NEGOTIATING HEALTH AND IDENTITY

Lay Healing, Medicinal Plants, and Indigenous Healthscapes in Highland Peru

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Abstract: Global health-care models for developing countries urge integration of traditional medicine with Western biomedicine. This article shows how residents of a remote Peruvian village negotiate among biomedicine, traditional medicine, lay indigenous medicine, and local knowledge of medicinal plants. Villagers' health-care choices reveal that they often resort to medicinal plants before modern pharmaceuticals. Their discourses show that these choices reflect social and cultural processes beyond the medical: the revitalization of Andean identity, the conflictual relationship that villagers have with modernity, and the desire to evade or subvert the power that Western medicine has over them. This article elaborates the concept of the healthscape as an individual's subjective vision of a landscape's medical resources and institutions, limited by cost and accessibility and shaped by the uneasy coexistence of Western and indigenous medical systems.

Although the introduction of Western medicine in developing countries has indisputably increased longevity and decreased child mortality, it has been less effective against chronic disease, and it can be experienced as alienating and dehumanizing (Janes 1999), as it does not take into account the social and emotional realm of health. When Western medical policies and initiatives dribble into places that have preexisting, culturally embedded medical systems, they are often accompanied by hegemonic cultural ideas. Because Western medicine is mostly regarded as superior to alternative forms of medical care (Baer, Singer, and Susser 1997), positive elements of local medical systems have often been rejected, thus contributing to their decline. It is important to consider that many governments in developing countries have put in place biomedical systems not only because of their therapeutic worth but also in the name of social advancement, capitalism, and development (Baer 2003); indeed, "biomedicine has become a metonym for modernity in the domain of healing" (Conner 2001, 7). Yet local medical systems can offer inexpensive and culturally appropriate healing that reinforces social identity. Despite the decline of local medical knowledge, approximately 80 percent of people in developing countries still rely on traditional medicine (World Health Organization [WHO] 2003), and there has been a recent revitalization of indigenous medicine and health knowledge. The realization of this revitalization

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has led to initiatives attempting to integrate traditional medicine into Western medicine. This integration, however, can be fraught with difficulty.

It is in the spaces, relations, and discourses where local medical systems intersect with and are integrated into Western medicine that the effects of global power relations on local practices can be seen (Del Casino 2004). Thus, health-care choices and the discourses surrounding them are produced within the realm of global power relations. When people seek health care, not only are they seeking to treat their ill health but they also are producing and reproducing narratives that act as metaphors for deeper understanding of "how the social world is constructed" (Miles 2003, 110), their cultural identity, and their culture beyond the medical (Conner 2001; Janes 1999; Wayland 2004). Given the prominent role of local health systems in indigenous cultures, it is crucial to consider and examine the repercussions on indigenous medicine and local knowledge. In a context where biomedicine (itself an expression of a set of cultural values) is introduced, local narratives are a fundamental expression of indigenous people's encounters with Western medicine and its influence on lay indigenous knowledge.

This article explores the interstices of Western and indigenous medical systems in a Peruvian village. We describe the processes of transculturation, the negotiations of cultural identity, and health seekers' conflicting relationships with modernity. The villagers, who self-identify as campesinos, or peasants, have access to a biomedical primary health care (PHC) clinic but rely on long-standing lay knowledge of indigenous medicine, mostly characterized by the use of medicinal plants, which has been passed down from previous generations. Thus, we are concerned primarily with lay medical knowledge as practiced in the family at the household level or in informal social networks, referred to herein as indigenous medicine, as distinct from more formal versions of "traditional" medicine, recognized by external bodies such as the World Health Organization (WHO). Both traditional and indigenous systems of health knowledge can be distinguished theoretically from Western medicine (Waldram 2000) or biomedicine, although they may have incorporated certain practices from Western medicine.

The article first examines the literatures on primary health care and medical pluralism and then extends medical pluralism to the study of indigenous medicine, especially the lay knowledge of medicinal plants, in the healthscapes of a small village in the Peruvian Andes. We elaborate the healthscape as a framework for understanding how indigenous campesinos interpret their alternatives for seeking health, and we apply that framework in describing the setting and results of an ethnographic study of the village, focusing on the inhabitants' discourses concerning healing and medicinal plants. The discussion interprets those discourses as reflections of the inhabitants' complex and ambivalent relationship with modernity. We conclude by addressing the lessons that a pluralist approach offers for the debate on integrating indigenous and Western medicine.

BACKGROUND

Modernist biomedical perspectives assumed that traditional medical systems would eventually die out with the implementation of technologically superior

biomedicine. That expectation gave way in the 1960s and 1970s to the recognition that traditional medical systems were persisting rather than disappearing. International health initiatives took a renewed interest in traditional medicine, which was considered both cost effective and accessible, and recommended that it be integrated into biomedicine, and specifically into PHC clinics (WHO 2002). Furthermore, an understanding of cultural aspects of traditional medicine was considered important in delivering biomedical health services (Miles and Leatherman 2003), and the integration of traditional medicine into biomedicine would lower the financial barriers that kept the poor from medical care, thereby increasing its use (Nigenda and Cifuentes 2004). Thus, institutionalizing and formalizing traditional medicine would potentially save it from the threat of globalization. International health initiatives, such as the WHO Traditional Medicine Strategy 2002–2005 (WHO 2002), continue to focus on integration of traditional medicine into PHC.

