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Ethnicity and Health: Experience with an Urban Mapuche Health Program from the Perspective of Key Actors

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Abstract
This article explores the relationships and tensions between ethnicity and health, describing the perspectives of various social actors on a Mapuche clinic in the context of a national health program. A qualitative methodology was used to carry out this case study of the Mapuche clinic "La Ruka," located in an urban area of the Metropolitan Region of Chile. The study analyzes the narratives of traditional health practitioners (including a *machi*, *lawentuchefe*, *lonko*, and intercultural facilitator), consumers, conventional healthcare professionals, and local health authorities and community leaders who share a physical, political, and symbolic space around the Mapuche health experience. The systemization of experiences method was applied to the data, acquired through nonparticipant observation, individual interviews, and focus groups. The results suggest that this healthcare experience is highly valued by its protagonists. However, there is a tension surrounding cultural diversity programs that recognize non-Western approaches to healing, such as indigenous practices. This study examines the health-related, cultural, and political tensions involved in projecting indigenous traditions into a homogenizing space such as healthcare in a multicultural neoliberalism system.

Keywords Culturally competent care · Ethnicity and health · Cultural diversity · Ethnic groups · Health policy

Introduction: Health Programs for Indigenous Peoples

Chile is a multiethnic, multicultural, and multilingual nation. According to figures from the most recent census (INE, 2017), 12.8% of the population identifies as an indigenous or native ethnicity. Within this group. 79.8% report that they identify as Mapuche, the largest indigenous group in Chile. Various affirmative action initiatives have endeavored to address the economic, social, cultural, and political asymmetries between indigenous groups and the general population. Numerous studies indicate that this imbalance is very evident in healthcare [4, 10, 18, 20, 21, 25, 26]. Since the 1990s, several public policies have been developed in an attempt to bridge gaps and ensure equitable access to healthcare regardless of ethnic or cultural background. The concept of intercultural health emerged during this period, as an avenue to provide care to indigenous populations and as a public health strategy to reduce disparities between the indigenous and Western medical systems. This concept is based on mutual respect and equal recognition of the knowledge and practices of each system [16]. A series of programs has been designed to meet the social needs of indigenous populations following this framework and the recommendations of the Pan American Health Organization. The first initiative was the Mapuche Population Health Program (*Programa de Salud con Población Mapuche*, PROMAP), launched in 1992 partly in response to Convention 169 of the International Labour Organization (ILO). This program focused on improving the quality of care delivered to the Mapuche population at public health centers, including through the use of intercultural facilitators to mediate communication barriers between the centers and indigenous persons. The National Program for Health and Indigenous Peoples was implemented in 1996, initially in four sectors of the country, with the objective of delivering culturally relevant healthcare that would overcome the equity gaps affecting indigenous populations. Some authors [5, 23] have

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noted that while these first intercultural health programs served the laudable goal of resolving health problems by integrating different types of resources (biomedical treatments and indigenous traditions), they were not well-publicized and suffered from a lack of awareness. The Special Health Program for Indigenous Peoples (*Programa Especial de Salud para Pueblos Indígenas*, PESPI) was developed in 2008 as a component of the ORÍGENES health program in an attempt to establish an intercultural health system that would recognize that medical systems cannot resolve all health problems and that other therapies, such as indigenous remedies, have validity. This program, which has continued throughout various administrations to the present day, is founded on three main principles: first, equity, that is, bridging gaps in access to care attributable to indigenous ethnicity; second, an intercultural focus on the part of health professionals and staff; and, third, social participation by indigenous persons in formulating, executing, evaluating, and monitoring local plans for the program in each territory [17].

