Bringing Body to Bear in the Andes: Ethnicity, Gender, and Health in Highland Ecuador

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Introduction

Medicine everywhere is a means to effect change, to reproduce and reconstruct the world in accordance to one’s own vision. When that everywhere is localized to the highlands of Ecuador, multiple external stakeholders—the Ministry of Health, governmental and non-governmental organizations—meet local, indigenous lives and realities. In this context, medicine is a product of a plethora of perspectives, and health is even more so.

It has been increasingly documented that civil society in the Ecuadorian Andes has crystallized around the institutions of indigenous rural communities that developed historically in opposition to blanco-mestizo urban administrative centers (Beck and Mijeski 2000; Cruz 1999). The area’s scholars have explored the evolution of such indigenous institutions in local government and national politics and their involvement in the process of democratization and decentralization (Bebbington 1997; Cruz 1999; Korovkin 1998, 2001; Paley 2004). In part due to the activism of the Confederación Nacional de Indígenas del Ecuador (National Confederation of the Indigenous Peoples of Ecuador, known
publicly by the acronym CONAIE), as of 1998 the constitution of Ecuador has described the state as “pluricultural y multiétnico.” Yet such civil society has not involved indigenous groups exclusively. Indigenous organizations often identify with a concept of ‘indigenousness’ by creating economic and political links with external Western development agencies. Intensified networks of NGOs continue to have significant impacts upon international and national politics and local lives.

The Ecuadorian Ministry of Health thus far has not internalized ‘pluricultural y multiétnico’ at the policy or organizational level. Nevertheless, several NGOs have initiated programs seeking to enhance the health of ‘indigenous’ bodies by encouraging the participation of indigenous communities, through health clinics specifically focusing on rural Kichwa–speakers and community outreach work involving locally recognized healers. Here, transformations in health and politics manifest themselves uniquely in, on, and through the human body.

This human body, however, is not conceived of identically by NGOs, the Ecuadorian state, or Andeans themselves. In considering health programs, it is important to deconstruct such a monolith. How do the indigenous people of the Andes understand their bodies and selves? How is the acknowledgement of (and commitment to) indigenous bodies as Ecuadorian, as stated in the 1998 constitution, portrayed in health care policy and practice? How do political and health NGOs conceive of ‘indigenousness’ and the ‘indigenous’ body? And, finally, how do these notions converge in the Ecuadorian highlands?

As both an aggregate and an individual unit, body indexes much more than a collection of particles or biological organism. Nancy Scheper-Hughes and Margaret Lock (1987) discuss the multiplicity inherent in ‘body’:
The individual body should be seen as the most immediate, proximate terrain where social truths and social contradictions are played out, as well as the locus of personal and social resistance, creativity, and struggle. [1987:31]

They posit “three bodies”—the embodied individual, the social body, and the body politic—as a heuristic for understanding the interaction of individual, community, and state in the production of illness. Certainly within the sociopolitical context just described, the national and global manifest themselves on the local, indigenous individual in distinctive ways.

In this article, I seek to elucidate the various notions of the ‘indigenous body’ subscribed to by those involved in making medicine in the Ecuadorian Andes. I propose the term making medicine to draw attention to the constructedness of medicine both as a process and an outcome, a product of not only a plethora of actors but also of ideologies. As such, and to highlight the facets of this term, this article is divided into five parts: (1) a brief overview of medical anthropology in the Andes, providing context for the region and further scholarship; (2) an examination of this anthropological literature to demarcate how indigenous men and women of the highlands imagine one’s own vision of body; (3) a further study of the indigenous rights movement and its implications on “indigenousness” as seen by the Ecuadorian state; (4) a review of international NGOs and literature describing their health programs to reveal the “indigenous” body which underlies their operations; and (5) a conclusion that suggests reproductive health activism as a
way to explore how the indigenous movement acts upon human bodies to renegotiate identity.

**Health and anthropology in the Andes**

Before addressing the question of what constitutes an ‘indigenous body,’ I turn first to larger ideologies of health in the Andes to situate the body within its cosmological context. North American anthropologists concerned with health first turned to the Andes in the 1960s and 1970s with questions regarding nutrition, traditional medicine, and morbidity. The original publication that grounded subsequent scholarship, *Health in the Andes* (Bastien and Donahue 1981), focuses on health maintenance and an evaluation of Andean notions of well-being. Specifically exploring ethnomedicine, physical adaptability to extreme environmental factors, and improving health, the scholarship of the volume centers on a physicality of Andean bodies and purports to address an objective reality of the individual body.

