Interculturalidad and Chilean Health: Stakeholder Perceptions and the Intercultural Hospital Delivery Model

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Abstract

This study examined interculturality of Indigenous Mapuche healthcare in Chile's Makewe Hospital. We conducted a descriptive, qualitative, semi-structured, cross-sectional pilot study interviewing key stakeholders, resulting in 11 interviews of patients, Mapuche and occidental providers, public health professionals, administration, and community leaders. We focused on six topics: services and preferences, community participation, interculturality, access to culturally appropriate care, government integration of Indigenous culture and interculturality promotion, and the future of Indigenous care. All groups believed in the need for both kinds of care. However, for community participation, Mapuche indicated no knowledge of interculturality in healthcare, nor any participation, compared with some professionals who believed there was a focus on it. Interculturality expressed by respect for Mapuche ethnomedicine was uniform; however, integration did not appear to Mapuche as effective, whereas professionals and administration interpreted interculturality as a philosophical goal. Regarding culturally appropriate access, Mapuche responses were focused on practical issues, whereas administration and professionals responded by explaining exclusion of Mapuche *machi* providers as being sensitive to community desires. Government promotion of interculturality was uniformly agreed to be poor. Finally, the future of Indigenous care was seen by Mapuche both optimistically and pessimistically, due to concerns regarding general cultural preservation, whereas professionals emphasized the need to promote preservation. These results indicate a fractionated understanding of definitions and goals among stakeholders. Future policy should focus upon a broader group to implement interculturality, including nongovernmental organizations, academics, and cultural advisors, combined with community-based participatory research, to promote evidence-based, efficient policy efforts and implementation for interculturality in health for the Mapuche.

Keywords

Intercultural healthcare, healthcare policy, Indigenous Peoples, Mapuche, Makewe Hospital, traditional medicine

Authors

We note that with respect to author contributions, Elizabeth Lincoln (EL) conceived the study, and EL, Bryan A. Liang, and Tim K. Mackey jointly performed research, conducted analysis, and wrote and edited the manuscript.

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Introduction

The Mapuche are the largest group of Chilean Indigenous people (Park & Richards, 2007). Despite their numbers, they have faced tremendous social and economic challenges within the dominant Chilean society, including healthcare (Bolados, 2009). The concept of *interculturalidad,* or interculturality, is often emphasized by the Chilean government and policymakers in programs aimed at incorporating Mapuche culture into various sectors of Chilean society. Since interculturality began as a policy objective, the government has created intercultural offices and policies, including situating hospitals within predominantly Indigenous communities (Bolados, 2009).

Interculturality has many definitions and interpretations, depending on context and applicability to particular segments of society. Intercultural health generally refers to methods used in the health sector to incorporate traditional Indigenous medicine and occidental (Western) practices in a complementary manner, emphasizing "mutual respect, equal recognition of knowledge, willingness to interact, and flexibility to change as a result of these interactions" (Mignone, Bartlett, O'Neil, & Orchard, 2007, n.p.). Overall, intercultural health attempts to incorporate and integrate use of traditional medicine within the public health system.

The Chilean government has created various programs attempting to address existing health inequities of Indigenous populations lacking access to adequate healthcare services (Boccara, 2007; Organización Panamericana de la Salud, 199). Unfortunately, areas with the highest density of Indigenous people continue to have the worst health outcomes. For example, in the IX Region, which has the highest concentration of the Mapuche, health outcomes are the worst in the country (Rojas, 2007). This condition is exacerbated by socioeconomic inequities between the Mapuche population and their non-Mapuche counterparts, another key social determinant of health (Torri, 2011). Rojas (2007) asserts that persistent disparities among the Mapuche likely reflect a history of discrimination in healthcare provision, lack of culturally appropriate approaches, and ongoing economic disadvantages.

Historical events that have led to the overall erosion of Mapuche culture in Chilean society has created the need to promote interculturality to the Mapuche community, specifically in healthcare. At the core of Mapuche medicine are the protocol and ceremonies of the *machi*, the Mapuche healer (Avendaño, 2013). Any system attempting to incorporate Mapuche ethno-medicine into its framework must involve *machi* authority. The intercultural hospital is one care-delivery model that has emerged to meet this demand.

An example of this intercultural concept is the Makewe Hospital, which has attempted *interculturalidad* through a culturally competent model of healthcare. The Makewe Hospital is located in the territory of Padre Las Casas, where most of the population identifies as Mapuche. It is situated in a rural setting 12 km away from the nearest major city, Temuco. Of the approximately 10,000 people in the catchment served by the hospital, 95% are Mapuche. The hospital was founded in 1927 by the Anglican Church and since 1999 has been overseen by a local Mapuche Association (Boccara, 2002).

The hospital's services include specialized treatment programs for infants, adults, women, and the elderly, oral health, tuberculosis, as well as drug and alcohol addictions. The hospital also has programs for promotion and recognition of Mapuche identity, which includes training for physicians and involvement of community leaders within the hospital. Although the hospital is occidental, strategies to promote intercultural delivery system values include actively involving Mapuche in health policies; advising educators; and providing Mapuche patients with various comforts such as signs in Mapudungun (the Mapuche language), other bilingual

materials, comfortable rooms with culturally specific accommodations, and coordination of therapy and specialists (Turina, 2009).

Workers at the Makewe Hospital have a special relationship with the *machi* in the territory and can assist patients with transport to the *machi*'s locations for treatment off site, which can otherwise prove to be an obstacle for patients who wish to use traditional treatment but lack transportation. Keeping the *machi* in his/her traditional locale is one way Makewe Hospital attempts to respect the *machi* within the appropriate and effective context, rather than in the occidental hospital setting (Torri, 2011).

