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The Right to Health Care Viewed from the Indigenous Research Paradigm: Violations of the Rights of an Aymara *Warmi* in Chile's Tarapacá Region

ADIMELIA MOSCOSO, CARLOS PIÑONES-RIVERA, RODRIGO ARANCIBIA, AND BÁRBARA QUENAYA

Abstract

This paper reflects on the right to health care from the Indigenous research paradigm. We analyze the case of an Aymara wise *warmi* (woman) who died after the Chilean health care system failed to provide culturally appropriate care. In the wake of her death, our cooperative launched an interdisciplinary and collaborative research project in an effort to file an administrative complaint against the family health center that treated her. We explore the events surrounding her treatment and death, as well as the institutional written response. Our work elucidates the significant differences that exist between institutional and Indigenous perspectives on what constitutes a violation of the right to health care. We demonstrate that in order to establish the existence of such violations, Aymara people are compelled to develop evidence using a naturalistic scientific and legal framework that does not coincide with their ontology. Consequently, some events and violations are not legally recognized as culturally inappropriate health care unless they are viewed through an Indigenous lens. Finally, we reflect on the problem of evidence production, specifically regarding the right to health care. We argue that the fight for the right to health care can benefit from the Indigenous research paradigm—not only for the benefit of Indigenous people but also to provide culturally appropriate care to all people.

Adimelia Moscoso, MSc, is a member of Cooperativa Apacheta, Iquique, Chile.

Carlos Piñones-Rivera, PhD, is a professor in the Department of Social Sciences at the Universidad de Tarapacá, and a founding member of Cooperativa Apacheta, Iquique, Chile.

Rodrigo Arancibia is a member of Cooperativa Apacheta, Iquique, Chile.

Bárbara Quenaya is a member of Cooperativa Apacheta, Iquique, Chile.

Please address correspondence to Carlos Piñones-Rivera. Email: carlospinonesrivera@gmail.com.

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Introduction

They came and took her against her will using deceitful tactics. They said they would just remove some liquid and bring her back, but my mother never returned. They took her away. My mother was much happier being treated by a qulliri, someone with a great deal of knowledge developed by our ancestors. They heal people with herbs and other things.[1]

Stories like this one are part of the social memories and shared histories of Indigenous communities worldwide and are important for studies on the provision of culturally inappropriate health attention. This paper explores violations of the right to health care (considered part of the right to health) involving Indigenous peoples. We focus on the case of an Aymara wise *warmi* (woman), her family, and their community in the Tarapacá region of Chile. Doña Francisca died after the health care system failed to provide culturally appropriate care. Our analysis is based on an interdisciplinary and collaborative research project conducted by our cooperative after her death. We offer scientific and legal evidence that served as the basis of an administrative complaint filed against the family health center responsible for her care, the purpose of which was to prevent further harmful actions by that specific facility and the state.[2]

The family's testimony and the documents required to file the administrative complaint inspired two related questions regarding the Indigenous perspective. First, which knowledge system should we use to develop the evidence that allows us to identify rights violations against Indigenous peoples? Second, does the right to health care as enshrined in law include all of the dimensions appropriate for our Indigenous communities?

Reflections on the violation of human rights in health care tend to ignore both of these questions.[3] The traditional approach requires Eurocentric scientific evidence concerning rights formulated in accordance with a Eurocentric matrix.[4] As Linda Tuhiwai has argued, there is

> *(1) a legal framework inherited … which includes views about what constitutes admissible evidence and valid research; (2) a "textual" orientation, which will privilege the written text (seen as expert and research-based) over oral testimonies (a concession to Indigenous "elders"); (3) views about science, which will allow for the efficient selection and arrangement of "facts"; (4) "rules of practice" such as "values" and "morals," which all parties to the process are assumed to know and to have given their "consent" to abide by, for example, notions of "goodwill" and "truth telling"; (5) ideas about subjectivity and objectivity which have already determined the constitution of the tribunal and its "neutral" legal framework, but which will continue to frame the way the case is heard; (6) ideas about time and space, views related to history, what constitutes the appropriate length of a hearing, "shape" of a claim, size of the panel; (7) views about human nature, individual accountability and culpability; (8) the selection of speakers and experts, who speaks for whom, whose knowledge is presumed to be the "best fit" in relation to a set of proven "facts"; and (9) the politics … and the way those politics are managed by politicians and other agencies such as the media.*[5]