A small group of scholars, distinct from those whose work appeared in the aforementioned volume, continued to investigate health in the Andes during the 1980s and 1990s with research that included the cultural and social significance of illnesses and traditional preventive and curative measures. A number of articles emphasize the particular social roles played by women in indigenous households and the connections between gender roles, family, community, and illness (Finerman 1982, 1983, 1984, 1987; Larme 1998). Yet, though expanding earlier definitions of environment and adaptability, these still cling to the paradigms of adaptation, reciprocity, and a romanticized idea of “the Andean” (Finerman 1982, 1983, 1984, 1987; Larme 1998; Leatherman 1998; Oths 1998, 1999; McKee 1984). With few exceptions, the fieldwork that led to
these publications was conducted in Spanish, lessening the degree of nuanced understanding and contextualization that the subsequent analyses can provide. Furthermore, these articles largely approach Andean culture as bounded and discrete, exploring Schep-Hughes and Lock’s individual body, with some attempt to consider the body as a symbol through which to consider cultural conceptions of nature and society. This scholarship examines, somewhat narrowly, the Andean individual and social body in the Andes without studying the Andes within nations and in the world.

Libbet Crandon-Malamud’s From the Fat of Our Sons (1991) was one of the first book-length ethnographies on the region. A study of medical pluralism in a Bolivian Aymara community with two distinct religious sectors, it depicted how medicine is a resource through which people negotiate and express cultural identity and political and social power and introduced the body politic (Schep-Hughes and Lock 1987) into considerations of health in the Andes. In suggesting the larger political and economic context of health in the Andes as necessary to adequately analyze health belief and practice, Crandon-Malamud attempted to redirect the locus of her fellow Andeanists. Though this group created the Andean Health Researchers’ Network to increase collaboration and further discuss the direction of future research in the Andes, published a special volume of Social Science and Medicine (1998) devoted to renewed Andean health scholarship, and produced the edited volume Medical Pluralism in the Andes (2003), their collective work still falls short of capturing the complex interplay of local, national, and global factors that contribute to the diversity of situations. Margaret Lock and Patricia Kauffert have called for a “semiotic return to local sites of research for further reflection on the way competing truth claims and practices are contested as a result of the ceaseless appearance of new knowledge” (1998:23) to better understand how globalization
affects body politics. In considering the existing medical anthropology literature on the Andes, however, the appeal might first be to turn to the world and then return to the local highland community. Consideration of health and illness, and conceptualizations of the Andean body itself, needs to be widened and connected to national and international before narrowing again.¹

**Andean bodies, Andean selves**

The local site—the Andean conception of the Andean body—provides grounding on which to eventually postulate how local, national, and international actors come together to make medicine in the Ecuadorian highlands.² Existing literature on medical anthropology in the Andes, as cursorily described in the preceding section, draws heavily on notions of the experienced body and social body. Here, I turn to the myriad articles addressing these themes to extract the underlying concepts that construct Andean bodies.

Homeostasis serves as the dominant trope through which the individual body subsists. The Andean body, in its ideal, healthy state, reflects a balance between humanity, the environment, and the spiritual world. Christine Greenway succinctly depicts this world view as “a conception of cosmology in which bodies and spirits are intertwined with mountains and stars in webs of reciprocal duties” (1998:993). Constant exchange between these groups through the human body—the porosity of the skin, orifices, and food intake through the mouth—maintain this equilibrium and often operate around the nodes of *hot* and *cold* (Finerman 1987; McKee 2003). Yet this homeostasis is not a static state but a process: as Joseph Bastien (1985) indicates, Andean well-being is often described as dynamic, constantly moving between extremes of *hot/cold/wet/dry*. Bastien suggests a pendulum swing in which, rather than aiming
to gain balance, continual flow and movement are fundamental to well-being, a further indication of the reciprocity that is the hallmark of social relations in the region.

Several beliefs and practices tie the natural environment and the individual body to one another. Common language links the human body to the physical topography of the region: talking about the body through talking about the environment and vice-versa conveys the underlying connection between the two in Andean ideology (Bastien 1985; Larme 1998). Bastien (1985) constructs a topographic–hydraulic model physiology to explain how Qollahuaya Andeans look to their mountain and its waterways for understanding their bodies. The prevalence of exchange of ingredients between the earth and the body in medical treatment with plants, in prevention with hot–cold balances, and in religious ritual emphasizes the ongoing production of balance, or exchange between these entities (Bastien 1985; Finerman 1987). Furthermore, the spirit deities, or apus (jirka in Ecuador), are the personified essences of geographic features—mountains, rivers, rock outcrops, sun, moon, rainbows—and interact significantly with human bodies. The centrality of the superhuman environment to Andean bodies manifests itself through a set of wayras, air- or wind-borne illnesses, as documented by Ann Larme (1998) and Eduardo Estrella (1991), among others.

