it has not become stagnant during all this time. In spite of all that has happened to us this medicine has prevailed. This is why I always say that with the old we can do something new, and the fault is ours if things become stagnant. What was said a thousand years ago can become important today as long as we nourish and renew its importance. The Mapuche medicine is ancient but through the passing of these thousands of years, it has always viewed the human being as a whole; as body, spirit, mind and thought, constantly struggling to solve the problems; for one, and at the same time for all, and not like western medicine, then we do not talk of modern medicine like western medicine does. For me modern medicine must aim at wholeness. (Director Francisco Chureo Zuñiga, personal interview, January 2002.)
Preserving Ethnic Boundaries

Conflicts of interests between the Mapuche and the Chilean state colour their understanding of intercultural health and hinder any uncomplicated implementation. The Mapuche oppose the concept on the ground that it lacks mutual recognition. However, the lack of recognition in the field of intercultural health does not seem to give rise to tendencies of identity change or assimilation. Instead, the conflicting interests between the Mapuche and the dominant society accentuate ethnic difference.

As an ethnic group, the Mapuche have formed different strategies in maintaining their symbolic borders in relation to the Chilean society. In order to analyse these processes, the sociologist Sergio Cuadra developed a discourse analysis, which is based on the focus of ethnic boundaries. Cuadra’s model demonstrates that every discourse contains distinct references. The references are in turn based on the symbolic resources that a group have acquired (Cuadra 2001:20). These discursive social references are used to preserve the group’s boundaries in relation to surrounding groups (ibid.:20). Preserving the boundaries involves a constant reflective process where signification comes from the selection among a number of different references (ibid.:53). Furthermore, activating old symbolic resources and creating and assimilating new ones affects the group’s social references, which in turn can influence the group’s discourses (ibid.:53). This interplay between symbolic resource/reference/discourse is viewed by Cuadra as the fundamental dynamic element in boundary preserving (ibid.:20).

An important point made by Cuadra is that, in preserving boundaries, the Mapuche’s primary cultural social references (i.e. cosmology, traditional hierarchies, ceremonies, local communities, etc) interact with political references - a development especially evident in the case of the indianismo movement. These discourses often mix different types of references from varying spheres: religious references are mixed with political ones, the cultural/traditional sphere with the economic and so on. Moreover, new
elements (human rights issues, environmentalism, democracy and modern development, etc) can become additional important social references that affect the Mapuche’s political discourses (Cuadra 2001:21). When new social references are assimilated, their interaction with the primary social references assist the Mapuche to accommodate social change in society. According to Cuadra, this interplay between the political and the ethnical identity reinforces the Mapuche’s symbolic boundaries.

Cuadra argues that an extensive boundary deliberation is enacted between the Mapuche people and the Chilean society, and that this process can be analysed through different discursive social references (ibid.:35). By balancing between tradition and modernisation, the Mapuche people seek new social references, and in the process, control over important resources (ibid.:53). Cuadra identifies the concepts autonomy, integration, modernity, traditions, nature and culture as central characteristics in the Mapuche’s main discursive references (ibid.:69). He concludes that the Mapuche’s discourses, social references and symbolic resources grow and acquire significance with the help of these concepts in relatively concrete contexts (ibid.:69).

If the project for an intercultural health system can be seen as one of the “relatively concrete contexts” that Cuadra discusses, then the discursive social references within that field are relevant for an understanding of the Mapuche’s boundary deliberation. The concepts identified by Cuadra are relevant for the Makewe Hospital and the Boroa-Filulawen project: In both cases traditional symbolic resources are activated and new ones are incorporated. As a result of this, they can gain control over important symbolic discourses and maintain their boundaries as an ethnic group.