Despite the fact that the right to culturally appropriate care is clearly established in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights, legal and epistemological systems are overwhelmingly Eurocentric.[6] There are at least three key aspects of this reality that deserve further attention. First, the two primary references that can be used to address the problem of the right to health care from a legal perspective (biomedical law and the right to health care for Indigenous peoples) fall under the umbrella of a legal monism that assumes that the state is the only entity that produces and applies legal standards.[7] However, Indigenous peoples have their own systems of representation, values, and principles for regulating social organization that do not align with European approaches, and these must be considered legal systems in their own right (articles 5, 34, and 40 of the United Nations Declaration on the Rights of Indigenous Peoples). In the area of the right to health, this opens up the possibility of exploring the right to health care from an Indigenous perspective and of using an intercultural approach to the law.

Second, from an Indigenous perspective, producing evidence may require making assumptions that are not shared by modern Eurocentric science. Science is based on naturalist assumptions; that is, it assumes the existence of an area of reality (nature) that is governed by its own laws (the laws of nature) and is separate from the domains in which intentionality, human action, agency, or historicity operate as a sphere of human decisions.[8] However, for the Aymara people, there is reciprocity between human and non-human entities (e.g., the *mallkus*, or sacred mountains) that departs from and surpasses naturalism.[9] Eurocentric science has been used to persecute, destroy, and colonize other forms of knowledge.[10] This leads us to ask how we can legitimize evidence that does not share the naturalistic assumptions of modern Eurocentric science. This is a problem of epistemic (and ontological) pluralism.[11]

Third, in the health care field, Indigenous peoples do not engage in medical monism. Rather, they articulate medical knowledge through praxis (especially biomedical and Indigenous medical knowledge). Should we restrict the analysis of the violation of rights to the evidence presented from a biomedical perspective? Do other forms of medical knowledge have the right to produce their own evidence, even if it does not coincide with the biomedical point of view? Through these questions, we show the problems that arise when using a homogenizing approach to medical pluralism.[12]

It was due to this complexity that we adopted the Indigenous research paradigm, which emerged in the 1970s and has since contributed to redefining research with and from Indigenous peoples. We use the term "Indigenous research paradigm" in the singular because this is how it is established in the literature.[13] Furthermore, it is important to note that this convention does not annul the diversity of Indigenous views; rather, it emphasizes shared aspects that go beyond and prevail over the colonial nature of scientific research. It is also clear to us that these views are specific to each Indigenous peoples and that differences exist between communities.

This complex approach is based on the need to decolonize research. The Indigenous research paradigm seeks to open up a space for including Indigenous people as producers of knowledge. This stands in contrast to other research paradigms in which Indigenous peoples are seen only as objects.

Like any paradigm, it makes explicit the ontological, epistemological, and methodological assumptions implicit in conducting research.[14] The Indigenous research paradigm is unique in that it recognizes the participation of Indigenous peoples and considers their ontologies, methodologies, values, and sociocultural, economic, and political practices, most of which are symbolically or materially violated within the colonial logic of research.

This paradigm is the only one that allows us to work systematically from an ontological, epistemological, methodological, and axiological pluralistic perspective.

Specifically, it allows us to do the following:

1. Develop knowledge about Indigenous peoples that recognizes the connection between knowledge production and coloniality.
2. Recognize Indigenous peoples not only as objects of research but also as producers of knowledge.
3. Validate the intrinsic value of our *own* (Indigenous) knowledge, even when it does not fit into the scientific and naturalistic standpoint.
4. Adapt methodology to community practices, to their ethical standards and, at the same time, to the demands of academia.
5. Avoid separating knowledge production and the Indigenous political struggle.
6. De-center the focus on the individual and expand research to consider family, community, and territorial domains.[15]

Although there is a considerable amount of literature on health and Indigenous peoples, including studies on the right to health care as one of the fundamental aspects of the right to health, very little research has been conducted on the right to health care from the perspective of this paradigm.[16]