Experience with PHC in practice, however, has led many to argue that integration of traditional medicine is neither realistic nor desirable in many poor rural areas (Wayland 2004). The focus on integration tends to understand traditional medical systems and those that use them as static, clearly bounded entities. Such a focus neglects processes and actions that reflect people's reliance on multiple medical techniques rather than a single system of medicine (Miles and Leatherman 2003). Thus, wholesale integration of traditional medicine into biomedicine faces conceptual, practical, and political barriers. Because medical systems reflect the cultures in which they are practiced, it is hardly surprising that the integration of one medical system into another would be problematic. Janes (1999) argued that the integration of indigenous medical systems into biomedicine can render them so much like biomedicine, so rationalized and sanitized of their alternative epistemological tenets, that they may not be able to meet the human and social needs arising from the rapidly approaching health crises that structural adjustment and the epidemiological and demographic transitions produce.

Many of the assumptions underpinning arguments for integration are assimilationist and can lead to the loss of identity of indigenous medical practices once integrated into biomedical systems. Hence, attempts to integrate traditional medicine and PHC can result in its subordination to biomedicine (Baer 2003; Hyma and Ramesh 1994), or its biomedicalization (Waldram 2000). Medical systems are embedded in cultural systems and loss of cultural identity can render local medical systems inappropriate or ineffective. Accordingly, "medical decisions are life decisions and bear upon all aspects of human existence" (Stoner 1986, 46), and illness and health cannot be detached from their social contexts.

Recent scholarship tends to reject the assumptions of the integrative approach and instead focuses on a model of medical pluralism to describe interrelationships between biomedicine and traditional medicine (Janes 1999; Zulawski 1999). Proponents of this model argue that persons seeking health care rely on a variety of medical systems, including indigenous medicine and lay knowledge, regardless of the presumed authority of biomedicine. Medical systems are not static but dynamic and syncretic; and most societies are better understood as a mosaic of intermediate models in which biomedicine is one of several different medi-

cal systems to which people turn when confronting illness (Casteñeda, Billings, and Blanco 2003; Hyma and Ramesh 1994; Izugbara, Etukudoh, and Brown 2005; Madge 1998; Pedersen and Baruffati 1985; see also Koss-Chioino, Leatherman, and Greenway 2003 and references therein).

Although biomedicine and indigenous medical systems have typically been described as opposites, pluralist approaches recognize that the boundaries between the two systems are blurred: they are at the same time complementary, competing, and overlapping (Ngokwey 1995). In fact, Stoner (1986, 47) suggested that the point of departure for research in medical pluralism should be the multitude of medical techniques, with "less emphasis on the particular 'system' from which they derive and in which they operate." It follows that even though people practice indigenous medicine, parallel use of biomedicine does not necessarily change people's beliefs about health and illness. It indicates they seek a solution for their health needs, not a change in ideology (Madge 1998).

Medical pluralism builds on Crandon-Malamud's (1991) study of power relations in medical discourse, especially her observation that "social identity and power are negotiated through the treatment of illness" (qtd. in Greenway 2003, 93). Conceptual models have become more complex in response to a very complex issue, moving away from "placing biomedically oriented value judgements on the ethnomedical ideas or health practice" (Miles and Leatherman 2003, 9). Medical pluralism has proved especially useful in producing a fuller understanding of traditional medicine in the Andes (Koss-Chioino et al. 2003). Scholars researching medical pluralism have often examined the variety of recognized traditional medical specialists, including *curanderos,* bonesetters, herbalists, and traditional birth attendants (Birn 2005). It is perhaps this "professional" bias that has led health research to focus primarily on medical practitioners rather than on lay knowledge and healing, even though the home is often where illness is first treated, by members of the family (Baer 2003; Finerman and Sackett 2003; Pedersen and Coloma 1983; Wayland 2001). We argue that medical pluralism is equally valuable as a framework for the analysis of lay knowledge, self-healing, and treatment in the home, which only a few researchers have considered (e.g., Finerman 1989; Finerman and Sackett 2003; Popay and Williams 1996; Wayland 2001).

HEALTHSCAPES: LOCAL KNOWLEDGE, LAY HEALING, AND POWER RELATIONS

Within the framework of medical pluralism, we employ the term *healthscape,* by which we mean the biophysical, social, and psychological space in which everyday "health seeking" plays out, within the interstices of the various medical systems. The suffix *scape* commonly describes a picture, view, or representation of such a view, as specified by the prefix, in this case, *health,* and by extension, the physical and social environments framed in that view. The healthscape shares important attributes with Appadurai's (1993) ethnoscapes and his notion of scapes more generally as perspectives on spaces through which global influences—of people, money, ideas, and technologies—flow. In a healthscape, as in an ethnoscape, each element must be understood in relation to other elements. Traditional medicine and biomedicine need to be understood in relation to the other, as well as to the

livelihoods, scarce resources, and restrictions of access within which health seeking takes place. Appadurai's formulation of scapes privileges the social imaginary and is not as closely concerned with the objective reality of physical landscapes and social institutions in place.