From this perspective, health can be made an important component in preserving ethnic borders in relation to the surrounding society. In the following quotation, in which the machi, Victor Caniullan, explains the relation between identity and health, the references to traditional symbolic resources (the mapudungun
language, religion, ceremony and tradition) are clearly expressed and form a unifying factor for the Mapuche’s social identity and community:

In health and identity, the Mapuche understands the health of the Mapuche, especially those who speak mapudungun, because each word entails a message when it comes to health. Every word says something, and wants to say this is, or that is identity. Secondly, health for the Mapuche is religious, it is a ceremony performed. This way you experience what culture is; the Mapuche’s dance, the Mapuche’s language, etc. You experience the knowledge and understand a part of the Mapuche world and health is lived and experienced. A grand ceremony such as nguillatun is held every second or fourth year in a community. Furthermore, in the field of health you can arrange four machitun within a month that represent even more identity. Indeed, the non-Mapuche can be made to think about different cultures, as part of an identity. (Machi Victor Caniullan, personal interview, February 2002.)

By incorporating references to self-determination and autonomy, the field of health can, in a broader political perspective, also represent an important symbolic resource in the struggle for recognition and territorial autonomy. The machi, Victor Caniullan, gives expression to this aspect of health when exploring the issue:

The Mapuche's health is independent and has its own autonomy. […] At a political level, this can contribute to the creation of a space, or within the space of the Mapuche’s territory, to produce autonomy. The only thing that has not been soiled by the wingka is the health and its practitioners; it is the only thing left intact. Education is intervened with, the longko’s political role is intervened with, but not health, it cannot be intervened with or occupied. Intercultural health aims at intervention; that is the goal, to intervene in the health of the Mapuche. This is why the intercultural theme as a concept is very dangerous. (Machi Victor Caniullan, personal interview, February 2002.)
PART VI: CONCLUSIONS

Although this thesis does not uncover nor fully analyse the whole complex of problems related to intercultural health, it has highlighted issues relevant for the Mapuche in the intercultural context. The relevance of intercultural health must be understood as part of a larger socio-political context. Discourses of intercultural health acted out within the socio-political space, as identified by Cuadra, are shown as resulting from the new interplay between modernity and multiculturalism in the country. In addition to the question of healthcare, the field gains political meaning, that springs ultimately from the relation between the Chilean society and state and the indigenous people.

Apart from an agreement that intercultural health should be based on respect between different cultures and medical systems, I have found few signs of correspondence between the parties involved when it comes to the understanding of how this objective should be realised. From the state’s point of view, the question of intercultural relations has generally been a question of bilingualism, in intercultural education as well as in intercultural health. The state has initiated and supported projects that focus on the communication between the Mapuche patient and hospital workers by implementing intercultural facilitators in the established hospitals with the main function to orient and support Mapuche patients and facilitate intercultural communication.

The underprivileged situation of the Mapuche is recognised by the Chilean state first and foremost as a social problem to be solved by integration and economic development in the country. The state’s programme for an intercultural health system is part of a larger development programme, with the main objective to promote economic development and productivity. Although, the programme also promotes cultural development and aims at social and cultural equality, in practice, economic development is of overriding importance. The Mapuche’s demands for legal recognition and collective rights are well known to the state,
but their granting has been prolonged due to resistance from political and economic agents. This is evident in the continuing conflicts between state-supported projects and the indigenous people in the country, in which the Mapuche are commonly perceived as representing the static and anti-modern.

As regards the Mapuche, the state of health among them is symptomatic for their situation in general. Fundamental issues such as legal recognition, means of subsistence, territorial autonomy, equality and participation in development plans are their solution to the situation and, consequently, also the key to tackling the health condition among the Mapuche. In fact, the relation with the Chilean society is seen as the major part of the problem, and it has to change in order to bring about a genuine recognition and valorisation of the Mapuche medicine and culture. The concept of intercultural health is not regarded as legitimate as long as fundamental aspects such as social and political equality, legal recognition, and the valorisation of the Mapuche medicine and culture in development programmes are not considered.

To demonstrate this position, the Mapuche in projects related to intercultural health dispute the concept of intercultural health. The discourse of intercultural health is indeed being incorporated and used, but given, by the Mapuche, an altered meaning and a value of relevance for the Mapuche, which involves the struggle for control over resources while maintaining symbolic community and ethnic identity. The focus is both on internal values of the Mapuche community, with a re-valorisation of the Mapuche medicine and culture, and on the Chilean community, as a possible way to make the Mapuche medicine and the institution of *machi* recognised by the state.