We have adopted the decolonization of methodologies perspective, which is very much a part of the Indigenous research paradigm.[17] In this paper, we develop the methodological proposal advanced by Adimelia Moscoso, which incorporates Aymara methodological practices.[18] Moscoso is a member of the Cancosa and Chalvire Indigenous communities. Over the course of her career, she has sought out research approaches that reduce the reproduction of colonial power and adapt to communities' characteristics and needs. In her master's degree thesis, she defined the categories required to do so: care through attachment, recognition of the Aymara approach to time and space, *lurjipan uñasiña* (observation), the use of oral archives, the use of broad thematic guidelines in the territory (*in situ*) of the Aymara, oral informed consent and reciprocity, responsibility, and respect for communities and individuals. She has determined that these safeguards are necessary for generating trust, security, and respect.[19]

We, the authors of this paper, are members of the Cooperativa Apacheta (Apacheta Cooperative), an entity focused on the rights of Indigenous peoples. The cooperative includes both Indigenous and non-Indigenous individuals. Our analyses reflect an interdisciplinary approach that draws on expertise developed in the fields of medical anthropology, sociology, psychology, Indigenous rights, and the right to health. Most importantly, they reflect our scientifically informed Indigenous perspective, which has been forged through intercultural dialogue involving members of Aymara communities in the Tarapacá region and non-Indigenous stakeholders who have been supporting Aymara struggles for more than a decade.[20] As a result, each time we identify the analysis as emerging from our Indigenous perspective, the reader must recall that we are presenting analyses rooted mainly in local Aymara culture. While those analyses may be informed by the various scientific disciplines in which we have been trained, that training also allows us to identify aspects that are fundamental to the analysis that we are conducting but that the scientific approach leaves out.

We note that most of the analyses that we conduct from our Indigenous perspective reflect the reality of Indigenous elders living in rural communities in the Tarapacá region. This reality differs from that of the Aymara who belong to other age groups or who live in other localities (especially urban spaces), and the forms they have adopted in terms of Indigenous cultural practices.

The paper is structured as follows: We begin by presenting the main aspects of Doña Francisca's case. We then analyze them from the perspective of the Indigenous research paradigm. This means that we include arguments grounded in scientific disciplines, as well as arguments that arise from our own Indigenous perspective. Finally, we outline the main conclusions that can be reached based on this case to elucidate critical aspects of the Indigenous research paradigm in the analysis of the right to health of Indigenous peoples.

The case of Doña Francisca

Doña Francisca came from a family of farmers and artisans that is part of the Willq'e community. Its members follow a centuries-old tradition based on Andean medical knowledge.[21] The medicine practiced by the people of this community is not a form of "alternative" medicine; rather, it is their primary form of health care, and they prefer it over biomedicine due to the undesired side effects of the latter. Doña Francisca was recognized as a wise woman, as she was one of the few people alive familiar with her culture's knowledge. In this respect, she took on the responsibility of conveying this knowledge to the new generations. This is one of the main objectives of the Children of Willq'e Aymara Indigenous Association, of which she was a founding member.

Doña Francisca eventually sought care at the family health center in the village of Pica, a state-run clinic based on a biomedical approach. Her chief complaints were type 2 diabetes (for which she received insulin), high blood pressure, and stage 5 chronic kidney failure (which was under control). However, in July 2019, she stopped going to the center because her medications began to produce side effects. The doctors told her she needed to use a catheter, but Francisca refused to consent to that approach. Francisca also told her family that she did not want to undergo dialysis.

Doña Francisca was also being treated in accordance with Andean medical knowledge with the help of her partner, Francisco, a traditional *yatiri* (Andean shaman) and *qulliri* (bone-setter and herbalist) from the village of Caquena in Putre. According to her family and Francisco, the treatment was based on plants such as *pingo pingo*, quinoa bark, *marancela*, parsley, and celery. Francisca also received care at home, which helped her on various occasions when she was seriously ill.

On Friday, August 28, 2020, an ambulance arrived at Francisca's home. No one had called for it. It is still not clear why it was sent. Maybe a neighbor was worried; maybe the health center took the initiative. Whatever the case, the ambulance crew took Francisca with them, telling her that she was only to undergo tests at the health center, which was untrue. She and her partner voiced their opposition, but they took her with the excuse that they needed to extract liquid from her lungs and would bring her back home promptly. They said they would call her sons to update them. They administered a PCR test for COVID-19 and proceeded to take her to the city of Iquique (more than 117 kilometers away). All of this was done without consulting with or informing her family. Francisco told his partner's son what was happening. With the help of an acquaintance who worked in the hospital in Iquique, the son found out that his mother was in a special ward for people suspected of having COVID-19. The doctor on duty told him that his mother was stable and that they had decided to keep her in the ward until Monday.