The Andean body is linked to other Andean bodies within a community, as well as to the spirit world. Economic and social reciprocity, both with community members through the sharing of work and goods and with apus through ritual offerings ensure against illness and attest to one’s state as a moral body. Alternatively, disrupting social harmony by refusing communal duties or through the expression of negative emotions puts the body at risk for reprimand by the spirit world through illness (Greenway 1998b,
Larme 1998). Andean bodies are hard-working bodies, strengthened by sweat and weakened by laziness and sleep, reaffirming the necessary interaction with the natural environment of fields, rocks, and sun and the communal responsibilities of labor.

Due in part to the porous boundaries separating the human, natural, and cosmological, vulnerability characterizes individual bodies. Larme (1998) shows how the medical cosmology of Puno, Peru, centers around images of human vulnerability to an often hostile and unpredictable environment. The core concept of *debilidad* (weakness, vulnerability) refers to the belief that at any time a human being is vulnerable to natural or supernatural forces intruding into the body, lodging in a particular organ and creating illness (Larme 1998). Not only does this highlight the fragility of the human body, it also conveys the permeability of the natural and supernatural through the Andean body.

In summary, the Andean body, according to emic perspectives vis-à-vis anthropologists’ interpretations of illness and birth, is defined by a convergence of individual, social, and cosmological bodies. The permeability, balance, and reciprocal relationship between these three entities ensure a distinctly Andean identity.

**The Warmi in the body**

Although men and women equally share the many characteristics described above, the literature also offers some insight into how women’s bodies are distinct from men’s. Most notably, women’s childbearing is the locus of this difference. As Carole Browner and Carolyn Sargent (1990) note:
Reproductive studies can provide a particularly powerful lens through which to view how broader social processes articulate with a society’s patterns of gender role organization and its associated ideological and sociopolitical dynamics. [Larre and Leatherman 2003:202]

Several Andean scholars have emphasized the beliefs and practices surrounding reproduction. In doing so, they illuminate the unique conceptions of women’s bodies and the social hierarchies in which they are implicated.

Through her studies of pregnancy, childbirth, and postpartum health, Ruth Finerman (1982, 1983, 1987) depicts the woman’s body as healing and laboring. The woman is the principal health provider within the family unit; such expertise extends to the woman’s own care as she herself controls her own childbirth process, directing family members if and when assistance becomes necessary. The woman’s body is a mother’s body. Finerman (1982) documents how a married female is consistently referred to as “girl,” “unmarried,” or “child” in Saraguro, Ecuador, until her first successful delivery, despite her civil married status. As uniquely linked to Pachamama (Mother Earth), women’s bodies are imbued with fertility in a reproductive and productive sense: in the fields, women must plant the seeds as men till the soil ahead (Botero 1991). This relationship depicts the nature of the woman as complementary to that of man.

To wit, whether gender relations in the Andes are based primarily on a model reinforcing equality or equity is disputed in the literature. Most scholars of the region convey men and women as complementary to one another in division of labor and “natural”
composition and disposition, though increasing attention is being paid to how women’s status is an amalgam of Andean and Western concepts. Of the scholars whose works are reviewed in this article, Sarah Hamilton (1998) is the only one to strongly argue for “gender parallelism” in subsistence, reproduction, and political involvement.

It seems suspect, however, to suggest that one static mode of gender relations can describe such a vast region. I propose that such relationships are under constant negotiation in response and resistance to changes within the community and through national and global factors such as migration, ‘development’ projects, education, et cetera.

Yet, it seems the female body is considered to be more débil (weak) than the male body (Larme 1998; Oths 1999). Because women have an extra orifice, the vagina, through which illnesses can enter, and from which they can lose what are believed to be irreplaceable fluids each month, women become open to illness and debilidad (weakness). Childbirth further ‘opens’ the woman to ‘cold’ and wayras, the air- or wind-borne illnesses already described, and her internal organs may be displaced or damaged (Larme 1998; Platt 2001). Furthermore, women’s role in biological reproduction can create illness in others: sickening the fetus by viewing a corpse, passing ‘cold’ to the baby through her breast milk, causing illness through the odor of her menstrual blood and creating the opportunity for limbu wayra (associated with the rainbow, Cuiche) to affect others should they encounter her aborted fetus (Larme and Leatherman 2003; McKee 1984; Platt 2001). Women’s conceived propensity for negative emotions—worry, sadness—also contribute to their vulnerability, as disrupting the social harmony puts them at risk for recourse through spirit-derived illness to higher degrees as described above (Larme 1998). Linking the Andean view of the woman’s body to the social status of women, Larme and Thomas
Leatherman (2003) conclude that Andean knowledge about women’s bodies and the effects of childbearing play into and reinforce their subordinate position in present-day Andean society as these beliefs become a rationale to constrain women’s roles, reinforcing inequalities and hierarchies between men and women. Here, the conception of the woman’s biological body excludes her from certain areas of work and behavior based on medical rationale, thus creating and reinforcing gender inequalities in the larger social body.