In contrast, healthscape is both an objective reality and a subjective life space (Williams 1996) as understood by individuals embedded in overlapping cultural systems. It is the mutually constitutive ecological landscape of health-care resources and the social experience of that landscape as it is viewed and experienced by different actors working and living within it. Although the objective landscape of health resources is the same for all inhabitants, each individual views that landscape from a unique perspective. We use the singular *healthscape* to mean the landscape and its social, biophysical, and institutional resources related to health; we use the plural *healthscapes* to call attention to the multiplicity of visions, each based on a unique experience but shared and overlapping within social networks.

The term *healthscape* borrows from Gesler's (1992) use of the phrase "therapeutic landscape" in examining the healing properties of environments. Although the healthscape draws on cultural-geographical meanings of landscape as "a text to be read for what it says about human ideas and activity" (Gesler 1992, 736), it stresses health seeking as a social process in a unique place and focuses on becoming as opposed to a static, unchanging essence. This research does not examine the healing properties of a place, nor the specific beliefs, practices, and experiences of a particular group of people. Rather, it aims to reveal the interaction of various medical systems at the local scale as they are influenced by factors at other scales.

The view of a healthscape can be articulated from many perspectives: in this article we attempt to understand the perspective of health seekers, in this case poor, rural, indigenous peasants. Although the representation of their point of view is fraught with ethical difficulties, it is nevertheless developed with the postcolonial understanding that not only does the Westerner gaze on the indigenous but also the indigene gazes on the Western. This reciprocal gaze makes something different of "indigenous" from what existed before global influences arrived: the local and the indigenous become defined in opposition to the modern, the monetary, and the global. Within this framework, the article explores whether the integration of indigenous and Western medicine is desirable or even possible in the context of global power relations.

Although it is commonly thought that indigenous people rely on formalized traditional medicine, the first site of health care in practice is often the informal space of the home (Browner 1989), and the first resources deployed are usually medicinal plants. Women in Browner's (1989, 165) study maintained that "curanderos don't know much, we know more about healing." This suggests that although traditional medicine and its practitioners can sometimes be romanticized, power relations are just as much present (albeit different) when people visit these practitioners as when they visit biomedical doctors. Indeed, both are members of societies recognized by the rest of the community as possessing knowledge on how to heal, who wield power over other members of the group.

Knowledge of medicinal plant use is not homogeneous across regions or communities. Indigenous medical systems, like other medical systems, are processes embodied through social relations and practice. Because they are often passed down orally, they vary among places and among families within a specific place. Social networks are the main conduits for information concerning health and can offer people a matrix of knowledge and advice (Izugbara et al. 2005). Friends and families often share medicinal plant lore freely (Wayland 2003), and the choice of which plant to use or where to seek health care often comes from recommendations from "lay referral networks" (Pedersen and Baruffati 1985, 1145). This observation highlights the recursive relationship between knowledge production and use, and between health-seeking behavior and broader social networks (Izugbara et al. 2005).

People access medicinal plants before health clinics for a variety of reasons. From a selection of studies (Izugbara et al. 2005; Pedersen and Baruffati 1985; Wayland 2001, 2004), six main reasons for using medicinal plants were culled: medicinal plants are described as stronger and more effective than pharmaceuticals, as geographically accessible and affordable, and as traditional and natural; those that use medicinal plants do not need to consult the doctor and thus feel more independent; medicinal plants are culturally appropriate and hence people know more about them than about pharmaceuticals; and finally, those that use them believe plants to be more appropriate for certain illnesses, such as those that are typically incurable and must be endured but for which symptoms can be relieved, such as colds, the flu, and chronic illnesses.

Wayland (2004) found that, although her respondents turn to medicinal plants for most cases, they also continue to access health clinics and use pharmaceuticals, all the while denigrating them. Because of poverty, this is not always a choice: when pharmaceuticals are available but beyond their financial means, people may deny their desire for them rather than admit they cannot purchase them (Bastien 2003). In other cases, pharmaceuticals may be rejected en masse because of negative experiences (Pedersen and Baruffati 1985) or deleterious side effects (Wayland 2004) associated with specific medicines.

Those negative experiences are in many cases products of power relations involved in the practices of healing. When there is a professional healer in the relationship who potentially possesses deeper knowledge and on whose judgment the diagnosis depends, whether he or she is a traditional medical practitioner or a biomedical doctor, there are inevitably power relations. With the professionalization of Western medicine, alternative forms of therapy have been disregarded, appropriated, or referred to as inferior, primitive, or fraudulent (Farnsworth et al. 1985; Pedersen and Barufatti 1985; Wayland 2001). Health workers in developing countries may undermine traditional medical knowledge (Wayland 2001), attempting to exert control over the use of indigenous medicine by claiming that its treatments are ineffective, by denying that they are used (e.g., because the knowledge has been lost), or by underestimating their use (Wayland 2003). Wayland (2004) also observed that some physicians claim that people misuse medicinal plants and harm themselves, although rarely are they able to provide an example.