On Monday, August 31, the PCR test results became available and indicated that Francisca had COVID-19. The entire family was ordered to quarantine in their home, even though her son regularly took PCR tests for work. The son asked to take another PCR but was forcefully told that he could not. The family was told they would be fined if they did not comply with the quarantine. Their inability to be with and support Francisca had a significant emotional impact on the family.

The next day, Tuesday, September 1, arrangements were made to bring Francisca home so that she could continue to quarantine there. She was released from the hospital on Wednesday, September 2. However, she was in an awful physical and mental condition; she could not recognize anyone or even speak. No one in the house slept that night because of her pain and discomfort.

On Thursday, September 3, a doctor was called to examine Francisca and decided that she would have to return to the hospital in Iquique. She was taken back to the facility that same day. The family received a call from the hospital that evening informing them that she was seriously ill and was not likely to survive. The family was told that Francisca had passed away the next day at approximately 2 a.m.

Because her son and her partner were in quarantine, one of Francisca's sisters had to manage the matters related to her death. The sister asked the funeral home to drive the hearse past her house so that Francisca's son and her partner could say some semblance of a goodbye. However, the health officials and the police refused to allow this. As a result, the family had to wait for their quarantine to end and for the cemeteries to reopen to say their farewells, which did not occur until the end of October. The family is still dismayed by what happened so abruptly to Francisca, as they feel it was not her time. Some of them are receiving psychological support because of the circumstances surrounding her death, which have made it very difficult for them to mourn.

All of this was included in a complaint alleging that Francisca's rights had been violated because the facility failed to provide culturally appropriate care, ask for informed consent, and respect patient and family decisions. Such rights are guaranteed by Chilean Law 20584 on Patients' Rights and Duties, which also outlines a procedure for filing complaints so facilities can remedy irregularities. The aforementioned regulation also allows for an appeal to be filed with the Health Superintendency if the response to the claim is unsatisfactory or the irregularities reported are not addressed.

Once the complaint was filed, the family health center issued a written response concluding "that there was no lack of service as alleged by the claimant, nor a violation of the patient's rights, mainly because the medical care provided was within our powers as a primary care provider."

This response was deemed unsatisfactory

by the family, who took the case to the Health Superintendency, where it is currently pending. The following analysis addresses Doña Francisca's experience and elements of the written response provided by the family health center. Both elements are part of the same alleged lack of cultural appropriateness.

The violation of the right to health from the perspective of the Indigenous research paradigm

The events described above constitute clear violations of the right to health. Certain elements would constitute a violation of any person's rights. The most prominent are the provision of incomplete information, insisting on performing procedures without the patient's consent, and the exposure to risks associated with the care received when a precise diagnosis has not been provided. Furthermore, other interventions specifically violated the right to health care of Indigenous peoples, including the obligation to protect free and equal access to health care promotion, protection, and recovery, as well as an adequate response to the other factors that influence health, as enshrined in international law (including Convention 169 of the International Labour Organization; the United Nations Declaration on the Rights of Indigenous Peoples; the American Convention on Human Rights; the Universal Declaration of Human Rights; and the International Covenant on Economic, Social and Cultural Rights).[22] We examine this in greater detail in the paragraphs that follow.

Failure to provide culturally appropriate health care

The health system recognized the absence of culturally appropriate care but tried to hold Francisca responsible for this deficiency. The institutional written argument was that "when the patient's medical file was reviewed … it was impossible to find any request of culturally appropriate attention."[23] This deficit is a clear violation of international standards on the right to health of Indigenous peoples. As noted in an interpretative guide to Convention 169 of the International Labour Organization, "Right to basic health care is a fundamental right to life and States have an obligation to provide proper health services to all citizens."[24]

According to Chilean regulations—Indigenous Peoples Health Policy, General Norm 16 on "interculturality in health services"—culturally appropriate attention does not depend on a request made by the patient. It is actually the health care provider's responsibility.[25] Comprehensive services with an intercultural approach must be made available to guarantee access to health care. As stated in the policy, "The model of care with an intercultural approach must incorporate cultural appropriateness of services, understood as the adaptation of services to the characteristics of the culture."[26] This means that it is not enough to develop such programs. As noted by Jorge Contesse, there must also be "training for health care operators in conducting case-by-case analyses of ethnic affiliation and the possible implications that said circumstance would have for the provision of an examination and treatment."[27] This is even more critical in cases in which providers are aware that the patient identifies as a member of an Indigenous community, as in this case.