**The Body *indígena* as body *Ecuatoriano* **

Shifting now to a specific region of the Andes, I focus on Andean bodies within the modern state of Ecuador to examine how the state has configured ‘indigenous’ bodies through history and in response to the indigenous rights movement. The power to define what it means to be indigenous and the ability either to dominate or to assert one’s autonomy as a member of an ethnic group has been at stake for centuries in Ecuador. In decrees, laws, and ordinances regarding indigenous peoples, the colonial and modern state have insisted that the only relevant means of identifying indigenous peoples was external to them, through labels based increasingly on external characteristics such as dress, shoes, housing, language, and genetics (Beck and Mijeski 2000; Miles and Leatherman 2003). This labeling by blanco-mestizos with power and land identified *indígena*s as a place at the bottom of social, political, and economic ladders—and relegated to supervision and subservience to those doing the labeling (Price 2003). With state modernization campaigns in the second half of the twentieth century, such labels further became markers of “backwardness” and served to categorize Andean bodies as targets of *blanqueamiento*, or elimination of all that was nonwhite (Whitten 2003).
Over the past thirty years the indigenous peoples of Ecuador have organized and mobilized to reshape their identities after centuries of domination. Seeking both inclusion in state services and governmental processes, and autonomy through decentralized rule, the indigenous rights movements claim national citizenship and an aspiration to maintain distinct identities (Korovkin 2001). CONAIE, founded in 1986, represents the collective desires of these movements—and has increasingly made them heard by the state. To CONAIE, being indigenous involves “an inherent sense of belonging to and identifying with a historically defined group” (Beck and Mijeski 2000:123). It is, then, a process of self-identification by Andeans as having Andean bodies and belonging to a large Andean social body. This sharply contrasts with the label of ‘indigenous’ that was forced on Andean bodies prior to the recent indigenous movement as a form of state control.

Due to the increasing visibility and strength of the indigenous rights activism and CONAIE, in 1998 the constitution of Ecuador described the state as “pluricultural y multiétnico.” This recognizes that indigenous peoples are products of a national experience that has been dramatically different from that of blancomestizo Ecuadorians. ‘Pluricultural y multiétnico’ is about difference: the different constructions of selfhood, the different experiences of life as well as alternative worldviews and cultural practices as highlighted in the labeling of former eras. In acknowledging the desire for greater indigenous participation in determining the future of Ecuador and the value of diversity within that nation, the changing of the Constitution provides for the creation of three indigenous institutions: Bilingual Education Service, Indigenous Development Service, and Indigenous Health Service. Yet, as of 2005, the Bilingual Education Service, a subdivision of the state education system providing instruction in both Kichwa and Spanish
to indigenous students, is the only branch of the state in which ‘indigenousness’ is incorporated in a formal way. Admittedly, the Indigenous Development Service has been working in some capacity with the state in land reform, with significant involvement by CONAIE, to limited success. Yet, the Indigenous Health Service (Dirección Nacional de Salud Indígena) fails to receive mention in the evaluative report on the Ecuadorian health system written by the Pan American Health Organization in 2001. In fact, only twice does the report mention “the indigenous population”: both times, indigenousness is connected to low literacy rates. Nor does the Indigenous Health Service appear on the Ministry of Health’s website, despite its having a detailed organizational chart listing its various groups and subgroups.

