

BOOK REVIEW ESSAYS

Indigenous Peoples, Postcolonial Ontologies, Neoliberal Regimes, and Approaches to Understanding Medical Pluralism in Latin America

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This essay reviews the following works:

Tell Me Why My Children Died: Rabies, Indigenous Knowledge, and Communicative Justice.

By Charles L. Briggs and Clara Mantini-Briggs. Durham, NC: Duke University Press, 2016. Pp. ix + 303. \$26.96 paperback. ISBN: 9780822361244.

Una enfermedad monstruo: Indígenas derribando el cerco de la discriminación en salud.

By Charles L. Briggs, Norbelys Gómez, Tirso Gómez, Clara Mantini-Briggs, Conrado Moraleda Izco, and Enrique Moraleda Izco. Buenos Aires: Lugar Editorial, 2015. Pp. 198. \$17.71 paperback. ISBN: 9789508925022.

Privatization and the New Medical Pluralism: Shifting Health Care Landscapes in Maya Guatemala.

Edited by Anita Chary and Peter Rohloff. Lanham: Lexington Books, 2015. Pp. vii + 191. \$85.00 hardcover. ISBN: 9781498505376.

The Good Life: Aspiration, Dignity, and the Anthropology of Wellbeing.

By Edward F. Fischer. Stanford: Stanford University Press, 2014. Pp. ix + 261. \$24.95 paperback. ISBN: 9780804792530.

Of Medicines and Markets: Intellectual Property and Human Rights in the Free Trade Era.

By Angelina Snodgrass Godoy. Stanford: Stanford University Press, 2013. Pp. vii + 173. \$24.95 paperback. ISBN: 9780804785617.

Tarahumara Medicine: Ethnobotany and Healing among the Rarámuri of Mexico.

By Fructuoso Irigoyen-Rascón with Alfonso Paredes. Norman: University of Oklahoma Press, 2015. Pp. ix + 383. \$24.95 paperback. ISBN: 9780806143620.

The way in which people use multiple, and sometimes competing, health care options to seek care—medical pluralism—has been a focus of inquiry in medical anthropology since the early twentieth century, when W. H. R. Rivers laid the groundwork for the study of non-Western/local medical systems.¹ Contemporary approaches to studying health care in pluralistic settings address fundamental theoretical questions in the study of choice, cultural hegemony, health disparities, racism, structural violence and resistance. Understanding health behavior in pluralistic settings is also part of a critical policy analysis. Theory in the study of medical pluralism in the twentieth century moved through a sequence of models from studies of the barriers to use of biomedical services posed by local “beliefs and practices”; to approaches that highlighted the barriers to access posed by the provision of substandard medical services, discrimination, and abandonment of indigenous communities; to a rejection of rational choice models, which assume agency in choice of treatment and focus on constructing and testing decision trees; to contemporary

¹ W. H. R. Rivers, *Medicine, Magic, and Religion: The Fitzpatrick Lectures Delivered before the Royal College of Physicians in London in 1915 and 1916* (London: Routledge, 1999).

models much more focused on the critical assessment of the ways in which postcolonial power structures persist and are inserted into approaches to health and accessibility of health under several different regimes of care. In the last decade the study of medical pluralism per se has enjoyed renewed interest, as late twentieth-century theory began to reassess the role of agency and choice within the context of postcolonial and neoliberal regimes of power in a more nuanced and contextualized way. At the same time, some theorists in anthropology took an “ontological turn,” that is, an approach to cultural relativism in which analysis focuses not on how communities experience the world but how they construct multiple worlds, in order to reaffirm the role of ontology/culture in thinking in health and other aspects of life.²