Furthermore, health care personnel cannot assume that the patient knows how to request culturally appropriate health care. It is thus essential to identify cultural affiliations and take special measures regarding members of Indigenous communities. The application of the principle of equality and nondiscrimination in access to human rights does not mean that the same treatment should be given to all people.[28] On the contrary, much attention has been paid to taking special steps to eliminate any determinants that lead to discrimination.

From our Indigenous perspective, this kind of adaptation to the health system is the minimum needed considering the history of colonial and state violence against Indigenous communities and their medical knowledge.

Lack of familiarity with the articulation of medical knowledge

One of the arguments in the state's written response to the complaint is that culturally appropriate health care was not only not requested but unnecessary. The response states, "In fact, she has been visiting our family health center for various treatments and benefits for years."[29] Regarding this point, we must first clarify that an Indigenous person seeking care at a biomedical health care center, even over a prolonged period, does not exempt the center from its duty to provide culturally appropriate health care. On the contrary, it is precisely the fact that native peoples use biomedical treatment and Indigenous medical practices simultaneously that makes such a provision imperative. Medical anthropology has studied this for more than 50 years in terms of medical pluralism, stressing that in the case of Indigenous peoples, there is often an articulation between different forms of medical knowledge and not the exclusive use of one or the other.[30] The same point has been raised in the Tarapacá region of Chile.[31]

Which aspects can facilitate or hinder such articulation from our Indigenous point of view? First, if an ailment occurs within the family domain and is handled by an Indigenous health care provider, it is unlikely that the ailing person will visit a biomedical health center. Biomedical care is imperative only in certain situations—for example, when it is deemed that a person is close to death and that such attention can prolong their existence in the earthly domain (*Aka Pacha*).

Second, the reluctance among Aymara elders to rely on care provided by the family center is often due to the proposed interventions being considered invasive, from a perspective in which the body must be kept "closed" to protect a person's health; thus, any interventions that "open up the body" are rejected.[32]

Third, such reluctance is related to the side effects of conventional medicines. For the Indigenous communities of the Tarapacá region, it is believed that patented medications may benefit one part of the body but harm another. This is based on a relational understanding of the human body. Members of these communities believe that treatment based on medicinal plants always benefits the entire organism and has no side effects.[33] In this regard, protocols for providing treatments with cultural appropriateness do not exist within the Chilean biomedical system. From our Indigenous perspective, special consideration is necessary, especially in the case of the elderly, as they are accustomed to treatments based on medicinal herbs and understand that their bodies have less resistance to the ingestion of chemical elements.

Fourth, the willingness to seek treatment will depend significantly on *recibimiento* (reception), the way trust and familiarity are forged. "Reception" allows people to express how they are experiencing the ailment emotionally, physically, and spiritually. If there is no respectful approach, especially with a *jachamama* (grandmother), there is unlikely to be a willingness to reveal their actual ailments. These ailments may be related to their failure to deliver on promises made to protective entities such as *Alak Pacha*, *Manqha Pacha*, and the saints. The intercultural facilitator, a state employee belonging to an Indigenous people whose role is to articulate the needs of users of Indigenous origin with the health care network, should play a vital role in this context because they must understand the patient's language and worldview. They must also pay attention to the history of persecution and subordination of the patient's forms of knowledge. This is critical because even today, health care teams hold prejudices, disparage patients' beliefs, and punish patients who ascribe to other world views.[34]

From our Indigenous point of view, the criticism of Doña Francisca's decision to visit the family health center "only intermittently" (as the written response describes) is grounded in medical monism. By insistently denying the contribution made by Indigenous medical knowledge to the treatment of Francisca's ailments, the health center interprets the *alternating* between both forms of medical knowledge as an interruption of treatment (*intermittency*). In other words, a situation of medical pluralism is *negatively* perceived from a monistic medical perspective.

This monism is in and of itself a violation of rights, given that Chile's health care policy on Indigenous people states that "the recognition that no medical system can satisfy all health care needs on its own suggests that the official model should not be viewed as the only desirable and valid approach."[35]

The imposition of biomedical interventions without the patient's consent

An additional element of the lack of cultural appropriateness was the failure to secure free and informed consent to the proposed biomedical treatment. The complaint established that Francisca was misled about the medical procedures, where she would be taken, and how long she would be away from home. This information was provided without the assistance of an intercultural facilitator, although Chilean regulations require such services to be provided.