Indeed, sometimes the knowledge has been lost, as global influences, especially the monetization of rural economies, have disrupted the production and reproduction of indigenous knowledge. For example, Browner (1989) observed in Latin America that among indigenous people living closer to larger urban centers where biomedicine had taken precedence, there was a loss of knowledge and confidence in indigenous medicines. The loss of indigenous medical knowledge and practices accompanies the introduction of Western medicine and associated cultural values, and it is part of a larger process of transculturation.

RESEARCH METHODS

This research employs a health geographies framework in a case study of a rural Peruvian village. A variety of ethnographic methods were employed during 2004: participant observation; semistructured and open-ended interviews; and analysis of a variety of print and photographic sources (including statistical data, pamphlets, photographs, and other documents from the Ministry of Health of Peru; various pamphlets and posters in the local clinic meant for villagers; minutes from meetings held by the Institute for the Study of Medicinal Plants [Instituto de Ecologia y Plantas Medicinales (IEPLAM)], and field notes taken by the first author).

Fifty-three interviews were conducted between June and September 2004. These included one with an official of the Ministry of Health; two with administrators of IEPLAM, a nongovernmental organization; five with curanderos, herb vendors, and rural women from a separate community; seven with doctors, medical technicians, a dentist, and an elected community member of the Local Committee for Health Administration (Comités Locales de Administración en Salud [CLAS], administering the PHC clinics); and thirty-eight with residents of the village. All interviews were conducted in Spanish or in Quechua with an interpreter. A young woman from the village was hired as a guide and to translate interviews conducted in Quechua into Spanish on-site. Interviews were transcribed in Spanish and then translated into English; the four interviews quoted in the article are numbered to distinguish them but are not otherwise identified to preserve confidentiality.

Participant observation was conducted mostly during the daily activities of women in the village, and it included helping prepare and share meals, household duties, and informal conversations. Introduction to the residents of Añawi came through the founder of IEPLAM, and it should be noted that some of the Añawayans supply medicinal plants to the institute, which hopes to develop a commercial market in medicinal plants as a vehicle for development of local livelihoods. Thus, some interviewees had a vested interest in medicinal plants, whereas others may have felt compelled to consent to interviews, although most appeared to speak out of genuine curiosity and interest in medicinal plants and indigenous healing practices. The interviews lasted from fifteen to ninety minutes. Several interviews that evinced reluctance, extreme shyness, and brief answers were kept brief in an effort to alleviate the discomfort that they appeared to generate. The interviews were later transcribed, translated into English, and

analyzed in an inductive manner. The interviews were color coded according to a hierarchical set of themes, and those data were organized in Microsoft Excel. The interviews were reread following coding, the themes were revised, and the data resorted according to the revised set of themes. Simon Fraser University's Office of Research Ethics granted ethics approval.

For reasons of confidentiality, pseudonyms were assigned for towns and villages involved in this ethnographic study, except when referring to Lima or Cusco. *Añawi,* Quechua for a type of thorny plant with yellow flowers, is the name given to the primary research site. Añawi lies approximately fifty kilometers from Cusco in the municipality of Paukcha, in the Sacred Valley of the Inca region of Peru. Añawi is composed of three informal zones determined by elevation: lower (3,300 meters), middle (3,400 meters), and upper (3,500 meters). A paved road runs from Paukcha to an archaeological site and tourist attraction, from which a dirt road, in poor condition, leads to and then winds through Añawi, stopping in middle Añawi. A walking trail starts from lower Añawi, cutting through the switchbacks of the dirt road. Some of the villagers' adobe houses run along the length of the trail. Each family's dwelling consists of two or three small adobe houses, with the living area usually separated from the cookhouse. The cookhouse is usually a small adobe dwelling with a mud stove in one corner. Most families raise guinea pigs for family consumption or to sell. The guinea pigs also live in the kitchen, often in the opposite corner from the mud stove and within easy reach of the cook.

RESEARCH SETTING: THE HEALTHSCAPES OF AÑAWI

Although the Andean economy has been significantly monetized, most people in Añawi remain subsistence farmers. This relationship is a significant contributor of conflict concerning their local economy. They have no fixed income, and the little money they make comes from selling their produce or animals. Añawayans, for the most part, eat the plants and animals they raise. They are proud of their food, consider it natural and healthy, and attribute their good health to it. However, as the rural economy becomes more monetized, Añawayans have more access to refined foods. Rice, pasta, and sugar in its many forms are desired and sought after. When they can afford it, they eat sugar with breakfast and rice and pasta for special occasions such as birthdays. These items are considered luxuries, and status and prestige accompany the consumption of such products.

Although one could characterize all Añawayans as poor, there was a great deal of variation among their incomes, ranging from nothing to thirty Peruvian *nuevo soles* per week (around Can$12). In some families the male head of household spent up to four months working in different regions in Peru in mines or construction. Other families live entirely on what they farm. Regardless of income, most families sell produce and animals to pay for clinic visits or pharmaceuticals when necessary, so the livestock acted as a fragile bank account.

