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Living Well and Health Practices among Aymara People in Northern Chile

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The current Chilean health model seeks to promote health equity among indigenous peoples by means of state intercultural health programs. As implemented regionally, these have been widely criticized as depoliticizing mechanisms meant to dominate the indigenous population. Study of the experiences of several indigenous health agents and associations fostered by these programs reveals that the strategic use of the concept of living well by indigenous peoples raises questions about the issues that are to be included in or excluded from the intercultural medical field.

El actual modelo de salud chileno busca promover el acceso equitativo a la salud entre los pueblos indígenas a través de programas estatales de salud intercultural. Tal y como se aplican a nivel regional, estos han sido ampliamente criticados como mecanismos de despolitización diseñados para dominar a la población indígena. El estudio de las experiencias de varios agentes y asociaciones de salud indígenas impulsados por estos programas revela que el uso estratégico del concepto del buen vivir por parte de los pueblos indígenas plantea interrogantes sobre qué asuntos deben o no incluirse en el campo médico intercultural.

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The enormous importance of indigenous knowledge in the construction of the concept of living well[1] has been highlighted by Gudynas (2011) and others. This notion has gone beyond a culturalist or romantic vision of the relationship between indigenous communities and their territories and taken root in both South American academic and political discourse and the language of some sectors of indigenous communities. On the one hand, the emergence of the term has been addressed from a postcolonial perspective focused on the "coloniality of power" and "of being" in the naturalization of indigenous subalternity (Quijano, 1991). On the other, the term has found wide acceptance in what anthropologists term the "ontological turn" of the discipline (analyzed in González-Abrisketa and Carro-Ripalda, 2016), in which the debate around living well implies questioning not only the "political semantics of living well"

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but the "very nature of the reality in which one is supposed to live well" (Burman, 2017: 155). Rather than take sides, I would like to welcome an exploration of living well without linking original cultures to a unique ideological and ahistorical view that is merely relational and essentially opposed to paradigms such as modernity. Some studies have highlighted the importance of understanding indigenous communities as actors capable of appropriating the language of neoliberal multiculturalism and playing with it by reversing its effects (Albró, 2010; Freddi, 2018; Pitarch and Orobitg, 2012). Here I would like to explore the implications of the concept of living well for indigenous actors' health practices. I will focus on the emergence of the concept in debates regarding the implementation of the Programa Especial para el Salud y Pueblos Indígenas (Special Program for Health and Indigenous Peoples—PESPI) in the northernmost part of Chile. PESPI aims to address the inequalities in health indices for indigenous versus nonindigenous people, following agreements made between mainly Mapuche and Aymara associations and the Chilean state after the end of the dictatorship in 1989.

Aware of the importance of recognizing indigenous knowledge as historical production, I consider it significant to examine the emergence of this type of concept in a context in which it is not yet part of official language of the state, as is the case in Chile. Tracing the emerging use of "living well" in Chile responds to Jacques Galinier's (2009) invitation to address the "internal exegesis" of fieldwork—the comments, jokes, and perceptions, often far removed from academic interpretations, that are spontaneously shared by our interlocutors with regard to unforeseen events that constitute local "obsessions" and interests. "Living well" emerged spontaneously in conversations with indigenous actors when addressing topics as varied as work opportunities in the PESPI program, the organization of indigenous associations in northern Chile, and generic discussions regarding the problems that affect the Aymara.

I carried out my doctoral research among the Aymara between 2009 and 2013, focusing on the cities of Arica and Iquique and the rural provinces of Putre and Parinacota. These territories, under Peruvian and Bolivian sovereignty until 1879, house an important part of the Aymara population, which according to the 2017 census amounts to 7.2 percent of Chile's indigenous population. The territory's multiculturalism is part of a tradition of ethnic exchanges dating to the precolonial period. My research involved 125 people of Aymara origin identified (or self-identified) as such via indigenous surnames, territory, or indirect kinship. The methodology was predominantly qualitative with an ethnographic approach and involved extended periods of coexistence (from three to seven months). Interviewees were between 18 and 70 years old and played a variety of roles in the intercultural medical field: users, health agents, indigenous leaders, relatives of users, and local authorities. I also interviewed officials, teams administering primary and secondary care, and national authorities on intercultural health issues.

