CULTURAL POLITICS AND HEALTH: THE DEVELOPMENT OF INTERCULTURAL HEALTH POLICIES IN THE ATLANTIC COAST OF NICARAGUA

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Submitted to the Graduate Faculty of

Arts and Sciences in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

University of Pittsburgh

2006

UNIVERSITY OF PITTSBURGH

ARTS AND SCIENCES

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The Autonomous Region of the North Atlantic of Nicaragua (RAAN) gained political autonomy in 1987 after indigenous Miskitu took up arms against the Nicaraguan government. As part of the autonomy process RAAN officials developed a policy document, The Health Model of the RAAN, that guides regional health system reform. The Health Model is guided by the concept of *interculturalidad* which is meant to simultaneously represent cultural difference, inter-connectedness and inequalities based on ethnic relations as historically constituted in society.

Drawing on fourteen months of participant observation in health meetings and workshops, and interviews with national and RAAN health officials, indigenous leaders, indigenous community members and health providers, this study examines the role of discourses of the indigenous movement, *interculturalidad* and cultural difference in the development and implementation of health policy in the RAAN. Analysis of interview material, health policy documents and meeting transcripts shows that although both Nicaraguan and RAAN health officials agree that the health system of the region should be guided by the notion of *interculturalidad,* the concept and process it represents is interpreted differently by the actors involved. For national health officials *interculturalidad* is simply recognition that culture is an important variable in health and that indigenous medicine should be accepted. For RAAN health officials *interculturalidad* is a political concept that also refers to the transfer of decision making

power to the region. These interpretations lead to different policy propositions and conflicts in the negotiations between the national government and the RAAN. The concept of *interculturalidad* is broad and vague which makes it open to multiple interpretations, manipulations and degrees of control. The Nicaraguan government can therefore co-opt the discourse of *interculturalidad* and promote the image of a Nicaragua that recognizes its multi-ethnic character and its inclusiveness without implementing concrete policy changes that deal with resource distribution and political power.

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ACKNOWLEDGEMENTS

The present work would not have been possible without the support and contribution of many individuals to whom I am deeply thankful. First, I would like to thank everyone who helped me with my research in the Región Autónoma del Atlántico Norte. To the people of URACCAN, especially the Chancellor, Master Alta Hooker, I thank for their openness and access to the facilities of the university and information. I want to thank the coordinator of IMTRADEC, Lic. Serafina Espinoza, and all the staff of the institute; Douglas, Pastor, Teresa, Dialla, Loyda, Manzanares, Pablo, Trudy Davis, Geert Jan, and Dr. Cuadra, for helping me understand the Health Model, providing me access to the RAAN health system and making me a part of the institute during my period of fieldwork. I also want to thank the people of the Programa Integral de Salud del Llano Norte, for their support with my research in the communities.

To Arturo Chow, Wangki Cunningham and their daughters, Selene and Anette, thank you for providing me with a family and a home away from home, I am deeply indebted to you, I will always cherish the perspective you gave me on Nicaragua and your friendship. Other people also contributed to the present work through information, friendship and support, among them are: Dr. Myrna Cunningham, Dr. Wilfredo Cunningham, Rose, Delia, Dr. Zelaya, Dr. Hernandez, Eddie McDonald, Juan Gonzáles, Ned Smith, Myriam, Dr. Anton, Asisclo, Doña Marta, Doña Dinora, Dr. Carrión, Doña Maria, Don Wendel, Junior, Eufemia, Norma, Donald, Carmen, Dr.

Campos, Dr. Blandon and Don Pastor. I owe special thanks to all the people in the communities of the Northern Savanah, especially those of Santa Marta and Auhya Pihni for allowing me to live in their communities and making me feel like I belonged.

Outside of Nicaragua I want to acknowledge the help and support of the Institute of International Education Fulbright program, which funded my research, especially Jody Dudderar and the U.S. embassy contact person Mayra Vargas, who made moving to Nicaragua a smooth process. In the University of Pittsburgh I want to thank my dissertation committee members, Dr. Harry Sanabria, Dr. Martha Terry, and Dr. Joseph Alter, whose thoughtful comments vastly improved the present work. I want to thank especially my dissertation advisor, Dr. Kathleen DeWalt, who not only provided guidance through my graduate studies and dissertation but who also provided much needed encouragement and support during the most difficult moments of my graduate education. To Dr. Richard Scaglion, thank you for making grant writing a less painful process through your wonderful grant writing class. I also want to acknowledge the graduate students in the anthropology program who made graduate school such a wonderful place, especially; Blane Connor, Claudia Petruccio, Patrick Wilson, Mike Haller, Daisy Yang, Nuringa and Amy Spier.

On a personal note, I want to thank Leah Voors, whose support was invaluable for the completion of the present work, thank you for your positive encouragement and love, and for providing me with a refuge from work when I needed it most. Last but not least, I want to thank my parents, Luis R. Ruiz and Elsa M. Cora. Thank you for your love and encouragement, and for instilling in me the social and critical consciousness that led me to anthropology, the approach I have taken in my work and the way I view the world.

1.0 INTRODUCTION

This dissertation examines the role of identity politics in the attempt to transform the local health system in the Región Autónoma del Atlántico Norte – Autonomous Region of the North Atlantic – (RAAN) of Nicaragua. Specifically, it explores how discourses of cultural difference in the indigenous movement and debates about *interculturalidad* (the role and inclusion of cultural diversity in state institutions) frame discussions of health system reform and health policy, and their implementation.

The process of transformation of health systems, and all other aspects of society, with a discourse centered on cultural difference and *interculturalidad* poses various important questions. The first and central question of this dissertation is: how does framing the discussion about health reform in terms of culture influence the development and implementation of policies and interventions? Finding the answer to this question inevitably requires grappling with other related questions. What is the connection between the discourse of the indigenous movement and indigenous political autonomy, and the transformation of the health system? How do different understandings of "culture" and "*interculturalidad*" affect the formation and implementation of health policies and health reform? How do these different understandings of "culture" arise out of the structural positions of the different actors involved?

In Nicaragua, the mobilization of indigenous Miskitu was successful in attaining political autonomy for the RAAN region, redefining indigenous group's relation to the state. The

mobilization for autonomy takes as a starting point “cultural difference” and indigenous identity. Autonomy in the region is not an end result but a process in which *interculturalidad* is debated. Autonomy is meant to deepen democracy, providing indigenous groups with greater equality.

Since health has always been an important measure of inequality, discussions about health and the health system provide an important site for the enaction of politics. In the RAAN, as part of the autonomy process, an attempt to reform the local health system has been undertaken. However, within the regional political autonomy process, health is not only a barometer for the inequalities suffered by indigenous groups in the region, but also a site of cultural revitalization and affirmation through indigenous world-view of health and local indigenous medicine. As I will demonstrate in this dissertation, the debates about health system reform and policy are not just about resources and how they are allocated in order to tend to the health needs of the population. They are also about reproducing the “cultural difference” that legitimate claims for their control in the first place. For this reason “culture”, as identity politics, frames discussions about health in the region. Even in discussions centered on inequality and poverty, “culture” is always present, as these inequalities are cast in a discourse of “ethnic marginalization”, further feeding the logic of the need for an intercultural reconfiguration of state institutions based on cultural diversity.

It is important to analyze the role that “culture” plays in framing health policy in multi-ethnic situations if we are interested in the results these might have for the health of the population. The important question here is whose interests are served by the use of “culture” as the central concept in framing health issues? Some have argued that culture as an explanatory as well as organizing factor in health obscures the larger role of structural and economic inequality in producing ill-health on populations, thereby maintaining the status-quo (Farmer 1999; Navarro

1984; Velimirovic 1990). Moreover, attempts at democratizing health through programs such as "community participation" initiatives have been seen as being poorly conceived from the top down and highly manipulated by governments in order to provide a mere appearance of change (Ugalde 1985; Morgan 1993). Based on these critiques, it is important to ask the same questions about health programs and policies based on what in Latin America is called intercultural health.

The situation described in this dissertation, with parallels elsewhere in Latin America, provides a different starting point from those found in these critiques of the role of culture in health. The attempts to reform the health system arise out of the discourse of the indigenous movement, from the bottom up. They involve civil society and grass-roots organizations challenging state institutional practices and transforming them. While some have argued that social movements have the capacity of providing an alternative and advancing more equality and democracy, others have launched a similar critique to the above on culture and health, that argues that a reliance on culture is co-opted and indeed beneficial to governments and the logic of capitalism, thereby maintaining unequal relations (see Hale 1997 for a review). However, social movements, the state and international organizations are not monolithic. Therefore it is difficult to make clear-cut predictions as to the outcome of these processes. There is a multiplicity of factors involved, along with multiple strategies and axes through which power is either exerted or challenged.

This dissertation uses the case of Nicaragua in order to examine the role and effects of the use of "culture" as the starting point and central thrust in the advocacy for the reform of the health system in multi-ethnic contexts. Throughout this dissertation I argue that the adherence to discourses of and about culture and cultural difference limits the possibility of subsequent political change in the health sector.

1.1 THE RAAN

The Región Autónoma del Atlántico Norte is located in the northeastern region of Nicaragua, bordering Honduras to the North and the Atlantic Ocean to the east (see Figure 1). The RAAN is the larger of two autonomous regions created after the civil war of Nicaragua in the 1980s. Along with the RAAS (Autonomous Region of the South Atlantic) it forms what is referred to as the Atlantic Coast of Nicaragua, formerly known (along with parts of modern day Honduras) as the Mosquitia[1]. The RAAN is the largest administrative region in the country with 34,200 square kilometers, which represents 24.6% of all Nicaraguan territory. Along with the RAAS the Atlantic Coast represents around 45% of all the national territory. The Atlantic Coast contains various ecological zones rich in exploitable natural resources which have been identified as the key to the regions development (World Bank 1997). It contains the largest area of relatively pristine forest in Central America, pine savannahs, coastal wetlands, mangroves and extensive marine platforms offshore. The region also contains deposits of exploitable minerals, such as gold. These different ecological zones provide the region with a rich reservoir of exploitable natural resources that have historically made the region attractive to international resource extraction companies and national governments interested in economic development schemes.

[1] In this dissertation references to the "Atlantic Coast" will refer to both the RAAN and the RAAS as a whole.

Figure 1: Political Map of Nicaragua

Source: **http://www.lib.utexas.edu/maps/americas/nicaragua_pol_97.jpg**

Despite the fact that the RAAN is rich with exploitable natural resources the region is one of the poorest of Nicaragua. With a Gross National Income per capita of US$730 in 2003, Nicaragua was the second poorest country in Latin America. Moreover, Nicaragua was ranked

118 out of 177 countries on UNDP[2]'s Human Development Index in 2003 (UNDP 2004: 141). In 2001, according to the Living Standard Measurements Survey (2001), 46% of the population lived below the national poverty line, with 15% living in extreme poverty. The average income of the poor is estimated to cover only 24% of the cost of the basic food basket. The situation in the Atlantic Coast region is worse than the rest of the country. The Atlantic Coast has the dubious distinction of being the poorest region in the second poorest country of Latin America. In 2001, 61% of the population lived below the national poverty line, with 20% living in extreme poverty (World Bank 2003). According to the poverty map twelve of the nineteen municipalities in the Atlantic Regions are classified as extremely poor. Poverty in the Atlantic Region is further exacerbated by the lack of infrastructure. The region is virtually isolated from the Pacific given a lack of roads. In the RAAN the vast majority of roads are unpaved, and become almost intransitable during the rainy season. The result is an increase in transportation costs for all products. The cost of living is therefore from 15 to 20% higher than the rest of the country. This is more worrisome when one considers that despite cultivation for subsistence by a portion of the population (including indigenous groups) the main source of food is through purchase (WFP-Nicaragua 2005).

In Nicaragua a reference to the Atlantic Coast is not merely a geographical designation, but also one that marks cultural, racial and ethnic boundaries within Nicaragua. It is an ethnically diverse region with the majority of the population being identified as indigenous[3]. Estimates indicate that 52% of the population are indigenous peoples (Miskitu 50% and Mayagna, 2%), 45% being of the Nicaraguan majority group Mestizo, and 2% being Creoles, an Afro-Caribbean

[2] United Nations Development Programme.
[3] The label of "indigenous", or "*indígena*" in Spanish, is used to refer to populations that are descendants of the populations living in Latin America before European contact. Although the label can be very problematic and identification as "indigenous" can be a fluid category, the label assumes that there is some continuity.

ethic group (Jamieson 1999). The indigenous population is mostly scattered in communities that range from about a hundred to two thousand in population. The Atlantic Coast throughout its history to the present has been isolated from the rest of Nicaragua. The Atlantic coast was not incorporated into the country until the end of the 19th century after being indirectly colonized by the British.

The Autonomous Region of the North Atlantic has been undergoing a process of political transformation for the past two decades. Its indigenous populations have forced the Nicaraguan state to confront the question of diversity and indigenous rights. After a prolonged conflict, the answer by the Sandinista government to the question of diversity was political regional autonomy. Since 1987 when the autonomy law was passed, the institutional configuration of the autonomy regime has been the central preoccupation of the RAAN. The implementation of autonomy extends to all spheres of government and society and entails a transformation of all institutions. The local health system has been undergoing such a transformation, guided by a policy document titled El Modelo de Salud de la RAAN, the Health Model of the RAAN (URACCAN 1996). The Health Model attempts to reform the local health system of the RAAN with the goal of not only providing better health services to the population, but also with the expressed purpose of incorporating the principles of autonomy and indigenous rights within the health system. The Health Model is an integral part of the process of autonomy.

The transformation of the RAAN's relationship with the Nicaraguan state has developed from discourses of "cultural difference" and indigenous rights which have gained wide currency and acceptance internationally. Policies that deal with cultural difference have become a central element in evaluating countries' development (see UNDP 2004). It must be borne in mind that the autonomy regimes themselves developed through a conflict in which armed sectors of the

indigenous population questioned the legitimacy of the Nicaraguan state through discourses that asserted their cultural difference. Nicaragua, like most Latin American countries, has come to slowly accept the validity of these discourses. However, the various governments as representatives of the state have at every turn blocked or slowed down the gains that regional advocates have attempted to implement. This dissertation examines the role that discourses about "culture" have in the advocacy for health system change and the central government's resistance to it. Moreover, this dissertation is concerned with how discussions about "culture" get translated into health programs and how they meet the needs of the indigenous population.

1.2 METHODS

The research for this dissertation was carried out in two periods of research totaling fourteen months of fieldwork. The first period of research in the RAAN lasted two months, in June and July of 2001. This first visit to the RAAN was one of preliminary research during which the feasibility of the study was assessed and initial contacts were established. The second period of research occurred for twelve months from March 2003 to March 2004.

Literature on the functioning of the Autonomous government in the RAAN is scarce. The literature is even rarer for the Health Model and the actual implementation of the policies it contains. References to both processes abound in the literature of the region but lack specificity. Given that the Autonomous regimes had been created since 1987 and the Health Model since 1996, when I first arrived to Nicaragua in 2001, I expected to be able to research the functioning of the policies contained in the Health Model. However, when I arrived in the field I found that the Health Model was still in a process of negotiation. The implementation of the Health Model

did not have a unified institutional structure but was instead a patchwork of initiatives and programs carried out by different organizations, most of them NGOs. My research therefore had to concentrate on the debates and negotiations surrounding the process of implementation of the Health Model as opposed to the functioning of the Health Model itself. My very first contact with the coordinator of the Institute of Traditional Medicine and Community Development (IMTRADEC) and the president of the Health Commission of the Autonomous Regional Council (CRA), made clear that the Health Model was about more than just health. It is impossible to separate its advocacy and attempts at implementation from the political process of autonomy of which it is part. I was aware of the political basis of the Health Model from the document itself; in fact it was this political underpinning which interested me in the RAAN in the first place. The first task was therefore to understand what different people understood the health model to be and how their understanding was related to their positions in the institutions within the autonomy process. The debates about autonomy and the health model at the regional and national level form the basis for the formation of health policy in the RAAN. However, simply concentrating on the debates and discourses used also necessitated an analysis of how the policies arising from these debates were implemented. In order to ascertain the connection between political debates and practice in the period of fieldwork in 2003-2004, research was divided into two phases: an institutional and a community phase of research.

The first phase of research focused on the institutional development of the health model. The goal was to understand the process of the formation of health policy and the development of the health model through the negotiations of the different institutions that deal with health in the region. This phase of research therefore took place mainly in Puerto Cabezas, the region's capital. Most of my research was done through the Institute of Traditional Medicine and

Community Development (IMTRADEC), which is part of the Universidad de las Regiones Autónmas de la Costa Caribe Nicaraguense (URACCAN). IMTRADEC is the only institution that is acknowledged by everyone to be the best representative of the Health Model, adhering to and advocating for the principles of the Health Model. IMTRADEC engages in a wide variety of activities all of which are tied together by the institution's mission of furthering the implementation and institutionalization of the health model (IMTRADEC 2006). The institute does health related research; implements community development programs, provides workshops, organizes and runs a university degree program of study for nurses as well as other certificate programs of study, and organizes indigenous healers. However their work does not limit itself to the implementation of these different programs. IMTRADEC is also heavily engaged in political advocacy. The coordinators have been involved in the negotiations toward the decentralization of the health system and are the unofficial advisors of the presidents of the health commission of the CRA. Working with IMTRADEC provided me with access to a vast network of health sector contacts, from the health secretary of the RAAN, the director of the local SILAIS, to indigenous healers and community members serviced by their projects. Moreover, IMTRADEC coordinates and organizes the bi-annual sessions of the Regional Health Council, which is a three day forum that involves all institutions and sectors working in health in the region. It is important to note that despite the use of the words "traditional medicine" in the institute's name, as the description of the institute's activities above indicate, its activities are geared toward health issues in general. As will be discussed in chapter four, the use of "traditional medicine" in the name symbolizes "cultural difference" as applied to the health sector.

During this first phase of research I conducted open-ended qualitative interviews with members of IMTRADEC, the Ministry of Health (MINSA) and the regional government, as well as members of other NGOs conducting health related activities in the RAAN. I also attended regional and national health meetings, forums, workshops and symposia, some of which were recorded and transcribed for analysis. Through IMTRADEC I also attended workshops for indigenous healers and members of some communities. These workshops ranged from indigenous knowledge exchanges between healers to workshops about healthy practices with community leaders. I became heavily involved in the activities of IMTRADEC and worked with them on various projects and activities including a research project they were implementing (see URACCAN-IMTRADEC 2004). My involvement with IMTRADEC provided me with a greater understanding of the Health Model but at the same time it also influenced the way I came to understand the Health Model. As such even though the analysis and interpretation of the Health Model presented throughout this dissertation is completely mine, it is heavily influenced by the work of the institute and may contain some bias toward the Health Model as the Institute understands it.

My work with IMTRADEC provided limited access to communities. Given the wide range of activities conducted by the institute with very limited personnel, activities in communities were limited and did not allow for immersion in community dynamics that I was seeking to conduct the second phase of research. For the community phase of my research I was looking for a community where the principles of the Health Model were being developed. The Health Model however does not have a unified institutional structure. The implementation of the Health Model has been carried out piecemeal by NGOs that are in coordination with the SILAIS and the health commission of the CRA-RAAN, but are not directly accountable to them. This left

me with just a few choices. There was a program similar to the PSILN being implemented in the community of Yulu in the Southern Savannah region, but this program was in the initial stages of implementation. There was also the possibility of working with Acción Médica Cristiana (AMC), which carries out most of its work in the communities of the Rio Coco. However working in the Rio Coco would have made it difficult to follow up on the institutional aspects of the Health Model and continue my work with IMTRADEC. I decided to conduct my research with the Programa de Salud Integral del Llano Norte (PSILN).

I approached the program director of the Programa de Salud Integral del Llano Norte (PSILN), Dr. Blandón, during one of the sessions of the Consejo Regional de Salud (CRS). I became interested in carrying out the communal portion of my field research within the communities served by the program, after watching a proposal for the formation and functioning of Community Health Commissions by the founder of the program and former director Dr. Salvador Salas. The proposal was based on the PSILN's work and was structured by the guidelines set within the Health Model policy document. There were various practical and methodological reasons for my interest in doing my research within the program.

First, the program is based on the community of Santa Marta, which is just 48 Km from Puerto Cabezas. There are two buses from Santa Marta that make one daily trip to Puerto Cabezas and back. Depending on the conditions of the road the trip takes from one to two hours. From a practical point of view, being based close to Puerto Cabezas would allow me to keep in touch with IMTRADEC and be able to attend important workshops and meetings and thus continue with my work on the institutional aspect of the health model. Many people in the coast tried to dissuade me from choosing the PSILN and Santa Marta as the base of my research for various reasons. Many people assumed that an anthropologist should be interested in doing his

work in communities where indigenous culture and medicine were considered to be more "authentic". As one Miskitu put it, "Santa Marta is almost a *barrio* of Puerto Cabezas". People suggested that I should carry out my research in the communities of the Rio Coco, where Miskitu are believed to preserve Miskitu culture. Pineda (2001) argues that he was also dissuaded from doing his research in Puerto Cabezas for the same reason. This in itself shows the role of anthropological research in contexts where notions of identity and culture are an important part of the political process. The role of the anthropologist is understood as part of the process of revitalizing culture itself by studying and affirming its "authenticity".

From a methodological standpoint, the PSILN was attractive on various accounts. The program was conceived by Dr. Salas as part of the development and implementation of the Health Model. The program was considered by some as a pilot project of the Health Model since it tried to implement the basic structure of the primary health care network envisioned in the document. The fact that the PSILN's work with communal health commissions was being used as an example for further implementation in the RAAN in the bi-annual meeting of the CRS helped validate its position as a pilot project of the health model. However, the project is run by an NGO supported by the Catholic Church, and its coordination with regional health authorities was sometimes lacking. Despite these limitations the PSILN provided a good example of the development of the Health Model up to that particular moment in time in 2004, because many of the elements of the Health Model have been implemented mainly through NGOs and civil society institutions such as IMTRADEC. Moreover, given the financial problems that the local government and health system have in the region, NGOs will continue to have a very important role in the implementation and development of the Health Model.

Working with the PSILN also provided access to twelve communities through their vehicle which traveled to all communities, and through workshops and other activities in which representatives and leaders of all communities participated. Since transportation is difficult in the RAAN, it would have been hard to have access to various communities for research without the help and support of the PSILN. This enabled me to see the model from a sub-regional perspective, that of the communities of the Llano Norte, as opposed to just that of one community. During this second period of fieldwork I followed closely the activities of the PSILN in its clinic in Santa Marta. I interviewed the staff, the MINSA *auxiliares* who staffed the health posts in six of the twelve communities. I interviewed members of the health commissions of all communities, *wihtas* (village headman), health leaders and community members. I also attended multiple workshops for health leaders, community health commissions, *auxiliares*, and midwives. My work on community members themselves, as opposed to leaders, was focused on the community of Santa Marta where the PSILN is based, where I attended community meetings and interviewed community members. The goal of the second phase of research was to assess to what extent the debates and policy discussions being held at the institutional level had an effect in concrete programs and policies. I was also interested in how community members understood the Health Model and the policies and principles it outlined. During most of my period of research with the PSILN there was little to no knowledge of the existence of the Health Model. I ascertained PSILN's staff and members views on the Health Model through questions based on the document's principles and programs. However, toward the end of my field research a new director of the PSILN came on board and with this change in leadership came a new focus on the Health Model by the PSILN. These changes entailed workshops that presented the principles and organizational structure of the Health Model to the community. My participation in these

workshops allowed me to get a greater sense of the debates that the Health Model engenders in Miskitu communities.

The research presented in this dissertation was approved by the Institutional Review Board of the University of Pittsburgh. Every attempt has been made to safeguard the identity and privacy of the informants who so kindly shared their lives, views and experiences with me. For this reason most of the names of individuals used throughout the present work are pseudonyms, especially those of Miskitu community members and health providers. The only exceptions are the names of public officials whose views and expressions are part of public discourse. I have also retained real names when the materials are part of the public record, such as national and regional meetings and newspaper articles.

All translations from Spanish sources that appear in this dissertation were done by the author. This includes quotes from policy documents, newspaper and academic journal articles and books. All research material, interviews, fieldnotes and transcripts of meetings and workshops, were collected primarily in Spanish and sometimes in Miskitu. During my period of fieldwork I took Miskitu language classes but my level of proficiency only allowed me to understand and follow conversations and meetings. This is one of the main limitations of the present work. All materials in Miskitu were translated to Spanish with the assistance of informants in the field, some of which were paid for their services. However, all translations from Spanish of the data presented in this dissertation were done by the author.

1.3 SUMMARY OF CHAPTERS

Following this introduction, I will provide a review of the literature in order to establish the relationship between indigenous movements, identity, culture, politics and health. The goal is to present the debates that have been briefly mentioned in this introduction surrounding the possibilities and limits of "culture" in social movements and health with special attention to these debates in Latin America. The chapter provides a theoretical background to the ways that anthropology and the social sciences more generally approach the use of the concept of culture in identity politics. In this chapter I argue that notwithstanding the critiques and limits of social movements based on cultural/ethnic identity, the recent gains made by indigenous people and other ethnic minorities have been intimately tied to their assertion of cultural difference. For this reason culture lies at the center of indigenous advocacy and political transformation. I also argue that the literature indicates that health is an important component in the assertion of cultural difference by indigenous groups.

I then review the critiques in medical anthropology related to the use of culture in public health. The discussion in chapter two poses an important question: do policies and programs influenced by the indigenous movements discourse under the concept "intercultural health" present a different approach to health policy and programs? Or are they old concepts and approaches repackaged by health policy makers in the present?

Chapter Three provides a background to the complex historical and political economy of the RAAN. It focuses on the development of ethnic identities in the region and the relationship of its population to Nicaragua and other international colonial powers. This provides the context for understanding the formation and development of the current political configuration of autonomy. The process of autonomy, although being a central element of indigenous advocates

in the region, was primarily a Sandinista project that the population of the region was forced to accept. Even while providing many concessions to the region's population and granting indigenous rights, the Autonomy law delimited the spaces open to local control. Moreover, the process lacked specificity which provided subsequent governments with avenues with which to circumvent the process of autonomy and weaken it. What is clear however is that the legitimacy of local claims could only be made through their assertion of cultural difference.

Chapter Four provides an analysis of the Health Model of the RAAN. It analyzes the role that the health sector plays in the wider autonomic process through the assertion of cultural difference. In it I argue that "culture" acquires a central role in health debates because it legitimizes local control of resources. Without the discourse of cultural difference there would be little difference between the RAAN and other administrative departments of Nicaragua. I then show how this reliance on "culture" as the basic framework for discussion is amenable to appropriation by national officials who hold a different and more restricted understanding of the role of culture in health.

In Chapter Five I provide a case study of the representation, management, debates and policy discussion of an epidemic of a culturally patterned mental illness known locally as *grisi siknis*. This case study contextualizes the arguments made through out the dissertation. It demonstrates how the approach to the epidemic differed between regional and national health officials. The different views pertained to different interpretations of the concept of *interculturalidad* which affected the policy recommendations proposed. The case study exemplifies the constraints that a discourse based on cultural difference places on regional health officials and advocates.

In Chapter Six and Seven I present the experience of twelve communities that participated in the PSILN which was developed as a pilot program of the Health Model by an NGO. Both chapters provide an analysis of the challenges of implementing aspects of the Health Model in the communities. During my period of fieldwork the members of these communities were introduced to the Health Model. Interestingly enough, a similar dynamic in the debates about the Health Model at the institutional level were found at the community level. Discussions about culture as expressed through indigenous medicine provided a point of agreement among the various sectors. However, discussions that delved into the organizational and resource aspects of the Health Model were the source of fierce disagreement and debate. I argue that this is in part due to the exigencies of maintaining and reviving culture at the institutional level which guides health program planning and implementation. By trying to represent the cultural difference and authenticity of Miskitu indigenous culture, health policy and planning adheres to ideas of an idealized indigenous culture that does not take into account the practical economic realities and outside influences that affect communities.

In the final chapter I provide an overview of the arguments developed through out this dissertation. I revisit the issue of the effects and role of identity politics in reforming health systems in multi-ethnic contexts and insert the case of the RAAN presented through out this dissertation within the broader debates of culture, politics and health.

2.0 INDIGENOUS MOVEMENTS AND THE CULTURAL POLITICS OF HEALTH

The political and economic transformations in Latin America since the 1980s have centered on the inclusion of cultural diversity in all state institutions including the health system. Indigenous movements have had a leading role in advocating for the inclusion of cultural diversity within the state and in shaping the discourse and language that guide these transformations. In this chapter I review the literature on these political and economic transformations in Latin America paying particular attention to how indigenous discourses have been incorporated in the formation of health policy.

There is a parallel discussion and debate in the Latin American literature of identity politics and indigenous movements, and the scholarship on international public health that centers on the role and utility of the concept of "culture" and its relationship to politics in addressing the needs of ethnic minorities within the state. The discussion in both is concerned with evaluating the results and process of policies, initiatives and movements that view culture as the central organizing principle or variable. Scholars with a political economy orientation have criticized the use of the concept "culture" because it may serve as an excuse that replaces real political and economic changes needed to meet the needs of the most vulnerable populations. My aim in this chapter is to present the connections between culture, politics, representation and health; and how anthropology and the social sciences more generally have approached these connections.

2.1 INDIGENOUS MOVEMENTS AND THE STATE IN LATIN AMERICA

Indigenous movements in Latin America are currently at the forefront of political debates and transformations of the state. Their visibility in the international arena increased dramatically in the 1980s. Various factors have contributed to this increased international visibility. First, the beginning of the "democratic transition" in Latin America from authoritarian rule provided spaces for new forms of organization and protest. Second, the formation of indigenous organizations and their support by NGOs at the grassroots and international levels since the 1970s had a profound effect in the struggle to position indigenous groups within the political arena (Van Cott 1994; Brysk 2000). Neoliberal policies implemented in the 1980s also had an important effect on the rising demands made by indigenous groups. The reduction of spending in the social sector affected indigenous groups, historically the poorest population in Latin America, the most (Psacharopoulos and Patrinos 1994). Moreover, neoliberal policies infringed on the social contract that had been established between the state and its populations, such as the dismantling of the benefits of land reform[4]. The effects of globalization had another important impact. Increased access to new forms of communication, such as the internet in the 1990s, provided indigenous groups with an ever-expanding network for organizing, the formation of alliances, and sympathy from an international audience (see Brysk 2000). These networks provided a source of international pressure on local governments, whether in the form of human rights or the deepening of democracy, which provided local indigenous movements with leverage for their demands.

[4] See for example Collier and Lowery (1994) and Stephen (2002).

The rise of so-called “new social movements”, of which indigenous movements are a part, caught the attention of social scientists in the last two decades of the 20th century (Escobar and Alvarez 1992; Alvarez, Dagnino and Escobar 1998). Escobar and Alvarez (1992, 3) provide a distinction between these “new” social movements and “old” social movements. The “old” and the “new” were considered to be based on both the empirical reality of political, economic and social transformations in Latin America; and on a change in the theoretical perspective of scholars. The “old” relied on theories of modernization and dependency that defined politics within the relationship of traditional political actors based on structural relations of class. In the “new” social movements “a multiplicity of social actors establish their presence and spheres of autonomy in a fragmented social and political space” (Escobar and Alvarez 1992, 3). The “new” social movements in essence draw on different “identities” as an incitement for organizing and carving new political spaces for the promotion of identity specific demands, such as women’s rights, indigenous rights and gay rights.

The decade of the 1980s is a watershed for these forms of collective action because of the “crisis of development” and the modernization process in Latin America. The economic difficulties and political crisis in Latin America helped expose the inadequacies of the program of development and its prevailing ideologies, whether from the left or the right that tried to sustain or revolutionize it. As Escobar (1992) has argued, development is both economic and cultural discourse. The discourse of development marginalized indigenous groups from “dominant circuits of material and symbolic production” (67). The crisis of the 1980s helped accelerate the questioning of the fundamental assumptions, meanings, and practices embodied in the development discourse. The increase in global connections, through new forms of communication, allowed groups that had been previously marginalized to question the existing

mechanisms for the production of meanings, identities, and social relations. These "new social movements" questioned the fundamental relationship of the state to their populations by debating notions of "citizenship", "rights" and "democracy" among others. Moreover, they proposed new alternatives according to their visions and identities. The political and economic crisis also added new allies to various social movements as state repressive mechanisms and violations of human rights helped produce sympathy and pressure internationally for a reordering of the social order in Latin America[5].

Although indigenous movements became more visible in the 1980s, indigenous organizations had been slowly forming in the previous decades through grassroots organization by NGOs and the Catholic Church (Brysk 2000), and by the continued presence of indigenous leaders in international meetings dealing with issues relevant to indigenous peoples (Niezen 2003). Indigenous organizing has also been influenced by the history of organizing in the local context, such as peasant or rural organizations (Mallon1992). The formation of indigenous intellectuals started coming to fruition in the 1980s. Indigenous intellectuals drew attention to the plight of indigenous people and voiced their concerns. Indigenous people's plight found resonance with the growing human rights movement, which had slowly been coalescing, and indigenous rights gradually became incorporated into the human rights agenda.

It is within the international arena that the language of indigenous rights begins to take shape. Subsumed within the label of indigenous rights, is a summary of the demands indigenous people consider necessary for their economic, social, and cultural reproduction. These rights

[5] The best example in the 1980s is that of Rigoberta Menchu's account of the Guatemalan state's repression of its indigenous population and their human rights violations (Menchú with Burgos-Debray 1984). Despite the controversy created by Stoll's (1999) work, the fact remains that Menchu's story sparked international attention to indigenous peoples political and socio-economic conditions in Latin America. She became a symbol of the struggle of indigenous groups against the state.

pertain to collectivities as opposed to individuals, as human rights are usually understood. These demands include the right to land, respect and recognition of their culture including their customary laws, and most importantly self-determination and autonomy. Autonomy can be defined "as the recognition of an ethnic group as an autonomous political entity possessing a territory over which it maintains legal jurisdiction" (Van Cott 1996: 45). The discourse of human rights has accepted indigenous rights as part of its advocacy for indigenous people even though human rights are usually considered in individual, as opposed to collective terms. Stavenhagen (2002) has explained the argument of indigenous rights/collective rights advocates as follows:

> Indigenous rights advocates argue that even the most basic of individual rights are hardly enjoyed by ethnic groups or minorities who are systematically discriminated against or excluded by the power structure in the prevailing system of social stratification (37).

Given the persuasiveness of these arguments in the context of Latin America, many involved in the human rights community have accepted the idea that indigenous rights are a precursor for the enjoyment of human rights.

The indigenous movement at the international level, with the continued acceptance of indigenous rights, has strongly influenced the current of change in the relationship between indigenous groups and the state. International multi-lateral organizations and changes in international law and jurisprudence have increasingly incorporated and helped propel indigenous rights. For example, the International Labor Organization's Convention 169 and the draft United Nations Declaration on Indigenous Rights have recognized indigenous groups as peoples, which allows for self-determination. Self-determination for indigenous groups has taken the form of demands for autonomy. This has been the most contentious aspect in the negotiation between indigenous groups and the state. The possibility of self-government has made some government representatives nervous, fearing an increase in ethnic tensions and demands for secession from

the state. For most indigenous groups self-government is a necessary in order to participate fully within the political system while maintaining control over the decisions that directly affect them. It also insures the protection of indigenous lands which are understood as the basis of indigenous economic and cultural survival.

Indigenous movements have had some successes in redefining the relationship between indigenous groups and the state (Assies and Hoekema 1994). Constitutional reforms in different countries throughout Latin America have recognized the multicultural and pluri-ethnic composition of the nation and have included some indigenous rights. Constitutional reforms have been adopted in Guatemala (1985), Nicaragua (1986), Brazil (1988), Colombia (1991), México (1992), Paraguay (1992), Perú (1993), Bolivia (1994), Panamá (1997), Ecuador (1998) and Venezuela (1999). The indigenous rights recognized in these constitutional reforms, and the forms they take, vary widely from country to country. There are various configurations of indigenous political autonomy, from community autonomy to protected areas to regional autonomy. They also entail different conceptions of participation in the decision-making process, collective ownership of land, and the provisioning of social services (such as bilingual education and health). Van Cott (2000) has argued that these changes were possible because of recognition among the elites that a multicultural state would improve the "legitimacy and governability of the state" (32). Moreover, Van Cott (2001), in an analysis looking at nine Latin American countries, concluded that debates about autonomy and *interculturalidad* have come about in contexts of peace talks after armed conflicts and other periods of crisis in the legitimacy and governability of the state (see also Anaya Muñoz 2004).

Notwithstanding the numerous successes that indigenous movements have had throughout Latin America, there are still many challenges and debates confronting the formation

of new social contracts between the state and indigenous people (Sieder 2002). The implementation of these constitutional reforms, and the laws associated with them, has been a continuous source of political debate and friction. In some countries constitutional reforms and laws are not always adequately implemented if they are implemented at all. There is also the challenge of creating or transforming laws so as to incorporate indigenous demands. There is still a great deal to be done.

The results of granting indigenous rights and/or autonomy have been varied. Self-government has been plagued by institutionalization problems, conflicts with the central government and fractures between indigenous groups (Assies and Hoekema 1994; Rizo 1998; Aussies, van der Haar and Hoekema 1998). Decentralization strategies and political autonomy of indigenous regions have faced problems regarding limited budgets, centralized allocation of resources that limit local decision-making and the persistence of local central-government related institutions that replicate vertical implementation of policies (Assies 1998; Calla 1998; Hoekema 1994).

The challenges do not only pertain to conflicts between indigenous groups and the state. Indigenous movements vary considerably in their approach and goals, locally within a country as well as internationally. As Stephen (2002) has shown in the case of Mexico, indigenous people living in different regions and communities have different understandings of their relationship with the nation given their different local histories and practical realities. There are always conflicts not only between different indigenous movements and organizations but also within them (Warren 1998b).

Indigenous movements and their evolving relationship with the state have presented many challenges and spurred many debates for social scientists. This poses questions as to how

to study and understand such complex phenomena. Also, and perhaps more contested, who benefits from these developments? These questions as well as the important role the construction and representation of culture has in the process necessitate an understanding of the relation between culture, politics and anthropology, to which we now turn.

2.2 CULTURE, POLITICS AND REPRESENTATION

In his article on anthropologists' lack of engagement with multiculturalism debates in the United States, Turner (1993) makes a distinction between "culture as anthropological theory versus culture as identity politics" (411). Turner implies that anthropologists' lack of engagement with debates about multiculturalism is due to a use of culture in multiculturalism that falls outside of the anthropological understanding of culture. Warren and Jackson (2002) discuss the dilemmas of an "engaged anthropology" in Latin America. The dilemma for Warren and Jackson centers on the same key issue of how to disentangle the anthropological understanding of culture from its use in identity politics in indigenous movements. The dilemma consists of approaching the subject theoretically and empirically while being aware of the importance and political implications of the understandings and representations of culture used by indigenous movements in advancing their goals. Warren and Jackson (2002) write that documenting indigenous activism "poses important analytical and ethical dilemmas, among them the politics of anthropological research and the dilemma of representing the cultural continuity that indigenous movements assert in the face of so much evidence to the contrary" (3). Whether we are discussing multiculturalism in the United States or *interculturalidad* in Latin America, the central question revolves around the understanding, representation and use of culture in the

marketplace of ideas. And more importantly, how these are connected to politics and power. As Turner (1993) has argued, "culture in general has thus ceased to be a purely academic concern of anthropological theory and had begun to emerge as a fundamental political issue" (425).

Indigenous movements, as well as many other ethnic movements throughout the world, conceptualize themselves as distinct cultures. Culture becomes synonymous with ethnic identity. Conceptions of culture present in identity politics have become salient at the same time that anthropologists have rejected static and bounded views of culture. These conceptualizations of culture make anthropologists uncomfortable. Turner (1993) summarizes the reasons as follows:

> From an anthropological standpoint, this move, in its most simplistic ideological forms, is fraught with dangers both theoretical and practical. It risks essentializing the idea of culture as the property of an ethnic group or race; it risks reifying cultures as separate entities by overemphasizing their boundedness and mutual distinctiveness; it risks overemphasizing the internal homogeneity of cultures in terms that potentially legitimize repressive demands for communal conformity; and by treating culture as badges of group identity, it tends to fetishize them in ways that that put them beyond the reach of critical analysis (412)

In many instances in Latin America, claiming indigenous rights and receiving financial or political support from the international community depend to a large extent on an "essentialist" view of culture that demands from indigenous groups a display of "authenticity". This occurs at a time when anthropology itself has come to understand indigenous groups as being forged through the colonial encounter itself (Urban and Sherzer 1991). Moreover, the present political and economic context in which indigenous peoples are embedded, coupled with the dynamic nature of cultural and social relationships themselves, are conducive to cultural change (Jackson 1995; McFall and Morales 2000; Pineda 2001). This places anthropologists in a difficult position as empirically and theoretically sound research may have political consequences for those we study.

Anthropologists have debated whether we should understand these indigenous movements, and ethnicity in general, as "constructed" or "invented" identities or as movements that originate out of a culturally "constructed essentialism" (see Ericksen 1992 and Hale 1997 for reviews of these debates). In dealing with these issues some have come to use the word "strategic essentialism", which might provide clues as to the solution of the concept of identity, but may not account for what people themselves think of their actions (Pineda 2001). Some have argued that groups inevitably mix strategic essentialism with other lines of argument to legitimize their existence (Warren 1998a). Analytic attention has started to focus on the production and consumption of authenticity rather than on the elaboration of criteria for an objective standard (Jackson 1995a; Warren and Jackson 2002). From this vantage point Warren and Jackson (2002) argue that for anthropologists, "the issue is not proving or disproving a particular essentialized view of culture but rather examining the ways essences are constructed in practice and disputed in political rhetoric" (9). Furthermore, they argue that "the anthropology of indigenous organizing becomes the study of the choices that people in different settings make in the ongoing process of their own identity formation" (11). They also point out that these choices are contingent on wider political and economic pressures as well as local history.

Alvarez, Dagnino and Escobar (1998) have stressed the importance of understanding the relation of culture and politics when attempting to understand social movements. For them "culture is political because meanings are constitutive of processes that, implicitly or explicitly, seek to redefine social power" (7). The view of culture's relation to power dynamics necessitates an understanding of culture that goes beyond discourse and that accounts for social practices. In this sense "the symbolic and the material", "discourse and practice" are intricately bound. As Ferguson (1994) has argued in studying development, discourse "does something"; it is used as a

guiding principle to frame projects and action that may have real effects in everyday lives. Moreover, discourses not only have an effect on social reality but also provide the conditions from which new discourses arise, or old ones are reformulated, that attempt to challenge that social reality. When discussing social movements Nash (2001) made this point when she argued that:

> The emergence of new social actors cannot be subsumed in "identity struggles" without addressing the institutional and economic systems which both define and are reconstituted by their presence. The emergence of "women" and "ethnic groups" as protagonists of change is due not so much to what were once considered to be "ascribed" characteristics as to the special responsibilities these groups bear in the new structural conditions they encounter (20).

From this vantage point culture "is not a sphere, but a dimension of all institutions—economic, social and political", culture "is a set of material practices which constitute meanings, values and subjectivities" (Jordan and Weedon quoted in Alvarez, Dagnino and Escobar 1998: 3). In order to underscore the importance of the relationship between culture and politics, Alvarez, Dagnino and Escobar (1998) use the concept of cultural politics. They define cultural politics as "the process enacted when sets of social actors shaped by, and embodying, different cultural meanings and practices come into conflict with each other" (7). The concept of cultural politics emphasizes the importance of the struggles over interpretation and meaning for the exercise of, or resistance to, power.

Escobar (1992) has warned of the potential pitfalls of thinking about politics in the conventional sense, meaning formal politics between groups and state government institutions. He stresses the importance of understanding politics as "struggles over cultural meanings at the level of daily life" (71). Individuals and collectivities are always within multiple fields of interaction ranging from the household, the community, the region, the state and the global order. The struggles over cultural meanings occur among multiple axis of interaction (such as gender,

kinship relations, ethnicity) that help shape people's choices and strategies. As such any understanding of social movements must pay careful attention to the different axis of interaction that help shape collective action and identity production.

When one takes an approach that looks at the intricate and complex relationship between culture and politics, or culture and power (whether at the level of daily life or embedded in global relations), the question always arises as to who benefits from particular discourses and practices. This has been one of the central debates since the increased visibility of social movements in the 1980s. The question has been raised as to whether social movements, such as the indigenous movements, lead toward more autonomy and the reconfiguring of structural power relations or if they in essence maintain the underlying structure. Hale (1996; 1997) in his surveys of the literature on social movements and identity politics has delineated two theoretical perspectives that deal with the subject, what he labels as the materialist and discursive theoretical camps. The discursive camp sees the turn toward identity politics as a process of creative renewal, in which social movements based on identity politics have the potential of expanding democracy, widening sociopolitical citizenship and even of creating a "new hegemony of the masses." This happens by challenging the state's economic and political models, and by questioning authoritarian and hierarchical politics (Escobar and Alvarez 1992; Jelin 1985; Slater 1985). The materialist camp, argues that the state and dominant groups have responded to opposition by encouraging people to express discontent through the idiom of identity, which provides a less threatening challenge than class based mobilizations (Jameson 1984; Dirilik 1994; Rouse 1995; Vilas 1994). Some have argued that some of the propositions advanced by social movements are beneficial to the logic of advanced capitalism (Varese 1994).

These opposing views give primacy to either culture, as expressed in the struggle over meaning in discourse, in which the material circumstances are not taken into account, or to political economic considerations that leave culture as a residual category in social phenomena. In reference to indigenous autonomy, Smith (2004) has argued that the discussion "too frequently glosses over the complexities indigenous landscapes present today" (205). He argues that the discussion has been too polarized and has had "little sensitivity to self-determination in real time and place" (205). The process of negotiations over meanings and structure occurs in a complex field of interactions that vary in diverse forms of social movements. As such, a categorical evaluation of the process as a whole is unlikely to do justice to the advances made by certain social movements in improving the conditions of their existence, or in doing justice to the persistence of unequal relations in the contemporary world. As an example, one could think of the case of political autonomy over the control of resources in an indigenous territory. Some would argue that a concession made by the indigenous leadership to a multi-national company to extract resources is congruent with the logic of advanced capitalism in circumnavigating the state (Varese 1994). Others might argue that the fact that the benefits from the transaction go to indigenous people shows a fundamental transformation of power relations within the state itself. So in essence in these multiple fields of relationships of power there are no clear-cut ways of valuing the goals of social movements. For this reason Hale (1996; 1997) has argued that a step toward bridging this theoretical divide is with engaged ethnographic research that documents and accounts for the wide range of material consequences –from empowerment and renewal, to entrapment in new or persisting forms of oppression—that can result from mobilizations. In a similar vein Warren and Jackson (2002) argue that:

> The trick for anthropological analysis is to find a way of mirroring the process we are attempting to study—to pursue multiple lines of interpretation to see if they yield insights

> into the highly situational and dynamic process of indigenous organizing, rather than to prematurely classify the outcome of these changes as either one of structural autonomy or one of subordination to the dictates of the wider system (17)

In looking at the dynamics of the negotiation over power inherent in the inclusion of diversity within the political system and at the role social movements' play in this process, it is important to pay attention to the multiplicity of actors involved in their situational context. There is a variety of actors that has to be taken into account, and these actors cannot be viewed as representing a unified voice, whether we are referring to the state, indigenous movements or international organizations such as NGOs engaged in the process. In order to understand the intricate connection between culture and politics we need to analyze how an instrumental view of culture is understood and used by social actors in their struggle not only over meaning but over resources. As such, following which representations of "culture" are used in different contexts will allow for a critical understanding of culture. Whether an individual or collectivity subscribes to an instrumental view of culture, as Warren and Jackson (2002) argue, representation is double sided. By this they mean that cultural displays and representations are created for auto-consumption or for negotiation with regional, state or transnational audiences. As such, these different representations can provide insight into the way power mediates the content and context of intercultural interaction.

Recent studies of indigenous movements in particular, and social movements in general, have illuminated the variety of factors that shape interactions and provide the basis for conflicts over representation and power within the struggle for the negotiation of diversity within the state. These studies help us understand the mechanisms for organization in social movements and their possible drawbacks in local circumstances as well as pointing to avenues for the results these movements might have in practice.

The form of organization of an indigenous movement and its understanding of and demand for indigenous rights and autonomy depend heavily on local circumstances and are therefore context dependent. Mallon (1992) has argued that different national discourses have presented different opportunities and forms of indigenous organization in different states. Furthermore, the presence or absence of previous forms of political organization, such as labor movements can have an effect on the political form and inclusiveness of such movements and their goals. At a more localized level these differences occur at the regional and community level as well. The presence or absence of centralized authority and natural resources in a given community affects the presence of the state and the form of political activity in different communities (Varela 1984). Stephen (2002) has shown how national symbols are interpreted in relation to local history and forms of organization and how these lead to different forms of political action and different levels of confrontation with the state. Smith (2004) argues that the embeddedness of a region in global markets helps shape local meanings of autonomy where in the case he researched, it combines ethnic-purist, market-led, and state-sponsored development models. Indigenous communities interpret these developments within their everyday lives and use different means from within the movement or outside of it in order to convey their struggles for self-determination to a wider audience (Gray 1997; Korovkin 2001). In this sense the lived experience of members of a particular community (their modes of subsistence, ways of reproducing the community, their ethnic identity and the like) are important points of reference in interpreting the discourse and practice of indigenous movements. Given the variety of social contexts in different regions and communities it is no surprise that there are difficulties in forming a unified indigenous movement, with different conceptions of community and participation, as Warren (1998b) in her study of the Pan-Mayan Movement has shown.

The institutionalization of movements has also provided drawbacks to social movements. The institutionalization of a social movement occurs when social movement organizations are integrated into the realm of formal politics. Institutionalization has the potential of putting pressures on traditional organization and authority figures (Alberoni 1984). Warren (1998) has analyzed how indigenous intellectuals take center stage in these struggles and how their class status has changed. It has been argued that in struggling within the system indigenous intellectuals "lose touch with their roots" and use Western concepts uncritically (Ramos 1994). In this sense indigenous movements may rely on Western (Jackson 2002) or alternative discourses (Gow and Rappaport 2002). However, as Warren and Jackson (2002) have argued, in both situations "political discourses from dominant society continue to intrude in the *Realpolitik* of collective decision-making…because so many interested parties with complex and varied agendas participate"(17). In some cases indigenous leaders are displaced by younger indigenous people with formal education, creating another set of tensions (Padilla 1995; Hernandez-Cruz 2000; Leyva-Solano 2001). The question of leadership provides avenues from which to think about how institutionalized movements may restrain the possibility of popular participation and input as movement leaders negotiate their positions and alliances in the international and national arena (Matamoras 1992; Scherrer 1994). Alberoni (1984) has argued that segments of a movement that become institutionalized through state-sponsored organizations can become assimilated into government priorities and separated from their constituent organization. The institutionalization of oppositional movements in other cases suggest that they may create centralized bureaucratic power structures that may inhibit a movement's vibrancy and affect its connection to those it purports to represent (Feierman 1990). In some cases the political system has manipulated indigenous identity by incorporating indigenous leaders into political party

politics (Castillo Cocom 2005). And even worse, some governments have used the discourse of ethnic preservation to hide persistent domination over indigenous groups (Baines 1999).

There is no doubt that the progress of indigenous movements and the movement toward a multi-ethnic state is a complex process that can not be judged outright. Although global discourses (such as that of the indigenous movement, human rights and others) and global processes (such as structural adjustment) have an effect on the process in all countries, the local context determines the shape it takes.

2.3 *INTERCULTURALIDAD* IN LATIN AMERICA

Since the late 1990s in Latin America, the inclusion of cultural diversity within state institutions has been guided by the discourse of *interculturalidad* (Escuela de Antropología Aplicada and UPS 2000; Fuller 2002). The concept of *interculturalidad* as it has developed in Latin American thought attempts to address some of the critiques and pitfalls presented in the previous section. It attempts to provide a political conception of culture that is neither static nor reified. Tovar Gonzalez (2000) has argued that the concept of *interculturalidad* is more appropriate than the concept of multiculturalism because the prefix "inter" conjures notions of connectedness as opposed to fragmentation and yet still incorporates within itself the notion of difference.

Interculturalidad is conceptualized as both a political and epistemological project (Walsh 2002b; de la Cadena 2006). Walsh (2002a; 2002b; 2002c) has articulated *interculturalidad* from a position inspired by post-colonial and sub-altern studies. She places *interculturalidad* within the "geopolitics of knowledge" and the "coloniality of power" as proposed by Mignolo (2000).

From this perspective the geopolitical aspects of the economy are intimately linked with knowledge production. Knowledge produced at the periphery of the centers of economic power are subjected to a devaluation of their importance, a result of the colonial relationships that have shaped the interaction of the centers (the United States and Europe) and the peripheries (Latin America and Africa). Mignolo argues that because of the importance accorded to knowledge produced in these centers of power a trap has been set in that "the discourse of modernity created the illusion that knowledge is de-localized and that it is necessary, from other regions of the globe, to 'move up' to the epistemology of modernity" (Mignolo in Walsh 2002c: 19). From this perspective Mignolo argues that:

> If, for example, in order to understand the Zapatistas I base my analysis on Bourdeieu or in sociological methods, then, what I am doing is reproducing the colonization of knowledge, negating the possibility that for the socio-historical situation of Latin America, the knowledge generated by the Zapatistas is more relevant than the one produced by Jurgen Habermas. One of the negative consequences of the geopolitics of knowledge is to impede that knowledge be generated from other sources, drink from other waters. *Caramba*! How am I going to think of civil society and "inclusion" without Habermas and Taylor? How am I going to think departing from the Zapatistas or Fanon that produced knowledge based on other histories: the history of black slavery in the Atlantic and the history of European colonization of indigenous groups in the Americas? (Mignolo in Walsh 2002c: 19-20)

Indigenous movements and the rise of indigenous intellectuals challenge the very conception of modernity itself, and the knowledge that sustains unequal and colonial relationships within the state. Walsh (2002a) in her study in Ecuador, argues that the indigenous movement and its discourse of *interculturalidad* is not asking for "recognition" or for "inclusion" within the State but is struggling for a more fundamental transformation. The point of departure is a challenge and a struggle for the transformation of "colonial difference", which is both political and epistemic. An intercultural approach moves beyond culture. As Walsh (2002a) conceptualizes it, it not only challenges cultural difference but colonial difference as

well. By which she means that an intercultural approach questions and looks for strategies with which to change the unequal structural relations that have been historically constituted in society, which have their roots in the colonial history of Latin America. As such, there is an emphasis not only on cultural difference but also on social justice and resource distribution. For her *interculturalidad* is:

> based in the necessity of constructing relationships *between* groups, and also *between* practices, logics and different form of knowledge, with the goal of confronting and transforming power relations…that have naturalized social inequality (Walsh 2002a).

Walsh (2002a) criticizes approaches that "simply use…ethnic pluralism of society and the right to difference as a starting point". The problem with this approach which she labels multiculturalism in opposition to *interculturalidad*[6] is that a debate centered on cultural diversity looks at ethnic relationships and conflicts as a problem that lies within discourse and communication. The problem with these proposals is that they conceive the problem as "an issue of personal willingness, not as a problem linked to power relations" (Walsh 2002b: 119).

The discourse of *interculturalidad* in practice, as with terms such as "democracy" (Paley 2002), has multiple derivations and is used in a wide variety of ways. The term "*interculturalidad*" is now widely used by a variety of actors with competing visions and agendas. It is no longer in the control of the indigenous movement and its intellectuals, but has gained common currency within governments, international organizations such as the Inter-American Development Bank, and academics. As such each of the various actors re-conceptualizes it according to their interests. These different interpretations of the term involve

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[6] This distinction between multiculturalism and *interculturalidad* is one that is shared with other Latin American academics that have tackled the topic of diversity within the state (Tovar Gonzalez 2000; Tubino 2002; Etxeberria 2002). Although this distinction may provide conceptual clarity in identifying different discourses and approaches to the inclusion of diversity within the state, in reality as we will see what is labeled as multiculturalism and *interculturalidad* by these authors, in policy documents and political discourse in Latin America is expressed through only the concept of *interculturalidad.*

different effects in policy. In reality, an intercultural vision of the democratic state as constructed theoretically and philosophically is confronted with contexts that are inherently unequal. Walsh (2002a) argues that institutional reforms that rely on multiculturalism are simply "additive". These are reforms such as creating a ministry of indigenous affairs, which simply adds a new institution without transforming the overall system itself (see also Diaz-Polanco 1998). Although this is viewed as a positive step, Walsh (2002a) sees this as limiting. In reference to an indigenous institution in Ecuador she goes on to say:

> Despite of its existence within the state, it does not have the power or possibility of substantially altering the state, or of promoting major changes and relationships outside of its particular spheres of operation…outside of the indigenous.

Moreover, in the end, these policies' concentration on cultural specificity helps promote the continued fragmentation of society. In this sense she says that:

> Suggesting that the problem of *interculturalidad* is simply a problem of the treatment of indigenous peoples, and not a historical and structural problem of society as a whole, can lead to fundamentalisms and ethnicisms that many times are useful in constructing the parceling and separation of society.

This opens up the possibility of co-optation of the concept of *interculturalidad*. Mignolo has argued that "when the word '*interculturalidad*' is used by the state in its official discourse, its meaning is equivalent to 'multiculturalidad'. The State wants to be *inclusive*, reformist, to maintain a neoliberal ideology and the primacy of the market" (Mignolo in Walsh 2002c: 26).

The discourse of *interculturalidad* in Latin America addresses the critiques that have been discussed in the previous section. It rejects bounded and static conceptions of "culture" by focusing on the interaction and exchange of social actors who embody different meanings. Moreover, these interactions and exchanges are understood as being shaped by unequal structural relations that have deep historical roots. However, in lay and political debates about diversity in

the state the concept that has come to define the political transformations in Latin America is understood and used differently by different sectors of society. It is important to understand the basis of this discourse because its approach is incorporated into health policy advocacy and debates.

2.4 POLITICAL SYMBOLISM OF HEALTH

The realm of health and medicine holds a central place in human society. Byron Good (1994) has argued that in Western medicine, despite its materialist basis, moral and "soteriological" issues, those dealing with suffering and salvation, are "fused with the medical and at times erupt as the central issue of medical practice"(67). He goes on to say that "illness combines physical, and existential dimensions, body infirmity and human suffering…medicine as a form of activity joins the material and moral domains" (67). It is this connection between the material and the moral which drives Good to see medicine as a "symbolic form", a symbolically mediated mode of apprehending and acting on the world, "through which reality is formulated and organized in a distinctive manner" (68). As such medicine is "a central site for the discussion of many of the most important value issues in society" (87).

Although Good (1994) is referring specifically to Western medicine in general, and Western medical practice in particular, his statement applies to all medical systems. The moral and soteriological dimensions of health and medicine make it at one and the same time appear above politics as it is used as a central domain for political struggles. In dealing with matters of life and death and with human suffering, medicine seems to be too important to be manipulated by politics. At the same time medical systems reflect the values and structure of the society in

which they are found. As such, the realm of public health and medicine is a central site for political struggles, in attempting to shape or transform a vision of society itself. Moreover, as I mentioned earlier in the introduction, health indicators serve as a barometer of the inequalities and injustices in a society. Stories of children dying of preventable diseases are commonly used in political rhetoric to denounce societies or governments, whether local or global, that allow such things to happen (Butt 2002). A good example would be the Zapatista response to Salina's promise of pardon if the Zapatistas surrendered. To which the Zapatistas replied:

> should we ask pardon from the dead…those who die "natural" deaths of "natural causes" like measles, whooping cough, breakbone fever, cholera, typhoid, mononucleosis, tetanus, pneumonia, malaria, and other lovely gastrointestinal and lung diseases? Our dead…dying of sorrow because no one did anything (Marcos and the Zapatista Army of National Liberation 1995: 81-82).

It is for these reasons that health and medicine have become important political symbols as well sites for political struggle.

The most comprehensive case study of health as a political symbol is the one of Costa Rica presented by Morgan (1993). In her study of the community participation initiative, Morgan asserts that in Costa Rica "health is imbued with the highest moral connotations –altruism, purity, self-control, charity, goodness", while politics is "characterized by deceit, corruption, avarice, and a lust for power"(9). From this vantage point she argues that "the moral imbalance of politics and health is useful to politicians, who can inflate their own moral standing by professing their concern for health" (9). But the benefits of health as a political symbol are not accrued only by politicians but also by government themselves. Again in this vein Morgan asserts that "a government which deliberately promotes health places itself, by symbolic association, above the dirty business of politics" (9).

The symbolic association between a government's promotion of health and politics becomes even clearer if we look at the role of health as a central symbol in Cuba. Feinsilver (1993) views health in Cuba in the following terms:

> The central metaphor in Cuba's anti-imperialist struggle…is that of health. The health of the individual is a metaphor for and symbol of the health of the "body politic", and which the achievement of the status of "world medical power" is synonymous with victory over the imperialists. Medical doctors are the protagonists in this war both at home and abroad. They are warriors in the battle against disease, which is largely considered a legacy of imperialism and underdevelopment (22).

Feinsilver's analysis sees the importance of health in Cuba not only for the legitimacy of the revolutionary regime for its population but for the legitimacy of the regime at the global level. Good health statistics are symbolic of good government and efficiency. As Feinsilver has argued in the case of Cuba, "socialist governments rely on their ability to meet the socioeconomic needs of their populations to legitimize their regimes" (200).