Despite such efforts, little is known of differing stakeholder perceptions of the relative effectiveness of this approach to *interculturalidad* among this Indigenous population, to gauge its possible application more broadly. Hence, we wished to determine views held by the Makewe Hospital's patients, Mapuche and occidental providers, administration, public health professionals, and community leaders in regard to this model of interculturality. We did this by assessing these various stakeholders' reactions to modalities of intercultural healthcare delivery.

Methods

General Approach

We employed a semi-structured qualitative survey to obtain descriptive information of preferences and perceptions of interculturality at the Makewe Hospital by those who use its services and are part of its infrastructure. We wished to obtain pilot information on patients, Mapuche and occidental providers, administration, community leaders, and public health professionals of the IX Region in Chile. These last professionals were surveyed to obtain a third-party perspective regarding the functionality of Makewe Hospital, relative to other policy objectives and hospitals in the area.

Using a consensus process between investigators and Makewe Hospital administration, we identified several stakeholder groups to interview. These included Makewe patients in the community served by the Makewe Hospital, professionals from Servicios de Salud Araucanía Sur (Health Services of South Araucanía), a community representative, a *lawentuchefe* (Indigenous herbal expert), occidental hospital professionals, and the hospital director. Participants were recruited using a convenience sampling methodology and served as volunteers for the study. We note here that the participants as a group are not necessarily representative of the entire population, nor are individual participants representative of others in their stakeholder group; however, they fulfilled our overall goal of obtaining a diverse sample of perspectives and experiences of Makewe Hospital stakeholders.

The interviews were performed in Spanish between May 11 and 22, 2013. They took place on site in the hospital users' homes, at the Makewe Hospital for professionals and community leaders, and in the city of Temuco, Chile, for the health service professionals. This region was selected for its high concentration of Mapuche and the presence of the rural community of the Makewe Hospital. The result was 11 interviews of various individuals, carried out by one of the authors (EL) who was temporarily living in the community. These interviews were then transcribed, analyzed, and separated into themes by the interviewer.

Survey Instrument

The survey is reproduced in Appendix A. A semi-structured interview approach was adopted. The structured questions served as a guide in combination with open and follow-up

questions, depending on responses. For each participant, the interviewer used a series of questions that were subject to change or modified in order to remain appropriate for the position and experience of the respondent. The questions were predetermined and edited with assistance of the hospital director, as well as academic professionals from SIT World Learning to ensure cultural sensitivity and appropriateness.

No monetary incentive was provided. In some cases, a recorder was used during an interview, and in others, the interviewer took notes, depending on the respondent's preferences as determined at the beginning of each interview.

Analytic Approach

We were interested in exploring the following topics in this work: services and preferences, community participation, interculturality, access to culturally appropriate care, government integration of Indigenous culture and interculturality promotion, and the future of Indigenous care. We then constructed themes encompassing those topics with at least seven of the 11 interviewee responses. Within these themes the responses of groups such as users, occidental health professionals in the hospital, health service professionals, and community leaders are hence reported. "Community leaders", when used collectively, refers to the Hospital Director, community representative, and lawentuchefe participants. After the interviews, themes (in the table below) were created based on participant's responses.

Ethics

We employed informed consent principles from SIT World Learning, as an introduction before interviews (Appendix B). The project also received Institutional Review Board approval in Chile through officials associated with SIT World Learning. The IRB documentation was completed before the study was conducted, detailing in both English and Spanish the specific project proposal, the informed consent process the interviewer intended to pursue, instructions to participants, an interview guide with detailed questions, and the survey instrument. We did not use a signature form for documenting informed consent for Mapuche interviewees because such systems are not deemed acceptable in the Mapuche culture. To respect these norms, the interviewer obtained informed consent orally from subjects before the interviews. This method of obtaining informed consent in a culturally appropriate manner was specifically reviewed during the IRB approval process. The informed consent process employed an introduction for each interview explaining the nature of the study, the anonymity of responses, and the ability for the subject to refuse to participate or to terminate participation at any time.

Results

Interviewees and Themes

We interviewed 11 individuals for this study. Interviews lasted between 20 and 60 minutes depending on responses. The subjects included three hospital professionals (one general practitioner, one psychologist, one social worker), three hospital users (patients), the hospital director, two health service professionals from Servicios de Salud Araucanía Sur, one *lawentuchefe*, and one Indigenous community representative (*dirigente comunitario*).

We found that all six identified themes of interest were discussed by a majority of respondents in this study (Table 1). This did not vary with respect to Mapuche versus non-Mapuche respondents, professional status, or patient status.

Table 1
***Perspectives of Interviewed Stakeholders on Six Themes Relating to Culturally Appropriate Healthcare in Makewe Hospital, Chile* (Translated from Spanish)**

Theme 1: Two Systems of Care

Interviewee	Comment
User X	"I prefer both services, I use both." "You can only use the *machi* for 'the evil.'" "I go to the hospital exclusively for bone pain, cancer, blood issues, breast cancer."
User Y	"I have never used the services of the *machi*, but when my father was sick we went to the *machi* two times."
User Z	"It depends on how I feel. I go to the hospital for stomach pain, but if I take pills and the pain still exists, I go to the *machi*."
Social Worker	"Personally, I do not go to the *machi*. I am agnostic."
General Practitioner	"I have never gone to the *machi*, I only use occidental medicine, but I accept that my patients use the Mapuche medicine and the *machi*."
Health Service Professional X	"Both, depending on the illness. If I have an infection, I go to the occidental hospital. If it is of the Mapuche origin, I go to the *machi*."
Health Service Professional Y	"The hospitals need to respect the equilibrium. When it is necessary, go to the *machi* or the doctor. But, in my opinion, none of the systems can improve the health completely without the help of the other, we need each other."
Community Representative	"We prefer both, depending on the family."
Lawentuchefe	"I am not against pills, I understand that they can help, but in small doses and small quantity, because the person can become dependent on them. We forget that we are not made of metal, we are made of sensible elements within our bodies, and yes they will be thrown out [wasted]. I am sure that what will improve the hypertension will surely give us a gastric ulcer, a stomach ulcer, and if not it will turn into cancer. This is, more than anything, my message: Use the pill on the first day in smaller quantity, because it will have a rapid effect, and you will soon forget the pain. But after that use the herbs, because the herbs will make you better in a way that is not caused by medication, it will improve it more effectively. So treat first with the pills, and afterwards with the herb."
Hospital Director	"I know when I need to go to one and when I need to go to the other."