For purposes of this paper, I will focus on material collected from interviews and ethnographies involving two indigenous associations: Suma Qamaña Taki of the city of Arica and the Pachan Kutt'aniña of the General Lagos Commune. Both participated in the PESPI program and had been formed in accordance with the requirements established by a 1993 law regarding indigenous associations. They welcomed Aymara leaders and people interested in promoting

health and traditional Aymara medicine (following the processes of revaluation and recognition addressed by the state's intercultural health policy (MINSAL, 2003). Suma Qamaña Taki's members are of Aymara origin and originally came together because of the prevalence of tuberculosis in the indigenous population in the late 1990s. Pachan Kutt'aniña focuses on traditional medical agents (*yatires*, *quillires*, and *usuyires*[2]) from the rural areas of Putre and Parinacota. The creation of both associations was closely linked to the PESPI program requirements, which enable interested parties to implement actions and transfer funds from the state to legally recognized entities.

Given that health and illness are components of the power systems through which subjects move (Gavilán et al., 2017: 480; Seppilli, 2005), I had to locate the Aymara's health experience within the policies developed especially for them by the Chilean state. This meant placing the research within what, following Bourdieu's (1976) concept of "field," I will call the intercultural medical field (Boccara, 2007). This space was created in the 1990s in response to demands made by indigenous peoples themselves to participate in the postdictatorial democratic project (Alarcón, Vidal, and Neira, 2003). The main goal was to address the evident health inequalities suffered by indigenous peoples vis-à-vis the nonindigenous population,[3] and the model employed included their participation in the construction, implementation, control, and evaluation of the process (MINSAL, 2003).

In other regions PESPI, which was established in Arica in 1997, has been characterized by the presence of intercultural facilitators in hospitals and primary care centers, the creation of orchards and botanical gardens for the cultivation of indigenous medicinal plants, and the implementation of various mechanisms of recognition and valorization of indigenous medicine. Nowadays the program in Arica and Iquique provides access to services such usuyires' attention during pregnancy and the presence of quillires in primary-care centers and in the rural health teams that make bimonthly visits to the most isolated areas. Cultural facilitators at Arica Hospital help users who come from interior villages to navigate the medical bureaucracy and coordinate schedules, examinations, referrals, and visits to specialists.

Although more than 20 years have passed since the implementation of PESPI on a national level, there are no regional data regarding its effects on the health profiles of the Aymara population in northern Chile. The few recent studies on this population's health adopt an exclusively biological and epidemiological viewpoint. For example, a study on cardiovascular risk factors among the rural Aymara of northern Chile (Vargas et al., 2016) seeking to determine the risk prevalence among this population mainly engages with the biomedical literature and identifies culture as either a risk factor (insofar as this entails a diet based on cereals, meat, and tubers and lacking any fruits or vegetables, an expected condition on the Chilean plateau) or a protective one such as the stigmatization of tobacco consumption.

THE INTERCULTURAL MEDICAL FIELD AS AN AREA OF STRUGGLE

Problematizing the evident social control intent intrinsic to intercultural health programs does not mean denying these processes. The Aymaras of

northern Chile have witnessed a radical transformation in the state's stance toward ethnic diversity and have historically employed strategies of mediation and negotiation rather than frontal opposition (Abercrombie, 1998). The Aymara of the highlands were originally part of the network of fiefdoms belonging to the Tiwanaku and later the Tiwantinsuyu empires (Hidalgo, 1982) of pre-Hispanic times, a territory that was annexed to Chile after the 1879 War of the Pacific. During colonial times, these groups belonged to the Viceroyalty of Peru. Only after the war that redefined the borders and contemporary relations between the nascent national states of Chile, Peru, and Bolivia did they come to witness the transition from a homogenizing state discourse to one that promotes interculturality and expressions of local ethnicity.