The program has been implemented mainly in traditional Mapuche territories but has also been extended to the territories of other indigenous populations, including the Aymara, Atacameño, and Rapa Nui. These programs have been described from both a public health and an anthropological standpoint by many authors [1–3, 5, 7, 8, 11–15, 22, 23, 27, 28], who have shown that the intercultural space developed by PESPI is complex, heterogenous, and fraught with multiple tensions. For example, there is tension regarding the degree to which the biomedical team validates the cultural knowledge of the indigenous healers, affecting the ability of the program to overcome the paradigmatic obstacle of assigning equal value to traditional indigenous and Western medical practices. There is also tension surrounding the complexity of interculturality in healthcare, which is a label that encompasses notions as diverse as (a) provision of healthcare to indigenous persons; (b) use of indigenous therapies in addition to or instead of conventional biomedical treatments; (c) provision of care in a physical facility that replicates indigenous spaces; (d) celebrating indigenous rituals and ceremonies; (e) signage in the indigenous language; and (f) support for the symbolic efficacy of the healing act to strengthen intercultural communication and overcome the barriers imposed by biomedical language.

The complexities and tensions surrounding the program are also reflected in its application in urban contexts, which differ significantly from the original or traditional spaces in which these groups have lived (especially the rural Mapuche territories). It should be noted that today, nearly 65% of indigenous Chileans, especially the Mapuche, live in urban areas, particularly the Metropolitan Region, the most densely populated area in the nation. Currently, all healthcare services in the Metropolitan Region include some component of intercultural healthcare, especially services located in areas with a larger indigenous population. Few studies have explored this new reality, other than the graduate thesis work of several students [6, 29, 30] and a report generated by the health system [19]. Therefore, this study contributes to the scientific literature by providing background information about experiences in intercultural health in the modern health system of an economically leading country in the region. For that reason, it is vital to address the reality of the indigenous population in the urban context in a way that considers the perspectives and perceptions of the key social actors involved.

This article presents the results of a systemization of experiences with the intercultural healthcare provided at the Mapuche health center "La Ruka,"[1] a clinic overseen by the Chilean Health System and located in an urban area of the Metropolitan Region. The voices of the social actors who participate in this intercultural space (traditional Mapuche practitioners, consumers, primary care providers, and local and central public policy-makers) characterize the tensions that come into play when the indigenous ethnic and cultural dimension is introduced into a homogenizing space such as healthcare, as well as insights into how these tensions are resolved or may be addressed in the future.

Methods

This case study was performed using the systemization of experiences method to explore and analyze local knowledge and processes through a critical understanding of the factors that have made the experience possible [14]. The steps for the development of data collection were designed together with the Mapuche community. First the objectives were agreed; then the researchers proposed the techniques to Mapuche community, and the decisions about the participants and deadlines were taken together. In this way, this is a work directed from the beginning by its main actors, a central feature of a systematization [14].

The data were collected using a qualitative methodology, primarily nonparticipant observation in clinic waiting rooms, ethnographic interviews with persons who have received care at the Mapuche health center "La Ruka," semi-structured interviews with traditional Mapuche healers and local authorities, and focus groups with members of the primary care team. A total of 40 social actors associated with La Ruka participated in the study, including 19 consumers, 4 traditional Mapuche practitioners, 12 members of the healthcare team, and 4 actors associated with local public policy on intercultural health.

[1] Ruka: Mapuche name for the traditional type of house in this indigenous culture. This structure is also used for preparing medicinal herbs and as a gathering place.

The interviews focused on experiences with Mapuche healthcare, the value of this service, and practices of interculturality in healthcare. The fieldwork was documented using field notes, and interviews were recorded. A total of 19 interviews with consumers, 3 focus groups with primary care staff, and 3 interviews with traditional Mapuche practitioners were conducted, including (a) a *machi*, who provides diagnostic and therapeutic services and prescribes medicinal herbs; (b) a *lawentuchefe*, who prepares and distributes the medicinal herbs (the *lawen*); and 3) an intercultural facilitator, who provides an orientation to Mapuche health practices and the services available, registers patients, and fills out the admission form.

The individual and group interviews, as well as the fieldwork notes, were transcribed and coded using a framework matrix with initial pre-established categories according to the program's dimensions (interculturality, participation, and social recognition of the indigenous people). The team of facilitators analyzed each interview by the following workday, investigating emerging topics relevant to the project. An interpretive analysis was performed to elucidate the experiences of key actors in this intercultural practice with a focus on concepts of health and ethnicity. The preliminary results for each actor were established and then discussed with the Mapuche community responsible for the program. In this way, the experience was completed from the different points of view. This community then worked with the research team to define the format to disseminate the findings of the study.