Theme 2: Impressions of Hospital or *Machi*

Interviewee	Comment
User X	"[Makewe Hospital] needs a *machi* in the hospital. The *machi* is too far. The vehicles bring the people to the *machi*, but it is better in the hospital."
User Y	"The doctors have always been very nice to me at Makewe." "I do not feel different in Makewe than other hospitals. I do not have this experience [of interculturality]."
User Z	"The doctors are good, they accept the Mapuche medicine." "There aren't any problems."
Social Worker	"You have to know the territories; … the criticism is, how do we demonstrate a complementary hospital? … They protect the protocols."
General Practitioner	"Makewe Hospital is the most near to the Mapuche population. We are poor in infrastructure and resources, and there are many policies, but it is close to the community."
Psychologist	"This program is not intercultural. Because the government brings the same program here as in Arica, all the way to Punta Arenas. We do not have the requirements to be intercultural."
Health Service Professional X	"They never wanted a *machi* in the hospital, and they do not have one." "Makewe is special, within the community."
Health Service Professional Y	"And the hospital can help the people to evaluate the *machi* in their location of value, not in the hospital." "For Makewe, their energy is not in the hospital, health is in the community."
Community Representative	"Makewe has the best health system in this territory."
Lawentuchefe	"Good in the sense that there is no discrimination, there is respect. They do not interfere in what I do. […] There are some that are completely the contrary, and say that, 'yes, take advantage of the herbs.'"
Hospital Director	"What happens is that each community has its own autonomy, with its *lonkos*, it has its people who decide, and if there is a transgression, in terms of bringing the *machis* to the establishments of occidental health, someone will pay for the transgression. I pay for mine [transgressions]."

Theme 3: Challenges

Interviewee	Comment
Social Worker	"We have culturally appropriate locations to welcome these people [older people of the community]. This role is not private, this is the role of the state. We have a role as a state, as a society. The state gives us resources, and the state has to give them to the most vulnerable people."
General Practitioner	"The challenges are because we cannot do the exams, we need to wait and we tell our patients that they need to go to Temuco for their exams. Other challenges are the poverty in the community, problems with child nutrition, and a lot of alcoholism in this region, too."
Psychologist	"The program of mental health that is established here is very oriented to the statistics, the numbers, and not to the reality of the population. … There should be more intervention. … Here the work is, for example, 80% here and 20% in the community; it should be at least 50/50."
Health Service Professional X	"For Chile in general, there have been initiations in different establishments with intercultural advisors and facilitators, and space for interculturality within the hospital. In some there are more, in others none—it depends heavily on the directors. The directors need to be the initiation of the intercultural program, but we currently lack more people for this." "To improve the inequality, so that the advisors have good teams, and more respect in the system. I try to organize the advisors."
Health Service Professional Y	"The most important is the formation of the conscience, especially for the chronic illnesses, because they are not defined in Mapuche terms, it isn't Mapuche in nature, it is of the occidental world. Then the occidental world needs to communicate in a clear manner for the Mapuche people."
Community Representative	"We have good communication, familiarity, our community is familiar and communal. But we lack the economic resources, the money, the instruments for the doctors." "The users do not understand our mission […] but they are happy with the system."
Lawentuchefe	"Personally, I think that there is no interculturality because to have interculturality there needs to be rights." "Nothing is Mapuche."

Hospital Director	"The people are not content with the lack of specialists. […] On the other hand, we put our position within the Mapuche medicine, that the people have the possibility to obtain their own remedies."

Theme 4: Government

Interviewee	Comment
Social Worker	"Unfortunately, poor … I believe that in the next few years, a political orientation will incorporate the concept of interculturality. […] There is a reality in the countryside that is distinct from the city."
General Practitioner	"Yes, there is governmental assistance [but] … none are effective."
Psychologist	"The government brings the same program here as in Arica, all the way to Punta Arenas. We do not have the requirements to be intercultural. But, yes, what we can do is to be open to this, to facilitate it, to understand it, and to comprehend the traditional medicine."
Health Service Professional X	"The government helps with a quantity of resources for cultural advisors, but it depends on the municipality. There are enough programs, and they work decently well. Sure, there is a policy there. Also, there is an opening, to have people with true understanding of the Mapuche, and to create satisfaction."
Health Service Professional Y	"In the government, one has gained the space in this era [for intercultural programs/attention]. The truth is that we have two systems of healthcare in Chile, and we have factors to protect. It is all complementary, all in the duality of the Mapuche worldview. Our survival and understanding is alive."
Community Representative	"The politics are complicated, there isn't much to say. They say one thing and do another." "Our interaction with nature is very important, but they [the government] always take the economic perspective and disregard respect for our land."
Lawentuchefe	"Every government that comes here tells the foreigner that they have here the Mapuche culture, that a community is given millions of dollars for beneficiary programs for the Mapuche, but I don't see it. I will give you an example. They are talking about how they are forming a subsidy of land for the Mapuche community. What land subsidies? The land is ours. They took the land away from us. From 100% of the land, we have 5%. So the land is not subsidized. It is not a subsidy."