This transformation of state discourse in the face of vast internal diversity can be traced to a period before Incan presence. Around the year 1540 the southern Andean area had an ethnically mixed population made up of fishermen, farmers, and shepherds belonging to various cultural groups "that established cultural and economic exchange relations with eastern peoples all the way to the Chaco and the Amazon and southern ones all the way to the Mapuche-inhabited Sub-Andean periphery" (Hidalgo, 2004: 50). These relationships were based on the intense mobility that characterized these populations in pre-Hispanic times. Settlement dispersion led to the creation of an articulated territory of local elites that had access to distant resources coming from a wide network based on reciprocity and redistribution. In spite of the fractures caused by the creation of the current nation-states, the Aymaras of northern Chile come from an Andean highland tradition characterized by multiethnic elements and transnational uses of territory.

These mechanisms come to the fore when the Aymaras of Chile question their specificity regarding processes they observe in neighboring countries such as Peru and Bolivia. Many have engaged with the process of Chileanization in the area and are still reluctant to associate themselves with the inhabitants of neighboring countries (Albó, 2000). Starting at the end of the nineteenth century, the inhabitants of Chile's borders underwent the forced elimination of their specificities as an indigenous people: the Aymara language was banned, and a nationalist ethic was imposed via mechanisms such as compulsory military service and the establishment of state-sponsored schools throughout the territory (González, 1996; 2002). Other strategies, such as the installation of municipalities and the militarization of geopolitical boundaries (Gunderman, 2003), formed the basis of the current Andean landscape. The dictatorship (1973–1989) played a key role in the dissolution of the ethnic units organized around communal property that were the basis of the private and familial character of Andean property. Intense migration starting in 1960 produced a predominantly urban population, but this did not stop its cultural updating through strategies as diverse as dance, music (Chamorro, 2017), the economy, and health (Carreño, 2013), all of them closely connected with its communities of origin. Aymara transnationality has also been accompanied by the indigenization of the urban area in response to acculturation pressures in the 1970s that several writers (e.g., Van Kessel, 1980) have seen as critical threats to their survival.

As in the rest of Latin America, the era of "coloniality" forged in the creation of nation-states (Martinez-Andrade, 2008) has been followed by an era of neoliberal multiculturalism (Hale, 2005)—avowal of the ethnic and cultural diversity represented by indigenous peoples alongside the expansion and strengthening of the neoliberal economic model over the entire territory. In contrast to the situation in Bolivia, with its campaign centered around living well, Chilean neoliberal multiculturalism has involved an internal transformation of the state that, since the end of the dictatorship, has sought to instill a desire for democracy and consumption in the indigenous population (Paley, 2001)—a construction of national citizenship based on the culturalist logic of diversity.

The PESPI program emerged within this framework. Its origins are tied to the reconstitution of the conflictive relations between the state and indigenous peoples not only in the Andes but throughout the national territory. First implemented in the Mapuche areas, it has been extended to health services all across the country. Given that territories with key natural resources are at stake, governments have enforced the fragmentation of indigenous property in their effort to reconcile the advancement of a fragile recently recovered democracy with the economic model forged during the dictatorship. Consequently, PESPI follows a rationale whereby the state offers benefits to indigenous peoples in exchange for their adherence to the consolidation of the neoliberal model (Aylwin and Yañez, 2007; Yañez and Molina, 2008). The epidemiological profiles issued from this perspective demonstrate the need to prioritize issues such as indigenous access to and participation in health programs in general. Andean specificities include the country's highest rate of infant mortality, the prevalence of cardiovascular diseases, and an increase in gastric cancer and tuberculosis (MINSAL, 2005; 2007). In response the Chilean state has laid the foundations for what, following Bourdieu, can be considered an intercultural medical field. The use of the field concept (Bourdieu, 1976) is useful in that it links the political and institutional sphere that manages health services with the individual and collective events in which health is sought, constructed, desired, or lost. Encompassing all the social actors that participate in the health/disease/care process (Menéndez, 2005), the medical field is crossed by forms of subjectivation in which the boundaries of what health is and what lies beyond it—the authorized limits and transgressions in the management of the indigenous body—are defined.