Collectively the volumes discussed in this essay address medical pluralism in terms of theory and policy options in health and access of health care in the context of long-term and ongoing inequity, violent racism, and the persistence of postcolonial power structures in several countries of Latin America. Several of the books extend the analysis to address the further exacerbation of health inequities as a result of neoliberal social and economic policies that move toward the privatization of health care and privilege personal responsibility and choice in health. Others emphasize the opportunities for agency presented by shifting systems of delivery. They touch on several key areas of theory in contemporary medical anthropology: the continuing impact of structural violence on health; the new and emerging conceptual framework for understanding the interplay of agency and structure in contemporary studies of medical pluralism; the potential for resistance to inequity to be co-opted; the potential for a new approach to understanding resistance and agency in health within the context of the study of postcolonial ontologies of health; and, to use Sherry Ortner’s terms, a reemergence of interest in the “anthropology of the good” after decades of focus on “the anthropology of the dark.”³

Tell Me Why My Children Died (by Charles Briggs and Clara Mantini-Briggs) and *Una enfermedad monstruo* (by Charles Briggs, Norbelys Gómez, Tirso Gómez, Mantini-Briggs, Conrado Moraleda Izco, and Enrique Moraleda Izco) tell the story of the ethnographically based, participatory epidemiological investigation of a mysterious outbreak in which thirty-eight Warao children died in 2007 and 2008. Living in the isolated Delta Amacuro region of the Orinoco Delta in northeastern Venezuela, about twenty thousand Warao-speaking people have poor access to health care and other services. Although contacted during Columbus’s first voyage to the Orinoco Delta, the Amacuro Delta has remained relatively isolated. Anthropologist Charles Briggs and physician Carla Mantini-Briggs have conducted research in this area for some time. They were invited by nurse and community health worker Norbelys Gómez; local Warao healer and community leader Tirso Gómez; community leader and president of the Health Committee, Conrado Moraleda Izco; and local director of the Partido Movimiento al Socialismo and the Partido Socialista Unido de Venezuela, Enrique Moraleda Izco, to participate in an investigation of a mysterious and, finally, monstrous epidemic.

Tell Me Why My Children Died is framed in conventional ethnographic format and places the process of participatory epidemiological investigation directly within contemporary theory in cross-cultural communication. Briggs and Mantini-Briggs provide a balanced approach to the concerns of structure and policy but also highlight the agency of individuals and communities in resisting these structures with an on-the-ground working understanding of the dynamics of medical pluralism and health seeking for Warao families with differential access to multiple health resources. *Una enfermedad monstruo* tells the story in the form of narratives and discussions by and among the collaborators in order to provide an understanding close to experience of the meaning of the investigation to both the local health workers and leaders and the communities of which they are part. The satisfaction of unraveling the epidemic of a mysterious illness is palpable, as is the ultimate frustration of the failure of governments at all levels and the refusal of the health care system to accept the results of the investigation and act to provide simple measures to prevent future outbreaks. Each of these volumes is important in its own right, but together they present an approach to action that is novel and powerful.

The story told in both volumes ends in the identification of the illness as an outbreak of rabies carried by bats, which could have been prevented with bed nets and rabies vaccinations. The report, which made this very clear, was, in the end, simply ignored by the government health establishment, and the narratives of the families were officially erased. An inability to accept a locally produced report based on the narratives of Warao people, and the unwillingness of politicians to take responsibility for failing to prevent, and then act

² See Stacey Ann Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Bloomington: Indiana University Press, 2011); Philippe Descola, *Beyond Nature and Culture* (Chicago: University of Chicago Press, 2013).

³ Sherry B. Ortner, “Dark Anthropology and Its Others: Theory since the Eighties,” *Hau: Journal of Ethnographic Theory* 6, no. 1 (2016): 27.

to limit, the epidemic reproduced long-standing traditions of devaluing indigenous lives and discounting the voices of the Warao.

In *Tell Me Why My Children Died*, the participatory, ethnographically grounded, epidemiological approach drew on long-established connections with communities, community leaders, indigenous health workers and traditional healers in the delta. The epidemiology of the mysterious illness is built from the narratives of the families affected by the epidemic, the health care workers who attended the ill children, the professional epidemiologists who first investigated the illness, the journalists who covered the stories in the local and national press, and the local and national politicians and Ministry of Health staff. It was carried out against the backdrop of President Hugo Chávez's Bolivarian Revolution in Venezuela, but it lays bare the persistence of long-standing structures of power that steal the voices of the poor and indigenous. Families of children lost to the epidemic were dismissed, and struggled to get even a small amount of information about what had afflicted their children and, in many cases, what treatments the children had even received.