Ethical considerations: Participation in this study was voluntary. All participants provided oral informed consent. Participants are only identified by age and gender to protect their anonymity. The results of this study were shared and discussed with the Mapuche community responsible for the program, who authorized this publication.

Results

The Mapuche health center La Ruka is an initiative propelled by members of the group Kallfulikan (from the Mapudungun words *kalfu* (blue) and *likan* (mystical stone with spiritual powers). This group, made up of Mapuche individuals and families in the Metropolitan Region, conducts educational activities in the community with the goal of reviving and maintaining Mapuche culture in the city, as part of the territory that belongs to the Mapuche people. Since the year 2000, the group has also participated in health-related activities under the PESPI framework. In 2002, after conversations with the municipal government, the group acquired a working space adjacent to a primary care center. In 2006, the Ministry of Health authorized development of La Ruka as a Mapuche healthcare center, representing an inclusive model of healthcare. The program operates as follows: (a) services to the public are available 2 days per week; (b) care is offered to any consumer who requests services, regardless of indigenous or nonindigenous ethnicity, health insurance status, residency, or nationality; (c) the clinic provides the services of traditional Mapuche practitioners including a *machi*, *lawentuchefe*, and *dungumachife* (who translates the elocutions of the machi in Mapudungun during the trance as part of the traditional treatment), as well as an intercultural facilitator.

Below we present a vision of how social actors associated with La Ruka incorporate interculturality in health into their dialogue between traditional indigenous medicine and the conventional biomedical model that predominates in the national healthcare system.

Perspectives from Consumers

Applying the criteria of structural representativeness, a sample was enrolled that reflected the general consumer population at the clinic, according to the following sociodemographic characteristics: (a) 15 women and 4 men; (b) self-identified Mapuche ethnicity; (c) ages 39 to 84 years, with the largest proportion of participants aged 60 years or older.

These individuals evaluated access to Mapuche treatments as an alternative health service and assessed the results of this care in terms of resolution of various health problems, pains, and illnesses, according to their personal experiences. The consumers were referred to the center mainly by "word of mouth" from family members, neighbors, and other acquaintances who recommended the clinic based on their own experience with the machi.

Consumers reported that the health services provided included a visit with the machi, who analyzed a vial of the consumer's urine and other elements as needed. Then the consumer received an herbal infusion prescribed by the machi. Consumers brought in their own plastic bottles each week to be refilled. This experience was evaluated positively by those interviewed (often in contrast to their impressions of the biomedical model of health and illness), highlighting aspects such as the benefits of natural medicine based on herbal remedies. The use of herbs was highly valued as they are seen as "natural" and therefore healthier and less likely to cause side effects as compared to allopathic medications. As one consumer noted, "…pills help one thing and hurt another…" (female, 67 years of age). It is not altogether surprising that consumers associate the Mapuche model of health and illness with ideas in general society regarding alternative, natural, or homeopathic medicine.

While the majority of consumers reported that they did not completely understand the Mapuche cosmovision, they respected the knowledge of the practitioners. Consumers also appreciated that the treatment did not require taking a separate infusion for each ailment; the herbal infusion was prepared using secret and diverse techniques to act on all complaints

simultaneously. Consumers also valued the machi as an agent of wisdom and healing; as one woman stated, "the (machi) sees your life" (female, 60 years of age). Therefore, the care provided by the machi was revelatory, involving a discovery and exploration of aspects of the consumer's life that (s)he may have considered irrelevant to the illness. This approach recognizes the integral nature of a person, allowing the healthcare process to become a space for learning about and understanding facets of life beyond the biological and individual, extending to the community, spiritual, and ancestral levels. One consumer reported going to La Ruka to connect with Mapuche traditions, noting "…it lets me get in touch with my roots" (female, 39 years old). In this sense, La Ruka is not just a health clinic but also a space for the release, recovery, and resistance of the Mapuche culture, where the rites and traditions of the *wallmapu* (traditional Mapuche territory) can be enacted.