Anthropological studies are dominated by the viewpoint that intercultural programs such as PESPI are a continuation of historical forms of domination of indigenous peoples (Boccara, 2007). While it is important to recognize the mechanisms of depoliticization that underlie the ethnic-based governance deployed by the Chilean state, Bourdieu's notion of field reminds us that there are unfinished areas the boundaries of which are in continuous negotiation and movement along with the practices and trajectories of their constituent social actors. Thus the uses of the intercultural medical field are fundamental to our understanding of the extent to which these are mechanisms of domination and of the way they have been employed by subjects who, in spite of everything, have decided to participate in them. The story of the indigenous association known as Suma Qamaña Taki will allow us to reflect on what

indigenous actors in the intercultural medical field have made of concepts up to now excluded from the state's language such as "living well." Through trips to Bolivia to meet with indigenous leaders, yatires, and other spiritual authorities, the members of this urban association have appropriated this concept, translating it into a community practice of health promotion among the users of Arica's medical offices. One Aymara indigenous leader described the process as follows: "We want to be something more than sick, defeated people. [Even though] . . . we have always been isolated, separated from our people, the Chilean Aymaras have to learn from our Bolivian brothers—their unity and courage."

THE USES OF "LIVING WELL"

During the early days of December 2010, I accompanied Álvaro and Sandra,[4] both leaders of Suma Qamaña Taki, on an interesting trip to Bolivia. As part of the scheduled activities, we were to meet with a group of amawtas, yatires, and Aymara spiritual leaders in La Paz. I had previously met them in the city of Puno, and my fellow travelers wanted to do so now in order to emulate their experience in Chile. Suma Qamaña Taki had been established under the wing of the PESPI, one of whose initial tasks was overseeing the organization of groups like this and installing their democratic rhetoric, consensual decision making, and active participation. Among the actors involved, especially the anthropologists who have rotated as program directors, there was serious uneasiness regarding the modes of participation and decision making the program promoted. The fact that these associations were financed by the state and international agencies such as the World Bank and that the incorporation of figures such as anthropologists enabled the creation of what Boccara has called an "ethnobureaucracy" has done nothing to reduce the importance of the effects of these opportunities for participation.

Having participated in the social activism of urban émigré indigenous elites that, in the North of Chile, dates to the 1980s (Gunderman, 2003), association members are aware of the political uses that have been made of their ethnicity. From their viewpoint, the advancement of the neoliberal development model that accompanies multiculturalism has weakened their organizational capacity and territorial sovereignty. However, they argue that their PESPI work is fundamental. They place substantial emphasis on the prevention and treatment of tuberculosis, which is prevalent in the Chilean indigenous population. According to epidemiological profiles of the area, the incidence of this disease among the Aymara is up to nine times greater than in the nonindigenous population (Pedrero, 2014: 79–81). Faced with this reality, association members have employed strategies that range from door-to-door information provision to specific case follow-up and treatment for people who have difficulty gaining access to health services. As Álvaro told one of the Bolivian amawtas we met in the Church of San Francisco de la Paz, "We take care of the poorest ones, those nobody wants to see, who are sick with tuberculosis and—what a coincidence!—also happen to be Aymara." With this statement, Álvaro raised the question with the traditional authorities of the role of traditional Aymara

medicine in the treatment of a disease that is also prevalent in Bolivia (according to the World Health Organization,114 cases per 100,000 in 2016, with a downward trend). Little by little, the debate between Chilean and Bolivian Aymaras on tuberculosis and traditional medical treatment took on a political tone. Tuberculosis became an excuse to talk about the state of indigenous medical knowledge in different parts of the territory and the importance of spiritual support for those suffering from the disease and of fostering a community in which it could be treated, overcoming its stigmatization and current difficulties of prevention and treatment.