Residents of lower Añawi tended to be more involved in the cash economy (with men who worked away from home), went to the clinic or pharmacy more in the case of illness, and were more likely to sell their produce. Those in up-

per Añawi, the farthest from the village and neighboring towns, relied more on subsistence farming to meet their family's needs and were more likely to use indigenous medicine in the form of medicinal plants in the case of illness rather than to sell their produce.

Añawayans' native tongue and primary language is Quechua. Children, many of the men, and those women who have attended school also speak Spanish. Most women, however, speak little, if any, Spanish. Many couples in Añawi, including those with children, live in common-law arrangements because the marriage license is too expensive. Working outside the village can give a man access to health insurance from the employing company, but without a marriage license, neither his wife nor children have access to his health insurance.

The people of Añawi have access in Paukcha to a PHC clinic that charges a user fee (from two to three Peruvian nuevo soles, or Can$0.70–$1) for consultations, and a subsidization program for pharmaceuticals, as part of Peru's CLAS program (Gold 2009). There is also a clinic in the neighboring village, three kilometers from lower Añawi, but it is rarely open, and there are no doctors on duty. During 2004, the building looked derelict and unused, and none of the villagers knew its hours of operation. The CLAS clinic in Paukcha is difficult for the villagers to reach. It is approximately ten kilometers from Añawi, several hours' journey by foot. Otherwise, a taxi could be called to middle Añawi with the village's one telephone, adding considerable expense to the clinic's user fee. Furthermore, the road to the highway is in very poor condition, and driving on it would lead to great discomfort if one was ill. The other option is walking approximately four kilometers to catch a *combi*, a usually overcrowded minivan that runs irregularly if at all.

All resources in the field site, including medicinal plants, medical clinics, and money and access rights at the disposal of health seekers, are scarce in some way. Most medicinal plants are restricted to narrow ecosystems, and some are threatened by over harvesting and habitat conversion or degradation. Pharmacies and the treatment and counsel of PHC clinics are restricted to particular points in a landscape that imposes heavy travel and financial costs on the ill. Community-based support networks and medicinal plants are often both nearer and more readily available, and that reality shapes social identity and choice. Many of the people in Añawi care for their health at home with medicinal plants. In the 1980s, though, locals were coerced to go to the clinic in the case of ill health, according to the accounts of both villagers and older PHC workers.

Campesinos indicated that doctors and health workers forced people to come to the clinic when they were sick rather than stay and be treated at home by issuing "soft threats." If they did not comply, and a family or community member died as a result of an illness that was not treated in the clinic, they would not be issued a death certificate and would face other "legal problems." A health worker confirmed this practice (Interview 1). The health worker said that from the clinic's point of view, they had an obligation to the government to collect accurate accounts of illnesses or deaths, which are difficult to enumerate if patients are not in the clinic when it occurs. In the case of death, for example, if the ill person does not come to the clinic to be treated and dies in the village, the workers have to first

travel to the village and do an autopsy, which results in higher costs for the family. Although the clinic's perspective on this may seem intuitive, the campesinos experience this policy differently. One man explained that during this enforcement, many people died on route to the clinic because the arduous trip exacerbated their illness. The villagers who informed me of this policy conveyed a sense of obligation toward the clinic, saying that they were obliged and forced to take their ill to the clinic, implying that they were not visiting the clinic by choice. Indeed, this obligation appears to have fueled some disdain toward the clinics.

This distrust has further consequences. Many people only go to the clinic when their illnesses are grave and therefore often at an advanced stage. This frequently necessitates more serious intervention than if the convalescent had come to the doctor early. This was often the case with tooth problems. The dentist in one of the local clinics (Interview 2) indicated that most of her practice consisted of pulling rotten teeth that could potentially have been saved with earlier intervention. As is often the case of an advanced affliction, the problem cannot be easily fixed, likely resulting in a decreased chance of positive outcome, which can also influence people's confidence in biomedicine. The repercussions from that era not only have compromised the efficacy of biomedicine but also have contributed to an overall decline in indigenous health knowledge.

RESULTS

All interviewees were asked what they do when they or their family members fall ill with a variety of common ailments, such as colds, the flu, or gastrointestinal problems. All of them initially responded that they use medicinal plants. They were then asked if they went to the clinic. Seventeen of the twenty-nine said they used only plants to heal, even when they were very ill, and twelve responded that they go to the CLAS clinic when their illness is grave. Of this minority, however, many qualified their answers. Some said they went because they were obligated to take their sick to the clinic, some complained that they sometimes went but the CLAS was too expensive or that going to the CLAS and taking pills did not actually heal their illness in the end.

Villagers employ medicinal plant species that grow wild at various elevations on village land, as well as plants growing both at higher and lower elevations outside the community. Plants at higher elevations are often picked seasonally and preserved to last the year as tinctures, salves, ointments, or teas. Medicinal plants growing on the community's lands are picked frequently, as they constitute one of the chief resources of the healthscape. Discussions about plants are rarely limited to their medicinal properties. Villagers eagerly discussed different uses for plants that grow in every niche of the mountains. They have a wealth of stories recounting current and traditional uses of plants. Some are used to wash clothes or hair, to dye fabric, or to bring prosperity to a home. Others serve to keep evil spirits or pesky farm animals out of the yard. One type of plant is put in *chicha* (maize beer) to boost its intoxicating effects; another is slipped in the drinks of men who consumed too much alcohol to stop them from drinking. Some plants are used to flirt with members of the opposite sex or in matchmaking rituals, and others are

used as climatic indicators of the upcoming season. Plant knowledge is a source of pride for many, and the way people handle plants and care for them suggest a sense of affection and responsibility toward them that transcends merely utilitarian concerns.