Consumers also valued the inclusive character of the Mapuche healthcare model at La Ruka. Specifically, Mapuche medicine is available in addition to conventional treatments; care is provided free of charge; the waiting time to receive care is minimal; there are no age or residency requirements; and there is no need to spend money on tests or medications.

Finally, the experience of consumers provides a vision of how La Ruka operates within the context of the national healthcare system. One drawback noted is that there is insufficient communication about this service by the health system, even in the neighborhoods in which La Ruka is located. Furthermore, there is a clear distinction between one model and the other, achieving access to Mapuche health services but failing to accomplish truly intercultural care. In fact, only one person interviewed identified intercultural health as the meeting of two cultures or two health systems:

> Well, it's not really intercultural health; the two are not really united. They would have to work together, and more communication is needed before this happens. People would have to stop seeing Mapuche medicine as something esoteric. Schools should teach the Mapudungun language so that children grow up with this knowledge. (female, 38 years old)

The other interviewees viewed intercultural health as synonymous with Mapuche health, materialized in La Ruka, "this is intercultural health" (female, 39 years old), or as an alternative health system with different means and ends.

Perspectives from Traditional Practitioners

La Ruka employs a healthcare team including the following traditional Mapuche practitioners: a machi, a lawentuchefe who officiates the dungumachife (translating the speech of the machi during the trance), and two intercultural facilitators. Each of these team members play defined roles assigned both according to tradition and as a function of the program structure.

The intercultural facilitator provides an orientation to the space and access to services and registers patients. In his/her role as mediator between the two types of health systems, the facilitator must understand Mapuche culture. The machi is responsible for diagnosing the illness of the consumer. This task involves analyzing the urine, the numerology, and the hands of the consumer. This traditional practitioner is born with a special ability or gift from his/her ancestors. The machi must also nourish his/her connection to nature. Becoming a machi and imparting one's wisdom to the community is a moral imperative within the Mapuche cosmovision. Finally, the role of the lawentuchefe is to prepare the herbal infusions for treating the illnesses identified by the machi. The pathway to becoming a lawentuchefe is similar to that of the machi, as it is seen as a gift from one's ancestors ("it's hereditary"). In the case of the lawentuchefe at La Ruka, her grandmother was a machi, and her mother gathered herbs.

The Mapuche health practice occurs in two locations. The meeting with the machi takes place in the open air, facing toward the west, in front of a *rehue* (sacred ceremonial totem), in an interactional model that is distinct from the biomedical vision. In this view, there is a proxemic dimension to medicine in which the use of space is significant for the relationship between the machi and patient as well as the results of the treatment.

Herbs are gathered in the context of the *wallmapu*. In the city, the herbs are largely transported from the southern region of the country (where there are Mapuche communities), generally by commercial providers or family members. These herbs are complemented by others that are obtained locally from a garden (such as boldo or rosemary) near La Ruka. The preparation of infusions involves not only the medicinal plants but also the spiritual aspect of the process, which includes chanting prayers in Mapudungun and carrying out the preparation in a designated place within the structure. The preparation and use of herbs have been one of the elements of Mapuche healthcare that has encountered the most resistance from the biomedical or scientific cosmovision, as the process is performed inside La Ruka (Fig. 1).

The practices of these healers are the expression of a qualitatively different mode of approaching health and illness. The machi is not homologous to the figure of a physician or other health professional, as the Mapuche view health and illness through an ecological and social prism that transcends the physical, biological, and individual (and includes one's ancestors). Moreover, the practice is not standardized, and there are no protocols for treating specific complaints as in the biomedical model. Instead, the medicinal practices vary according to the experience of each machi, according to a central aspect of Mapuche culture: territoriality. As stated by the machi:

Fig. 1. Photograph of the exterior of the "Ruka"

> We are each very different, as persons, as human beings, for many reasons… you have to look at our origins, you have to look at our predecessors, our beliefs, our lifestyles, our… the sector, the place in which we were born; all of these factors have to do with the way that we are. The kind of life that we have.