I return to an initial query of this article: How is the acknowledgement of (and commitment to) indigenous bodies as Ecuadorian, stated in the 1998 Constitution, portrayed in health care and policy? As demonstrated above, the indigenous rights movement operates at the policy level in education, development, and health to move state conceptions of indigenous bodies away from labels of ‘backwards’ and ‘targets’ for hegemonic incorporation and towards recognition of the multiplicity of bodies that comprise Ecuador. The creation of the Indigenous Health Service acknowledges indigenous bodies as distinct from blanco-mestizo bodies; yet, the Ecuadorian state has failed to develop health programming that works towards addressing the needs of these different types of bodies. Furthermore, in framing its indigenous population as illiterate in the PAHO report, the Ministry of Health chose to highlight the ‘indigenous’ body as a barrier to good health, rather than recognizing the distinct health programming requested by the indigenous rights movement and provided for in the 1998 Constitution. In practice, then, the Ecuadorian health system
represents a further attempt at blanqueamiento and remaking of Andean bodies—and ailments—in their own (blanco-mestizo) image.

**Taking health to the High Sierra**

At the Fourth World Conference on Women in Beijing in 1995, indigenous women utilized the vast forum of nongovernmental and international organizations present to demand that the world pay attention to their particular realities as it embarked upon the International Decade of Indigenous Peoples. In Ecuador, state conceptions of the ‘indigenous’ body circulate alongside Andeans’ notions of themselves and with international conceptions: the national indigenous rights movement parallels an international reproductive rights movement. Overwhelmingly, international NGOs and multilateral organizations—such as the International Planned Parenthood Federation (IPPF), *Centro Médico de Orientación y Planificación Familiar* (Medical Center for Education and Family Planning also known as CEMOPLAF), and the UNFPA—have supported both forms of activism in Ecuador.

Strategic alliances with NGOs—one operating in opposition to state services but now increasingly, due to economic austerity programs, in conjunction with the state—force certain models of democracy, health, and ‘development’ onto communities (Fisher 1997; Turshen 1999). Yet individual and social bodies may also gain from such acceptances. NGOs occupy a position between the local community and the state, while simultaneously extending beyond the state: these organizations are well-placed to play a role in the identity politics of indigenous organizations helping local actors confront national interests. Marcelo Cruz explores the modernizing role of NGOs, local indigenous organizations, and
the state in the context of agrarian reform and demographic change in the Colta region to conclude “the sense of ethnic identity is being renegotiated” at the community and national levels through NGO involvement in agriculture (1999:383). Julia Paley (2004) extends a similar argument as she shows how a certain type of Andean reciprocity is appropriated and promoted by NGOs within the push for participatory democracy in Cotacachi. Such cases document how NGOs, though well intentioned, may occupy the place of the state in Foucault’s (1980) explanation of the mechanisms through which the state impels individuals into certain types of conformity. He argues that institutions in turn alter the ways in which individuals conceive of themselves and their bodies, often reshaping them to serve state—or in this case, NGO—ends. It seems crucial, then, to elucidate the notion of the ‘indigenous’ body around which NGOs construct their programming.

As a basis for further exploration of this NGO–state entanglement, I seek to identify the type of ‘indigenous’ body to which reproductive health NGOs direct their programs. To do so, I analyze publicly accessible literature that promotes or evaluates NGO-sponsored reproductive health services, focusing on the way in which the ‘indigenous’ body is constructed through language and the assumptions of the articles’ arguments.

Three primary NGO-sponsored reproductive health programs supplement Ministry of Health services and private clinics in Ecuador.8 The largest of these, CEMOPLAF, operates 23 health clinics in 11 provinces in the country, seven of which are in the Andes region.9 These clinics offer family planning and prenatal and delivery care, community health care, STI/HIV prevention, and adolescent reproductive health education, as well as laboratories, pharmacies and community-based contraceptive distribution, and health outreach programs at subsidized costs commiserate with client
income. In three highland provinces, CEMOPLAF operates “integrated programs” in rural communities of Kichwa-speakers; these integrate health and agriculture to include food security, sustainable agriculture, and natural resource management programming with family planning and community health. Once funded largely by USAID, CEMOPLAF now counts on myriad international donors for support, including Family Planning International, the World Neighbors, and the Bill and Melinda Gates Foundation.

Turning to a story in the Sierra Club’s online newsletter, *Population Report* (Sierra Club 2004), that highlights the success of CEMOPLAF’s ‘integrated programs’ in the Andean region reveals how the program conceives of ‘indigenous’ bodies. The article introduces the remote locations, low literacy levels, and Kichwa language of the communities in which the program operates at the onset. A further description of the communities states that “social indicators are predictably lower than the national average in these rural zones,” adding poverty to the characteristics. After describing the combination of health and agricultural programs CEMOPLAF sponsors through a list of services and rationale based on an outcome of increased “contraceptive prevalence,” the article projects the following as the “key to success”:

The integrated approach should consider the human being as the principal factor of development… Relating the indigenous concept of the appropriate treatment of “mother earth” to women’s reproduction has been an effective way to link agricultural and reproductive health themes in training processes with participants. [Sierra Club 2004]
Here, a connection between the Andean woman’s body and Pachamama (Mother Earth), though acknowledged as ‘indigenous,’ becomes a tool through which to transmit health messages rooted in the Western biomedical system. Rather than represent an integration of Andean and Western (NGO) notions of the body and health, it instead advocates a Western body using Andean cosmology. Furthermore, it is interesting to note that the organization that presumably authored the article, The Sierra Club, urges on its website, “It is imperative that we understand the intrinsic connections between women’s health and the health of the environment” (2005). The Sierra Club undoubtedly refers to a connection between limited environmental resources and population control measures, a demographic approach. Yet the statement could also speak to a more fully realized conception of the Andean body as linked to the environmental and spiritual world, an indigenous perspective on the ‘indigenous’ that does not appear to be shared by CEMOPLAF.

The Ecuadorian International Planned Parenthood Federation (IPPF) affiliate, Asociación Pro-Bienestar de la Familia Ecuatoriana (Association for the Well-Being of the Ecuadorian Family, also known as APROFE), runs 22 clinics in major cities and in more remote areas of the Pacific coast. Clinic-based health services include contraception and sterilization, family planning counseling, laboratory services, and cytology. Additionally, APROFE administers extensive health education and training programs addressing family planning and STIs as well as sells contraceptives at subsidized prices through hundreds of distribution posts and private clinics. Yet despite these offerings, it is unclear to what extent these services are made available to Andean communities.
On the IPPF Country Profile page summarizing the work of APOFE in Ecuador, the mention of ‘indigenous’ bodies is nearly absent. Only in presenting a brief overview of Ecuador that concentrates on the economic do the authors acknowledge the existence of such bodies: “In the rural mountain and Amazon areas it is estimated that 76% of children live in poverty—which rises to 80% for indigenous children and adults” (2005). Again, “indigenous” bodies are defined primarily by where they are located and by the poverty in which they live. Additionally, the words “rises to 80%” demonstrate that being indigenous is regarded as a risk factor for further poverty.

Finally, the Jambi Huasi clinic in the highland town of Otavalo provides services drawn from both Western biomedical and local medical traditions. Their staff of fourteen includes two indigenous medical doctors, one of whom serves as a full-time health educator. Its clinic-based offerings incorporate prenatal and delivery care, a referral system for obstetric complications, primary health care, family planning, and an on-site laboratory and pharmacy that dispenses allopathic and herbal medicines. Jambi Huasi maintains an extensive outreach program, which travels to highland communities with medical and educational services, including, but not limited to, contraceptive distribution and promotion. Though the clinic claims to be sustainable through its own ‘cost-recovery measures,’ a large percentage of its initial funding came from United Nations Population Fund (UNFPA).

An array of materials documenting Jambi Huasi—a magazine article, a short documentary film, and two radio broadcasts all created through UNFPA, the clinic’s major donor—offer insight into the conception of the ‘indigenous’ body that underlies the clinic’s programming. Turning to the article, Don Hinrichsen first introduces an Andean woman, a typical patient chosen to embody
the clinic. Blanca is described as speaking in “accented Spanish” and, later, as “poor.” Hinrichsen continues to depict the rural highland community in which she lives as “bypassed by development.” Here, language (not Spanish), poverty, and geography (remote location inaccessible to modernity) are linked together and again tied to the Andean body. Reference to these three ‘indigenous’ attributes repeats considerably in the discussion of Jambi Huasi’s programs in the article, as well as in the film and radio broadcast. The language of the clinic’s clients, in all of the UNFPA promotional materials, is professed to be Quechua; however, Kichwa (Quichua) is the dialect of prevalence in and around Otavalo.\(^{12}\) Though many variant spellings and dialects exist, Jambi Huasi’s clients identify their native tongue as Kichwa (Quichua). Such a mistake in reporting conveys a tendency to essentialize the ‘indigenous’ body and negate the intracultural diversity found among them. In the film, the perceived cultural unity common to the ‘indigenous’ people of the highlands is further asserted as it commences with the description, “descendants of the Inka” accompanied by song performed with an Inkan flute. This not only connects ‘indigenous’ bodies through language and music, but also through ancestry and biology. Jambi Huasi also takes an integrated approach to health in Otavalo, combining two systems of medicine in its offerings. This clearly recognizes the ‘indigenous’ body as having unique health needs, as well as the distrust through which many Andeans view Western biomedicine. Nevertheless, though treatments based on the curative plants utilized in local medical practice are offered, the ideology of the Andean body does not seem to have permeated Jambi Huasi. Photos in the article and footage in the film reveal that health education efforts hinge upon biomedical models of human physiology. According to the clinic’s communication and education specialist, “[b]ecause we are not preaching fertility regulation and
the use of contraceptives alone, these traditional communities are much more receptive to our messages and services” (2005). While Jambi Huasi acknowledges the validity of local medical knowledge, the clinic’s integrated approach mainly incorporates Andean ideas of the ‘indigenous’ body as a means to appeal to potential clients and increase utilization of Western biomedical services.