Plants occupy a significant place in Andean beliefs, folklore, and cultural identity. Several informants described plants as the children of Pachamama (Earth-Mother), and therefore siblings to humans. Others described the use of medicinal plants as an inheritance from and link to their ancestors. Every year during planting season, a ritual is observed whereby the Pachamama is paid an offering so she will watch over fields and livestock. According to Andean folklore, if she is not paid, crops may fail and the miserly campesinos and their livestock may fall ill and die. Plants are generally held in high esteem, and some believe they must be respected and their permission asked when using them as medicine. One informant who is particularly fond of plants and has a beautiful garden of medicinal and other plants described his plants as his children, and later as the children of God (Interview 3). Some assert that prayer must be used in conjunction with medicinal plants for them to heal. Although such customs abound in Andean folklore, several Añawayans stated that they no longer believed in the old ways. Few considered it necessary to ask the plant's permission before using them for healing purposes. A common response to questions concerning customs, traditions, and folklore was, "We almost don't believe in it." The same people, however, admitted to having paid Pachamama her ritual offering that year.

Many Añawi informants stated that there was a general loss of indigenous medical knowledge in the community healthscape. Many have forgotten, not learned, or learned very little about indigenous medicine. Recently, however, many have found themselves unable to afford health care, yet they no longer possess indigenous medical knowledge. The PHC clinics and enforcement of their use, rural to urban migration, and the monetization of the rural economy have caused a break in the oral transmission of medicinal plant knowledge for many Añawayans. Information culled from interviews revealed that loss of knowledge was not homogeneous among all community members, and it varied according to three main factors: proximity of the family's dwelling to Paukcha, their wealth relative to the rest of the community, and their age. Añawayans living at lower elevations were closer to Paukcha and more affected by the policies that pressured campesinos to go to clinics when ill. This appeared to lead to more significant loss of indigenous medical knowledge than among those living at higher elevations, several of whom said they had never visited the local clinic.

One informant opined that when people move to the city, they become *despierto* (sharp, alert, awake) and thus no longer interested in traditional knowledge (Interview 4). He confided that as the education system draws children away from farmwork into schools, they no longer want to live in the community, because no money is to be made in the fields of Añawi. More time at school means less time at home learning traditional skills, including the uses of medicinal plants. Although such practical knowledge may have been critical in times when there were no clinics, more importance is now given to earning money to purchase pharmaceuticals or go to the clinic. As they move to urban centers and start to earn

money, they "get to know chemical pills," use them exclusively, and are no longer able to heal with medicinal plants (Interview 5). Other informants suggested that loss of knowledge comes with earning money (because those that earn can afford pharmaceuticals), or the cultural transformation of leaving rural life for modern amenities that an urban lifestyle can sometimes provide.

With monetization of the rural economy and a desire for modernity comes disdain for tradition. Most villagers no longer wear traditional clothing, and many young people have left for the cities. Various informants reported that children rarely want to take part in traditional customs and have a sense of shame for their culture and ethnicity:

> When I wear traditional clothing, my children are ashamed of their origins. They tell me their friends would make fun of them saying that their father is a *cholito*.[1] So my children tell me, "Papa, change your clothes seeing as you earn money." Now it has changed, and we have left all of that. We used to have festivals, but even that we have given up. (Interview 4)

This disdain, however, coincides with a revitalization of that which is traditional. Many adults lament the fact that children want to leave the community and are no longer interested in such things as medicinal plants, which are considered part of the old ways they are attempting to discard. Many younger people also prefer to use pharmaceuticals instead of plants to alleviate illness. Regardless of these changes, however, Añawayans made it clear in their discourse that medicinal plants and indigenous medical systems played a significant role in their lives:

> We come from dust, and to dust we will return. I believe that for that reason, we are attracted to the earth. The earth connects us all. As humans we have a connection with the earth, and I believe that without earth, humans cannot be happy or feel complete. The connection with the earth means that we are in contact with nature—plants and everything else the earth produces. (Interview 6)

The preceding passage is an informant's response when asked about the relation among plants, humans, and the earth; it reflects the integral part that plants play in Añawayans' life and cultural identity, beyond their use for medicinal purposes.

Añawayans often pit medicinal plants against pharmaceuticals, healing at home against going to the clinic, traditional against modern, natural against chemical, thereby creating what appears to be a dualistic worldview. These dualisms reflect the transculturation that has accompanied the monetization of the Andes and other global influences. Numerous villagers opined that people either heal with medicinal plants or with pills, the traditional way or at the clinic. Boundaries between such categories are not so impenetrable in everyday life, however, and when medicinal plants do not work, people often resort to pills even if they must sell animals to afford them.