Hospital Director	"The state looks at us as numbers, the people, not as people. So the state is a cold state that doesn't care if the people are poor."

Theme 5: Definitions of Interculturality

Interviewee	Comment
Social Worker	"It is important to have a compromise that this person needs healthcare, within their capacity to receive it."
General Practitioner	"The relationship between doctor and patient is the most important, for a personal relationship of the two cultures and worldviews, because they have the same objective, their objective is progress in the health of the person. The [Mapuche] society, according to the community, accepts the differences [in systems of medicine] for the human relations."
Psychologist	"When one is offered interculturality, it is noted, and they like it, but you have to show it. When it is presented to them, they value it. In this moment one remembers that it exists, and they appreciate it, and they use it, they ask for it." "I don't have very much clarity with respect to interculturality, but from what I understand, the best comparison is with the Mapuche because they are intercultural …and this I have learned a little here, day by day. The most important is to understand them, in the totality of the word."
Health Service Professional X	"The importance of interculturality is to truly understand the Mapuche culture—or other Indigenous groups—it is not only to understand the *machi*, but his or her protocol, the worldview of the Mapuche, too."
Community Representative	"The medical team needs to work together and accept the Mapuche preferences."
Lawentuchefe	"Personally, I think that there is no interculturality because to have interculturality there needs to be [human] rights."
Hospital Director	"What we want is that the complementary method is to improve the quality of life of both populations; there does not exist another interest." "The interculturality I understand is not only the respect, but whoever wants to speak about interculturality should speak by actions and should practice it every day."

Theme 6: Future

Interviewee	Comment
User X	"If the parents do not talk with their kids, the medicine will disappear. That is why we talk a lot with our kids about the medicine and culture of the Mapuche."

	"Makewe helps to avoid the loss of culture and medicine for the Mapuche."
User Y	"I am scared that no one will know about the herbs, and they will only go to the hospital. It is bad for themselves [the young people] because they should know. But there will always be plenty of people looking for remedies and they will use Mapuche medicine."
User Z	"I hope that the medicine continues [to be used] and is valued; I don't worry, the medicine is well established. For the young people, it depends on their parents: if they have the rights to use it, they will not pay attention to use it."
Social Worker	"In some areas it is maintained, in others it isn't. But more than this, the people have the ideas of the city [as opposed to the countryside]. My vision for the future is that where there are *machis*, where there are *lonkos*, one will maintain the culture. Where there is one, it is much stronger than the culture that, for example, we have surrounding the hospital."
General Practitioner	"The Mapuche medicine has a lot of value in the community, but it is very traditional and it is not going to change; there are never changes in the treatment. The strength is to maintain the traditions for the people."
Health Service Professional X	"The preservation of the Mapuche medicine depends greatly on the community: the adolescents, the *machi*, the *lonko*. All of the people are involved in the process to preserve it; the protection of the areas with Mapuche medicine, and to protect the forest is very important."
Health Service Professional Y	"The system [of interculturality in health] currently works for definite protection, to defend the Mapuche medicine. The problem is the lack of native plants, and now the *machis* cannot find the plants that they need. […] Because of the destruction of land … the food now has more fat, cholesterol; now this is accessible but bad for our health. But I think that our culture is strong, and we will advance."
Community Representative	"We always return to the topic of the land. It is impossible to have representation because our system is very focused on the state. The politics are not public, we do not have senators, and on the political scale there are the politicians, afterwards the Chileans, and lastly the Mapuche. We live in a planet [world] that is far from the land."
Lawentuchefe	"What will happen with the reduction of land, because the cake is being divided, for me, for my brother, but the part for me, for my kids and their kids, they won't have

	anything. If we have an animal, where will we raise it? I will preserve the medicinal herb there in my land, and I will not eat? So the issue needs to be evaluated. Or to clean the land, and sacrifice the medicinal plants, and cultivate food to eat? Or to leave the medicinal plants as they are, and not cultivate anything, and die of hunger?"
Hospital Director	"I believe that this will be the next conflict between the state and the Indigenous groups of Chile. … In the future, because if we maintain our stance firmly, in what we want, in what we want to do, we will maintain it. If the contrary happens, we will suffer."

Services and Preferences

We found somewhat unexpected agreement across professional, administrative, and Indigenous user respondents with regard to services and preferences. All Makewe Hospital users, health service professionals, and Makewe community leaders preferred both healthcare system delivery options: Mapuche *and* occidental. This perspective appeared driven by context; all subjects identified different situations of necessity for Indigenous versus occidental care. For example, one user indicated the Indigenous *machi*'s services are used when one has *mal* (evil), while she indicated other situations and conditions more appropriate for occidental treatment (User X, Table 1, Theme 1). The only respondents, who said they do not use the Mapuche health system, or the *machi*, were occidental professionals of Makewe Hospital (none of the three interviewees who were healthcare providers identified themselves as Mapuche).

In another interesting finding, the *lawentuchefe* discussed the presence of new disease states in the Mapuche. He observed that these previously perceived non-endemic diseases, known as *winka* diseases, had been impacted by changing cultural dynamics leading to the recognition of these new disease states in the Mapuche community. These diseases include diabetes, cancer, obesity, and HIV/AIDS. Consequently, he does not advocate for occidental medicine but accepts its necessity within the community and advocates complementary use of both:

> I am not against pills, I understand that they can help, but in small doses and small quantity, because the person can become dependent on them. We forget that we are not made of metal. … This is, more than anything, my message: Use the pill on the first day in smaller quantity, because it will have a rapid effect, and you will soon forget the pain. But after that use the herbs, because the herbs will make you better in a way that is not caused by medication, it will improve it more effectively. So treat first with the pills, and afterwards with the herb. (Table 1, Theme 1)

Community Participation

Indigenous users provided a mixture of responses regarding Indigenous community participation at the Makewe Hospital. Users generally had positive impressions of the hospital and were satisfied with its system and healthcare delivery. However, respondents indicated they were not aware of *any* intercultural work carried out by the hospital or government...