The political symbolism of health also relies on the organization of health care delivery as it is connected with the ideology and structure that is being promoted in wider society. A good example would be the emphasis on participation in health care. In Cuba the socialist ideology saw the success of improving health in embedding "medicine within a significant transformation of the socioeconomic structure" (Feinsilver 1993: 28). In Cuba popular participation in health was meant to symbolize and instill in individuals a socialist ethic, as individuals assumed responsibilities toward society in the formation of the "New Revolutionary Man". In Costa Rica, however, popular participation in health was meant to convey a commitment to democracy. On this point, Morgan (1993) says that "Participation is an important ideological element within the symbolic domain of democracy" (7). These two different symbolic associations about participation and health with the ideological system, show how the meanings attached to health are variable, situational, and therefore amenable to political debate and struggles.

These political connections are also founded on the "mode of acting and apprehending the world" inherent in a particular medical system. Adams (1998) shows the role doctors played in the democratic revolution of Nepal. She argued that the "scientific truths" attributed to medicine and science were seen as giving doctors a base from which to pursue political change within the moral grounding of objectivity. She says that Nepalis had "a growing desire…to infuse medicine with politics, but only in order to make truth heard" (25). In the case of Nepal, "western medicine" was seen as a sign of modernization that would in turn help propel Nepal into the "modern" world as a democratic state. Similarly to the case presented by Morgan (1993) a discourse based on health and medicine, gave moral authority to those using it, since it placed them above the "dirty business of politics". However, Adams (1998) concentrates on the rise of this discourse from the "truth claims" of Western medicine. In the case of Nepal this causes some contradictions. As Adams has said:

> Nepali medical professionals hope to establish an objectivist social system based on standards of efficiency, equality, and democratic representation while protecting their distinctive Nepali society and culture. But preserving their cultural distinctiveness often requires these agents of modernity to behave as "non-modern" subjects (26)

This points to the confrontation and attempt to merge different symbols arising from distinct social contexts and histories.

Health and medicine as political symbolism emerge out of two related but distinct aspects. First, the health of a population, whether assessed through statistics or through qualitative accounts symbolizes the equality present within a society or government. And secondly, the way in which the health system is constituted is meant to symbolize the wider values and structure of the society in which it is found, which points to the inherent political nature of health and medicine.

In the past two decades in Latin America, the transformation of political systems and society has centered on the recognition of the multi-ethnic composition of the nation. It is for this reason that in dealing with the health of indigenous groups the political symbol that reflects this multi-ethnic recognition has become “intercultural health” which has been developed on the basis of the discourse of *interculturalidad* (see Alvarez, Alvarez and Facuse 2002; Betancourth and Jaramillo 1997; Fernandez Juarez 2004; and Orellana Salvador 2003). Health programs and reforms are meant to reflect the plurality of ethnic identities and the recognition of the practices and beliefs of the different ethnic groups within the state. As such, health has become a site for the forging of the multi-ethnic state.

2.5 INDIGENOUS PEOPLE, HEALTH AND CULTURAL POLITICS

2.5.1 Health, Poverty and Indigenous Peoples

Among indigenous groups in Latin America, health becomes a site for political struggle. First, the precarious socio-economic and health conditions of indigenous populations give legitimacy to claims of marginalization and the inherent inequality that indigenous groups suffer. Since health and economic data are not systematically collected by national governments by ethnicity, there are few empirical data about the situation of indigenous people. The conditions of indigenous people have to be estimated by using the data available on the regions in which they are concentrated and by scattered studies on the health situation of indigenous people done in different countries. Psacharopoulos and Patrinos (1994) show that indigenous people are concentrated in the poorest regions of most Latin American countries. For example, their data showed that in Bolivia 64.3% of the indigenous population were living in poverty compared to

48.1% of the non-indigenous population, in Guatemala 86.6% to 53.9%, Mexico 80.6% to 17% and in Peru, 79% to 49.7% (Psacharopoulos and Patrinos 1994: 207). In a follow-up study covering the "Indigenous People's Decade" from 1994 to 2004, Hall and Patrinos (2005) found that despite the political advances made by indigenous groups in the form of more political representation and autonomy, very few gains were made in reducing poverty among indigenous groups. In terms of the health of these populations, no systematic data are available, but the scattered studies available indicate that indigenous populations have worse indicators (infant mortality, life expectancy, maternal mortality) than the national averages in their respective countries (PAHO1997; see also Hall and Patrinos 2005).

2.5.2 Indigenous Health Policy

The precarious economic and health conditions of indigenous groups serve as a basis for promoting not only a transformation of the health system but of the relation between indigenous groups and the State. The causal factors are seen not only as medical but also as structural. As such increasingly the consensus among international organizations has been to link the improvement of health conditions to self-determination. As indigenous groups have come to represent themselves in international meetings and summits, the rights they claim have become part of an international effort to encourage and press Latin American countries to recognize and grant various indigenous rights to their indigenous populations. This has been the result of a host of international meetings and summits, among them, the Universal Declaration of Human Rights (1948), *Cumbre para la Tierra* (1992), the *Convenio Constitutivo del Fondo para el Desarrollo de los Pueblos Indígenas de América Latina y el Caribe* (1992), *Cumbre de las Américas* (1994), *Convenio 169 de la Organización Internacional del Trabajo sobre Pueblos Indígenas y Tribales*

en Países Independientes (1989), *Decenio Internacional de las Poblaciones Indígenas del Mundo* 1994-2004 (1993), and the *Declaración de los derechos de los Pueblos Indígenas* (1997) among others. In one way or another, these international meetings have addressed the issue of health of indigenous peoples, and these have been linked to rights to self-determination, education and land.

The Pan American Health Organization (PAHO) has also contributed and responded to these international summits. Its policy recommendations for indigenous groups come from the Health of Indigenous People Initiative (see PAHO 1998b). This was the result of the "celebration" in 1993 of the "Year of Indigenous Peoples." PAHO decided to respond by holding a consultation and workshop on indigenous health in Winnipeg Canada in 1993. The resolution from Winnipeg, Canada, established five principles for work in indigenous communities: the need for a holistic approach to health, the right to self-determination by indigenous peoples, the right to systematic participation, respect for and revitalization of indigenous culture, and reciprocity in relations.

An interesting result of international meetings and accords has been the incorporation of elements that go beyond health services in the evaluation of State's commitment to indigenous health. Rojas and Shuquair (1999) and PAHO (1998a), for instance, use as criteria for assessing a country's commitment to the health of its indigenous population the rights to land, language, education and religion, cultural revitalization, as well as the indigenous group's access to health care and the inclusion of traditional medicine.

A large number of these policy recommendations are not new. They are based on the Alma Ata declaration of 1978, with its focus of primary health care (PHC) as the basis for health care structuring. The basic components of PHC are community involvement and participation,

appropriate health technology, and the reorientation of health services away from urban, hospital-based care toward country-wide health programs. It also included an emphasis on preventive medicine and the employment of community health workers and traditional medicine to serve the needs of the community. These developments resulted in a move throughout the countries of the World to use the primary health care paradigm to structure the health system. Programs for the expansion of primary health services to the poor and rural populations were instituted in many Latin American countries, some before the Alma Ata declaration as in Costa Rica and Chile, and others like Nicaragua after the declaration. Interestingly enough, although the Alma Ata declaration has fallen out of favor in international health policy (see Banerji 1999; Navarro 2001; Rifkin and Walt 1998), it remains the basis for most health programs for indigenous people and many of the poor (see Fassin1992; Fernandez Juarez 2004; Naranjo and Crespo 1997; Teran and Mato 1995), the difference being that primary health care (PHC) is not the focus of the country wide health system but of the rural areas.

2.5.3 *Interculturalidad* and Decentralization

Approaching indigenous health from a broad holistic perspective that includes other aspects not conventionally thought of as part of health policy, such as education and land rights, is a step forward in tackling the complex factors that influence indigenous health. However, one has to question the possibility of acting on these, given that they depend on a political process that may fall outside health policy-makers hands. It does however put pressure on governments to recognize the importance of a holistic approach to health. There are two aspects of indigenous health policy that help advance these goals, *interculturalidad* in health and decentralization.

Perhaps the main focus of indigenous health policy is on cultural difference expressed through the discourse of *interculturalidad* and intercultural health (Cuijema and Ochoa Davila 2003; Cunningham 2002; Orellana Salvador 2003; PAHO 1998). Intercultural health as generally used in Latin America today by indigenous group leaders and advocates refers to a normative principle that forms part of a wider political proposal for the inclusion and valuing of diversity within the state. As was discussed in a previous section (page 44-47), *Interculturalidad* is proposed as a new paradigm in which cultural diversity is recognized, respected and valued; and moreover, a perspective that challenges what Walsh (2002b) has referred to as "colonial difference". It is an attempt to challenge the unequal structural relations of indigenous and Afro-Latin American groups in society. This challenge is not only political and economic but also epistemic, meaning that it challenges the differential value assigned to knowledge that comes from groups within different structural positions. As such, there is an emphasis not only on cultural difference but also on social justice and resource distribution. From this perspective indigenous medical knowledge is not only accepted as something that affects health but is also officially recognized and supported. Intercultural health then is understood "in the general framework of the liberation and development of indigenous peoples at the interior of national societies" (Servicio de Salud Araucania IX Region and Ministerio de Salud de Chile, 1996: 56).

The intercultural approach has been adopted by PAHO and many Latin American countries with indigenous populations. In introducing the definition of *interculturalidad*, PAHO (1998a: 20) asserts that the,

> past and recent historical processes in the region, have determined that between the different cultures exists a spectrum of relationships that, in the majority of societies, arise in conditions of subordination, asymmetry and conflict.

Interculturalidad is then seen as an approach that helps redress this situation. PAHO (1998a) then asserts that the concept of *interculturalidad* "involves the equal and respectful inter-relationships of the political, economic, social, cultural, linguistic and gender differences, established in a particular space between different cultures"(20). All definitions of *interculturalidad* share these elements. *Interculturalidad* is meant to convey acceptance, respect, horizontal relations, inclusion, equity, reciprocity and solidarity (PAHO 1998a; Almaguer, Vargas and Garcia 2002).

The elements presented above address what *interculturalidad* entails but it is not entirely clear what it means. Almaguer, Vargas and Garcia (2002) define *interculturalidad* as a "relationship of respect and an understanding of the way of interpreting reality and the world, a process of communication, education and formation" (4). Specifically they see intercultural health as "the openness to knowing and understanding culture and how the worldview of a population affects what is understood as health" (5). This definition is based on an understanding of *interculturalidad* as a process of cross-cultural communication. The model they pose as representing the process goes through four stages: respect, horizontal dialogue, mutual understanding and synergy. The process of *interculturalidad* for them is a process of communication that in the final stage of synergy is meant to produce results that could not be envisioned by adhering to the precepts of just one culture. The understanding and definition of *interculturalidad* as primarily a process of communication, is a common one. In this sense dialogue is seen as the basis of the intercultural approach. In Servicio de Salud Araucaria IX Region-Ministerio de Salud de Chile (1996) they indicated that "*interculturalidad* is based on dialogue, in which both parties listen to each other, in which both parties talk and each one takes

what can be taken from the other, or simply in which they respect their particularities and individualities" (35).

A different view of *interculturalidad* sees communication as an initial step in the process of inclusion of cultural diversity in health institutions and places emphasis on political action as opposed to the process of communication. Cunningham (2002), for example, argues that "*interculturalidad* is the basis that replaces ethnocentrism in inter-ethnic relations of domination, and constitutes itself in the process of different cultures living together in contact, and that guarantees each one spaces in which to develop autonomously" (8). The use of the word autonomy is important in highlighting the different conception held towards the meaning of *interculturalidad*[7]. Cunningham sees the basis of *interculturalidad* in the transfer of power to different cultural groups so they can use their resources according to their socio-cultural reality. It is equally composed of communication and action. She focuses more on the making and process of intercultural action as opposed to intercultural communication. Her model for the process of *interculturalidad* can be contrasted to that of Almaguer, Vargas and Garcia (2002). She sees the process of *interculturalidad* as composed of three stages: inter-relation, auto-determination and equity. In this model, interrelation is the process of communication, followed by increased control by indigenous groups over their own situation, leading to equity in terms of resources. In this sense Cunningham (2002) argues that intercultural health implies that "all health systems [referring to indigenous and institutional] have the possibility of being practiced in conditions of equality by those who have practiced them traditionally and also that they can count on resources" (8).

[7] See also Orellana Salvador (2003) who links *interculturalidad* in health with indigenous autonomy and decentralization.

The previous quote points to another important aspect of *interculturalidad*. In many instances in Latin America, intercultural health is linked with indigenous forms of medicine (CIES and Reyes 1987; Fernandez-Juarez 1999). The promotion of indigenous medicine is considered a fundamental aspect (and point of contention) of the process of intercultural health, because it lies at the basis of the respect for other cultures and with the goal of valuing other forms of knowledge. It is important to note that intercultural approaches to health are not only about indigenous medical systems. Cunningham, Moreno and McCoy (2003) argue that *interculturalidad* emerges out of a "double right: the right of indigenous peoples and ethnic communities to maintain and cultivate their traditional medical practices and, the right established in international and national legislation that health is the right of all citizens" (25). In other words, the term *interculturalidad* on the one hand emphasizes the importance of "cultural rights" and on the other it points to the government's responsibility to provide adequate health-care through access to institutional medicine. An example of using an intercultural approach for example would entail going through indigenous forms of organization in order to develop vaccination programs. However, the acceptance and integration of indigenous medicine in the health system does present a major challenge of intercultural health in Latin America.

Perhaps we should view the two models presented here not as opposing models but as complementary models that emphasize different aspects of the process of *interculturalidad*. The last stage in Almaguer, Vargas and Garcia's (2002) model called synergy could be seen as the beginning of what Cunningham (2002) calls self-determination. And conversely, what Cunningham calls interrelation can encompass the previous three steps presented by Almaguer, Vargas and Garcia. We can view them as two ends of a continuum. However, the emphasis on one end of the process or the other (communication or political action) can serve as the basis for

different interpretations of intercultural health, the expectations of different stakeholders of the intercultural dialogue, and the policies that arise out of these. The backgrounds of these authors provide clues to explain this difference in approach to intercultural health. Almaguer, Vargas and Garcia (2002) write for the institutional health system of Mexico and Cunningham (2002) writes from the point of view of an indigenous activist in Nicaragua.

The recognition of this difference in "intercultural health" and of the need for different policies to deal with indigenous peoples are at the center of the advocacy for decentralization in the health system in areas with numerous indigenous populations (Cujilema and Ochoa Davila 2003; Cunningham 2002; PAHO 1997). These efforts at decentralization are part of conceptions of *interculturalidad* as political action. Decentralization does not arise out of an intercultural preoccupation but with broader concerns about efficiency and local responsiveness (Birn, Zimmerman and Garfield 2000; Bossert, Larranaga and Ruiz-Meir 2000). However, the main outline of decentralization, its reasoning, and expected results are aligned with the goals of the indigenous movement. The rationale for decentralization is that local autonomy in decision-making processes along with inputs from the local population will lead to increased responsiveness of health care to local needs, increased quality and social empowerment. In evaluating decentralization, Bossert (1995) outlines the need for ways to assess improvement of equity and the democratic process. In terms of the indigenous movement control over resources and autonomy in issues related to health is heavily aligned with the goal of political autonomy and self-determination of indigenous groups. Cunningham (2002) for example, sees decentralization as the key to and end result of intercultural health.

2.5.4 Cultural Politics of Indigenous Medicine

Given the centrality of culture in indigenous health policy, cultural revitalization then becomes an important component of health advocacy and policy, along with other criteria, such as access to resources (land) and services (expansion of health care). The logic and basic idea behind these developments are well represented in Warry's (1998) case study of Canada's Health Transfer policy towards its indigenous population. The problems facing indigenous groups are seen as not only economic. Warry argues that:

> From an Aboriginal perspective, individual and community problems do not stem simply from poor socioeconomic conditions, but are also directly attributable to low cultural esteem, or lack of cultural identity, which is critical to feelings of self-worth…a feeling of control over one's life is an essential element to positive self-image and physical well-being (84).

From this vantage point Warry argues that "the process of self-governance and community healing are related" (256), by which he means that active involvement in and control of not only of health issues, but also other matters pertaining to indigenous well-being (such as land ownership and education), provides indigenous people with a way to resolve their own problems and be empowered in the process. He goes on to say that:

> Individual healing fuses self-actualization and political commitment through a deeply spiritual understanding of one's cultural identity. This process of individual healing produces people who are firmly committed to the idea of cultural revitalization and self-determination (256).

For Warry state recognition of self-government has "great symbolic and practical value" for indigenous people since it "conjures up ideas about cultural integrity, sovereignty, and equality" (256).

It is important to stress the importance of indigenous movements at the international level as well as locally in the development of the inclusion of the wide range of factors that are

deemed necessary for the health of indigenous populations, found in the PAHO documents and the different international conferences and declarations. However, although Warry's argument is consistent with international discourse of the indigenous movement, it is important to realize that the connection among self-determination, health and identity is more complex. Cultural revitalization in health, usually taking the form of the promotion of indigenous medicine, is important not only as a way to improve the health of the population, but as a way to legitimate claims to self-determination itself.

Cultural revitalization is very important to indigenous groups. It is meant to counter discourses that stand in the way of claiming indigenous collective rights. Indigenous rights are based on difference. They are based on a group's establishing that it has been a separate collective entity (Stavenhagen 1994; Jackson 1995). Indigenous claims parallel those of the nation-state in claiming the ownership of land and the natural resources contained in them, and so they come in conflict with the interests of the state. National discourses of *mestizaje* in some cases, have worked in erasing these collective differences (Gould 1998). In Guatemala, for example, the discourse of *mestizaje* has been used by the government as a rationale for denying claims to indigenous people. The Guatemalan government has claimed that indigenous people have been subsumed within the national category of *mestizo*, and therefore have the same rights as all citizens (Hale 1996). The discourse of *mestizaje* in Nicaragua has also been effective not only in government's claim but also in making indigenous people themselves deny their own indigenous identity (Gould 1996; 1998). From this vantage point, it is easy to see why cultural revitalizations have come to be an important component for the political struggle of indigenous groups. An implicit prerequisite for the recognition of indigenous groups and their access to funding and support from international audiences is for indigenous people to represent their

authenticity (Conklin 1997; Grahan 2002; Jackson 1995a; Oakdale 2004; Warren and Jackson 2002).

Cultural revitalization in health for the most part concentrates on indigenous medicine. Indigenous groups advocate for the revitalization and inclusion of indigenous healing within the health system because it is considered an integral part of their ethnic world view, cosmology and identity (Pinzon, Suarez, Garay and ICAN 1991). Indigenous health beliefs and medicine serve to establish indigenous groups' authenticity. Medical anthropologists have recognized the importance that medical beliefs and indigenous medicine have in the formation of indigenous groups' ethnic identity (Crandon 1991; Barrett 1995; Garcia 1995; Gordon 2000; Jackson 1995b; Langdon 1991; Pinzon et al. 1991).

World view, present in indigenous beliefs about health and illness, and the ethnic identity that derive from them are crucial to claiming indigenous rights within nation-states. Albert has argued that "indigenous discourse legitimates itself by making reference to cosmological knowledge" (Albert quoted in Graham 2002, 204). Indigenous healers are considered repositories of cultural knowledge, and are considered important in the transmission of cultural values, culturally mediated history and indigenous cosmology. Moreover, healing rituals are sites where complex negotiations of the social environment take place as cultural politics are expressed within the ritual practices of healers. Healing rituals can provide a space in which politics and social change are mediated, expressed and shared within groups (Gray 1997b; Langdon 1991; Taussig 1987). In the context of indigenous rights, traditional medicine serves as a way of asserting difference and as a way by which links to ancestors are made, a crucial element in making claims to land and autonomy within a nation-state (Jackson 1995a). In these contexts, where claims are contingent upon establishing cultural difference through particular

cultural modes of organization and structures, the traditional healer and indigenous medicine has an important role to play. The Pan-Mayan movement, for example, has revitalized indigenous culture by trying to institute forms of organization that link it to the past, such as a council of elders and indigenous healers (Warren 1998b). In Colombia education of indigenous shamans has been attempted as part of a wider strategy of gaining indigenous rights (Jackson 1995b). Indigenous healers in Chile and other ritual specialists help define ethnic boundaries and spheres that should be subject to indigenous control (McFall and Morales 2000). These are demarcated by the authority of their connection to the land by way of their ancestors. In Nicaragua a similar cultural revitalization of indigenous world view through indigenous medical beliefs and practices is underway (Cox 1998; Fagoth, Gioanetto and Silva 1998; URACCAN 1997). In contexts of minority populations within the state outside of Latin America, traditional medicine has been a locus for the retention of cultural and ethnic identity as well as a site of struggle between state visions of modernity and ethnic visions of the future (White 2001). The importance of indigenous medicine to the indigenous movement was evident in the meetings about indigenous medicine that accompanied the indigenous mobilizations in protest of the 500 year celebration of the New World's "discovery" (Gabriel 1994).

Endorsement of the inclusion of traditional medicine into national health care systems is not new. In the 1970s it emerged in the context of nation-states formation in Africa and Asia. Akerele (1983), the then director of the Traditional Medicine Programme of the WHO, explained that the traditional medicine component of the Alma Ata declaration and the subsequent formation of the Traditional Medicine Programme were the result of two main factors: the changed political power that in much of the world accompanied national independence, and the minimal resources that were available for the extension of health care. As he put it, "the first

factor is related to national group pride and is associated with past heritage and newly gained national independence. The second factor is linked to utilization of all available resources" (Akerele 1983:1). In the restructuring of their health systems, the newly independent countries had incorporated indigenous forms of medicine in the provision of health services. This was about more than just health. The role that Western medicine had played in the process of colonization of the "Third World" must be recognized (Comaroff 1993; Arnold 1993). This strategy was meant to broaden the reach of health services, but it was also a movement rooted in the construction of the newly decolonized nation. From this perspective, the transformations that were being implemented in the field of health in some of these countries have to be seen from its political dimension. Lozoya (1991) for example, has said that in Africa and Asia, "all the actions were notably inscribed within the political discourse of national identity, anti-imperialism and cultural reinvindication", and yet, "Latin America was still asleep" (272). What he means is that in Latin America, although the use of traditional medicine was attempted, it was part of scattered programs that lacked true government backing. In Latin American, more prominent recognition of traditional medicine was made possible in a context in which indigenous oppression, mobilization and rights became part of the international community's consciousness. It occurred when indigenous movements started gaining spaces within national politics.

2.6 CULTURE, POLITICAL ECONOMY AND PRACTICAL LOGIC IN HEALTH

For those familiar with the health development literature, the components that drive indigenous health policy (primary health care, participation, i*nterculturalidad*, decentralization, traditional medicine) will arouse skepticism as to the possibility of real change. The results of

programs, initiatives and reforms along these lines have produced mixed results at best, and many critiques and explanations for the failures. The main critiques mirror the persistent theoretical divide within medical anthropology between culturalist and political economy approaches. They differ in their emphasis on the role of culture and politics in health. As Brodwin (1997) has phrased it, in the culturalist approach, "local residents are the supposed beneficiaries of improved services" while in political economic approaches, "they are the ultimate victims of a repressive social order that co-opts PHC programs" (71). However, both approaches coincide in a critique of centralized and "top to bottom" approaches to health policy development and implementation. Indigenous health policy at first glance would reduce part of this skepticism. The basis of indigenous health policy is in indigenous rights and autonomy, which theoretically place it at the grassroots and decentralized level. However, given the parallels between intercultural health and other approaches, it is important to take a careful look at whether this difference lies at the level of discourse or practice. Moreover, the political context may inhibit the possibility grassroots movements to produce concrete political change.

2.6.1 The Role of Culture in Health

What I call the culturalist approach encompasses two ways that culture's relationship to health is theorized. The first one, closely aligned to the "health belief model", looks at how indigenous cultural beliefs and practices may cause disease and illness or hinder public health initiatives (Foster 1984; Nichter and Nichter 1989). The second one sees the problems in health systems as not giving enough validity to indigenous cultural health beliefs (Bastien 1987; Fernández Juárez 2004).This second approach takes into consideration the role of power, but only insofar as inequality in relations gives prominence to one health system over another

(Carames Garcia 2004). What both approaches have in common are the centrality of culture to health and an emphasis on the process of cross-cultural communication whether as a barrier to accept traditional health beliefs and practices on the part of institutional health systems and health initiatives, or as a barrier to the acceptance of health beliefs and practices based on Western medicine by the recipient population (Bastien 1987; Lopez 2004; Steffensen and Colker 1982). From this point of view the problem with public health programs and interventions arise when local culture is not taken into consideration and not incorporated in the planning and development of interventions. Furthermore, there is a tendency in the culturalist approach to place high hopes on the possibility of indigenous medicine in improving the health of the population, sometimes in a romanticized version (Bastien 1992). The culturalist approach looks for mutual interaction and cooperation between Western and indigenous medicine, thereby attempting to bridge the cultural gap in communication and understanding Intercultural health approaches gravitate toward a culturalist approach, and place emphasis on dialogue and cultural sensitivity (Almaguer, Vargas and Garcia 2002; Servicio de Salud Araucania et al. 1996; Teran and Mato 1995). In this sense health policy is guided towards "cultural competence" in health (Comelles 2004). Cultural competence implies the ability of health programs, services and professionals to effectively communicate across cultural barriers, therefore providing better care.

The political economic approach centers on the role that differential distribution of resources has in affecting health. Some see international health development projects as mechanisms through which imperial control and exploitation in peripheral areas are advanced (Elling 1981; Whiteford 1990). From a political economy approach an emphasis on culture is suspect. Culture has been argued to have the potential for abuse in health research and policy. Farmer (1999; 2005) has written about the conflation of cultural difference and structural

violence. His argument is that many times “culture” is used as an explanation in health issues and this use of culture masks the role of economic and political inequality in health (Farmer 1999, 248-257). An uncritical understanding of the relationship of culture to health can also lead to the “racialization” of health beliefs and the reduction of complex phenomena when dealing with groups with a different ethnic identity (Lambert and Sevak 1996). Foster (1999) has argued that the acceptance of a cultural model in international public health deflects the responsibility of failure from the agencies implementing policies and programs. Culture then becomes a scapegoat for the failure of public health programs, reproducing a “blaming the victim” explanation (Lambert and Sevak 1996). Critiques such as these argue that the focus of research to explain the failure of these programs is better placed on the bureaucracies and institutions that develop and implement them (Foster 1999; Justice 1986).

Briggs and Mantini-Briggs’ (2003) detailed study of a cholera epidemic in Venezuela provides a sobering example of the conflation of structural violence and cultural difference. They show how the cholera epidemic was understood in racial terms as a disease that affected “Indians”. Official explanations for the higher vulnerability of the indigenous population and spread of the disease were placed squarely on cultural beliefs and practices. Moreover, this “cultural logic” led to, and was supported by, racial stereotypes that were masked in biological discourse, such as assertions of indigenous people being prone to disease given their weak immune systems. Lacking in these explanations was the role of economic inequality in the epidemic, such as the lack of infrastructure in the areas where indigenous communities live and the failings of the health system. As Briggs and Martini-Briggs (2003) concluded “when a racial logic seems to explain everything, gaining access to up-to-date medical research seems to be unnecessary” (220).

Velimioric's (1990) critique of the traditional medicine initiative in PHC programs also sees programs that depend on appeals to cultural appropriateness as masking and maintaining inequalities. He argues that traditional medicine does not address the key issues in primary health care, the expansion of coverage and quality of services. He goes on to say,

> Contrary to the intention of its proponents, the WHO initiative actually detracted from the goal of assuring adequate primary health care for all. Far from being a step forward, it was a step back. It created unrealistic expectations that since "something was being done," all would be well. It tended to institutionalize the status quo and thus create a double standard—one for rural areas (largely TM [traditional medicine]) and another for urban centers (largely biomedicine). It seemed to assume that nothing could change in the years ahead. (59)

Moreover, Velimioric (1990) argues that traditional medicine has not been proven to be effective in addressing the "real problems" used in making a case for the PHC initiative in the first place. He goes on to say that "measles can be prevented only by vaccination and not by drinking urine, and polio is not caused by disturbance in a person's spiritual environment" (54). For Velimioric, traditional medicine could be integrated in order to ensure that cultural beliefs are taken into consideration in order to implement effective programs but the danger is to view it as a stand alone initiative that supersedes or even replaces biomedicine.

The approaches to culture in public health have also been criticized for their potential of essentializing cultural difference when used uncritically. Taylor (2003) criticizes cultural competence programs as "so many specialized tools to be stashed in a briefcase and trotted out each time one of 'them' shows up". Briggs and Martini-Briggs (2003) caution that "'Cultural competence' is now stressed in many medical schools, but it can easily become a crash course in stereotypes that can further…destructive cultural reasoning" (328). Comelles (2004) also sees the potential of abuse of "cultural competence", but sees a role for it in the future in so far as it stays away from "taxonomic conceptions of 'culture' and comes closer to a "fluid conception of

culture" (25). Nonetheless, indirectly, he casts doubt on the possibility of achieving this outcome.

These potential dangers of the use of culture in health are especially troubling when we think of the importance accorded to culture in reforms subsumed under the heading of "intercultural health", especially as indigenous health issues are strongly linked with identity politics, which, as explained before, have a tendency toward essentializing cultural difference. Therefore, the static view of culture criticized above may be used and held not only by medical and public health institutions but also by the target populations for health interventions. From a political economic perspective, the problem is not "culture" in and of itself. The problem is the nearly sacred position that "culture" and "cultural difference" are given in liberal notions of identity politics. This may create a problem when culture trumps other avenues through which to advance the health of the population, and to address economic inequality. For example, Farmer (1999) bemoans the fact that:

> Americans may impose –through the World Bank or the International Monetary Fund, say or through foreign policy writ large- social and economic policies that drive up inequalities, leaving the destitute sick out of the frame of analysis. But heaven forefend that we should require that the Third World poor be subject to "culturally inappropriate" medical standards. (35)

This preeminent position of "culture" in identity politics, as expressed in "political correctness" as we have come to understand it in the United States, creates tensions within the public health community. Kowal and Paradies (2005) argue that public health finds itself in a bind in multi-ethnic contexts. This bind arises out of the fact that public health is committed to acting in order to improve the health conditions of the population and is also committed to respecting cultural difference and self-determination. When these two commitments collide,

public health is hard pressed to intervene for fear of imposing Western values. The bind is then that public health is "compelled to act, but always in danger of inflicting further harm" (1355).

Just as identity politics has had limited success in providing better living conditions in other aspects of life such as land tenure, it can have some benefits in public health. Some social scientists argue that understanding mobilizations around culture from its political dimensions reveals complex relationships that go beyond critiques of culture masking and perpetuating social inequalities (Santiago-Irizarry 2003; Shaw 2005)[8]. Santiago-Irizarry (2003) observes that movements based on culture are a resource redistribution strategy in which communities attempt to increase their participation in the health system. Similarly Shaw (2005) argues that these attempts at gaining resources are aimed at achieving equal access and distributive justice. However, this potential for empowerment and resources is not without difficuslties. Santiago-Irizarry (2003) observed that claims made from "ethnoracial" activism can be transformed by the dominant society. Similarly, Shaw (2005) noted that these approaches are restrained by the discourse of culture itself. In maintaining cultural continuity and using cultural elements, these approaches sometimes cannot escape the notion of "culture as cure" (Santiago-Irizarry 2001). The potential for success of "political interventions" however, is also limited by the political context in which they develop, to which we now turn.

2.6.2 The Role of Politics in Health

As mentioned before, the realm of health is full of political symbolism and intricately bound with the political process. Lack of attention to the political dimension has been at the

[8] See also Singer (1995) who argued that critical medical anthropology could move from critique and theory to practice by being engaged in community health organizing with a political agenda meant to resist and transform local structural relations of inequality.

center of critiques and explanation for the failures of public health initiatives and policies, such as popular/community participation and PHC. Navarro (1984) argued that the policy of the World Health Organization (WHO) saw PHC more as a technical problem than as part of a larger political economic development strategy. Moreover, he argues that it did not look at the underlying causes of poor health. This seems to overlook the fact that "most improvements in health have been due to changes in economic, social and political structures rather than in the health sector" (Navarro 1984, 469).

As an example, we could look at the use of health workers and traditional medicine to expand health coverage under PHC initiative. The policy at the international level was based on the Chinese success in their health care model with the utilization of "barefoot doctors". The Chinese model of PHC served not only as the model for the inclusion of traditional medicine but also as the model for the PHC initiative itself. The problem with the adoption of the model, once again, was that it was stripped of its political dimension and abstracted as a "technical" solution to be applied in circumstances very different from China (Navarro 1984; Velirovic 1990). Adams (1998) has argued that "the barefoot doctors were political by design" and that their agendas "were aimed at convincing people of the political underpinning of health and the benefits of following a Maoist agenda" (167). The success of the model depended as much on the political process in the country as it did on the cultural salience of traditional medicine for people in the communities they served, a point made even more apparent when the political situation changed (White 1998). The framing of the policy as a "technical" matter resulted in its uncritical implementation, which led in some extreme cases for traditional healers to be in created in the implementation of some programs when they were not found (Pigg 1995).

Arguments have also been made that governments and dominant groups try to appropriate and control the resources of programs that have the potential to politicize the population. This was the case with community participation initiatives. Community organization around health has the potential, under the right circumstances, to spark political activism and mobilization. Donahue (1989), Green (1989) and Paley (2001) have shown, in Nicaragua, Guatemala and Chile respectively, that communities that organized around health may make demands that governments may have not anticipated. These demands and mobilizations may provide avenues for popular empowerment (Green 1989) and the discussion of the meaning of democracy within national contexts (Paley 2001). However, the discourse of community participation was taken over and controlled by government themselves. Ugalde (1985) argues further that the concept of "community participation" within WHO sponsored programs served as an ideological position that helped to legitimate low-quality care for the poor while at the same time generating support for regimes that did not seek equity. By adopting the discourse of community participation governments and politicians could use the positive symbolic attributes of participation (democracy and equality) while at the same time inhibiting its development by excessive government control (Morgan 1993).

There is no doubt that the failures, or successes, of these initiatives were tied to the political situation of specific local contexts and the state (Morgan 1989). Morgan (1989) shows how the local political situation in Costa Rica with various political parties contending for power led, in part, to the failure of the community participation component of PHC. On the other hand, the shaping of the state structure in Nicaragua during the early 1980s provided the space for a successful implementation of community participation (Donahue 1989). In some cases, such as Guatemala, community participation was repressed (Heggenhougen 1984). The state's

commitment and its structure had a decisive role in the success of these programs. The role of the state, however, is not enough; the relationship between the state and its citizens also has an important role to play in the responses that a country's population has to health programs (Whiteford 2001). These cases demonstrate the potential that PHC programs had to flourish under the right political circumstances or, under repressive political circumstances to be done away with.

Paley (2001) has shown that even in circumstances where substantial changes in the political system have taken place, such as Chile's change from an Authoritarian regime to democracy, results are not much different. Paley (2001, 114-117) contrasts the government response to two community health responses to meningitis epidemics that occurred during the dictatorship and after the transition to democracy. In both cases the community organized health campaigns by itself, but made demands to the government for support. During the dictatorship the community's demands were ignored. After the transition to democracy, the members of the health group were invited to a meeting with the ministry of health officials, and were heard and praised for their efforts. However, as Paley says: "if the welcome was warm, the response was similar, no resources [were] allocated" (115). Paley sees a difference in the understanding of democracy between government officials and community activists, with varying expectations of what the responsibility of the government should be.

The above example highlights the inability of major discourses, such as that of participation and democracy, to effectively deal with health. Moreover, these broad discourses are amenable to multiple interpretations, manipulations and degrees of control from different groups in society. Morgan (1993) has shown how the concept of popular participation is broad enough to foster the illusion of consensus in the face of radically different interpretations and

practice. This same principle as we will see can be applied to other broad concepts and discourses such as that of *interculturalidad*. Because indigenous health policies have incorporated elements of these discourses, it stands to reason that the discourse of indigenous rights, autonomy and intercultural health may have the same difficulties and be co-opted, in whole or in part, by national governments. The literature of indigenous movements we have already discussed certainly provides many parallels of co-optation. A good example here would be Bolivia's 1994 Law of Popular Participation, which provides indigenous peoples with more access to the political system and at the same time establishes limits upon it (Albó 2002).

Paley's (2001) example also points to another important barrier to the success of health programs. Political change does not necessarily imply economic changes which are ingrained in a privatized economic model. Interestingly enough, although for most governments in Latin America health is considered a right and a public good, neoliberal economic policies and structural adjustment interfere with the ability of governments to preserve the right to health (Waitzkin et al. 2005; Evans 1995). This helps support the contention that broad discourses such as democracy and participation may give the appearance of change while maintaining the status quo.

These discourses can also shift the locus of responsibility away from governments and onto populations and individuals. Popular participation provides the promise of self-determination while at the same time not providing the structural changes needed for self-determination to take place. In situations such as these, health strategies can increase people's perceptions of responsibility to take charge of their health while at the same time not structurally empowering them to satisfy their health needs (Donahue and McGuire 1995; Barrett 1996). The

same principle applies to autonomous regional governments, decentralized institutions, and programs.

2.6.3 Practical Logics in Health

In discussing the explanation for the failures of PHC initiatives, Brodwin (1997) criticizes the polarization of explanations for and barriers to PHC initiatives. He sees culturalist approaches as too simplistic and not being able to account for the dynamic process of culture itself or the political and economic constraint on individuals. On the other hand, he sees most political economic critiques as detached from the lived experience of individuals. The emphasis on governments, international organizations and market forces paints a picture of passive individuals oppressed and acted upon. He argues for the inclusion of "practical logic" at the local level in a given social context in order to help account for and explain the complexity of various factors that affect local decision-making, and ultimately affect the success of health initiatives. He argues that communities and individuals apply, transform and manipulate material and symbolic power in the local context. Brodwin is focusing the view on the effects that local fields of power have on health. In this sense he is focusing on the "politics of everyday life" (Escobar 1992).

As was mentioned before, indigenous communities interpret discourses of indigenous rights and autonomy from within their everyday lives and use different means and strategies in the attempt to realize them (Gray 1997a; Korovkin 2001). In this sense the lived experience of members of a particular community (their modes of subsistence, ways of reproducing the community, their ethnic identity and the like) are important points of reference in interpreting the discourse and practice of indigenous movements. Health issues are no exception.

Studies have linked political relations in the nation and the local level, and their effects on health behavior and participation in health programs. Gordon (1992) pays attention to how local health related decision-making is mediated through social relationships such as patron-client relationships that structure the political economy of the Dominican Republic. He also examines how political and economic changes can result in changing patterns of health-seeking behavior. In looking at the results of health programs in local contexts attention also has been paid to local forms of organization. The relationship between rural community structure and national centers of patronage affects participation in, and the success of health programs (Crandon-Malamud 1983; Donahue 1989). Crandon-Malamud (1991) argues that medical dialogue can work as a strategy to negotiate social identity and thus, gain access to different resources. Here, the negotiations of identity are fluid and although referring to national referents of identity, they are negotiated according to the individual's personal experience. Whiteford (1997; 2001) argues that an individual's perception of the state's commitment to help resolve their problems affect participation in health projects.

These studies indicate that the practical realities of the local context affect the way in which individuals view health and health programs. It is out of these local contexts that "practical logics" about what understandings and strategies better address the concerns of local residents arise. In terms of the indigenous movement and indigenous health policy, the practical logics in communities may conflict with the prevailing notions and expectations of leaders of indigenous movements, health advocates and officials.

2.7 CONCLUSION

In this chapter I have presented the connections between culture, politics, representation and health which guide the presentation and analysis of the Health Model of the RAAN presented in the rest of this dissertation. Here I will summarize some of the most important points derived from the literature review presented in this chapter. Indigenous movements have been able to achieve some of their objectives by articulating alternative discourses based on cultural difference that challenge national discourses of the nation and development. These movements have been successful because many Latin American countries were undergoing political and economic crises that threatened the governability of the state (Van Cott 2001). These social movements based on identity have been criticized for their uncritical use of the concept of culture. Moreover, some social scientists have argued that the acceptance of cultural demands by states is a way to deflect protest. Cultural issues present less threatening demands that allow for the continued implementation of neoliberal policies that in the long run have a negative impact on vulnerable social groups such as the indigenous population of Latin America. However, indigenous movements and states are not monolithic. The historic national and local context shape the way indigenous movements develop, the strategies used and the response from government and state institutions. An analysis of these issues therefore has to pay meticulous attention to the particular context under study.

The transformation toward multi-ethnic states shapes all institutions and aspects of society. As such, the discourse of cultural difference and indigenous rights has influenced the formation of health policy directed toward indigenous groups and other ethnic minorities. The influence of these discourses is evident in the promotion of indigenous medicine and concepts such as *interculturalidad* and intercultural health. Health initiatives and policy can serve as

political symbols for the values of the society in which they occur. From this vantage point an intercultural health system is meant to symbolize a multi-ethnic society that embraces its diversity. However, indigenous health policy is based on initiatives and approaches that have been criticized and in many cases discredited in the international public health literature. This raises the question as to the possibility of indigenous health policy providing a true alternative. The concept of "culture" in health has received criticism similar to those found in the literature of indigenous movements and identity politics. The use of "culture" has been argued to mask the political and economic inequalities that are argued to be the real source of health inequalities. Indigenous health policy however relies on the concept of "culture" since it legitimizes the discourse of cultural difference that lies at the center of indigenous movements' limited success since the 1980s with the formal recognition of some collective rights..

Advocates of indigenous movements', as we will see later in this dissertation, would argue that the context from which indigenous health policy emerges provides a different starting point than that found in the critiques found in the public health literature. The explicit political approach of indigenous activism and the discourse of *interculturalidad* that accompany the advocacy for indigenous health policy moves beyond culture to the pursuit of resources and political decision-making power in the health system. However, as the literature of the role of politics has made abundantly clear, these discourses can be appropriated and reinterpreted by national governments and international organizations. Indeed, there are different interpretations of the process of *interculturalidad* that may lead to different policy propositions.

The rest of this dissertation deals with these issues in the implementation of health policy influenced by the discourses of indigenous rights, cultural difference and *interculturalidad* in the

RAAN, embodied in a policy document called the Health Model. Te next chapter provides the context from which the Health Model developed.

3.0 THE RAAN: HISTORY, AUTONOMY AND ETHNIC IDENTITY

Nicaragua has been considered a pioneer in the legal recognition of indigenous rights by Latin American states. It was one of the first states to reform its constitution (1986) and acknowledge the multi-ethnic composition of the state, granting a measure of rights to indigenous communities. Nicaragua was also the stage of a landmark legal decision in the Organization of American States court in which land claims against the Nicaraguan state were recognized for the indigenous community of Awas Tigni (Acosta 1998; Gomez 2003)[9]. This leading role in international indigenous rights was the result of the struggles of the peoples of the Atlantic Coast[10] of Nicaragua, from the regions that are now known as the Región Autónoma del Atlántico Norte (RAAN) and the Región Autónoma del Atlántico Sur (RAAS). The configuration of autonomy for these two regions has been considered by some as a progressive political arrangement to deal with the question of diversity and indigenous rights in Latin America (Díaz-Polanco 1997, 119).

If we focused on the laws and the political rhetoric that surround indigenous rights and the region's political autonomy regimes, we might be seduced into conceding Nicaragua this leading role as a champion of *interculturalidad* and indigenous rights. However, despite seemingly progressive laws, what is written in the law books and reality are two very different

[9] This decision is expected to have wide repercussions through out Latin America. See Gomez (2003).
[10] Throughout this chapter the "Atlantic Coast" refers to the territory that lies in both what is now the RAAN and the RAAS. The history of both autonomous regions can not be separated.

things (see for example Aviles1992; González Pérez 1997). Political autonomy is a process as opposed to an endpoint (Ortega Hegg 1997). Almost twenty years have passed since the recognition of political autonomy for the region in 1987, and the configuration of all regional institutions is still heatedly debated and contested. Underfunded regional governments have been ineffectual in producing the political, economic and social changes that the population of desire. There is widespread disillusionment and cynicism among the population toward autonomy (IWGIA 2002: 95).

In the past 25 years much international and academic attention has been focused on the Atlantic Coast and the RAAN. The overarching concern has been the question of diversity within the state. The interest has revolved around two issues. In the 1980s the focus was centered on understanding the conflict between the region and the Sandinista government. During this era the question was how a leftist regime would handle ethnic demands. Since the 1990s the literature has focused on understanding the functioning of and conflicts in the autonomy regimes created in the region. During this period the question revolves around the contradictions of what Hale (2005) calls neoliberal multiculturalism, which refers to promoting cultural and ethnic diversity while promoting a neoliberal restructuring of the state.

Understanding the present political relationship between the Atlantic Coast and the Nicaraguan State necessitates an assessment of the complex history of the region. The path towards autonomy and indigenous and ethnic rights in the Atlantic Coast has been a painful and bloody one. Like Van Cott (2001) has argued in her analysis of other Latin American countries, the move toward a multi-ethnic state in Nicaragua was the result of peace negotiations that threatened the governability and legitimacy of the state. Groups from the region, mainly composed of indigenous Miskitu, took up arms against the Sandinista government in the 1980s.

This conflict drew a lot of international attention because it contradicted deeply held assumptions about political processes in Latin America at the time. The assumption was that oppressed peoples such as indigenous groups would welcome a leftist government whose platform was based on redressing social inequalities (see for example Institut Catala d'Antropologia 1986: 23). The conflict of the Atlantic Coast with Nicaragua epitomizes identity politics in Latin America since it moved away from the traditional right and left positions that have been at the center of Latin American politics (Hale 1997; Alvarez, Dagnino and Escobar 1998).

A vast literature on the conflict has been produced (see for example, CIDCA 1987; Diskin 1991; Gordon 1998; Hale 1994; Institut Catala d'Antropologia 1986; Jenkins 1986; MacDonald 1988; Nietschmann 1989; Ohland and Schneider 1983; Vilas 1989). The literature reflects a wide variety of perspectives, from viewing the Miskitu as pawns in a Cold War conflict (for example Institut Catala d'Antropologia 1986) to those that condemned the Sandinista government outright (Nietschmann 1989)[11]. The best scholarship delved deep into the complex political economic and cultural history of the region (CIDCA 1987; Gordon 1998; Hale 1994; Vilas 1989). Out of these theoretically and historically informed studies a picture of complex shifting "multi-ethnic hierarchies" emerge heavily influenced by the actions of colonial powers and the changing political economy of the region (Hale 1987; 1994).

Different ethnic groups coexist in the Atlantic Coast: the Miskitu, the Creoles (of Afro-Caribbean descent), the Mayangna (formerly known as Sumu), the Garifuna[12] and the Mestizo, and all have representation in the regional government. The multi-ethnic character of the region has been both a strength and a weakness of both the RAAN and the RAAS. Unlike other political configurations of regimes of autonomy for indigenous groups, such as the *resguardos* of

[11] See Diaz Polanco (1987) for a critique of Nietschmann's position
[12] Small communities of Garifuna are found in the RAAS but not in the RAAN.

Colombia, in the RAAN and RAAS indigenous groups share the regional government with all other ethnic groups. This can be a strength when one considers the discourse of *interculturalidad* in Latin America presented in Chapter 2. It fosters interaction between ethnic groups and a unified voice among all minority groups vís a vís the Nicaraguan state. Moreover, it is also a way to avoid ethnicism on the part of indigenous groups. Diaz-Polanco (1996) for example, has advocated regional autonomy in Mexico that is not different from that found in Nicaragua on these bases. On the other hand, the legacy of the multi-ethnic hierarchies causes distrust and tensions between ethnic groups. Recent studies in political ecology on the region have shown how the legacy of these ethnic hierarchies is used in conflicts over control of resources and lands (Meltzoff and Schull 1999; Mollet 2006). Pineda (2001) shows the opposite process in which solidarity between ethnic groups converge against outside actors. Tensions however are not limited to inter-ethnic tensions. Tensions also exist between Miskitu communities over the demarcation of communal lands (Hale, Gordon and Gurdian 1998). As we will see in this chapter, this is partly caused by the way indigenous rights are conceptualized in the Nicaraguan constitution and the Autonomy law that created the autonomous regions.

In Chapter Two of this dissertation I reviewed the literature on indigenous movements, culture and power. I argued that the literature points to the fact that individuals and social groups are immersed within different fields of relationships in which power, the construction of meanings and identity, and resources are negotiated, contested and resisted. I further argued that an understanding of these social processes requires the exploration of these different relationships in order to understand the contradictions, strategies and potential results of these processes. This chapter traces the historical development of the major relationships that affect everyday life in the RAAN today.

Any reference to a Multi-ethnic Nicaragua necessarily requires grappling with the complex history of the Atlantic Coast. The Atlantic Coast has always been problematic for the construction of the Nicaraguan nation and at the same time has been instrumental in the recent re-imagining of the nation as multicultural and multi-ethnic (Baracco 2005; Hooker 2005; Kinloch Tijerino 1995).

3.1 ETHNIC HIERARCHY FORMATION AND POLITICAL ECONOMY

The Atlantic coast of Nicaragua has been, throughout its history, geographically, culturally and economically isolated from the rest of Nicaragua. This has been both a feature of the geographical separation of the Atlantic from the Pacific region, and the historical political instability of Nicaragua. Hale (1987) provides the most comprehensive sketch of the history of the region and presents a framework with which to understand the connection between the evolving political economy of the region and the rise of ethnic identities. He shows that an understanding of Atlantic Coast history necessitates a grasp of the shift in inter-ethnic relations through various transitions in the Atlantic Coast's political economy. The most important factor shaping social change in the Atlantic Coast was "external domination" by the British and later the United States. These external pressures configured changing ethnic relations and fostered shifting hierarchies that placed one ethnic group or another in an advantaged position. These outside influences are not only related to the presence or absence of colonial and imperial powers in the region but also to changes in the region's political economy (Noveck 1988).

3.1.1 Miskitu Emergence

Helms (1969) referred to the Miskitu as a "colonial tribe". This designation was based on the observation that the Miskitu did not exist as a recognized ethnic group prior to European contact. The Miskitu emerged as a direct result of contact with British settlers in the Atlantic coast of Central America. Before contact with the British, indigenous groups in the Atlantic Coast of Central America, from modern day Belize to Panama, lived in small scattered settlements. They were kin-ordered egalitarian groups and engaged in various subsistence activities with the division of labor determined primarily by gender. Men engaged in hunting and fishing activities that required semi-permanent camps along the river ways (Magnus 1978). Women tended agricultural plots close to the main villages and planted a combination of autochthonous products, such as manioc and maize, and other European-introduced cultigens (Helms 1971; 1978). Helms (1969: 77) argues that differences in local dialects existed that formed the basis for ethnic differentiation between kin groups. During this time the relationship between these groups alternated between mutual raiding and trading. However, no particular group had an advantage over the others.

The arrival of the British in the coast in the middle and late 17th century altered indigenous society in the Coast significantly. Spain was never able to conquer or control the Caribbean coast of Central America. Spanish settlements concentrated on the Pacific side of the central mountains where the social and political organization of indigenous groups provided a system the Spanish could tap into for labor and tribute without major efforts on their part. The semi-nomadic and scattered social organization of Coastal indigenous groups made their submission difficult, since they could move to other impenetrable areas of the Coastal geography. Spain's lack of presence in the Caribbean Coast presented an opportunity for other

European powers aspiring to benefit from the colonial exploitation of the "New World". It is in this context that what came to be known as the Mosquito Coast became one of the centers of the power struggle between the colonial powers of England and Spain (Floyd 1967; see also Helms 1969; and Helms 1975: 201-216).

During the 1630s small English settlements started appearing in the Atlantic coast. These varied between buccaneers and privateers extracting natural resources from the coast (Helms 1975: 213). The Atlantic Coast of Central America served as a staging area for English raids on Spanish settlements and ships (Floyd 1967). Indigenous groups in the region established trading relations with these English settlements and some of these settlements were expressly created as outposts for trade with indigenous groups (Hale 1987: 35-36). Indigenous groups traded local goods as well as their fishing skills for foreign goods.

Indigenous settlements close to these trading posts benefited disproportionately from this trade and began to rise to prominence in the region. In addition, these indigenous groups began to inter-marry with outsiders, mostly of African descent. These African groups came from a shipwrecked slave vessel and were further augmented by escaped slaves (Hale 1987: 36). The offspring of these intermarriages were raised as natives and assumed an indigenous identity. Hale (1987) argues that three main factors contributed to the indigenous acceptance of the English presence on the Coast. First, English traders went to great effort to establish friendly relations with indigenous peoples, which contrasted sharply with the brutal and genocidal policies that the Spanish had adopted in the Pacific region. An alliance with the English shielded them from Spanish incursions. Secondly, intermarriage with groups of African descent fostered openness to the establishment of relations with outsiders. And third, the allure of foreign

exchanged goods helped propel these indigenous groups to prominence over other indigenous groups.

It was during this time in the 17th century that the name Miskitu came to be used. Concurrently the rise of "chiefs" that later came to be known as "kings" and the "Mosquito Kingdom" appeared. Contact with Europeans and foreign goods drastically changed the structure of Coastal society. Before European influence, raiding and warfare among indigenous groups in the coast occurred but there was no technological or political advantage. Trade relations with Europeans by some indigenous groups changed this balance with the introduction of metal implements, and later of muskets used in raiding. During most of the 17th century the Miskitu engaged in slaving expeditions against other indigenous groups as far north as Belize and south to Panama, subjugating them and forcing tribute (Helms 1983). This cemented Miskitu dominance under the tutelage of the British. Miskitu dominance created a new differentiation between Miskitu and other indigenous linguistic groups who came to be known collectively, despite their differences, as Sumu, presently known as Mayangna (see von Houwald 2003: 29-54). The Sumu had no choice but to either assimilate and assume a Miskitu identity, or retreat inland away from the Coast. When the option was to retreat inland, these Sumu groups were still dependant on the Miskitu for foreign goods and Coastal resources. The Miskitu became the intermediaries between the Sumu and the British, exchanging foreign goods for indigenous crops and products. This is the root of the strained relations between Sumu and Miskitu that last to this day. Encouraged by the British, the Miskitu also engaged in raids against Spanish settlements that penetrated the Coast thereby maintaining British-Miskitu dominance of the coast (Floyd 1969; Helms 1975, 210-216; Jenkins Molieri 1986, 24-31).

The success of the Miskitu in their rise to dominance was realized not only by access to foreign goods but also by changes in political organization. Olien (1983) asserts that the Miskitu underwent a "transformation from a basically tribal organization…into a chiefdom, with one individual clearly in authority over a hierarchy of positions" (200). This hierarchical position emerged with the Miskitu chief, later to be known as the Miskitu king. These Miskitu kings were able to organize raiding expeditions and control trade in the region. The specific extent of the power of these kings has been a subject of debate in the anthropological literature. Olien (1983) and Dennis and Olien (1984) argue that the Miskitu king had real internal power over the Miskitu of the region in affecting trade, raiding, and the administration of justice.

Helms (1986), however, argues that the Miskitu kings had no real power because real power rested in communal authorities. She argues that the Miskitu kings were an imitation of the British in order to make themselves favorable to the British and thus continue to receive foreign goods. Furthermore, Helms argues that the Miskitu kingdom provided the British with an excuse to bypass Spain's (and then Nicaragua's after independence) claims to the region. She cited the fact that Miskitu kings used European symbols such as military uniforms and scepters and received a European education since early in the 17th century. Noveck (1988) suggests that these two lines of argument collapse the role of the Miskitu kingdom in two different political economic moments in Coastal history. The rise of the Miskitu kingdom lies in the insertion of some indigenous groups within the mercantile system of Britain. This insertion created not only a differentiation between indigenous groups as Miskitu and Sumu, but also hierarchical differentiation within the Miskitu themselves. The capacity and success of some individuals in organizing slave raids and maintaining close ties with British traders may have brought them to prominence over other individuals. These emerging leaders increased their personal wealth,

prestige, and power. During this early period Miskitu kings did hold internal power given their ability to make others dependant on them. Noveck (1988) argues that the movement away from the mercantile system in the late 18th and early 19th century (related to a move toward industrialization in England), and the abolition of the slave trade decreased the kings power. It is during this time that the Miskitu king seems to have more of a symbolic role than a real one.

No matter what the answer to the question of the extent of power of the Miskitu kingdom is, what is important is the fact that the presence and relationship with European settlers profoundly altered society in the Atlantic Coast. And moreover, this change in coastal society brought with it the emergence of different ethnic identities that define Coastal relations in the present day. The Miskitu kingdom, whatever its form or actual power, is a potent symbol for the construction of the Miskitu nation and its claims to autonomy (Garcia 1996; Hale 1994).

An important feature of this period in history is the shifting racial and ethnic designations and hierarchies that evolved as a direct result of these encounters. Ethnic identification was reworked to reflect distinctions between the Miskitu, who had access to foreign goods and acquired British symbols, and the Sumu who did not. Furthermore, these emerging ethnic identifications inserted themselves within European racial categories. Miskitu intermarriage with African populations was one factor influencing ethnic distinctions at the time. The Miskitu were widely referred to as sambos and separated from “real Indians”, the Sumu (Helms 1977). The Miskitu began appropriating European discourses of civilization and negative classifications of Indians in their dealings with the Sumu. These discourses on race and ethnicity provide a source from which contemporary populations in the region draw in their conflicts and competition over resources (see for example Mollet 2006).

3.1.2 Creole Emergence and the Decline of the Miskitu Kingdom

Political economic transformations in the Coast related to the changing relationship of the British with the region slowly began a Miskitu decline and the emergence of Creoles as the dominant group. Hale (1987) pinpoints this period between the years of 1740, with the establishment of a formal British presence in the coast, and 1894 when the *reincorporacion* occurred and Nicaragua exercised its rights to sovereignty over the territory.

Before 1740, the British presence in the Atlantic coast consisted of scattered settlements of traders, woodcutters and a few plantations which did not form a coherent colonial presence. This changed in 1740 when the British created the position of Superintendent to oversee affairs in the Coast. Englishmen established various settlements, the most important of which is Bluefields. They bought concessions and lands from Miskitu kings and established plantations and formal commerce in the region. Some plantation owners also had African slaves. There were also “free coloureds” who owned property and engaged in commerce, although their role was more limited than that of Europeans. The ethnic group now known as Creoles arouse out of these groups (Gordon 1998). The Miskitu kingdom, although not necessarily ceding its power to the British, certainly deferred to them and to the “free coloured” communities in order to maintain favorable relations.

In 1783 the Britain signed a treaty ceding the Atlantic Coast to Spain. Despite having the rights to the region Spain did not establish a strong presence. Some British planters and traders left the Coast. However, some decided to stay behind, especially free blacks as well as some former slaves who refused to leave with their former masters. Those who stayed behind were joined by immigrants from the West Indies and formed various communities throughout the region. During the lack of English formal presence, the Miskitu kings reasserted their dominance

by attacking some of the settlements that remained and those of the Spanish. Although not all settlements were brought under Miskitu control, many free blacks came under Miskitu control as much as the Sumu. They also faced a choice similar to that of the Sumo and assimilated into Miskitu culture.

The decline of Miskitu control of the region and the rise of what came to be known as Creoles began in the 1830s with the return of the English to the coast. The English returned because of the geo-political importance that the Nicaraguan[13] Atlantic Coast acquired with plans to build an inter-oceanic canal. English economic interests in the region were also rekindled with the immigration of Creole British subjects from Jamaica and Belize who settled in the towns established by free blacks on the coast (Gordon 1998). These new immigrants were involved in commerce and export that were important for the British. The proximity to English culture of these Creoles, their status as British subjects, and the importance of their commercial activities gradually made them the new intermediaries in Coastal society.

Creole ascendance to prominence came through the relocation of the Miskitu King to Bluefields, the center of Creole influence and control. Moreover, the superintendent, the representative of the British interests, insisted that the king have an advisory council, which was mainly composed by Creoles. The Miskitu kingship therefore, although still in the hands of a Miskitu king, was controlled by Creoles. Hale (1987) argues that by this time the Miskitu king was already estranged from the Miskitu themselves, given their British education and increased loss of power. The rise of the Creoles was intimately linked to their close relationship with Britain, which they used to construct their identity. The Creoles saw themselves as the

[13] 1821 marked the end of the Spanish colonial period in Central America, and the beginning of Nicaragua, although in the 1830s Nicaraguan state formation was still in its initial stages.

"torchbearer[s] of English civilization" (Gordon 1987: 137). They contrasted themselves with Miskitu, whom they viewed in racist terms as inferior.

In 1860 Britain once again ceded control of the Coast, this time to Nicaragua as a result of direct pressure from the United States over the control of a potential inter-oceanic canal. Britain ceded the territory to Nicaragua under the condition that a Mosquito Reserve be formed, where the Miskitu and Creole would have a certain degree of autonomy. One can not underscore the importance that this treaty has had for Miskitu claims to self-determination. However, the boundaries of the Mosquito Reserve were limited and left a large part of the Miskitu population out of its protection. The boundaries of the reserve did however protect the most important Creole towns, such as Bluefields.

By the 1860s the political power of the Creoles had already been consolidated. However, keenly aware that the Mosquito Reserve's intended purpose was to protect the indigenous population, the Creoles went to great lengths to maintain the Miskitu kingship, by this time known as the "hereditary chief", in Miskitu hands. They were attempting to deflect arguments that the Mosquito Reserve had lost its legitimacy given the alienation of Miskitus from the reserve (Hale 1987: 41) Interestingly enough, as we will see later, Creoles today are criticized by Miskitu for hiding behind indigenous rights to further their interests at the expense of Miskitu.