Despite the fact that many of the locals use pharmaceuticals, however infrequently, they tend to denigrate them, attributing negative past experiences to

1. *Cholo* or *cholito* usually refers to someone with both mestizo and indigenous attributes. Mestizos often use the term to refer to indigenous people in a derogatory or insulting manner.

them. By denigrating pharmaceuticals, campesinos also speak about their relationship with modernity. For example, some villagers asserted that out-of-date pills from Western countries were purposely sold in clinics either to cause harm or simply out of spite. The fact that such discourses are reproduced affects the current perception and consequent use of pharmaceuticals. Añawayans often claimed to prefer to treat themselves with medicinal plants at home over going to the clinic. They repeatedly stated, in both interviews and casual conversation, that medicinal plants cure disease, whereas pharmaceuticals merely calm their symptoms. Many informants asserted that pharmaceuticals could aggravate illness or actually kill a person, especially children. Pharmaceuticals were also described as "calmantes no más" (calming and nothing more). When asked what they meant, informants responded that pharmaceuticals may take pain away from an illness but do not cure it, and that if pharmaceuticals are taken, one may feel better for a while, but the illness remains and eventually returns. Another informant stated that when people start using pharmaceuticals, they are no longer able to heal with medicinal plants (Interview 7). They believe an illness is not cured by pharmaceuticals in the way that medicinal plants can cure an illness.

The dualistic and conflictual role in their healthscapes that villagers construct between pharmaceuticals and medicinal plant use is related to a broader dichotomy between chemical and natural. Añawayans hold high regard for all that is natural. According to Añawayans, natural food products are smaller and have more nutrients than those grown with chemicals; natural is healthy, and chemical is contaminated. Medicinal plants are considered natural, whereas pharmaceuticals are chemical. One informant claimed children in the village are healthy because they eat natural foods and therefore do not need to go to the clinic very often, and that those who eat naturally can cure with medicinal plants, whereas those who do not must take pharmaceuticals and go to the clinic.

DISCUSSION: MODERNITY, IDENTITY, AND AMBIVALENCE

The relationship Añawayans have with modernity is complex and ambivalent. Nostalgia for and shame of traditional life mingle with a longing for modernity. Despite claims that plants cure better than pharmaceuticals, those who had the means often purchased pharmaceuticals when ill. If medicinal plants do not help, they do visit the clinic, if with reluctance. Western medicine is not refused in an attempt to rigidly hang on to traditional beliefs, but it is denigrated to highlight its costs and to validate the importance of medicinal plants in their healthscape. In this sense, discourses surrounding medicinal plants are metaphors that reflect cultural processes beyond the medical (Miles 2003; Van de Geest 1989).

While seeking to revitalize Andean cultural identity through the elevation of the status of natural goods and old ways, many thought they were better off now and told stories about how there used to be no doors on the houses, only cowhides, that roofs were now made of tile instead of straw, that wool clothes they used to wear itched and were uncomfortable, and that now people washed their hair with shampoo or soap instead of human urine that fermented in an urn for several weeks before its use.

A factor leading to this complex relationship is the state of class and ethnic relations in the Andes and frustration with their economic status. Because pharmaceuticals are largely financially inaccessible to them and representative of an oppressive class, Añawayans retort that pharmaceuticals do not work: "to admit to [their] curing power is to recognize that positive treatments are available but unattainable" (Bastien 2003, 183). Several villagers claimed that after spending large sums of money on pills and tests, or being refused treatment in clinics because they could not afford the fee or pills, they were ultimately cured with medicinal plants. Several asserted that it was their poverty that made them able to and more suited to heal with medicinal plants. Villagers often said that medicinal plant information was revealed to them by praying to God, and they believe that God helps them because they are poor. Because they were poor and lived in the country, they considered themselves strong and able to endure hardship, unlike weak city folk, who were delicate and could get sick at any time.

Many expressed the view that the poor could heal with medicinal plants, whereas the wealthier had to be healed with pharmaceuticals. One woman's story of her husband's illness is an example of this apparent difference between the rich and poor (Interview 8). Her husband had been sick for many years and was eventually taken to hospital where they spent a great deal of money for pills and treatments that failed to cure him. When she brought him home, still ill and now very broke, she prayed to God, who revealed that her husband was not meant to heal in the clinic but rather with medicinal plants from their backyard. With their use, he was then cured.

In this account, she transforms the facts of being poor and pharmaceuticals being inaccessible to her as a source of pride, because medicinal plants had the power to cure him in the end. Furthermore, they were free, not causing her family to go into debt. In such accounts, poverty is converted to a source of pride and a positive characteristic that gives them access to desirable resources, such as medicinal plants. Poverty, they claim, is the reason they eat all natural foods from their own fields, are healthier, and are able to heal with medicinal plants. However, poverty is also expressed as a source of frustration. When Añawayans need to visit the clinic or purchase pharmaceuticals and cannot afford to do so, or must sell their animals to pay for them, then poverty is obviously undesirable. In this sense, there is an element of rationalization in their elevation of medicinal plants, of making a virtue of necessity.