The medical and health service professionals, in contrast, described the Makewe Hospital as having a focus on interculturality and close relationships with the local Indigenous community. This contrast may reflect the fact that *interculturalidad* is a Western concept and

therefore not a term or concept Mapuche patients recognize separately or within the healthcare delivery context.

Similar differences arose between Western professionals. When interviewing the Makewe Hospital social worker and psychologist, the former discussed modifications the hospital made to accommodate *ancianos* (older people of the community) as an effort to engage the Indigenous people. He also discussed how important it is for Chile to allocate resources to communities to allow them to assist vulnerable Indigenous populations there. In contrast, the psychologist interviewee indicated the distinct *lack* of interculturality in the hospital's mental health program, which is primarily run by the national government. He stated that government overgeneralization of Indigenous Peoples is the primary factor preventing a culturally appropriate health delivery system. He stated, "Because the government brings the same program here as in Arica, all the way to Punta Arenas[,] [w]e do not have the requirements to be intercultural" (Table 1, Theme 2). Thus, there appears to be a lack of agreement even between occidental stakeholders regarding interculturality and its integration success at Makewe Hospital.

With regard to community participation, Indigenous community leaders expressed that the Mapuche community respected work done by the hospital. However, they did not discuss any active community-based participation in developing and integrating Mapuche identity into hospital operations or programs. Yet, the hospital director, a Mapuche, was more inclusive in his interpretation of "community"; he indicated that the hospital's mission always involves the community and saw inclusion of Mapuche as within the scope of broader community participation. This may or may not comport with the broader Indigenous stakeholders' perspectives, given the limited mention of community engagement by individual Indigenous users, as well as the integration of the Mapuche hospital director into occidental systems, its norms, and its cultural assumptions.

Interculturality

When directly discussing the concept of interculturality, all respondents indicated there is respect for Mapuche ethno-medicine within the Makewe Hospital. However, substantive *integration* of Indigenous care services does not appear to exist. Administrators expressed interculturality as a goal or philosophy rather than a reality based on actual care integration; for example, the hospital director stated, "The interculturality I understand is not only the respect, but whoever wants to speak about interculturality should speak by actions and should practice it every day" (Table 1, Theme 5). The *lawentuchefe* indicated his work at the hospital (now terminated due to lack of funding) represented an *aspect* of interculturality, but he did not believe the concept actually exists presently due to lack of respect or empowerment of Mapuche medicine by the occidental world. He stated, "Personally, I think that there is no interculturality because to have interculturality there needs to be rights" (Table 1, Theme 3).

The views of Mapuche patients may indicate potential for interculturality, as by the respect accorded traditional medicine, but limited as an unfamiliar occidental notion, because none of the users specifically recognized or referred to the concept in interviews. Overall, results indicate that users are satisfied with the health system at the intercultural Makewe Hospital but do not perceive that it is different as a result of its efforts at being intercultural.

Access to Culturally Appropriate Care

When assessing practical aspects of Indigenous care, Mapuche patients noted at least some access to Indigenous-based care at Makewe Hospital. Indigenous interviewees frequently expressed opinions concerning practical aspects related to the absence or presence of a *machi* in

the hospital. For example, User X said she would like a *machi* to provide services within the hospital because transport to the *machi* is often too difficult. In this context, it is important to note the difference between Indigenous care access—the ability to receive traditional Mapuche remedies within the hospital (including access to a *machi*)—versus Indigenous accommodative access—changes made to provide access and comfort of Indigenous users receiving occidental care. Hence, it appears that accommodative access rather than intercultural Indigenous care access is the norm at Makewe Hospital.

The professional participants had similar perceptions of access to culturally appropriate care—focused on the presence of *machi*. For example, the hospital director, *lawentuchefe*, social worker, and health service professionals all had justifications for Makewe Hospital's policy to exclude *machi.* These interviewees discussed the need for preservation of *machi* traditional protocol outside the hospital. In a more indirect fashion, the hospital director emphasized the autonomy of the community in keeping the *machi* in his/her own location, rather than in the hospital—a foreign, occidental establishment that may potentially alter the effectiveness of *machi* treatment. This is in contrast with at least one Mapuche patient who indicated Indigenous care access within the hospital would be desirable.

Government Integration of Indigenous Culture and Promotion of Interculturality in Health

Consistent and significant dissatisfaction was expressed across stakeholders regarding government activities promoting Indigenous care integration as part of interculturality. Similar to sentiments expressed in a survey by Organización Panamericana de la Salud in 1996, none of the interviewees were content with governmental support for intercultural health programs generally, nor specifically for initiatives at Makewe Hospital.

Even occidental professionals, who recognize and support health ministry programs, indicated "none [of the intercultural programs] are effective" (General Practitioner, Table 1, Theme 4) and that programmatic rules are not community oriented (Psychologist, Table 1, Theme 3), despite the importance of public health as the government's role, especially in providing resources for the most vulnerable citizens (Social Worker, Table 1, Theme 3). The social worker bluntly described government assistance as "unfortunately, poor" (Table 1, Theme 4), although he (and other professionals) seem optimistic for the future. No Indigenous respondent expressed such optimism.

Health service professionals recognized the need for the government to improve aid for Chile's Indigenous groups. They expressed more optimism for aid and effectiveness of programs than respondents directly engaged in or receiving healthcare services, including administrators, occidental professionals, and the Makewe community leaders. The latter note the misinterpretation of the Mapuche culture and their lower socioeconomic status in Chile as a primary problem and reason for limited responsiveness of government.