In addition, the traditional practitioners note that there is a close relationship between their practices and central aspects of the Mapuche cosmovision such as language, understanding that their practices require an agency that stems from fluency of the Mapudungun tongue. The machi stated that "the language is fundamental, because to connect with the space (…) with our ancestors, with the natural environment, nature (…) without the Mapuche language there is no machi." In this practice, the central connection is with the spirits of the ancestors, and there is no way to communicate with these spirits without speaking in Mapudungun. The machi serves as an agent, emerging as more of a mediator of knowledge than as the figure of a specialist who possesses knowledge as an individual: "…because fundamentally, it is the spirits that are saying what the patient has, through you (…) It is they that are speaking for you" (machi). This perspective reflects a totally different conception than the rationalist style of specialist education in the biomedical model.

The lawentuchefe shares a similar cultural model, understanding that the work of preparing the herbs must also be mediated by acts in the Mapudungun language. This mediation through language, impregnated with a vision of nature that acts as a living agent to provide the plants, is projected to the very act of collecting the supplies for the work. As explained by the interviewee, "When you go and look for herbs, and you can't just go in and grab things (…) you have to ask for permission… because you can get sick… because you don't know… so you always have to ask a person who speaks Mapudungun to do it" (lawentuchefe).

The narratives of the traditional practitioners illustrate the constant tensions provoked by the presence of indigenous practices in the context of a biomedical health system, represented in this case by the adjacent primary care center. Therefore, while there is a perception that the creation of La Ruka represents an advance, the experience falls short of achieving interculturality, as noted by one interviewee:

> ...it still doesn't exist… it is a concept imposed, let's say, on indigenous populations, but that in this case benefits the State since they can implement it as public policy. Interculturality means that there are conditions of equality... there is no dialogue between the specialists, the conventional medical team, and the Mapuche medical practitioners. (lonko in the community)

This perception was confirmed by each of the Mapuche health practitioners interviewed, who stated that, functionally, the center had not achieved interculturality. That is, in theory, there is the capacity to coordinate between the two systems, but operationally, there is no recognition of this possibility, and there is an asymmetry in which the Mapuche practices are seen as questionable.

The absence of a real interculturality translates into constant clashes and tensions between the conceptions and approaches to health and illness in the two systems. As noted by the lawentuchefe:

> ...The Ministry of Health, when they question us… and when they say, 'Do you have a sink? You have to have a sink because it's part of the health code.' We told them that the health code is yours, not mine; I'm not doing conventional medicine, my model and my system have their own world. And I am not in your space, this is my space. (lawentuchefe)

Perspectives from Healthcare Professionals

Three focus groups were conducted with a total of 13 primary care staff from the primary care center adjacent to La Ruka (10

women and 3 men). The participants were health professionals, paramedical staff, and administrative staff.

The consensus impression of the health team was that La Ruka is nationally recognized as a success and that they identify and differentiate the clinic as an intercultural health initiative under the umbrella of the Metropolitan Region Primary Health System.

The staff recognized that when consumers seek alternative or natural remedies to treat their illnesses or pathologies, it is often because of overuse of medication on the part of the biomedical model. It is this characterization as "natural" or "alternative" that provides legitimacy for the Mapuche model.

The healthcare providers reported that they perceive interculturality as the integration of different visions of health and illness that includes both the immigrant and indigenous populations, according to a symmetric and horizontal logic; that is, "…it has to do with how to finally talk about all of these visions" (female, health professional). This challenge is relevant to the harmonious efforts of La Ruka and the primary care center, reflected in the fact that most La Ruka patients also receive services at the conventional clinic. There is an understanding that receiving treatment from the machi does not imply abandoning care from the other health professionals at the clinic.

The experience of working in the same location has allowed the primary care team to develop a greater understanding of the Mapuche cosmovision and health practices. This awareness is significant, given that for most of the staff, Mapuche medicine, especially the use of traditional healers, is part of Chilean history rather than a current practice, above all in an urban area. "…if I weren't at La Ruka, I wouldn't even know what Mapuche medicine was, what a lonko is, or a machi; for me it would be like something out of a history book about a time when there were machis, and nothing more" (female, paramedical staff).