The discourse of intercultural health can be used as a way of protest, resisting the fundamentally unequal relations in the society. The medical aspects of the Mapuche’s lack of territory and unequal conditions can thereby constitute yet another legitimate claim for the Mapuche in their political struggle.
APPENDIX

A. Map over Chile and the Mapuche Ancestral Territory

B. Map over the IX Region of Chile (the Araucania)

C. Mapuche Classification of Illnesses

**ORIGIN**

Disharmony → KUTRAN

Physical-social-psychic

**Etiologic-Therapeutic**

- WINGKA KUTRAN: TB, cancer, pneumonia, Aids, rheumatism
- MAPUCHE KUTRAN

**Etiologic**

- RE KUTRAN: Chafo, kaychi, fonwa, kelü, nge, etc
- WENU KUTRAN: Machi kutran, kastikanten, konün
- WEDA KUTRAN: Weküfütun, kalkuntun, perimontun

**Localisation**

kutran + longko piwke furi pel pütra, etc.

**Symptomatology**

- PICI (Minor)
- FÜTA (Major)

**Duration**

- LEF (Acute)
- KUYFI (Chronic)

D. Glossary Mapudungun – English

- **Ad mapu** – the Mapuche law-code. (Also the name of a Mapuche political organisation formed in 1978.)
- **Dungunmachife** – the mediator between the *machi* and the people during the ceremonies.
- **Filulawen** – “plant of the serpent”.
- **Gutamchefe** – Mapuche medical agent, specialist in treating fractures and dislocated joints.
- **Kultrun** – the sacred drum painted with symbols representing Mapuche cosmology. Used in ceremonies and for religious and medical practices. Composes one of the *machi*’s most important instruments and symbols.
- **Lafken mapu** – the Mapuche western territory according to cosmology.
- **Lof** – a social unit based on the extended family.
- **Longko** – ”head”. Traditional leader of the *lof*. Important socio-political authority.
- **Machi** – the authority on religion and medicine.
- **Machitun** – ceremony lead by the *machi*.
- **Makewe-Pelale** – ”searching for Makewe”, the name of a tree used as medical plant.
- **Mapuche** – ”people of the land”. Commonly perceived as originating from and unifying different regional identities:
  - **Lafkenche** - the people from the sea/coast (west).
  - **Muluche** - the people from the humid area.
  - **Nagche** - the people from the valley.
  - **Pewenche** - the people from the area where the pewen tree grow (towards the east, by the mountains).
  - **Pikunche** - the people from the north.
- **Puelche** - the people from the east, from a territory now belonging to Argentina.

- **Wenteche** - the people from the central region.

- **Williche** - the people from the south.

- **Mapu** - “land”.

- **Mapudungun** - “language of the land”. The Mapuche’s indigenous language.

- **Meli witran mapu** – the construction and principles of the Mapuche world according to cosmology.

- **Miñche mapu** – a supernatural dimension that represents the underground in Mapuche cosmology. Associated with negative spiritual forces.

- **Nag mapu** - the territorial dimension in Mapuche cosmology.

- **Ngenechen** – an important and powerful spiritual force.

- **Ñgenpin** – a religious authority, who is ”master of the words”.

- **Nguillatun** – important religious ceremony.

- **Piku mapu** – the Mapuche northern territory according to cosmology.

- **Puel mapu** – the Mapuche eastern territory according to cosmology.

- **Rewe** – a sacred wooden “ladder” (often with a face carved out in the top), the centre of the nguillatun and other ceremonies and meetings. Composes one of the machi’s most important instruments and symbols.

- **Ruka** – the Mapuche’s traditional wooden house. Constructed according to the principles of Mapuche cosmology.

- **Toki** – traditional military leader, temporary elected during warfare.

- **Weipife** – the person in trust of the traditional knowledge.

- **Wenu mapu** – one of the supernatural dimensions in Mapuche cosmology. Associated with the positive forces and the spirits of the ancestral family.

- **Werken** – messenger or spokesman. Important socio-political authority.
• **Willi mapu** – the Mapuche southern territory according to cosmology.

• **Wingka** – "thief". Expression commonly used for individuals or practices/habits conceived as non-Mapuche.
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