Similarly, the Mapuche community representative, hospital director, and *lawentuchefe* are less sanguine regarding government intercultural efforts. Most have had negative interactions with governmental representatives, whom the *lawentuchefe* described as attempting to resolve complex issues with simplistic solutions such as misplaced land subsidies and a strict economic perspective on the issue. By the same token, these respondents often identify the greatest challenges for the hospital as being financial. Almost every response to the question about challenges resulted in commentary about the lack of financial resources for Makewe Hospital from the government. Descriptions of limited financial resources often led to discussions about the reduction of land for Mapuche and lack of government support for integration of Mapuche perspectives, needs, and communities. The *lawentuchefe* concluded, "nothing is Mapuche" in

reference to the lack of Mapuche culture in schools and governmental representation (Table 1, Theme 3). He also noted that limited cultural understanding might lead to communities' loss of Indigenous medicine and even survival. He asked:

> What will happen with the reduction of land, because the cake is being divided for me, for my brother, but the part for me, for my kids and their kids, they won't have anything. If we have an animal, where will we raise it? I will preserve the medicinal herb there in my land, and I will not eat? So the issue needs to be evaluated. Or to clean the land, and sacrifice the medicinal plants, and cultivate food to eat? Or to leave the medicinal plants as they are, and not cultivate anything, and die of hunger? (Table 1, Theme 6)

Future of Indigenous Care

The future of Indigenous care integration was also a prominent topic and evoked a variety of responses. On one level (similar to discussion of the lack of financial resources) many remarked on the history and future of the Mapuche population, and their struggle for equity, rights, and especially land in Chile. For example, the Mapuche community representative commented,

> We always return to the topic of the land [when talking about Indigenous culture]. It is impossible to have representation because our system is very focused on the state. The politics are not public, we do not have senators, and on the political scale there are the politicians, afterwards the Chileans, and lastly the Mapuche. We live in a planet [world] that is far from the land. (Table 1, Theme 6)

On another level, there was a mix of optimism and pessimism among the patients, specifically about ethno-medicine; they are concerned that Mapuche medicine will disappear, but they have confidence that if the traditions have a space within each home and family, it can nevertheless be preserved. The social worker and general practitioner were also hopeful Mapuche medicine will not disappear, because these traditions are strong, and as long as there are *lonkos* (traditional leaders) and *machis* in the community, there will be a Mapuche culture and hence its form of ethno-medicine.

The health service professionals focused on preservation of Mapuche medicine as a community responsibility. For Health Service Professional X, similarly, the future is deemed dependent on this community conscientiousness, but primarily for adults to focus on the preparation of the environment for the next generation of their Indigenous communities. While the *lawentuchefe* discussed his fears for the future of Mapuche medicine, the hospital director predicted that the conflict between the Mapuche and the Chilean government will be more important in affecting the future of Indigenous care.

Limitations

This study represents pilot work assessing Indigenous–occidental interculturality efforts in a single facility for the Mapuche. Low sample size may limit the generalizability of the findings. It could, however, provide a baseline of stakeholder perceptions useful contextually in additional work. In the future, studies looking to further explore this issue in detail should aim for a larger sample size of participants.

Further, because we are not members of the Mapuche, our relationships with the Mapuche may have resulted in different responses than if we were part of the Indigenous group.

As well, our cultural heritage originating outside Chile could also influence our ability to obtain relevant perceptions of stakeholders and to fully interpret the findings. A common public health bond and fluency in Spanish of the interviewer may have mitigated this concern somewhat.

Finally, the concept of interculturality may itself be a limitation, because many of the Mapuche population do not recognize this predominantly occidental concept. We sought to assess characteristics of importance such as access and perceptions of satisfaction to address this concern, but there may be other factors and characteristics that are more important for the Indigenous Mapuche hospital users, or there may be alternative concepts within the Mapuche culture that express satisfaction for cultural efforts more appropriately. These are areas for additional work in this and other Indigenous settings.

Discussion

In our stakeholder interviews regarding *interculturalidad* and perceptions of the intercultural healthcare delivery model applied by the Makewe Hospital, we found Mapuche users, community leaders, and professionals are interested in using both the occidental and traditional methods for healthcare needs. We found that the Makewe Hospital experiences difficulties in supporting its mission and intercultural initiatives, owing primarily to economic deficiencies as well as generalization of policies that do not leave professional time for community pertinence. Additionally, as is shown in Makewe Hospital's decision to exclude the *machi* from the hospital, with both support for and complaint about this form of access by Indigenous users, Mapuche communities are not uniform in opinion and make decisions based on their autonomy and unique perspectives.

We found none of the interviewees are content with the current government aid, nor efforts to engage in interculturality, although professionals at the government's Servicios de Salud Araucanía Sur were more positive on the issue. Fundamentally, it seems poorly understood. Mapuche diversity and perspectives appear to have limited acceptance or understanding within government and occidental entities, which may be thwarting effectiveness of programs designed to promote interculturality. Indeed, it appears there is no universal agreement across stakeholders as to interculturality, Mapuche ethno-medicine locale, or success in implementing intercultural programs in the Makewe Hospital.

Perceptions of medical and public health professionals were much more optimistic regarding interculturality than those of Indigenous patients themselves. But even among healthcare providers there was discord, with social worker and psychologist perceptions of interculturality engagement diverging. Even the fundamental concept of access to culturally appropriate care differed, focusing upon the need for *machi* to remain outside the hospital for cultural reasons; however, at least one user indicated the practical need for *lawentuchefe* in the hospital while another pointed to transportation concerns to receive such care.

Consequently, Mapuche Indigenous care is at a crossroads. Joint Mapuche and occidental care is accepted by most but does not appear to have been effectively implemented in practice or to jointly agreed-upon standards. Fragmented stakeholder perspectives regarding participation, the intercultural concept in healthcare, and needs of the community seem to have resulted in different goals amongst stakeholders.