In Añawi, choices and practices within the healthscape reveal villagers' sense of their cultural identity and positioning (Crandon 2003). The repeated claim that "plants heal, pharmaceuticals only calm" serves to validate and maintain their cultural identity as those who heal from plants. It concretizes their identities as poor, rural folk who eat natural foods and are resilient, which in turn contrasts them with their lighter-skinned counterparts or oppressive elites (Koss-Chioino 2003), who are frail, eat nonnatural food, and are limited to using expensive pharmaceuticals that only serve to alleviate symptoms while disease lingers, waiting to reappear. This reifies their position as practical people and campesinos who are able to live off an inhospitable land.

Their expressed preference for medicinal plants can be understood as a site of

cultural identity (re-)creation through their healthscapes, given their understanding of medicinal plants as an inheritance from their ancestors and representative of Andean culture. They are renegotiating their identities in part through their relationship with the land, which functions as a potent symbol of expression (Williams 1996). This sense of place and identity does not stand alone but emerges in relation to other scales, particularly those global influences broadly understood as modern. Discourses and narratives surrounding the use of medicinal plants reveal the dynamic cultural mix of old and new, of traditional and modern. They reveal complex and conflicting relationships that Añawayans have with Western goods and modern amenities and, in this context, with biomedical clinics and pharmaceuticals. For example, many Añawayans, especially women, feel that doctors treat them rudely and insult them by speaking to them in harsh tones and instructing them to wait or to sit down. By treating illness with medicinal plants, they can avoid this source of power relations. Accordingly, the type of healing system in a place is not haphazard but "reflects localized understanding and controversies about how the social world is constructed, how and where power and influence are manifest" (Miles 2003, 110). In this manner, Añawayans diminish the power of pharmaceuticals by constituting them as powerless to cure disease.

CONCLUSION

Biomedicine continues to work from a modernist approach: unlike other disciplines that aim to understand the plurality of voices within different societies, it has been influenced little by critical social theory and postcolonial thought. Although primary health care attempts to partake in relations with the other by addressing cultural sensitivity, it does not yet grapple sufficiently with contemporary social theory in its understanding of the other (Gold 2009). This touches the very core of interactions between patients and health workers and the way that they view one another. Within a biomedical framework, there is a potential for health workers to consider patients as a homogeneous group and to see bodies as the "site of objective intervention to be mapped, measured and experimented on" (Turner 1996, qtd. in Valentine 2001, 17). Pharmaceuticals are prescribed and designed to act on everybody with the same effects, and health can be perceived as a one-dimensional, purely corporeal product to be purchased from the pharmacy or clinic. Within the framework of indigenous medicine, however, medicinal plants are regarded as good for different people at different times, and choice of medicinal plants may vary with the convalescent's body type and physiology, just as the choice of health care varies with the convalescent's resources and position within the healthscape that he or she sees.

On the Añawayan healthscape, medicinal plants growing in and around the village are particularly meaningful to inhabitants' health, precisely because they are part of the landscape they are familiar with and a direct link to their indigenous health knowledge and identity. Thus, medicinal plants carry meaning for them beyond the mere bodily treatment of ill health and into the realm of social relations, cultural identity, and traditions, which is integral to the healthscape. In this manner, the healthscape can be seen as focusing both health seekers and ser-

vice providers on observing the human interactions produced on the landscape and the ways those interactions are interpreted among imagined communities. Dispersed medical resources, unequal access rights, and spatially differentiated power relations all have consequences for their health. In this framework, health is understood not only as something purchased in a pharmacy or clinic but also as part of a social network that coordinates the healthscapes of many inhabitants.

Such an analysis may shed light on why integrationist PHC continues to struggle in places such as Añawi. However, it is likely that integrationist PHC structures, such as the one that exists in Añawi, will remain the primary source of PHC for indigenous rural people in the near future (Hall and Taylor 2003). Therefore, PHC should be understood as a medical enterprise driven by financial and commercial imperatives that attempts to maintain its authority through control and power relations (Miles 2003; Wayland 2003). Among poor rural populations, the PHC system as it is currently organized is impractical, even at times counterproductive. The rural poor have difficulty financially accessing PHC and are thus more likely to look after those in ill health in their own homes and communities with indigenous health knowledge. It follows that the integration of traditional medicine into PHC neither is viable nor would it necessarily be desirable considering the cultural divide between the two systems.

For PHC clinics to negotiate this interaction in a way conducive to strengthening the health of rural indigenous people, they must be able to respect local knowledge and realize that although it may not be testable in a scientific framework, for those who use it, it is a valid, efficacious, and rational first resort for many campesinos. The PHC health workers and policy makers should operate from the understanding that they are one of many resources, each with its own costs and access limitations, in the healthscapes of the people they aim to serve. Effective public health care in poor indigenous societies needs to navigate carefully the uneasy coexistence of these two systems in parallel. Medical pluralist approaches have been favored recently over injunctions that traditional medicine should be integrated into biomedicine, spurred on by the recognition that past pressures to use PHC have attenuated indigenous lay knowledge, to the detriment of all. Building a nexus of institutions that can stabilize, reconstruct, and expand this lay indigenous knowledge is regrettably beyond the scope of this article and is a worthy subject for further research.

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