In sum, an analysis of program information on reproductive health services available to Andean bodies illustrates that most often *indigenous* is defined by location in poor, rural, inaccessible areas. Language is often evoked, through discussion of low literacy rates and usage of Kichwa. These emphasize the otherness of the ‘indigenous’ body as not in the mainstream location of cities and towns nor in the mainstream demographic—and abjectly so. To a certain degree, these are the realities of some Andean bodies in poverty, in lived experience and demographic statistics. Nonetheless, there are other ways in which the ‘indigenous’ individual and social body are portrayed. The Pan American Health Organization (PAHO) portrays indigenous women’s bodies as triply disadvantaged due to their sex, ethnicity, and rural residency patterns that limit their access to resources. This admits to a vulnerability created though exploitation throughout history and in colonialism and continued through the structural inequalities of global economics and power hierarchies that impact Andean bodies. Recalling Andeans’ perceptions of their own bodies, as communicated through medical anthropologists in the second section of this article, vulnerability appears to be a theme shared with NGOs in identifying the ‘indigenous’ body. In the Andean perspective, however, the precarious position of the body is the result of an unstable natural and cosmological environment, and the volatility of the social body. NGOs seem to point to the instability of economic and political
environment in the permanence of this vulnerability, implicating the larger political context of state and world.

**Intersections of identity**

Because the calls for reproductive rights and for indigenous rights emerged nearly simultaneously on the international stage, reproductive health provides a way in which to explore how the Ecuadorian indigenous movement acts upon human bodies in pursuit of health in a changing state. The initial stage in understanding the interrelationship between these multi-sited movements involves clarifying how participating actors—Andean individuals, the Ecuadorian state, and NGOs—conceive of the ‘indigenous’ body. As traced through medical anthropology literature, state discourse, indigenous rights, and reproductive health programs, the ‘indigenous’ body holds a multiplicity of meanings. The question remains: How do these distinct views shape the possibilities of inclusion and health available to indigenous persons in the Andes?

The most recent anthology of work on health in the region, *Medical Pluralism in the Andes*, recognizes that, “It seems that Andean peoples are actually encountering more public health and medical practitioners, if only through the ubiquitous non-governmental and foreign health agencies. To what degree this will affect their medical notions is a topic that needs study” (Koss-Chioino et al. 2003:129). Increasingly, community-based Kichwa-speaking health promoters, midwives, and herbalists participate as outreach liaisons as the local part of the global NGO complex. Though substantial research has been conducted in the 1970s and 1980s, medical anthropology in this region falls short of connecting bodily indigenous struggles with those of the state, and world, vis-à-vis global NGOs.
Anthropological approaches that pay attention to what Paul Farmer and others have termed structural violence could be used to probe the articulation between Western biomedicine and local systems of medical knowledge and practice and how ‘developers’ synthesize these multiple worlds. In highland Ecuador, this happens within the context of a lucha (struggle) for indigenous incorporation into state identity, practice, and policy—that is, a lucha being developed internally and externally. Further examination calls for ethnography in Spanish and Kichwa in homes, community meetings, and health clinics, with NGO administration, local men, women, and indigenous rights movement leaders, and state officials.

In Ecuador, gender intersects with other forms of discrimination—including ethnicity and poverty—to deny women their rights as human beings. As women become increasingly incorporated into movements that assert their freedom from such discrimination, such activism provides a locus in which to examine negotiation and transformation of social (in)justices. Through the reproductive rights movement and indigenous rights movement, Andean women fight back at the body politic.

Endnotes

1 Admittedly, one scholar has initiated such an effort. Jason Pribilsky examines HIV/AIDS and tuberculosis with respect to masculinity, transnational migration, and childhood in the Ecuadorian highlands and New York City. See Pribilsky (2001, 2004).