Group members are extremely well-trained in this regard. Years of PESPI participation have enabled them to employ the limited funds at their disposal to strengthen their action network in the territories and neighborhoods where the Aymara population of Arica is concentrated. They know the faces and stories of people who suffer from tuberculosis and can clearly report on the main obstacles to treatment and the conditions of vulnerability that characterize groups outside the reach of biomedical care—for example, the translocal population that moves seasonally between rural areas (to engage in agricultural work) and urban areas (where it goes through periods of unemployment and informal labor). Crossing national borders is a daily practice for these people. In doing so, they not only expose themselves to contagion, as group members warn, but also gain access to a shared imaginary regarding what it means to be an Aymara. This imaginary is what Álvaro, Sandra, and Luisa were talking about with the Bolivian experts, some of whom had been active in the decolonization process promoted by the Evo Morales government.

The recognition of Andean medicine practices, the need to reinforce them through exchanges, and the joint development of strategies to validate the transnational nature of the therapeutic itineraries of the Arica population, which seeks health alternatives both in the official system and in the innumerable traditional and emerging medical alternatives offered by Peru and Bolivia (Carreño, 2013), were some of the many topics addressed by Bolivians and Chileans during these days of training, talks, and demonstrations on Aymara health. In this meeting, territory was at the core of the conversations; a Pan-Andean horizon fractured by the imposition of nation-states was recalled, reproducing the imaginary of a shared memory (Crapanzano, 2007).

A few weeks after this first trip, a meeting was held in Arica with representatives from the Ministry of Health, which runs the PESPI program. Suma Qamaña Taki members participated alongside the leaders of various inland and highland valley communities. A delegation from Pachan Kutt'aniña in the area surrounding Visviri (on the border with Bolivia and Peru) was also in attendance. The hotel conference room was full, the audience made up of representatives of local health teams and indigenous associations. The tables were divided into groups dominated by white coats and groups dominated by hats and colorful *aguayos* (carrying cloths). The first speaker was the national director of PESPI, an anthropologist. After explaining what the program was about and the interests of intercultural policy, she posed an interesting question: "Do you know what makes Aymaras sick?" There was an uncomfortable silence, but some whispers attested to piqued interest. Finally, some voices were heard: "Tuberculosis, cancer, AIDS!" Upon hearing this response, Suma Qamaña

Taki's Sandra decided to speak: "They die of pollution because of everything being thrown into the valleys where the grandparents lived; of poverty, because they come to the city to get sick with tuberculosis and die like dogs." Her powerful response was followed by the testimony of another indigenous woman, who introduced herself as the leader of the Copaquilla community in the Andean foothills: "As in Copaquilla, the mines filled up with arsenic and the water with lead, and now people are dying of cancer and cannot work the land. That's what Aymaras die of." These answers increased the tension, and the director spoke again:

> Well, they are right about some things: we have data showing there is more tuberculosis and cancer among Aymaras. But I was not asking about that. I was asking about the traditional Aymara diseases—fear, land grabbing, soul pain, which doctors cannot heal. For that we need and therefore want to have yatires in doctors' offices and in the medical watch, so that health is addressed in a comprehensive fashion.

The way in which the director put an end to the conflict aroused by her question is a good example of the struggle inherent in the field of intercultural health. While she defended the need to know the "traditional" diseases of the Aymara, justifying the incorporation of yatires into primary care, Aymara participants wanted to talk about the political and economic aspects of the health conditions being addressed. At the end of the meeting, Gregorio, one of the yatires with Pachan Kutt'aniña, said,

> What is missing here is not yatires in the doctor's office. You know where to find the yatire if you need him. I travel with the rural watch to reach more people, because there are also old people in the villages who cannot move, but the problem of Aymara health is that living well has been lost; the people are landless, without water. If there is no water, there is no life, there is no health; there is pollution. That is the problem of the living well that our grandparents spoke of; that has been lost because the earth is angry, the souls are angry, and many misfortunes are happening.