Mapuche communities in the area have undertaken the work of transmitting knowledge about Mapuche medicine, according to health professionals and technical staff who attended courses provided by these groups. However, these courses are not currently available. Moreover, the scope of the classes was limited to an information about Mapuche medicine rather than a broader understanding of intercultural medicine. Finally, the health staff report that there has been limited emphasis on an interculturality that would include other cultures such as those of migrant populations that come into contact with the clinic.

While most of the healthcare staff accept the idea of Mapuche medicine and the need for an intercultural paradigm in the biomedical setting, the accounts of those interviewed reflect the tensions involved in accepting these practices, especially in symmetry with biomedical approaches. For example, several professionals mentioned that the primary care setting was the most appropriate location for Mapuche medicine as the cases tend to be less complex and therefore are at a lower risk of adverse effects from the traditional treatments, noting that there is little evidence of the clinical efficacy of many Mapuche practices.

In terms of evidence, the various staff interviewed held different opinions. Some of the interviewees felt that any benefits from the Mapuche medical treatments were largely placebo effects, lacking the validity of biomedical treatments. Others stated that Mapuche health practices are supported by some evidence regarding phytopharmaceutical effects of herbs. Furthermore, these staff appreciate the broader Mapuche vision that includes social determinants of health, allowing for a psychosocial and contextual analysis rather than an exclusive focus on the biological aspects of health. The interviewees observed that the mental health system produces many of the referrals to the traditional clinic.

In addition, the healthcare team values the collaboration of the traditional Mapuche practitioners with encouraging patients to participate in health promotion and prevention campaigns, health fairs, and vaccination drives, increasing coverage and compliance with these initiatives among the Mapuche population that visits the health center. These spaces are typically the only point of contact between the health professionals and traditional Mapuche practitioners. Some of the professionals noted that one way to improve interaction and consolidate the unity of the healthcare team might be to include these Mapuche practitioners in the facility's periodical technical meetings.

Furthermore, the professionals recognize that there is a lack of awareness regarding this public policy among the general medical population. Most had not heard of the program funded by the Ministry of Health until joining the primary care center, and the topic is not covered during the education process for physicians or medical staff.

In conclusion, the medical staff value the presence of the Mapuche clinic but question its scientific validity. The staff also recognize that they lack sufficient awareness of Mapuche culture, cosmovision, concept of health, and the public policy behind this experience. Finally, the staff recognize the lack of interculturality in the care provided. As one participant noted metaphorically, "…we share a land (…) but it's like the Bio Bio River is separating us because of the prejudices that exist" (male, health professional). There is no meeting point that joins the work of the primary care center and La Ruka.

Perspectives from Key Actors in Local and Central Public Policy

Four in-depth interviews were conducted with actors involved in implementing the public policy behind this experience. The actors interviewed were three employees of the Chilean government and one political leader from the Mapuche group Kallfulikan, including three males and one female.

The interviewees agreed that La Ruka occupies a strategic location within the health system and the neighborhood. Those interviewed stated that they had each made efforts to maintain and strengthen the various elements of La Ruka that would make their shared vision of intercultural health a reality. Such efforts included spreading awareness regarding intercultural health strategies and taking into account the opinions and suggestions of others who participate in providing healthcare or allocating various types of resources, including indigenous and nonindigenous individuals. The Mapuche organization also noted that the group felt validated by their inclusion in the health system and by the willingness of the staff to work with them, as reflected in one interviewee's statement: "All of the agreements, all of the work that we do, is contracted through the highest authority, through the municipality (…) and the highest health authority in the region" (male, community leader).

In general, the experience of La Ruka reflects advances in recognition of health as a space in which individuals can exercise their rights and engage in intercultural dialogue. There was consensus among those interviewed that persons of other cultures (in this case Mapuche and Chilean or "huinca") are human beings who should be allowed to exercise their rights and that diversity should be valued as an important resource. Therefore, the two groups seek to coexist respectfully and share physical, political, and healthcare spaces as a way to improve social harmony in general. For example, one of the actors associated with local policy noted that intercultural health refers to "the ancestral health knowledge of our original populations and how it relates to Chilean society. The Mapuche society, the people we know here in Santiago, the ones participating in intercultural health, can speak like a *huinca* practitioner" male, municipal authority).