According to these regulations, "Intercultural facilitators should be the link between the health team and the indigenous communities. They must be people who belong to an indigenous community and be endorsed by it." Among their functions, the regulations note, are to "guide, inform and support the patient and their family members when they require outpatient and inpatient health care [and] ... support the patient and the health team in resolving situations where the cultural aspect is relevant to health recovery."[36]

In Francisca's case, the entire informed consent procedure was flawed because it entailed coercion.[37] This coercion occurred when she was at home with her partner, and the ambulance came to take her away. Considering that she was refusing the medical care, the medical personnel needed a written and signed document proving that refusal. However, Doña Francisca was afraid of signing any document in light of other occasions in which such a signature brought adverse consequences to her and her community. She also observed that the staff was especially insistent on having her sign, which further entrenched her distrust of the situation. Later, we will discuss historical-structural reasons for her refusal to sign.

The critical point here is that when the complaint points out that Doña Francisca was taken against her will, the health center's response asserts that the lack of a signed document refusing the treatment proves a *tacit* expression of willingness on her part. This assertion misinterprets the facts because the lack of such a signed document reflects her refusal to sign and is not a "tacit expression of willingness" on her part.

From our Indigenous perspective, we are fully aware of the negative impacts that the signing of documents has had on our people.[38] This historical reality underpins Francisca's mistrust and should lead us to consider that it is legitimate for a person's consent to be expressed orally and in their mother tongue. Historically, the Aymara people have used the spoken word to transmit, communicate, dialogue, and legitimize their present and past experiences. From the Indigenous perspective, oral expression has as much or more value than the written word because it has an axiological meaning: it brings the *value of the word* into play.[39]

Such a refusal should have led to the search for all possible alternatives to provide culturally appropriate information. The staff's failure to do so calls into question the procedure of consent. How can someone validly give their consent to something if they do not fully understand what it is they agree to? The violation of this point is critical, even from the point of view of hegemonic law. As Valentina Fajreldin puts it, "as this relationship [doctor-patient] also involves an asymmetry of power, the international debate has focused on the model of autonomy, which as a general principle posits the defense of individual freedoms, such as the right of patients to make decisions about their bodies concerning medical treatment that is often technocratic and dehumanized."[40]

From our Indigenous perspective, a critique can be formulated regarding the naturalization of protocol-based interventions, which are understood from a universal perspective that assumes they are good for everyone and thus unquestionable. However, the claim of universality is a form of cultural monism, embedded in biomedicine, which contradicts the Indigenous approach to health care. Interventions can be harmful, yet from the biomedical perspective, they are rarely considered as such because they have been conceived with the explicit purpose of being beneficial. It is thus fundamental to consider the Indigenous perspective in order to identify any harm not perceived from a biomedical perspective.

More importantly, contextual conditions that allow the expression of willingness without constraints or coercion should be safeguarded. From our Indigenous point of view, this supposes a context of respect, responsibility, and reciprocity. As Linda Tuhiwai Smith points out, consent is relative, as there is no specific period for the generation of said trust with the *jachamamas* (grandmothers) and *jachatatas* (grandfathers). It can take minutes, months, or even years, as this is granted depending on the credibility of the person requesting it.[41] Furthermore, any trust granted is assumed to be reciprocal, taking place within a negotiation context, and is not a static decision. Therefore, the quality of the interaction is much more important than the signing of a document. Signing a document thus becomes more of a barrier than an avenue to dialogue and understanding, which is why incorporating oral informed consent in research has been highlighted.[42]

The exclusion of the qulliri

The state's written response to the complaint had a double impact on the family. In addition to the harm they suffered, there was now a direct attempt to delegitimize the character and medical knowledge of one of its members, Francisco. Even if he was not present during the sequence of actions we have described, the intercultural facilitator of the family health center engaged in this delegitimation using the following argument in the written response: "One becomes a *qulliri* or *yatiri* through the recognition granted by the local Indigenous community. Francisco *is not recognized as such in Pica.*"[43]

On the contrary, his local community recognized Francisco as a *qulliri* and *yatiri*, as established in the minutes of Meeting 16 (March 2, 2021) of the Children of Willq'e Aymara Indigenous Association.[44] Furthermore, according to an interview conducted by our cooperative with Francisco on June 12, 2021, he has performed this role for 60 years and has done so consistently during the 30 years he has lived in Pica.