The leader from Copaquilla who had spoken during the meeting sadly reiterated Gregorio's viewpoint: "I don't know why they come here to teach us about *ajayu* [spirit, soul, or vital force], soul pain, land grabbing. We know about that and can look for someone in the know if needed. But when you ask them about pollution, the mining companies, there and then they change the subject."

These thoughts eloquently reflect the awareness that the indigenous participants of PESPI have of the limits of a culturalist view that reduces their health problems to the treatment of traditional illnesses. However, despite these limits and given an increasing awareness of them, the exchanges, trips, and dialogues brought about by Suma Qamaña Taki's activities have come to incorporate historically excluded subjects into the medical field. For example, upon her return from meeting with the Bolivian amawtas and talking about her experience, Luisa said,

> I'm so happy, because this makes me feel like I can communicate with my grandmother, who died of tuberculosis. We have nothing. We are simple

> people. No one would think we could do something for the health of others. We are not doctors, or nurses, or anything. . . . Sometimes they despise us because we talk about this terrible disease. They close the door on us because it is shameful to talk about tuberculosis. But working on this I have realized that the disease is still out there and among the poorest people, who are always the outcasts of society.

The lack of data regarding the impact of PESPI policy on indigenous peoples is also consistent with the complexity of the concept of health promoted by these associations. On the one hand, few seem to be interested in any concrete improvement of health conditions in these populations during recent decades. Izquierdo's (2005) study among the Matsigenka of the Peruvian Amazon attests to this. On the other hand, the links to political aspects of health such as the pollution issues mentioned above or the affective dimension mentioned by Luisa tend to be excluded from the concept of health promoted by the state. As described by Izquierdo (2005), what seems to be at stake is the very definition of health, which, from the viewpoint of the social actors, is intrinsically linked to political and territorial aspects not rendered visible in the biomedical parameters with which health is measured. The rhetoric of damage, anger, and transgression with which disease is approached from the Aymara perspective and that Gregorio summoned in his response to the director's question refers precisely to a deep link between the idea of health and the memory and history of the Aymara people. Living well, then, is an effective concept for calling attention to these aspects of health as opposed to the biology-based or culturalist perspective of the state. "Living well" includes health from the Aymara perspective and is increasingly employed by indigenous social actors to refer to the contrast with a concept of health that is based merely on access to biomedical services.

Suma Qamaña Taki members continue to travel to Bolivia whenever they can, seeking dialogue enmeshed in transnational experiences. Their role as health agents has grown more important in that their voices have joined those of leaders and political representatives of the local urban Aymara such as the Copaquilla leader. Pachan Kutt'aniña continues to participate in PESPI, joining the traveling rural health teams. It has already managed a successful communal request for a full-time doctor in General Lagos. Likewise, in the course of these past few years, both associations have participated in tripartite territorial meetings on health and indigenous peoples, where their experience has been taken as an example of the massive implementation of living well at the central level. These initiatives have carried titles such as "Tracing a Path Together for the Suma Qamaña (Living Well) of Indigenous Peoples" and "Suma Qamaña (Living Well) for Health Promotion: Dialogue and Reflection on Self-Esteem, Personal Development, Drug Prevention, and Intrafamily Violence for Parents and Youth in the Community." The concept of living well is employed not only by transnational leaders but also by local associations that have appropriated it to unify aspects previously isolated by indigenous politics. The persistent use of it in spite of the hegemony of the developmentalist model in the area provides a glimpse of the potential long-term effects of this struggle for the expansion of the field of health in the Aymara world.