From a healthcare standpoint, interculturality benefits consumers through complementarity:

> The patient stands to gain by having both sides, not with the idea of saying "mine is much better than yours," but to look for complementarity, putting to the side the more folkloric aspects of it. (male, health authority)

However, the indigenous view of the reality of intercultural health is more critical, consistent with the narratives from the traditional health practitioners as well as most of the conventional primary care team. As noted by the Mapuche community leader:

> ...at least for us, we do not consider this to be intercultural health. We work in Mapuche health. The idea of intercultural health is that both cultures, the conventional and the Mapuche, can complement each other, discuss cases with each other, establish a power structure to share experiences, share the work, and, most importantly, work towards the common cause of healing people, improving their quality of life. If we can achieve that then we can talk about having intercultural health. (male, Mapuche community leader)

While there are various tensions surrounding interculturality in health and its practical application, none of the actors interviewed disputed its relevance in the health system or the necessity of gradually extending the role of Mapuche medicine in particular or indigenous health in general.

Despite the apparently common goal of interculturality, it must be acknowledged that there is a certain degree of ambiguity on the part of the government in terms of listening to the demands and realities of indigenous populations regarding healthcare. As noted by one interviewee:

> The major issue is that there is an incorrect interpretation (…) of the indigenous culture by the health authorities. Because the State looks at it in economic terms, and conventional medicine, in this case public health, also looks at it from an economic standpoint (…) from that point of view (…) they do not want to talk about the issue and prefer not to recognize indigenous treatments that they don't regulate, so they use it as an excuse, 'we can't regulate it, they are indigenous populations, and we aren't going to get involved. (male, Mapuche community leader)

With the above in mind, it is important to note that without being recognized, Mapuche health cannot enter into an intercultural encounter with biomedical health. This recognition is not simply having a physical space to provide care but rather a series of conditions that would allow the actions undertaken by the practitioners to generate a greater impact. In the words of one interviewee:

> It's hard to talk about intercultural health when we don't have our land, we don't have clean water, we don't have suitable places to go to find the remedies without having to get permission from CONAF (National Forest Corporation, Corporación Nacional Forestal) or the landowners. (female, local authority)

The authorities interviewed, therefore, expressed interest in pursuing intercultural health initiatives in conjunction with the international accords and norms that define standards for such actions. As noted by one interviewee:

> So, we need to have a policy, and that is what we are trying to do in the area of healthcare, with all of the advances that we have made ... a local intercultural healthcare policy. (male, health authority)

However, according to the Mapuche cosmovision, recognition must go beyond a healthcare policy and include recognition of the Mapuche culture as a whole, as noted by one interviewee:

> If you ask me what's missing here, it's recognition from the State that we have a plurinational nation, not pluricultural but plurinational; there were nations before this one here, including the Mapuche nation. Yes, there are treaties in place, but they aren't recognized and they have been violated by the State. (female, local authority)

Conclusion

The plurality of social actors involved in this experience support the creation of a space for interculturality in health and its associated discourses and practices. This experience has pulled back the curtain on the advances and setbacks associated with restoring and re-elevating indigenous practices within a highly classist and racist society such as the Chilean culture.

From the viewpoints of the actors associated with the group Kallfulikan (leaders and healthcare practitioners), (a) it is crucial to restore Mapuche self-determination and autonomy in order to foster dialogue and agreements with the health authorities to advance this Mapuche health project; (b) the health program can be an avenue to revitalize the Mapuche language and culture in the city; (c) official recognition through the Special Health Program for Indigenous Peoples (*Programa Especial de Salud para Pueblos Indígenas*, PESPI) has been helpful in supporting access to Mapuche healthcare; however, it has not allowed for the establishment of a truly intercultural health program. These conclusions are in agreement with other studies in identifying the strengthening of identity and recovery of cultural practices [7, 29, 30], and not as an intercultural experience. On the contrary, there is evidence of an encounter in administrative aspects over the understanding of health or practices. (d) The demand for Mapuche medicine in the city is associated with the need for territory, access to herbal medicines, spiritual connection, and the ancestral wisdom that allows the machi and lawentuchefe to apply their knowledge; and (e) the relative ease of access to this indigenous health experience is greatly appreciated, as this care is provided regardless of residency, ethnic origin, or health insurance status.