It is thus clear that any denial of this status represents an act of symbolic violence in the context of intercultural health. Symbolic violence is "a form of violence exercised without physical coercion through the different symbolic forms that make up people's minds and give meaning to action."[45] Given that, from the Indigenous point of view, medical knowledge is connected to other areas of life, delegitimizing their health knowledge also calls into question their knowledge regarding other cultural and social dimensions, such as ceremonies, rituals, music, singing, weaving, and their native language.[46]

Within our Indigenous perspective, this delegitimization is clearly related to communities' oral histories. This kind of action has constituted the foundation for historical processes of genocide that began with European colonization (extirpation of idolatries) and then transformed into assimilation processes. The most worrying aspect is that such delegitimization is enacted by an agent of the state, which monopolizes legitimation and delegitimation in Western society. Thus, this represents a moral affront and one more act of "epistemicide" (the killing of knowledge systems).[47]

This delegitimation contradicts the spirit of Chile's Indigenous Peoples Health Policy, which, at least nominally, recognizes Indigenous medical knowledge:

> *there is an urgent need to accept that native peoples have different concepts of health and disease and that there are traditional specialists for diseases that the official health system will never know how to cure, as it lacks the codes to understand their etiology, and therefore their rehabilitation, much less their prevention.*[48]

For this reason, Administrative General Norm 16, concerning interculturality in health services, establishes that "the Ministry of Health, health services, and other health sector bodies will ensure their actions guarantee the respect, recognition, and protection of the health systems of indigenous groups and their traditional agents recognized within their communities."[49]

The state enjoys symbolic power that is reinforced by a legal structure. Therefore, the fact that a state agent engages in this type of disqualification represents a form of unacceptable symbolic violence. From our Indigenous perspective, it also contravenes community values in that a person belonging to the community must respect their elders. This respect is based on recognizing the accumulated knowledge and contribution to the community's care and development. It is important to note that Francisco's contribution as a *yatiri* involves human and non-human members of his community and territory.

The delegitimization of Andean medical knowledge

Moreover, it is equally unacceptable for the intercultural facilitator to serve as the spokesperson for a point of view that calls into question the effectiveness of Andean medical knowledge. The state's response to the complaint indicates that the intercultural facilitator

> *pointed out that, unfortunately, indigenous medicine did not evolve due to the impact of colonization, technology, globalization, etc. The person in question acknowledged that indigenous medicine, particularly that of the Aymara, is good. However, such knowledge is limited to preventive or palliative treatment, but there is no possibility that a person with chronic ailments such as those suffered by Francisca could have been stabilized or treated only with natural medicine.*[50]

In this regard, it is necessary to clarify that from the point of view of medical anthropology, there is no basis for suggesting that Indigenous medicine has not evolved. Critical medical anthropology has defined medical knowledge as a process of transformation in a permanent state of flux that adjusts to the health needs of communities and territories.[51] Moreover, considering that medical knowledge is not isolated, the scientific literature on medical pluralism has consistently described the multiple transformations that have occurred in the medical knowledge of native peoples, mainly due to the connection with biomedical knowledge, which has often consisted of the incorporation of different preventive, diagnostic, or therapeutic elements. Furthermore, recent research on this issue shows that the processes of cross-border mobility connect the transformation of Andean medical knowledge in northern Chile to changes happening in neighboring countries (Bolivia and Peru).[52] The passage of a law on traditional ancestral medicine in Bolivia in 2013 has reinvigorated that process.

Viewed from our Indigenous perspective, it is important to note that the defense of cultural integrity does not necessarily mean maintaining forms of existence that are tied to the past. One of the inherent characteristics of a cosmovision is the establishment of certain principles that link life to different planes, some of the most important of which are the symbolic, social, cultural, political, spiritual, and territorial. However, these principles are not restricted to the past; there is a reciprocal transformation of the cosmovision based on reality and of reality based on the cosmovision.