The fall of the Miskitu in Coastal society was propelled further by the integration of the region into the world economy. After the creation of the Mosquito Reserve, the Coast became an enclave for North American export companies. These North American companies concentrated on the export of lumber, rubber extraction, bananas and mining. As North American capitalists and administrators came to dominate the productive process of the region, Creoles still retained a prominent role in Coastal affairs. Creoles occupied jobs as middle-level administrators, bosses

and skilled workers. Indigenous groups like the Miskitu however, were left at the bottom of the labor hierarchy, as they were used for seasonal labor. Noveck (1988) has argued that this was advantageous to the development of capitalist exploitation in the region. He argues that the ability of indigenous groups to engage in subsistence production when wage labor was unavailable, freed "capital from the burden of reproducing the work force with wages" (26). The Miskitu came to depend on seasonal wage labor in order to obtain the foreign goods on which they had become dependant.

Creoles still retained control of the government. The leadership role of Creoles was also due to the inroads of the Moravian church into Coastal society. The Moravian church, as we will see in a later section, has been instrumental in forging Miskitu identity during the 20th century (Garcia 1996; Hale 1994; Hawley 1997). The Moravian church arrived in the Atlantic Coast in 1845 and established itself in Bluefields (Jenkins Molieri 1986). The Creoles were one of the first groups to convert to the Moravian church and therefore by the time the church began gaining Miskitu converts, Creoles already had a leadership role within the church. The Moravian Church was able to succeed in gaining Miskitu converts in the region through their sponsorship of social programs in agriculture and health, among others. Hawley (1997) has argued that the Moravian church provided Miskitus with a message based on the Protestant ethic and the value of community at a time where most Miskitus found themselves in a period of uncertainty. In the 1880s mass conversions occurred, called the "great awakening", in which the church tripled the number of adherents.

The period from 1740 to 1894 saw a complete reversal of the ethnic hierarchy of the Atlantic Coast. As class positions changed a new shift in the construction of ethnic identity also began to take place. During their rise, the Miskitu were considered sambos as opposed to "real

Indians" (the Sumu). Now with the change in their fortunes and the presence of a population that more closely resembled Africans phenotypically, the Miskitus once again began to be conceptualized by outside forces as "Indians" (Helms 1977). Here class differences once again took an ethnic connotation. Just as the proximity of the Miskitu to the British at one time created a separation between Miskitu and Sumu, now the Creole claimed the same in contrasting themselves with the Miskitu. Shifts in identity associated with economic and social advancement changed; some Miskitus were claiming a Creole identity to legitimate their improved social standing.

3.1.3 The *Reincorporación* and Nicaraguan Sovereignty

In 1893, Nicaragua underwent a "liberal revolution" with the rise of Jose Santos Zelaya to the presidency. His government promoted a complete integration of Nicaragua into the world economy accompanied by a program of national integration. The Atlantic Coast represented an important frontier for economic development. Zelaya's government made various attempts to bring the Mosquito Reserve under Nicaraguan sovereignty through attempts at bribery of Reserve officials (Vilas 1989: 38). When these attempts were unsuccessful the Mosquito Reserve was taken by force in 1894 when Rigoberto Cabezas took Bluefields.

The Nicaraguan government's argument for the *reincorporación* were based on two main points: a racist attitude towards the abilities of the peoples controlling the Mosquito Reserve's government, and the lack of legitimacy of the government due to its control by Creole as opposed to indigenous Miskitu (Vilas 1989: 38-39). On the first point the Nicaraguan government argued that men who were superior (such as foreign capitalists and government officials) should not be dependant on a group whose abilities, in their eyes, were suspect. On the

second point the Nicaraguan government questioned the legitimacy of the Mosquito Reserve on the grounds that it had lost its purpose because of the usurpation of power by Creoles. In this sense, they argued that they would liberate the Miskitu from the tyranny and control to which the Creoles had subjected them.

The reaction to the *reincorporación* on the part of the local population was at once immediate and uneven (Hale 1994). The "hereditary chief" as well as Creoles in the region sent multiple appeals to external authorities such as Britain and the United States claiming their rights under the Mosquito Reserve, but these went largely unheeded. This response, at least initially, was mostly from Creoles. Hale (1987) argues that the *reincorporación* affected mostly Creole interests, and marginally affected indigenous groups such as the Miskitu. Therefore, there was no unified voice or movement to oppose the *reincorporación*. There were various attempts at rebellion. The Creoles for example engaged in rioting and were able to take Bluefields back for a very short period of time (Gordon 1998, 61). The Miskitu leader Samuel Pitts made attempts at rebellion after various unheard appeals and protests. He proclaimed himself the Miskitu King, was killed, and his followers dispersed soon afterwards in 1907 (Rossbach 1985). These attempts at rebellion, however, were short lived and had limited appeal within the population of the Coast given the ethnic fractures within coastal society.

The sovereignty of Nicaragua over the Atlantic Coast, especially its relationship with indigenous groups, was cemented with the signing of the Decree of Reincorporation by Miskitu community leaders. Cabezas, the Nicaraguan commander in charge of the *reicorporación*, needed to legitimate Nicaragua's action by establishing the willing acceptance of Nicaraguan sovereignty by the Miskitu. This would free Nicaragua from the treaty with Britain since the creation of the Mosquito Reserve acknowledged that Miskitu could freely choose to accept

Nicaraguan sovereignty. Cabezas rounded various community leaders who signed the decree. This incident has been controversial in Miskitu oral history (Hale 1994). Miskitu claim that the incident was based on coercion and deceit.

The *reincorporación* placed Nicaraguan *mestizos* from the Pacific in government positions displacing Creoles. *Mestizo* control of the regional government was accompanied by a process of dispossession of indigenous lands. Large tracts of land were awarded to various *mestizo* elites and foreign companies. Moreover, this dispossession was accompanied by the imposition of taxes on indigenous peoples and Creoles alike. The process brought into sharp relief the difference between the coastal population's relative autonomy before the *reincorporación* and its present submission under the sovereignty of the Nicaraguan state.

After various and constant appeals by Coastal leaders, Britain reluctantly agreed to intercede resulting in the Harrison-Altamirano Treaty of 1906. The treaty established that indigenous peoples were entitled to allotments of land and should receive titles to the land. The allotments of land as established in the treaty were supposed to be made to individual households as opposed to communities, and it was minimal considering the actual patterns of use by indigenous peoples. The Nicaraguan government proved ineffectual in the titling process since those in charge of the titling process had interests in obtaining lands for themselves. The British therefore took charge of the titling process from 1910 to 1916. For practical purposes land titles were given to communities and community blocks as opposed to individual households. Even through this arrangement, communal titles provided only minimal allotments of land without taking into account the actual use of the land by indigenous communities and population growth in the future. Not all communities received titles; the titling process took place mostly within the confines of the Mosquito Reserve, leaving out a good number of indigenous communities. The

titling process did however set the conditions for future land claim conflicts. Gordon, Gurdian and Hale (2003) argue that, on the one hand, the granting of communal titles cemented the concept of communal and indigenous ownership of land. On the other, community titles left unclaimed lands which would become considered national lands by the Nicaraguan state, and would cement Nicaraguan sovereignty over the Atlantic Coast's territory.

From the time of the *reincorporación* to the 1930s there was an increase in activities of American companies in the region (Dozier 1985). Miskitu communities provided labor for these companies and became dependant on company stores for foreign and manufactured goods (Helms 1971). This gave rise to what in Miskitu oral history has come to be known as "company times" (Helms 1971; Hale 1994; Garcia 1996). During this period the Miskitu were not totally engulfed by the international market. The boom and bust nature of an economy based on resource extraction developed into an employment pattern among Miskitu in which they alternated between wage labor and subsistence activities. However, the availability of foreign goods from company stores and the relative abundance of wage work and currency during boom periods created a favorable attitude toward American companies and the United States. This contrasted heavily with the experience Miskitu had with Nicaraguans. American companies may have extracted resources from indigenous lands but they provided Miskitu with work and desirable goods, which confirmed this era in Miskitu consciousness as a time of abundance (see Helms 1971; Hale 1994). In contrast, the presence of Nicaraguan *mestizos* were associated with land loss, and there were no tangible benefits as those provided by North American company stores.

This period in coastal history created a further transformation in the ethnic hierarchy. The *reincorporación* put Nicaraguan *mestizos* at the top of the local ethnic hierarchy. This was

experienced from the vantage point of tangible economic losses on the part of both Creoles and Miskitu. Creoles lost their control of the government and their share of the local economy. The Miskitu started seeing their economic livelihoods threatened by a process of land dispossession that they had very few means to confront. Herein lies the antipathy toward the Nicaraguan government. This period accentuated a dichotomy between Spanish/Nicaraguan and British/North Americans. It was the British who had granted titles to land in spite of recalcitrant Nicaraguan elites. It was the North Americans who provided periods of plenty through their companies while maintaining an unthreatening appearance in their exploitation of natural resources, in contrast to Nicaraguan practices.

Hale (1994) has argued that the contrasts created through out the Coast's history created what he calls "anglo-affinity" among the Miskitu. Not only did Nicaragua threaten and displace Coastal people economically, but they were also culturally alien to them. Throughout a period spanning almost three hundred years the peoples of the Coast had developed their identity through their relationship with Britain in opposition to the Spanish. Their values and points of reference had come through this relationship and were further cemented by the Moravian church, which created a division between Protestant (Anglo) and Catholic (Spanish) (Hawley 1997). Hale (1994) has further argued that understanding the Coastal populations affinity for and lack of criticism of British and North American practices must take into account the multiple spheres of oppression that affected the Miskitu. While there is no doubt that Anglo economic interests in the region affected the Miskitu negatively, they shielded Miskitu from first Spanish and then Nicaraguan practices whose negative effects were more tangible and destructive from a Miskitu point of view.

The historical period from the 1630s to the 1930s as a whole created the bases for the Coast's major social cleavages. On the one hand, it created a dichotomy between the Coast and Nicaragua. On the other, it created internal ethnic differentiation within Coastal society. These two main cleavages have created a legacy that permeates coastal politics to this day.

3.2 MISKITU COSCIOUSNESS: FROM SOMOZA TO THE REVOLUTION

The rise of a Miskitu militant ethnic consciousness developed within a period of regional economic recession and increased penetration of the Nicaraguan state during the 1950s and 60s. This spanned both the period of the Somoza family dictatorship and the beginning of the Sandinista revolutionary government in 1979. Understanding the conflict that erupted with the Sandinistas requires an understanding of the role of the changing political economy of the region during this period and the rise of organizations that attempted to ameliorate the effects of these changes on Miskitu livelihoods. Moreover, the narratives used by Miskitu as the basis for their demands of indigenous rights were forged during this period.

3.2.1 The Somoza Years

The economic booms that occurred during the beginning of the twentieth century started coming to a halt in the 1940s and became a full-fledged recession in the 1960s. North American companies started withdrawing from the region because of dwindling profits due to natural resource overexploitation, as was the case for the lumber industry, or crop diseases, as was the case for the banana industry (see Jenkins Molieri 1986: 139-163). Furthermore the International Court of Justice's decision in favor of Honduras, setting the border with Nicaragua in the Coco

River, adversely affected the economy of the region. This affected North American companies that exploited this area, some of which decided to leave, and also Miskitu communities who lived on the Nicaraguan side of the Coco River but planted their crops on the Honduran side.

The Pacific of Nicaragua was not doing much better economically. Starting in the 1950s the Somoza government, on advice from the World Bank, began a process of capitalist modernization (Vilas 1989). The future and growth of the Nicaraguan economy were linked with export-oriented agriculture (Biderman 1983). The Atlantic Coast had a central role in the overall economic program of the country. On the one hand the Atlantic coast provided an escape valve for the agrarian pressure experienced in the Pacific of Nicaragua. On the other, it presented an arena for economic expansion given its abundance of natural resources.

The agricultural frontier began to expand into the Atlantic Coast on account of the boom in cotton on the Pacific, which displaced small farmers who started migrating to lands in the interior of the Atlantic Coast (Biderman 1983). This migration of small farmers would be further aggravated by the growth of export cattle raising and irrigated rice production (Vilas 1986, Chapter 2). Small farmers moving to the Coast produced food for the local market. This expansion of the agricultural frontier increased tensions with indigenous communities in the Northwestern region of the Coast which is now the RAAN. The settlement of these farmers conflicted with land use patterns of Miskitu and Mayangna communities who considered some of these as communal lands. Moreover, it brought with it an influx of *mestizos* who became merchants and middle men between the Miskitu and the local market. This relationship was felt by the Miskitu and also the Mayagna in ethnic terms.

As part of Nicaragua's economic expansion starting in the 1950s, the Somoza government went to great lengths to identify and develop untapped economic activities (see

Jenkins Molieri 1986; Vilas 1989). With the withdrawal of North American companies the Somoza government directed regional economic development. The Somoza program for the Atlantic Coast was a comprehensive program to exert Nicaraguan sovereignty and bring the region into the Nicaraguan nation. As such, a great number of projects and programs were launched influenced by the ideology of *mestizaje*. These initiatives included improvements in education (in Spanish), infrastructure and communication, accompanied by programs aimed at increasing agricultural production and natural resource exploitation.

These development programs achieved limited success. One of the reasons was the Somoza family's tendency to use these programs for personal enrichment. Another reason was the inability of government institutions to take into account indigenous communities in the implementation of their economic projects. For example, according to Jenkins Molieri (1986: 149) in a forestry project in the pine savannahs, indigenous peoples intentionally burned down pine forests in protests against the project's implementation. The Somoza government did provide concessions to some indigenous communities when it was necessary, such as providing land titles and providing lands to indigenous communities displaced by the new Honduran-Nicaraguan border. These were concessions made to maintain order and peaceable relations. It is important to keep in mind that exerting control in a region devoid of infrastructure would be a challenge. Moreover, the low population density of the region made small concessions to some indigenous communities relatively easy to make.

The combination of the departure of North American companies, the settlement of the Honduras-Nicaraguan border, and the increased presence of *mestizos* in the region exerted an inordinate amount of pressure on Miskitu communities. The work of Helms (1971) and Nietschmann (1973) during the sixties shows how the transformation of the political economy of

the region affected Miskitu community dynamics and livelihood[14]. The participation of the Miskitu in the market economy, as mentioned before, was uneven, with alternating patterns of wage work and subsistence production. By the 1960s the opportunities for wage work dwindled with the departure of North American companies. With them went the cash with which Miskitu bought foreign goods as well as the company stores that provided them. Helms (1971: 111) argued that although the Miskitu did not lack the means of survival, for them life was not "psychologically satisfying until cash and well-stocked commissaries return[ed]".

On account of the economic depression in the Coast money became scarce and subsistence resources were being sold to obtain cash. The move to cash crops, mainly rice and beans[15], was accompanied by a change in the division of labor as men became more heavily involved in agriculture[16] (Helms 1971: 123). These transformations created tensions within Miskitu communities, since the selling of crops for cash conflicted with gift-giving obligations within kin networks and the importance of generosity within Miskitu communal social relations (Helms 1971; Nietschmann 1973). In addition, this was compounded in some Miskitu communities of the Coco River where the best lands for cultivating cash crops were in Honduras and hence became unavailable[17]. Selling their crops in the local market and obtaining goods was a highly unequal relationship. The control of *mestizo* merchants and middle-men in the transportation of crops to the market and the buying of Miskitu products and the selling of goods

[14] For an in depth review and analysis of these transformations in community dynamics to the present, see Chapter Seven, pages 246-250, of this dissertation.
[15] These crops were used for both cash and subsistence.
[16] Before this perios men were primarily involved in seasonal labor outside the community and other activities such as fishing. It was the possible commercialization of crops which brought Miskitu men to be more actively involved in agriculture.
[17] This did not affects all Miskitu communities in the Coco river. Many communities ignored the political boundary of the border and continued to plant their crops on the Honduran side. This practice continues up to the present. However, this practice is not without difficulty, since problems with Honduran authorities do arise. Furthermore, this has created tensions between the Miskitu in Honduras and those of Nicaragua.

were characterized by disadvantageous terms for the Miskitu. Some Miskitu were able to acquire some of these merchant and middle level positions but these either began to identify as *mestizo* or were conceived as such by community members (Bourgois 1982: 314; Vilas 1989: 85). The transformations in Coastal political economy created a crisis within Miskitu communities. Internal differentiations and community fractures came to the fore. This crisis however was felt in ethnic terms as the presence of *mestizos* became more pronounced through government projects and merchants. The Miskitu did not have broad social institutions that would help shield them from these processes until religious organizations created organizations that linked Miskitu communities. Helms (1971: 158) argued that Miskitu communities although at times referring to themselves as a "nation" were, for the most part, autonomous communities that interacted individually with state institutions.

Religious organizations were able to provide a sense of order and unity within the crisis experienced by Miskitu communities. These religious organizations also helped the development of a sense of Miskitu "nationhood". Capuchin missions and the Moravian Church were the main protagonists in this process (Hale 1994: 124-128; Hawley 1997; Jenkins Molieri 1986: 47-76; Smutko 1996; Wilson 1975). The Moravian Church had been in the region since 1849, and had developed a strong presence and institutional structure in many Miskitu communities by this time. The church filled many of the functions relegated by the state, such as education and health. The possibility of upward mobility for the Miskitu was therefore intimately related to participation in the Moravian Church (Wilson 1975). Hawley (1997) argues that the message of the Moravian church, centered on the value of community and hard work, was well received by community members because it helped counteract the perceived fragmentation in the communities. The transformation of the church also had another important role. Church

positions, such as that of minister, were beginning to be filled by Miskitu themselves. In addition, participation in the church gave Miskitu a sense that they were members of a broader community of Christians.

The work of the Capuchin missionary Gregorio Smutko in the 1970s added a spark to the creation of a Miskitu consciousness. Smutko was influenced by the ecclesiastical reforms of Vatican II and began to train his fellow missionaries in consciousness raising courses based on Paulo Freire's liberating education (Smutko 1996; Hawley 1997). Moreover, Smutko had studied anthropology and used his research on the Miskitu as part of his missionary work. He began to develop materials and workshops that fused Miskitu history with biblical narratives. These texts and workshops emphasized the Miskitu kingdom and the bravery of the Miskitu nation in fighting the Spanish. This missionary work emphasized auto-reliance and indigenous rights by forging a Miskitu historical narrative. These materials were embraced by Moravian pastors as well, who began to use Smutko's materials in Miskitu communities.

The work of Smutko was accompanied by social and political organizing. With the help of other sectors he created a cooperative organization in the Rio Coco, known as Association of Clubs of Agricultural Workers of the Rio Coco (ACARIC). The organization had economic and political goals. On the economic side, the organization was meant to shield Miskitu communities from the depredations of *mestizo* merchants by trying to control market prices of crops. On the political front, the organization pressed the Nicaraguan state for representation of Miskitu in local and national politics (Smutko 1996). This project was not strictly a Capuchin enterprise; many of the community representatives for ACARIC were Moravian pastors. ACARIC did not last long as an organization. However, Hawley (1997) argues that Smutko's work "provided

organizational tools and a repertoire of ethno-historical symbols which the Miskitu appropriated in a regeneration of latent ethnic-nationalist aspirations" (121).

The departure of Smutko and the end of ACARIC gave way to an organization led by the Moravians called the Alliance for the Progress of the Miskitu and Sumu- ALPROMISU. This organization carried many of the same messages that ACARIC had pursued before. Through this organization Moravian pastors started disseminating an indigenous rights message. Moreover, it fostered inter-community linkages that helped propel a message of a Miskitu nation. Hawley (1997) argues that some Moravian pastors even had a millenarian message that talked about the return of the Miskitu king and Miskitu self-rule.

The response of the Somoza government to these organizations was cautious. ACARIC for example, fit into the general economic strategy pursued by the government of creating rural cooperatives to organize agricultural production (Vilas 1989). In this sense ACARIC did not provide major threats to the work the government was trying to do. ALPROMISU on the other hand, had a more politicized agenda that appealed specifically to indigenous identity which conflicted with the government's nationalist agenda. In the end the government monitored the organization closely but allowed it to exist because the strategy of the organization worked from within the government structure. Moreover, the Somoza government was able to co-opt members of the organization[18].

[18] The leaders of ALPROMISU, for example, were replaced after the Sandinista revolution on account of being Somoza informers.

3.2.2 The Sandinista Revolution:

The Frente Sandinista de Liberacion Nacional (FSLN) came to power in 1979. With the Sandinista victory a revolutionary process began to take shape in Nicaragua. The Sandinistas espoused a social development program that, although very different in ideology and scope from the preceding development attempts by the Somoza government, still maintained important continuities. The FSLN's Historical Program of 1969 contained many of the development aspirations that the Somoza regime had attempted in the Atlantic Coast (see Vilas 1989: 102-105). This included the development of agriculture and the exploitation of resources from the region. The difference between the programs was an emphasis on the peoples of the Atlantic Coast as being an integral part of the process. Similar to the previous government, the FSLN's development strategy for the Atlantic Coast was part of a broader nationalist program that emphasized the sovereignty of Nicaragua over all its territory and the natural resources therein. For the FSLN the peoples of the Coast had to be developed as revolutionary subjects and brought into not only the nation but also the revolutionary process.

The peoples of the Atlantic Coast for the most part did not actively participate in the revolutionary struggle that led to the FSLN's victory. There were some local Sandinistas who took action in the Coast, especially in Bluefields, but they were not part of the main confrontations that toppled the Somoza regime (Gordon 1998). In the first few months of the revolution there was confusion as to who would be in charge of regional affairs. The FSLN's message of a revolution heavily dependant on grass-roots movements, created positive expectations of local control. This was especially the case in Bluefields (Gordon 1998). However, when FSLN leaders came from the Pacific to take control of the region it caused tensions and confrontations.

The Miskitu in the North did not know what to make of the Revolution (Hale 1994). This changed with the return of a group of Miskitu university students who were in Managua during the revolution, the most important of whom were Steadman Fagoth and Brooklyn Rivera. These students went to the Coast with the intention of participating in the revolution from within the Coast. They tapped into the existing structure of ALPROMISU in order to make inroads into the Coastal population. They were chosen as leaders of ALPROMISU because of their education and accusations that the former leaders of the organization were Somoza informants and sympathizers. The name of the organization was then changed to MISURASATA - Miskitu Sumu Rama and Sandinistas Working Together. However, despite new leadership and a new name, the organization relied on ALPROMISU's already established network of Moravian pastors as the link to the communities.

MISURASATA would become the most important organization in the Coast. At its founding, the organization was aligned with the Sandinista revolutionary program. In one of its founding documents "General Directions", MISURASATA places indigenous struggles within the general ideological program of the Sandinista revolution (MISURASATA 1983a). The document places indigenous groups as actors within the struggle against foreign exploitation, imperialism and colonization. The struggles of indigenous groups are interpreted as creating revolutionary subjects who are not very different from the peasants and working class that the FSLN claimed formed the basis of the revolution. However, there were differences in the concept of imperialism and colonialism used by MISURASATA in contrast to their use by the Sandinistas. For MISURASATA these concepts included internal colonialism from the part of the state as well (Baracco 2005: 143). This vision contrasted with views from the Sandinista leadership. On the one hand the Sandinistas viewed the indigenous peoples of the Coast as

heavily influenced by the exploitation of North American imperialism, and therefore in need of Sandinista tutelage to become true revolutionary subjects and part of Nicaragua (see Wheelock 1981). In addition, the Sandinistas at first did not see the necessity of grassroots organization based on ethnic identity; they believed that the interests of people on the Coast would be better represented in other mass organizations, such as peasant and women's organizations (Adams 1981).

Notwithstanding Sandinista apprehension, MISURASATA was given government recognition and accepted as another mass organization within the revolution. The relationship was tense because of progressively bolder MISURASATA demands. MISURASATA demanded the recognition of communal lands, benefit from natural resource exploitation, more participation in INNICA, the right to bilingual education in indigenous language, and the respect of indigenous forms of healing. The Sandinistas, in an effort to keep the peace provided many concessions to the organization. MISURASATA received representation and recognition in the government, control of the literacy crusade in indigenous languages, and agreements about remuneration to communities for resources extracted from their lands (Vilas 1989: 122-123). The issue of land here is important; in the agreements MISURASATA did not contest the existence of national lands, just reaffirmed the existence of communal lands.

In 1981 there was a major shift in MISURASATA's position vís a vís the government, expressed in the document "Plan of Action 1981" (MISURASATA 1983b). The organization demanded full control over all institutions of the state in the region and the replacement of INNICA and all Coast mass organizations with MISURASATA. In essence, the program outlined by the document demanded the handing over of the Coastal government to the organization with little or no national control. Furthermore, there was a shift in conceptualizing

Coastal lands, not as communal lands but as a unified "national/indigenous" block over which the Nicaraguan government had little power. These demands were accompanied by a militant "ethnic discourse" that defined sharp contrasts between indigenous peoples and *mestizos*, creating an ethnic and historical narrative that provided the rationale and imperative for self-determination (Diskin 1991)[19]. This shift in MISURASATA's position created further distrust of the organization by the Sandinista government. It led to the imprisonment of MISURASATA leaders and violent confrontations during the arrests[20]. After the arrests the relationship between the Miskitu and the government got more bellicose. The arrested leaders left for Honduras and Costa Rica and were followed by many Miskitu youths. In exile they would receive *contra*[21] and United States support and start waging war against the Sandinista government.

Understanding the shift in demands and narrative within MISURASATA requires an appreciation of the various influences that converged on the organization. There was a reciprocal relation and influence between the organization's leaders and the communities that served as its base (Hale 1994, 157). MISURASATA leaders tapped into an already existing network of Moravian pastors when it replaced ALPROMISU. Within this network, a narrative of Miskitu resistance and rights was already in circulation derived from the work of Smutko and the social memory of Miskitu communities. MISURASATA leaders simply incorporated this discourse into their dealings with the state (Hawley 1997). MISURASATA's work was also influenced by "Fourth World" ideology[22], refining this discourse in conjunction with what had become an

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[19] See Diskin (1991: 168-169) for a good summary of the key points in Miskitu "ethnic discourse".
[20] For a detailed account of these confrontations and arrests see Hale (1994).
[21] I differentiate the counter-revolutionary forces (contras) and the MISURASATA factions. Although there was mutual assistance, their motives for engaging the Sandinista government differed. Moreover, their cooperation was a conflictive one fomented more by U.S. financing and interests than by a shared vision among the different groups.
[22] The term "Fourth World" is used to designate the existence of "nations without states", that is populations that have maintained a distinct political culture separate from the states in which they reside, and who are descendants of the indigenous or autochtonous populations that pre-date the formation of "modern" nation-states. "Fourth World

international language of indigenous rights and organization (Diskin 1991). The role of MISURASATA leaders was refining and extending this discourse, not its creation.

The literacy campaign had a defining role in extending the discourse of indigenous rights, a sense of Miskitu nationalism, and MISURASATA's reach. As Baracco (2005) has shown, the literacy crusade was a nation building project. It was about more than teaching people to read. The didactic materials used promoted a particular vision of Nicaraguan history aimed at creating what Anderson (1983) calls an "imagined community". The literacy crusade attempted to create not only a sense of Nicaraguan nationhood but also a notion of the "revolutionary subject" (see Baracco 2005, Chapter 4). In the Coast the literary crusade served the same purpose but, under MISURASATA's control and its implementation in indigenous and Creole languages, it served to construct the Miskitu nation instead of the Nicaraguan nation (Baracco 2005, see also Freelamd 1999). The literary crusade disseminated notions of indigenous rights, the Miskitu Kingdom, and Miskitu struggles against the Spaniards and Nicaragua. The literacy crusade therefore extended MISURASATA's reach and incorporated young Miskitu who worked with as much fervor as the Sandinistas but with different intentions.

These internal dynamics were compounded by external intervention in the role of the United States. Hale (1994: 152-154) cautions against placing emphasis on the U.S. intervention as an explanatory factor for Miskitu mobilization. The U.S. government did indeed manipulate indigenous struggles in Nicaragua for its geopolitical ends (Diskin 1987). However, as the above exposition shows, the roots of Miskitu mobilization occurred before heavy involvement on the part of the U.S. The role of the U.S. government in the conflict was in providing resources that

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ideology" is a reference to the discourse, produced and disseminated by indigenous leaders, academics and human rights advocates in the 1970s, that argues for a reconfiguration of state relations toward these groups with an emphasis on self-determination and an oppositional stance to the claims of sovereignty of the state. See Nietschmann (1994) and Manuel and Posluns (1974).

made armed resistance a viable alternative during 1981. These material resources also expanded the reach of MISURASATA members in exile. The acceptance of U.S aid by the Miskitu also fit within the social memory of their struggle with the Spanish (including Nicaragua), in that a basis existed for foreign assistance that had developed into a sense of Miskitu Anglo-affinity (Hale 1994).

The armed struggle between the Sandinistas and the Miskitu took a hard social toll on the Miskitu. The MISURASATA and Moravian ideological messages along with Sandinista actions during this initial period served to galvanize support for MISURASATA. MISURASATA leaders along with the Moravian church began cautioning Miskitu of the threats of "communism" in both material and religious terms. The message that Sandinista communism would outlaw Moravian religious practices was disseminated. Given the strong links between the Moravian Church and Miskitu identity this message resonated among the Miskitu. The war-related Sandinista action of relocating the communities of the Rio Coco and their subsequent burning, lent credence to the charges against communism. These confirmed a lack of respect for property, and the burning of churches a lack of respect for the Moravian Church (Hawley 1997: 127). Among the Miskitu, with the religious and biblical references that permeated indigenous notions of their identity, the war against Nicaragua was conceptualized as a "holy war" (Hawley 1997; see also Reyes and Wilson 1992).

Miskitu ethnic consciousness as a group with a distinct and defining historical trajectory began to develop around 1950 to 1981. As this section has shown this was partly the result of a regional economic recession and the increased penetration of the Nicaraguan state and *mestizos* through government led development programs. The organizations that developed to confront the assault on Miskitu livelihoods provided the sense of a shared experience among communities

that were able to reconstruct their history and imbue their actions with purpose. The war between the Sandinista government and the Miskitu was the result of the confluence of the development of Miskitu ethnic consciousness, the increased fervor and expectation that the Revolution created, and the geopolitical interests of the U.S. This coupled with a revolutionary government that during its initial stages was not ready to deal with ethnic demands.

3.3 NEGOTIATING PEACE AND AUTONOMY

During the period from 1981 to 1984, the war deeply affected the lives of the Coast inhabitants. It has been estimated that by 1987 250,000 people, both indigenous and *mestizos* were forced to relocate to other settlements within the country or outside of it, on account of *contra* and MISURASATA activity in the North, close to the border with Honduras (Vilas 1989: 150). Among the Miskitu these relocations were both forced and voluntary; to the government resettlement project of Tasba Pri, Puerto Cabezas, Costa Rica and Honduras[23]. In terms of infrastructure, whole communities were destroyed and burned by the Sandinistas after the relocations. In addition, communication and social service infrastructure such as bridges, telephone cables, schools and health facilities were targets of *contra* and Miskitu armed factions (Vilas 1989: 149; CAHI 1986; Garfield 1989). The war also paralyzed the regional economy: communities could not get involved in agriculture; there was lack of supplies and markets and a

[23] The Tasba Pri resettlement project by the Sandinistas involved around 9,000 people (Vilas 1989: 150). Many of the inhabitants of these Rio Coco communities decided to cross the border and have been estimated at around 17,000 (Perez-Chiriboga 2002: 44). Vilas (1989: 147) argues that some of these refugees in Honduras were forced to move there by counter-revolutionary and MISURASATA forces. Refugees also moved to the capital city of Puerto Cabezas whose population tripled (Vilas 1989: 181). The resettlement of this population as refugees to Puerto Cabezas and Honduras changed local dynamics and perceptions in these two locales (see Pineda 2001: 128, and Perez-Chiriboga 2002).

lack of credit (Vilas 1989:181-182). Moreover as a low-intensity conflict the war was at times especially gruesome and brutal, causing a great deal of anxiety to the population, the effects of which last to this day (Reyes and Wilson 1992; Nygren 2003).

By 1984 the Sandinista government realized that military force alone was not sufficient to end the war. The war had a huge political and economic cost for the Sandinistas. From a political stand-point, the war undermined the government's legitimacy and its ability to govern and achieve its objectives. The specter of violation of human rights, whether they were occurring or not, debilitated international support and recognition that the Revolutionary government was trying to achieve. Furthermore, the image of a *mestizo* state repressing ethnic minorities helped give credence to the argument of human rights violations. From an economic standpoint, the war consumed most of the government's budget, severely limiting its ability to implement its programs and provide services to the population.

In an effort to provide a political solution to the conflict with the Miskitu, the Sandinistas developed a strategy for the Atlantic Coast that was based on three initiatives carried out in conjunction. First, they opened dialogue and negotiations with Coastal groups at different levels. Second, the Sandinistas assumed a stance of political flexibility, in which concessions were made that seemed risky during a war but enhanced the view of a government open to achieving a peaceful settlement. And third, they went to great lengths to increase the material well-being of the Coast's population, through social and economic aid, projects and services. This all formed part of a strategy that advanced a program of autonomy as the political solution to the Coast's demands.

In 1984 the Sandinistas created the National Autonomy Commission to study, discuss and delineate the process, content, and structure of autonomy regimes in the region. The

autonomy process took stock of the demands presented by indigenous groups, among them, the recognition of ethnic identity; the right to benefit from the exploitation of resources; recognition of indigenous languages, social organization, indigenous traditions and religion; access and participation in the political process at all levels and in the administration of the region; and the right to bilingual education, among others. All of these demands were included in the development of the concept of autonomy. In the process elements of these demands would be implemented in the region as the process of negotiation over autonomy developed. For example, individuals from the Coast gradually began replacing *mestizos* from the Pacific in the administration of the Coast (Vilas 1989: 155-156). However, the Sandinistas established limits on the new spaces they opened, and advanced a vision of autonomy that conformed to the concessions they were willing to make (González Pérez 1997; Hale 1993). Autonomy would then have to be multi-ethnic, in that all ethnic groups (including the *mestizo* in the region who formed the majority) would participate in the government. More importantly, autonomy was conceived within the framework of a unified national sovereign state that recognizes minority rights and undergoes a process of politico-administrative decentralization as part of a wider democratic strategy (González Pérez 1997: 262).

At this time the population of the Coast did not have a unified organization that represented its interests. From early on in 1981 MISURASATA fractured into different groups, one led by Fagoth in Honduras, and another by Rivera in Costa Rica[24]. Their disagreements centered on personal conflicts and differences in politics and strategy. Moreover, there were armed units within these two main factions based in Nicaragua that functioned autonomously. More importantly, there were groups of Miskitu and Creole individuals who opted to work from

[24] These different factions assumed different names such as KISAN, MISURA and YATAMA. Here I will refer to MISURASATA factions in order to avoid confusion.

within the Sandinista revolution to achieve their rights to self-determination. The Sandinista government entered into dialogue and negotiation with all of these groups. After announcing its intention to grant regional autonomy, the government initially tried to focus on peace negotiations with the main MISURASATA armed factions. Peace talks and negotiations were carried out in 1985, but these ultimately proved unfruitful and reached an impasse. MISURASATA did not agree to lay down its arms before all its demands were met. In addition, the organization denounced the government's plan for autonomy as simply an administrative reorganization that under the appearance of self-determination, maintained the same basic structure (MISURASATA 1985). MISURASATA's view of autonomy was in recognition of an indigenous territory. After the failure of these negotiations the Sandinista government alienated these organizations from the process of autonomy. MISURASATA factions would not have a say in the development of autonomy or the regional government until after the Autonomy law was passed.

The Sandinista government concentrated its efforts on the population living in the Coast. It was able to reach cease-fire agreements with Miskitu armed detachments based on the Coast, the first of which occurred in the community of Yulu in 1985 (Diskin et al. 1986). These organizations retained their former names but were conceived as dialogue factions, even though their actions were opposed by the organizations to which they once belonged[25].These demobilized combatants were incorporated into the process of consultation for autonomy. The government also worked with people who were willing to work from within the revolution. One example of this was the creation of an organization called MISATAN, whose founders were

[25] The agreement in Yulu was with a detachment of the organization known as KISAN, a splinter group of MISURASATA headed by Fagoth. After the cease-fire, the detachment retained the name KISAN, but was known as the KISAN dialogue faction. Its "parent" organization KISAN continued its armed resistance and was known as KISAN war faction. Formal ties between the two KISAN factions however did not exist.

Sandinistas from the Coast. Through these organizations and contact with communities the Sandinista government started to disseminate the autonomy proposal. The National Autonomy Commission created Regional Autonomy Commissions with delegates from all sectors of Coastal society, including religious organizations and community delegates. A lot of work went into the discussion of the autonomy proposal and its amendment through suggestions from these various sectors in order to legitimize the autonomy project. Among this work were workshops for the leaders and delegates of rural Miskitu communities (see González Pérez 1997).

The process of consultation was accompanied by political concessions and the abolition of restrictions created during the war. The government declared amnesty for combatants willing to cease armed conflict and become part of the autonomy process. It released people held on counterrevolutionary and conspiracy charges from detainment. It allowed and provided resources for the return of displaced refugees to their communities, from both Honduras and from within Nicaragua. The government also increased funding and projects that provided food, health and education to the Coast, all of which had been severely interrupted during the war. All of these initiatives counted on the active participation of the Coastal population. It created a sense that the Sandinista government was committed to peace and that the autonomy project held promise for a solution to the conflict and political change.

Hale (1994, Chapter 7) provides the only account and analysis of Miskitu communities' experience of the autonomy process. His analysis is critical for understanding Miskitu community members' views of autonomy today. He shows how Miskitu communities still supported the position of MISURASATA leaders and had great reservations about the autonomy proposal. However, the burdens of the war and the fact that receiving material and economic aid was heavily tied to participation in the autonomy process were influential in their participation.

Hale shows that the Miskitu viewed autonomy as a step in achieving many of their demands, and resolving the conflict that had caused so much suffering. However, Hale argues that the Miskitu did not relinquish their more militant ideas about indigenous rights which were in tune with those of the MISURASATA factions. The strategy in Miskitu eyes was to accept autonomy as one step in a process of gradual change that they could deepen in the future. In essence, autonomy was a Sandinista project that they were willing to accept given their precarious conditions after years of war. There was therefore an atmosphere of both hopefulness and apprehension in community acceptance of autonomy, an acceptance that added legitimacy to the autonomy process.

The autonomy proposal was developed in a series of stages: the dissemination of the autonomy project, the promotion of an autonomy proposal and debates and suggestions, and the synthesis of agreed upon viewpoints into a single proposal. The development of an autonomy document was achieved in a relatively short period of time with wide participation from community representatives and wider sectors of Coastal society. From the formation of Regional Autonomy Commissions at the end of 1984 to the approval of an autonomy law in October of 1987, scarcely two and a half years lapsed. Moreover, by the time the Autonomy Law was approved the Nicaraguan constitution had been reformed creating the basis for the law. This is impressive if one considers the fact that armed confrontations were still occurring during this time, and massive reconstruction efforts were still to be completed. The approval of the law deflated MISURASATA's bellicose stance, and they soon returned to the negotiating table.

The approval of the Autonomy Law was just the beginning of the autonomy process. Although the law was approved and went into effect in 1987, the political structure of the autonomous regimes did not begin until regional authorities were elected in 1990. However, in

this same year the FSLN lost the presidential elections of 1990 and the alliance party UNO (National Opposition Union) took control of the government and took Nicaragua into a very different economic and political direction. Autonomy therefore developed in a very different political atmosphere and under very different political circumstances.

3.4 THE AUTONOMY LAW

The notion of autonomy today is viewed cynically by many of the region's population. This is in large part due to problems implementing autonomy regimes as we will see in the next section. The language and content of the Autonomy Law provide another important source of contention. As a member of the Regional Council of the RAAN told me in 2001, "the Autonomy Law has many vacuums". These "vacuums" were the result of the political atmosphere that surrounded its development. The Autonomy law is composed of general statements where ambiguities abound. This lack of specificity was the result of major preoccupations of the FSLN with maintaining the sovereignty of the state and marginalizing possible separatist interpretations of the law. In addition, as Gonzalez Perez (1997: 282-283) argues, these ambiguities resulted from the need for quick approval of the law to hasten the peace process. The most contentious issues therefore were left to be specified at a later date. In this section I will review some of the most important points of contention in the Autonomy law.

The Autonomy law and the constitution firmly establish cultural rights for the populations of the Atlantic Coast. These include: the establishment of indigenous and Creole languages as official languages of the region in conjunction with Spanish (art. 5); the right to bi-lingual education in native languages (art 5.5); the right to the preservation of indigenous

medicine (art 11.8); the recognition of communal ownership of the land and the right to communal benefit from its exploitation (art 5.3, 5.6, 9, 36); the right to communal forms of indigenous justice (art. 18); the right to the maintenance of culturally defined forms of social and economic organization (art. 5.6). The recognition of these rights is not in doubt and they are further cemented within the reformed Nicaraguan constitution of 1986 and subsequently with the reforms in 1995. These rights cover most of the demands of indigenous groups and organizations that participated in the conflict, except for the demand for a separate indigenous territory. The problem with the law lies in the ambiguities inserted in the creation of the institutional structure that is supposed to insure the exercise and preservation of these rights.

The Autonomy Law created two autonomous regions, the Autonomous Region of the North Atlantic (RAAN) and the Autonomous Region of the South Atlantic (RAAS). Although the majority of the population of both regions is *mestizo*, this division conformed roughly to the concentration of the most influential ethnic groups; Creoles (RAAS) and Miskitu (RAAN). The regions are administered by an Autonomous Regional Council (CRA) of forty five members, democratically elected and with representation of all ethnic groups. The representatives of the region to the National assembly also form part of these Regional Councils. From these elected members the CRA elects a Council Board and a Regional Coordinator. The Regional Coordinator is responsible for the executive functions in the region. The members of the CRA also divide themselves into commissions that are responsible for the oversight and administration of specific areas of government, such as the health commission. In addition, regional authority lies within municipalities and communities according to the dictates of the CRA. The CRA is an administrative entity; its authority lies in drafting and approving resolutions that regulate regional government administration. These resolutions have legal weight as long as they do not

conflict with national laws. Regional authorities can develop and submit legislation to the National Assembly in the event that a law is required but its approval representation in the National Assembly two representatives per autonomous region, so it is in large part in the hands of the representatives from the Pacific of Nicaragua. The autonomous regions through their Regional Councils are responsible for all administrative decisions. The autonomous governments have the responsibility of administering all social services and programs including health, education, and transportation. They also have the responsibility of developing and implementing economic strategies.

Most of the problems that derive from the Autonomy law lie in the repeated affirmation of national sovereignty and shared control, administration, and coordination of the national government with regional authorities. This is established in the second article of the law which states that the "communities of the Atlantic Coast form an indissoluble part of the unitary and indivisible State of Nicaragua". This preoccupation is evidenced in all aspects of the law. The administration of all social services has to be done "in coordination with the pertinent Ministries of the State" (Art 8 no 2). The problem does not lie in this shared responsibility, but in the lack of definition as to how coordination will take place. There is no definition of the functions and roles that the different ministries and regional administrative authorities will have in this process. For example, as we will see in the case of health in the next chapter, the following questions arise: who will control the policies of the Ministry of Health in the region? If the regional administration does not have control over the local MINSA institutions, how will regional authorities be able to enforce their resolutions? Regarding the more contentious issue of the exploitation of natural resources, the law states that "the rights to property of communal lands will be recognized, and it should benefit its inhabitants in just proportion through accords

between the Regional Government and the Central Government" (Art 9). Here the question arises as to who determines what a "just proportion is" (Gonzalez Perez 1997: 280). As Gonzalez Perez (1997) has argued, this lack of specificity "has operated as a centralist lock by the State [to] not only executive regional institutions, but also of all the autonomous system, since it allows the national government to translate resources and functions to a functionary that is…over regional authorities" (284).

These problems of specific functions do not only affect the relationship between regional and national government. The law is also unclear as to the specific authority of municipalities and communities, in terms of administration, their role in the overall government structure, and authority to concede and receive benefits from the exploitation of resources. These vacuums in the law leave spaces in which authority, control and power are heavily contested between authorities at different levels.

When the law was developed and approved it was expected that a law providing the specific regulation of the Autonomy law would resolve these problems. However, this law was not approved until 2003. Therefore a situation developed in which each level of government (from national to communal) made its own decisions according to what it considered its authority to be, creating a situation of continuous tensions and conflicts (Gonzalez Perez 1997). Even after the autonomy law was passed, the functioning of the autonomous government changed very little (Hooker 2006).

Another source of tension in the law lies in the rights of communities. Many of the benefits of the law for indigenous groups lie in the recognition of community property rights and their right to their forms of social organization according to indigenous culture. The rights of communities again are not ambiguous, as an official from the region has expressed it: "here the

real autonomous structure is the community". However, there are two problems relating to community rights. The first one, related to the points above, is the lack of regulations as to the articulation of indigenous communities with the overall regional government structure. The second problem had to do with communal land titles. Many communities do not have communal land titles. In those that do hold titles other problems are evident, such as land titles that do not conform to use patterns or land titles granted to community blocks (see Hale, Gordon and Gurdian 1998). Since the law establishes the importance of remuneration for resources extracted from community lands, obtaining land titles has become imperative. The Regional Council has as one of its functions resolving "boundary disputes between communal lands" (Art 23.4). However, the process for the demarcation and titling of communal land is not contained in the autonomy law. The process of demarcation and titling needed a separate law, which was not approved until 2003. The titling issue created inter-community conflicts, and conflicts between communities and the regional and central government.

As this brief discussion shows, the ambiguities and vacuums in the autonomy law provide mechanisms that the national government can use to weaken the autonomy regimes. This was exactly what happened when the FSLN lost the 1990 elections. The Autonomy law could not stand by itself. It required further laws that added weight and specificity to it, and these laws had to be passed in the National Assembly out of the Coast population's control. The Autonomy law, however, did provide the Coast with a legal basis for engaging the central government and attempting to claim its right to self-government.

3.5 AUTONOMY IN NEOLIBERAL NICARAGUA

In 1990 the National Opposition Union party (UNO), an alliance of different political parties and groups opposed to the FSLN came to power after the electoral defeat of the Sandinistas. The new government rapidly guided the country in a different direction. Economic policy was guided by structural adjustment policies characterized by decreased social spending; deregulation and privatization of state enterprises; the elimination of subsidies and price controls; and the liberalization of the economy (Dijkstra 1999; Evans 1995; Goma and Font 1996; Walker 1997). This new neoliberal direction of Nicaragua affected the autonomous regions negatively. Opening Nicaragua to foreign investment led to an attempt to give economic concessions to the Coast's resources that ignored the Autonomy law (Ortega Hegg 1992). The autonomous governments were constituted in 1990 when the first elections for the CRA coincided with the national elections. The UNO and subsequent governments viewed the Autonomy law as a Sandinista policy as opposed to a reconfiguration of state relations with the region. This government acted as if the Autonomy Law did not exist, enacting policies that weakened the autonomy regimes (González Pérez 1997).

The RAAN's economy and infrastructure had been virtually destroyed during the war. Many indigenous communities were not economically self-sufficient anymore and depended on government subsidies and support (Gonzalez Perez 1997: 353). The RAAN was one of the poorest regions of Nicaragua and 85% of its population could not meet its basic needs (Vargas 1993). Given these circumstances the neoliberal restructuring of the economy affected the region in two interrelated ways. On the one hand the policy of structural adjustment limited the amount of funds available for social programs that were needed in the Coast, such as health, agricultural subsidies, and price controls of goods and services, all of which were reduced in 1990 (González

Pérez 1997: 358). On the other hand, the liberalization of the economy and the need for foreign investment made the region attractive for economic expansion once again (Ortega Hegg 1992). The central government's weakening of regional government responded to both. The centralization of all state functions allowed the government to manage the limited amount of funds that entered into the region, while insuring that its priorities and policies were implemented, such was the case with the local representation of the major ministries. Ignoring the regional government allowed the national government to be the only beneficiary of the exploitation of the region's natural resources.

From early on in 1990 the government gave natural resource exploitation concessions and licenses for commercial fishing, logging, and mining to private companies without consultation with the newly elected regional government. (Romero 1991). The Ministry of the Economy even tried to give concessions without the approval of the president, Violeta Chamorro. For example, Chamorro created the Bosawas Reserve in 1991 by presidential decree when she was left with no other alternative to stop commercial logging and mining concessions (Stocks 2003: 248). Another important case was a logging concession that was being negotiated by the central government with a company from Taiwan which sparked heated debates with regional authorities (Aviles 1992). The central government argued that the Nicaraguan constitution states that natural resources belong to the state, and since the Atlantic Coast is part of the state, the natural resources of the region therefore belong to state (Romero 1991: 7).

During the first years of the regional government the main point of contention was its relationship with the central government. The ambiguities in the Autonomy Law discussed above provided the central government with an opportunity with which to debilitate the government. The most drastic of these attempts was the creation of the Institute of Development of the

Autonomous Regions (INDERA) as a new cabinet position which lasted just three years because of constant pressure and protests from members of the regional government. With INDERA the central government thus created a centralized administrative institution that had more power than the regional governments. Moreover, its budget was larger than those of the autonomous governments. The lack of funding for the autonomous governments severely limited their capacity to achieve any of their goals. It has been estimated that in 1994 the regional government's budget was able to cover only 25% of programmed activities and initiatives (González Pérez 1997: 358). Given the lack of funds, the regional government has become heavily dependant on financing from international governments, international lending institutions and NGOs to carry out its activities and projects.

The regional government also suffered during these early years because of a society heavily divided ethnically and politically. The former leaders of MISURASATA had opted to integrate themselves to the political process in 1989 and formed the regional political party YATAMA (Yapti Tasba Masrika nani Asla Takanka/Union of the Sons of the Mother Earth). As an indigenous party, the YATAMA political platform was based on an ethnic discourse similar to that of MISURASATA and although working from within the autonomy process, its goals were still associated with achieving an indigenous territory. In the 1990 elections YATAMA allied with UNO for the national elections. The regional results of these elections made YATAMA as the majority party in the CRA-RAAN (Council of the Autonomous Region of the North Atlantic) and UNO as the majority party in the national elections. These results point to the saliency that notions of indigenous lands and rights had for the Miskitu population, and antipathy toward the FSLN, despite the autonomy they had helped achieve (Hale 1990; Rizo 1990). However, the CRA-RAAN was composed of individuals from YATAMA and the FSLN

who just a few years prior had been involved in the conflict[26]. Divisions also occurred within political parties themselves. Such was the case of YATAMA whose leaders still did not have a unified political strategy (Matamoros 1992). Brooklin Rivera, former leader of MISURASATA, and one of the founders of YATAMA was named the director of INDERA, thereby undermining the authority of the regional government that his own party controlled. To make matters worse the CRA members did not have a lot of experience in government and had to contend with a completely new system of regional government that was ambiguously defined.

Conflicts within the regional government along with an emphasis on central and regional government negotiations neglected the needs and aspirations of communities where more than half of the indigenous communities did not hold a title to their lands (Gonzalez Perez 1997: 374). As a whole, this process resulted in a negative view of autonomy as a whole and regional and national government officials in particular. In an effort to not be denied the benefits from the exploitation of resources some communities negotiated natural resource exploitation themselves in 1991 (Aviles 1992). However the result of direct negotiations with the lumber company was highly unequal given community's lack of information. Other communities established an alternative development organization and created a business partnership with Canadian indigenous groups for community-controlled timber operations (Anaya 1996). However, communities' ability to negotiate these types of deals was severely limited by community organization, lack of land titles and their powerlessness against the state. For this reason the community of Awas Tigni was forced to appeal to the OAS Human Rights Commission after its efforts to halt a lumber concession on its lands were initially unsuccessful.

[26] The members of the first CRA-RAAN were divided as follows: YATAMA 44%, FSLN 42%, UNO 14% and PUCA 1%. (Gonzalez Perez 1997: 332).

Since the second half of the 1990s the autonomous government of the RAAN has slowly and painstakingly gained some ground in achieving a functional regional government. These advances have been strengthened by the support of numerous international development agencies. In the early 1990s the crisis in Latin American governments and the deep social dislocations of structural-adjustment and neoliberal policies caused a shift in the policy of international development agencies (Gray 1998; Gardner and Lewis 2000; Renshaw 2001). This shift in policy is characterized by emphasizing the development of civil society and social capital, furthering democracy, and the promotion of human and cultural rights. This has been most notable in the policy of the World Bank and the Inter-American Development Bank (IDB) whose focus on the eradication of poverty has led to the development of a wide variety of projects for indigenous groups in Latin America that emphasize the preservation and promotion of culture.

Hale (2005) has referred to the logic behind these policies as neoliberal multiculturalism. In reference specifically to the World Bank he argues that neoliberal multiculturalism provides support for indigenous rights initiatives that appear to challenge aspects of the neoliberal economic framework the World Bank is purported to advance. Hale further argues that there is a dichotomy in that the promotion of cultural rights "restructure[s] the arena of political contention, driving a wedge between cultural rights and the assertion of the control of the resources necessary for those rights to be realized" (13). However, international organizations, such as the World Bank do help promote change in the legal recognition of cultural and land rights but the governments themselves may provide barriers in the full realization of these rights (Gordon, Gurdian and Hale 2003).

The RAAN government has functioned under these conditions of international support. For example the Program RAAN-ASDI-RAAS, financed by the Swedish International Development Organization, supports regional government institutions in defining the functions of regional government institutions and their development of programs and laws. Similarly the Austrian government has provided similar support for the decentralization of the health system. The World Bank and the IDB have similarly implemented various projects of infrastructure and institutional development that are sometimes tied to acceptance on the part of the government of other projects that incorporate different measures of cultural rights.

One of the first advances on the part of the regional government was the reform of the Nicaraguan Constitution in 1995. In it the Autonomy Law became part of the Constitution thereby eliminating the possibility that it could be invalidated by another ordinary law. The law also recognized the existence of "indigenous peoples", not limiting itself to the Atlantic Coast. And perhaps most importantly the 1995 constitution established that the CRA has to approve all natural resource exploitation concessions and contracts (Acosta 1996). Further gains and advances were obtained with the Organization of American States' court in which land claims against the Nicaraguan state were recognized for the indigenous community of Awas Tigni in 2001 (Acosta 1998; Gomez 2003). The decision forced the Nicaraguan state to develop a land titling process that, after a long period of inertia and official government stalling, came to fruition in the Land Demarcation Law, passed in 2003. Other advances in the autonomy process have been gained in recent years. In 2003 the Autonomy Law was regulated and given specificity through another law. In 2002 the General Health Law recognized the right of the RAAN to administer health services through its own "health models". What all of these advances have in common is that they did not arise out of negotiations between the central government and the

regional government alone. All of the advances gained in the last few years have been forced in one way or another by international organizations. The Land Demarcation Law was the result of the OAS human rights court decision. A study that preceded the court decision and the Land Demarcation Law that attempted to determine the land claims of the communities was financed and allowed by the Nicaraguan government after threats of withholding further funds and loans (Gordon, Gurdian and Hale 2003), and the General health Law was developed and approved after pressure from the IDB and the possibility for a loan to modernize the health sector (Espinoza 2002). However, the approval of the laws has not meant that they have been implemented successfully or expeditiously. As Hale (2005) has noted, the Nicaraguan government through its functionaries has placed innumerable bureaucratic and political blocks throughout the process that have the effect of only partially implementing the laws at best. The regional governments at the present find themselves in an up hill struggle to gain as many advances as possible through multiple negotiations with all government institutions.

The result of the slow process in the development of autonomy regimes has been a generalized distrust of the Autonomy Regimes in general and regional government officials in particular. This is coupled with generalized government corruption at all levels. Politicians and government officials are viewed as interested in the general political process and their own self-interest as opposed to the well-being of their constituencies.

3.6 CONCLUSION

This chapter has provided a general overview of the complex history of the Atlantic Coast and the RAAN. I have gone into some detail about some aspects of the region's history

because they are essential in understanding the multiple factors that affect Coastal society and politics today. The history of the peoples of the Atlantic Coast is deeply embedded in the social memory and historical narratives that are used today in the pursuit of their rights (Gordon, Gurdian and Hale 2003; Offen 2003). The history of ethnic hierarchies and identity formation also form the basis of inter-ethnic relations in the RAAN (Meltzoff and Schull 1999, Mollet 2006).

The formation of the regimes of autonomy and the recognition of indigenous and cultural rights in Nicaragua were based on discourses of cultural difference. As the history presented in this chapter shows, these cultural differences have been intimately related with the shifting political economy throughout the history of the Atlantic Coast which has at different points in history placed one ethnic group or another in an advantageous position. The armed struggle of indigenous groups was the result of the convergence of various factors; the emergence of a political consciousness on the part of indigenous groups through the work of mostly religious organizations that created a network between communities; an increased visibility in the Atlantic Coast of representatives of the Nicaraguan state; the formation of an indigenous rights discourse internationally that gave legitimacy to Miskitu concerns; and the interests of the United States in undermining the Sandinista government which made the option of armed resistance possible.

Even though the conflict was about more than cultural difference, when the Sandinista government searched for ways to resolve the conflict, culture became the focus of negotiation. The possibility of a different political arrangement with the Atlantic Coast was possible because the Nicaraguan government could not reconcile the history of the Coast with prevailing constructions of the nation (Hooker 2005). As such, cultural difference was what gave legitimacy to regional claims. The configuration of autonomy, however, was a Sandinista project, not one

that developed from the Coast (Hale 1995). As such the Autonomy Law set the boundaries of legitimate political discourse and demands. “Cultural” demands and rights therefore became the arena for legitimate negotiations between the Atlantic Coast and the state. Cultural rights were recognized but issues pertaining to resources and political power were ambiguously defined at best, providing avenues through which to weaken the autonomy regimes and deflect regional demands.

Indigenous and regional demands are now institutionalized within the Nicaraguan political process and autonomy; what was initially a Sandinista project has become the driving force of regional demands. After the Sandinista electoral defeat, the autonomy regimes have developed under the limitations imposed by the Sandinista government. At every turn the Nicaraguan government has tried to weaken and place barriers on effective implementation of autonomy regimes when the initiatives move beyond strictly cultural concerns and involve economic resources. The result has been that regional governments have been largely ineffectual and have lost their legitimacy in the eyes of their constituency. The development of the autonomy regimes develop through international pressure that is also based on the concept of culture and cultural difference. In the next chapter I will discuss how the political processes discussed here have affected the development of the Health Model as a policy document whose aim is the reform of the health system.

4.0 CULTURAL POLITICS AND THE HEALTH MODEL OF THE RAAN

Regional health efforts in the RAAN are guided by a policy document called The Health Model of the Región Autónoma del Atlántico Norte (URACCAN 1996). In my interviews with regional health officials I always started with the open ended question "what is the Health Model?" The question is rather complex given the different strategies and initiatives contained in the document. The most concise response that generally covered all of its aspects was that given by Dr. Ned Smith, the Health Secretary of the RAAN in 2003:

> We have been able to define it as a plan designed with many strategies in order to improve the living conditions of the population in the RAAN, which contains different programs directed to the most vulnerable sectors of the population, particularly the people that live in the rural areas, and which contains elements that bring together the union of traditional medicine and Western medicine.

This response provides a hint of the complexity of the Health Model but what is highlighted out of all the elements and strategies in the document is the role of indigenous medicine. Interestingly enough the proposal for the inclusion of indigenous medicine is one of the least developed elements in the written Health Model document. However, in public discourse about the Health Model present in many conversations, meetings, workshops, and interviews this aspect was the one that seemed to define what the Health Model was all about. For example, a doctor in the region thought that the Health Model was "primarily about adjusting the health system to the cultural reality of the indigenous populations through the respect and inclusion of

traditional medicine". This is definitely the case but shows a limited understanding of what the Health Model is trying to achieve.

The Health Model is part of a wider political struggle for a fully functional regional autonomous government. As such it is influenced by and an integral part of discourses of "cultural difference", "ethnic struggle" and "indigenous rights" which were instrumental in obtaining regional autonomy in the first place. The Health Model therefore has to be examined as a political document as opposed to a technical one.

The development and implementation of the Health Model has been a long and contentious process. Ten years after the creation of the document many of the proposed strategies have yet to be implemented. In order to understand the difficulties that the Health Model has encountered it is important to understand the political context that surrounds the discussion, debates and attempts of implementation of the Health Model. Understanding the primary role that indigenous medicine has in the interpretation of the Health Model requires an appreciation of these wider political processes and the use of discourses of indigenous rights. The Health Model is more than a policy document; it is a political symbol for the promotion of cultural diversity within state institutions. It is also guided by the discourse of *interculturalidad*.

In this chapter I analyze the debates and implementation attempts of the Health Model. Specifically, I provide an analysis of why "culture" acquires such a central place in the Health Model. I argue that the Health Model is part of a wider strategy that relies on identity politics to achieve its objectives, an increase in the decision making power of regional authorities and the control of resources. I then analyze the tensions that centering discussion on culture creates, and argue that the use of "culture" as the driving force for regional health reform has unintended consequences as the discourse of culture is co-opted by institutions of the central government.

4.1 THE HEALTH MODEL: BASIC OUTLINE

The Autonomy Law that created the RAAN established the authority and responsibility of the autonomous government to administer the health sector, through the Autonomous Regional Council of the RAAN (CRA-RAAN) in coordination with the Ministry of Health (MINSA). In an effort to exercise this authority the CRA-RAAN in coordination with all health sectors in the region began a process of research, negotiation, and consultation to assess the state of the health sector and develop a strategy to guide its administration and regulation. The result of this process was the document El Modelo de Salud de la Región Autónoma del Atlántico Norte - Health Model of the Autonomous Region of the North Atlantic (URACCAN 1996). The Health Model is a policy document that establishes the principles, procedures and strategies for restructuring the health system in the region. The general objective of the Health Model is the:

> improvement of the health levels of the population of the RAAN, their families and communities, within the framework of the environment and considering the particularities of each one of the ethnic communities of the region, as part of the process of autonomy (URACAAN 1996, 35).