Consumers of this experience emphasized that (a) Mapuche health is a natural, accessible, and effective option; and (b) while consumers value the knowledge of the machi, they have limited understanding of Mapuche traditions or cosmovision of health. This is consistent with a study by Ochoa et al. [16] which reports that even indigenous users, although they value Mapuche health practices, do not have detailed knowledge of them.

The narratives of actors in primary care team, public policy, and indigenous issues suggest that (a) the Mapuche health experience developed by the Kallfulikan community has allowed health professionals to develop some understanding of the Mapuche cosmovision; (b) despite this increased awareness, the biomedical team does not value the Mapuche culture in general or the Mapuche cosmovision of health as highly as they value "huinca" system; this has been reported in previous studies [6, 19, 29]. Instead of interculturality, there is an import of cultural practices to biomedical administrative logic, without considering both medicines as valid. (c) There are heterogenous opinions on the efficacy of Mapuche health; some interviewees believe that the two systems cannot be compared as they represent two completely distinct paradigms, and therefore, the efficacy of indigenous practices cannot be measured in the same way that Western care is evaluated, while others feel that Mapuche treatments should be subjected to scientific testing as part of an evidence-based medical model; (d) perceptions of the concept of "intercultural health" are also heterogenous; some interviewees see indigenous practices and culture as "different" and feel that these practitioners only have the right to occupy the spaces within the dominant society to which they are assigned, while others understand the concept as a network of relationships in which different cultures are influenced by one another, under a framework of mutual respect and esteem.

Finally, the experience of Mapuche healthcare at La Ruka represents, in political terms, an initiative that supports the goal of interculturality. However, the practices and narratives of the actors involved in its implementation indicate that La Ruka represents an experience of Mapuche health that coexists in time and space with a conventional primary care clinic but that the traditional practices are not conferred the same value as the biomedical treatments. This is associated with the public politics that recognize the Mapuche culture; however, this recognition is partial. For a long time and even at present, the Chilean goverment has harshly penalized Mapuche actions that favored principles of autonomy, self-governance, and territorial control [24]. Thus, the indigenous politics in Chile and Latin America has applied the hegemonic logic of a neoliberal state that rather seeks to homogenize the conception of citizenship and development, disguising as interculturality the coaptation and bureaucratization of cultural practices, what some authors have called "multicultural neoliberalism" [7, 24], in the words of Hale [9] "proponents of neoliberal multiculturalism are most apt to embrace the rights of 'recognition', categorically denied or suppressed because notions of citizenship, nation-building and societal development were predicated on the image of a culturally homogenous political subject" (p. 490).

The richness of this study stems from the integration of the perspectives presented, allowing for triangulation of the various viewpoints and a better understanding of the complexity of this case. Limitations of the study include the impossibility of transferring this experience to other contexts, given that the opinions shared are based on this specific and concrete experience. While these insights may be relevant to other experiences in the urban context, within a substantive theory of interculturality in health, these accounts do not represent the experiences of other Mapuche communities who maintain their traditional health practices, with or without state sponsorship. Therefore, the scope of this investigation is limited to an analysis of the narratives of various key actors in order to elucidate issues of interculturality and the experience of implementing an indigenous health policy in an urban context, evidencing aspects common to the Latin American context on how from public policy indigenous development is unknown and hindered, although its purpose indicates the opposite. Future studies could contrast health practices in urban and rural contexts, as well as those that are implemented outside the hegemonic public health policy, identifying the strengths and barriers to this practice from the Mapuche social claim.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict(s) of interest.

Ethical Approval This study was developed in the context of a systematization of experience. All procedures performed were governed under the ethical principles of participatory action research; participants were volunteers. The Mapuche community was part of the analysis team and approved the publication of this material.

Statement of Informed Consent Informed consent was obtained verbally from all individual participants included in the study.

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