To promote and achieve goals of Mapuche interculturality in healthcare, first, using the Makewe Hospital's experience, Indigenous health policy should have a broad community focus rather than a narrow hospital-based one for providers. Whether it is an urban, mixed, or rural community, each professional and worker in the hospital should have relevant training

concerning the worldviews, lifestyles, preferences, and practices of the local Indigenous community and society they serve. Professionals must understand the people of the community and their context (i.e., the mix of cultures, preferences, and practical concerns), and should consistently involve community members. Doing so can develop shared expectations through participation, understanding, and respectful governance systems, and can favor success as defined and agreed upon by these groups. For generalizable and evidence-based policy, these efforts should mirror ongoing engagement in community-based participatory research in global health that aims to improve health and quality of life in local communities (Betancourt, Green, & Carillo, 2002; Godkin & Savageau, 2001).

Governments should also shift their limited partner engagement to broader community entities in countries such as Chile, where intercultural efforts such as the Program of Integral Development for Indigenous Communities, also called Origenes, are a mainstay. Yet past sponsored programs, including those in the Makewe Hospital, are largely absent of Indigenous representation, as noted in this study, and have limited coordination of community resources. By using partnerships that include civil society, nongovernmental organizations, academia, and the private sector, a full collaborating group of stakeholders and activities can result in continual evaluation, feedback, and improvement in ethno-medicine-focused healthcare delivery models (Liang, 2011; Mackey & Liang, 2012).

For example, specific sensitivity training can integrate these groups in the orientation and continuing education of hospital providers and staff (Cianelli et al., 2008). Beyond simple "Mapuche identity" efforts, integrating nongovernmental organizations, academics, and others with experience in Indigenous and occidental health settings can facilitate mutual communication and engagement, particularly between providers from each, and establish respect within the team of health professionals and with the community, including its individual members (Bacigalupo, 2007; Cianelli et al., 2008). Expanded use of *asesores culturales*, or cultural consultants, should also be explored (Nicholson & Schmorrow, 2013). In our data, one health service professional did refer to this concept, and its drawbacks, in the Chilean system:

> For Chile in general, there have been initiations in different establishments with intercultural advisors and facilitators, and space for interculturality within the hospital. In some there are more, in others none—it depends heavily on the directors. The directors need to be the initiation of the intercultural program, but we currently lack more people for this. (Health Service Professional X, Table 1, Theme 3)

Dedicating additional resources for cultural advisors may hence be a key component moving toward an equitably balanced healthcare system.

In addition, professional engagement and government policy should integrate protected, additional time for Indigenous activities promoting interculturality. This avoids challenges to time (as well as financial) resources that may assume allocated periods based on occidental encounters are adequate for Indigenous patients. With Indigenous-based, reserved, integrated, community-focused time, professionals can tailor interculturality approaches to the reality of the community and mix of people(s).

We emphasize, however, that generalization of policies must be sensitive to the communities at hand—their specific context. Policies cannot consider all "Indigenous Peoples" or "vulnerable groups" homogeneously; discrimination can occur when assuming all underserved populations have the same needs. Indeed, underserved groups such as the Mapuche are the most

vulnerable due to their economic inequality, and consistently have poor health status (Rojas, 2007). As a general matter, addressing their needs will require additional resources. Yet the Mapuche themselves have a spectrum of differing needs, requiring acknowledgment of the unique context driving the needs of specific Mapuche communities. Each is dependent upon other critical factors such as location (e.g., the Makewe Hospital is in a rural setting), resources, and public health needs in that community. Employing policies permitting flexibility by community, while simultaneously encouraging intercultural sensitivity, should be prominent in programmatic efforts. This, too, is an area for potential inclusion and integration of academic and global health community resources.

Conclusions

The study of the interculturality model of Makewe Hospital is ultimately the study of the traditional Mapuche community in today's society. The challenge of integrating an Indigenous perspective into public health and the healthcare system is reflective of policymakers attempting to integrate an Indigenous People into occidental governance and healthcare norms while attempting to maintain cultural identity and heritage. Interculturality, consequently, requires a multitude of resources and a shared sense of ideals. Hence, employing a broader set of engaged participants may promote policy goals in interculturality in healthcare.

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Appendix A:
Survey for Makewe Hospital Stakeholder (Translated from Spanish)

I. Introduction:

Hello, my name is Elizabeth and I am a student here in Chile for the semester. I study public health, and for one month I have the opportunity to conduct research on a topic of my choice. I am studying the concept of *interculturalidad* in this community. I hope to learn how the health system of Makewe Hospital functions and how it appears to the patients, doctors, and other health workers in the community. If you are comfortable, I would like to speak with you in order to learn more regarding your opinion of the efficacy of Makewe Hospital and your experiences there. If you are not comfortable with any questions at any moment, please tell me and we will stop the conversation. I will not use any of your responses or name without your consent.

II. Interview Guide

Users

1. How many years have you used the services at Makewe Hospital?
2. In general, do you prefer to use the services in the hospital, the services of the *machi*, or a combination of the two?
3. On average, how many times per year do you use the hospital services?
4. What type of services do you use in the majority of your visits to Makewe Hospital? Your treatment with the *machi*?
5. How do you feel about your experiences with the doctors of Makewe Hospital?
6. How would you characterize the quality of services in the hospital? Which aspects need the most improvement? What are the best aspects?
7. Can you compare your experience in Makewe with other hospitals?
8. What are your projections for the future of Mapuche medicine? Do you think that hospitals like Makewe Hospital help the Mapuche preserve their medicine?