The Health Model establishes that all of its proposals are guided by the following principles: integrated health care, social participation, cultural revitalization, reciprocity, and equity. Integrated health care refers to the integration of all different levels of health care, that is, primary care, secondary care, prevention, and community health development. The emphasis is on prevention and primary care but the ideal is for the inhabitants of the Coast to have a basic package of services that provides for all of their health care needs including their physical, mental, spiritual and mental well-being. Health is therefore conceptualized from a holistic perspective. The principle of social participation is based on the premise that achieving good health requires individuals to be active participants in identifying their own health concerns,

planning health initiatives and in being active participants in health program and project implementation. The principle of cultural revitalization refers to the promotion and acceptance of indigenous cosmology and medicine from within the health system. Its goal is to move beyond simple tolerance of the practice of indigenous medicine. All health initiatives have to take into account how they relate to the Coast inhabitants' culture and perceptions of health and illness. Moreover, the incorporation of indigenous medicine helps promote social acceptance and participation within the health system because it shows respect and acceptance of indigenous cosmology which is an integral part of indigenous identity. Reciprocity refers to the principle that health is not the responsibility of one sector, such as the central government or the regional government. The responsibility of health care is shared among all of these sectors including the individual. In addition the principle of reciprocity is also related to cultural revitalization in that the influence and exchange between indigenous medicine and institutional medicine is not unidirectional but mutual. The principle of equity posits that all individuals in the Coast should have equal access to health services. Therefore there is an emphasis on the most vulnerable sectors of the population. The case of inaccessible rural communities is a case in point. So for example, in keeping with this principle of equity the Health Model posits that the restructuring of rural health services should mean that no individual has to travel more than two hours from his/hers place of residence to receive health care.

While the Health Model is a policy document that attempts to administer all health services in the region and reform all aspects of the local health system, not all of its strategies or the basic outline of its initiatives can be presented here. I will highlight some of the most important and central strategies contained in the document that will be discussed throughout this chapter and at other points of this dissertation.

The main strategy on which the whole implementation of the Health Model rests is deepening the process of decentralization of the administration of health services to regional authorities. Decentralization is understood as the "planned, and ordered transfer of political, administrative, and technical authority of central institutions toward the periphery, as well as the responsibility of the acts that said authority generates, and the different capacities and resources (political, financial, physical, technological, human resources)" (URACCAN 1996: 36). Most functions of the health system are thereby transferred to regional authorities. The role of MINSA is only normative, of oversight and of technical support.

The Health Model also calls for a reordering of the primary and secondary health networks that provide services to the population. At the secondary level it posits the creation of rural hospitals in all municipal heads. The primary health care network forms the basis of the health system. Its expansion is imperative given the inaccessibility of most of the rural population. The primary care network is organized around health posts centrally located to serve a group of communities. At a higher level groups of health posts in a given area will have a health center with more resources that will serve as a point of referral to a doctor. In cases where this is not possible the Health Model proposes the creation of mobile units that can travel to communities with doctors and other staff and expand the reach of the health system. The community is the basic and most important unit of the health system. The health system through the health posts and the health centers is responsible not only for providing health services. It must engage in activities of community health development, such as organizing health leaders and midwives and supporting the creation and development of communal health commissions. These "community agents" form the basis of community participation by being responsible for the planning, organization and implementation of all health related activities in the community.

In the participation of “community agents”: “special attention will be given to the integration of *curanderos, profetas* and *sukyas* [indigenous healers], giving them recognition at the local, municipal, and regional level as representatives of the medical culture, that has historically provided care in the communities” (URACCAN 1996: 44).

The Health Model proposes a new administrative model in which two elements are highlighted: regional control of the health sector and social participation. The main administrative organ is the CRA-RAAN with its Health Commission, which develops, coordinates and provides oversight of all health activities in the region. The Government Coordinator is responsible for the implementation of health resolutions and decisions that emanate from the CRA-RAAN, through the regional health secretary. At this level, there are two other institutional bodies that have a supportive role with the health secretary. The central MINSA has a normative-technical role. The other body is the Regional Health Council, composed of representatives of all sectors working in health in the region, including NGOs, MINSA representatives, and civil society institutions. The Regional Health Commission has an advisory role and in its sessions discusses regional health strategies and proposals. The administrative model continues through the municipal and local health unit level with a similar structure. At each level of administration health commissions provide an advisory role and help implement health decisions. At the community level this is represented by community health commissions.

The last aspect of the health system that I want to highlight here is the proposed system of financing the health system. The budget allotment on the part of the central government for health is severely limited. Budget allotments for health are distributed to the different departments and regions of Nicaragua based on their proportion of the population. For the

RAAN this amounts to 4%. However the costs of health care are higher in the RAAN because the territory represents 34% of Nicaragua's national territory. The population is highly dispersed and many communities are inaccessible through surface transportation given the lack of infrastructure. The lack of infrastructure increases the prices of all products because of transportation costs. For these reasons, the Health Model proposes alternate sources of financing which conform to the principle of reciprocity in the sharing of the responsibility in contributing to the regional health system. The proposed financing derives from external cooperation, the regional government, the municipality, community solidarity, the private business sector, the sale of services to the Nicaraguan Institute of Social Security (INSS), and the ssle of services to individuals with the ability to pay. Of special interest here are contributions by the different levels of local government. The regional government will contribute 25% of its income from the exploitation of natural resources (obtained through concessions, rents, selling, fines etc.). The municipal government will contribute 10% of its income from taxes. Finally communities that obtain benefits from the exploitation of resources will contribute "a total no less than 20%" of their income toward the maintenance of the health units in their communities and support of the health personnel who work in them. Most of these financing schemes were still not implemented at the time this research was conducted. However, they remain part of a strategy for future implementation that is still discussed and debated.

In this section I have briefly outlined the main content of the proposals and strategies contained in the Health Model. These main points will be developed further at other places in this dissertation. At this juncture, I want to point out that the scope of the Health Model is broad and is about much more than indigenous medicine and culture, although these elements appear throughout. After reading the outline of the strategies in the Health Model, anyone familiar with

international public health will ask: what is new about these strategies? This is a pertinent question here. These initiatives are guided by notions of primary health care and community participation that have been a part of international public health since the seventies. As the review in Chapter two indicates, the impact of these initiatives has been severely limited and curtailed for a variety of reasons. Health officials in the region would argue that the difference lies in the context that surrounds the proposal and attempts at implementing these health initiatives. As the president of the Health Commission in 2003 expressed it to me:

> this is an effort that comes from the people, we consulted with our communities during the whole process of developing our Health Model. This is not something imposed from above by the central government; it is something we are constructing with our own sweat [efforts]. It is part of our struggle for our historical rights.

4.2 AUTONOMY AND THE HEALTH MODEL

Alta Hooker has been part of the Autonomy process since its inception, and has been actively involved in the development of the Health Model. She was a member of the first elected CRA-RAAN from 1990 to 1994, and president of the directive council of the CRA-RAAN from 1994-1996; she was also the president of the Health Commission during the period in which the Health Model was developed, has been the coordinator of IMTRADEC, and is presently the rector of URACAAN. In reference to the negotiations being carried out with central MINSA authorities she commented: “publicly we have told the ministry of health that we are implementing the Health Model with or without them”. Interestingly enough González Pérez (1997) quotes her expressing the same sentiment in reference to the autonomy process: “The

central government wants to see tired *costeños*[27] in their struggle for autonomy, but we have told them that we are going to do it with them or without them" (7). This indicates what I will discuss in this section, that development of autonomy and the Health Model are part of the same process.

In the previous chapter[28] I recounted some of the early difficulties in implementing autonomous governments, some of which last to the present day. From the election of the first regional governments in 1990 the central government attempted at every turn to ignore or weaken the authority that the Autonomy Law deferred to the regional governments. Some have argued, as a resident of Puerto Cabezas told me, that "in the early years of Autonomy very little was achieved" (see also González Pérez 1997). However, members of the CRA-RAAN during this early period worked hard to claim their role in the administration and government of the region. Members of the CRA-RAAN tried to further the autonomy process through the limited domains that the Autonomy Law made relatively clear and the areas that the central government was willing to negotiate. One of these early domains was the health sector.

Between 1987, with the approval of the Autonomy Law, and 1990, leaders in the region had attempted to further the process of autonomy by drafting a proposal for the regulation of the law presented to the central government in 1989. The proposal contained the main elements for the decentralization of the health system towards the region. Cunningham, Moreno and McCoy (2002) have argued that "because of the importance of health, once the first Autonomous Regional Council was installed, health was one of the first issues addressed" (43). As was discussed in the previous chapter, the most important and contentious issue during the early period of the autonomous government was the issue of natural resources. However, this was one of the least defined and contentious elements in the Autonomy Law. Juan González, president of

[27] Reference to people who live on the Atlantic Coast.
[28] See pages 115-121 of this dissertation.

the Health Commission in 2003, argued that in contrast to the issue of natural resources, "one of the things that was clear in the Autonomy Law is the authority of the regional government to administer the health sector". The Autonomy Law is clear in asserting this authority but in reality it is in no way clear in the way and process by which administration of the health sector will take place. However, it provided a small opening through which the RAAN government could begin making some progress in defining the attributes and function that the RAAN governments would have in the future. More progress could be achieved in the areas of health and education than in the area of natural resources. This does not mean that the area of natural resources did not take precedence on the agenda of the CRA-RAAN, because it did (González Pérez 1997). What I am arguing is that some areas of government, such as health, provided more openings than others. In addition as the next sections will demonstrate, discussions about health define "cultural difference" which serves as the basis of demands for the implementation of autonomy. As a regional official has said, "the process of autonomy has been a difficult one. We have been struggling in many fronts, in all aspects of coastal society and government. We look for spaces, opportunities and points of convergence to *incidir* [make inroads] in the process."

The health sector was one of the areas in which the central government was willing to provide openings to negotiate. The central government was willing to decentralize some state functions, primarily education and health (Vargas 1993). González Pérez (1997) has referred to these decentralization attempts as "selective" which "prioritizes areas that are not vital to the economic model of the Nation-state" (427). In 1992 this policy of decentralization in health was implemented through the creation of Sistemas Locales de Atención Integral a la Salud (SILAIS) –Local Integral Health Care Systems. The SILAIS represented a regional administrative structure in all of Nicaragua's Departments and Autonomous Regions. These decentralization

efforts were part of broader public policy that conformed to the government's policy of structural adjustment in diminishing the size of the government and promoting the responsibility of civil society (see Evans 1995). Ortega Hegg and Parés Barberena (2000) have argued in regards to the process of decentralization in general that in Nicaragua:

> The proposals of state reform in general constitute "unilateral statements", originating from the central government, pressured by interests and agendas of international organizations and that have not been fertilized by the impulses and demands of the different representative expressions of society, nor of the different levels of the State (7).

In the specific case of decentralization of the health system, true administrative decision making was constrained by central MINSA directives and a limited budget whose funds were already earmarked for specific programs and initiatives (Bossert, Bowser and Correa 2001; Ortegga Hegg and Pares Barberena 2000). This centralized structure in a supposedly decentralized institution is a cause of frustration for regional SILAIS employees. One of whom commented to me "we try as much as we can to adjust our work to the realities and problems of the region but we are just MINSA soldiers, whatever the boss in Managua says goes".

The central government's program of decentralization provides both an opportunity and a challenge. The opportunity comes from the attributions the Autonomy Law confers on the regional government and the overlap of intentions. As was mentioned before, even before 1990, decentralization in health was part of regional government plans. Decentralization presents a challenge in that the direction of the transformation of the health system is usually centralized. In this sense a regional government official remarked: "decentralization is not a process in which they tell you here do this or that yourselves when we have not been part of the process that decides if what they [the Central MINSA] are telling us to do needs to be done". Moreover, the RAAN had a different status than the other Nicaraguan departments where decentralization of health was taking place. For regional officials decentralization was not an internal process within

MINSA institutions but a process that transferred the authority of MINSA to institutions of the regional government. As Alta Hooker argued, “here in the SILAIS their boss is Managua but we are in an Autonomous Region, their boss should not be Managua, their boss should be the Autonomous Government. The law [of autonomy] says so, we are responsible for administering health.”

During the first CRA-RAAN, from 1990 to 1994, the political uncertainty of the functions and roles of the regional government minimized the amount of work that it was able to do. This time is considered by some in the region as a period in which the heavily divided members of the council learned how to work together. It is important to keep in mind that the members of the CRA just a few years prior had been on opposing sides of a war. The development of the Health Model occurred during the second CRA-RAAN from the period of 1994 to 1997. It was during the second CRA-RAAN that specific activities began to be organized around various issues. The process of decentralization carried out though the SILAIS sparked interest in developing the Health Model. The formation of the SILAIS demonstrated that a new model for the organization of health services was needed, one which conformed to the political configuration of autonomy. This process was made possible through the financial and technical support of the Austrian Development Cooperation, which has been involved with the development of the Health Model from its initial stages.

In 1994 the process began with a diagnostic of the health status of the population and the health sector. Out of the results of this diagnostic training workshops (*capacitaciones*) were developed for members of the CRA-RAAN (Rupilius and Hooker 1996). In the words of a former member of the council, the role of these workshops was to “prepare our council members for the negotiations with the central government. Not all of us knew about the health sector”. The

development of the Health Model in these initial stages was also heavily influenced by the international indigenous movement, specifically the recognition of indigenous rights in by international multilateral organizations. The most important of these were the Pan-American Health Organization's (PAHO) Indigenous Peoples Initiative of 1993 and the ILO 169 accords of 1989. The documents from these international conventions, with their emphasis on indigenous rights through local control and participation, converged with the aspirations of regional officials. Moreover they added international legitimacy to local efforts and were therefore taken as central elements in the Health Model (see Cunningham, Moreno, and McCoy 2003). The discourse of indigenous rights and cultural difference played a central role in the advocacy for the necessity of developing a different health care model. The guiding principles and concepts of the Health Model and those proposed in international indigenous health policy and *interculturalidad,* are the same: reciprocity, cultural revitalization, social participation and equity.

The Health Model's development continued with negotiations with MINSA authorities toward the decentralization of the health system. However these negotiations, which started before the Health Model was approved as a resolution by the CRA-RAAN, have been largely unsuccessful. From these initial negotiations to 2005, 52 accords have been signed between regional authorities and the MINSA, but the Health Model is still in its infancy of implementation (Hooker 2006). Through various workshops and meetings with representatives of the various institutions and organizations that worked in health, and members of civil society and community representatives, the Health Model was finally developed and approved by the CRA-RAAN through a resolution in 1996. Despite minimal advances in these negotiations with MINSA and the process of decentralization, the Health Model was developed in order to provide

a policy outline of what the regional government wanted to accomplish through the administration of the health sector. All of these efforts depend on the decentralization of the health system to regional authorities.

The attempts on the part of regional health officials to decentralize health is in large part guided by the overall goal of the administration and control of the region's resources, whether they be health resources or otherwise. In 2001, a health official, rather idealistically argued that:

> if the central government finally lets us receive what we think is just from the exploitation of our natural resources, in a sustainable way of course, we would have the best health system in Nicaragua. This is a rich region, there is no need for its people to be so poor and for the infrastructure to be so deteriorated. The problem is that they do not reinvest those resources here. After all, that is a big part of what autonomy is all about.

A close examination of the Health Model reveals the connection between the control of health resources and the overall goal of control of the most contentious issue in the autonomy process, natural resources. Health is conceptualized in its broadest possible terms, where social and economic well-being are integral. As such, the preservation of communities' well-being is heavily dependant on local control and protection over the natural resources that provide material well-being. Not only that, the maintenance of culture and self-sufficiency is intimately connected with these resources. For this reason the Health Model posits that health: "has to do with social organization, economic development, quality of life, the distribution of resources, [and] the social and natural environment of the communities" (URACCAN 1996: 23).

The connection between health and natural resources is made in the first half of the Health Model document which provides the rationale for its development. Here the connection between the health model, autonomy and the control of resources is made more explicit although still thinly veiled. In addressing the difficulties in implementing the autonomy regimes it goes on to say that:

> Health is a fundamental aspect and, despite that indigenous peoples and ethnic communities have developed mechanisms of self-preservation and self-curing, it is expected that the modernization process that the Government is advancing, will not only exclude *costeños* in the process of the reordering of services and privatization, but that it also endangers the resources used traditionally because of deforestation and the stealing of the intellectual property associated with them (URACCAN 1996: 16).

There is an assertion of central government influence and control and the negative impact it will have on the health of the population. Moreover, there is a connection being made here between indigenous medicine, represented in an assertion of "self-curing", and possibility of the loss of this resource through the exploitation of the natural resources used for medicinal purposes.

In the second half of the Health Model, where the "technical" aspects and specific strategies and proposals are presented, there is a subtext that connects decentralization, autonomy, resources and the health system. In the beginning of this second part of the document the need for a fundamental transformation of the health system is reasserted. It further argues that:

> This transformation should make [the health system] into a flexible structure, that can confront different situations in an efficient manner, in correspondence with the population's own cultural values and integrating the own resources [*recursos propios*], that the region has at its disposal (33).

There is an implicit claim of ownership of the RAAN's resources. In addition, in the finance section of the Health Model, different regional authorities contribute to the health system through affixed percentages of their income from the exploitation of natural resources. There is no mention of the difficulties in attaining these resources from the Central government. The issue is not confronted directly but simply taken for granted. A wholesale endorsement of the Health Model by the Central government would therefore implicitly recognize these contentious elements.

In this section I connected the Health Model to the wider strategy of the furthering autonomy process through local control of government and the region's resources. Decentralization of the health system is therefore not about health alone but also about autonomy. This has made the implementation of the Health Model as a whole a contentious issue, since it is integrated within the autonomy process that the central government has been reluctant to deal with. These negotiations and regional claims for health, decentralization and autonomy are framed within a discourse that is heavily dependant on "cultural difference" and indigenous rights.

4.3 CULTURAL POLITICS AND THE HEALTH MODEL

The promotion of the Health Model, as well as the process of autonomy, is based on discourses of indigenous rights and cultural difference. In Chapter Two of this dissertation I reviewed the connection between cultural politics and health. In the discourse of the international indigenous movement now widely accepted by international organizations, social justice, the right to culture, and access to resources are intimately related. As some studies have shown the successes of the indigenous movement are in most countries dependant on establishing of "authenticity" and "cultural difference" (Stavenhagen 1994; Jackson 1995). I argued that indigenous medicine is important in the process of establishing "cultural difference". In this section I want to identify the different ways that the concept of "Culture" is used in order to promote the Health Model and to reestablish the "cultural" difference" that legitimates local control and the autonomy regimes.

Health officials that were or had been part of the autonomy process connected the Health Model to the wider struggle for autonomy and indigenous rights. The question of "what is the Health Model?" often elicited a history lesson on the relationship between the Coast and Nicaragua with special attention to indigenous rights. It was not until these historical reasons were presented that a presentation of the Health Model took place. McDonald, former president of the Health Commissions of the CRA-RAAN in 2001 and subsequently advisor to the health Commission began his narrative as follows:

> This process of autonomy takes place in the spirit of maintaining the idiosyncrasies, the culture, the worldview of the people, and around their historical rights to maintain their ancestral behavior. In the contemporary world, so called social development, has really permitted a deterioration of the social behavior of the population. The culture and destiny of the Atlantic Coast has confronted attempts to conquer it, first by the Spanish, then by other countries, and Nicaragua. With a rebel spirit I think we have been able to maintain until today part of the traits that have characterized us ancestrally. Based on this, a difficult process developed, a bloody one, a conflict of one ethnic population against the Nicaraguan State. And I say this because the revolution attempted to impose other forms of organization [on the Coast]…And as part of [indigenous] aspirations, and as part of the change in the Sandinista Front comes the Law of Autonomy. Many have questioned the law, others argue that it is very good, others that it has many vacuums…No law is perfect, not even that of the United States…With barely 11 years [this interview was conducted in 2001] we can not have a perfect law. But luckily, one of the things that is clear in this law has been the issue surrounding health, education, transportation, and it also says administering culture. If we talk about culture, culture is the actions of each human being through his behavior. Then, from here derives the necessity of health. And one of the biggest problems that we have surrounding health is that the contemporary world is still clinging to the idea that Western medicine, or chemical medicine, is the only solution to health problems, which is not true because health has to do with behavior, with your environment, where you live, your world-view and your way of being. And so the Health Model that began to be implemented in 1997 develops out of these preoccupations, to maintain our culture with the spaces provided by the Autonomy law.

This narrative was the preamble to a more in depth discussion of the Health Model. This narrative contains many of the elements of similar ones about the importance of the Health Model and of the rationale for its development. I have chosen McDonald's narrative because it is one of the most concise while still presenting many of the important points. In this narrative

there is the establishment of “authenticity” and “cultural difference”. It is out of this difference that a conflict ensued because of the imposition of external forms of organization. It is implied here that these outside forms of organization, whether “social development” or “Western medicine”, are a threat to the culture of the people of the region. Autonomy, no matter how imperfect, provides the mechanisms for self-government which helps maintain culture, which in this narrative is the reason autonomy regimes were created in the first place. Finally, the administration of health is a mechanism through which that “cultural difference” is preserved. Culture is the point of departure and framework through which autonomy and by extension the Health Model is understood and debated.

External forces, whether “social development”, as MacDonald in the quote above expressed it, or internal colonization by the state, threatens indigenous culture not only through acculturation schemes as would be the case with education in Spanish, but alsowith the dispossession of the material basis on which indigenous identities develop. The Health Model develops out of a concern for the effects that these forces may have in Miskitu culture. For example the Health Model states that:

> The act of colonization has been the most severe disease that has confronted indigenous peoples and ethnic communities, to the extent that it has been directed toward the destruction, subjugation, or invalidation of community organization and social stability, affecting identity, generating insecurity and impotence, destroying value systems, and more than anything not knowing or negating the form in which individuals and collectivities understand and explain life, sickness and death. Colonization has acted against the meaning that preserves and guides each culture and each individual within them. Without cultural meaning, life is transformed into subsistence and resistance (URACCAN 1996: 22).

In this quote a relationship is established between culture and health. In this instance the “most severe disease” that confronts indigenous people is not one that affects individual bodies, but one that affects their collective culture. For the Miskitu health is conceptualized in holistic

terms. Cunningham, Moreno and McCoy (2002) argue that among the Miskitu "the term used to refer to health is wan wina yamni sa, which means being able to do any activity, productive, cultural, recreational" (24). Cunningham (1995) found that in the Rio Coco communities a healthy person was considered to be one who dressed well, looked happy, and does not have any worries. Fagoth et al. (1998) has argued that health for the Miskitu is being in harmony with the environment. Definitions such as these are used by regional health officials to refer to the importance of culture in health. A regional health official argued that

> In our Miskitu communities health is more than just not having a cough or a fever, it is about having all the things necessary to live a full and satisfying life. That includes their relationships with each other in the communities, being able to maintain a harmonious relationship with their lands, in essence being able to practice their culture…culture is more than just beliefs, those beliefs are related to their own relationship to their environment. And that is something we want to try to promote and maintain with our Health Model and our Autonomy.

The conception of culture, as with the conception of health, is one that encompasses a multiplicity of factors. Culture and health are intimately related since being healthy in essence is dependant on "cultural meaning" without which life turns to mere "subsistence and resistance" as the previous quote implies. These discussions about culture and health do not occur in a vacuum. Culture and health are intimately related to the control of resources. The indigenous community takes center stage in these connections. Indigenous culture is preserved in indigenous communities, through forms of organization and access to the resources on their communal land. It is at the communal level that the "harmonious relationship" with land and the environment take place. The argument that culture is about "more than beliefs" places discussions about culture within broader struggles for indigenous rights. This broader struggle for indigenous rights in the RAAN takes the form of the autonomy regimes.

The central position of culture forms part of the rationale for health decentralization and the implementation of the Health Model. In negotiations and discussion with central government institutions cultural difference forms the basis for demands of local control and decision making. A regional health official argued that:

> we say that the health system has to be organized differently, but it has to be organized by us, you can not think of a health system for the people without the people, because if the people are not involved the system will not respond to their cultural reality. Not too long ago the Health Minister came to the region and he told us that he had forgotten the list of diseases of this region. But who is he to tell us what we get sick of? He doesn't know what we get sick of. MINSA statistics do not reflect the afflictions of black women, Miskitu women and Miskitu children. For them…our diseases are one more in the bag. Our diseases are defined by us, with the system that we have here.

The assertion of cultural difference distances MINSA as a *mestizo* central government institution that is incapable of understanding and dealing with the health problems of the region[29]. Regional officials argued that the Western education of MINSA officials and most doctors created a barrier to effective implementation of any health initiatives in the region. The limitations of a Western education do not only affect health officials but the whole autonomic process. In explaining the role of the regional university URACCAN and its relationship to the Health Model, Alta Hooker said:

> We wanted to change the idea of an education of subordination, an education that from the very beginning tells you that you do not have the same rights as others, because you do not know your history, you do not know where you come from, who you are. Then you try to copy patterns, you try to be like the other, and you do not try to separate your own knowledge, your own ancestral knowledge, because you try to forget them and erase them because they are viewed as inferior.

Western education not only limits the inclusion of indigenous cosmology and medicine in the health system, it also constrains the frameworks through which all aspects of the relationship between regional and central government are understood. The development of alternative points

[29] For a detailed example of how this lack of understanding of Miskitu culture and health is used to promote the Model and decentralization see the case study of grisi siknis in the next chapter.

of view and frameworks, from what Hooker called “ancestral knowledge”, is posited as the way to develop new alternative frameworks with which to confront the challenges that indigenous peoples face. In this sense a regional official argued that:

> indigenous peoples are contributing new answers to the problems that face the world today. Our relationship with the environment, our forms of organization, our forms of healing all provide alternatives to the destructive forces of the modern world. It is therefore important to allow indigenous people to have a space in which to develop these alternatives. Our indigenous people and ethnic communities can best resolve their problems and provide solutions to the problems that affect them and the rest of society.

In the search for this cultural knowledge, for these alternatives to the modern world the discourse invariably turns to indigenous cosmology. In an indigenous society that, as we have seen in the previous chapter, has been heavily influenced by Christianity and outside influences, “ancestral” and “authentic” knowledge is found mainly within indigenous medicine and its practitioners. As the director of IMTRADEC put it:

> Throughout the years we have lost a lot of our beliefs and knowledge. From the influence of the church to the acculturation programs that have come from the Pacific. Luckily our people have been able to maintain some of that knowledge through the practices of our healers. They are the ones that remember and remind us of the influence of the environment on our lives, how to stay healthy. Our beliefs usually remain hidden except when we get sick, when we confront difficult situations. But we are losing that knowledge, the young people are not interested in becoming healers. Our most important ancestral knowledge is in jeopardy and we have to preserve it, revitalize it. It is a big part of what makes us Miskitu, of where our culture comes from.

Although a good portion of the discourse of cultural difference and autonomy that underlies the Health Model underscores that “culture is about more than beliefs”, it is indigenous medical beliefs and knowledge which provide the most apparent display of “cultural difference” besides indigenous languages. As Graham (2002) has argued indigenous discourse becomes legitimate to international audiences when it makes references to its cosmological knowledge. It is from these references that a “performance” or display of authenticity derives.

A large part of the Health Model document deals with issues that are not very different from the public health challenges that other regions of Nicaragua face. As the outline of the Health Model shows, the document concerns itself with structuring the provision of services to a mostly poor and underserved population. What distinguishes the RAAN from the other regions of Nicaragua is the "cultural difference" of a large proportion of the population that is indigenous. Highlighting and promoting indigenous medicine is therefore a powerful political symbol. Giving prominence to indigenous medicine within the Health Model serves as a way to highlight the uniqueness of the RAAN in comparison to the rest of the administrative departments of Nicaragua. It is meant to represent the "cultural difference" on which the political process of autonomy and indigenous rights rests. Indigenous medicine also represents a vision of the structuring of a multi-cultural and multi-ethnic society. Furthermore, the lack of understanding of the cultural needs and realities of the region is what gives legitimacy to decentralization efforts and the transfer of resources and power to the region. The argument is that only the people of the RAAN understand the needs of its population and therefore the health officials of the RAAN should have the decision making power and resources transferred through decentralization so they can effectively implement health policies that reflect the social and cultural context of the RAAN.

4.4 INTERCULTURALIDAD: CONFLUENCE AND CONTRADICTIONS

Although the word *interculturalidad* appears only once in the Health Model policy document it has come to be its defining concept. This is in part due to the currency that the discourse of *interculturalidad* has gained at the end of the 1990s throughout Latin America,

especially surrounding health (see Fernández Juárez 2004). In the RAAN the term appears in the title of symposia, workshops and health meetings; URACCAN offered a masters degree in Intercultural Public Health; and it appears in health documents. *Interculturalidad* has become virtually synonymous with the Health Model.

In Chapter Two of this dissertation I argued that health as political symbolism emerges from two related but distinct aspects. Bad health indicators among a particular sector of the population can be used to indicate conditions of inequality in society. The other aspect is that the discourse used and the way a health system is constituted are meant to symbolize the values and structure of the society in which it is found. The discourse of *interculturalidad* or intercultural health encompasses both of these aspects. *Interculturalidad* refers not only to cultural difference but also to unequal structural relations in society that have developed along ethnic, cultural and racial lines (Walsh 2002). As such there is an important component of social justice and redistribution of resources. However, *interculturalidad* is also an epistemological project that argues that unequal structural relations prioritize some forms of knowledge and devalue others (such as indigenous knowledge). These two aspects of *interculturalidad* can come into conflict with each other in practice, in the development of programs and policies. The conflict arises when emphasis on cultural revitalization takes preeminence. As I have argued in the previous sections this is due in large part to the fact that cultural difference legitimates appeals for greater resources and access to political power.

In reference to health, Cunningham, Moreno and McCoy (2003) argue that *interculturalidad* emerges out of a "double right: the right of indigenous peoples and ethnic communities to maintain and cultivate their traditional medical practices and the right established in international and national legislation that health is the right of all citizens" (25). In other words

on the one hand it emphasizes the importance of "cultural rights" and on the other it points to government's responsibility of providing adequate health-care through access to institutional medicine. In the use of the discourse of *interculturalidad* in the RAAN there is tension between the aspects of the concept that refer to cultural rights and aspects that refer to political and economic inequality. In most cases when the term is used in reference to health the main point of reference is the inclusion of "traditional" or "indigenous" forms of medicine in the health care system. The emphasis on indigenous medicine, once again, comes from this being the aspect that most dramatically asserts cultural difference.

In the promotion of the Health Model and autonomy the role of economic and social inequality is stressed as an important factor in the lack of adequate health care and of worse economic indicators than the rest of Nicaragua. However, this attention to inequality is based on cultural difference as well. For example, a member of the CRA argued that:

> The biggest problem we have is that the region is neglected by the central government. There is very little economic and social investment here and a complete lack of infrastructure. The costs of everything are higher here and so building a health post and transporting medicines is more expensive. We therefore cannot rely on health budget formulas developed based on percentage of the total population as if all things were equal. This situation no doubt has its origins on our unwillingness to submit to the culture and principles of the Pacific. The state, to say it some way, rewards its own *hijos* [sons] and we seem to be distant cousins in this country.

In a similar vein local health officials and advocates criticized the decisions made by MINSA around the allocation of resources. The World Bank for example, through local government institutions executed a project called *Programa de Modernización del Sector Salud* (Health Sector Modernization Project). In one presentation MINSA officials showed the construction of health posts and centers in other departments of Nicaragua. These were either improvements on older buildings or new ones built to replace old buildings. The presentation contained before and after pictures. Even though the project did indeed bring resources into the region local officials

commented that the old health posts and centers that were replaced looked better than most of the ones in the region. This in turn was interpreted as another sign that the region was marginalized. As one of them commented to me: “this is what happens when you are not part of the central political circles, the sectors with greater needs are overlooked”.

Confronted with situations of economic inequality and lack of political power that are heavily associated with ethnic and racial distinctions, the concept of *interculturalidad* acquires a political dimension. The concept as it applies to the Health Model is concerned with redressing the unequal relations that have been historically constituted in society. The following quote by a staff member of IMTRADEC is illustrative:

> The Health Model is based on the notion of *interculturalidad.* And by that we mean a recognition that race and ethnicity have been determinative factors in the marginalization of some groups and their exclusion from the decision-making process. *Interculturalidad* is a process by which indigenous peoples come to participate in the decisions that affect them, in which they have the power to transform the political process through their own views and experience.

In discussing the difficulties in the implementation of the autonomy regimes and the Health Model attention is also paid to the political implications of a relationship of autonomy with the state. As we have seen in the previous chapter and this one, the control of local decision-making and the region’s resources are at the center of conflicts in the region. As a member of the CRA put it:

> [The Central Government] fears that we want to separate ourselves from Nicaragua. Well the truth is that we have always been separated. Their fear is not that the population may want to separate from the rest of the country, which is not true, after all I doubt they care too much about our ethnic communities. Their fear is really losing the economic resources that this region has. More than anything they fear losing all control. Right now we share it which is as should be but they wish they had more control.

As we have seen so far in this chapter, regional discourses may center on culture and cultural difference, but there is an emphasis on and preoccupation with socio-economic and

political inequality and the distribution of resources. Health problems are not narrowly understood as an issue of mere cultural misunderstanding and interpretation. However, the issue of the acceptance of indigenous knowledge and cultural practices is another problem that needs to be dealt with and forms an integral part of the discourses that underlie the Health Model.

In discussing the difficulties of implementing the Health Model the acceptance of cultural difference with its associated forms of knowledge and practices formed the other loci of contention. To illustrate, the president of the Health Commission of the CRA commented:

> the central government and MINSA really do not understand our attempts of implementing the integration of indigenous medicine. They have been slow to accept it, and in many ways I understand it. Their education has conditioned them to think that there is only one truth. I think they feel that we want to replace doctors with our *curanderos* which is absolutely ridiculous. *Interculturalidad* is about the integration of different forms of knowledge, and in health different forms of healing. There are good things and bad things in both systems so why not interculturalize both of them and make them both better.

There is also a need to value and revitalize indigenous medical practices. In the same interview the president of the Health Commission of the CRA also argued that:

> Our healers provide better care than the doctors [meaning institutional medicine]. They resolve most of our people's problems. In a study, I don't know which one, it said that nurses in the region prefer to go to a *curandero*. If this is the case then why not open spaces for them to participate in the Health system. They are a valuable resource and we believe indigenous medicine is the best alternative. This region has the second highest infant mortality rate in Nicaragua, this is due to the lack of resources for health in the region, but God knows how much worse the situation would be without our healers.

From this vantage point of cultural revitalization *interculturalidad* in the context of the Health Model acquires another dimension that is political, albeit thinly veiled. In this notion of *interculturalidad* there is an emphasis on the recognition and value of other cultural forms of knowledge. The following quote from a staff of IMTRADEC is illustrative:

> *Interculturalidad* is the process of acceptance and mutual understanding between medical systems, in the case here in the RAAN between our traditional medicine and the health system. Our goal with the Health Model is to create a health system in which the cultural

> reality of the population becomes an integral part of the way public health and health services are practiced.

As can be seen from the previous discussion, the discourse of *interculturalidad* and by extension the Health Model, is composed of two interconnected strands. The first refers to an explicitly political process which views cultural difference from within the political economic divisions that have been constructed historically in Nicaragua. The second strand relates to the importance of cultural context and knowledge in the implementation of effective health programs and policies. This second position is also political, in that the values assigned to the different knowledge systems are the result of the same relations of colonization and subordination that created the economic and political inequalities that *interculturalidad* as an explicitly political process attempts to redress. However this second aspect can be interpreted as simply a "technical" problem of bridging the gap in health knowledge across the cultural divide.

The discourse of *interculturalidad* would seem to be informed by the critiques of the role of culture in health that have been discussed in chapter two. However, the discourse of *interculturalidad* encounters two main difficulties in practice as the central domain for regional health system reform and advocacy through the Health Model. First, in discussions and negotiations with the central government, the dual aspects of *interculturalidad* allow national health officials to center the discussion on culture as a "technical" problem while marginalizing the most contentious discussions about resources. Second, the perceived necessity by regional health officials and advocates of establishing and maintaining cultural difference and authenticity reinforces this view of culture as a "technical" as opposed to political problem in the health system.

From the point of view of MINSA representatives *interculturalidad* is viewed as a "technical" problem of being able to take into account and include the cultural context and

reality of the local population in health programs and policies. The explicitly political aspects that deal with decentralization, autonomy and resources become a secondary concern. For example, the sub-director of the regional SILAIS argued that:

> The Health Model in its structure is basically the same as the structure that the health system currently has. The difference is that the Health Model calls for the integration of indigenous medicine into the health system. This has been the difficulty, getting the system and health workers to come to understand indigenous health beliefs and behavior.

No mention was made here of the wider process of decentralization or of attempts of local control of the Health System. It was acknowledged that these attempts emerge out of the conflictive political process of autonomy, but in these accounts there was little acknowledgement of the political implications this process had on the regional health system. The problem in reforming the health system is therefore "cultural" as opposed to "political".

The emphasis on cultural revitalization by regional officials and health workers also served, at least in practice, to give legitimacy to this limited view of the Health Model and *interculturalidad*. As discussions of health problems in the region take culture as a starting point, an understanding that the main problem was a lack of intercultural exchange and understanding becomes the common ground that brought the different sides to discussions and negotiations. The need for a discussion about "culture" in fact was the least contentious issue, since all sides agreed, as has become the conventional wisdom in international public health, that in multi-ethnic and multi-cultural contexts cultural variables are important determinants of health program success. Regional officials and advocates understood this. In an interview with a member of the CRA I asked about the attempts to implement of one of the most contentious issues of the Health Model, financing the health system. His response was the following:

> We haven't been able to implement that yet. This is a long process and we have to deal with many issues and problems. First we need to get them [the central government] to accept that the cultural and social reality of the region requires a different approach to

> health and to get them to accept the importance of indigenous medicine. We have been able to make many advances on this point. Little by little we will deal with some of the more difficult issues such as decentralization and the financing of the system. That doesn't mean we haven't been working on it, just that these issues require longer negotiations. We have to go step by step to realize our whole vision.

Not surprisingly discussions centered on culture produce less conflict than those that deal with substantive issues related to local control and resources. The strategy by regional health officials and advocates is then to use culture as the departure for realizing these goals in the long term. Centering the discussion on culture is less threatening to the interests of central government control. However, the possibility for discussions centered on culture to move forward to address these other issues has yet to fully materialize and seems tenuous at best.

4.5 HEALTH MODEL IMPLEMENTATION

Implementation of the Health Model has been a slow and uneven process. There is still no unified institutional structure in charge of its execution. The CRA-RAAN through its Health Commission is supposed to be in charge of its implementation and administration. However, it has very little control over budgetary decisions. The SILAIS-RAAN as the MINSA representative in the region is in charge of the health budget and the administration of the health system and although it is an integral part of the implementation of the Health Model, it is constrained by the heavily centralized mandates of the Ministry of Health and a very limited budget.

There have been some significant recent advances in the implementation of the Health Model that are meant to remedy this lack of coordination. In 2002, the Ley General de Salud (General Health Law) legally recognized the ability of autonomous regions to create their own

models of care. The law also recognized the creation of the post of Health Secretary of the RAAN.

The creation of the Health Secretary of the RAAN, as part of the governor's cabinet was meant to remedy the lack of a unified regional decision making authority. The position was officially sanctioned and filled in the summer of 2003, but the actual function and role of the position had yet to be defined by the time that Dr. Ned Smith assumed the position. In the 7th Session of the Regional Health Council, after Dr. Smith had already assumed his post, a discussion arose as to what the responsibility of the Health Secretary would be. At that particular time the position had very little control of the administration of the local health system which was in the hands of the SILAIS-RAAN director. The discussion made apparent that no one understood clearly what the role of the Health Secretary was. In that discussion for example a member of the CRA commented:

> I think the role of the Health Secretary is too ambiguous. It looks that on paper Ned [the Health Secretary] should be doing what Florence [Silais-RAAN director] is doing, but then what would be Florence's role? I think that maybe we should do away with the position of the SILAIS-RAAN director and have the Health Secretary fulfill that role.

It is precisely this lack of clarity that has affected the implementation of the Health Model. At the time Dr. Smith's role was to participate in a Dialogue Commission created to negotiate and advance the process of decentralization of the health sector in the region. Dr. Smith was well aware of the limitations that the political process and uncertainty of roles imposed on the implementation of concrete programs and strategies. He argued that:

> One of the main problems we've had with the implementation of the Health Model is that those at the forefront of its advocacy have been concentrating on its political aspects. This has consumed most regional efforts. Of course that aspect is important but it is time to move from the political to the technical aspects of the Health Model. And by that I mean the operationalization of the components and ideas contained in the document.

Given the lack of regional control over the health system and lack of resources, the Health Model is actually advanced through a variety of NGOs and civil society institutions that implement programs and provide financing for different aspects of the health system. These NGOs and civil society institutions sign agreements with the SILAIS and CRA-RAAN. The result is that the Health Model is implemented piecemeal by a patchwork of NGOs and civil society institutions that provide different programs and services throughout the region, contributing to the overall goal and objectives of the Health Model without achieving a unified coherent structure. For example the NGO Acción Médica Cristiana (AMC) works with the communities of the Rio Coco building community health infrastructure, organizing indigenous healers, publishing Miskitu medicine books and contributing to other community health development aspects. The Programa de Salud Integral del Llano Norte-PSILN, financed and run by the Catholic Church, works in the communities of the Northern Savannah. The PSILN provides health care and organizes community health commissions and leaders as part of a pilot project for the extension of services. Other NGOs and institutions work in the region to varying degrees in this manner.

Of these NGOs and civil society institutions the Institute of Traditional Medicine and Community Development (IMTRADEC) of URACCAN University has had the greatest impact. IMTRADEC is at the forefront of the push for the Health Model. As part of its mission it has attempted to be engaged in a wide variety of activities and projects that advance the main goals and ideas of the Health Model on several fronts. At the institutional level IMTRADEC is responsible for the dissemination of the principles of the Health Model and with political advocacy to help make the model a reality. For example, IMTRADEC has a very close relationship with the president of the Health Commission of the CRA and performs an advisory

role. The coordinator of IMTRADEC is also heavily engaged with MINSA officials in the discussion and formation of public health policy for the region. The institute also engages in other activities such as health related research, training nurses, community development, organizing indigenous healers, and preparation of herbal remedies based on indigenous medicine. All of the activities of IMTRADEC are guided by the principles of the Health Model with emphasis on community development, social participation, *interculturalidad* and indigenous medicine. Dr. Carlos Cuadra of IMTRADEC expressed the relationship of the institute to the Health Model in the following terms:

> Our work here at IMTRADEC is directed toward the acceleration of the implementation of the Health Model. We try to bring elements into the health system that MINSA does not have the capacity or the will to implement. For example, the training of nurses with an intercultural component, in which indigenous healers come and teach them classes about Miskitu cosmology. We try to develop human resources that will be able to implement the Health Model. The institute also provides information and research that may be used for the formation of health policy.

The activities of the above mentioned NGOs and institutions have been instrumental in keeping the Health Model as the point of reference for the development of health policy and the transformation of the regional health system. Moreover, the work of these institutions bring with them international development and donor agencies that apply indirect pressure on the Nicaraguan government through their potential economic contributions, which has helped advance aspects of the Health Model and encourage acceptance within the health system. The most influential has been the Austrian Organization for Development which has not only funded IMTRADEC, but has also engaged in lobbying for the development of the Health Model.

International donor development agencies and NGOs form an integral part of local health officials' strategies for the implementation of the Health Model. The Health Secretary for example argued that:

> Because of our economic situation and the slow pace of the political process of decentralization, NGOs are very important for the development of the Health Model. They don't only provide services and projects that we can not carry out at the moment but provide us with practical experiences that help us develop and test strategies and approaches that will be helpful as we move from the political process of the Health Model to its technical aspects as a government.

These international organizations also help shape the form and discourses used by local officials in their approach to the Health Model and their negotiations with national authorities. Community, traditional medicine, indigenous rights and culture are issues that attract international donors. In discussing the unwillingness of central MINSA to implement the Health Model a member of the CRA said:

> If they were intelligent they would get on board with us. This whole thing of indigenous medicine is something that is being accepted more and more internationally, especially in European countries. There is a lot of interest and possible funds from international cooperation for these issues.

Because of its appeal to international organizations, which provide solidarity, and international development agencies, which provide economic support, the Health Model is actively promoted and presented to international audiences through Latin American health exchanges, congresses and presentations. This provides another incentive for placing culture at the center of the Health Model.

One result of the slow development of the Health Model, along with the lack of a unified institutional structure is that there is very little knowledge about and impact of the Health Model in the communities whose issues it is meant to address. As we will see in Chapter Six, despite the participatory rhetoric and the inclusion of indigenous communities in the development of the Health Model, there is virtually no awareness that attempts at transforming the health system are under way. The process is very similar to that of the autonomy process. The obstacles that the Nicaraguan government has put in place around development of the Health Model result in

regional efforts that are focused on the political process as opposed to the provision of tangible health benefits to rural Miskitu communities. It contributes to a wider view that autonomous governments have provided few tangible benefits and that their role is mainly to provide sustenance for corrupt politicians. In regards to the health sector there is a sense that the appeal to indigenous issues is nothing more than a way in which some individuals exploit the situation of indigenous people for their own benefit for employment in studies and health programs. This view is compounded by the fact that in the health sector Creoles and mestizos have more representation in positions in the health system and NGOs. As one Miskitu expressed it:

> This Health Model thing it sounds good but where is it? I'll tell you where it is, it's in a bunch of documents and proposals for projects. It's in discussions between politicians. Is it in the communities? No. Those people use our misery for their own interest. They get a good salary from an NGO and say we're doing something for the health of our indigenous peoples. It would be bad enough if it was just Creoles and Spanish [referring to Mestizos], but our own are doing it too. I'm not saying that there are no programs that are good in the communities and help people, there are some, but go to the communities and tell me how many good projects you see.

The view expressed in the quote above appeared in different variations during my period of fieldwork. The point I want to make is that the process of autonomy and the Health Model are undermined by a political process that produces very few concrete results. When I asked about advances of the Health Model people variously mentioned the following: *encuentros interculturales* (intercultural gatherings) between indigenous healers and doctors, symposia and meetings in which *interculturalidad* served as the guiding principle in discussions, the ability of indigenous healers to cure in the hospital if the patient called for one, training of health nurses and workers from an intercultural approach, and the production of books and other materials that helps preserve indigenous medical knowledge among others. These initiatives provide very little benefit to scattered Miskitu rural communities. However, they do produce an illusion that something is being done. Moreover, they tend to concentrate on the purely "cultural" aspect of

interculturalidad as opposed to its political dimension in addressing the political economic inequalities that produce ill health, which as we will see in the next chapter is the main concern in Miskitu communities. This is in part the result of focusing on "culture" as the central arena of debate. This connection will become clearer in the next chapter with the discussion of the case study of *grisi siknis*.

Concrete programs based on the Health Model are those implemented by various NGOs and civil society institutions that actively engage in community development. These programs provide communities with valuable resources such as wells and latrines, and some of them provide primary health care. However, as we will see in Chapter Seven, these are understood by recipients as conceptually separate from the Health Model and other regional and national government programs. They are therefore judged and viewed in very different terms.

4.6 CONCLUSION

In this chapter I have presented the main features of the Health Model as a policy document whose goal is the reform of the regional health system of the RAAN based on the process of autonomy and the discourses of cultural difference and *interculturalidad*. The development of the Health Model is an integral part of wider attempts at implementing autonomy regimes in the region. The Health Model is an attempt by regional officials to further the institutional development of the authority of the autonomous regimes.

In Chapter Three I discussed some of the main features of the development of the autonomy regimes and the difficulties they have faced in its implementation. The process of autonomy as Hale (1994) has argued was a Sandinista project that provided many concessions

for the development of indigenous rights while at the same time delimiting the spaces in which the government was willing to negotiate. As such the population of the region accepted it as a step in the direction of achieving the cultural, political and economic goals they had envisioned. However the attainment of these rights depends on the establishment of cultural difference. The Autonomy Law is clear in establishing "cultural rights" but it is not as clear in how political and economic rights will be achieved.

The discourse of cultural difference and *interculturalidad* emerges from an understanding that cultural difference and political economic inequality emerge from a deeply rooted historical process. As such appeals to culture are political in that they attempt to transform the relationship between the state and indigenous/ethnic minorities. This transformation is not only about the inclusion of culture in state institutions but about the transfer of political decision-making and resources. However, what gives legitimacy to this process of transformation is cultural difference itself. Indigenous advocates therefore are obligated to take culture as a starting point in all discussions with the state.

The Health Model in the RAAN attempts to transform the health system based on these discourses. It contributes to the overall process of autonomy by reproducing the cultural difference that gives legitimacy to regional claims through its attempts at preserving and revitalizing indigenous cosmology and medicine. The references to indigenous medicine and intercultural health are political symbols that attempt to signify the region's special status among administrative departments and the ideal of the creation of a truly multi-ethnic Nicaragua. However, the emphasis on these issues and culture limit health advocacy. The dual strands of the discourse of *interculturalidad* between cultural knowledge and political transformation, although

intimately related in indigenous advocacy, can be conceptually separated by the representatives of the government institutions with which they are struggling.

The realm of culture, with its multiple interpretations allows for a sense of mutual agreement. It is also less threatening to the central government. As such, the Health Model is advanced only in limited aspects from a culturalist perspective of the exchange and understanding of different forms of knowledge. The main struggle and point of contention center on issues that deal with political power within the health system. The response to these issues move at a slow pace with multiple negotiations and committees as the government, like in all aspects of the autonomy process, presenting stumbling blocks to its smooth implementation. As the brief overview of the Health Model showed, culture is the backdrop of the document but most of the strategies and policy aspects involve financial, political and organizational aspects of the health system. The fact that most discussions center on the cultural domain indicates that the cultural discourse has been co-opted and placed as the central arena of discussion by central government institutions.

Lastly, the results of the political process and negotiations around the Health Model have been concentrated at the level of the regional and central government. The communities whose needs the Health Model is supposed to address have been left out of the process. As we will see in Chapter Six, the perception is that such debates have very little to offer them. In the next chapter I present a case study that exemplifies the arguments presented in this chapter, before moving on to deal with issues of the community.

5.0 INTERCULTURAL INTERPRETATIONS AND HEALTH POLICY: THE CASE OF *GRISI SIKNIS*

Between August 2003 and February 2004, seven indigenous Miskitu and Mayagna communities in the Autonomous Region of the North Atlantic of Nicaragua (RAAN) suffered an epidemic of an illness known locally as *grisi siknis*. *Grisi siknis* is a local culturally patterned mental illness that appears simultaneously in a group of individuals. During these episodes those affected display aggressive behavior directed at others and themselves (Dennis 1981). The *grisi siknis* epidemic attracted a lot of interest and drew wide national press coverage. This is significant given the usual lack of attention to issues related to the RAAN at the national level. The press coverage seemed to some to be sensationalistic, the region appearing as a final frontier of the exotic in Nicaragua. Some people from the Pacific of Nicaragua residing in the region even received calls from family members worried about their security, not because they were worried about them being affected with the illness but because they were worried about the aggressive behavior of those who were. The sensationalistic tone of the coverage prompted officials of the region to counteract what they considered the negative images being portrayed in the media by organizing a national forum on *grisi siknis*. In confronting this phenomenon many looked for a "rational" explanation. They were looking for an answer that could fit within one or several academic disciplines such as medicine, psychology, sociology or anthropology.

Recognized as an anthropologist doing research in the region, I found myself on various occasions being questioned, mainly from doctors and people from the Pacific, about my opinion

from an anthropological perspective; at the same time they provided their own opinions on the subject. Some expected me, an anthropologist, to serve as a "cultural translator". I felt uncomfortable in attempting to provide the anthropological view of such phenomena, and in essence providing "cultural translation". This ambivalence was due in large part with my conversations with some Miskitu community members, healers and health officials, who saw in attempts of translation and "scientific" explanation a lack of respect to Miskitu worldview and the principle of *interculturalidad*.

Looking at the interpretations of *grisi siknis* from both points of view and the debates over representation and interpretation elucidates the difficulties with and limits of *interculturalidad*. The debate poses some interesting questions. Can the cultural interpretation of phenomena such as *grisi siknis* be translated to a "scientific" one while maintaining respect for Miskitu culture? How do Miskitu people feel about such attempts at translation? And moreover, can the causes of *grisi siknis* be debated without prioritizing occidental explanations over those of the Miskitu? This is the fundamental challenge of *interculturalidad*. More importantly it puts local health officials in a difficult position as they try to balance both interpretations and manage the way the region and its population are perceived by the rest of Nicaragua.

Even more important is how a health system based on the principle of *interculturalidad* can deal with such conditions. The *grisi siknis* epidemic provided regional health officials with a way to validate the Health Model in that the epidemic dramatically displayed the cultural difference on which the promotion of the Health Model rests. On the other hand managing its interpretation and the representation of the region it projected proved a difficult task. The management and subsequent discussion of *grisi siknis* along with attempts to establish health policy that is able to deal with such episodes reveal the difficulties created by the use of culture

as the driving force behind the decentralization of the regional health system and the formulation of policy. The case of *grisi siknis* shows how different conceptions of *interculturalidad* affect the way the central and regional government differ in their approach to health policy. Culture is embraced by both and yet co-opted by central government authorities in the MINSA through an alternate understanding of the role of culture and *interculturalidad* in health.

This chapter will provide an analysis of the different interpretations of *grisi siknis* in the region in order to contextualize the debate about *interculturalidad* and show some of the difficulties that the discourse faces in practice. I will not provide an in depth analysis of *grisi siknis* as an illness since I did not personally research the epidemic or *grisi siknis* cases, I only interviewed three affected individuals of the grisi siknis case of Wawa Bar with Jose Manzanares, an indigenous healer who works in IMTRADEC. Those interested in more in depth research of the illness itself can refer to other sources (Dennis 1981; Pérez-Chiriboga 2000; Jamieson 2001; Martin and Nahel 1987; Rupilius 1998; and Dennis, Cuadra, Carrasco and Sanchez 2000). Here I am more interested in how different people come to understand *grisi siknis* and in the debates about the representation of the Miskitu that these different interpretations of *grisi siknis* engender. This serves as a backdrop for an analysis of the contradictions created when health system reform is promoted through a framework based on culture.

5.1 *GRISI SIKNIS* AMONG THE MISKITU IN THE RAAN

Between August 2003 and February 2004, seven indigenous Miskitu and Mayagna communities in the Autonomous Region of the North Atlantic of Nicaragua (RAAN) suffered an

epidemic of an illness that is known locally as *grisi siknis*. *Grisi Siknis* is a culturally patterned illness that has traditionally affected only the Miskitu[30]. The symptoms manifested by those affected and the mode of treatment are patterned by Miskitu world-view. The most commonly recognized source of *grisi siknis*, and the one Miskitus believe to have caused the 2003-2004 epidemic, is a *brujo* (sorcerer) who calls upon the spirit of *liwa*[31], *duhindu* and the last person to have died in the community to cause individuals to get sick. In order to cure the illness, a *curandero* must provide therapies both for the individual and the community as a whole. Spirits must be sent back to their proper spheres and away from the social sphere of the community.

What is known as *grisi siknis* among the Miskitu is the manifestation of a group of symptoms that occur simultaneously among a group of people. There are two groups of symptoms that can be used to categorize the cases as moderate or severe, which are general malaise and attack, respectively (IMTRADEC 2004). General malaise symptoms are present in all cases, and precede the attack symptoms. The symptoms of general malaise include headaches, palpitations, chills, weakness, dizziness, and loss of consciousness. Attack symptoms include convulsions, aggressive behavior towards others and self, destruction of property, visions, and attempts to escape the community toward rivers. These attacks last from 45 minutes to an hour and a half, up to four times a day, and may last for up to six months. After the attacks those affected have no recollection of their actions during the episodes. What makes *grisi siknis* such a concern to local people is its collective manifestation as it tends to affect a group of individuals at the same time. For instance, those suffering from an attack episode at the same time during the

[30] Although grisi siknis is considered an illness of the Miskitu, it has recently affected *mestizo* women and a Mayagna community (see Dennis, Cuadra, Carrasco and Muller 2000).
[31] Liwa and duhindu are the names of spirits that are part of Miskitu Cosmology. Liwa govern all bodies of water and duhindu govern the pine savannah. It is important to note that because of Christian beliefs in most cases these spirits are now viewed as evil.

2003-2004 epidemic worked collectively to destroy property, and at times an individual took a leadership role in directing the actions of the others.

The mechanism for the spread of *grisi siknis* is unclear, although some have suggested that the most plausible explanation is suggestion. We do know some of the characteristics and main features observed in the spread of the illness. In his study in the late 1970s, Dennis (1981) observed that the spread of the epidemic of *grisi siknis* he researched followed patterns very similar to those of an infectious disease epidemic. He noted that it started in a particular focal household, moving to vulnerable individuals in the community and finally moving outward slowly to nearby communities. The spread from individual to individual is usually prompted by an affected person calling the name of another individual in the community. The individual whose name is called soon starts to develop the same cluster of symptoms. The name of an individual does not have to be called out in order for him/her to be affected but this is the most commonly reported pattern of transmission. It is in part for this reason that often those affected at the same time within a community or across communities have social or kinship connections. Fletes, the director of mental health in central MINSA, noted that many of those affected had the same last names[32].

Grisi siknis affects mostly Miskitu adolescent girls from the ages of 13 to18 (Dennis 1981). However, recently gender, ethnicity and age groups affected by *grisi siknis* have shown some variation. In recent outbreaks it has affected men although they tend to be in their teens as well (Rupilius 1998; IMTRADEC 2004; Wilson et al. 2001). In the community of Raiti, in 2003, 48% of those affected were male. Moreover, a small outbreak was reported among *mestizo* women (Dennis et al. 2000) and the Mayagna community of Santo Tomas Umbra in the 2003-

[32] This observation was made by Fletes during the *Grisi Siknis* Forum.

2004 epidemic. This is interesting because previously *grisi siknis* was always an illness thought confined to the Miskitu. However, this should not be surprising given that the different ethnic groups in the region have continually influenced each other.

Grisi siknis is not a major problem in terms of the number of people affected at any given time, if we look at it from the level of the whole population of the region. However if we look at it from the point of view of the burden it imposes locally, it has the potential to adversely affect whole communities that range in population from a few hundreds to a thousand. The psychological and social burden that the appearance of *grisi siknis* imposes on a community is startling. According to data collected by IMTRADEC in 2003 on the community of Raiti, for example, of a population of around 1600, 45 individuals (2.8%) suffered attacks and 94 individuals (5.8%) suffered milder symptoms. A total of 139 individuals, or 8.6% of the community, suffered in some way from the illness. These numbers in and of themselves are not that alarming until we examine the impact this has on a community and take into consideration that individuals in the midst of an attack display an extraordinary amount of strength, requiring three or four individuals to restrain them. Individuals suffering from an attack need to be restrained in order to prevent them from hurting themselves or others, since those affected sometimes threaten others with machetes, sticks or knives. Because of the number of individuals needed to take care of and restrain those suffering from attacks, large sectors of the communities were unable to work and plant their crops during the planting season. The burden on the families and communities as a whole is therefore also economic.

The case of the community of Santo Tomas Umbra is illustrative of this point. In a community of around 640, 19 suffered from attacks, and their aggressive behavior was such that all other members of the community evacuated to the nearby community of San Carlos. Those

affected by *grisi siknis* damaged or destroyed nearly all the property in the community, including houses and the property contained in them. In this case, although workers at IMTRADEC did not count those suffering from milder symptoms because there were so many of them, they asserted that nearly all the rest of the members of the community suffered some symptoms. In order to restrain the affected individuals in the community, using the words of Pablo McDavis of IMTRADEC, an "army of about sixty men was assembled at San Carlos, and we went in and it took about two hours to chase them down and be able to restrain them".

The drastic nature of the *grisi siknis* epidemic of 2003-2004 drew wide national attention to the region. Health authorities scrambled to find a way to deal with the condition while the members of the communities affected appealed for help and relief. To compound matters the national media became interested in the exotic aspects of the illness and started producing negative representations of Miskitu culture. Regional officials then had to look for a way to deal with both the epidemic as well as the cultural representations that derived from the illness.

5.2 *GRISI SIKNIS* IN ANTHROPOLOGICAL PERSPECTIVE

Grisi siknis is not new in the RAAN. One of the first accounts of an epidemic was written by Charles Napier Bell (1989) in the 1870s. During that time missionaries called the epidemic the "great awakening", since they interpreted Miskitu behavior as a display of conversion to Christianity as the "holy spirit" came to take possession of their bodies. This phenomenon is not unusual; similar occurrences have been documented in other areas of the world where major socio-cultural and religious changes were underway (Schieffelin 1996; Parle 2003; Allen, Naka and Ishizu 2004). An anthropological understanding of such phenomena in general and of *grisi*

siknis specifically is important because anthropological explanations form part of the debate and discussion over interpretation of *grisi siknis*.

Phenomena like *grisi siknis* have been categorized by anthropologists as culture-bound syndromes (Simons and Hughes 1985). The term "culture-bound syndrome" was used to connote a constellation of patterned behaviors influenced by the cultural environment, recognized and named locally, and considered deviant behavior by members of the culture in which it was found. These constellations of symptoms and behaviors cross-cut the symptom clusters used by Western based diagnostic criteria, thereby making the "syndrome" difficult if not impossible to classify by psychiatrists. Culture-bound syndromes were in many instances considered unique to a culture.