2 This discussion is limited only in region to the Andes and includes Quechua and Kichwa-speaking groups—linguistically recognized as dialects of the same language—of the highlands of Bolivia, Peru, and Ecuador. Aymaran groups also count themselves as Andeans, though they will not be dealt with thoroughly here. Of course, combining all such peoples living along a 4,700 mile-long mountain chain into one amalgamate for exploration does pose specific problems, foremost among them the denial of intracultural diversity. Such essentialization is not the
desire of this paper; yet, given the limited information that offers insight into Andean conceptions of ‘body,’ discussion will proceed with this acknowledged caveat.

3 Humoral theory, with its emphasis and divisions of foods and phenomena into categories of ‘hot’ and ‘cold’ with one often used to counteract the other, has been described by George Foster (1994). Medical systems based on this theory have been documented globally, including in China, India, and Latin America; its origins are traced to Hippocrates and Greek medicine.

4 Again, it cannot be presumed that such conceptions of ‘body’ are maintained by Andean indigenous populations. The fieldwork from which these interpretations originate took place in the 1970s and 1980s. One notable exception is the work of Tristan Platt, which was conducted in the mid 1990s.

5 Reproduction is often the locus for anthropological and health investigations, perhaps due to the exclusion of other salient women’s health issues. As addressed by the Fourth World Conference on Women in Beijing in 1995, anthropologists and health practitioners are increasing turning to other concerns and capabilities of women to avoid essentializing women as reproducers.

6 A number of studies have been conducted regarding the use of ethnic labels amongst and between various groups within Ecuador by linguists and anthropologists. All reflect that ethnic identity and ethnic labels are subjective, situationally variable, and subject to social negotiation (Price 2003; Stark 1991). I adopt the term ‘indigenous’ throughout this paper because it has the most overlap in local, state, and international discourse.

7 Indigenous peoples of Ecuador include not only Kichwa-speaking Andeans but also 12 other indigenous nationalities. Nearly each of these has its own political organization that participates independently and under the auspices of the collective umbrella organization, CONAIE.

8 The reproductive health programs presented in this paper document all NGO-sponsored projects that were accessible to me from Ann Arbor, Michigan. I conducted two Internet searches (once in March and once in April 2005) through Google, and via the following websites: Médicos de Mundo, Family Planning International, International Planned Parenthood Federation, World Neighbors, Marie Stopes International, Alan Guttmacher Institute, American Jewish World Service, Save the
Children, UNFPA, UNIFEM, WHO, and PAHO. I also corresponded with Dr. Miguel Artola, Health Project Director for Peace Corps/Ecuador, and Teresa de Vargas, Director of CEMOPLAF, in March. This method of program survey does not claim to be comprehensive and is acknowledged to be more likely to come across organizations based in the United States.

9All information gathered regarding CEMOPLAF’s activities in Ecuador came from Family (2004) and correspondence with Teresa de Vargas, Director.

10 Material on APROFE was derived from International Planned Parenthood (n.d.).

11 Information regarding Jambi Huasi was obtained in Hinrichson (1999), Serrano (1999), and Kwitatkowski (2002).

12 The difference here between Kichwa and Quichua is one of orthography and not of phonetics.

References cited

Bastien, Joseph

Bastien, Joseph and John Donahue, eds.

Bebbington, Andrew

Beck, Scott and Kenneth Mijeski
Botero, Luis Fernando

Brown, Carole and Carolyn Sargent

Crandon-Malamud, Libbet

Cruz, Marcelo

Estrella, Eduardo

Sierra Club

Finerman, Ruth
1983 Experience and Expectation: Conflict and Change in Traditional Family Health Care among the Quichua of Saraguro. Social Science and Medicine 17(17):1291-1298.
Bringing Body to Bear in the Andes


Fisher, William

Foster, George

Foucault, Michel

Greenway, Christine

Hamilton, Sarah

Hinrichson, Don

International Planned Parenthood Federation

Korovkin, Tanya

Koss-Chioino, Joan, Thomas Leatherman and Christine Greenway, eds.

Kwitatowski, Laura

Larme, Ann

Larme, Ann and Thomas Leatherman

Leatherman, Thomas

Lock, Margaret and Patricia Kaufert

McKee, Lauris

Miles, Ann and Thomas Leatherman
Oths, Kathryn

Paley, Julia

Pan American Health Organization
2001 Profile of the Health Service System of Ecuador. Washington, DC: PAHO.

Platt, Tristan

Pribilsky, Jason

Price, Laurie

Scheper-Hughes, Nancy and Margaret Lock
 Michigan Discussions in Anthropology

Serrano, Alvaro, dir.

Stark, Louisa

Turshen, Meredith

Whitten, Norman, ed.