CONCLUSIONS: HEALTH AND LIVING WELL

The ethnographic scenarios presented above show that the concept of living well in Chile has entered an intercultural health field subject to relations of domination and the depoliticization of indigenous subjects (Ferguson, 1990) in the context of global development (Freddi, 2018). Although culturalism dominates the PESPI program, addressing the latter from the perspective of Bourdieu's concept of "field" reveals the junctures and negotiations over what is included in or excluded from the definition of health. As we have seen, Chilean Aymaras have a historical tradition of border management meant to protect their resources, and this experience shows in the activities carried out by the aforementioned associations. Living well, as promoted by my interlocutors, transcends the limits assigned to their activities in the medical field, which should merely involve tuberculosis prevention and traditional Aymara medicine offerings. Dissatisfied with this mission, association members have taken advantage of the areas of health conquered to enter the liminal spaces in which health services are absent. Through their "microphysical" actions (Foucault, 1977) they have positioned themselves as health agents acknowledged by the Aymara population interested in engaging in transnational dialogue. This apparently transcends the borders of the political project to operate in intimate spheres of subjectivation.

Sandra and Luisa reinforced their own role as health agents by meeting with Bolivian specialists, creating what Crapanzano (2007) calls a common imaginary—one based on the visual, mnemonic, and entirely sensory recreation of the indeterminate time and space that Aymaras visit whenever they need to reimagine themselves as a community different from today's fragmented people. The health practices promoted by these associations can be seen as largely an alternative to the fragmented ideas of their community in other spaces. When Gregorio talks about the land's and the grandparents' being "angry" to explain current Aymara problems, he is remembering the fragmentation undergone by the Aymara community that has left them divided, undergoing internal litigation for lands and natural resources, with high unemployment rates and increasing dependence on mining jobs in the North. By summoning these aspects, Gregorio places living well as a central element in the understanding of his community's current context and the need to view health from a perspective that includes the most conflictive aspects of the relationship between indigenous peoples and the state (e.g., the use of territory).

Thus, living well has become a provocative concept in the Chilean intercultural medical field in that it vindicates the historical, political, and territorial aspects of health. As has happened with the concept of interculturality, living well is subject to "comfortable and welcoming" use (Burman, 2017: 157) or, worse, vulgarization by the national state (Aqarapi, 2016, cited in Burman, 2017), being stripped of its connections with issues such as access to territory, the transformation of the relationship with nature, and the suspension of the naturalized operation of the neoliberal system. However, insofar as it is appropriated and enacted in a "microphysical" dimension, it retains its political potential. Insofar as it reproduces a shared memory and identifies a common territory and a specific relationship with it while addressing specific cultural and biographical modes of belonging, it enables the claiming of rights.

NOTES

1. I will use the term "living well" (*buen vivir* in Spanish), opting for the Quechua and Aymara expressions only when they are employed by informants. The research context was characterized by the linguistic hegemony of Andean Spanish, so the term is employed in indigenous languages only on specific occasions and with particular connotations.

2. *Yatires*, *quillires*, and *usuyires* are the main medical figures recognized by indigenous communities in both rural and urban areas. While the yatire's role is the closest to that of the classical shaman, quillires are healers or herbalists removed from the more religious functions associated with the management of evil. Usuyires are associated with midwifery and the management of women's sexual and reproductive health. The implementation of PESPI in Arica involved establishing a dialogue with these practitioners around the need to recognize and value indigenous medicine. All Chilean interviewees are health agents acknowledged by their communities as well as the state, having willingly entered the rationale of neoliberal multiculturalism. In Bolivia, for example, yatires have fulfilled a more explicitly political and visible role in the decolonization process (Burman, 2011). For this reason, along with *amawtas* (spiritual and political leaders) they are seen as important sources of inspiration for Chilean indigenous associations.

3. Epidemiological studies centered on the Arica and Parinacota areas and ethnic-based health monitoring undertaken for decades show that indigenous peoples have a higher probability of death from illnesses linked to poverty than the nonindigenous population. Generally speaking, infectious diseases such as tuberculosis and gastric cancer are prevalent among people identified as Aymara by surname, kinship, or appearance in the registries of the National Corporation of Indigenous Development, and deaths due to external causes are three times those among the non-Aymara population (Pedrero, 2014).

4. Participant names have been modified to preserve the confidentiality of the data collected.

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