However the concept of culture-bound syndrome has been criticized and has been largely abandoned (Hughes1996). There are two main approaches and goals in the criticism of the concept. The first is centered on the "culture-bound" aspect of the term and its utility in cross-cultural psychiatry. The second one is centered on the "syndrome" aspect of the concept and its utility in anthropological research. In looking at its utility as an analytic concept used in cross-cultural psychiatry the term has been abandoned because its reliance on the concept of culture obscures more than it illuminates. The *uniqueness* of these syndromes has been questioned. Hughes (1985), for example, provides an analysis of 185 "culture-bound syndromes" and established the non-uniqueness of the major symptomatic constellations. In this sense the argument is that labeling a particular phenomenon as cultural with its emphasis on the "exotic" from the Western point of view, hinders the possibility of being able to deal with it in similar terms than other psychological problems.

A different approach centers on the centrality of culture in understanding these phenomena. This approach argues against the use of the term “culture-bound syndrome” because of its emphasis on symptoms. Guarnaccia (1993) argues that “illness categories are not only syndromes of symptoms, but also syndromes of meaning” (p. 166). In this sense these phenomena have to be understood within the social context in which they are found. Low (1985) has argued that these phenomena are culturally patterned “idioms of distress”, through which the individual is sending a clear message that something is wrong. This does not mean that the individual is consciously aware of what he/she is doing or that he does not experience the episodes through the body. Finkler (1989) has argued that we can see these phenomena as “the embodiment of existential conditions and experience of suffering in the same way as, for example, a cold is the embodiment of a pathogen” (82). Moreover she says that “human beings must confront adversity and contradictions that become incorporated into the body and expressed in states of worry, anxiety and trembling” (82). From this perspective an analysis of the appearance of these phenomena in their socio-cultural and political economic context can reveal the effects of particular practices and situations on groups of individuals. The classic example is Ong’s (1987) analysis of spirit possession occurring among women factory workers in Malaysia. She argued that spirit possession within the factory was a reaction to the capitalist discipline to which they were submitted by working in the factory. Possession in the factory expressed the socio-cultural dislocation experienced by women through the political economic changes occurring in Malaysia. In this case, and others in the literature, the anxiety or inability to fulfill or live up to salient roles and cultural values can give rise to culturally patterned “deviant” behavior.

Grisi siknis has been understood within the context of changing expectations and the fulfillment of social roles as well as the inability to cope with stressful and changing situations. Phillip Dennis (1981) was the first to provide an anthropological interpretation of *grisi siknis* and its causes. He interpreted the causes of the illness as related to the ambiguities inherent in the sexual maturation of young women. His argument was that young women were victims of *grisi siknis* because they were undergoing a change of status in life that causes them stress given the socio-cultural expectations imposed on them. He proposes two sources of this stress: first, the fear and risk involved in the change of status in life by moving from the sphere of her parents with her dependence mostly on her mother, to a role of wife and family provider; the second source as he saw it came from the desire, typical of teenagers, to experience liberty of movement and action and to have sexual partners. This interpretation also accounted very well for the sexual content expressed in most visions experienced by individuals during an attack. His interpretation is strengthened by Jamieson's (2000) analysis of gender relations among the Miskitu which gives a more nuanced view of the tensions experienced by adolescent girls. Jamieson argues that young Miskitu women are expected to abide by a culturally constructed concept of "shame" that requires them to avoid any contact with men and are therefore meticulously observed by their parents and adults. At the same time, however, young Miskitu women are "expected to use their charms and sexual skills to attract their future spouses" (p. 268). In a subsequent article that deals with *grisi siknis*, Jamieson (2001) builds on his previous article, arguing that the vulnerability of young women to suffer from *grisi siknis* arises from conflicting expectations of women. Here he analyzes *grisi siknis* as a rite of passage and adds the role of social status in Miskitu communities. Miskitu girls have the lowest status in the community by virtue of being women and young. Adolescent girls therefore find themselves in

an ambiguous position in which they are trying to find their voice in the community. *Grisi siknis* is considered by Jamieson as a performance that is meant to convey girls' changing status into sexual beings who are moving up in status in the community.

These understandings of *grisi siknis* help explain why adolescent girls are usually the ones affected, but it does not account for the episodes that occur among men, as they did in the 2003-2004 epidemic, and in the case researched by Rupilius (1998). Dennis (1981) for example, says that in the epidemic he researched in 1977 the few men who were affected were believed to be homosexual before they exhibited symptoms. Moreover, Dennis' explanation of *grisi siknis* centers the understanding from within Miskitu cultural practices themselves.

Other research points to a different context for *grisi siknis*. It centers on the political-economic context of the Miskitu in a particular moment in time. Martin and Nahel (1987) observed outbreaks of *grisi siknis* in Miskitu refugee camps in Honduras during the *contra* war in which Miskitus were fighting the Sandinistas. Martin and Nahel (1987) indicated that those most affected were individuals who had lost one or two of their parents during the war. They also observed that those who were single or lived in non-stable marital relationships were more likely to be affected. Pérez-Chiriboga (2000), who also studied *grisi siknis* episodes in refugee camps, made a similar argument in that *grisi siknis* in this instance developed in times of extreme stress and social dislocation caused by the war. Furthermore, Perez-Chiriboga argues that the *grisi siknis* epidemics in refugee camps, known among the Honduran Miskitus as *bla kira*, also served as a form of expression of Miskitu identity in the face of internal contradictions. Rupilius' (1998) research, although not as in depth as the ones mentioned earlier, also points to the role of conditions external to Miskitu practices on *grisi siknis*. He researched a *grisi siknis* outbreak in a work camp of Miskitu men digging a canal in the region in 1996. He viewed the separation from

their communities for an extended period of time, along with the hard physical labor required for the job as the causes of the outbreak.

The studies that have specifically dealt with *grisi siknis* in depth, along with studies of similar phenomena in other cultures, explain *grisi siknis* as the result of the inability of individuals to cope with the pressures exerted on them by the socio-cultural and political-economic environments in which they are immersed. These pressures on the individual can come from within Miskitu cultural practices themselves or from an external source. The recent epidemic may indicate some changing trends among the Miskitu of the region. A condition that was thought by the Miskitu and documented by research to affect primarily young women is now affecting more men and a wider range of age groups.

The question becomes, in the absence of an extreme stressful situation such as war, what makes men and older women more vulnerable than before? The answer to this question is beyond the scope of the present dissertation. First, I did not research the epidemic in depth within the locales in which they took place. And second, the purpose here is to see how *grisi siknis* is interpreted from a regional and national level through the debates of the Health Model and *interculturalidad*. However it is pertinent to ask this question since the discussion of the *grisi siknis* epidemic between regional and national health officials in part tried to answer it. In the discussion of the debate some conditions were put forth as triggers for the epidemic. From the perspective of health officials the socio-economic conditions of the area had an effect on the inability of individuals to carry out their daily activities. This however is at the center of debates about interpretations. The interpretation of *grisi siknis* as based on political-economic realities of the region provides a major contradiction for officials in the region. As will be shown later, on the one hand, these interpretations help bring to light the conditions of inequality in which people

in the region live. On the other, it is based on an interpretation that runs counter to the beliefs of Miskitu people, and that for some, shows a lack of respect for Miskitu culture and represents an affront to the ideal of *interculturalidad*.

5.3 *GRISI SIKNIS* MEDIA COVERAGE AND REPRESENTATION

The *grisi siknis* epidemic received wide media coverage at the national level through newspaper and television reports. These reports made the RAAN visible to the rest of Nicaragua. It is important to analyze these representations of the epidemic because they help shape the perception of the region to the Pacific. Newspaper articles and special reports of *grisi siknis* represented the region as the final frontier of the exotic in Nicaragua. The articles' structure and prose are similar in tone to those of explorers, not only providing accounts of events but also providing meticulous descriptions of people and places that accent their "otherness". These descriptions provided two main foci of reporting, the economic conditions in which people live and representations of Miskitu people and culture.

Newspaper articles brought to the attention of the Pacific the difficult conditions in which the Miskitu live. Accounts invariably contained descriptions of the remoteness and dangerous nature of the region. An account referred to the population of the affected community of Raiti as "remote, *pobrisíma* [poverty-stricken], dark and mysterious" followed by describing the community as "inhospitable" (Vargas 2003, Nov 28). In one account the reporter wrote that:

> mobility in this region is dangerous and difficult. Traveling at night could even mean death in the entrance to Raiti, where on both sides of the Coco [river], this community is

> protected by ferocious currents capable of destroying any boat[33] (Treminio and Vargas 2003, Nov 28).

A special report titled "Miskitos: Hysteria, Witchcraft and Abandonment" provides an interesting assessment of conditions in the region (Ruiz Sierra 2003). The title itself also provides a clue as to the writer's assessment of the causes of the epidemic. It does so not only through direct descriptions of the social situation of the region, but also through descriptions of events. In this report the community was described as follows:

> Namahka has no infrastructure. It is just a sea of mud, a paradise for mosquitoes. Fifty miserable wooden houses can be found dispersed in a plain and deforested surface. Behind them the jungle, in front, the Coco river (Ruiz Sierra 2003, Dec 1).

The following description implicitly provides a visceral picture of the situation of the community and it served as the opening of the article:

> Elisa and Yamali Jorbín were lying in a thin, dirty bed. Their breathing was so weak that they looked like two bodies without life. Besides the cot, the room was almost empty, only a small doll with amputated arms adorned the place (Ruiz Sierra 2003, Dec 1).

The article also provides the following curious description of a child who did not play any role in the events he was describing except that the child was the only one not paying attention to an attack victim:

> a child three years old, naked and with his body full of mud. His eyes sunk in their sockets, like a cadaver, his stomach inflated, in the manner of the gravely malnourished (Ruiz Sierra 2003, Dec 1).

The article closes with a dramatic description that seems a metaphor for the situation as the reporter perceives it in the region:

> I saw a dog with mange that looked like a skeleton, of medium stature and brown in color. He was resting in the mud with his eyes closed. Only the animals can allow themselves to sleep in tranquility in Namahka (Ruiz Sierra 2003, Dec 1).

[33] All quotes from newspaper articles were translated from Spanish by the author.

These descriptions of the situation in Namahka use powerful imagery. Anyone familiar with colonial accounts of indigenous groups will easily recognize the imagery of "dirty indians" that was used to rationalize their inferior position. I am not arguing that it was the reporter's intention to do so, the descriptions were probably an attempt to show, as the title of the article suggests, the abandonment that these communities face from the government. However, no reasons behind these conditions were made explicit. Moreover, the argument of abandonment was always accompanied by the mitigating factor of "cultural beliefs". This can be seen in the following description in the same article:

> These stories of witchcraft, of curses, of young people running with their eyes closed, who have the strength of various men, would sound like a children's fantasy in almost any other part of the world. But not in the Miskitu communities of the Coco river. Here everything acquires a magical dimension. Each day is the exact repetition of the previous day, so that any small change is attributed to the supernatural. Poverty and isolation do the rest. Along the Coco river distances are not measured in kilometers, but in days. There are no roads and only few a count on a motorized boat. (Ruiz Sierra 2003, Dec 1)

The previous quote shows how cultural beliefs are seen as superseding the economic situation in which the Miskitu live. Even when these conditions are brought to the attention of the reader they are embedded within negative characterizations of their beliefs, as would be comparing them to children's fantasies. There is also a link to the imagery presented earlier. The recurring theme of mud throughout the account and the assertion that "each day is the exact repetition of the previous day" provide an impression of a group of people who are stuck, which would imply a group of people that have not progressed. Implied it is not difficult to discern an assertion of backwardness.

The implied connection between Miskitu beliefs and backwardness is problematic because it is the main aspect of the epidemic's accounts and its representation of Miskitu culture. In one

article the reporter asserted that "the concept of magic, witchcraft, [and] curses, is profoundly linked to Miskitu culture. Even in those that have received higher education" (Ruiz Sierra 2003, Dec 2). The same article later recounts that: "Zacarías finds himself in a complex situation, with a Masters in Public Health, he is a rational person that does not share the faith, intrinsic in his race, in curses, sorcery and witchcraft" (Ruiz Sierra 2003, Dec 2). The implication in the last quote is that believing in witchcraft is irrational. Taking both comments together gives a sense of a tension between being educated and being Miskitu. A strong connection is drawn between "irrationality" and "race". This invariably puts even educated Miskitus in either a suspect position, as represented in the first quote, or in a complex situation in which that which is "intrinsic" to the "race" must be confronted in others and maybe in oneself.

The connection between beliefs and the type of medicine that people seek was the basis for assertions that were misleading. For example a reporter stated that the "family members of those affected do not believe in modern medicine and believe blindly in healers" (Treminio and Vargas 2003, Nov 28). This is not true in the region, where Miskitu communities are always looking for more access to Western medicines and health posts[34]. The reporter did not provide the information that Miskitus differentiate between illnesses that are treated by a the healer and those that are trated by Western medicine. He seemed to have taken the refusal of modern medicine in the case of *grisi siknis*, for the refusal of modern medicine in general. In the accounts of the refusal of "modern medicine" there is an implied stubbornness in maintaining customs and refusing to embrace change and not being more rational. This is reflected in the following quote:

> They want to stay there, and want to maintain their culture, customs, and language, and it is doubtful that the people Dr. Alvarado [Minister of Health] sent will convince them that that ancient syndrome called grisi siknis, is only stress that can be cured with psychiatric medicines (Treminio and Vargas 2003, Nov 28).

[34] See Chapter Six of this dissertation.

In many ways the representation of Miskitu culture that emerges from the reporting of *grisi siknis* shows some of the preconceived notions held by people in the Pacific of Nicaragua about the RAAN and its indigenous inhabitants. This points out the obstacles to a vision that is based on a concept of *interculturalidad*. Perhaps the challenge of *interculturalidad* from the point of view of reporters themselves is better expressed in the following quote:

> The clash between cultures is almost impossible to save if not with incredible patience, and with a very open mind, enough to respect the intelligence, the antiquity of a culture…that does not want to renounce their own laws and forms of organization (Treminio and Vargas 2003, Nov 28)

5.4 *GRISI SIKNIS* AND REPRESENTATION IN THE RAAN

After a reunion on January 17, 2004, a group composed of Alta Hooker, Rector of URACCAN and former coordinator of IMTRADEC, Lic. Margarita Gurdián, Vice-Minister of MINSA, and Galio Gurdián and Jorge Grumberg, two anthropologists who have worked in the region, decided to organize a forum on *grisi siknis*. The proposal for the forum argued that "the image that has been constructed of the 'Coast' is eminently negative and currently the worst it has been in the past 10 years". This statement was followed examples of the negative images held of the Coast. Among them was that "the people of the coast are lazy, difficult to satisfy, superstitious, women are 'hot' [implying promiscuous], etc". More relevant for our interests here is the negative image that "since the outbreak of November 2003, '*grisi siknis*' is associated with the 'occult world', exotic and pagan, a cultural anomaly, in contrast with the Pacific". The forum was then conceived for two purposes. First, to "analyze from a mass-media and academic point of view the phenomenon of *grisi siknis* in order to make visible the contribution of the Regional Health System and of URACCAN (IMTRADEC) to the health of Nicaragua, as a first step in the

transformation of the negative image of the RAAN at the national level". Secondly, in order to "know how to prevent and treat it, including recommendations containing operational and practical aspects". The forum was composed of two panels, a media panel and an academic panel. The forum clearly served two objectives, legitimizing the Health Model of the region and its intercultural approach, and mediating representations of the region to the rest of Nicaragua. However, from the very beginning, during the organization of the forum, the way of managing these two objectives became a source of contention.

During my first period of fieldwork in the summer of 2001, *grisi siknis* was used as a prime example of the need for the Health Model and as a basis for the legitimacy of regional claims for the autonomous administration of the health system. As part of his response to a question about the relationship of MINSA and regional health authorities, Eddy McDonald in 2001, at the time the President of the Health Commission of the regional legislative body, said:

> When there was a collective crisis in a community, it even appeared in Univisión and had coverage of almost half an hour in Primer Impacto [a Latin American television program], they [MINSA] said they were coordinating with URACCAN to go and cure the disease, because their specialists got there to the community and left running. Horrified because they had never seen that type of disease (laughs). Then (still laughing) if the Minister did that, it means that whether they want to or not, in a way they have accepted that there are other ways to cure. That has allowed us to keep opening new spaces but it is still difficult

I did not know it at the time of the interview, but he was referring to a *grisi siknis* outbreak in the community of Krin Krin in the beginning of 2001. I came to know the details of the case of Krin Krin in a workshop for indigenous healers I attended during that summer. In discussing the Health Model with Serafina, at the time responsible for ethnomedicine at IMTRADEC, she specifically used the case of *grisi siknis* to exemplify the need for the health model. She even said that the *grisi siknis* case had "fortified" her belief in the importance of

healers and the need for the Health Model as a way to effectively address the health concerns of the indigenous population.

Two years later, even before the *grisi siknis* epidemic of 2003-2004, the episode in Krin Krin was brought up at different times in order to underscore the importance of the Health Model. Just before the news of the epidemic reached Puerto Cabezas, I was asked by IMTRADEC to form part of a team that would help design a questionnaire about health in the region. We were discussing what to include in the questionnaire when the topic of information about indigenous medicine came up. During a long discussion about the different types of indigenous medicines and their relevance to the health of the population, a member of the group commented: "I think we have to include it, MINSA needs that information too, we don't want them to go like they did in Krin Krin and go running screaming". This was followed by laughter all around. Humor seemed to accompany these descriptions of MINSA officials and their apparent inability to deal with *grisi siknis* themselves. A story that I heard recounted with delight on various occasions during the 2003-2004 epidemic related an incident that occurred to Dr. Fletes, the director of Mental Health of MINSA at the national level. He had gone to Raiti leading the commission of MINSA specialists sent to investigate the epidemic. Pablo, a healer who works in IMTRADEC, provided an account of the incident:

> All of a sudden one of them started to go into convulsions, and then another and another. In no time they started running and chasing people. And (laughs) a boy started chasing Dr. Fletes and (laughs) and he fell down and the boy started hitting him with a belt [a fajearlo] (laughs) like he was a *chavalito* [little boy].

The humor with which these stories are told contrasts sharply with the serious tone which people from the region use when recounting their own experience in witnessing *grisi siknis*, and its source of legitimacy for the efforts to implement the Health Model. Before recounting the story of Dr. Fletes, Pablo had recounted his own experience in Raiti in a very sober tone.

> I tell you, Edgardo, that it was horrible. I think I'm going to tell Serafina [Coordinator of IMTRADEC] to send someone else next time. I went through a fright when I was followed by one of the affected with a metal rod and when he was close to sticking it in me I fell and he jumped over me and kept going.

During the epidemic and the time leading up to the forum, in discussions of *grisi siknis* people expressed how the appearance of the illness helped to underscore the need for the Health Model of the region. Manzanares, an indigenous healer who works with IMTRADEC commented, "I think that even though this disease has been horrible for those communities, it will probably help to promote the model, maybe finally they will pay more attention to the *curanderos*".

The outbreaks of *grisi siknis* support the promotion of the Health Model, and the advancement of the autonomy and decentralization process of which it is part, by asserting in a dramatic way the cultural difference that legitimizes these claims. Moreover, the inability of government agencies from the Pacific to deal with the situation, in contrast to the local population's ability to do so, serves to support giving the control of local affairs to the local population. However, the dramatic character of this assertion of difference can be represented and interpreted in such a way as to cast a negative image on the populations of the RAAN, as evidenced by the treatment of *grisi siknis* in the media.

As mentioned before, the reaction was to organize the forum in order to help manage these representations of the region, specifically ones that speak of an "occult world", the "exotic", and the "pagan", making *grisi siknis*, and by extension the region, into a "cultural anomaly". The strategy to combat these negative representations was to find ways to translate the illness into "scientific" language and through cross-cultural comparison, to locate the phenomenon within a broader category of human experience. In this way *grisi siknis* is not a cultural anomaly, but a culturally mediated expression of "universal" human psychological

reactions to the environment. This type of strategy is familiar to anthropologists. Phillip Dennis, a North American anthropologist who studied *grisi siknis*, understood this well. When he was invited to the forum, he wanted to talk about anorexia nervosa as a culture-bound syndrome, to show that even in "modern" societies, such as that of the U.S, there are cultural expressions that seem to defy logic. However, organizers did not see the connection, and as the specialist in *grisi siknis*, had him talk about *grisi siknis* itself. An academic understanding of *grisi siknis* also had the advantage of locating the source of *grisi siknis* in the economic conditions of the region and its population. Arguments about isolation and inaccessibility and other harsh realities facing people in affected communities helped make a case about the lack of attention of the central government to development of the region. This would also be advantageous in legitimizing regional claims.

The problem with media coverage was not necessarily what was reported but how it was reported. The beliefs held by Miskitu in the region do involve witchcraft and spirits as the reporters showed, but these can be understood in a different light through a "scientific gaze". This however is a subtle point. Organizers then wanted to control the discussion of witchcraft and keep it to a minimum, thereby avoiding having it become the central aspect of discussion. This created some internal debates leading up to the forum. In managing the representation of the illness, and by extension the Miskitu and the region, organizers prioritized an academic explanation without necessarily contemplating how local Miskitu would feel about it. The coordinator of IMTRADEC was then asked to "control" what the indigenous healers said; they did not want them to sound too combative or to dwell on witchcraft. Witchcraft was to be an exposition of beliefs to be analyzed so as to be understood by the Pacific, not an exposition in and of itself. In the forum the sole indigenous point of view would come through IMTRADEC

and a brief exposition by Doña Porcela, the healer who had helped control the epidemic. The coordinator of IMTRADEC disagreed with the position of the organizers. She commented:

> How am I going to control them [indigenous healers]? They speak for themselves. And they are the ones who know about this illness better than any of the other presenters. I can't control them, especially when I agree with them. How can we have *interculturalidad* this way? We were given very little time to present but Porcela [healer that works with *grisi siknis*] is presenting, she has to present.

Healers in particular did not subscribe to an interpretation of *grisi siknis* as caused by economic conditions. As a healer argued; "We have always been poor, if it were poverty [that causes *grisi siknis*], almost everyone here [in the RAAN] would be affected". The Miskitu explanation was seen as being suppressed in the process. For the Miskitu witchcraft plays a central role in the *grisi siknis* epidemic. Healers attribute the severity of the recent epidemics starting with Krin-Krin, to stronger prayers [oraciones] that combine different types of spirits as opposed to just one. This is what is seen as the cause of the numbers of those affected and the recent variations in age and sex that the epidemic has experienced.

The day before the forum I traveled to Managua with a group of indigenous healers and staff of IMTRADEC. There was a meeting to discuss the *grisi siknis* epidemic and the forum. In that meeting, Pablo and Doña Porcela discussed their experiences and the causes of the epidemic. The epidemic was attributed to a person that they identified by name. This person traveled from community to community as a healer or as a magician. He would go into the community and depending on the identity he assumed either cure people or do magic tricks, like taking rocks out of his eyes. According to Pablo this person would stay in a community for long stretches of time and befriend the young. He would then teach the young how to make *grisi siknis* in a community. Then, out of curiosity the young would do the rituals to see if they would work and in the end unleashed the epidemic that struck the region. Pablo and Porcela then discussed the

difficulty in dealing with community members who wanted to know who was responsible for the epidemic. Like in many such cases described in the anthropological literature, the healer is not only supposed to cure the illness but also to identify those responsible. It was difficult for them to avoid telling the community the name of the responsible person because of the insistence of community members. Pablo summed up their argument against telling them the name as follows:

> We told them that we were there to help. We did not want more suffering by saying who was responsible. We told them that we were instructed not to, which was good because they would have looked to kill him. Then we told them that the laws of Nicaragua do not recognize witchcraft so no good would come of that information.

When IMTRADEC recommends a healer for cases such as *grisi siknis* it also sends someone from the institute to accompany him/her. The healer is instructed that their role is to cure, not to assign blame, given that this could cause complications because the actions of community members cannot be controlled once they find out. In a healer workshop I attended three of the healers present in the *grisi siknis* meeting took part in a prolonged discussion of witchcraft. In it the healers were discussing what to do with those who did witchcraft and caused harm or even death to a person. One of them argued, with the approval of all others, that there was nothing in the laws of Nicaragua that dealt effectively with this problem. And moreover, there could be no respect for their beliefs when witchcraft was not recognized in Nicaraguan laws. One of them said: “I don’t know about Nicaraguan laws but they have to be killed”. Another one in the meeting argued: “Not kill them but send them to jail in Managua”. To which the previous healer replied: “No, then they will teach each other and there will be more, you have to kill them”.

In Miskitu communities, communal authority and law deal with cases of witchcraft but there are limitations as to the punishments they can give. Stories abound in the region of how communities have dealt with these cases. In the community of Wawa Bar in 2004, when *grisi*

siknis appeared, the person responsible was identified. The *wihta*, or village headman, is said to have drawn a confession out of the accused by "taking him to the sea", a euphemism for nearly drowning the accused until he confessed. In this case the accused was ordered to cure those affected or he would be submitted to more harsh punishment.

It was probably stories such as these which made the organizers of the forum nervous to let healers speak freely and prompted the initial attempt to try to control discussions of witchcraft. A discussion appealing for stronger laws to deal with those who cause illnesses such as *grisi siknis* would have been counterproductive. In some ways although it was not explicitly expressed, these appeals would have been interpreted as a sign of backwardness by a Nicaraguan audience that was probably inclined to interpret it in those terms. The view held by the general population of the Pacific towards inhabitants of the Atlantic Coast has always been mediated by negative racial stereotypes and has included negative views of occult practices and witchcraft (Lancaster 1991). However, in their attempt to keep this part out of the discussion, the organizers of the forum seemed, at least in the eyes of the healers and some RAAN health officials, to prioritize the etic academic explanation as opposed to the emic explanation based on indigenous beliefs. This was interpreted by some, in the words of a health official, as a "lack of respect for indigenous beliefs", and in the words of another as a "lack of *interculturalidad"*. Another point of view to understand this situation is that of indigenous healers. Their work either supplements their livelihood or provides it in its entirety. For them an explanation that locates *grisi siknis* outside their sphere of therapeutic influence is sure to be considered a threat. And yet we could not consider this as only a matter that concerns healers as the insistence of community members for the name of the sorcerer responsible indicates.

5.5 THE *GRISI SIKNIS* FORUM

The forum took place in the beginning of February in Managua. In the end all of the views we have discussed were reflected in the organization of the Forum. In the morning the reporters who had covered the epidemic participated in a media panel to talk about their experiences and challenges in covering the story. In the afternoon there was an academic panel that represented the different ways of understanding and interpreting *grisi siknis*. There was a presentation by Dr. Fletes as the representative of MINSA, one by IMTRADEC, a brief presentation by Doña Porcela, and two presentations by anthropologists Phillip Dennis and Jorge Grumberg. Both morning and afternoon sessions were followed by comments and discussions.

The organization of the activity as a whole was structured to help manage the interpretation of *grisi siknis*. The media panel presented the problem and ways of understanding *grisi siknis*. In many ways their view was that of the uninformed outsider. The academic panel helped to manage these representations and mediate them. However, the voices on the academic panel did not present a unified voice. The MINSA perspective was presented first, that of the better informed outsider, who had participated in the management of the epidemic but who did not represent the region, and who in the process was expected to change. This was followed by the presentation of IMTRADEC which simply discussed Miskitu cosmology and its relation to *grisi siknis*, showed different case studies, and gave the emic perspective. The presentation of Porcela Sandino followed, the "authentic" voice, which could now be better understood after the presentation of Miskitu cosmology by IMTRADEC, which provided some context. Finally the two anthropologists, the "academic authorities" on culture and "knowledgeable outsiders", would help bridge the gaps. Dennis provided the analysis of the *grisi siknis* epidemics he had

researched and Grumberg provided cross-cultural cases to establish the non-uniqueness of cases such as *grisi siknis* and how these could be interpreted.

The media panel discussed the experiences of reporters covering the story. The main focus of the discussion reflected what had appeared in their stories, recounted above. It could be summarized with the following quote from one of the reporters:

> The first lesson is knowing that we are living within two types of medicines and how we reported that to the Pacific, that doesn't exist there. This is part of the diversity of our country and we have to understand it and respect it. On the other hand I think that the other lesson is the isolation. A fact that as a Nicaraguan I never stop being amazed at the isolation in which diverse communities live. I mean, it is easier for me to travel very quickly to Europe, to any other country, than it is to [travel] to a point in my own country, it's incredible.

These were the two topics through which discussion among reporters was centered. The main problem was with translating what they saw. As another reporter said:

> For all of us a common denominator is the challenge of covering this type of phenomena. It was first us trying to understand this in the small amount of time we had there. And secondly...how to explain it to people here in the Pacific, because it is not the same thing for people in the Pacific, who believe in witchcraft, than what people in this region conceive as witchcraft. Or conceive as *grisi siknis* in itself. Then I think that the challenge was in that part…because we were not doctors, we were not psychiatrists, we were not anthropologists, but we were confronted by this reality, and truly the challenge was to explain ourselves what was happening here.

This quote helped set the direction of the discussion of *grisi siknis* in the forum. The assertion that they were not "experts" and were in the forum to learn helped counteract the representations of *grisi siknis* and Miskitu culture in their newspaper accounts. It served a higher purpose which was to underscore the issues underlying the political tensions between the regions that go well beyond health. As another reporter said, "I think that a big group in the Pacific does not know the culture of the Atlantic. And because we do not know it we do not understand it". Another part of the discussion in this part of the forum, that helped open up its narrative, was about the role of the government in the isolation of these communities. Having voices from the

Pacific articulating the concerns of the RAAN helped give these concerns added legitimacy and also raised awareness, as evidenced when a reporter said "I think that the government does not worry about those people". The reaction towards the reporters was congenial. No debate about the way they represented the epidemic occurred, even though that was one of the reasons for having the forum in the first place. The focus was on the fact that they served to voice the problems of the RAAN. As one of the audience members from the region said:

> I would like to thank the members of the media for their coverage, I would like to recognize [your efforts]. The fear we have always had with this culture-bound syndrome is to have them presented as part of folklore. I think that you, in your testimonies show that you are trying to make an effort to present it from a different perspective. Utilizing other axis of interpretation, like human rights or the axis of an integral approach by talking about problems in education and other problems.

In the second part of the forum the discussion turned to an academic understanding of *grisi siknis*. This served as a way to correct the images presented by the media. This was not explicitly stated except once by Grumberg in his discussion when he said that:

> [*Grisi siknis*] can not be read, as in a newspaper in Managua, as a phenomena typical of primitive and closed groups [pueblos] where the magical and irrational predominate. We can say that this is false in the most complete sense of the term.

In the afternoon the forum moved to the "academic panel" starting with the presentation from Dr. Fletes as the representative of MINSA. Fletes argued that *grisi siknis* originates from emotional and cultural threats. From a long list of contributing factors he highlighted political-economic concerns, among them, problems on the frontier with Honduras, feelings of abandonment by the government, labor migrations, and threats to communities' autonomy, lack of adequate education and bi-lingual education and domestic abuse, among others. The illness itself was cast in psychiatric terms. The possible causes provided in this session for *grisi siknis* represented a multitude of pressing issues and concerns for the RAAN. In this sense the

discussion by Fletes in an attempt to find a "rational" explanation for *grisi siknis* voiced many of the demands that the RAAN's government had been making for years.

The presentation by IMTRADEC presented by Serafina Espinoza, and followed by Doña Porcela provided the Miskitu explanation for *grisi siknis*. IMTRADEC's presentation was an exposition of indigenous cosmology that helped the audience understand the belief system and its relation to *grisi siknis.* In this presentation there were no etic explanations of the illness, which were deliberately left out. Doña Porcela presented the view of indigenous healers, and here I quote all of her exposition in the forum as translated by Manzanares:

> What I want to emphasize is that many say that these patients get sick because of problems of hunger, or because of bad diet, or because they consumed contaminated water, but this is not so. This one [the witch] utilizes black magic, a man who uses black magic, he sells to people in the mountains, in the rivers, in the trees. The Waspam municipality is more affected, this is regrettable, there are many cries from the community members. And unfortunately there are no laws since the times of Somoza until now, there are none. That is why they practice freely this type of sorcery [maldad], then it keeps increasing. For my part to the authorities [I ask them] to find a way to punish the wicked [los malechores]. Even if I die, I hope that this will be a reality, the application of justice. Also, you see me, with a red dress, this has a lot of meaning. My dream told me that I will only live for a year and I will be with my red dress, and when I put on my white dress I will be dead because the mute keep working even harder. Right now I am persecuted by the witches [los brujos] since I am the one confronting them. I feel various weird symptoms, but I am with God.

The last formal expositions were by Dennis and Grumberg. Their presentations followed the explanations anthropologists have given for these types of phenomena as presented earlier in this chapter. For Dennis *grisi siknis* presented the pressures on young women during their transition to womanhood. For Grumberg, in a wider sense these phenomena "represent a channel for the expression and liberation of tensions…it is always in situations that have to do with the search for solutions to a shared crisis". These interpretations bolstered the argument of RAAN authorities for change.

In the end, Porcela, as representative of indigenous healers, addressed their concerns in the forum. But as stated earlier the organization of the forum helped to manage the different interpretations of *grisi siknis* in a way that would set *grisi siknis* as a basis for the discussion of regional demands. This interpretation highlights cultural difference and the political economic context of the region. However, how these interpretations are converted into action is another matter, in which interpretations about *interculturalidad* and the political situation of the region form the main axis of debate.

5.6 INTERCULTURAL HEALTH POLICY AND *GRISI SIKNIS*

The management and subsequent discussion and policy development of the 2003-2004 epidemic serves to highlight some of the main problems inherent in the health system and its inability to effectively deal with health problems across the cultural divide. Even after the epidemic became known to health officials, no response was made until two months after beginning in the community of Raiti. This allowed for the epidemic to spread to other members within the community and subsequently to other communities.

The failure to respond quickly is in large measure due to the lack of inter-institutional cooperation in the region and a lack of knowledge about *grisi siknis* even though an epidemic had occurred two years earlier in the community of Krin Krin that necessitated a response. A brigade of specialists and researchers went to the area from the national MINSA but they were unable to manage, control and cure the cases, this despite the knowledge that there is an Institute of Traditional Medicine (IMTRADEC) in the region that works with indigenous healers and that IMTRADEC had sent and indigenous healer that was able to control the 2001 epidemic. The lack

of communication between MINSA and IMTRADEC displays a lack of institutional and intercultural exchange that only exacerbated the situation. Once the brigade was sure that they were not able to handle the situation, MINSA officials hired an unknown local healer who required payment in order to perform the rituals for the cure. The debate at this juncture was who was going to pay the healer. Health officials did not want to finance an indigenous healer, and at first indicated that the affected community had to come up with the funds. Given poverty in the community, it was impossible for the community to raise the money. With the worsening situation MINSA decided to pay the indigenous healer. However, this aggravated the situation because it chose a healer who was not recognized in the region and who was not able to manage the epidemic and in fact made it worse. Here, the lack of interinstitutional cooperation is apparent. IMTRADEC was then contacted to provide assistance, as it once had, in identifying a healer capable of dealing with the epidemic. Once again the issue of payment came to the forefront, MINSA and IMTRADEC debated who should pay for the services. IMTRADEC is a research and indigenous healer capacity building institution, it does not have funds for curing illnesses. In the end MINSA paid for the healer, who was able to control the epidemic but the payment required ($US 600) was always in dispute[35].

The *grisi siknis* forum made clear the different visions of intercultural health held by national officials and regional officials. This was especially apparent in the comments after the presentations of both panels. It was in these sessions that contributions toward the solution of *grisi siknis* developed and discussions and presentations about the formation of policy took place.

[35] It is important to note, that although the payment of $US600 may seem high given the standard of living in the region, the healer worked in four different communities for two months with her husband in order to cure the epidemic.

National health officials emphasized the lessons learned in terms of how to elucidate what *grisi siknis* was and its possible causes. The emphasis was on cross-cultural communication. A comment made by Dr. Carlos Fletes, director of Mental Health at the National level, is illustrative:

> This forum is important because we need to understand these indigenous phenomena. We know that there is little that we can do except provide support. It is important to understand the culture and some of the mechanisms involved in their world-view in order to allow indigenous people to use their traditional healing methods to deal with a cultural illness that needs a cultural cure.

It should be noted that the support he alludes to does not necessarily mean financial support. Moreover, in the quote it is evident that despite the explanations rooted in the social and economic context, "culture as cure" takes a prominent position. The comments of the Minister of Health, Dr. Alvarado, were in a similar vein. He said that "when we started to hear the first news, we immediately said that we had to do something…we have to send a commission. A commission that goes not with the idea of asserting truth, but one that goes to learn and see how to resolve this". Later on he summed up the most important point of the meeting as follows: "The fundamental element for me is understanding that diverse cultures exist, and that in this cultural diversity rests the enormous potential of the nation".

It is interesting that the emphasis on the part of national health officials was centered on concepts such as "learning", "understanding" and "dialogue". The process of communication seemed like an end onto itself. The representatives of the national government did propose ways to deal with the root causes of *grisi siknis*. The causes of *grisi siknis* presented by Dr. Fletes were mainly those of poverty and isolation. However, many of these issues could not be resolved using only the competencies of the MINSA. It necessitated solutions that involved other sectors of government and society, none of which were at the forum. Despite these limitations, national

health officials from MINSA did not propose any radical alternatives from within the competencies of the health system with which to deal with *grisi siknis* or the other problems facing the region. For example, Dr. Fletes recommended that health workers needed to be trained in understanding local culture, *grisi siknis* and how to deal with the illness. The recommendations specific to the health system were ones that can be interpreted as a move of the health system to adapt as opposed to change. In many ways the policy recommendations were framed within the development of cultural competence on the part of the health system.

These comments contrast with those of RAAN health officials and activists who were more interested in fundamental changes in the health system in order to respond to issues such as *grisi siknis* in a culturally sensitive but institutionalized way. Moreover, they responded to wider preoccupations within the framework of the Health Model, autonomy and *interculturalidad*. Dr. Myrna Cunningham, one of the leaders in the development of the Health Model, commented that "if we leave without recommendations, we came here to waste our time, you learned, we shared…but nothing gets resolved". This comment reflects a desire to move beyond simple comprehension and understanding to action. Later on she provided the following comment:

> I think that what is important is to leave here with strategies that adequately manage potential future episodes. I think that the most important thing is what percentage of Dr. Fletes' [National Mental Health] office should be assigned for things such as Doña Porcela [the indigenous healer who treated the epidemic], so that at the last minute there will be no need to look for ways to finance the specialists that go into the communities….and therefore [avoid] the crisis you always face.

Her comment points to direct strategies that move beyond the health system's conventional way of thinking. Towards the latter stages of the forum, after general recommendations had been made and her previous comment had not been directly responded to, Dr. Myrna Cunningham made the following statement:

> These problems will not be resolved if we do not advance the process of decentralization. How do we make people in the coast feel like they have more responsibility? Not only by telling them, but transferring more responsibility, for example. I think that we have come a long way with dialogue, but we have not been able to crystallize decentralization. And if this is not realized, we will not be able to have holistic approaches; we will not be able to do what we are mentioning as recommendations.

This last comment is illustrative of a view that a truly intercultural approach to health care can only occur through a transfer of power to the local level. Dr. Pedro Rupilius, who has worked in the region for many years, asserted that "it is time for us to lose our fear and for us to institutionalize in the structures of our budgets and strategies, the development of traditional medicine". The emphasis of these comments is on understanding intercultural health as encompassing political action.

These two approaches are startling in their contrast. It shows different conceptions of intercultural health and its approach to dealing with issues in a multi-ethnic context. One is based on cultural sensitivity and communication and the other is based on political action. The national health authorities' discussion was for the most part always centered on culture rather than policy.

After the forum health officials had a meeting to discuss what the standing policy on *grisi siknis* would be when another epidemic occurs. The standing policy agreed upon was that *grisi siknis* was to be left to communities to resolve using their traditional modes of organization, through their village headmen. The role of the health system personnel was to attend to anyone hurt by the aggressive behavior of those affected, and to tend to the physical health of those undergoing the attacks. In essence the policy is to leave the financial burden of dealing with the management of *grisi siknis* on the community. This highlights the inability of MINSA to grapple with a broader view of intercultural health policies. The question that arises is, would the policy be the same if it were an illness recognized by Western psychiatry? A close examination of the presentation made by Dr. Fletes in the forum suggests that it would not. In his presentation Dr.

Fletes discussed how they debated over the use of Western medications when they responded to the epidemic. He said that the population did not want them and furthermore, that "we will not be as irresponsible as to give treatment because it could be something else". The implication was that treatment was not given because they did not completely understand the condition, but the fact that they were prepared to give treatment suggests that MINSA was ready to cover the costs. The policy displays reluctance on the part of the ministry to finance indigenous forms of healing. It is very different from the view expressed by Dr. Myrna Cunningham in the quote presented earlier.

The standing policy also shows a lack of understanding of the socio-economic realities in which indigenous people live. It is true that phenomena like *grisi siknis* have traditionally been deal with by communities themselves, either by a community healer or by the community looking for a healer from outside and paying them in kind. However, the current situation is that indigenous healers are in short supply because the increasing effects of modernization as well as the continuing effects of Christianization have reduced the number of individuals who learn to become healers. Moreover, it takes specialized healers to deal with *grisi siknis*, and they are even rarer. In his presentation at the forum Dr. Fletes himself recognized that in an outbreak such as the one that occurred in 2003-2004, local healers cannot deal with the quantity of patients. The reasoning behind the standing policy also lacks an understanding that indigenous healers do not provide their services for free. And furthermore, indigenous healers usually are not full-time healers but have other jobs or work in their subsistence activities. A healer who goes to another community to deal with a phenomenon like *grisi siknis* that can take a long time needs support not only for his/her time and efforts but also for his/her knowledge. In essence the current

conceptions of interculturalidad of national health officials result in policies that will not be able to deal effectively with the issues affecting the indigenous population.

5.7 CONCLUSION: *INTERCULTURALIDAD* AND HEALTH POLICY

The case presented here about the *grisi siknis* epidemic highlights some of the main problems and contradictions that occur when culture is the driving force for regional health system reform and health policy. It was apparent that both the central and regional government agreed that culture had a profound effect in the way health services in the region should be provided. However, there exist various interpretations of culture, *interculturalidad* and their role in public health policy.

The case of *grisi siknis* presented regional health officials with a paradox. On the one hand *grisi siknis* provided an opportunity to present and advance the need for the Health Model and legitimize the decentralization of the health system. *Grisi siknis* illustrates in a dramatic manner the cultural difference between the RAAN and the Pacific Coast of Nicaragua. This cultural difference forms the basis for autonomy, decentralization and granting indigenous rights. In the case of the Health Model, *grisi siknis* demonstrated that dealing with health issues in the RAAN required a different way of organizing and conceptualizing the local health system in order to meet the needs of its population. However, such a dramatic display could be construed as a sign of backwardness in general popular perception. The way out of the bind was to control the way *grisi siknis* was understood from an academic point of view. This allowed regional health officials to not only legitimize and provide a "rational" explanation of *grisi siknis*, but also to use it as a platform for voicing the geographic, social and economic isolation of the region.

However, this approach inevitably alienated the population whose interests they were attempting to advance, as academic explanations for some minimized the validity of Miskitu cosmology. Those who felt alienated by this approach called into question the conception of *interculturalidad* being used. The approach taken by RAAN health officials is in many ways consistent with critiques of the use of culture in public health in that there was a concerted effort to understand *grisi siknis* from a political economic context. However, their approach was restricted by wider racialized perceptions in society and the academic conventions of Western knowledge. In this instance RAAN officials were not able to escape the sacred position that culture holds identity politics and opened themselves to criticism from the population whose interests they were representing. In their efforts at cultural translation into academic and Western language, they were not able to advance the idea of *interculturalidad* as an epistemological enterprise that presents indigenous knowledge as opposed to indigenous beliefs that need to be mediated and understood through "Western" social science. (Walsh 2002b). If RAAN health officials and advocates had taken a different avenue, however, they would have fallen into a purely culturalist explanation that would not have served to advance their political aims. Furthermore, it would have been difficult to counteract the negative representations of Miskitu culture.

The negotiation with national health officials was not very productive either. Although there was widespread acknowledgement of the precarious socioeconomic situation of the region, these concerns were too broad for the health sector through MINSA to handle by itself. Even for the specific topic of health policy, the discussion showed that there were two different conceptions of culture and *interculturalidad* that led to different approaches to health policy.

These two approaches conform to those presented earlier in the introduction of this dissertation (pages 48-51) from Almaguer, Vargas and Garcia (2002) and Cunningham (2002).

For national health officials, "culture" is seen within the context of values and beliefs. The process of *interculturalidad* is therefore mainly a process of communication in which those cultural values and beliefs are understood and respected (Almaguer, Vargas and Garcia, 2002). This conception of *interculturalidad* gives primacy to concepts such as "learning", "understanding" and "dialogue". The end result from this understanding is an assumption that the health system itself is not the problem. If the problem is culture and being able to communicate across the cultural divide, then an "add culture and stir" approach is all that is needed. The policy recommendations therefore are limited to adding elements of "cultural competence" to the staff of the health system through workshops and education.

Local health officials have a different conception of *interculturalidad* and its end result in health policy, which conforms to the model of political action presented by Cunningham (2002). *Interculturalidad* is an epistemological concept that brings together different forms of knowledge that have been placed in a hierarchy through differential access to power. As such *interculturalidad* is not only about communication, although this is important, but also about political action and the redressing of historically constituted situations of inequality. From this vantage point of *interculturalidad* health policy is meant to transform the health system in such a way that there is equal access and recognition for different forms of knowledge within the health system. The concepts that are central to this approach are therefore concepts such as "budgets", "strategies", and "decentralization". The aim is to allow for spaces for reconfiguring the local health system in a way that allows for local decision-making through the transfer of resources. However, these understandings of culture and *interculturalidad* have yet to leave the circles of

academia and political activism, as the reporting of *grisi siknis* and the stereotypes it helped propel demonstrate. In attempting to appease the potential for stereotypes and prejudice, local health officials were then forced to try to control the representation of culture in a way that alienated some sectors of Miskitu society.

The case presented in this chapter provides an example of how government institutions and Western discourse impose limits on indigenous movements and indigenous rights advocates. The main platform of indigenous rights is the discourse of "culture" and "cultural difference". These discourses therefore mediate the interactions and negotiations between indigenous or ethnic minority representatives and the government and state. Using culture as the central domain of discussion or as a starting point can divert discussions away from significant social and political change. It allows those engaging in discussions about health to agree that culture is important but the concept itself and its derivations are so diffuse and so open to multiple interpretations that the end result may have very little impact in substantial policy. Government representatives can say that they are doing something and that discussions are occurring without necessarily dealing with the real issue, resources. As Foster (1999) has argued for multilateral public health institutions, meetings to discuss health issues can be an end in and of themselves. These workshops and meetings provide a sense that something is being done. There is no doubt that the *grisi siknis* forum along with other meetings about intercultural health will be pointed to as signs that MINSA is concerned with the health of its indigenous population, but is anything being done? These meetings are an important step in the process but if as some regional health officials indicated, their role is simply gaining knowledge of culture without transforming it into meaningful action, very little is being achieved. The irony of *interculturalidad* is that the concept

meant to be a bridge between groups holding different understandings, meanings and views is understood differently by those coming together under its banner.

6.0 THE PSILN: THE HEALTH MODEL IN MISKITU COMMUNITIES

The Health Model of the RAAN has as one of its main goals the expansion of health services to rural, scattered, and highly inaccessible indigenous communities. However, as discussed in Chapter Four, the process of achieving this goal lacks a unified institutional structure. The implementation of the Health Model is done through a variety of NGOs and civil society institutions that are not directly accountable to the health commission of the CRA-RAAN, even if there is communication between the different institutions working in the health sector.

This chapter and the next one present the experience of one of these NGOs, the Programa de Salud Integral del Llano Norte (PSILN) - Integral Health Program of the Northern Savannah. Even though the PSILN was conceived as a pilot project of the Health Model and derived its rationale from it, many of the staff and the communities where the PSILN worked were unaware of the existence of the Health Model. This changed during the last two months of my field research when a new program director emphasized the importance of understanding and diffusing the Health Model. This provided me with an opportunity to observe and participate in workshops and discussions that centered on the Health Model. In this chapter I want to analyze how the Health Model gets translated to the community level and discuss some of the main difficulties in its implementation. I am interested in answering the following questions: does the Health Model as conceptualized by regional health authorities conform to community needs?

How do community members understand the Health Model? Does the notion of *interculturalidad* used in policy discussions translate into community members lived experience?

In this and the following chapter I will argue that the situation in communities mirrors the dichotomy present in policy debates. Discussions centered on culture, as is the case with indigenous medicine, provide an opening for dialogue that is less problematic than discussions that deal with resources and the organizational structure of the health system. In many ways this aspect of the Health Model overshadows other complex issues. In the next chapter I will deal specifically with problems at organizational and resource level. This chapter will focus on the experience of the acceptance and use of indigenous medicine and how it affects the way individuals in the community come to perceive the PSILN in particular, and the Health Model in general. The recognition of indigenous medicine and its inclusion in the health system is widely accepted by community members and leaders. In many ways it served as a reaffirmation of their worldview and signaled recognition of their identity. The use of indigenous medicine at the institutional level (in this case at the program level) does pose some contradictions. However as I will show in this chapter these contradictions do not pose major concerns for community members. The use of indigenous medicine and its interrelation with institutional medicine are a fact of everyday life that does not necessarily require institutional sanction. Community members' major concerns center on gaining access to institutional medicine and in controlling the resources that reach the community.

6.1 EL PROGRAMA DE SALUD INTEGRAL DEL LLANO NORTE

The PSILN was developed by Dr. Salvador Salas, who is originally from the RAAN, in the year 2000. The project is financed and managed by the Catholic Church through the Vicariato Apostólico de Bluefields. The main goal of the project is to extend health coverage to 13 communities (12 Miskitu and one Mayagna) located in the RAAN's Northern Savannah region, between the cities of Puerto Cabezas and Waspam. The project is based in the community of Santa Marta, which lies 48 km northeast of Puerto Cabezas on the road to Waspam. In Santa Marta a clinic constructed next to the Catholic Church serves as the program's base of operations.

The clinic is equipped with three examination rooms, a reception area, a pharmacy, laboratory, an administrative area with a conference room and a storage area for medicines and supplies. The program also has a pickup truck that is used to visit the different communities for community health development work, and also to transfer patients to Puerto Cabezas in cases of emergency. At the time of my field research the clinic was the only building in the community that had electricity twenty four hours a day, made possible through the use of solar panels[36]. Although it is an outpatient clinic, it has two beds that are used for attending births and for patients who come from distant communities or come at night and need a period of observation when their condition is not considered severe enough to transfer them to Puerto Cabezas. The clinic is staffed by two doctors (one of whom is the coordinator of the program and the other a doctor doing his/her social service), two nurses, an *auxiliar*, a pharmacist, driver, laboratory

[36] The community of Santa Marta had a gasoline power plant provided by the government because it is the main stop for travelers on the road between Puerto Cabezas and Waspam. The power plant provided electricity from 6pm to 10pm. After my period of field research electricity has been brought directly from Puerto Cabezas to the communities of Sisin and Santa Marta, so that electricity is now available all 24 hours.

technician, receptionist and an administrator. The clinic serves as the center of a network of MINSA health posts in seven of the thirteen communities. These health posts are staffed by health *auxiliares* who are paid by MINSA. The *auxiliares* are MINSA employees who have had formal study and training in Western medicine but who do not have a full degree in nursing. The medicines that they administer to patients come from the SILAIS-RAAN. The PSILN has a signed agreement with the SILAIS that recognizes its health work in the 13 communities and agrees to coordinate all health interventions with the program. Moreover, the PSILN made a commitment to the SILAIS that it would be responsible for the continuing education and oversight of the *auxiliares* in the seven health posts, which receive additional economic compensation from the program for their participation.

The program was conceived as part of the Health Model in particular and PHC initiatives in general and is therefore based on an integrated approach. The clinic is not only responsible for providing health services but is also heavily engaged in community health development. The program organizes and trains birthattendants, health leaders and community health commissions envisioned in the Health Model. The program also envisioned working with indigenous healers but this component of the program was never implemented.

The structure of the PSILN is in accordance with the restructuring of primary care as proposed in the Health Model. The clinic of Santa Marta serves as a health center within a network of health posts and communities, which expands the basic package of health services. Moreover, the program truck is used periodically to transport doctors to the most distant communities within this network and provide health consultations, thereby expanding health coverage. Health programs such as the PSILN serve to implement aspects of the Health Model despite the precarious economic situation in the health sector. In this regard, Ned Smith the

region's health secretary has argued in reference to the work of the PSILN and AMC that "I think it is important to open more spaces for NGOs…we will need their help in implementing the Health Model and expanding health services while the Health Model continues to advance". In addition the founder of the program Dr. Salas had presented a proposal in the 7th session of the Regional Health Council, based on his work with the PSILN, for the approval of regulations for the functioning of territorial and communal health commissions.

This grounding on the Health Model was not explicitly acknowledged during the first four months of my period of research with the PSILN, although it was made explicit in the internal documents of the program. By that time Dr. Salas was not the coordinator of the program. The coordinator during most of my period of research was Dr. Javiera Blandón, who was from the Pacific of Nicaragua. However, toward the end of my period of research a new program coordinator made the relationship of the Health Model to the program more explicit.

6.2 DISCOVERING THE HEALTH MODEL

After working in the PSILN for four months, I discovered that when one speaks about the Health Model different people interpret it in very different ways. When I asked people about the Health Model, I was referring to a policy document that outlined the future of the health system in the Region. When I came to the PSILN to carry out research with its assistance, I explained to the program's staff that I was doing research on the Health Model. I erroneously assumed that they interpreted it the same way. This became clear when a new program coordinator took charge of the project. After assuming his position, Dr. Harold Campos met with local health authorities and the staff of the program. One of the main points of transformation in the PSILN

for Dr. Campos was to fully integrate the program within the overall goal of the Health Model. Before the arrival of Dr. Campos the only two members of the staff who had knowledge of the Health Model were Dr. Blandón, the former program coordinator, and Nurse Delia, who was the sub-director of the program. However their knowledge of the Health Model was not extensive. For example, when I asked Dr. Blandón about the Health Model, she simply stated that "I read the document not too long ago. It looks good the way it is written. We'll have to see because in this country things get politicized". Dr. Campos on the other hand got the staff together and charged them with the tasks of first learning the Health Model, and then disseminating and teaching it to community members through workshops, meetings and community outreach.

Pedro, the clinic administrator, came to me after these meetings with the document El Modelo de Salud, and asked me if I was aware of its existence. I was somewhat puzzled by his question given that I had explained that the Health Model was the focus of my research. After reminding him about it I retrieved a photocopy of it (which I always carried with me) from my backpack. I told him that my interest in coming to the RAAN emerged from reading the document after I found it in the University of Pittsburgh's library. Pedro then laughed and said:

> So that's what you were referring to, I thought you were talking about the health model as, I don't know, the structure of the health system, the network of services, and how the communities used them

After the introduction of the Health Model document to the clinic staff I heard similar comments about what people understood as the Health Model when I had mentioned it before. Pedro also commented on the fact that a foreigner would know about the existence of the Health Model and he, a Miskitu working in health in the region, did not. As he expressed it:

> *Parece mentira* [it's unbelievable] that you found this in your library in the United States and I did not know about it. The good things we do seem to always go to developed countries without the masses knowing about it.

This comment was made in jest and was followed by laughter, and yet hidden within it we find two important points related to the Health Model. The first point is providing the Health Model for foreign consumption and not promoting it in the communities for which the Health Model was developed in the first place. During my interviews with community health leaders, I always asked if they had heard of or knew about the Health Model. Only one person, prior to the new initiative in the PSILN to make the model known, had any knowledge or had ever heard of it. And yet the Health Model is actively promoted nationally and internationally[37]. This is significant in that the aspect of community participation requires an articulation of the different levels involved in the health system, of which community health commissions are a part. The second point is related to Pedro's characterization of the Health Model as something "good". I became interested in understanding what made the Health Model "good" in the eyes of Pedro and community members when it was presented to them.

Harold Campos' directive to the PSILN staff to disseminate the Health Model to members of the communities was eagerly embraced by all. During a short period the staff got together to read and discuss the document. They developed different activities and workshops among themselves and community health leaders. This culminated with a meeting in Santa Marta with all the staff of the PSILN, including Dr. Campos, health leaders, the *auxiliares*, the *wihtas*, and members of the community health commissions. Moreover, before this meeting three different members of the staff were assigned to go out into the community each day and present and discuss the Health Model with community members in Santa Marta. This afforded me an

[37] The only individual who knew about the Health Model was participating in a HIV/AIDS certificate program offered by IMTRADEC, whose work is based entirely on the Health Model.

opportunity to see how people in the communities understood the Health Model and to assess the main points within the model that appeared to be the most important to them.

I also became involved in the process. I was asked by Pedro to give a talk and present the Health Model to not only the health leaders but also to the staff. For obvious reasons, I felt uncomfortable with this request and had reservations about accepting. I noticed that suddenly I had become an "expert" (as Pedro expressed it) on the very object of research that I was trying to understand. I was afraid of introducing my own bias and understanding of the Health Model up to this point, and yet I could not refuse. Pedro referred to me as a "valuable resource" in fulfilling the task of disseminating the Health Model, as opposed (at least in my mind) of the "burden" I imposed with my constant presence and questions while everyone was trying to do their work. It was a moment when I could contribute and reciprocate for the assistance and openness that the PSILN had afforded me, so it seemed inappropriate to refuse. I also provided the PSILN with copies of summaries of the Health Model in Miskitu that I obtained through IMTRADEC after one of the first issues that arose in these meetings with community members was the lack of the Health Model in Miskitu.

Before my own presentation of the Health Model, members of the staff got together in groups and read parts of the document and discussed it. Then some of them went out into the community of Santa Marta to present aspects of the Health Model to groups of people they were able to round together. The first time I witnessed these meetings I met with Pedro and Luisa, the PSILN pharmacist. They were in the administrative offices reading the Health Model out loud. The aspect of the document that most caught their attention was the inclusion of indigenous medicine in the health system. Pedro was reading the document without pause until he reached the following part:

> Despite the fact that indigenous medicine is a system of knowledge, beliefs, and practices destined toward preventing and curing sicknesses that has been maintained throughout the history of colonization and that has been enriched with European and African medicine, it has not been incorporated or articulated within the health system of the MINSA. Despite its recognition and legalization in the Autonomy Statute since 1987, there have not been major changes that reflect the respect toward the cultural aspects of the population (URACCAN 1996, 24)

After reading this section Pedro paused and commented that the statement was true and started recounting a story about something that had happened to his sister. She had been hospitalized with abdominal pain and the doctors had not been able to cure her. What she really had was yumuh, which the doctors could not cure[38]. His family then brought a *curandero* to treat her in the hospital, and Pedro commented: "we brought him hidden [*a escondidas*] because at that time it was not permitted [for an indigenous healer to provide treatment in the hospital]". He then noted that after the treatment by the *curandero* she was cured and she was able to leave the hospital. He concluded by saying: "Some people do not believe it but Miskitu sika [Miskitu medicine] works". He then commented "I have heard that now you can bring a *curandero* to the hospital and usually they will let him do something". He expressed that he was unaware that the Health Model may have been responsible for this change. After his comment a discussion followed between Pedro and Luisa about different forms of Yumuh and they shared experiences with Miskitu medicine. I then asked them why the integration of Miskitu medicine was so interesting and important to them. Pedro responded:

> It is part of our culture, and our traditions. When people make fun or ridicule our beliefs they are not respecting our culture. Having indigenous medicine in the health system means that our culture is being respected, that it is being recognized.

At this juncture Luisa interrupted and commented "and do not forget that it works, indigenous resolves many of our health problems". These two elements represent the main points that

[38] A brief description of yumuh can be found on page 220 of this dissertation.

underlie Miskitu interest in the component of indigenous medicine in the Health Model; "identity" and "effectiveness". The element of identity is related to how indigenous worldview and conceptions of illness are important in defining Miskitu culture and identity. The element of effectiveness is based on Miskitu lived experience in their interaction with Miskitu medicine, in its use and evaluation of its effectiveness.

In the small outreach meetings with community members in Santa Marta the same dynamic just described among the PSILN staff was evident. Someone would read excerpts from the Health Model and then someone would translate them in Miskitu. At the end most of the comments concentrated on indigenous medicine. Personal and known stories would be recounted that underscored the effectiveness of Miskitu medicine in a variety of situations. The inability of doctors to cure was also prominent, similar to the story of Pedro's sister. In these small meetings that included from two to eight members other aspects of the Health Model were simply read and presented and rarely commented on. The exception was in some of the gatherings by the staff of the PSILN when some of the elements of the Health Model, such as the community health commissions, were associated with the work that the program was doing and how this articulated with the Health Model. These comments however, tended to focus on the difficulty of getting health commissions to work.

It was in the larger meetings that a dichotomy between discussions of indigenous medicine and other aspects of the Health Model were apparent. The first of these meetings was in one of the workshops for health leaders and members of the PSILN staff. It was in this meeting that I gave a small presentation of the Health Model after being asked by Pedro. In preparing the presentation I went to great pains to try to keep my own perceptions of the Health Model out of the presentation. I limited myself to providing an outline of the Health Model that

was taken literally from the document. My presentation covered the rationale and history of the development of the Health Model, its objectives, basic principles and organizational structure. My presentation of the Health Model allowed me to ask questions to those present and lead discussions which proved very illuminating. Discussion alternated between two main points, the incorporation of indigenous medicine, and the role and responsibilities of the community within the Health Model's organizational and administrative structure.