Occidental Professionals

1. Where did you complete your medical training?
2. What is your specialty or title?
3. How many years have you worked at Makewe Hospital?
4. Why did you choose to work at Makewe Hospital?
5. For your own health, do you prefer the hospital or the *machi*?
6. How would you characterize the quality of services in the hospital?
7. How do you feel about the importance of having a hospital with the philosophy of Makewe Hospital?
8. How would you characterize governmental assistance for the philosophy of Makewe Hospital?
9. What are the greatest challenges for a professional at Makewe Hospital?
10. Do you have experiences in other hospitals? How would you compare other hospitals to Makewe Hospital?
11. Have you seen a change in the preferences of Mapuche patients for treatment with the presence of Makewe?
12. How do you define your own concept of *interculturalidad*?
13. Do you think that the model of Makewe Hospital could potentially function in other locations in Chile or for other Indigenous groups?

14. How do you feel about the future of Mapuche medicine?
15. How would you characterize community participation for the administration of Makewe Hospital, or other projects with the goal of *interculturalidad*?

Community Representatives/*Lawentuchefe*

1. What is your speciality or title?
2. How many years have you worked with Makewe Hospital?
3. Why did you choose to work for Makewe Hospital?
4. For your own health, do you prefer the services of the hospital or the *machi*?
5. How would you characterize the quality of services in the hospital?
6. How do you feel about the importance of having a hospital with the philosophy of Makewe Hospital?
7. How would you characterize governmental assistance for the philosophy of Makewe Hospital?
8. What are the greatest challenges for your work with Makewe Hospital?
9. Do you have experiences in other hospitals? How would you compare other hospitals to Makewe Hospital?
10. Have you seen a change in the preferences of Mapuche patients for treatment with the presence of Makewe?
11. How do you define your own concept of *interculturalidad*?
12. Do you think that the model of Makewe Hospital could potentially function in other locations in Chile or for other Indigenous groups?
13. How do you feel about the future of Mapuche medicine?
14. How would you characterize community participation for the administration of Makewe Hospital, or other projects with the goal of *interculturalidad*?

Professionals from Servicios de Salud Araucanía Sur

1. What is your specialty or title?
2. How many years have you worked in the healthcare field?
3. Why did you choose to work in this field?
4. For your own health, do you prefer the services of the hospital or the *machi*?
5. How would you characterize the quality of services and reputation of Makewe Hospital?
6. How do you feel about the importance of having a hospital with the philosophy of Makewe Hospital?
7. How would you characterize governmental assistance for the philosophy of Makewe Hospital?
8. What are the greatest challenges for your work with intercultural healthcare?
9. How would you compare other hospitals to Makewe Hospital?
10. How do you define your own concept of *interculturalidad*?
11. Do you think that the model of Makewe Hospital could potentially function in other locations in Chile or for other Indigenous groups?
12. How do you feel about the future of Mapuche medicine?
13. How would you characterize community participation for the administration of Makewe Hospital, or other projects with the goal of *interculturalidad*?

Appendix B:
Informed Consent Form for Makewe Hospital Survey Participants

Formato de consentimiento informado
Nombre del estudio:……..
Formulario de Consentimiento
(Para los participantes del programa)

Descripción y Propósito del Proyecto

El objetivo de este estudio es…….. El propósito de este estudio es también enseñar a los estudiantes la planificación, diseño y ejecución de un estudio y la redacción de un informe completo.

Se le pedirá responder a preguntas que ayudarán a la investigadora a lograr los objetivos de este estudio. Sus respuestas a esta entrevista serán recogidas por la investigadora en la forma de tomar notas y/o grabación de audio, si usted lo autoriza. Todas las notas de las entrevistas y grabaciones serán utilizadas exclusivamente para los fines de este estudio. Esta entrevista o cuestionario (según sea el caso), tendrá una duración de aproximadamente……. minutos, dependiendo de sus respuestas.

Evaluación de Riesgos y Beneficios

Este estudio está diseñado para representar un riesgo mínimo para sus participantes. Las preguntas están diseñadas para no requerir divulgar cualquier información que pueda ser perjudicial para usted.

Los Investigadores Principales

El investigador principal es……, una estudiante de la Universidad de…… y una estudiante con SIT Chile: Salud Pública, Medicina Tradicional, y Empoderamiento Comunitario. Ella/El puede ser contactada por correo electrónico a…… Además, si desea ponerse en contacto con SIT, puede hacerlo poniéndose en contacto con la Directora Académica del programa en Chile.

Participación Voluntaria

Usted debe tener 18 años para poder participar en este estudio. Su participación en este proyecto es voluntaria y usted es libre de retirar su consentimiento y descontinuar su participación en el proyecto en cualquier momento sin penalización. No es necesario responder a cualquier pregunta que usted no desea responder.

Uso de la Información y Los Datos Recogidos

La información recopilada en este estudio se utilizará en forma agregada. Los datos serán utilizados para escribir un informe de clase. Habrá tres copias del documento: una para el investigador principal para mantener, una para la biblioteca de SIT Chile, y una para ser enviado al asesor en el país y/o para la organización involucrada. Una presentación oral resumiendo los hallazgos será presentado a una comisión académica de SIT Chile y a los otros estudiantes que participan en SIT Chile.

Confidencialidad de Los Expedientes

Sus resultados individuales serán confidenciales. Sólo los resultados agregados se informarán en un reporte que forma parte del curso de Estudio Independiente a través de SIT Chile.

Información sobre Los Derechos del Participante

Si usted tiene alguna pregunta sobre sus derechos como un participante, puede comunicarse con la Directora Académica del programa en Chile.

El Consentimiento del Participante

El estudio se ha descrito a mí y entiendo que mi participación es voluntaria y que puede terminar mi participación en cualquier momento. Yo entiendo que mis respuestas se utilizarán como se describe. Al participar, doy fe de que soy mayor de 18 años y que doy mi consentimiento para participar en este estudio.