Moreover, contemporary discussion in the field of medical anthropology on the effectiveness of Indigenous medical knowledge highlights that its complexity requires an approach that goes beyond traditional Eurocentric scientific knowledge.[53] The facilitator's value judgment only reproduces the prejudices present within the ideology of biomedicine, which subordinates Indigenous medical knowledge in assuming that it is palliative (non-curative), ineffective, or iatrogenic. In the international literature, such judgments have been exposed as part of the "hidden values" that operate as "tenacious assumptions of biomedicine," one of which is the assumption of the inefficiency of non-scientific knowledge.[54] Medical anthropology literature has documented and analyzed this in detail, including the specific case of the Tarapacá region of Chile.[55] Consequently, the question of whether "a person with chronic ailments such as those suffered by Francisca could have been stabilized or treated only with natural medicine" is a matter that involves seeking out and presenting evidence. Further, there is no evidence of this assertion in the written response.

Given all of this, the judgments issued by the intercultural facilitator seemed to reflect his "internal colonialism."[56] Scholarship in the social sciences has found the role that some Indigenous people play within the structure of the neoliberal multicultural state to be problematic. Scholars have denounced the figure of the "authorized Indian" (*Indio permitido*): "that person who assumes an ornamental role in the new state" and who, in the political sphere, "speaks in modern terms, translating their practices into a politically acceptable discourse and leaving the unacceptable outside of the public domain, without necessarily abandoning them."[57] From our Indigenous perspective, this also constitutes an attack on the culture from within, which in the Andean axiology implies a lack of loyalty, a betrayal of the community, and an affront to a person's own cultural identity.

Lastly, using the authority conferred on the intercultural facilitator to discredit Andean medical knowledge is arbitrary, as the facilitator does not receive any form of legitimacy from the anthropological sciences, biomedical knowledge, or community recognition. As a result, the official's judgment subverts the roles assigned within Chilean institutional and intercultural health care.

The deterioration of the relationship between biomedical and Indigenous knowledge

We have identified a need to move away from analysis at the individual level and focus on the territory, the community, and the family. This approach is very much part of our Indigenous perspective. Events like those analyzed in this paper cause harm not only to an individual's health but also to the collective health of the Aymara people, as they represent the reproduction of biomedical dominance over Indigenous medical knowledge. Indigenous medical knowledge is identified by academics and political bodies (see the Historical Truth and the New Deal with Indigenous Peoples Commission) as one of the pillars of cultural identity.[58] If this type of rights violation is repeated, medical knowledge with territorial specificity cultivated and protected by people like Francisco is made to disappear. Indeed, the refusal of the health service to recognize the knowledge of people like him is part of the symbolic violence that forms the basis of the difficulties of passing this knowledge on to new generations. Thus, collective and transgenerational harm is caused that should be avoided from an intercultural point of view.

Conclusion

States must be more willing to develop efficient structures and public policies that guarantee respect for the human rights of Indigenous peoples. Political officials must take responsibility for promoting these rights beyond the formalities that have been used for so many years to prevent them from being exercised. Despite abundant national and international regulations on the subject, the right to cultural appropriateness in health care has not permeated the institutional and cultural structure of the health system in Chile, and minimal progress has been made.

According to the Indigenous research paradigm, intercultural health is yet another sphere in which the coloniality of knowledge and power continues to operate. The need to sustain an Indigenous paradigm is based on the fact that many of the aspects identified as problematic are neither perceptible nor acquire the character of validated evidence.

The problem of evidence comes to the fore in the domains of scientific knowledge and in the law, specifically regarding the right to health. First, knowledge validation procedures are culturally determined. Second, the Indigenous perspective must be fully included in interpreting what constitutes a violation of rights. Fully included means including ontology, epistemology, methodology, and axiology in order to refrain from reproducing certain tenacious biomedical assumptions. We have offered various examples throughout this paper: the idea that the only truth is the naturalist one, that non-biomedical knowledge is inferior, that biomedical knowledge guarantees universal well-being, that the ideal approach to health care is medical monism, that Indigenous knowledge is opposed to its scientific counterpart, and that the only valid reference for assessing the right to health care is the Eurocentric model of law.

Throughout this paper, we have argued that the right to health care can benefit from the Indigenous research paradigm. Moreover, the contributions of this paradigm are not limited to the approach to Indigenous issues; they can be extended to all aspects in which a stakeholder's point of view becomes relevant in ontological, epistemological, methodological, and axiological terms.

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Ethics approval

This study was conducted in accordance with the Helsinki Declaration and was approved by the Universidad de Tarapacá Scientific Ethics Committee for studies involving humans (reference number 27/2020). We obtained informed consent from all of the subjects involved in the study.

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