After I finished my presentation I asked if anyone had any comments or questions. The most interesting and heated discussion occurred surrounding the role of the community vís a vís community health commissions. It was Pedro who started this discussion. His comments and reaction came after I discussed the Health Model's organizational structure after drawing the organizational chart that appears in the document (URACCAN 1996, 52). He argued that on paper the organizational structure was great but in reality the most difficult part was how to make community health commissions part of the process as an advisory body that reflected community participation. He went on to say:

> From a person who is from the Region and Miskitu, I know that working with our people is difficult. Community organizing is not easy, you have to give a lot of support to communal commissions in order for them to work. If there is no incentive, people will not want to work for this reason or for that. I think that among our people, people say yes yes and sign up on a list as part of a commission or whatever, but it is difficult to have a commitment. They have to be responsible people for it to work. You have to give them continuous support because they [community health commissions] are not part of the structure of the community

This perspective comes from someone working as staff of the PSILN. Indeed, during my interviews similar assessments were made[39]. After Pedro finished there was a long pause. I then decided to pose the question to the health leaders present. I asked them what they thought of Pedro's comments and if they felt they were accurate, why the health commissions had trouble

[39] See Chapter Seven of this dissertation where these issues are discussed at length.

functioning. The health leader of the community of Butku, Don Mateo, stood up and emphasized the importance of disseminating the existence of the Health Model to "our people". He went on to argue that there were committed people in the communities:

> I think that the Model has to be presented to the people, because if they know that there is a structure that exists to which they can go to, then maybe they will work with more energy. They will know that what they do goes not only from the community to the clinic and that's it, but that it forms part of a wider structure. There are many committed leaders. In this occasion they said by radio that there was going to be this workshop and that we had to get here by ourselves, and I said to myself, let's see how many of them show up. And here we have ten leaders. Here [the leader from SiSin] found out and she was in Wawa Bar, and came. She came late but she arrived from Wawa Bar at five in the morning and left for here and came. I think that is a sign of commitment and leadership, and that yes there are committed people that can do a lot for their community and with this knowledge [we gain here] we can go far.

Despite Don Mateo's assertion that there are community leaders who are committed to work selflessly for their community, subsequent discussion bore out some of the main difficulties in working as health leaders and as part of health commissions. These difficulties will be discussed in depth in the next chapter. Here I just want to highlight the nature of the discussion. Some health leaders thought that they should be recognized and compensated for their work which was not part of the rationale for the organization of health leaders. Health leaders and community health commissions are voluntary positions that are supposed to benefit the community not the individual.

There was also a certain amount of skepticism about the possibility of positive change from within the structure of the health system. For example, the health leader of Dikua Tara commented: "All of that looks good [the Health Model] but I do not see how politicians *lo van a trabajar* [will make it work], if you go to them all they say is that there is no money". Here the staff of the program argued that the point of "shared responsibility" or the principle of "reciprocity" in the Health Model stated that not only politicians but also community members

were responsible for improving health. The importance of effective organization in the community was stressed. At this point the health leader of Il Tara commented: “We can be organized, I think that is important, but with no money not much can be done”.

The issue of shared responsibility appeared once again in discussions about financing the health system. When mentions of the community contribution of “no less than 20%” of their income from natural resources came up there was a widespread critique of the measure. Once again the views about politicians came to the fore. Here I will provide an example from the discussion from a larger workshop because they are more illustrative. The wihta of Santa Marta commented: “Maybe we should contribute, but 20 [per cent] is too much, we have few resources and many needs”. Another community leader commented that: “Politicians take a lot from our natural resources, they get more than we do, let them use what they take from the people”.

As is apparent from the above discussion, the organizational and financial aspects of the Health Model were very contentious for community members. Discussions about indigenous medicine on the other hand had a very different tone. It matched what has already been discussed previously. One interesting issue that I noticed after giving my presentation was that by adhering to the Health Model literally in my presentation, indigenous medicine did not form the guiding principle of the Health Model since even though it appears throughout there is very little specificity about it. Therefore in dealing with the concrete issues that appear in the Health Model I had mentioned the inclusion of indigenous medicine in general terms. I became aware of this when after heated discussions and disagreement about the Health Model’s organizational and financial structure. Pedro asked me to give more details about the role of indigenous medicine in the Health Model. The discussion after this brief presentation, which was still in very general terms, was very different. The inclusion of indigenous medicine was praised as something that

was “good”. The importance of Miskitu medicine to “our people” and “our culture” formed a central part in these discussions. Discussion centered on how indigenous medicine worked and how it resolved many of community members’ problems. Members of the staff also accepted these views and there were no disagreements. The following quote captures the overall sentiment of the discussion:

> That seems very good. Our *curanderos* resolve many of our problems and we believe in them. It is difficult when doctors do not understand. I think it is good for doctors to understand our beliefs and learn from our *curanderos*. It is a big part of our culture.

6.3 COMMUNITY PERCEPTIONS OF NEED

During my interviews with health leaders and members of the community health commissions I asked if they had heard about the Health Model. As I have already mentioned, during most of my period of research only one person in the communities knew about its existence. Community members’ reactions to the Health Model itself were assessed from the various meetings recounted in the previous section. However, during interviews I asked community leaders questions that assessed their perceptions and thoughts about specific aspects contained in the Health Model in particular and health in general. I conducted in-depth interviews with 38 of the 52 health leaders and members of the health commissions who received training and workshops by the PSILN[40]. The responses to these questions help elucidate the

[40] I conducted interviews with community members who did not hold leadership positions as well and asked them similar questions to those presented in this section. The responses were similar to those presented here for health leaders. However, I have opted to present those of community leaders because community member interviews were conducted primarily in Santa Marta and Auhya Pihni so the responses would have been centered only on the concerns of those communities which have the best access to medicines by being in close proximity to the clinic.

dichotomy in the debates that arose out of the meetings and workshops mentioned above. In particular I want to concentrate on the answers to two specific questions and their follow-ups. The first is related to community health needs and the other to indigenous medicine.

I asked the following question to community health leaders and members of the community health commissions: "what is the greatest need in your community for improving health? And why?". Here are the responses to these questions coded by content with a quote representative of similar responses.

Lack of Medicines: (n = 17)

"We need medicines because MINSA does not have enough medicines, we can not travel to Puerto to buy medicines, it is expensive. [The cost of] the trip and the medicines is a lot for people like us who are poor".

A health post: (n = 11)

"We want a {health] post because when we get sick we have to travel a lot *para que nos vean* [to receive care]. Sometimes we have to carry our sick and miss work."

Sanitary infrastructure (wells and latrines): (n = 7)

"We need support, at least with materials, to build wells because we have problems, many of our sicknesses are diarrhea like that. Our community does not have money to do it [ourselves]". "We need to get organized to build *excusados* [latrines] but we do not have the money to buy the materials, we need to avoid contaminating our water".

Community Organization: (n = 3)

"We have to organize ourselves better. It is difficult to get anything without organization. Because you go to the government or an NGO and they ask you 'are you organized?' so we need to get organized so we can get what we need."

All of these responses are interrelated. I have presented them separately to give a clearer idea of the different health needs perceived to be important by community leaders. Many of the responses were not limited to identifying a single greatest need. Nineteen individuals mentioned

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The interviews of community leaders, although providing a smaller pool of responses better represents the concerns of all communities participating in the PSILN.

at least two needs. These responses differ because of the different resources available in the communities represented. In communities without a health post the need for one was a top priority. However the need for a health post is related to the need for medicines. One of those interviewed for example said “we need a health post because when we get sick we have to walk a long way to get medicines, and we have to take the person who is sick, how can they walk an hour when they are sick?”. However, the need for medicines is not limited to those communities without a health post. In communities with a heath post people complain that medicines in the health post are either not enough or unavailable. So these two answers can be seen as intimately related. The need for sanitary infrastructure was also dependant on the availability of these in the communities. Expression of the need for wells for example, where all from the farthest communities such as Te Kiamp, Dikua Tara and Kwiwi Tigni. Lastly, the need to organize is in itself a precursor for finding solutions for any or all of the other needs already mentioned.

What all of these needs have in common is that communities think they requires support from outside actors to fulfill them. In the various quotes represented, there is also a common theme that poverty and lack of resources are the main reason why many of these needs are not met. In all interviews there was a sense that the government had the main responsibility in fulfilling these needs. The following quotes are illustrative:

> The government does not care, politicians come to the communities when they need something but they do not give. They should look after the people but they don’t.
>
> [The government] should provide us with these things [referring to a health post and materials for wells], but they don’t have a lot of money and the little they have they steal.
>
> MINSA does not come [to the community]. We see them only two times [a year] during vaccination campaigns. But medicine? Nothing. They don’t fulfill their task [*no cumplen con su trabajo*]

When I asked if they were referring to the national or regional government they invariably referred to both. A recent survey carried out for the 2005 Nicaragua Human Development Report, which concentrated on the autonomous regions, asked about the things the government should do to benefit the population; they found that respondents considered health as the second priority behind generating employment (PNUD 2005: 85). In the same report the results of a survey in 2001 showed that 71% of respondents agreed with the following statement: "The regional government has the obligation to resolve all of the people's problems" (PNUD 2005: 246). This is indicative of the pervasiveness of the notion that the government has a responsibility to provide not only health services but to fulfill the needs of sanitary infrastructure. However, in the quotes presented above express the inability of government institutions to meet these needs. A survey carried out in 2001 found that 43.9% of those surveyed considered the regional government to be of no use to them, and 42% thought that it was of little use to them (IWGIA 2002, 95). The feelings expressed in the survey as well as those expressed in the quotes above are related to the difficulties in implementing the autonomous regimes as was discussed in Chapter Three. Since the governments, both regional and national, have not been able to meet Miskitu community needs, NGOs have stepped in to fill this void. NGOs and other development projects are not looked at in the same terms, they do no have the same responsibility as the government, but are seen as potential sources of resources. However they must conform to Miskitu preconceived notions of what an NGO or a development project provides, which can create different tensions and difficulties (see next chapter).

The responses to questions related to indigenous medicine provide a contrast, as expected, to the way Western medicine is viewed. I asked various questions related to indigenous medicine, one of which was: "What do you think about having indigenous medicine as part of

the health system?". All of the answers were similar to those in the discussions of indigenous medicine already discussed previously: its importance for Miskitu identity and its effectiveness. More importantly within these answers was a common thread of availability. Miskitu medicine and healers solved most of the health problems in the communities, especially in those where no health post was available. The concern was not that there was a need but that there would be recognition for their work and by extension recognition of Miskitu culture. When I asked community leaders if they felt their beliefs were respected when they received care in the health post or the clinic, the majority (57%) responded that it varied with the individual providing care. (some even named those in the clinic they felt respected their beliefs and those who did not). Twenty eight percent felt that their beliefs were respected (28%). A minority of those interviewed (15%) thought that their beliefs were not respected. This could indicate that for most respect for Miskitu culture, as represented by their conceptions of illness, had yet to be institutionalized in the health system. Yet even though for all of them the integration of Miskitu medicine was considered important, there was not the level of disappointment and outrage that was usually involved in discussion about the provision of health services and health infrastructure.

The difference in the reception of the different aspects of the Health Model can be better understood from the vantage point of a separation between health services which people in the communities feel they do not have, and indigenous medicine, which is a part of everyday life. Moreover, there is a view that the government has an obligation to provide health services and health infrastructure. As will be discussed in the next chapter, the parts of the Health Model that deal with community organization insert themselves within divisions in communities and their interaction with outside organizations. Indigenous medicine is less problematic in that although

there is a desire to have it incorporated within the Health System, at least in the communities where research was conducted, the interaction between indigenous medicine and Western medicine was not problematic despite the presence of some contradictions as the rest of this chapter will demonstrate.

6.4 MISKITU COSMOLOGY, HEALTH AND ILLNESS

The way many Miskitu view the world has a profound effect on their conceptions of health and illness. Miskitu cosmology has been described in the ethnographic literature in varying detail (Garcia 1996:120-144; Dennis 2004: 211-231; Nietschman 1973: 55-56; Perez-Chiriboga 2002). Recently as part of efforts in cultural revitalization in the region Miskitu and Creole scholars have also published accounts of Miskitu cosmology (Fagoth, Gianetto and Silva 1998, Cox 1998, Cox 2003, Cunningham, Moreno and McCoy 2002).

In Miskitu cosmology all aspects of nature are controlled and owned by spirits. These spirits are known in Miskitu as *lasas*. There are numerous *lasas* and mythical creatures, some of which appear only in stories (Cox 1998; Cox 2003). The most common *lasas* talked about and which present day Miskitu interact with the most are: liwa, duhindu (also known as swinta), alwani, and unta dukia. Each of these *lasas* has its own sphere of influence over particular areas of the natural environment. *Liwa* live in all bodies of waters, usually appear as sirens, and can be either male or female. *Duhindu* usually appear as short men with a wide brimmed hat, their sphere of influence is the savannah and they are the owners of deer and armadillos contained therein. *Alwani* is one of the most powerful *lasas* and is the lord of thunder and the sky. *Unta Dukia*'s sphere of influence lies in the mountains and the tropical forests. Although these *lasas*

usually appear in a recognizable form, like *liwa* as a siren, they can also assume other forms which on many occasions is that of a foreigner. Other aspects of nature, such as trees, animals and rocks are said to have an owner, so there are a variety of other spirits that inhabit and animate the Miskitu world.

When humans come into contact with *lasas* they get sick, and Miskitu use the word *siknis*, derived from the English word sickness, to denote these conditions. The *lasas* are not thought to only affect Miskitu; people warned me to be careful when walking between communities through the savannah, and my neighbor Marta thought I might have been affected by a *lasa* after I got sick from one of these trips. As she said "you don't have to believe but they can affect you, more when you don't know the area". In Miskitu cosmology the *lasas* cause illness for a variety of reasons. Fagoth et al. (1998: 18-19) argue that *lasas* affect individuals who are not in harmony with their environment. For example, a hunter who hunts more deer than he needs for his own consumption can be punished by *duhindu*. Pérez Chiriboga (2002) also comments on this. She recounts that during the *contra* war, Miskitu attributed the shortage of fish in the river as a punishment from *liwa* for the use of grenades and automatic weapons to catch fish. The *lasas* can also cause illness if they fall in love with individuals and try to take them as lovers. Drowning in the rivers and sea many times is attributed to *liwa* taking the person down to her secret place of residence. *Lasas* can also cause illness through inadvertent contact with humans whether direct or indirect, as might happen when passing through a place where the *lasa* has left traces of his/her essence. In some of these cases people fall ill because the *lasas* are thought to steal a person's soul (*lilka*).

Miskitu conceptualize humans as having two souls: *lilka* and *isigni*. Dennis (2004: 217) has described the *lilka* as "an image of the body". If a *lasa* takes possession of a person's *lilka*

the person can die if it is not brought back by a healer. The *isigni* is similar to Western conceptions of a ghost. When a person dies his *isigni* stays and roams close to the house where he lived. *Isignis* cause illness and sometimes try to take loved ones with them to the afterlife[41].

Illnesses are conceptualized as a person being possessed by a spirit. Being possessed does not mean that a person loses control of his/her consciousness or faculties, although that can also occur as is the case of *grisi siknis* (see Chapter Five). The *lasa* or spirit can simply "be there" in the body causing discomfort. For example, one of the most common illnesses found among the Miskitu is *yumuh*. *Yumuh* manifests itself through pain in the abdomen, and the affected are thought to have a small lump inside of them causing the discomfort. There are different types of *yumuh* depending on the animal spirit that has caused it. The spirit has to be coaxed out of the individual through massages with herb extracts while reciting specific "prayers" or invocations for the particular spirit causing the illness (see Fagorth et al. 1998: 32).

The Miskitu recognize a variety of healing specialists. In the area where I conducted my research they were referred to collectively in Miskitu as *Sika uplika nani*, and in Spanish as *curanderos*. Among the Miskitu, healers are classified hierarchically according to their power (see Cox 2003). The most powerful are the Prapit (taken from the English word prophet) formerly known as Ukuly. They are chosen by *alwani* when he strikes an individual with thunder. *Prapits* are said to predict the future and be able to control the weather. Their power extends to all of the supernatural. The most recognized Miskitu healer is the *sukya*. The *sukya* is the mediator between the spirit world and that of humans and engages in what in anthropology has commonly categorized as shamanism. Although *sukyas* were the main healers among the Miskitu, now very few healers identify themselves or are identified by others as *sukya*. *Spirit*

[41] For an example of an isigni causing illness see the story of Luisa, pages 238-239 of this dissertation.

upla is another type of healer similar to the *sukya* but who uses different forms of prayers such as Christian prayers and symbols along with those rooted in Miskitu cosmology. The most common healers are *sika upla,* who are herbalists with extensive knowledge of plants, and are what might be classified as a herbalist. These are not the only recognized healers, there are others such as the *piuta napa dadaikra,* who specialize in dealing with snake bites. And there are further subdivisions within these categories according to their specialty in one particular *lasa* or illness. Moreover, the practices of individual healers blur these boundaries. A healer may be known as a *sika upla* and still work with prayers and other practices that are more closely associated with *spirit uplas* or *sukyas*.

Healers learn their craft through a variety of means. Some are "called" to be a healer through dreams (Cunningham et al. 2002). Dreams have a special place in Miskitu cosmology since they are a point of contact between the human and spiritual spheres (Pérez Chiriboga 2002). Many healers learn the properties of plants and diagnose illness through dreams. Those healers who receive a calling fall ill if they ignore it. Medicinal knowledge is also passed to family members. Knowing the properties of plants and remedies is a closely guarded secret and, except for the most widely known, plants and cures are not freely shared. Some healers sell their "secrets" to others. Healing and other powers can also be learned directly from a *lasa* but this is widely considered a dangerous procedure because the *lasa* may want something in return. There are other ways individuals learn their craft. The story of Kramer, a specialist in snake bites in Santa Marta provides an interesting case. Kramer's son was bit in the foot by a venomous snake. When Kramer found out he put his son in a *pipante,* a small canoe used for travel in rivers, and took him to Wawa Boom because "in that time there was no clinic, no hospital, nothing". They reached Wawa Boom three days later. When they reached the healer he said that too much time

had passed but he would still try to cure him. Kramer's son was cured but since he did not have money to pay the healer he offered to work for him for fifteen days in order to pay the debt. Kramer worked for the healer for fifteen days. At the end of this period, according to Kramer, the healer said "you are a good man, I will teach you how to make medicine". He then taught Kramer how to cure snake bites and has been a recognized specialist in that area in Santa Marta ever since.

The Miskitu have maintained many elements of their cosmology despite their close relationship with different churches in the coast, especially the Moravian Church. The understandings of Miskitu indigenous worldviews although not lost, have changed with the introduction of Christianity. For example, when I asked informants to clarify what the *lasas* were, they would many times refer to them as demons, devils or evil spirits. Dennis (2004: 214) argues that the Miskitu bible has become a Miskitu text in which both Christianity and Miskitu cosmologies have been integrated. For example he provides an account in which an informant explained the *lasas* as manifestations of Satan after he was expelled from heaven. The importance of Christianity has also been used to explain the use of the word *prapit* and *spirit uplika* because such terms more closely conform to Christianity. Moreover, many of the practices used by Miskitu healers today show a degree of syncretism with not only Christian but other ideas introduced by foreigners, such as the use of cards for diagnosis.

The importance of Christian teachings has also had an effect on the way Miskitu view healers. Dealing directly with spirits that are considered to be demons or devils is viewed negatively by most Miskitus. This is one of the reasons why the term *sukya* is rarely used. For example, a healer in Puerto Cabezas was angry that she had been referred to as a *sukya* because of its association with sorcery and witchcraft. Recently with attempts to revitalize Miskitu

culture and medicine, the term *sukya* is used frequently because it has a connotation of authenticity, as the original name for Miskitu healers in the region. All healers however are viewed with a certain amount of suspicion because the power to heal necessarily implies the potential ability to harm through witchcraft and sorcery.

Witchcraft and sorcery are a part of daily life for the Miskitu. Among the Miskitu witchcraft often takes the form of *puisin*, taken from the English word poison, which can take a variety of forms and is placed in the path of the individual who is the target. The world is viewed as a dangerous place where an individual is in constant danger of being the object of witchcraft. Social relationships are therefore potentially hostile. During my research I was always given contradictory advice that reflects the contradiction between Miskitu notions of community (see next chapter) and witchcraft. On the one hand I was always told that it was bad to refuse when someone offered you something, you would be considered "proud". On the other hand Miskitu warned me not to accept gifts from people I did not know well because "you don't know what they want, they might want to do you harm". The accusations about witchcraft and the continuous preoccupation with potential threats point to the multiple fractures in Miskitu society. Moreover, witchcraft is used to explain sudden increase in power or wealth[42]. There is a generalized mistrust of people with power which helps explain the ambiguous feelings with which Miskitu healers are viewed. For example, I frequently heard stories of healers who would make people sick in order to receive payment to cure them. Witchcraft also involves a preoccupation with foreigners. Indigenous healers in a workshop commented that witchcraft was increasing in the Coast and that it was more powerful. The reason for this was the introduction of

[42] The introduction of the cocaine trade in the region has provided another explanation for increases in wealth and power. For example a Miskitu neighbor in Santa Marta commented on the appearance of an individual from the community of Sisin who came by with new clothes and gold chains: "That one must have found some cocaine or robbed it, he didn't have that last time I saw him. Either that or he is involved in something bad"

more powerful forms of witchcraft from Honduras and other parts of the Caribbean such as Belize.

Knowledge of medicinal plants is not confined to healers. During my research nearly everyone I spoke to said they knew at least a few plants to cure illnesses. I often heard comments like “here in the communities everyone knows a little, not so that people say that he has knowledge but enough to cure simple things”. Dennis (1988) shows that in Awastara some plants were almost universally known. In a survey in the RAAS, Barett (1993) reports that 67% percent of respondents in Miskitu communities knew some medicinal plants and used them for health care. Among the Miskitu not all illnesses are caused by spirits. Naturalistic explanations are also used. The one people referred to most frequently is that of “aire” which is usually expressed in muscle pains. It was explained to me as accumulating air in different parts of the body, and it affected men working in the bush. The treatment was therefore suctioning the air out with the use of a glass and a candle or through a massage. The dichotomy of hot and cold is also used to explain some conditions. For example, some people explained that there were two types of *catarro* or colds, *catarro* of the sun and *catarro* of water, and that each one is treated differently.

The brief description of Miskitu cosmology and conceptions of health and illness shows that the practice of what is labeled “indigenous medicine” is diverse and complex. This is one of the reasons why it is difficult to integrate indigenous medicine into the health system. Moreover, the influences of Christian beliefs and Western medicine have had an impact on Miskitu conceptions of health and illness which complicate the interaction between indigenous medicine and the health system.

6.5 INDIGENOUS MEDICINE IN THE PSILN

The PSILN does not have components in the implementation of the program that deal specifically with indigenous medicine. The only indigenous health specialists they work with are birth-attendants. However, the implementation of the program recognizes the fact that indigenous conceptions of health and indigenous medicine play an important role in the lives of the population that they serve. The official acceptance of indigenous medicine however is partial and guided by Western medical conceptions that accept only specific aspects of indigenous medicine. In this sense Dr. Blandón for example stated that:

> I believe in the curative property of plants…many of our [Western] medicines are derived from plants as well. These people have lived here for hundreds of years with nature and have learned through experience what plants work for this or for that [illness]. I believe in that, and because they have lack of access to [Western] medicine I think that one has to promote their use.

Acceptance of indigenous forms of medicine is limited to what we might call herbal medicine. Other aspects of Miskitu conceptions of health are only respected and rarely promoted. In this case Dr. Blandón argued that:

> I think we have to respect their beliefs if they believe in extraordinary things, if they believe in spirits. Maybe we have to respect that but…it affects people a lot because every illness, all pain they associate with a spirit, something that does not exist, something very strange. For me as a person I am respectful of those beliefs but I do not believe [in them].

This attitude on the part of the coordinator of the program did not reflect the attitude of many of the program staff as we will see in the next section. However, it does reflect the overall approach of the program towards indigenous medicine.

The use of medicinal plants and home remedies are constant topics of discussions in the training workshops provided by the PSILN to health leaders and *auxiliares*. These are primarily

carried out by Nurse Delia. These discussions about natural medicines and plants are carried out differently in workshops with *auxiliares* and health leaders.

Auxiliares have access to and prescribe Western medicines. They staff the health posts. The PSILN training workshops therefore center primarily on continuing the education of *auxiliares* through discussions about how to identify particular diseases and what medicines and appropriate dosages are used. In these workshops discussions about Miskitu conceptions of health center on how such conceptions affect their own ability to reach the population and appropriately treat different conditions. The role of indigenous medicine concentrates on herbal medicine and its use to extend the limited resources available given constant MINSA shortages.

In one of these workshops for *auxiliares* the topic was Sexually Transmitted Diseases (STDs). Most of the discussion centered on the difficulty of examining and identifying cases of STDs because of Miskitu cultural practices and conceptions of these diseases. On the one hand Miskitu conceptions of "shame" made examinations difficult (see Jamieson 2000). On the other, Miskitu understood these diseases as caused by *lasas*. For example, gonorrhea is widely associated as a condition caused by *liwa*. As such the first strategy of those affected is to go to Miskitu healers first. Discussion centered on how to overcome these difficulties. Delia argued that the role of the *auxiliares* was to attempt to dispel these notions and to work with any indigenous healers in the community so that they would send these patients to the health post to receive treatment. In the event that medicines for treatment were not available, the next step was to refer those affected to treatment in Puerto Cabezas or the Santa Marta clinic. The *auxiliar* of Tuara said that he knew of natural cures that can help cure gonorrhea and other diseases. Delia then instructed him to bring the recipe of these natural cures to share because "in the event that there are no medicines in the post and the patient does not want to go to Puerto [Cabezas] it

would be good to have this third alternative". These directives formed part of the official strategy for the incorporation of natural medicine into medical practice. The phrase that summed this perspective, which I heard numerous times in different variations, was "if you know of a natural remedy write it down and use it because MINSA does not give anything for that".

Workshops for health leaders were somewhat different although they followed a similar logic. Health leaders for the most part do not have access to Western medicines. They do not have formal education in health besides the workshops provided by the PSILN and sporadic workshops provided by MINSA. Their primary role is to help educate and organize the community in health matters. The workshops therefore center on the most common health problems such as respiratory and gastro-intestinal diseases. The emphasis is on prevention and how to disseminate knowledge about healthy practices to other community members. They also extend health coverage by learning the basics of primary health care. Their role is more important in communities that do not have a health post staffed by an *auxiliar*. In workshops that I observed they learned how to use thermometers, take a person's pulse and other basic techniques. Their role was to treat common diseases and to identify when a condition was severe enough to necessitate a transfer to a nurse or a doctor. They were also taught about medicines and dosages for some of the most common diseases such as parasites. However, they did not have access to these medicines.

Given the lack of access to Western medicines, natural medicine plays a more central role in these workshops. For example, in discussing respiratory diseases Delia provided health leaders with herbal remedies such as breathing the vapors of eucalyptus leaves in hot water to help alleviate symptoms. Discussions and sharing herbal remedies consume a good portion of these workshops. However the workshop also attempts to control when it is appropriate to use herbal

medicine and when it is not. On many occasions Delia reminded the health leaders: “first the doctor then the *curandero*, if you take them to the *curandero* first they can get [to the doctor] too late”.

One discussion along these lines emerged around snake bites. The ability of some Miskitu specialists to deal with snake bites is renowned throughout the region. Bites from venomous snakes require prompt care in order to avoid very serious consequences and death. Delia’s advice to refer as quickly as possible to the health post or clinic was met with arguments that reinforced the authority of Miskitu specialists in the matter. One of the health leaders for example argued that “here we have had snake bites for hundreds of years. We have people who have knowledge. They can cure it”. Delia in this instance countered that “not all of the people who say they can cure it can. You can not take that risk”. After some debate on the matter the conclusion was a compromise between these two positions, summed up in the following quote by the health leader of Butku: “Some know how to cure it, some do not, so we have to be sure of [the healer’s] abilities. If we are not, maybe we should send them to the doctor”.

As the brief discussion above illustrates, the official position of the PSILN on indigenous medicine is limited. Those aspects that are accepted and promoted are those that are similar to Western medicine such as herbal remedies. In addition natural remedies and the authority of Miskitu healers are incorporated within a hierarchy in which indigenous medicine is under the authority of Western medicine. This is not surprising, Ayora-Diaz (1998) has demonstrated that in the case of Mexico when indigenous medicine is incorporated into the formal health system it is legitimized through its rationalization in Western medical terms. In this sense what is accepted are therapeutic regiments that are analogous to the treatments of institutional medicine such as herbal medicine.

6.6 INDIGENOUS AND WESTERN MEDICINE IN PRACTICE

Despite the official position of the PSILN on the use of indigenous medicine, in practice the interaction and relationship between indigenous medicine and Western medicine is more frequent and complex. The points of contact between the health system and community members in need of care are the *auxiliares,* health leaders and nurses. In the communities they are primarily Miskitu and therefore share many of the same conceptions of illness as the population they serve. In the community of Auhya Pihni this relationship between the community and the *auxiliar* is even closer since she was a member of the community. In some communities the health leader is chosen because of his knowledge of or prior experience with health issues. In the community of Tuara the health leader had experience as a paramedic during the war and learned from the “guerrillas”. In the community of Sagni Laya the health leader was chosen because he was a Miskitu healer who gained his knowledge through dreams. These points of contact, the *auxiliares* and health leaders, between the community and the health system interpret the relationship between indigenous medicine and Western medicines in a different way than the “official” position of the PSILN. There is no hierarchical relationship; it is instead a complementary relationship that more closely resembles the way the population they serve view health in general.

The case of the *auxiliares* and nurses is more pertinent to a discussion of how the two systems merge, since they have formal training in Western medicine and are employees of MINSA. All of the *auxiliares* who worked with the PSILN have worked in conjunction at one time or another with recognized community healers. Maria, the *auxiliar* of Auhya Pihni for example remarked:

> I know my race and I know what sicknesses our healers can treat. One of our *curanderos* knows this too. He sends me people that come to him sometimes. And there are times when I go to him to see if someone's sickness can be cured by him because we do not always have medicines. Also not everything I see in the [health] post can simply be cured with medicines. I had someone come to me a little while ago with a rash in his skin. I treated it with a cream and it helped but it returned. Then I talked to one of our *curanderos* because I can treat the symptoms but not the cause. In that case I think that someone had done him *un mal* [meaning sorcery]. My treatment was effective but in this case it helped while he [the *curandero*] dealt with the real cause of the problem.

These comments are interesting in that they indicate that a biomedical understanding of a particular condition did not preclude an understanding of an illness within the Miskitu worldview. Moreover, unlike the official position of the program indigenous medicine did not limit itself to herbal medicine. This does not mean that all illnesses are understood in this way. In the same interview Maria also remarked that:

> Our race is sometimes too worried about witchcraft and *lasas*. I have to remind them that not everything is caused that way. People usually know where to go and to separate one thing and the other [meaning illnesses for the health post and those of healers]. But many people are just too worried about who wants to do them harm. There is too much mistrust among our people.

This comment reflects an understanding of the role that inter-personal relationships have in peoples' interpretations of illness. It shows that Miskitu illness interpretations are not always clear-cut and depend on complex factors.

The most interesting case of the relationship between indigenous medicine and Western medicine, even if admittedly atypical, is the case of Ana. Ana was the nurse in charge of overseeing the *auxiliares*. She was based in the Santa Marta clinic where she attended patients along with Dr. Alvarado and Dr. Blandón and nurse Delia. She was young but had extensive knowledge of Miskitu medicine.

I first found out about Ana's Miskitu medical knowledge in a conversation in front of the clinic with Don Israel, the PSILN driver, and Dr. Alvarado who lived with Ana. During the

conversation the topic of indigenous medicine came up. Don Israel's father is one of the indigenous healers of the community and he specializes in snake bites. Don Israel commented "My father is old and his knowledge will be lost with him if he dies. My mom tells me 'you have to go to the bush, learn the plants' but I have yet to learn". Upon hearing this comment Dr. Alvarado commented "Ah, Don Israel, it really is not that difficult". He then proceeded to explain in detail how to treat snake bites. I was surprised at Alvarado's knowledge of Miskitu medicine and asked him where he learned it. He avoided the question and seemed embarrassed about it. Don Israel kept prodding by commenting "this one knows, this one knows, tell us what more you know". Still somewhat embarrassed Alvarado began telling us some of the things he had learned, such as some procedures for making *sontin*[43], which usually refers to medicine used to attract lovers. There was a long discussion about the efficacy of *sontin*, with various stories from the community shared by Israel and Alvarado. The conversation then moved to recognized healers in Puerto Cabezas. Alvarado commented "there's Dona Nora in el Muelle [a *barrio* in Puerto Cabezas], she is part of Ana's family". Israel then added "Yes because she married Ana's uncle". At this point I commented to Alvarado "now that's where you learned all that stuff, from Ana". Feeling a little embarrassed he said that Ana knew a lot about Miskitu medicine. He and Israel then went on to tell me where she gained this knowledge, which I heard from her again later on.

Ana's grandfather was a much respected and widely known healer in the region. He lived in the community of Wawa Boom on the opposite side of the river from where the community is located. Don Israel's father, Kramer, learned to cure snake bites from him[44]. Ana's grandfather taught all of his children the art of Miskitu medicine. Ana herself learned it through her family.

[43] The word *sontin* is derived from the English word "something" and points to Creole influence.
[44] For the story of how Kramer learned to be a healer see pages 221-222 of this dissertation.

She said: “medicine is part of my family, it is hard to be part of my family and not know something about it”. All of Ana’s uncles had “knowledge” and in turn went to great lengths to teach their children and nephews. When I asked her why she had never mentioned it to me before, she said that: “if you have to advertise that you know then you probably do not know as much as you say you do”. Despite this reply however, Ana’s not acknowledging her knowledge of Miskitu medicine had to do with her attempt to keep some of her practices at the clinic a secret.

I was hanging out with Ana, Alvarado and Pedro at one of the community *ventas*. Alvarado asked me if I wanted to have a beer with him. I was not feeling well so I declined and commented that if I had one he might have to prescribe something for me the next day to cure the mess he had caused. He laughed and replied, “Well maybe you will get a prescription from Ana to go along with one of mine”. I was confused by this reply and especially at Ana’s uproarious laughter. Alvarado then commented to Ana, “You thought I didn’t know you were giving some of my patients your own prescriptions?” I then found out that Ana sometimes gives patients at the clinic her own prescriptions based on her knowledge of Miskitu medicine. I broached the subject with her later and she commented:

> I have this knowledge and I think that if someone can benefit from it, then I should help them. If the doctor gives them a prescription I tell them to follow the treatment that they have been given. I just provide an alternative, not an alternative, something to complement it…also some of these people are poor and the medicine prescribed is not available for free. I just write down what plants and things they need and how to prepare and take them. I do not prepare them myself because that is not my job and I do not want to get too involved.

Alvarado was not bothered by this practice. In fact he later told me that if he had patients that he thought Ana could help he would give them his prescription and send them to see Ana. He did not explicitly tell them that she would give them another prescription but there seemed to

be a mutual understanding that she would. These activities in the clinic remained out of view and without the knowledge of Dr. Blandón or Delia. This information made some of my other observations related to the relationship between Alvarado, Ana and the community clearer. For example, people in the community told me that Alvarado "respects our beliefs". I had taken that to mean that he simply treated them with respect and did not make comments that belittled or questioned Miskitu health conceptions. Now these comments acquired a new connotation. Ana and Alvarado also occasionally received gifts from community members, such as plantains and *yucca*. Although these gifts were also related to other aspects of their behavior in the community, their activities with indigenous medicine were a part of it[45]. Later I jokingly told Ana that she was the indigenous healer in the clinic that some people envisioned as part of the future of the health model. I told her that she was a "symbol of *interculturalidad*". She laughed at my comment and quipped "yeah, a symbol of *la interculturalidad escondida* [hidden i*nterculturalidad*]."

The idea of an *interculturalidad escondida* seems appropriate here. I have described in detail how I found out about Ana's indigenous medicine activities in the health clinic to provide an idea of how secret her practice was. It was not that I had not developed enough rapport with Alvarado and Ana before I finally found out about it. This "discovery" occurred toward the end of my fieldwork and by that time they had shared with me many details about their personal lives and the activities and practices of the clinic. Interestingly enough members of the community did not mention Ana's activities explicitly, although as I looked back into my interviews and field notes they had certainly given me hints that I had failed to notice. For example, as part of a response to a question about health services in the clinic, a community member commented:

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[45] See page 266 of this dissertation.

"That Ana has a lot of medicinal knowledge, she knows our culture and understands our beliefs". Miskitu refer to healers and individuals who know about medicinal plants and other aspects of Miskitu healing practices as having "knowledge". What I had taken to mean initially as knowledge of Western medicine is transformed by Ana's activities.

Although Ana's case may not be typical, it shows how Miskitus working within the health system affect its practice and Miskitu experiences with the health system. Similar activities occur with the relationship between the *auxiliares* presented above. There are two important points that can be taken from this. First, the fact that these activities are kept hidden from view shows that the principle of *interculturalidad* of the Health Model is still unevenly implemented. Individuals working in the health system still have ambiguous feelings about the acceptance of indigeous medicine despite the rhetoric of "openness" and "acceptance" in the health system and the PSILN. Secondly, indigenous medicine is a "fact of daily life" that is not a major concern for the Miskitu because of the availability of healers and the willingness of Miskitu working in the health system to make use of indigenous medicine. As has been noted with the quotes in previous sections of this chapter, indigenous healers address many of the health problems that community members have, and this goes largely unnoticed by the staff of the clinic. Furthermore, most of Miskitu interactions with the health system and the PSILN occur with *auxiliares*, health leaders and nurses who for the most part share the cosmology of the population they serve. However, these health practitioners are many times conceptually separated from MINSA, even if *auxiliares* are MINSA employees. In communities with health posts that are equipped by MINSA, community members often said that MINSA did not come to their communities, that they would come once or twice a year in vaccination campaigns.

6.7 CONTRADICTORY INTEPRETATIONS OF ILLNESS AND CONFIRMED ASSUMPTIONS

It was another one of those hot and humid mornings at the end of the rainy season. I had arrived at the Santa Marta clinic along with Pedro, expecting another uneventful day with a few patients with parasites and respiratory infections. As always I worked in the office with Pedro, observing the activities of the clinic and taking the time to type away field notes and transcribe interviews when things seemed to be slow. From the office Pedro and I heard a commotion in the adjacent building. Pedro and I, filled with curiosity, went to find out what was happening.

When I rounded the corner I saw Doña Luisa, the pharmacist, with a bundle wrapped in sheets in her arms. It was a one month old infant. I knew the child was not Doña Luisa's, I knew her children. As I got closer I realized that blood was seeping into the sheets. I thought that some sort of accident had happened. As Doña Luisa went inside the clinic she was received by Dr. Alvarado, who immediately went toward her and took the bundle away from her arms. Not being a doctor, I was not prepared for the sight I was to see as Dr. Alvadaro opened the sheets slightly to examine the infant before taking him to the examining room. The child's skin throughout its entire body had turned black; his skin was cracked in many places with blood and pus slowly oozing out. There was little time for explanations or questions, Don Israel, the driver, was quickly fetched and Dr. Alvarado with the baby in its bloody sheet in his arms got on the clinic's truck and drove off to take the child to the hospital in Puerto Cabezas. That night the bell of the church sounded when news reached the community that the child had died.

Discussions about the cause of the death of the infant demonstrate the multiple and contradictory ways in that Miskitu and health professionals interpret illness episodes and the boundaries between indigenous and Western medicine. The same incident was used to validate

conflicting assumptions. According to Alvarado, he had seen the child when it was born and had noticed that the child had a small round black spot "about the size of a *peso* [similar in size to a quarter]" on his back upper thigh. He had diagnosed it as a bacterial skin infection and had given the mother an antibiotic cream to apply to the affected area. He did not hear about the child or the mother again until Luisa brought the child to the clinic. The mother had not given the child the treatment because in consultation with some family members she had determined that this was not a *daktar siknis*, an illness for the doctor. The child's condition was diagnosed as *liwa siksa*. As the name implies the illness was determined to be caused by *liwa* the spirit that governs the rivers and the sea. It was therefore determined by the family to be a condition that could only be treated by a Miskitu healer.

This single incident was used to validate two sets of beliefs. For some, the death of the child showed the danger of indigenous medicine and the use of indigenous healers. It showed that "Miskitu beliefs can kill" when they prevent people from getting the treatment that can cure them and preserve their life. For others, the incident proved the opposite view. The fact that the child had died in the hands of Western medical doctors demonstrated that Western medicine could kill when it attempted to treat an illness that belonged to a Miskitu healer.

Liwa Siksa is scarcely mentioned in published accounts of Miskitu medicine. Fagoth et al. (1998) provide a brief description of the illness as "black spots on the skin with itching" (24). And in an herbal inventory they provide the name of the plant used to treat it and refer to *liwa siksa* as "secreting sores in the skin" (51). According to this description the medicinal plants are mashed and mixed with water to bathe the affected person[46]. Cox (2003) does not mention the

[46] Fagoth et al. (1998: 86) provide the name of the plants in Spanish as Pico de pájaro and helecho. Helecho is fern in English although the specific type of fern is not specified. Pico de pájaro is identified in Miskitu as Singsigya and the scientific name given is Senna Occidentalis.

name *liwa siksa* but describes a similar disease as *Wan tayara ulban* which translates as "spots on the skin". He provides a description similar to Fagoth et al. as "spots on the skin that turn to sores, it is believed that it is a sickness caused by bathing in a place where *liwa* has its dwelling" (129). The healer that treated the infant that died in Santa Marta described the condition in the following way:

> People get liwa siksa from bathing in rivers when *liwa* has been close or just passed. She is powerful. Just a little of her [meaning that not much contact is needed] and you get sick. She gets into your body. That baby was not in the river. But he had *liwa siksa*, I have seen it before. His mother was affected by liwa, maybe [washing] her clothes [in] the river. She did not get affected. [but the] baby is weak. You have to be careful with children. These spirits [*lasas*] affect kids a lot. You can't take them to places where spirits might see them. This one [the baby] was weak and liwa took him fast. I prepared my medicine, and gave it to the mother to wash the skin. He could have survived but if a doctor treats it, it will kill fast.

Various members of the family held the same interpretation as the healer, obviously including the mother. They called a Miskitu healer to examine the child because "here we see many skin diseases and our healers can treat those". Indeed during my period of fieldwork I met three people with various kinds of skin illnesses, mainly superficial dark spots on the skin which were all attributed in those cases to witchcraft[47]. Other members of the family wanted to take the child to the clinic when they saw that the condition had worsened and that the treatment was not working. Moreover, the mother was considered by some in the community as irresponsible because two previous births had ended in the death of the children. One of her cousins commented: "she neglected her other children and she neglected this one that is why they die". However the lack of consensus within the family prompted an uncle to talk to Luisa, the clinic's pharmacist who is from the community, to see the child and assess the situation. Luisa was

[47] One of these cases for example, was a young woman of 20 who had been to both Western doctors and indigenous healers. According to a healer, she had been the target of witchcraft when she had refused the advances of a young man. For this young woman, the fact that she had attempted so many forms of treatment unsuccessfully confirmed the witchcraft diagnosis.

neither a nurse nor a doctor but her status as someone who worked in the clinic along with being a member of the community and Miskitu made her a good choice to intercede.

Luisa heard about the child's illness the morning she brought the child to the clinic. When she saw the child bleeding throughout his body she got angry and yelled at the mother: "I told her that she was irresponsible toward her children, not to bring the child to the clinic and I just said I was going to take him." She did and no one in her family protested because they saw the severity of the child's condition even though some, especially the mother, later expressed their reservations. Luisa's interpretation of the child's illness was influenced by three factors: her evaluation of the mother's behavior, her work with the clinic, and her personal experience with the loss of an infant. She argued that "that girl [the mother of the child] has neglected all of the children, I don't know why she keeps giving birth if she is going to let them die". And to her *liwa siksa* was "just an excuse to do nothing as always". Luisa then argued that she had learned her lesson about indigenous healers because of a past experience. Luisa told me: "the same thing happened to me with a little girl I had, for taking her to the *curandero* first".

The previous month Luisa had recounted the story of the death of her child. The story shows some of the same ambiguities in the interpretation of illness and death among the Miskitu. Moreover she had recounted the story after I asked her about indigenous medicine, and she used the story to validate the efficacy of it. Here is Luisa's narrative:

> About ten years ago I had a baby girl that got sick. I thought she had yumuh and took her to a curandero but he did not cure her. Then I took her to the hospital with my mother but we got there too late. The baby had severe anemia and died. The child died in my mother's arms. Then my mother started getting these *ampollas* [rash] in her skin, in her arms and chest. In that time there was a *spirit mairim*, Wilson was her name, here in Santa Marta. She dressed in white and worked through songs, candles, water, and white flowers. I took my mother to her to see what was happening. Then she brought a glass of water with white flowers and told my mother that since she [the child who had died] was a baby she could not cross to the other side alone and her *isigni* had stayed in the place where she died, in the arms of her grandmother. Then she asked my mother if there was a

> dead family member that could take the baby with her and take care of her. Then she gave the little girl to one of my aunts that had died and she cured my mother from the rash. That *spirit mairim* had a very curious ritual when she finished her treatments, depending if the *isigni* was a child or an adult. If it was the *isigni* of a child she asked for coke and cookies and she would ask for a group of children to be brought to the *curación* [healing]. At the end she would give out the coke and the cookies to the kids. If it was the *isigni* of an adult she asked for a white chicken, she used the blood [of the chicken] to dip these little crosses made of coconut splinters, then she would rinse them and give them to the adults as an amulet.

It is interesting that the episode of her personal experience used to interpret the irresponsibility of the dead infant's mother in not taking the child to the doctor, served as the backdrop for a story used to validate a Miskitu healer's efficacy. This is even more interesting when one considers that Luisa's mother's illness was also a skin disease, even if not as severe as the child's. Later I asked her about this and she told me that in the case of her mother the death of her child made the case obvious. Therefore the evaluation of the different illnesses to her was dependant of the context that led up to them.

However, the diagnosis of *liwa siksa* was equally obvious to some people in the community who had seen similar diseases treated before. For these people the death of the child demonstrated one of two things: either that Western medical treatment was responsible for the death of the child, or that the healer who treated it was not powerful enough to contain the illness. Both of these views however were not mutually exclusive. Another interpretation that I heard only once interpreted the same events that had caused some to denounce the mother's irresponsibility in a different way. For this person: "maybe someone has done her *un mal* [sorcery], three babies dead like that, that is weird".

In the clinic the interpretations of the death of the child were not as one-sided as one might expect. For Dr. Blandón it was all very clear: she said about the mother, "she let that child die, you see there how believing in spirits kill, believing in those things is bad". The

interpretation by other members of the PSILN was more ambiguous. Dr. Alvarado was feeling depressed by the incident so Ana, Pedro and I bought some *chicha*[48] to help cheer him up. During the night the topic of *liwa siksa* inevitably came up and Dr. Alvarado asked Ana, "you think I killed him by taking him to the hospital, don't you?" To which Ana replied: "no, you did what you had to do, I don't think it helped but I doubt it made it worse". Alvarado slowly nodded his head and replied: "if it was *liwa siksa* then why didn't the child get better with the *curandero's* treatment?". Ana then explained: "because it is difficult to treat and not everyone has knowledge".

I have recounted this case here because it exemplifies the blurred boundaries between indigenous medicine and Western medicine. Through this example I want to avoid making generalizations about Miskitu conceptions of health and illness. In this case there was no consensus anywhere, not within the family of the dead infant or among the clinic's staff. The illness was discussed collectively but in the end it was interpreted differently according to an individual's point of view. In essence what I want to highlight is that a categorical pronouncement of illnesses that belong to the doctor or belong to the Miskitu healer is not a straightforward process. Individuals vacillate between explanations of illness according to the particular context. The same illness can be interpreted as proof of indigenous cosmology or proof of the dangers of its use.

[48] *Chicha* is a home made alcoholic beverage made with corn. In some Miskitu communities it is sold out of people's houses. In other communities all alcoholic beverages are banned. That was not the case in Santa Marta.

6.8 CONCLUSION:

In this chapter I presented how the Health Model is understood in the Miskitu communities where the PSILN is being implemented. In discussions of the Health Model a dichotomy similar to that found in discussions at the regional and national level was evident. The component of indigenous medicine stands out as one of the defining features of the Health Model. Similarly, discussions surrounding culture and indigenous medicine were less contentious than those that dealt with its organizational structure.

Indigenous medicine is widely accepted because it is a part of Miskitu everyday life and it is a resource that is available to community members. The "official" policy of the PSILN towards indigenous medicine was limited to recognition of herbal medicine and only in an implicit hierarchy that placed it under Western medical control. Its function was simply extending health care when Western care was not available. This position was perhaps the result of the lack of articulation in the implementation of the Health Model, which is dependant on NGOs to implement aspects of its programs without direct accountability from the CRA-RAAN, who is responsible for its implementation. The limited acceptance of indigenous medicine within the PSILN is one of the reasons that some community members perceive that their culture is not respected when they seek care.

The point of convergence between Western and indigenous medicine is with *auxiliares*, nurses, and health leaders. These health workers are usually Miskitu and therefore share the world-view of the population in the communities they serve. If we defined *interculturalidad* or intercultural health, in its most basic sense, as a horizontal interrelation of different conceptions of health and illness, we would have to argue that these health workers work within an intercultural framework. However, as Ana's phrase of "hidden *interculturalidad*" suggests, it has

yet to be institutionalized within accepted practices of medical care. Despite the non-institutionalized character of intercultural health, most of the community's experience with the health system is with these health workers. The most frequent experience with the health system is therefore one in which indigenous medicine is respected and accepted. The boundaries between different conceptions of health and illness are not always clear on the part of Miskitus themselves. Multiple interpretations exist for illnesses that do not clearly conform to one system or the other. Illness is interpreted within the context in which it arises and the Miskitu draw from their experience with indigenous medicine and Western medicine in order to decide where to seek care.

The major difficulties in communities comes not from the lack of interrelation between Western and indigenous medicine, but with the lack of availability of the former. In the communities of the Llano Norte the main complaint is the lack of medicines and health infrastructure. Interestingly enough, this is the part of the Health Model that is developed the most and the one where the most disagreements arise. This partly derives from a generalized cynicism about the government and its ability to help communities to meet what they consider to be their most pressing health needs. As a health leader commented to me after talking about the Health Model's proposal for the extension of services: "I have heard promises and promises that we're going to get this or that, until it happens I don't believe". The discussion about community responsibility in health meets with several problems. The financial contribution from community's natural resources contradicts the view that health is the responsibility of the government. Furthermore, there is a generalized feeling that those in government enrich themselves from their positions, so communities with scarce resources view contributing for their health care as the government passing on its responsibility to them. In terms of the

disagreements surrounding community organization, these respond to community cleavages and different expectations and interpretations of health development and communities. We turn to these issues in the following chapter.

7.0 COMMUNITY, DEVELOPMENT AND HEALTH

In an essay titled “The Communal Spirit”, Adan Silva Mercado, a Miskitu writer and artist, attempts to identify through poetic prose Miskitu “asla laka” or communal spirit (Silva Mercado 2002). He writes that community spirit is “so fragile it cannot be seen, it is like the wind”, and yet it is “as tall and imposing as the Mocó [mountain]”. He finds its “footprints” in the “soup that is taken to the sick neighbor; and the strong shoulders that carry [the sick] in a hammock to the nearest road [to get help]”. The communal spirit is “generous” like when “those that come back [to the community] with something from hunting and fishing share with everyone”. It is also “severe when the time comes to defend the community from aggressions”. After many descriptions such as these the essay ends with a series of questions: “Where—I ask myself - where is this spirit now? In what magical lamp is this genie hidden? Is it hidden now in the pockets of some merchant?”(3)

The tension present in Silva’s essay between Miskitu notions of community and the perception that economic and social changes threaten it has been a major preoccupation of regional authorities and community members alike. Miskitu community organization and structure are considered an integral part of their indigenous culture. The indigenous community is considered the locus of cultural preservation and transmission. Moreover, within the autonomy regime and the granting and implementation of indigenous rights, the community has a central role as a territorial and social unit. Social services, development programs and all other

government and NGO work with indigenous peoples are dependant on notions of community. The ideal or "traditional" Miskitu notion of community as Adan Silva Mercado has attempted to describe is still found to a great extent in Miskitu communities. During my period of fieldwork I observed many of the elements that he describes in his essay. However, as will be presented in this chapter, the current social and economic situation in the region gives rise to many contradictions within Miskitu communities.

In the implementation of health programs the notion of community and community participation has been very influential and a central organizing principle. This is more evident in health programs that deal with indigenous people, where community is considered a central element in their culture. In the RAAN the contradictions generated by the confrontation between local conceptions of community and the economic and social context, affect the way that both Miskitu and PSILN staff come to understand the goals of the program and their relationship with each other. Health programs such as the PSILN rely on notions of community that stress community solidarity and the fusion of interests in order to carry out their programs successfully. However they have to contend with conditions that foment community fractures which lead to frustrations. On the part of the community, there are expectations as to the contribution and role that these programs will have in the community but they have to contend with administrative practices that are at odds with Miskitu conceptions of community and development programs. However community fractures and the actions of individuals themselves go against the community standards to which they hold programs accountable for. In essence the concept of community is shared by both the program and the members of the community themselves, but the way that each acts circumvents the community expectations for which they hold each other accountable.

Taken together with the previous chapter, the exposition and analysis of community organization presented in this chapter elucidate why the organizational aspects of the Health Model within communities is viewed with skepticism and is not as widely accepted as discussions surrounding indigenous medicine.

7.1 COMMUNITY: FROM THE IDEAL TO THE PRACTICAL

7.1.1 Miskitu Community Contradictions in the Ethnographic Record

Miskitu conceptions of community are based on two interconnected bases. First, community is based on concrete and material connections between a group of individuals with a particular territory and its resources. No matter how ambiguously defined the boundaries of the territory that a community claims for itself, the use of the particular spaces claimed in building a house, planting crops, hunting, fishing, logging and other activities, provide a sense of ownership over a given territory. Even parts of lagoons and waterways and the resources contained in them are claimed by some communities as their own (Jamieson 2002: 289). Offen (2003) for example, argues that among the Miskitu the "idea of place brings together a cultural appraisal of the environment with a history of lived experiences in a way that constitutes the social processes of identity formation" (382). Among the Miskitu the community is their primary referent of identity. Being a member of a community grants the individual access to the resources contained within the communal territory which can serve either as the main source of livelihood or as a safety net when other economic ventures fail.

A second basis for Miskitu conceptions of community is the social relationships among the individuals who share a particular territory and derive their livelihood from the resources

contained therein. These relations are what Adan Silva was referring to as *asla laka* or community spirit. This "community spirit" is grounded in reciprocal material exchanges of labor (as in the case of *pana pana laka*[49]); gift-giving to extended kin, fictive-kin and friend networks; and in participating in activities that benefit the community as a whole. The communal spirit expressed in these exchanges is morally sanctioned by the importance and value of "generosity" among the Miskitu (Helms 1971; Dennis 2004; Nietchmann 1973, Jamieson 2003). Miskitu general reciprocity is important in the maintenance of community social relations, which achieves its most important and greater expression in the sharing of food (Nietchmann 1973: 182-188). In this sense Helms has argued that food sharing is "the institutionalized method for indicating mutual concern" (131). There is both an obligation to give (according to proximity in kin-relations) and also to receive, since refusal is considered a display of the negative trait of being "proud", which can be seen as a refusal of meaningful social relations between the parties involved. The behavior of individuals within the community is therefore evaluated by notions of "generosity"/"good" and notions of "proud"/"selfish"/"bad" which form part of Miskitu's moral economy (Jamieson 2003).

The two aspects of community presented above, are fused in the conceptions of community accepted and valued by the Miskitu and also by outside actors working in or with Miskitu communities, such as the regional government and health programs. Helms (1971: 132), for example, has argued that a sentiment of community aid and unity was a "point of village pride and of unity towards the outside" in the community of Asang. During my period of fieldwork similar community sentiments were often expressed in workshops, conversations and interviews. These notions of community have acquired added political importance with the

[49] Pana Pana Laka is a system of labor exchange through which kin exchange their labor in the fields during certain labor intensive periods in the agricultural cycle, such as clearing fields for planting.

recognition of communal rights in the Nicaraguan constitution and the Autonomy Law. From the vantage point of community rights, the resources contained within communal territory and communal social organization form the basis of Miskitu material livelihood, self-sufficiency and autonomy.

The conception of community presented above is an ideal that encounters many difficulties in practice. As was evidenced in the historical discussion of the region in Chapter 3, the Miskitu have had a long history of participation with outside actors and the market economy. Ethnographic works on the Miskitu have shown how these factors have affected the exchanges that form the basis of Miskitu "community spirit". In the 1960's both Nietchmann (1973) and Helms (1971) observed that the economic depression at the time made money difficult to obtain and individuals started selling subsistence products that would normally be given away as gifts in fulfilling social obligations[50]. This was observed to cause social conflicts between the individual or household who sold these products and those who would ordinary receive a share. In this sense Nietchmann (1973) argued that for the Miskitu:

> engagement with the market necessitates the accumulation of food and materials in quantities for selling, while at the same time somehow having enough to acknowledge traditional social relations and expectations. In Tasbapauni, a Miskito's livelihood strategy involves attempting to satisfy diametrically opposed goals with limited means (193).

In a recent work Kindblad (2001) analyzed this contradiction historically and ethnographically for a period of 140 years in the community of Tasbapauni, where Nietchmann also did his work. Kindblad follows the work of Parry and Bloch (1989) and analyzes economic

[50] Similar processes are observed in two very different ecological zones, with different subsistence products. Helms' (1971) case study takes place in a community on the Rio Coco. The subsistence products sold in the market were beans and meat from domestic animals. Nietchmann (1973) observes the process in a coastal community that extracts many of its resources from the sea. In this case turtle meat is the product exchanged which for these communities has a high social value in reciprocal exchanges.

activity among the Miskitu as the coexistence of two contradictory economic systems; short-term cycles and long-term cycles of exchange. Short-term cycles of exchange are based on the market economy and are associated with individual pursuits and competition. Long-term cycles of exchange on the other hand are based on gift-giving reciprocal relations and are associated with the reproduction of the social order. They reproduce the social order in the sense that the transaction is not merely economic is also symbolic. Kindblad shows that before 1960 these two "cycles of exchange" were isolated from each other because young men worked outside the community in foreign companies and the cash earned would be used to purchase goods that would circulate in reciprocal gift-giving exchanges. The resources extracted from communal land and marine resources circulated only within reciprocal long-term cycles of exchanges with all community members. In the case of Tasbapauni, when turtles became commercialized and foreign companies began purchasing them around the 1960s, turtle meat, an important product in reciprocal gift-exchanges, began being diverted to the market. The money obtained however, was not used to buy products that circulated in reciprocal exchanges but were used for the benefit of the individual and household and for accumulation. In the case of turtleing in Tasbapauni, with the added pressure of the decline in the turtle population because of overexploitation, fulfilling reciprocal exchange obligations and individual pursuits related to the market become difficult to realize as Niechsmann's quote above implies. Moreover, competition in extracting these resources caused the emergence of economic differences within the community.

Growing differentials in community members' economic well-being have strained community solidarity. Jamieson's (2002) work on artisanal sea-shrimp production in the coastal Miskitu community of Kababila is illustrative of how wealth differentials affect Miskitu perceptions of economic activity. Jamieson argues that local practices of sea-shrimp production

for the local market reinforce the image of a "limited good", which he argues is common among the Miskitu, in that economic and social upward mobility is realized at the expense of others. He shows how households that have the tools and property for the processing of sea-shrimp acquire a higher share of the profit from selling shrimp than those who participate in the activity but do not own the tools. Materials that would under other circumstances be lent to family and neighbors are rented, minimizing the economic benefit of those who do not own the "tools of production". This increases the accumulation of those who already had the tools while limiting the ability of those who do not to acquire them. Jamieson's work shows the importance of the accumulation of resources in achieving a higher economic position. However, as was stated before, the necessity of accumulating resources is incompatible with Miskitu notions of generosity and reciprocity and the meeting of social obligations. All economic transactions are therefore evaluated against Miskitu moral values. In this sense Jamieson (2003) asserts that:

> Individuals are…continually faced with choices offering them, on the one hand, societal approval and economic disadvantage or, on the other, economic advantage coupled with accusations that they are mean or proud (arrogant), that they do not study (take into account) their kin and fellow villagers (208).

These evaluations thus constitute a Miskitu moral economy. However, Jamieson (2003) rightly asserts that these moral judgments depend on context, as the point of reference can be the whole community, the extended kin-group, the household, or the individual. Disagreements in moral judgments related to an individual's behavior then arise out of the different points of reference of the various individual's involved.

As the previous discussion indicates Miskitu conceptions of community, based on sharing and reciprocal obligations are threatened by individual strategies for economic advancement Moral judgments about individual behavior are dependant on an individual's fulfillment of his

obligations to the community, his kin-group and his household. These obligations to different levels of social organization can come into conflict with one another. Most of the above studies however, concentrate on economic strategies based on the sale and distribution of natural resources. In the next section I want to concentrate on another economic strategy used by the Miskitu: participation in development programs and NGOs. The economic and material benefits derived from participation in such programs can increase an individual's economic status and help fulfill social obligations. However, access to these potential resources is linked to leadership positions within the community. The view that Miskitu have of development programs and NGOs, as we will see later on, affect their participation in health programs that try to implement aspects of the Health Model.

7.1.2 Economic Strategies, Community Leadership and Development:

In Puerto Cabezas a *mestizo* informant argued that "in the Coast if you want to *progresar* [advance] you have to either get into politics, or go to the sea and look for cocaine, or work for an NGO". In the communities similar assertions of economic opportunity exist. Martínez, from the community of Santa Marta, described the economic alternatives he saw in the Coast in the following terms: "to advance [economically], only cocaine or working for a [development] program". I heard similar assertions numerous times throughout my period of fieldwork. There seems to be consensus among many in the Atlantic Coast that these alternatives are the ones most likely to advance an individual's economic status. Of these three alternatives (politics, cocaine trade and working for an NGO), working for an NGO is the only one that is not associated with negative connotations. This highly desired alternative is one part of broader economic strategies adopted by individuals.

Subsistence agriculture still forms the basis of economic activities in Miskitu communities but there is a preference to engage in economic activities that generate cash income. Dodds (1998) for example, has demonstrated that when wage labor becomes available Miskitu household's planting diminishes considerably. I often heard complaints from older members of the community that "young people don't plant anymore, [they are] only interested [in] easy money". Dennis (2004:162-164) describes a similar complaint in Awastara, where "there has been a general decline in agricultural efforts" (163). A young Miskitu man in his late twenties from the community of Santa Marta argued, "working in the bush? That's hard work, you walk far, there in the Sun and with luck you get a *chelín* (a cent)". Subsistence agriculture still provides a large amount of Miskitu diet but selling crops planted in Miskitu communities does not produce enough cash income to cover all household expenses. Consequently there is a preference for activities that can generate more cash income than agriculture, whether as a supplement to agriculture or as a replacement for it.

Men tend to travel all throughout the Coast looking for sources of wage labor but this type of work, although highly valued, is not easily found. The activities that provide cash income vary widely between communities and the ecological zones in which communities are located. Miskitu communities located along the ocean coast have access to marine resources that can be easily converted into cash in the local market (such as shrimp, turtles and fish) which generate a higher economic return than agriculture (Jamieson 2002). There are also commercial companies that export lobster and hire Miskitu men as divers; this activity is relatively lucrative although very dangerous (Dodds 1998). In communities along the north coast of the RAAN cocaine floating in the sea after being dumped by trafficker boats also presents another economic opportunity that although heavily influenced by luck requires a certain amount of knowledge

about currents (Dennis 2003). These alternatives however are not available to all communities. In the communities of the northern savannah there is no access to highly valued marine resources. Moreover the soil is not fertile enough to meet both subsistence needs and the production of cash crops for the market. However, some men do travel to Puerto Cabezas to be hired as lobster divers. Small scale logging on the part of small groups of Miskitu men for sale in the Puerto Cabezas market provides a source of economic activity that is not as widely available in other coastal communities. One activity that is available throughout the RAAN is participation in development projects and NGOs who work in community development. This activity, as is also the case with wage labor, provides an assured source of income, even if for a short period of time, without being susceptible to the vagaries of the local market, to capital investment or transportation costs. All of the above mentioned activities are incorporated in individual strategies in the pursuit of cash income. For example, during six months that I worked in Santa Marta, Martínez worked in the following activities for which he received income: building a bridge on the road from Santa Marta to Auhya Pihni as part of a development project; logging with other men in the community to sell in the lumber market in Puerto Cabezas; building a house for a member of his extended family; and selling meat from game hunted in the community grounds. Most men in the communities had similar work histories.

Participating in development projects financed by the government (national or regional), by international government donors, or NGOs is highly desirable by individuals in the communities. Development projects provide the community with both communal and individual benefits. On the one hand, most projects' goals benefit all community members, such as the case with a road rehabilitation project financed and conducted by DANIDA, Denmark's international development agency. The community benefit derives from providing better access to

communities which facilitates, for example, the transportation of agricultural products for sale in the Puerto Cabezas market. On the other hand these projects rely on labor provided by the community and in some cases this benefits some individuals with cash income. The problem arises as to who gets these individual benefits when development projects are brought to a community. Development organizations deal directly with the community political structure and it is the community and those in leadership positions who decide who will provide this labor and thereby receive these individual rewards. For this reason leadership positions within a community have an important role in individual's economic strategies.

The political organization of communities is based on different positions institutionalized within the community. The most important position is that of *wihta*, or village headman. The *wihta* is known in Spanish as the *juez de mesta*, a name given by the Somoza government to the recognized leader of the community. The *wihtas* are the representative of the community with outside actors, especially the government. They are also responsible for settling local disputes, such as theft between community members. Communities also have two positions created during the Sandinista era, which work closely with the wihta. The *alcaldes*, also referred to as *el Segundo* (the second) in some communities, assumes the role of the *wihta* when they are not available and also help settle minor disputes. The *síndico* is responsible for administering and managing everything related to community natural resources. The *síndico* keeps community land titles (if they are available) and is responsible for collecting all money owed the community for the exploitation of its resources. During the Sandinista era, another organization was introduced, the *consejos de ancianos* (council of elders), composed of three community elders who perform an advisory role in the community and help the community reach decisions in all matters. These top leadership positions are filled through yearly elections in communal assemblies. Finally,

through government initiatives or programs, communities now have various commissions that are supposed to deal with specific problems in the community. There are for example, health commissions and drug prevention commissions, among others. These are composed of a president, secretary and in the case of the health commission a health leader. There are other members in communities who also have positions of influence such as the religious pastors and teachers. All development projects that take place in communal lands first consult with all or some of these political positions within the community. The creation of different positions and committees within communities is meant to increase participation. However, Dennis (2004: 236) suggests that the introduction of these different positions may have the effect of weakening community solidarity and effective organization because it is unclear who has authority. He further argues that during disputes an individual may try to circumvent the *wihta* and try to gain a more sympathetic ear with someone holding another position of authority in the community.

The main problem within a community's political organization is the confrontation of community obligations with extended kin obligations (Dennis 2004: 245-247). Most of Miskitu reciprocal obligations are associated with the extended kinship group where the obligation to share is at its strongest. These two expectations come into conflict in the positions of authority within the community, such as the *wihta* (judge or headman). *Wihtas* are supposed to maintain a position of neutrality and balance in community affairs while at the same time meeting obligations with their extended kin-group, which are given primacy. This causes conflicts between extended kin-groups, referred to in Miskitu as *kiamp*, for the control of these leadership positions. Moreover, the benefits associated with development projects and programs are channeled through these political positions. The following example from the community of Santa Marta will contextualize these tensions within Miskitu communities.

The community of Santa Marta, as with most Miskitu communities is composed of a few interrelated *kiamps* (extended kin-groups). In Santa Marta the most numerous and powerful of these extended *kiamps* are the Campbells and the Kramers. The division between these two *kiamps* has been along religious lines, the Campbells attaining leadership positions in the Moravian congregation and the Kramers within the Catholic congregation. The Campbell *kiamp* dominated community politics primarily because members of its extended *kiamp* had more economic resources. This was partly the result of remittances from family members, one of whom worked in the United States and another who worked on a Caribbean cruise ship. With the money from these remittances the elder Campbell had been able to buy a bus that traveled daily from Santa Marta to Puerto Cabezas, operated by one of his sons. Moreover other members of the Campbell *kiamp* owned the largest community stores in the community, and food services for travelers traversing the road from Puerto Cabezas to Waspam. At the time of my field research and three years prior, the position of *wihta* had been filled by two members of the Campbell *kiamp*.

Members of the Kramer family along with others families within the community accused the *wihta* of corruption, and furthermore accused her of benefiting only her *kiamp* through the economic and development activities carried out in the community. These complaints where widely circulated in December of 2003. The community had given a small scale logging concession to a presently defunct Nicaraguan company named Amerinica. In December 2003 the community decided to hold all of Amerinica's equipment in the community as ransom for lack of payment by the company. The need for cash for Christmas provoked the community's response. The company was forced to pay what was owed to the community but the distribution of the

money among community households brought to the fore the cleavages in the community[51]. The complaints followed two lines. The first complaint was centered on the fact that most of the individuals who worked with the company to extract the logs were part of the *wihta*'s *kiamp*. These men received their portion as members of a household plus an extra portion of the money for having worked in the project. The second cause of protest among the Kramer *kiamp* was over the way household was defined. They for example protested that Thomson, the former *wihta*, would receive the portion of a household when he lived in his mother's house and did not have a wife and kids to support. One member of the community expressed her discontent as followed: "that *wihta* is bad, how can Thomson receive the same as a family of six? I'll tell you, he is her (the wihta's) nephew and she is not in control, he is".

I heard similar protests after the implementation of a latrine project by FISE (Fondo de Inversión Social de Emergencia). The latrines had been secured a year before when Thomson was the *wihta*. It is the responsibility of the community leaders to identify the households where there is the greatest need. FISE simply comes into the community and builds the latrines in the locale that community authorities indicate. In this case protests were leveled against the former *wihta*, Thomson, for placing one of the latrines behind the house of the current *wihta*. More interesting still the latrine was placed next to a latrine that was still functional. The reason given by those opposed to this location was that she "wants it to attract people to her *comideria* (restaurant)".

[51] The practice of redistributing income from the exploitation of resources by a community to households is worrisome for regional government officials and those working in the development community. Income from resource exploitation is supposed to go to community wide projects and development. When I recounted this event to a regional official her response was that this "violates the spirit behind the laws that guarantee economic benefits for the communities in the exploitation of resources". Moreover, she said that in the Regional Council they were working on laws that did not allow these practices to continue.

The community conflicts displayed in the community of Santa Marta are not unique. I heard similar complaints and stories from members of other communities of the northern savannah. Dennis (2004:245-247) has also described similar processes in Awastara. There is a generalized distrust of people in positions of authority. As someone in Santa Marta remarked, "people don't think about the community anymore, it's all for themselves". It is acknowledged that assuming positions of leadership and authority is a way for an individual to gain access to resources and money, and in the process to fulfill social obligations with his extended kin-group through distribution of the resources gained.

The use of community positions for personal gain, and the individual benefits that some development projects offer have a detrimental effect on community solidarity and the ability for members of a community to work together. Not all projects have individual benefits. Many projects in communities only contribute materials and resources for communities to work with for the good of the community. These projects, like the PSILN that is recounted in the next section, are limited by a community wide perception that all development projects have plenty of money and should therefore remunerate individuals who contribute. This however is not the case for all communities. There are communities where communal work is mandatory and all able-bodied members must participate, such has been the case for the community of Sagni Laya. In other communities such as Butku, active individuals are able to mobilize the community for communal tasks. However, for the most part participation in leadership positions in the community is understood by individuals as a viable economic strategy that allows individuals to gain access to resources from development activities on the part of programs and NGOs in the community.

7.2 MISKITU NOTIONS OF COMMUNITY AND THE PSILN

The CBA (2003) carried out a community diagnostic in 2003 before I arrived at the in Santa Marta. In the diagnostic the community identified the resources and services available in the community, and then proposed a development plan based on what they wanted to achieve in all areas, including health, education and resource management among others. In the area related to health the PSILN was not mentioned as a resource. Interestingly enough, the PSILN clinic was briefly mentioned as "the community also has a semi-private clinic". This is odd when one considers that the clinic provides doctors on site, a truck that functions as an ambulance during medical emergencies, medicines that are not available without cost from MINSA and workshops for members of the community that are designed to increase community capacity. In this section I outline why the PSILN is not considered a community resource or part of the community.

The PSILN has encountered numerous difficulties in its implementation in the community of Santa Marta where it has its base of operations. The main difficulties that the program has encountered are associated with administrative guidelines and the practices of some of the PSILN staff that do not conform to Miskitu notions of community. The main reason for this is not that many of the staff comes from outside the community. The Miskitu are generally very open to outsiders when they are willing to participate and act as part of the community (Helms 1971: 18; Dennis 2004: 84). In analyzing the complaints and praises on some of the PSILN staff and their categorization as "good" or "bad" a picture emerges that conforms to Miskitu notions of community and reciprocal relations. At the same time community divisions are discouraging to the staff of the PSILN. In many ways neither group (community members or program staff) conforms to the expectations created by prevailing conceptions of community.

7.2.1 Religion, *Kiamps* and the PSILN

The PSILN encountered problems from the beginning stages of its implementation. These problems derived from the program's association with the Catholic Church. A large proportion of the Santa Marta population is Catholic but the community also contains a Moravian Church, the members of which are among the most influential people in the community. The first problem encountered was the location of the clinic. The present site of the clinic is next to the Catholic Church. The choice for this location was practical, in that the church had already built a small compound with a kitchen and dining hall and buildings that could serve as classrooms. Community members wanted the clinic in a different location, one that would be more "central". The proximity of the clinic to the church made it part of "the Catholic Church's grounds" and in many community members minds the clinic was therefore not part of the community but part of the Church. The coordinator of the PSILN, Dr. Blandón, explained this initial problem in the following way:

> Here in the Atlantic Coast region, we know that historically, in terms of religion the ones that were always here were the Moravians. Then came the Catholic Church eighty years ago, so it is a Church that is relatively new. Here in Santa Marta this is felt. It feels like people of the Moravian congregation…have jealousy toward the program, toward the things that the Catholic Church has done. Because this entire infrastructure and all of these things, have been realized through the Catholic Church. This division is still felt despite the fact that we have told them numerous times that this has been sponsored by the Catholic Church but this is a service for all the people, without looking at people's color, race or religion.

Dr. Blandón interprets the problem as deriving from the historical importance of the Moravian Church in the Coast. Although this is partly true, the problem between certain sectors of the community and the clinic are related to the conflict between the two main *kiamps* that dominate Santa Marta politics. As was mentioned before, the Campbell *kiamp,* which dominated community politics, was strongly linked with the Moravian Church, while the Kramer *kiamp* was

heavily associated with the Catholic Church. The association of the program with the Catholic Church immediately situated the PSILN within one of the major divisions of Santa Marta. Religious organizations in the Coast have been important in improving the material and social well-being of Miskitu in the coast (Hale 1994; Smutko 1996). Although most communal development projects are done for the benefit of the whole community, the implementation of such programs is carried out by members of the congregation of the church sponsoring them. Members of the Kramer *kiamp* did not control the PSILN, but its association with the Catholic Church had benefited members of the *kiamp*. For example, some members of the Kramer *kiamp* had obtained jobs with the clinic, such as the driver. Moreover, before the clinic was established in Santa Marta, members of the Kramer *kiamp* had traveled to the United States sponsored by Catholic priests. Most of the complaints against the PSILN came from the Campbell *kiamp*. The difficulty experienced by the clinic with the community derived from the fact that the Campbell *kiamp* controlled the community's political organization and the PSILN had to channel all its dealings with the community through a sector of the community whose stance was distrustful because of perceived lack of control. The clinic was therefore not considered to be part of the community by one of the most powerful sectors within the community.

7.2.2 Private Clinic vs. Sustainable Community Program

The PSILN is conceived as a sustainable project. The program has been financed by the Catholic Church through CARITAS-Nicaragua. The sustainability component of the project is based on two main elements: the selling of medicines and an initial "contribution" from patients the first time they seek services at the clinic. The clinic pharmacy contains medicines that are categorized depending on the source. There are medicines provided by MINSA; medicines

donated by international organizations and medical brigades[52]; and medicines bought by the program through special arrangements with pharmaceutical distributors. The medicines provided by MINSA and those donated by international aid organizations are provided free of charge. The medicines that are bought by the program are sold to patients. These medicines have two main purposes. First, they are meant to supply medicines that MINSA does not provide. And secondly, they supplement the medicines provided by MINSA whose quantity is never enough to cover the demand in the communities. The program buys medicines at discounted prices on account of their non-profit status and special arrangements. The costs of the medicines sold by the program are on average three times lower than their cost in Puerto Cabezas. The money derived from selling these medicines is used to buy more medicines and therefore sustain the pharmacy without need for further outside financing.

The second aspect of program sustainability is the charging of five córdobas ($0.33 USD in 2003) to patients the first time they visit the clinic in order to create their medical file. Dr. Blandón explained this payment as follows:

> The first time they come here they only pay five córdobas, which is only a *symbolic payment*. It obviously does not cover the costs of the program. The idea is to introduce the concept of sustainability to community members…we want them to see that this money is really for them, to maintain this service within the community (emphasis added)

The money obtained through this payment is saved in a bank account, to create a fund on which the program will be able to run in the future with reduced or minimal outside aid. As Pedro, the PSILN administrator phrased it:

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[52] Different groups of medical doctors and other medical personnel visit the coast on medical humanitarian missions at various times a year. They are referred to in the region as medical brigades. They bring medicines that are given out during medical consultations by the members of the brigades. The medicines that are left over after the brigades leave are donated to local health facilities.

> People have to understand that organizations do not have unlimited amounts of money to fund the clinic indefinitely. The intention of the program is for it to be able to survive when the Catholic Church that funds it decides to go.

The "symbolic payment" that Dr. Blandón saw as a symbol of sustainability was understood by community members very differently. The Miskitu saw this payment and the payment for medicines as a symbol of private ownership. Almost all the people I interviewed in the communities, including those who worked with the program as health leaders and health auxiliaries, saw the program either as a "private" or "semi-private" clinic. The following quote by the health leader of Il Tara, is illustrative of this sentiment:

> The program helps a lot. But it is a private [clinic]. You need money to buy medicines and pay to get seen [by the doctor]. People are poor, five [córdobas] is a lot for some. The first time I went I was surprised when they asked me to pay, I though it was a program of aid. But it helps, having a doctor close to the community.

This quote shows the ambiguous feelings of community members toward the PSILN. During my period of fieldwork some patients attending the clinic for the first time acted surprised and complained vociferously against the initial payment, which was waived on more than a few occasions. On the one hand the clinic provides services that are important to the population. On the other hand, payment for services conflicts with prevailing conceptions of the way development programs should work. This ambivalence is also a product of the activities of the program. The outreach to community members through training sessions, workshops and meetings are consistent with development projects that are understood as benefiting the community. And yet payment of any kind conflicts with the idea of community ownership of the project.

The lack of control over the program felt by members of the communities also enforces the view of the program as "private". The program had envisioned the creation of what it called *botiquínes communitarios*, a community medicine cabinet. The idea is that in communities with

no health post, basic medicines could be provided and sold in the community at lower prices. These *botiquínes* would be administered by community health leaders and the health commissions. This component is conceived under the same principles as the clinic pharmacy; the money obtained from selling medicines would be used to replenish the *botiquínes*' contents. This component of the PSILN had not been implemented yet, but members of the different communities continuously brought it up. In workshops the question was often heard at some point "when are we going to receive the *botiquines*?". The *botiquines,* although functioning under similar principles than the clinic, was understood in very different terms. The health leader of Te Kiamp argued that: the *botiquines* "would be an important resource of the community". The clinic however was not understood in the same terms.

Another element of the program that served to create the boundaries between the community and the clinic in Santa Marta where the program is based. One of them is a fence in front of the clinic. The fence has the practical purpose of keeping out animals, such as cows that are left to roam freely throughout the community. In Miskitu communities fences are rarely used to demarcate the boundaries of one house and the next. Trees mark these boundaries. Moreover, people routinely walk on other people's "property" to get from one place in the community to another. A community member commented to me: "that's of the Catholic Church, they have all that area closed off, you can't even get close to it without permission". Although this comment was clearly an exaggeration, it demonstrates some of the views held by community members.

7.2.3 Judging "Good" and "Bad" PSILN Staff members:

The staff of the PSILN was not exempt from constant evaluations and moral judgments of their behavior. These moral judgments coincide with Miskitu understandings about

community and social relationships. They were judged on how well their behavior coincided with the values of "generosity" and "reciprocity" that still form the basis of Miskitu social relationships. During my research in the community of Santa Marta I continuously heard people refer to staff members as "good" or "bad". The acceptance of the PSILN, or lack of it, was in large part dependant on community members' interactions with individual members of the staff.

The main focus of moral judgments about the clinic staff is related to their amount of interaction with the community. The program provided accommodations for clinic staff members from outside the community in a small Church rectory behind the clinic. Only Dr. Blandón and Nurse Delia lived there. The rest of the staff had moved out into the community and rented houses available from community members. This served as a main component in the staff's interactions with community members. Complaints were leveled at Dr. Blandón and Nurse Delia based on their lack of interaction with the rest of the community. A community member for example argued:

> That *doctora* [Dr. Blandón] and that Delia, they're bad! They never leave the clinic, you never see them walking around or talking to people. Unless you go to the clinic you never see them except when they are leaving in the [clinic] truck and then they act all proud not even looking out the window. Why do they come and work here? They must be paying them well.

This quote is interesting in two respects. The accusation of being "proud" is commonly used to refer to community members who fail to fulfill their social obligations of gift giving, or when there is a refusal to accept a gift. Both instances are considered a denial that a meaningful social relationship exists. In addition there is also the assertion that they are "paying them well", which places their relationship with the community in utilitarian terms. Although money is increasingly being used to fulfill social obligations, the exchange of money for the most part still lacks the symbolic value of other types of exchanges such as food exchanges. The assertion that "they

must pay them well" therefore places Delia and Dr. Blandón outside meaningful community social relations.

Attitudes toward other members of the staff provide a startling contrast. Dr. Alvarado was doing his year of social service. He was widely accepted and liked throughout the community. A community member said:

> Alvarado is a good person. He is always walking around talking to people and you can go to him and ask him about any health problem whenever you see him. He never tells you to wait until the clinic opens.

An interesting part of the quote above is that Dr. Alvarado would listen to people's medical problems outside the clinic. The fact that he took the time was highly appreciated by individuals in the community, even if he ended telling them that they would need to go to the clinic so that he would be able to treat them. He was constantly being compared to Dr. Blandón who would only listen to people's problems when she was on duty at the clinic. Dr. Blandón's actions of regimenting her relationship with patients through clinic hours served to create an impersonal boundary in her interactions. Dr. Alvarado's actions on the other hand blurred the lines of the professional services he was providing. Dr. Alvarado mingled with community members and went to community activities and parties. He would also go to the stores at night sometimes and talk to people. People therefore saw their relationship with him as being meaningful. This was further demonstrated through gifts of fruit, plantains and other locally grown products that community members would bring to his house occasionally. The difference between community members' views of Dr. Alvarado as compared to Dr. Blandón highlights the difference in the relationship that the community itself had with both individuals.

The acceptance or criticism of the program staff was not related to ethnicity or the regional origin of individuals. Community members instead judged an individual's attitude

toward Miskitu ways. One interesting example involves Daniel, the clinic's laboratory technician. Daniel comes from the mining sector of the RAAN and identifies himself as *mestizo*. Many community members believed him to be a Miskitu who was renouncing his "people", which was an attitude that was condemned by members of the community. As noted by one of the members of the Santa Marta elders council,

> He acts dumb as if he didn't understand [Miskitu]. He knows. He is acting proud. He is Miskitu. He does not try [to speak Miskitu] because he knows. Alvarado is not Miskitu but he tries to speak Miskitu.

This demonstrates the importance of displaying an attitude that accepts important aspects of Miskitu identity, such as language. The comparison to Alvarado again is interesting. It was not important that Alvarado did not speak Miskitu, what was important was the fact that he tried, something I heard numerous times. For Miskitu this demonstrated a willingness to accept important elements of Miskitu identity. Daniel originally from the Coast and not even attempting was interpreted as a rejection of Miskitu identity and culture and furthermore was understood as an assertion of Miskitu inferiority toward a *mestizo* identity. The acceptance of Miskitu conceptions of illness and medicine also served as an important measure of the staff's attitude toward the Miskitu. This is discussed in detail in Chapter Six.

Moral judgments on the behavior and attitudes of the individuals that formed the PSILN's staff affected the way community members came to relate to the program. As the previous discussion demonstrates these judgments are related to how close an individual's behavior conforms to the Miskitu code of conduct that forms the basis of their concept of community. The fact that the two members of the staff with the most authority were widely perceived as denying a meaningful relation with the community was one source of constant tension. Dr. Blandón and Nurse Delia's responsibility of enforcing administrative rules formed

part of these perceptions. Enforcing administrative rules that do not conform to Miskitu notions of meaningful social relations unwittingly served to demarcate a boundary between clinic and community. In addition, these judgments are not based only on notions of community that had Santa Marta as a referent, but also in wider notions of community that used the Miskitu as a whole as a referent.

7.3 COMMUNITY HEALTH INITIATIVES: RECOGNITION AND ECONOMIC OPPORTUNITY

The most frustrating aspects of the PSILN's work for its staff is organizing and training "community agents": the birth-attendants, members of the health commission, and community health leaders. As the term implies community agents are supposed to conform to notions that view individual's work as a selfless service given for the good and benefit of the community. The idea of community development and the training of "community agents" are based on the same notion by community members for judging the PSILN and its staff. However, the actions of these "community agents" do not conform to this understanding of community. In this section I argue that participation in the PSILN forms part of individual's personal economic strategies. This in part conforms to the community fractions that have been discussed in this chapter. Community agents' views conform to prevailing Miskitu perceptions of development programs and the opportunities presented by holding leadership positions.

In the previous chapter (page 208) I quoted Pedro's comment during a discussion about the Health Model in which he argued that organizing community health commissions is difficult

because it is not a structure that is part of the community. He also mentioned that people want incentives to participate. On this point Dr. Blandón commented:

> These people are not very interested in being trained, they do not see the importance or the point, maybe one or two put an effort in the workshops that we give them, but I think that they are more interested in being given a backpack, a rain coat, and that you give them something to eat.

Nurse Delia provided an equally bleak assessment of community organization:

> For them community organization is something foreign, something that did not exist in communities. Meaning they are not used to organizing themselves. When you go to a community and speak to people, they are always thinking of a monetary incentive. [They tell you] that you have to pay them, and they do not view it as something voluntary, as something *comunitario* [for the community], as something that they must do themselves.

Even though some community members view organizing as important and as part of a service to the community the way some of them behave or view their participation in the program closely corresponds to the perceptions of the PSILN's staff. In a workshop for health leaders about the Health Model, Don Simon, the health leader from Santa Marta, commented that there should be incentives for participating in the program. The incentives he mentioned were formal recognition and material incentives. Here are two of his comments to that effect:

> I think that they should give us an identity card as health leaders because if one goes to speak with any of those *instancias* there in that structure [of the Health Model] and for some other things, they ask you for some type of identification, to know that you represent the community.
>
> Another problem is that health leaders should be recognized with some type of salary or something because for my part, I miss work by coming to the workshops, and I imagine that others have similar problems [as well].

These two comments or suggestions, as we will see, are intimately related. They are related to the community contradictions experienced by the Miskitu between their role as members of a community and their pursuits as individuals. Before delving deeper into this

connection however, it is important to understand the context in which the appeal for recognition through an identity card was made.

The comment on the need for identity cards for health leaders was followed by the recounting of an incident that had occurred the previous month. Members of MINSA from Puerto Cabezas conducted a workshop for health leaders in the school building of Santa Marta. They gave their workshop to people who were not the health leaders with whom the PSILN was working. The health leaders in the program wanted to understand why the people from MINSA had not consulted with the people from the program to ascertain who the health leaders in the community were. The health leader from Auhya Pihni, Dona Dina, for example, argued that "this causes confusion in the community as to who the leader is". The health leader for Kwakwil, Don Martín, for his part, asked the head nurse of the project, Delia, why the program had not given MINSA a list of the health leaders of the communities.

The staff of the program, mainly Pedro and Delia, tried to allay the health leaders' concerns through various arguments. On the specific issue of the MINSA workshop, Pedro argued that the incident was a problem of coordination between the MINSA people and the program. He himself had found out about the workshop through the radio. He told them that the MINSA and the PSILN had signed an agreement and therefore knew that the program was working with community health leaders, so they should have contacted them. This lack of coordination certainly has an effect on how the Health Model is implemented. Pedro also pointed out that the responsibility was also on community leaders. They knew who the health leaders working in the program were, and therefore they should make sure to send those leaders to any workshops no matter who was giving them. All leaders agreed that formal recognition through either identity cards or a certificate was needed to cement their position as health leaders. This

seems to exemplify Pedro's previous point, that the communal structures of the Health Model are not part of a community's structure. It also points to some of the problems within communal organization. The health leaders who participate in the PSILN have made a commitment that lasts various years. However, the leadership of the community has the potential of changing every year when new community authorities are elected by community members. For this reason the health leader and other community authorities may in fact be at odds with each other if they are from different extended kin-groups that are at the center of community politics and cleavages. Since every activity in and for the community is channeled through the *wihtas*, they may circumvent the health leader of the program by choosing someone else within their kin network, and thereby channel the potential individual benefits that participation in any workshop or program may have to that individual. The issue of recognition interestingly enough is then not only for outside actors but also to cement the health leaders' position within their own community as well.

Delia explained the process and problems with identity cards and certificates. When the program started under the coordination of Dr. Salas, the PSILN had made an agreement with the president of the Health Commission at the time that identity cards would be given to the members of the community health commissions. However, according to Delia, no one had attended these meetings and after Dr. Salas' departure, the initiative had ended. It was the Health Commission of the Regional Council that was going to issue the identity cards, not the program because the program did not have enough funds to cover the costs. The program however did intend to recognize the work of health leaders with certificates of completion after a period of two to three years. The idea of the certificates was to recognize the knowledge that health leaders had gained through their attendance to workshops provided by the program, with the overall goal

that the communal structures that the program helped to create would be able to sustain themselves even in the absence of the program. Furthermore, the health leader could pass the knowledge to other members of the community who could potentially fill his role.

This was not the first time the issue of formal recognition had come up. During my research in the communities I heard these demands on numerous occasions. For example, four months before, in a workshop with these same health leaders the issue was discussed at length. That time it was the leader of the community of Te Kiamp, Jorge, who had brought up the issue. He asked when there would be a graduation and the awarding of certificates upon the completion of the workshops. Delia gave them the same reply recounted above, except that at that time she mentioned passing tests and the importance of attending the workshop or they would "fail" (*aplazar*) and would not be eligible to receive them.

The issue of formal recognition, whether through identity cards or certificates, seemed trivial to those working in the health program. The reason for this is that the understanding of community and an individual's role within a community are different from the views of the participants. After the workshop, for example, Delia commented to me: "I don't know why all the trouble with the certificates, their work within the community is not dependant on them". The assumption among health care workers is that members of a community have a communal ethic and that they are willing to work selflessly. This assumption is pervasive in many development projects that deal with community health. Understanding the demand for formal recognition requires an understanding of the motives that some of the health leaders have for participating. These motives are deeply connected to the contradictory demands of community and individuality in which the Miskitu are immersed. The two comments made by Don Simon presented above have to be understood in conjunction with one another. On the one hand there is

the demand for formal recognition, and on the other the appeal for some sort of material remuneration given the sacrifices, in terms of work, that some health leaders feel they have to make. The case of Jorge, from the community of Te Kiamp, who brought up the issue of the certificates in the workshop, is illustrative.

Jorge was only 29 years old when I met him, and yet he was both the *wihta* and the health leader of his community. He was also participating in a certificate program on HIV/AIDS being offered by IMTRADEC to community leaders and nurses. During the course of our interview he revealed that he hoped that his participation in these activities would help him secure a better financial future. He went on to say:

> Things are hard. We in the communities work very hard for the little we have. Poor, that is what we are poor. Sometimes we have trouble even having enough for meat. Before I could just go out and hunt but now even that is hard. I have to go farther and farther [to hunt]. That's why I study, with that certificate in HIV/AIDS and the other one from the program [as a health leader] I hope to be able to find some work. Maybe with an NGO or some other organization.

The certificate programs offered by university institutions such as IMTRADEC through URACCAN, and programs like PSILN, are not designed to certify individuals in order to enable them to get employment. Their rationale is to strengthen community capacity by giving communities access to the knowledge necessary to be autonomous and deal with outside institutions. It is not difficult to see how Jorge interpreted the certificate programs as bestowing on him some professional capacity. For example, the HIV/AIDS certificate was given by a university that does grant degrees necessary to get employment. Certificate programs also require those involved to study and sometimes to take exams or do some sort of research project. There is also the possibility of failing. All of these are elements associated with a course of study that does bestow a professional degree. This is not happening only in health; a friend working on a project on indigenous legal rights in communities at the time, the Lic. Wangki Cunningham,

observed a similar phenomenon with individuals who had received a certificate on Indigenous Rights from URACCAN.

Aware of the contradiction between the goals of these programs and Jorge's expectations of what they might provide for him, I asked him what would happen to his community responsibilities if he did find a job. He replied:

> If I find a job I'll take it. We in the communities have a *segundo* with the *wihta*. He can take over if I leave. I will still participate in the community when I am there and help out, but I have to think about my children. *Cultivar* [planting crops] can help me feed them, but what about their shoes, clothes? I have to look after my family and we in the community always have people who can step in.

Interestingly enough it is his status as a community leader, as a *wihta* and health leader, which provides him with the opportunity to be involved in these projects. These community leadership positions that are usually conceived as a service to the community are in fact potential sources of economic and social advancement. In the case of Jorge, he is willing to leave these positions once an opportunity presents itself and the position has served its purpose. If this were to occur the goals of the health initiatives would not be met because those with knowledge meant to benefit the community might in fact be looking to leave it. This is not to say that Jorge had no interest in serving the community, what I am arguing is that there are various motivations for participation in leadership positions and programs that need to be taken into account.

Jorge viewed his involvement in various programs as giving him recognition with outside actors that might provide him with employment. Formal recognition is not only obtained through certificate programs, it can also take very different forms. The case of Manuel, the health leader of the community of Tuara, provides a different strategy in using his formal recognition as a health leader. While Jorge saw his status as a health leader as giving him recognition from outside actors in order to get potential employment, Manuel used his status as a health leader in

order to get recognition among community members themselves and start his own entrepreneurial activities. Manuel went beyond the responsibilities of a health leader. He would go to Puerto Cabezas and buy medicines for the most common ailments in the communities, such as medicine for parasites and aspirin, to bring back to the communities where he would diagnose and then prescribe and sell his medicines. Manuel would sometimes enhance his authority by wearing a stethoscope and a lab coat. I first heard of Manuel's activities in a workshop for *auxiliares*. The *auxiliar* of Tuara brought it up with Delia during the workshop, he said:

> Manuel is going around with stethoscope and lab coat, please! Who does he think he is? Someone came to him with stomach pains and he diagnosed parasites with a stethoscope (laughs). People like to be checked with a stethoscope. They see you and quickly come to you and say check me out.

This quote attests to the implied authority that the stethoscope gave Manuel in the eyes of community members. This behavior is discouraged by the staff of the program. Delia quickly said that she would have to talk to him. Delia certainly had knowledge of Manuel's practices. In a previous workshop for health leaders, Manuel asked some questions regarding dosage of medicines during a discussion of gastrointestinal diseases. Delia quickly said to him:

> Remember we tell you the dosage so that you know, but remember that you are not supposed to be diagnosing and prescribing medicines. That is the job of the nurses [auxiliaries]. Your job is to help the nurses, help organize the community for health activities and provide basic information about healthy practices. Right, Manuel?

Manuel was keenly aware that his activities were frowned upon by the program's staff and that it could possibly even get him expelled. I never heard him discuss any of his activities in front of any of the program's staff. And it was not until I had broached the subject with him that I did hear him mentioning it to other health leaders. When I approached to interview him about the topic he seemed hesitant at first. He told me the basics of his activities but made certain to legitimize his actions. To this effect he said:

> I buy the medicines from Puerto [Cabezas] and sell them in the communities but I do not make much money from it. I provide a service to the communities because MINSA never has enough medicines. I like the workshops [provided by the program] because I can learn and help [people]. With what I pay for the trip I barely make a few *córdobas*. It helps me a little. But for poor people little helps.

Manuel saw his role as a health leader as being more broad than envisioned by the PSILN. In response to Delia's thinly veiled admonition (quoted above), Manuel had responded: "Yes, but if the nurse is not there, people come to me and I have to help. That's why we come [here] to learn in the workshops". Indeed community members did endorse Manuel's actions. I talked with the *wihta* of Tuara, and when asked about Manuel's work he responded:

> Our [health] leader helps us a lot. We have problems with the nurse who is never there, so Manuel helps the people. He knows [what he is doing]. He is not always there. He helps other communities [too]. But he helps more than the nurse.

The acceptance of Manuel's activities is perhaps related to a problem the community had with the *auxiliar*, which is not relevant to our present discussion. Nonetheless, the fact that he did not limit himself to bringing medicines to only Tuara, but also went to other communities, indicates that his actions are not solely motivated by fulfilling his role as health leader. As a health leader, people in the community trusted that Manuel had the requisite medical knowledge given his position. Manuel had other elements that enhanced his authority and reputation besides his participation in the workshops. He had learned basic medical knowledge during the war. However, he still links his authority with his participation in the workshops and his position as a health leader. The following quote is illustrative of this point:

> People know that I have knowledge. They come [to me] because I am the [health] leader, but they know I knew from before. I was a nurse in the war, you know? I was in Honduras and learned from the contras. They showed me to stop bleeding, work with [bullet] wounds, all of that. The workshops give me more knowledge but I already knew something. People know, and [also] know I work in the clinic [health program].

The last phrase in this quote is indicative of the authority that participating in the PSILN may confer. Between the lab coat, stethoscope, his position as health leader and people's knowledge that he "work[s] in the clinic", Manuel was able to present himself as a legitimate provider of health services to the members of his community and other communities. It is interesting to note that Manuel sold medicines just as the PSILN did, and yet his actions were viewed by community members as a resource in contrast to the work of the PSILN itself, which helped confer Manuel's authority in the first place.

The cases of Jorge and Manuel help illustrates why formal recognition is so important to those participating in the PSILN and those holding leadership positions or participating in development projects and programs. They also illustrate the problems that health programs face in their implementation. Individuals may be immersed within a community moral economy that values reciprocal relations and service to the community, but the political economic context in which they are immersed and community politics factor into their motives for participating in development projects and health programs. In the case presented here, participation in the PSILN formed part of individual economic strategies as the PSILN is reinterpreted within the context of community cleavages and conceptions of development programs.

7.4 COMMUNITY, CULTURE AND THE HEALTH MODEL

In international public health the concept of community has been at the center of programs and interventions that deal in primary health care or other services for the poor. The use of community in public health usually has taken the form of community participation which is meant to increase the health system's responsiveness to the needs of the target population. It is

also meant to empower communities. In the first chapter of this dissertation I reviewed literature that deals with “community participation”. These initiatives have been criticized as vertical politically motivated programs and mandates that have very little to do with real communities (Ugalde 1985; Morgan 1993). In some cases community interventions are criticized for “imagining” a community where none exists (Wayland and Crowder 2002). As has been mentioned before the case of the RAAN in Nicaragua is different. The concept of community has real meaning in Miskitu communities, where there are intimate ties between individuals and the territory they occupy. There are also tight links among the members of a community, which is composed of various extended kin-groups. Moreover, these relationships are cemented within a moral economy of reciprocity and exchange that in Miskitu is referred to as *asla laka* or community spirit. Miskitu communities also have legal recognition through the Nicaraguan constitution and the Autonomy Law. No matter how difficult defining the concept of community may be in the social science and public health literature (see Jewkes and Murcott 1996; Wayland and Crowder 2002; Willis 1977), most rural Miskitu communities will fit most if not all conceptions of community.

The main problem in the conceptions of community utilized in the RAAN, evidenced throughout this chapter, is a conception of community rooted in culture. Conceptions of community that rely on an ethic of reciprocity, selflessness and meaningful social relationships form the basic assumption in the planning and implementation of the PSILN and also of the community component of the Health Model as a whole. This conception of community is based on the importance that the community and Miskitu social organization have for the maintenance and preservation of Miskitu culture. The idea of a “communal spirit” as based in Miskitu social structure is in part a result of a conceptualization of “culture” as a bounded entity. The cultural

politics inherent in the development of the Health Model, with influences from international health policy, uses some of these static conceptions of culture. There is no doubt that it is imperative to adjust program implementation to indigenous cultural practices. The question then becomes how do we define what "indigenous culture" is. Based on the role of identity politics today the most accepted answer to this question would be that indigenous culture is what indigenous people themselves define as such. However, in the current climate of indigenous activism and cultural politics, attempts at defining indigenous cultural knowledge and practices may not necessarily yield a response that completely fits with the reality of lived experience. As has been mentioned throughout this dissertation, defining culture has serious political consequences. In the case of the RAAN one cannot attribute these conceptualizations of culture to local officials and activists. People in the communities are also adept at representing indigenous culture in very similar if not identical ways. I am not arguing that these representations of culture are deliberately manipulated, although this can be the case in some contexts. What I am arguing is that "culture" and cultural practices are conceptually separated from other mitigating factors of social life. For example, when I asked community members about their community organization and social relationships, the responses almost universally adhered to the idealized conception of community that has been presented in this chapter. It was not until more pointed questions were asked that individuals acknowledged the problems and contradictions in these definitions. Through decades of community development schemes and workshops, the Miskitu have become adept at the language and representations of "community" necessary to bring projects and resources to the community. Dennis (2004), who has done research in the region since the seventies, writing about development projects and workshops,

observed that “it is striking how little the format and content of such efforts have changed in twenty years”(251).

In order to ascertain how defining “culture” can have a definitive impact on health programs and policy perhaps it would be beneficial to look at attempts to revitalize indigenous medicine through its rescue from the past. In Nicaragua two of the best examples are the work of Avelino Cox (1998; 2003) and of Fagoth et al. (1998), which I have used in this dissertation. Both provide a good overview of Miskitu Cosmology and medicine. During my own fieldwork these books were invaluable in providing a good general background of Miskitu etiology of illnesses and medicinal practices. However, as works whose aim was both to revitalize and rescue indigenous cosmology and practices, many of the things contained in these books were not part of present day Miskitu practices. For example, I asked an informant about the practice of calling out an individual’s soul when it had been taken by a *liwa*. His response was as follows: “Yes, I remember it a little from one time when I was little, but now those things are lost, my father tells me stories about things like that, but you don’t see it anymore, maybe in the Rio Coco you might see it, they preserve our traditions much better than we do here”. I received similar responses when inquiring about the practices of *sukyas*. The mitigating factors of the repression of indigenous medical practices and Christianity scarcely have an impact on these accounts of Miskitu cosmology. The same can be said of Miskitu conceptions of community which are based on ideal conceptions of Miskitu morality, exchange and social relationships. These idealized conceptions of community ignore a long history of cultural, social and economic exchanges with other groups from outside the community[53]. When culture is invoked the focus seems to narrow

[53] See Chapter Three of this dissertation.

down to the bounded community. Moreover, it bypasses the current political and socio-economic context in the RAAN and the strategies that individuals pursue to gain their livelihood.

As the preceding analysis demonstrates, when looking at the difficulties of health programs it is important to move beyond these conceptions rooted in "culture" and look instead to the complex context in which individuals in Miskitu communities find themselves. Brodwin's (1997) concept of the "practical logic" of individuals and social groups in analyzing health programs is useful. As opposed to prevailing conceptions of culture, disentangling the "practical logic" of individuals helps understand how communities and individuals understand, transform and manipulate material and symbolic power in the local context. It forces us to investigate how local fields of power influence local decision-making and help explain the complex array of factors that affect health programs.

In this chapter I have discussed how Miskitu conceptions of community with associated expectations define the social interaction, expectations and views of community members and the PSILN staff. The expectations created by the concept of community, "asla laka" or communal spirit, functions in both directions in the interaction. For the PSILN staff and health practitioners and officials in general, the conception of reciprocal relations between groups of selfless individuals with a fusion of interests who value "generosity", guides the planning and implementation of health programs not only at the program level but at the level of health policy as contained in the Health Model. At the same time community members evaluate health programs and staff according to how their behavior conforms to their conception of community. However in this interaction both groups fall short of each other's expectations. The program fails when its administrative practices conflict with prevailing cultural conceptions of community.

Community leaders and members fail when the pursuit of their livelihoods and economic strategies conflict with behavior expected of them.

In the situation presented in this chapter individuals try to balance their community and social obligations with their own interests. They have to use all the means at their disposal, both material and symbolic in order to balance their position within multiple relationships that impose various degrees of obligation on the individual. As Jamieson (2003) has shown, moral judgments depend on context, as the point of reference can be the whole community, the extended kin-group, the household, or the individual. In the present day RAAN, cash represents the fastest means for socio-economic advancement and prestige. In an economy where the means to obtain cash and meeting social obligations are limited, individuals use all means at their disposal. Leadership positions and access to development projects have been re-signified as not only potential sources of cash income but also as avenues for meeting social obligations. Since these obligations are strongest for the household and the extended kin-group it is no surprise that community cleavages arise when positions that are supposed to benefit the whole community are used to fulfill obligations imposed by the social relationships that are given primacy. Participation in development programs and leadership positions are immersed within the logic of economic advancement. This is further reinforced by the beliefs that development projects have plenty of money, and that they are developed using indigenous people and indigenous rights to benefit non-indigenous people who work for the NGOs. The PSILN as well as other NGO programs that work with communities will inevitably fall within this “practical logic” and be interpreted within these community and individual dynamics.

There is no doubt that the analysis presented here is heavily influenced by the fact that the PSILN is an NGO. The question becomes, what does this tell us about the Health Model?

Although the interaction would no doubt be somewhat different if the work of the PSILN was administered by either the MINSA or regional authorities it would not be a stretch to say that these problems would persist. First it must be noted that for the present, given the precarious economic situation of Nicaragua in general and the RAAN in particular, NGOs will continue to be at the forefront of the implementation of parts of the Health Model[54] and will therefore have an impact on its implementation. Secondly, many of the elements implemented by the PSILN are derived directly from the initiatives of the Health Model. The development of "community agents" in health leaders and community health commissions is an integral part of the component of social participation and the extension of health services to poor rural communities. Internal community dynamics as has been presented in this chapter will continue to influence the participation of individuals in health related activities.

The analysis presented here along with that of the previous chapter demonstrates why the organizational structure of the health system as presented in the Health Model is a source of contention. At the root of these discussions and disagreements is access and control of economic resources and political power at different levels of social and political organization. At the level of RAAN-National relations, the contentious issue is control of the decision making process of policy formation and budgetary allocations in the health sector. At the level of the community and the individual the point of contention is who within the community will benefit from the resources that come from the community's relationship with outside actors, whether NGOs or other development organizations. And finally, there is the community's relation with government institutions. As was mentioned in Chapter Six many in the region believe that it is the government's responsibility to provide basic necessities and health care. Moreover, there is a

[54] See the comments of the Health Secretary of the RAAN quoted in page 156.

generalized lack of trust of politicians, government institutions (both regional and national), and those in positions of leadership more generally. Research in other contexts has indicated that individuals' perception of the commitment of the state in helping resolve their problems, affects their participation in health projects (Whiteford 1997; 2001). Communities' understanding of the Health Model is shaped by these perceptions. It is no wonder that when concepts of "social participation", "reciprocity in relations" and "shared responsibility" come to the fore, individuals in rural Miskitu communities wonder if the government is passing its responsibilities to them.

8.0 CONCLUSION: CULTURAL POLITICS OF HEALTH

In this dissertation I have presented a case study of the debates around and implementation of regional health system reform in the RAAN of Nicaragua to better understand the role and effects of identity politics and the use of "culture" in health. In Latin American anthropology and the social sciences more generally, there has been a debate on the effects of indigenous movements and cultural discourses in the transformation of Latin American policies, governments and states. In the simplest terms, the central question in these debates has centered on whether discourses based on cultural identity produce political transformations that reduce social inequalities or if they help maintain the status quo. The present work looks at these issues from within the realm of health reform and policy. Indeed a similar critique of the use of the concept of "culture" has been leveled by medical anthropologists from a political economic perspective. The argument is that an emphasis on cultural variables in health masks the role of political economy in the production of ill health. My aim in this dissertation has not been to answer the question posed by these debates but to provide an analysis of the mechanisms that may help answer the questions posed in the debates. In this case study I present an analysis of the process through which culture is used as a central element in health advocacy and how this focus on culture limits the debate and the formation and implementation of programs and policy.

Most of the critiques of the use of the concept of culture in health are focused on international organizations, such as the World Health Organization, and national governments.

The main argument is that when health inequalities converge with ethnic/cultural difference, culture serves as the most politically expedient explanation while social, economic and political inequalities which have a larger impact on health are either ignored or glossed over. Culture is reified and conceived as a static concept, as something that can be understood and used in the implementation of health programs. In the most extreme cases this uncritical use of culture leads to the "racialization" of health beliefs and institutional forms of racism (Lambert and Sevak 1996; Briggs and Briggs 2003). In terms of health programs, Foster (1999) has argued that the acceptance of a cultural model in international public health deflects failure from the agencies implementing policies and programs. Culture then becomes a scapegoat for the failure of public health programs, reproducing a "blaming the victim" explanation (Lambert and Sevak 1996).

The case presented throughout this dissertation is different from those presented in the above critiques of the use of culture in health. The attempt to transform the health system through the concept of culture does not emerge from international organizations or national governments. Instead, at least ideally, it arises from an oppositional indigenous discourse on the part of indigenous peoples and their advocates. According to indigenous movements' discourse, the appeals to health system reform emerge from the grassroots level. In the RAAN the use of the concept of culture in health is political. It attempts to transform the unequal structural relations which have marginalized indigenous peoples and ethnic minorities in the region. From the vantage point of medical anthropologists, with both a political economy perspective and an applied inclination, when "culture" becomes part of political interventions that deal with resources and structural change (even if at the communal level), a complex situation emerges that may transcend and overcome the context from which the critiques of the use of culture in health emerge (Santiago-Irizarry 2003; Shaw 2005; Singer 1995). Differences in health status

between populations of different ethnicities are then not explained by cultural difference though different beliefs and practices. Through political interventions when cultural/ethnic differences converge with health inequalities these are understood as a reflection of a differential distribution of resources and political power across ethnic populations within the state. The case of the advocacy by RAAN health officials and other members of civil society institutions and NGOs for the Health Model fit into this political view. The problem with political interventions in health is that they do not occur in isolation from wider social processes, discourses and institutions that may constrain and limit their strategies for political change.

The bases for the transformation of the relationship between indigenous groups and the state in the RAAN are discourses of cultural difference and indigenous rights. As such, they are based on a "politics of identity" that has been criticized by anthropologists for reproducing the same static and reified conceptions of culture that have been the center of critiques in the health literature described above (Taylor 1993; Hale 1997; Warren 1998, Warren and Jackson 2002). In this sense, the populations that are the focus of health policy and interventions may have a limited conception of "culture" similar to that of national and international health organizations. A way out of these difficulties in Latin America has been the discourse of *interculturalidad*. The concept of *interculturalidad* is meant to simultaneously represent both cultural difference and inter-connectedness. It attempts to encompass dynamic exchanges between individuals or groups with different cultural meanings and practices. At the same time the concept of *interculturalidad* is concerned with redressing inequalities based on ethnic relations as historically constituted in society.

Notwithstanding the potential of *interculturalidad* to overcome an uncritical understanding and use of culture, and the policies and political transformations that may arise

from this perspective, *interculturalidad* in theory and in practice are two very different things. The potential of *interculturalidad* depends on wider political processes. In health, similar potentially liberating concepts have been used as the basis of health advocacy, planning, and policy. “Community participation” and “democracy” are cases in point (Morgan 1993, Paley 2001). Community participation initiatives provided avenues for real political action but their success depended on the openness of governments and states to accept the political demands and consequences that these initiatives engendered (Donahue 1989; Green 1989; Morgan 1989; Paley 2001). Concepts such as these are broad and vague which makes them open to multiple interpretations, manipulations and degrees of control from various sectors of society. Therefore, the use of these terms can provide an illusion of agreement in the face of radically different interpretations and practice (Morgan 1993; see also Paley 2001). In essence these potentially liberating concepts on which health programs and policies for the poor and marginalized are based can be co-opted by governments in order to constrain concrete political change. In this dissertation I have argued that the same process of co-optation occurs for *interculturalidad* and intercultural health on which the Health Model of the RAAN is based. The question in this dissertation is how the use of “culture” allows for this co-optation to take place.

The discourse of *interculturalidad*, indigenous rights, and the institutionalization of cultural diversity within state institutions has come to be accepted in nearly all Latin American countries. However, openness to political participation is accompanied by limits on the political avenues through which indigenous and ethnic rights can be pursued. The political advances of indigenous groups and international support are dependant on a display of cultural difference and authenticity (Conklin 1997, Grahan 2002, Jackson 1995). This means that the pursuit of better conditions by indigenous groups is constrained to a discourse based on culture. These displays of

cultural difference are based on Western conceptions of how indigenous people should speak (Graham 2002) and behave (Conklin 1997).

The regimes of autonomy and the indigenous rights now recognized in the RAAN were possible because of recognition of the region's historical and cultural difference (Hooker 2005). Even if this recognition came after a prolonged conflict that threatened the legitimacy of the Sandinista government, it was impossible to reconcile the history of the RAAN with Nicaraguan constructions of the nation. However, concentrating on the discourse of cultural difference allowed the Sandinista government to provide concessions in its negotiations with RAAN leaders while placing limits on the issues for negotiation. As Hale (1994) has argued, autonomy was a Sandinista project that the population of the region was willing to accept with the hopes that it was a step to achieve all of their demands. By focusing on cultural difference, the Autonomy Law was clear in outlining a host of cultural rights while at the same time not articulating a clear process through which these rights could be exercised, and limiting areas that dealt with resources.

The Health Model of the RAAN is constrained by the wider processes discussed above. Both its development and advocacy for its implementation are part of the process of autonomy. As part of the autonomy process demands in the health sector are constrained within a cultural discourse. Moreover, part of the role of health advocates through the Health Model is to reproduce the cultural difference on which the process of autonomy is based. Although most of the components of the Health Model deal with policies related to the organization, financing and structure of the health system, the aspects that receive the most attention are cultural, especially those dealing with indigenous cosmology and medicine. These are the least developed aspects of the Health Model and appear in very general terms. The reason for the emphasis on these cultural

aspects is that the establishment of the RAAN's cultural difference legitimates all other claims made in the document. Nicaragua is the second poorest country in Latin America, and other administrative departments have economic and health problems as well. The leverage that health officials and advocates in the RAAN have for an arrangement of the health system that is different from other administrative departments in Nicaragua lies in two arguments. The first is that there is a cultural gap between the health system as organized by a westernized *mestizo* culture and the indigenous and Creole population served by the health system. Based on this argument the way to redress this situation is through a reorganization of health services by those who understand the culture of recipients, the people who live in the RAAN. The second argument is that historically Nicaragua has taken advantage of the resources and population of the RAAN based on racist notions of the inferiority of indigenous people and Afro-Nicaraguans. This has had negative cultural, social and economic consequences. Given that there are remnants of these historical inequalities in Nicaraguan society today, the way to address the situation is by giving the RAAN the economic resources and political power to make the decisions that define its future cultural and economic well-being. Stressing indigenous medicine or *interculturalidad* as the guiding principles of the Health Model is therefore a political symbol meant to legitimate these above arguments.

Interculturalidad and indigenous medicine however, are not only powerful symbols with which people in the RAAN try to advance their rights, they are also a political symbol for the national government as well. The discourse of *interculturalidad* is also accepted and used by the government. It helps propel the image of a Nicaragua that recognizes its multi-ethnic character and its inclusiveness. Such displays are important to governments at a time when international financial institutions and development organizations, such as the World Bank, have started to

pressure governments and reward approaches that take culture and multiculturalism into account (Gray 1998, Gardner and Lewis 2000)[55]. However, as I have argued throughout this dissertation, the understandings of what *interculturalidad* is, and what it entails, are very different among government officials when compared to the views of those of the RAAN.

Interculturalidad can be understood as a framework that deals with bridging cultural differences based on knowledge systems, values and practices; or it can be understood as a concept that understands cultural differences from the perspective of unequal power relations as historically constituted in society. As I have mentioned before, ideally, the concept of *interculturalidad* encompasses both. However the emphasis by governments tends to focus on the former. It therefore reproduces the conception of culture that has been critiqued in the beginning of this chapter. Culture becomes reified as something that needs to be understood and added to social policy. If the focus is only on culture as knowledge, values, meanings and practices, then major political and economic transformations are not viewed as necessary. These different views can be better appreciated when we think of the way the process of *interculturalidad* is understood in the Pacific of Nicaragua and the RAAN. In this dissertation I have used the models presented by Almaguer, Vargas and Garcia (2002) and Cunningham (2002) to explain these differences.

The Almaguer, Vargas and Garcia (2002) model for the process of *interculturalidad* is based on a notion of *interculturalidad* as a process of cross-cultural communication in which dialogue is the central component. The goal is to bridge cultural differences with the expectation that new insights will be gained in the process. For Cunningham (2002) however, *interculturalidad* is a process of political action in which self-determination and local control are

[55] See also UNDP (2004).

the central components. As I argued before, these two approaches are not mutually exclusive, but emphasis on one or the other can help determine the type of social and health policy being advocated.

The emphasis on culture has had other restrictive effects on the RAAN's attempt to institutionalize a fully functional autonomous government. Despite the various Nicaraguan governments' promotion of the multi-ethnic nation and indigenous rights, through the regimes of autonomy and the discourse of *interculturalidad*, the government has at every turn put stumbling blocks on the development of the autonomy regimes. This is in part related to the emphasis on culture. Social policy that deals with issues that are considered cultural are accepted and promoted but those that deal with real political power and economic resources are resisted (Hale 2005). Indeed, the small advances in the RAAN's government have been realized through international pressure, not from internal initiatives. From the beginning, the regimes of autonomy have been given the responsibility of RAAN affairs without providing the resources and political power to achieve its objectives. The result has been that a large part of the RAAN government's efforts have centered on negotiations with the central government for the transfer of resources and political decision-making power to the region. This emphasis on national-regional relations has alienated the population of the RAAN, the majority of which consider that the autonomous governments are of no use to them. This is in part due to regional officials' corruption as well, but from the very beginning the autonomous governments were set on a path to failure.

The health sector has suffered from the above limitations as well. The Autonomy Law states that the administration of the health system is the responsibility of the autonomous governments. However, the control of the budget and decision-making rests on the local SILAIS which responds directly to the Ministry of Health even if a relationship exists with the CRA.

This lack of control of the health system has limited the possibility of implementing the strategies and policies contained in the Health Model. The implementation of the Health Model has thus concentrated on its cultural aspects, with "intercultural exchanges" between doctors and indigenous healers, the incorporation of "cultural competence" among health workers through workshops and new education curricula, and other similar initiatives. These initiatives are important but they fail to address what people in indigenous communities view as their most pressing health needs. As the discussion in Chapter Six shows, although the cultural acceptance of indigenous cosmology, medicine and practices, were important to Miskitu community members, their major concerns centered on access to health resources, such as institutional medical care, medicines and health infrastructure. Acceptance of indigenous medicine was important to the Miskitu in that it validated their sense of identity and the work of those who resolved many of their health problems, indigenous healers. Indigenous medicine however was not a need but part of their everyday lives. Moreover their contact with the health system was mostly mediated through nurses, health *auxiliares* and health leaders who shared Miskitu cosmology and therefore minimized the cultural barrier of lack of acceptance of indigenous health knowledge.

The RAAN government's lack of control of the health system also makes the Health Model dependant on NGOs and other international development and aid organizations for implementation of various aspects of the model. The result is a lack of a unified institutional structure across the region. The Health Model, as of the time of my research, was implemented through a patchwork of different initiatives and programs. Although guided by similar principles they were not uniformly implemented. Reliance on NGOs also has the effect of relying on internationally accepted discourses of indigenous rights and indigenous health for the promotion

of the Health Model internationally. Here again indigenous medicine becomes a central component in the representation of the Health Model since there is a lot of interest in the preservation of indigenous medicine on the part of international audiences especially in Europe.

These two areas of emphasis in the implementation of the Health Model, national-regional negotiations and promotion to international audiences, again alienated the recipients of the policies proposed in the Health Model. Although an important component of the approach contained in the document is social participation in the communities where research was conducted, there was complete local ignorance that attempts at reforming the health system was underway. This included not only the people in the communities but the health personnel working in the health posts and those implementing health programs. The communities where research was conducted were on average 40 km from Puerto Cabezas and had fairly easy access compared with most other communities in the RAAN. It is interesting to look at how community members viewed the Health Model when it was presented to them. Similar to the discussions at the regional-national level, the cultural aspects of the Health Model were widely accepted and met with very few disagreements. However, its most substantive organizational and financial aspects were the source of disagreements and heated debates. This was especially the case in discussions that centered on community responsibility for the Health Model. Community members viewed policy propositions such as the contribution of a fixed percentage of acommunity's earnings from the exploitation of natural resources, as an initiative that passed the responsibility of health care from the government to the community. From the vantage point of Miskitu community members it is the responsibility of the government to provide adequate health care. Although many of the initiatives proposed in the document were attractive to members of the communities their lack of trust in both the regional and national government

made them skeptical about the possibility of the successful implementation of the Health Model. This is important to note because, as Whiteford (1997, 2001) has argued, individuals' perception of the commitment of the state to helping resolve their problems affects their participation in health projects.

I became interested in doing research on the Health Model of the RAAN and intercultural health after reading many optimistic assessments in the Latin American literature about the potential of indigenous movements of transforming the conditions of marginalization and poverty. As I read this literature I wondered what effects these discourses, movements and transformations would have in the health sector. The discourse of *interculturalidad* and intercultural health presented an approach that was attractive in that it placed cultural difference within its historical and political economic context. However, being familiar with anthropological critiques of international public health programs and the use of the concept of "culture" in health, I wondered if this approach really provided and alternative or if it was a concept that repackaged old formulas. From the discussion throughout this dissertation one is inclined to argue that the answer is the latter. However, before making this argument one has to keep in mind that indigenous movements and discourses of indigenous rights and cultural difference have had a positive impact on the current situation of indigenous groups in Latin America. Even if the results have not been as far reaching as expected, the constitutional and legal transformations in Latin America provide a point of departure and legal recognition from which indigenous groups and other ethnic minorities can advocate for their rights and social justice. In the RAAN this has been a slow and painful process given the sacrifices and blood spilled during the conflict that led up to this legal recognition.

That being said, as the case study presented in this dissertation demonstrates, attempts at health policy formation and health reform based on notions of culture are problematic and can limit the potential for substantive health political change. On the one hand, culture serves as an entry point for negotiations with national health authorities and can lead and be used for discussions of other important issues, such as lack of infrastructure and geographic and economic isolation, as the *grisi siknis* case study showed. When culture is placed as the central element in the agenda a refusal to enter negotiations or dialogue can be interpreted as racist and as a rejection of cultural diversity which has become an important component of human rights and government legitimacy. On the other hand, culture is open to multiple interpretations as to what it entails and its relationship with health. This allows government officials to engage in discussions about culture while limiting its potential effects on policy. In dealing with demands that take culture as the organizing principle, governments can place boundaries on political discourse.

APPENDIX A

ABBREVIATIONS AND ACRONYMS

ACARIC	Association of Clubs of Agricultural Workers of the Rio Coco. Organization created by Gregorio Smutko in the 1970s to facilitate Miskitu access to the agricultural market while shielding them from dependence on *mestizo* merchants. Out of the activities of this organization Miskitu political consciousness began to take shape.
ALPROMISU	Alliance for the Progress of the Miskitu and Sumu. Replaced ACARIC in the late 1970s and was lead by the Moravian Church. It pursued similar goals than ACARIC while disseminating a more politicized indigenous rights message.
AMC	Acción Medica Cristiana. NGO that carries out health development related activities in the RAAN.
CIDCA	Centro de Investigación y Documentación de la Costa Atlántica. Research and historical center of the Atlantic Coast.
CRA	Consejo Regional Autónomo. Legislative body of the autonomous regions. it is composed of 45 members per autonomous region and the Nacional Assembly representatives.
CRS	Consejo Regional de Salud. It is composed of representatives of all health related institutions in the RAAN and political authorities. It has an advisory role in the RAAN's regional health system by discussing and recommending health initiatives and policies.
FSLN	Frente Sandinista de Liberación Nacional

IMTRADEC	Instituto de Medicina Tradicional y Desarrollo Comunitario. The Institute of Tradicional Medicine and Community Development is part of URACCAN and does health related research, community health development and advocacy.
INDERA	Institute of Development of the Autonomous Regions. Created during the UNO government in 1990, it served as the central governments administrative structure in the autonomous regions, undermining the newly elected autonomous governments.
IWGIA	International Work Group of Indigenous Affairs
MINSA	Ministerio de Salud, Ministry of Health
MISURASATA	Miskitu, Sumu, Rama and Sandinistas Working Together. Indigenous - organization created after the Sandinista revolution to represent the interests of indigenous peoples in the Atlantic Coast. In the 1980s its political stance hardened and the organization took up arms against the Sandinista government.
NGO	Non Governmental Organization
OAS	Organization of American States
PAHO	Pan-American Health Organization
PHC	Primary Health Care
PSILN	Programa de Salud Integral del Llano Norte. Integral Health Program of the Northern Savannah. NGO funded by the Catholic Church which provides medical care and community development in the northern savannah.
SILAIS	Sistema Local de Atención Integral de Salud. Local Integral Health Care Systems The Ministry of Health's administrative structure at the Department and Regional level.
RAAN	Región Autónoma del Atlántico Norte
RAAS	Región Autónoma del Atlántico Sur
UNO	Unión Nacional Opositora. National Opposition Union. Coalition political party that defeated the FSLN in the 1990 elections.
URACCAN	Universidad de las Regiones Autónomas de la Costa Caribe Nicaragüense

YATAMA	Yapti Tasba Masrika nani Asla Takanka - Union of the Sons of the Mother Earth. Regional political party in the RAAN created by the leaders of MISURASATA after the autonomy regimes were created.
WHO	World Health Organization

BIBLIOGRAPHY

Acosta, Maria L.
1996 Los Derechos de las Comunidades y Pueblos Indígenas de la Costa Atlántica en la Constitución Política de Nicaragua y La Implementación del Estatuto de Autonomía en las Regiones Autónomas de la Costa Atlántica de Nicaragua. Agencia Canadiense para el Desarrollo Internacional.
1998 The State and Indigenous Lands in the Autonomous Regions of Nicaragua: The Case of the Mayagna Community of Awas Tingni. *In* The Challenge of Diversity: Indigenous Peoples and Reform of the State in Latin America. W. Assies, G. van der Haar, and A. Hoekema, eds. Pp. 261-274. Amsterdam: Thela Thesis.

Adams, Richard N.
1981 The Sandinistas and the Indians: The "Problem" of Indians in Nicaragua. Caribbean Review 10(1):23-25.

Adams, Vincanne
1998 Doctors for Democracy: Health Professionals in the Nepal Revolution. New York: Cambridge University Press.

Akerele, O.
1983 Which Way for Traditional Medicine? World Health (June):1-3.

Alberoni, Francesco
1984 Movement and Institution. New York: Colombia University Press.

Albo, Xavier
2002 Bolivia: From Indian and Campesino Leaders to Councilors and Parliamentary Deputies. *In* Multiculturalism in Latin America: Indigenous Rights, Diversity and Democracy. Rachel Sieder, ed. Pp. 74-102. Palgrave MacMillan.

Aleman Cunningham, Carlos
2001 Cultura Política en el Atlántico Norte. Managua: IEPA-URACCAN.

Allen, Matthew, Koichi Naka, and Hishizu Ishizy
2004 Attacked by the Gods or by Mental Illness? Hybridizing Mental and Spiritual Health in Okinawa. Mental Health, Religion and Culture 7(2): 83-107.

Almaguer, José, Vicente Vargas, and Hernán García
2002 El enfoque intercultural: Herramienta para apoyar la calidad de los servicios de salud. México: Secretaria de Salud de México.

Alvarez, Gerardo, Andrea Alvarez, and Marisol Facuse
2002 Discurso, Cultura, Salud: La Noción de Interculturalidad en Salud. Atenea (486):79-89.

Alvarez, Sonia E., Evelina Dagnino, and Arturo Escobar , eds.
1998 Cultures of Politics/Politics of Cultures: Re-visioning Latin American Social Movements. Boulder, CO: Westview Press.

Anaya, J. S.
1996 Native Nations Sign Historical Pact. Native Americas (Summer):43-46.

Anaya Muñoz, Alejandro
2004 Explaining the Politics of Recognition of Ethnic Diversity and Indigenous Peoples' Rights in Oaxaca, Mexico. Bulleting of Latin American Research 23(4):414-433.

Anderson, Benedict
1983 Imagined Communities: reflections on the Origin and Spread of Nationalism. New York: Verso.

Arnold, David
1993 Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India. Berkley, CA: University of California Press.

Assies, Willem J.
1994 Self-Determination and the "New Partnership": The Politics of Indigenous Peoples and the States. *In* Indigenous Peoples' Experience with Self-Government. W. Assies and A. Hoekema, eds. Pp. 31-72. Copenhagen: IWGIA and University of Amsterdam, IWGIA Document no. 76.
1998 Indigenous Peoples and Reform of the State in Latin America. *In* The Challenge of Diversity: Indigenous Peoples and Reform of the State in Latin America. W. Assies, G. van der Haar, and A. Hoekema, eds. Pp. 3-22. Amsterdam: Thela Thesis.

Assies, W. J. and A. J. Hoekema, eds.
1994 Indigenous Peoples' Experiences with Self-Government. Copenhagen: IWGIA University of Amsterdam.

Assies, Willem, Gemma van der Haar, and Andre Hoekema, eds.
1998 The Challenge of Diversity: Indigenous Peoples and Reform of the State in Latin America. Amsterdam: Thela Thesis.

Atkinson, Sarah
2002 Political Cultures, Health Systems and Health Policy. Social Science and Medicine 5(5):113-124.

Atkinson, Sarah, R. L. Rolim Madeiros, P. H. Lima Oliverira, and Ricardo Díaz de Almeida
2000 Going Down to the Local: Incorporating Social Organization, and Political Culture into Assessments of Decentralized Care. Social Science and Medicine 51: 619-636.

Aviles, Jeannette
1992 La Concesión Taiwanesa y los Sumos. *In* Persistencia Indígena en Nicaragua. German Romero, et al., eds. Pp. 197-232. Managua, Nicaragua: CIDCA-UCA.

Ayora-Diaz, Steffan I.
1998 Globalization, Rationality and Medicine: Local Medicine's Struggle for Recognition in Highland Chiapas, Mexico. Urban Anthropology 27(2):165-195.
2000 Imagining Authenticity in the Local Medicines of Chiapas, Mexico. Critique of Anthropology 20(2):173-190.
2002 Globalización, Conocimiento y Poder: Médicos Locales y sus Luchas por el Reconocimiento en Chiapas. México, D.F: Universidad Autónoma de Yucatán, Facultad de Ciencias Sociales, Plaza y Valdez Editores.

Banerji, Debabar
1999 A Fundamental Shift in the Approach to International Health by WHO, UNICEF, and the World Bank: Instances of the Practice of "Intellectual Fascism" and Totalitarianism in some Asian Countries. International Journal of Health Services 29(2):227-259.

Banes, Stephen G.
1999 Waimiri-Atroari Resistance in the Presence of an Indigenist Policy of "Resistance". Critique of Anthropology 19(3):211-226.

Baracco, Luciano
2005 Nicaragua: The Imagining of a Nation From Nineteenth-Century Liberals to Twentieth-Century Sandinistas. New York: Algora Publishing.

Barrett, Bruce
1993 Health Care Behavior on Nicaragua's Atlantic Coast. Social Science and Medicine 37(3):355-368.
1995 Ethnomedical Interactions: Health and Identity on Nicaragua's Atlantic Coast. Social Science and Medicine 40(12):1611-1621.
1996 Integrated Local Health Systems in Central America. Social Science and Medicine 43(1): 71-82.

Bastien, Joseph W.
1987 Cross-Cultural Communication Between Patients and Doctors in Bolivia. Social Science and Medicine 24(12):1109-1118.
1992 Drum and Stethoscope: Integrating Ethnomedicine and Biomedicine in Bolivia. Salt Lake City: University of Utah Press.

Bell, Charles N.
1989 Tangweera: Life and Adventures among Gentle Savages. Austin, TX: University of Texas Press.

Betancourth, Saida and Sandra Jaramillo
1997 Reforma del Sector Salud e Interculturalidad. *In* De la Protesta a la Propuesta: Memorias de los Talleres de Antropología Aplicada. Escuela de Antropología Aplicada, ed. Pp. 256-270. Quito, Ecuador: Universidad Politécnica Salesiana.

Bichmann, Wolfgang
1979 Primary Health Care and Traditional medicine-Considering the Background of Changing Health Care Concepts in Africa. Social Science and Medicine 13B:175-182.

Biderman, Jaime
1983 The Development of Capitalism in Nicaragua: A Political Economic History. Latin American Perspectives 10(1): 7-32.

Birn, Anne-Emanuelle, Sarah Zimmerman, and Richard Garfield
2000 To Decentralize or Not to Decentralize, Is That the Question? Nicaraguan Health Policy Under Structural Adjustment in the 1990s. International Journal of Health Services 30(1):111-128.

Bossert, Thomas
1995 Decentralization. *In* Health Policy and Systems Development. J. Janovsky, ed. Pp.147-160. Geneva: WHO.

Bossert, Thomas, Diana Bowser, and Leonor Corea
2001 Estudio de Descentralización del Sistema de Salud de Nicaragua: Informe Final. USAID, Facultad de Salud Publica de Harvard, International Health Systems Group.

Bossert, Thomas, Osvaldo Larranaga, and Fernando Ruiz Meir
2000 Decentralization of Health Systems in Latin America. Pan American Journal of Public Health 8(1-2):84-92.

Bourgois, Phillipe
1983 The Problematic of Nicaragua's Indigenous Minorities. *In* Nicaragua in Revolution. Tomas Walker, ed. New York.

Briggs, Charles L. and Carla Martini-Briggs
2003 Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare. University of California Press.

Brodwin, Paul E.
1997 Politics, Practical Logic, and Primary Health Care in Rural Haiti. Medical Anthropology Quarterly 11(1):69-88.

Brysk, Alison
2000 From Tribal Village to Global Village: Indian Rights and International Relations in Latin America. Stanford: Stanford University Press.

Butt, Leslie
2002 The Suffering Stranger: Medical Anthropology and International Morality. Medical Anthropology 2: 11-24.

Calla, Ricardo
1998 Indigenous Peoples, the Law of Popular Participation and Changes in Government: Bolivia, 1994-1998. *In* The Challenge of Diversity: Indigenous Peoples and Reform of the State in Latin America. W. Assies, Gemma van der Haar, and Andre Hoekema, eds. Pp. 77-96. Amsterdam: Thela Thesis.

Campos-Navarro, Roberto
1997 Curanderismo, Medicina Indígena y Proceso de Legalización. Nueva Antropología 16(52-53):67-87.

Caramés García, Mayte
2004 Proceso Socializador en Ciencias de la Salud. Caracterización y Critica. *In* Salud e Interculturalidad en América Latina : Perspectivas Antropológicas. G. Fernández Juárez, ed. Pp. 31-52. Quito, Ecuador: Abya Yala.

Castillo Cocom, Juan
2005 "It Was Simply Their Word": Yucatec Mayan PRInces in YucaPAN and the Politics of Respect. Critique of Anthropology 25(2):131-155.

Central American Historical Institute (CAHI)
1986 Nicaragua 1984: Human and Material Costs of the War. *In* Nicaragua: Unfinished Revolution. P. Rosset and J. Vandermeer, eds. New York: Grove press.

CIDCA, ed.
1987 Ethnic Groups and the Nation State: The Case of the Atlantic Coast in Nicaragua. Stockholm: University of Stockholm.

CIES and Jesus Reyes-Heroles, eds.
1987 El Futuro de la Medicina Tradicional en la Atención a la Salud de los Países Latinoamericanos. México, D.F.: CIESS.

Collier, George A. with Lowery Qaratiello, Elizabeth
1994 Basta! Land and the Zapatista Rebellion in Chiapas. Oakland, CA: Institute for Food And Development Policy.

Comaroff, Jean
1993 The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body. *In* Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life. Lindenbaum and Lock, eds. Pp. 305-329. University of California Press.

Comelles, Josep M.
2004 El Regreso de las Culturas: Diversidad y Practica Médica en el Siglo XX. *In* Salud e Interculturalidad en América Latina: Perspectivas Antropológicas. G. Fernández Juárez, ed. Pp. 17-30. Quito: Abya Yala.

Conklin, Beth A.
1997 Body Paint, Feathers and VCRs: Aesthetics and Authenticity in Amazonian Activism. American Ethnologist 24(4):711-737.

Connor, Linda H. and Geoffrey Samuel, eds.
2001 Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies. Westport, Connecticut: Bergin and Garvey.

Corredor Biológico del Atlántico
2003 Plan de Desarrollo Comunitario de Santa Martha. RAAN, Nicaragua: Working Paper of Projecto Corredor Biológico del Atlántico, Componente de Planificación y Monitoreo.

Cox, Avelino
1998 Cosmovisión de los Pueblos de Tulu Walpa: Según los Relatos de los Sabios Ancianos Miskitos. Managua: URACCAN.
2003 Sukias y Curanderos: Isigni en la Espiritualidad. Managua, Nicaragua: URACCAN and BID.

Crandon-Malamud, Libbet
1983 Grass Roots, Herbs, Promoters and Preventions: A Re-Evaluation of Contemporary International Health Care Planning. The Bolivian Case. Social Science and Medicine 17: 1281-1289.
1991 From the Fat of our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia.Berkley: University of California Press.

Cujilema, Manuel and German Ochoa Dávila
2003 La Salud Indígena en Ecuador, Mapa Estratégico de la Dirección Nacional de Salud de los Pueblos Indígenas. *In* La Salud en la Globalización. Dante Orellana Salvador, ed. Pp. 169-199. Quito, Ecuador: CIDES-Ecuador and Abya-Yala.

Cunningham, Myrna
1995 Medicina Tradicional en Comunidades Miskitas del Rio Coco. RAAN, Nicaragua: Fundación Wangki Luhpia.
2002 Etnia, Cultura y Salud: La Experiencia de la Salud Intercultural como una Herramienta para la Equidad en las Regiones Autónomas de Nicaragua. Organización Mundial de la Salud.

Cunningham, Myrna, Edda Moreno, and Antonia McCoy
2003 Sueños, Espiritualidad y Medicina Tradicional: Salud Miskita, Creole y Garífuna en la Costa Caribe de Nicaragua .Bilwi, RAAN: IMTRADEC-URACCAN.

de la Cadena, Marisol
2006 The Production of Other Knowledges and Its Tensions: From Andeanist Anthropology to Interculturalidad? *In* World Anthropologies : disciplinary transformations within Systems of Power. Gustavo Lins Ribeiro and Arturo Escobar, eds. Pp. 201-224. Oxford; New York: Berg.

Dennis, Philip A.
1981 Grisi Siknis Among the Miskito. Medical Anthropology 5(4):445-505.
1988 Herbal Medicine Among the Miskito of Eastern Nicaragua. Economic Botany 42(1):16-28.
2003 Cocaine in Miskitu Villages. Ethnology 42(2):161-172.
2004 The Miskitu People of Awastara. Austin: University of Texas Press.

Dennis, Philip, Pablo Cuadra, Ivan Carrasco, and Morlan Muller
2000 Las Maestras de Luxemburgo: Una Nueva Cara de Grisi Siknis? Un Abordaje Multicultural y Multidisciplinario. RAAN, Nicaragua: IMTRADEC-URACCAN.

Dennis, Philip A. and Michael D. Olien
1984 Kingship Among the Miskito. American Ethnologist 11:718-737.

Díaz Polanco, Héctor
1987 Neoindigenismo and the Ethnic Question in Central America . Latin American Perspectives 14(1):87-100.
1996 Universalidad y Particularidad. La Solución Autonómica. *In* Lo Propio y lo Ajeno: Interculturalidad y Sociedad Multicultural. Ursula Klesing-Rempel, ed. Pp. 205-238. México: Editorial Plaza y Valdez y Asociación Alemana para la Educación de Adultos.
1997 Indigenous Peoples in Latin America: The Quest for Self-Determination. Boulder, CO: Westview Press.

Dijkstra, A. G.
1999 Technocracy Questioned: Assessing Economic Stabilization in Nicaragua. Bulletin of Latin American Research 18(3):295-310.

Dirilik, A
1994 The Postcolonial Aura: Third World Criticism in the Age of Global Capitalism. Critical Inquiry 20(2):328-256.

Diskin, Martin
1987 The Manipulation of Indigenous Struggles. *In* Reagan versus the Sandinistas: The Undeclared War on Nicaragua. Thomas W. Walker, ed. Pp. 80-96. Boulder: Westview Press.
1991 Ethnic Discourse and the Challenge to Anthropology. *In* Nation-States and Indians in Latin America. Urban and Sherzer, eds. University of Texas Press.

Diskin, Martin, Thomas Bossert, Salamon Nahman, and Stefano Varese
1986 Peace and Autonomy on the Atlantic Coast of Nicaragua: A Report of the LASA Task Force on Human Rights and Academic Freedon. Pittsburgh: LASA.

Dodds, David J.
1998 Lobster in the Rain Forest: The Political Ecology of Miskito Wage Labor and Agricultural Deforestation. Journal of Political Ecology 5: 83-108.

Donahue, John M.
1989a International Organizations, Health Services, and Nation Building in Nicaragua. Medical Anthropology Quarterly 3(3):258-269.
1989b Rural Health Efforts in the Urban-Dominated Political Economy: Three Third World Examples. Medical Anthropology 11: 109-125.

Donahue, John M. and Meredith B. McGuire
1995 The Political Economy of Responsibility in Health and Illness. Social Science and Medicine 40(1):47-53.

Dozier, Craig L.
1985 Nicaragua's Mosquito Shore: The Years of British and American Presence.University of Alabama Press.

Elling, Ray H.
1981 The Capitalist World System and International Health. International Journal of Health Services 11: 21-51.

Eriksen, Thomas H.
1993 Ethnicity and Nationalism: Anthropological Perspectives. Chicago: Pluto Press.

Escobar, Arturo
1992 Culture, Economics, and Politics in Latin American Social Movements Theory and Research. *In* The Making of Social Movements in Latin America: Identity, Strategy and Democracy. Arturo Escobar and Sonia E. Alvarez, eds. Boulder CO: Westview Press.

Escobar, Arturo and Sonia E. Alvarez, eds.
1992 The Making of Social Movements in Latin America: Identity, Strategy, and Democracy. Boulder: Westview Press.

Escuela de Antropología Aplicada, UPS
2000 Dialogo Intercultural: Memorias del Primer Congreso Latinoamericano de Antropología Aplicada, Quito-Ecuador, 25 al 29 de enero de 1999. Quito, Ecuador: Ediciones Abya-Yala.

Espinoza, Jaime
2002 Nos Han Vendido (y hemos Comprado) un Sistema de Salud que No Funciona. Revista Envió(245): Electronic Document, http://www.envio.org.ni/articulo/1164, accessed October 24, 2004.

Evans, Trevor
1995a Ajuste Estructural y Sector Público en Nicaragua. *In* La Transformación Neoliberal del Sector Publico: Ajuste Estructural y Sector Publico en Centroamérica y el Caribe. Trevor Evans, ed. Pp. 179-261. Managua: CRIES.
1995b La Transformación Neoliberal del Sector Público. Managua: CRIES-Latino Editores.

Fagoth, Ana R., Fulvio Gioanetto, and Adan Silva
1998 Wan Kaina Kulkaia: Armonizando con Nuestro Entorno. Managua, Nicaragua: Imprimatur Artes Graficas.

Farmer, Paul
1999 Infections and Inequalities: The Modern Plagues. Berkley: University of California Press.
2005 Pathologies of Power: Health, Human Rights, and the New War on the Poor. University of California Press.

Fassin, Didier
1992 Antropología y Salud en Comunidades Indígenas: Manual de Capacitación para Promotores Campesinos de Salud. Quito, Ecuador: Instituto Francés de Estudios Andinos y Ediciones Abya Yala.

Feierman, Steven
1990 Peasant Intellectuals: Anthropology and History in Tanzania. Madison: University of Wisconsin Press.

Feinsilver, Julie M.
1993 Healing the Masses: Cuban Health Politics at Home and Abroad. Berkley: University of California Press.

Ferguson, James
1994 The Anti-Politics Machine: "Development", Depolitization, and Beurocratic Power in Lesotho. Minneapolis: University of Minnesota Press.

Fernández Juárez, Gerardo
1999 Médicos y Yatiris: Salud e Interculturalidad en el Altiplano Aymara. La Paz: CIPCA No 51.

Fernández Juárez, Gerardo, ed.
2004 Salud e Interculturalidad en América Latina: Perspectivas Antropológicas. Quito, Ecuador: Abya Yala.

Finkler, Kaja
1989 The Universality of Nerves. *In* Gender, Health and Illness: The Case of Nerves. Dona L. Davis and Setha Low, eds. Pp. 79-87. Hemisphere Publishing Corporation.

Floyd, Troy S.
1967 The Anglo-Spanish Struggle for Mosquitia. Albuquerque: University of Mexico Press.

Foster, George M.
1984 Anthropological Research Perspectives on Health Problems in Developing Countries. Social Science and Medicine 18: 847-854.
1999 Bureaucratic Aspects of International Health Programs. *In* Anthropology in Public Health: Bridging Differences in Culture and Society. Robert A. Hahn, ed. Pp. 345-364. New York: Oxford University Press.

Freeland, Jane
1999 Can the Grassroots Speak? The Literacy Campaign in English on Nicaragua's Atlantic Coast. International Journal of Bilingual Education and Bilingualism 2(3):214-232.

Freyermuth-Enciso, Graciela
1993 Médicos Tradicionales y Médicos Alópatas: Un Encuentro Difícil en los Altos de Chiapas. Chiapas, México: CIESAS Sureste, Gobierno del Estado de Chiapas.

Fuller, Norma, ed.
2002 Interculturalidad y Política: Desafíos y Posibilidades. Lima, Perú: Pontifica Universidad Católica de Perú, Universidad del Pacifico y Instituto de Estudios Peruanos.

Gabriel, John
1994 Initiating a Movement: Indigenous, Black and Grassroots Struggles in the Americas. Race & Class 35(3):1-17.

García, Claudia
1995 Tradición e Identidad Étnica: Creencias y Actitudes Tradicionales de los Miskitos en Torno a Ciertas Enfermedades. WANI: Revista del Caribe Nicaraguense 16: 36-42.
1996 The Making of the Miskitu People of Nicaragua. Sweden: UPPSALA.

Gardner, Katy and David Lewis
2000 Dominant Paradigms Overturned or "Business as Usual"? Development Discourse and the White Paper on International Development. Critique of Anthropology 20(1):15-29.

Garfield, Richard M.
1989 War-Related Changes in Health and Health Services in Nicaragua. Social Science and Medicine 28(7):669-676.

Giesecke Sara-Lafosse, Mercedes
2003 Cuestionando la Globalización desde la Interculturalidad. Revista de Antropología Cuarta Época, Año 1(1): 151-164.

Goma, Ricard and Joan Font
1996 Political Change and Socioeconomic Policies in Central America: Patterns of Interaction. Third World Quarterly 17(4): 737-751.

Gómez, Felipe
2003 El Caso de Awas Tingni Contra Nicaragua: Nuevos Horizontes para los Derechos Humanos de los Pueblos Indígenas. Bilbao, Spain: Universidad de Deusto, Instituto de Derechos Humanos.

González-Pérez, Miguel
1997 Gobiernos Pluri-étnicos: La Constitución de Regiones Autónomas en Nicaragua. México: Plaza y Valdés.

Good, Byron J.
1994 Medicine, Rationality, and Experience: An Anthropological Perspective. Cambridge University Press.

Gordon, Andrew J.
2000 Cultural Identity and Illness: Fulani Views. Culture, Medicine and Psychiatry 24: 297-330.

Gordon, Andrew J.
1992 Influences on Biomedicine in Rural Dominican Republic: An Analysis of Process. Medical Anthropology 13: 315-336.

Gordon, Edmund T.
1987 History, Identity, Consciousness, and Revolution: Afro-Nicaraguans and the Nicaraguan Revolution. *In* Ethnic Groups and the Nation State: The Case of the Atlantic Coast in Nicaragua. CIDCA, ed. Pp. 135-168. Stockholm: University of Stockholm.
1998 Disparate Diasporas: Identity and Politics in an African-Nicaraguan Community. Austin: University of Texas Press.

Gordon, Edmund T., Galio C. Gurdian, and Charles R. Hale
2003 Rights, Resources, and the Social Memory of Struggle: Reflections on a Study of Indigenous and Black Community Land Rights on Nicaragua's Atlantic Coast. Human Organization 62(4):369-381.

Gould, Jeffrey
1996 Gender, Politics, and the Triumph of Mestizaje in Early 20th Century Nicaragua. Journal of Latin American Anthropology 2(1):4-33.
1998 To Die in This Way: Nicaraguan Indians and the Myth of Mestizaje, 1880-1965. Durham: Duke University Press.

Gow, David D. and Joanne Rappaport
2002 The Indigenous Public Voice: The Multiple Idioms of Modernity in Native Cauca. *In* Indigenous Movements, Self-Representation, and the State. K Waren and J. Jackson, eds. Pp. 47-80. University of Texas Press.

Graham, Laura R.
2002 How Should and Indian Speak? Amazonian Indians and the Symbolic Politics of Language in the Global Public Sphere. *In* Indigenous Movements, Self-Representation and the State in Latin America. K. Warren and J Jackson, eds. Pp. 181-228. University of Texas Press.

Gray, Andrew
1997 Indigenous Rights and Development: Self-Determination in an Amazonian Community. Providence: Berghahn Books.
1997 The Last Shaman: Change in an Amazonian Community. Providence: Berghahn Books.
1998 Development Policy, Development Protests: The World Bank, Indigenous Peoples, and NGOs. *In* The Struggle for Accountability: The World Bank, NGOs, and Grassroots Movements. Jonathan A. Fox and David Brown, eds. Pp. 266-300. MIT Press.

Green, Linda B.
1989 Consensus and Coercion: Primary health care and the Guatemalan State. Medical Anthropology Quarterly 3(3): 246-257.

Guarnaccia, Peter J.
1993 Ataque de Nervios in Puerto Rico: Culture-Bound Syndrome or Popular Illness? Medical Anthropology 15:157-170.

Guzman Balbubun, Milton and Sol Sanchez Montoya
1997 Relaciones Interculturales: Salud e Investigación Aplicada. *In* De la Protesta a la Propuesta: Memorias de los Talleres de Antropología Aplicada. Escuela de Antropología Aplicada, ed. Pp. 131-153. Quito, Ecuador: Universidad Politécnica Salesiana.

Hale, Charles R.
1987 Inter-Ethnic Relations and Class Structure in Nicaragua's Atlantic Coast: An Historical Overview. *In* Ethnic Groups and the Nation State: The Case of the Atlantic Coast in Nicaragua. CIDCA, ed. Pp. 33-57. Stokholm: Akademitryck.
1990 La Conciencia Política Miskita: Hacia un Análisis Coyuntural. Wani: Revista del Caribe Nicaraguense (8):80-93.
1994 Resistance and Contradiction: Miskitu Indians and the Nicaraguan State, 1894-1987. Stanford: Stanford University Press.
1996 Mestizaje, Hybridity, and the Cultural Politics of Difference in Post-revolutionary Central America. Journal of Latin American Anthropology 2(1):34-61.
1997 Cultural Politics of Identity in Latin America. Annual Review of Anthropology 26: 567-90.
2005 Neoliberal Multiculturalism: The Remaking of Cultural Rights and Racial Dominance in Central America. Political and Legal Anthropology Review 28(1):10-28.

Hale, Charles R., Edmund T. Gordon, and Galio C. Gurdian
1998 Diagnostico General Sobre la Tenencia de la Tierra en las Comunidades Indígenas de la Costa Atlántica. Bluefields y Puerto Cabezas: Central American and Caribean Research Council.

Hall, Gillette and H. A. Patrinos
2005 Indigenous Peoples, Poverty, and Human Development in Latin America. London: Palgrave Macmillan.

Hawley, Susan
1997 Protestantism and Indigenous Mobilization: The Moravian Church Among the Miskitu Indians of Nicaragua. Journal of Latin American Studies 29: 111-129.

Heggenhougen, H. K.
1984 Will Primary Health Care Efforts Be Allowed to Succeed? Social Science and Medicine 19: 217-224.

Helms, Mary W.
1969 The Cultural Ecology of a Colonial Tribe. Ethnology 8(1):76-84.
1971 Asang, Adaptation to Culture Contact in a Miskito Community. University of Florida Press.
1975 Middle America: A Culture History of Heartland and Frontiers. Washington D.C: University Press of America.
1977 Negro or Indian?: The Changing Identity of a frontier Population. *In* Old Roots in New Lands. Ann M. Pescatello, ed. Pp. 157-172. Westport: Greenwood Press.
1978 Coastal Adaptations as Contact Phenomena among the Miskito and Cuna Indians of Lower Central America. *In* Prehistoric Coastal Adaptations: The Economy and Ecology of Maritime Middle America. Barbara L. Stark and Barbara Voorhies, eds. Pp. 121-149. New York: Academic Press.
1983 Miskito Slaving and Culture Contact: Ethnicity and Opportunity in an Expanding Population. Journal of Anthropological Research 39(2):179-197.

1986 Of Kings and Contexts: Ethnohistorical Interpretations of Miskito Political Structure and Function. American Ethnologist 13: 506-523.

Hernandez-Cruz, Antonio
2000 Tojob'al Autonomy: The Genesis of a Process. *In* Indigenous Autonomy in Mexico. Arcely Burguete Cal y Mayor, ed. Pp. 160-177. Copenhagen: IWGIA, IWGIA Document No. 94.

Hoekema, Andre
1994 Do Joint Decision-Making Boards Enhance Chances for a New Partnership Between State and Indigenous Peoples? *In* Indigenous People's Experiences with Self-Government. W. Assies and A. Hoekema, eds. Pp. 177-194. Copenhagen: IWGIA and University of Amsterdam, IWGIA Document no. 76.

Hooker, Alta
2006 Alta Hooker: "Aspiramos a que el Gobierno Nacional Respete a los Costeños". Revista Envio(288): Electronic document, http://www.envio.org.ni/articulo/3215, accessed October 24 2006.

Hooker, Juliet
2005 "Beloved Enemies": Race and Official Mestizo Nationalism in Nicaragua. Latin American Research Review 40(3):14-39.

Hughes, Charles C.
1985 Glossary of Culture Bound or Folk Psychiatric Syndromes. *In* The Culture-Bound Syndromes:Folk Illnesses of Psychiatric and Anthropological Interest. Ronald C. Simons and Charles C. Hughes, eds. Pp. 469-505. Dordrecht: Reidel.
1996 Ethnopsichiatry. *In* Medical Anthropology: Contemporary Theory and Method. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 131-150. Westport, CT: Praeger.

Instituto de Medicina Tradicional y Desarrollo Comunitario (IMTRADEC)
2004 Reporte de Grisi Sinkis en Raiti, Namahka y Samto Tomas Umbra. RAAN, Nicaragua: IMTRADEC.
2006 Instituto de Medicina Tradicional y Desarrollo Comunitario. RAAN: URACCAN and IMTRADEC. Electronic Document, http://www.proeibandes.org/uii/subredsalud/PerfilImtradecFINAL.pdf#search='IMTRADEC', accessed October 15 2006.

Institut Catala d'Antropologia
1986 Los Miskitos. Madrid: IEPALA.

IWGIA
2002 The Indigenous World 2001-2002. Copenhagen: IWGIA.

Jackson, Jean E.
1995a Culture, Genuine and Spurious: The Politics of Indianness in the Vaupes, Colombia. American Ethnologist 22(1):3-27.
1995b Preserving Indian Culture: Shaman Schools and Ethno-Education in the Vaupes, Colombia. Cultural Anthropology 10(3):302-329.
2002 Contested Discourses of Authority in Colombian National Indigenous Politics: The 1996 Summer Takeovers. *In* Indigenous Movements, Self-Representation and the State in Latin America. K. Warren and Jackson J., eds. Pp. 81-122. University of Texas Press.

Jameson, F
1984 Postmodernism, or the Cultural Logic of Late Capitalism. New Left Review 146: 43-92.

Jamieson, Mark
1999 Poverty Among the Indigenous Peoples of Nicaragua. Inter-American Development Bank: Indigenous Peoples and Community Development Unit.
2000 It's Shame that Makes Men and Women Enemies: The Politics of Intimacy Among the Miskitu of Kakabila. Journal of the Royal Anthropology Institute N.S (6):311-324.
2001 Masks and Madness. Ritual Expressions of the Transition to Adulthood Among Miskitu Adolescents. Social Anthropology 9(3):257-272.
2002 Ownership of Sea-Shrimp Production and Perceptions of Economic Opportunity in a Nicaraguan Miskitu Village. Ethnology 41(3):281-298.
2003 Miskitu or Creole? Ethnic Identity and the Moral Economy in a Nicaraguan Miskitu Village. Journal of the Royal Anthropology Institute N.S(9):201-222.

Jelin, Elizabeth
1985 Los Nuevos Movimientos Sociales. Buenos Aires: Centro Editor de América Latina.

Jenkins Molieri, Jorge
1986 El Desafío Indígena en Nicaragua: El Caso de los Miskitos. México: Editorial Katun.

Jewkes, Rachel and Anne Murcott
1996 Meanings of Community. Social Science and Medicine 43: 555-563.

Justice, J
1986 Policies, Plans, and People: Culture and Health Development in Nepal. Berkeley: University of California Press.

Kindblad, Christopher
2001 Gift and Exchange in the Reciprocal Regime of the Miskito on the Atlantic Coast of Nicaragua, Twentieth Century. Lund, Sweden: Dissertations in Sociology, 44. Lund University.

Kinloch Tijerino, Frances
1995 Nicaragua en Busca de su Identidad. Managua, Nicaragua: Instituto de Historia de Nicaragua-UCA.

Klesing-Rempel, Ursula, ed.
1996 Lo Propio y lo Ajeno: Interculturalidad y Sociedad Multicultural . México, D.F: Plaza y Valdez.

Korovkin, Tanya
2001 Reinventing the Communal Tradition: Indigenous Peoples, Civil Society, and Democratization in Andean Ecuador. Latin American Research Review 36(3): 37-67.

Kowal, E. and Y. Parides
2005 Ambivalent Helpers and Unhealthy Choices: Public Health Practitioners' Narratives of Indigenous Ill-Health. Social Science and Medicine 60: 1347-57.

Kunitz, Stephen J.
2000 Globalization, States, and the Health of Indigenous People. American Journal of Public Health 90(10):1531-1539.

Lambert, Helen and Leena Sevak
1996 Is "Cultural Difference" a Useful Concept? Perceptions of Health and the Sources of Ill Health among Londoners of South Asian Origin. *In* Researching Cultural Difference in Health. David Kelleher and Sheila Hiller, eds. Pp. 124-159. London: Routledge.

Lancaster, Roger N.
1991 Skin Color, Race and Racism in Nicaragua. Ethnology 30(4):339-354.

Langdon, Esther J.
1991 Interethnic Processes Affecting the Survival of Shamans: A Comparative Analysis. *In* Otra América en Construcción: Memorias del Simposio Identidad Cultural, Medicina Tradicional y Religiones Populares. Carlos E. Pinzon, Rosa Suárez, Gloria Garay, and ICAN, eds. Instituto Colombiano de Cultura.

Leyva-Solano, Xochitl
2001 Regional, Communal, and Organizational Transformations in Las Canadas. Latin American Perspectives 28(2):20-44.

López García, Julián
2004 Promotores Rurales de Salud en el Oriente de Guatemala: De la Negociación a la Desorientación ante Capacitaciones Medicas Occidentales. *In* Salud e Interculturalidad en América Latina. G. Fernández Juárez, ed. Pp. 153-168. Quito, Ecuador: Abya Yala.

Low, Setha M.
1985 Culturally Interpreted Symptoms or Culture Bound Syndromes: A Cross Cultural Review of Nerves. Social Medicine and Psychiatry 21187-196.

Lozoya, Xavier
1991 La medicina Tradicional y la Atención a la Salud en la América Latina. *In* Otra América en Construcción: Memorias del Simposio Identidad Cultural, Medicina Tradicional y Religiones Populares. Carlos E. Pinzon, Rosa Suárez, Gloria Garay, and ICAN, eds. Instituto Colombiano de Cultura.

Macdonald, Theodore
1988 The Moral Economy of the Miskito Indians: Local Roots of a Geopolitical Conflict. *In* Ethnicities and Nations: Processes of Interethnic Relations in Latin America, Southeast Asia and the Pacific. Remo Guidieri, ed. Austin: University of Texas Press.

Magnus, Richard W.
1978 The Prehistoric and Modern Subsistence Patterns of the Atlantic Coast of Nicaragua: A Comparison. *In* Prehistoric Coastal Adaptations: The Economy and Ecology of Maritime Middle America. Barbara L. Stark and Barbara Voorhies, eds. Pp. 61-80. New York: Academic Press.

Mallon, Florencia E.
1992 Indigenous Communities, Political Cultures, and the State in Latin America, 1780-1990. Journal of Latin American Studies 24: 35-53.

Manuel, G. and M. Posluns
1974 The Fourth World: An Indian Reality. New York: Free Press.

Marcos, Subcomandante and Zapatista Army of National Liberation
1995 Shadows of Tender Fury: The Letters and Communiques of Subcomandante Marcos and the Zapatista Army of National Liberation. New York: Monthly Review Press.

Martin and Nahel
1987 Bla Kira o las locuras del Patuka: Encuesta psiquiatrita en la Mosquitia Hondureña. Tegucigalpa, Honduras: Médicos Sin Fronteras.

Martinez-Echazabal, Lourdes
1998 Mestizaje and the Discourse of National/Cultural Identity in Latin America, 1845-1959. Latin American Perspectives 25(3):21-42.

Matamoras Bushy, Jorge
1992 Las Fracciones de YATAMA y la Situación Política de la RAAN. Wani 13: 1-19.

McFall, Sara and Roberto Morales
2000 The Ins and Outs of Mapuche Culture in Chile. *In* Cultural Politics in Latin America. Anny B. Jones and Ronaldo Munck, eds. Pp. 127-141. New York: St. Martin's Press.

Meltzoff, Sarah K. and Jennifer Schull 1
1999 Miskito Ethnic Struggles Over Land and Lobster: Conserving Culture and Resources on Corn Island. Culture and Agriculture 21(3):10-18.

Menchú, Rigoberta, with Elisabeth Burgos-Debray ed., and Ann Wright trasl.
1984 I, Rigoberta Menchú: An Indian Woman in Guatemala. London: Verso.

Mignolo, Walter
2000 Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking. Princeton, N.J: Princeton University Press.

Mills, A., J. Vaughhan, D. Smith, and I. Tabibzadeh
1990 Health Systems Decentralization: Concepts, Issues and Country Experiences. Geneva: WHO.

MISURASATA
1985 Comunique (September 12, 1985). Akwesasne Notes, Winter: 13.

Mollet, Sharlene
2006 Race and Natural Resource Conflicts in Honduras: The Miskito and Garifuna Struggle for Lasa Pulan. Latin American Research Review 41(1):76-101.

Morgan, Lynn M.
1989 The Importance of the State in Primary Health Care Initiatives. Medical Anthropology Quarterly 3(3):227-231.
1993 Community Participation in Health: The Politics of Primary Health Care in Costa Rica. Cambridge University Press.

Naranjo, Plutarco and Antonio Crespo, eds.
1997 Etnomedicina: Progresos Italo-Latinoamericanos Volumen 2. Quito, Ecuador: Abya-Yala.

Nash, June
2001 Mayan Visions: The Quest for Autonomy in the Age of Globalization. New York: Routledge.

Navarro, Vicente
1984 A Critique of the Ideological and Political Positions of the Willy Brandt Report and the WHO Alma Ata Declaration. Social Science and Medicine 18(6):467-474.
2001 The New Conventional Wisdom: An Evaluation of the WHO Report Health Systems: Improving Performance. International Journal of Health Services 31(1):23-33.

Nichter, Mark and Mimi Nichter
1989 Education by Appropriate Analogy. *In* Anthropology and International Health: South Asian Case Studies. M Nichter, ed. Pp. 287-306. Dordecht, Holland: Kluwer Academic.

Nietschmann, Bernard
1973 Between Land and Water: The Subsistence Ecology of the Miskito Indians, Eastern Nicaragua. New York and London: Seminar Press.

1989 The Unknown War: The Miskito Nation, Nicaragua, and the United States. New York: Freedom House.
1994 Fourth World: Nations versus States. *In* Reordering the World: Geopolitical Perspectives on the Twenty-First Century. G.J Demko and W.B. Wood, editors. Pp 225-242. Boulder, CO: Westview Press

Niezen, Ronald
2003 The Origins of Indigenism: Human Rights and the Politics of Identity. University of California Press.

Noveck, Daniel
1988 Class, Culture, and the Miskito Indians: A Historical Perspective. Dialectical Anthropology 13: 17-29.

Nygren, Anja
2003 Violent Conflicts and Threatened Lives: Nicaraguan Experiences of Wartime Displacement and Postwar Distress. Journal of Latin American Studies 35: 367-393.

Oakdale, Suzanne
2004 The Culture Conscious Brazilian Indian: Representing and Reworking Indianness in Kayabi Political Discourse. American Ethnologist 31(1):60-75.

Offen, Karl H.
2003 Narrating Place and Identity, or Mapping Miskitu Land Claims in Northeastern Nicaragua. Human Organization 62(4):382-392.

Ohland, Klaudine and Robin Schneider, eds.
1983 National Revolution and Indigenous Identity: The Conflict between Sandinistas and Miskito Indians on Nicaragua's Atlantic Coast. Copenhagen: International Work Group on Indigenous Affairs.

Olien, Michael D.
1983 The Miskito Kings and the Line of Succession. Journal of Anthropological Research 39: 198-241.

Ong, Aihwa
1987 Spirits of Resistance and Capitalist Discipline. Albany, NY: State University of of New York Press.

Orellana Salvador, Dante
2003 Autonomía e Interculturalidad en la Gestión de Salud Indígena. *In* La Salud en la Globalización. Dante Orellana Salvador, ed. Pp. 199-211. Quito, Ecuador: CIDES-Ecuador and Abya-Yala.

Ortega Hegg, Manuel
1992 Autonomía Regional y Neoliberalismo en Nicaragua. Boletín de Antropología Americana 25: 179-194.
1997 El Régimen de Autonomía en Nicaragua: Contradicciones Históricas y Debates Recientes. Alteridades 7(14):99-105.

Ortega Hegg, Manuel and Maria I. Pares Barberena
2000 Gestión Municipal y Descentralización de la Salud en Nicaragua. Managua, Nicaragua: CASC-UCA and FLASCO.

Padilla, G.
1995 What Encompasses Goodness: The Law and the Indigenous People of Colombia. *In* Ethnic Conflict and Governance in Comparative Perspective. Latin A. P. Woodrow Wilson Center, ed. Washington , D.C: Woodrow Wilson International Center for Scholars, Latin American Program, Working Paper Series, No. 215.

Pan-American Health Organization (PAHO)
1997 Health of Indigenous Peoples. Pan American Journal of Public Health 2(5):357-361.
1998a Incorporación del Enfoque Intercultural de la Salud en la Formación y Desarrollo de Recursos Humanos. Washington, DC: PAHO.
1998b Orientaciones Estratégicas para el Desarrollo de la Iniciativa de Salud de los Pueblos Indígenas, Informe Técnico. Washington DC: Document HSP/D 9, División de Desarrollo de Sistemas y Servicios de Salud, PAHO.

Paley, Julia
2001 Marketing Democracy: Power and Social Movements in Post-Dictatorship Chile. Berkeley: University of California Press.

Parle, Julie
2003 Witchcraft or madness? The Amandiki of Zuliland. Journal of Southern African Studies 29(1): 105-132

Parry, J and Bloch, M.
1989 Introduction: Money and the Morality of Exchange. In Money and the Morality of Exchange. Parry and Bloch eds., Pp 1-32. Cambridge: Cambridge University Press.

Perez-Chiriboga I.
2000 Ideology, Cosmology and Illness: A Miskitu Ethnography in Times of War. PhD Dissertation, Department of Anthropology, University of Illinois at Urbana Champaign.

Pigg, Stacy L.
1995 Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development. Social Science and Medicine 41(1):47-68.

Pineda, Baron L.
2001 Creole Neighborhood or Miskito Community? A Case Study of Identity Politics in a Mosquito Coast Land Dispute. The Journal of Latin American Anthropology 6(1):120-155.

Pinzon, Carlos E., Rosa Suárez, Gloria Garay, and ICAN, eds.
1991 Otra América en Construcción: Memorias del Simposio Identidad Cultural, Medicina Tradicional y Religiones Populares. Instituto Colombiano de Cultura.

Programa de la Naciones Unidas para el Desarrollo (PNUD)
2005 Informe Desarrollo Humano 2005. Las Regiones Autónomas de la Costa Caribe. Nicaragua Asume su Diversidad? Managua: PNUD.

Psacharopoulos, G and H. A. Patrinos
1994 Indigenous People and Poverty in Latin America: An Empirical Analysis. Washington, D.C: World Bank.

Ramos, A. R.
1994 The Hyperreal Indian. Critique of Anthropology 14(2):153-171.

Renshaw, Jonathan.
2001 Social Investment Funds and Indigenous People. Washington D.C, Inter-American Development Bank. Document No. IND-108.

Reyes, Reynaldo and J. K. Wilson
1992 Rafaga: The Life Story of a Nicaraguan Miskito Comandante. Norman: University of Oklahoma Press.

Rifkin, S. and G. Walt, eds.
1988 Special Issue: Selective of Comprehensive Primary health care? Social Science and Medicine 26: 877-977.

Rizo Zeledón, Mario
1990 Identidad Étnica y Elecciones: El Caso de la RAAN. Wani: Revista del Caribe Nicaragüense (8):28-51.
1998 Situación de los Derechos Indígenas en Nicaragua. Estado, Autonomía Regional y Comunidades Indígenas en 1998: Un Enfoque de la Antropología Jurídica. América Indígena (1-2):117-144.

Rojas, Rocío and Shuquair, Nur.
1999 Orientaciones de Marcos Jurídicos hacia la Abogacía en Salud de los Pueblos Indígenas: Estudios de las Legislaciones de Colombia, Bolivia, El Salvador, México y Honduras. Washington, DC: Organización Panamericana de Salud.

Romero, Rainiero
1991 El Proceso de Autonomía: Realidades, Desafíos y Alternativas. Wani: Revista del Caribe Nicaragüense (10):1-11.

Rossbach, Lioba
1985 Ascenso y Caída de Samuel Pitts (1894-1907). Encuentro (24-25): 55-64.

Rouse, R.
1995 Questions of Identity: Personhood, and Collectivity in Transnational Migration in the United States. Critique of Anthropology 15(4):351-380.

Ruiz Sierra, J.
2003 Miskitos, Histeria, Brujería y Abandono. La Prensa, Dec 1: Electronic document, http://www.laprensa.com.ni/archivo/2003/diciembre/01/nacionales/nacionales-20031201 05.html, accessed October 17 2006.
2003 El Curandero, el Medico y el Juez. La Prensa, Dec 2: Electronic Document, http://www.laprensa.com.ni/archivo/2003/diciembre/02/nacionales/nacionales-20031202-01.html, accessed October 17 2006.

Rupilius, Pedro
1998 Grisi Siknis: Un caso de histeria colectiva en la RAAN: Interpretación de las Causas. RAAN, Nicaragua: IMTRADEC-URACCAN.

Rupilius, Pedro and Alta Hooker
1996 Situación de Salud de la RAAN: Modulo de Capacitación para Miembros del Consejo Regional Autónomo. RAAN-Nicaragua: Unpublished Work.

Santiago-Irizarry, Vilma
2001 Medicalizing Ethnicity: The Construction of Latino Identity in Psychiatric Settings. Ithaca, NY: Cornell University Press.
2003 Binary Oppositions: Reinscribing Ethnoracial Hierarchies in Institutional Settings. Journal of Latin American Anthropology 8(2):174-195.

Scherrer, Christian P.
1994 Regional Autonomy in Eastern Nicaragua (1990-1994). *In* Indigenous Peoples' Experiences with Sefl-Government. W. J. Assies and A. J. Hoekema, eds. Copenhagen: IWGIA and University of Amsterdam.

Schieffelin Edward L.
1996 Evil spirits sickness, the Christian disease: The Innovation of a New Syndrome of Mental Derangement and Redemption in Papua New Guinea. Culture, Medicine and Psychiatry 20: 1-39.

Servicio de Salud Araucania IX Region and Ministerio de Salud de Chile
1996 Memoria del Primer encuentro nacional de salud y pueblos indígenas: Hacia una política nacional intercultural en salud. Saavedra, Chile: OPS-OMS.

Shaw, Susan J.
2005 The Politics of Recognition in Culturally Appropriate Care. Medical Anthropology Quarterly 19(3):290-309.

Sieder, Rachel, ed.
2002 Multiculturalism in Latin America: Indigenous Rights, Diversity and Democracy. London: Palgrave Macmillan.

Silva Mercado, Adan
2002 El Espíritu Comunitario. TININISKA 1(1):3.

Simons, Ronald and Charles C. Hughes, eds.
1985 The Culture-Bound Syndromes: Folk Illnesses of Psychiatric and Anthropological Interest. Dordrecht: Reidel.

Singer, Merrill
1995 Beyond the Ivory Tower: Critical Praxis in Medical Anthropology. Medical Anthropology Quarterly 9(1):80-106.

Slater, David
1985 New Social Movements and the State in Latin America. Amsterdam: CEDLA.

Smith, William D.
2004 The Topology of Autonomy. Critique of Anthropology 24(4):403-429.

Smutko, Gregorio
1996 La Presencia Capuchina Entre los Miskitos. Costa Rica: URACCAN and Vice Providencia de los Capuchinos en América Central y Panamá.

Stavenhagen, Rodolfo
2002 Indigenous People and the State in Latin America. *In* Multiculturalism in Latin America: Indigenous Rights, Diversity and Democracy. Rachel Sieder, ed. Pp. 24-44. London: Palgrave Macmillan.

Steffensen, Margaret S. and Larry Colker
1982 Intercultural Misunderstandings about Health Care. Social Science and Medicine 16: 1949-1954.

Stephen, Lynn
2002 Zapata Lives: Histories and Cultural Politics in Southern Mexico. Berkley: University of California Press.

Stocks, Anthony
2003 Mapping Dreams in Nicaragua's Bosawas Reserve. Human Organization 62(4):344-356.

Stoll, David
1999 Rigoberta Menchú and the Story of All Poor Guatemalans. Boulder, CO: Westview Press.

Taussig, Michael
1987 Shamanism, Colonialism, and the Wild Man: A Study in Terror and Healing. Chicago: University of Chicago Press.

Taylor, Janelle
2003 The Story Catches You and You Fall Down: Tragedy, Ethnography, and "Cultural Competence". Medical Anthropology Quarterly 71(2):159-181.

Terán, Carlos and Miguel Mato, eds.
1995 Políticas de Salud y Pueblos Indios. Quito, Ecuador: Abya Yala.

Treminio Urbina W, Vargas, M.
2003 Incrementa "Locura" en Indígenas. La Prensa, Nov. 28: Electronic document, http://www.laprensa.com.ni/archivo/2003/noviembre/28/regionales/regionales-20031128 06.html, accessed October 17 2006.

Tovar González, Leonardo
2000 ¿Es Posible una democracia Intercultural en Colombia? Colombia: Ministerio de Cultura.

Tubino, Fidel
2002 Entre el Multiculturalismo y la Interculturalidad: Más Allá de la Discriminación Positiva. *In* Interculturalidad y Política: Desafíos y Posibilidades. Norma Fuller, ed. Pp.51 75. Lima, Perú: Pontifica Universidad Católica de Perú, Universidad del Pacifico, Instituto de Estudios Peruanos.

Turner, Terence
1993 Anthropology and Multiculturalism: What is Anthropology that Multiculturalism Should be Mindful of It? Cultural Anthropology 8(4):411-429.

Ugalde, Antonio
1985 Ideological Dimensions of Community Participation in Latin American Health Programs. Social Science and Medicine 21(1):41-53.

United Nations Development Programme
2004 Human Development Report 2004: Cultural Liberty in Today's Diverse World. New York: United Nations Development Programme.

URACCAN
1996 El Modelo de Salud de la Región Autónoma del Atlántico Norte. Managua: Imprimateur Artes Graficas.

URACCAN and IMTRADEC
2004 Condiciones de Salud en Contextos Multiculturales RAAN, Nicaragua. Nicaragua: OPS, URACCAN and MINSA-Nicaragua.

Urban, Greg and Joel Sherzer, eds.
1991 Nation-States and Indians in Latin America. University of Texas Press.

Van Cott, Donna L.
1994 Indigenous Peoples and Democracy in Latin America. New York: St. Martin's Press.
1996 Prospects for Self-Determination of Indigenous Peoples in Latin America: Questions of Law and Practice. Global Governance 2: 43-64.
2000 The Friendly Liquidation of the Past: The Politics of Diversity in Latin America. University of Pittsburgh Press.
2001 Explaining Autonomy Regimes in Latin America. Studies in Comparative International Development 35(4):30-58.

Varese, Stefano
1994 Globalización de la Política Indígena en América Latina. Cuadernos Agrarios 4(10):17-24.

Vargas, M.
2003 La Prensa. Caos por Síndrome de Grisi Siknis. La Prensa, Nov. 28: Electronic document, http://www-ni.laprensa.com.ni/cronologico/2003/noviembre/28/nacionales/nacionales-20031128-20.html October 17 2006

Vargas, Oscar R.
1993 Entre el Laberinto y la Esperanza: Nicaragua (1990-1994). Managua: Ediciones Nicarao.

Velimirovic, Boris
1990 Is Integration of Traditional and Western Medicine Really Possible? *In* Anthropology and Primary Health Care. Jeannine Coreil and Dennis Mull, eds. Pp. 51-78. Boulder: Colorado: Westview Press.

Vilas, Carlos M.
1989 State, Class and Ethnicity in Nicaragua: Capitalist Modernization and Revolutionary Change on the Atlantic Coast of Nicaragua. Boulder, Co: Lynne Rienner Publishers.
1990 Clase, Estado y Etnicidad en la Costa Atlántica de Nicaragua. Nueva Antropologia XI(38):21-43.
1994 The Hour of Civil Society. NACLA 27(2):38-42.

von Houwald, Gotz
2003 Mayagna: Apuntes Sobre la Historia de los Indígenas Sumu en Centroamérica. Managua: Fundación Vida, Colección Cultural de Centro América-Serie Etnología No 1.

Walker, Thomas W, ed.
1997 Nicaragua Without Illusions: Regime Transition and Structural Adjustment in the 1990s. Wilmington, Delaware: SR Books.

Walsh, Catherine
2002a Interculturalidad, Reformas Constitucionales y Pluralismo Jurídico. Boletín ICCI-Rimay: Publicación Mensual del Instituto Científico de Culturas Indígenas 4(36): Electronic document, http://icci.nativeweb.org/boletin/36/walsh.html, accessed Oct 23 2006.
2002b (De) Construir la Interculturalidad: Consideraciones Criticas desde la Política, la Colonialidad y los Movimientos Indígenas y Negros de Ecuador. *In* Interculturalidad y Política: Desafíos y Posibilidades. Norma Fuller, ed. Pp. 115-141. Lima, Perú: Pontifica Universidad Católica de Perú, Universidad del Pacifico, Instituto de Estudios Peruanos.
2002c Las Geopolíticas del Conocimiento y Colonialidad del Poder: Entrevista a Walter Mignolo. *In* Interdisciplinar las Ciencias Sociales: Geopolíticas del Conocimiento y Colonialidad del Poder: Perspectivas desde lo Andino. Catherine Walsh, Freya Shiwy, and Santiago Castro-Gomez, eds. Pp. 17-44. Quito, Ecuador: Universidad Andina Simón Bolívar y Ediciones Abya-Yala.

Warren, Kay
1998a Indigenous Movements as a Challenge to the Unified Social Movement Paradigm for Guatemala. *In* Cultures of Politics/Politics of Cultures: Re-visioning Latin American Social Movements. Sonia E. Alvarez, Evelina Dagnino, and Arturo Escobar, eds. Boulder, CO: Westview Press.
1998b Indigenous Movements and their Critics: Pan-Maya Activism in Guatemala. Princeton University Press.

Warren, Kay and Jean Jackson, eds.
2002 Indigenous Movements, Self-Representation, and the State in Latin America University of Texas Press.

Warry, Wayne
1998 Unfinished Dreams: Community Healing and the Reality of Aboriginal Self Government. University of Toronto Press.

Wayland, Coral and Jerome Crowder
2002 Disparate Views of Community in Primary Health care: Understanding How Perceptions Influence Success. Medical Anthropology Quarterly 16(2):230-247.

Wheelock, Jaime
1981 Raíces Indígenas de la Lucha Anti-Colonialista en Nicaragua. Managua: Editorial Nueva Guinea.

White, Sydney D.
2001 Medicines and Modernities in Socialist China: Medical Pluralism. the State, and Naxi Identities in the Lijiand Basin. *In* Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies. Linda H. Connor and Geoffrey Samuel, eds. Pp. 171-196. Westport, Bergin and Garvey.

Whiteford, Linda M.
1990 A Question of Adequacy: Primary Health care in the Dominican Republic. Social Science and Medicine 30: 221-226.
1997 The Ethnoecology of Dengue Fever. Medical Anthropology Quarterly 11(2):202-223.
2001 Local Identity, Globalization, and Health in Cuba and the Dominican Republic. *In* Global Health Policy, Local Realities: The Falacy of the Level Playing Field. Linda M. Whiteford and Leonore Manderson, eds. Pp. 57-78. Boulder: Colorado: Lynne Rienner Publishers.

Willis, Cecil C.
1977 Definitions of Community II: An Examination of Definitions of Community since 1950. Southern Sociologist 9: 14-19.

Wilson, Morales, Padilla, and Fenley
2001 Grisi Siknis enter los Miskitos de Krin-Krin Rio Coco. RAAN, Nicaragua: IMTRADEC-URACCAN.

Wilson, John
1975 Obra Morava en Nicaragua. San José, Costa Rica: Seminario Bíblico Latinoamericano.

World Bank
1997 Nicaragua: Atlantic Biological Corridor Project. Washington D.C.: World Bank.
2003 Nicaragua Poverty Assessment: Raising Welfare and Reducing Vulnerability. Central America Department, Latin America and Caribbean Region. World Bank. Report No. 26128-NI

World Food Programme Nicaragua
2005 Food Security and Livelihoods Survey in the Autonomous Atlantic Regions Conducted in February-March 2005. World Food Programme Nicaragua and WFP-ODAV Rome.