In sequence, the chapters recount the powerful narratives of loss and bewilderment of the parents of the children who died, sharing the narratives of the onset of illness, the ways in which families sought, even fought, for help from both local healers and the biomedical health care system, and the impact of the loss of their children. Subsequent chapters turn to the narratives of health care workers in the national health system. The nurses, physicians, and community health care workers that worked to treat the affected children recount narratives of care and frustration as they tried multiple treatments and failed in each. They also reveal how biomedical providers discounted the narratives of parents as indigenous people. The narratives of local health officials and Venezuelan and Cuban epidemiologists who conducted a study of the epidemic document how a combination of poor communication, inattention to the narratives of parents, preconceived ideas that environmental factors such as mercury contamination and poor hygiene on the part of the "dirty" Warao were probably the cause, and stereotypes of Warao lives, hygiene, and medical knowledge influenced, and eventually, doomed the investigations by epidemiologists. Journalists covering the epidemic, who purported to be working with families and local health care workers to understand it, were no less influenced by stereotypes and political concerns. They also discounted the narratives of parents and local healers. In the end, the Warao families felt betrayed by journalists as well as by the national health care system.

Una enfermedad monstruo emphasizes the voices of community-based leaders and health care workers as researchers who resisted and continue to resist the silencing of their voices and the voices of the people they serve. It is a narrative of dedication and frustration presented from the point of view of the community workers and their analysis of the health seeking of families, and the decisions they made about where, when, and how to access their options are more clearly embedded both in the ontology of the Warao people and their astute understanding of the structures of power they confront. It is presented in Spanish and in a format accessible to communities.

The authors of these two volumes have incorporated a number of theoretical and conceptual goals beyond identifying the agents and causes of the epidemic. They address the ways in which each of the actors created narratives and attempted to manage the narratives of others, including the "narrative monopolies" of the social scientists. They draw together an understanding of authoritative knowledge and the degree to which local narratives that resist authoritative communication are seen as challenges, violent, and discredited; and the way in which indigenous actors/patients learn to present their bodies in "appropriate" sick roles in order to secure some attention; and comment on the structured production of epidemiological knowledge. In a point that overlaps with Angelina Godoy's concerns in Guatemala, discussed below, they comment on the need for advocacy for health communication rights.

Privatization and the New Medical Pluralism: Shifting Health Care Landscapes in Maya Guatemala, edited by Anita Chary and Peter Rohloff, is a tightly edited collection of papers that examine medical pluralism and health strategies by addressing the impact of health care privatization in Guatemala for the majority of the approximately seven million Maya people in the period since the end of the civil war (1954–1996). The goal of the overall analysis is to explore "the ground-level effects of healthcare privatization in Guatemala for indigenous Maya through a close analysis of the country's multiple transforming healing systems" (xxi). Each of the contributions aim to "connect the lived experience of healthcare privatization to broad themes of multiculturalism, indigeneity, and critical studies of global health in order to provide an updated and contemporary understanding of medical pluralism in an unequal society" (xxi). In discussing medical pluralism, the authors of individual essays go beyond historical, conventional rational choice models that pose decision-making as a choice between a binary of "ethno" and "bio" medical systems to document the far broader reality of medical pluralism in complex multicultural/plurinational settings, from public,

fee-for-service private practitioners and clinics; health NGOs that contract with the Ministry of Health to provide care; and multiple traditional Guatemalan and nonlocal alternative approaches to health care.

Chary and Rohloff review the history of Guatemala since the end of the civil war in 1996. The extension of primary care for indigenous peoples laid out in the Peace Accords of 1996 has reduced the percentage of Maya without access to primary care from 46 percent to about 6 percent. However, access to other care has been curtailed as a result of the privatization of health care beyond primary care. Long-standing social and economic disparities between Maya and non-Maya Guatemalans have been maintained and exacerbated. Mayas have life expectancies ten to fifteen years below that of non-Mayas. Infant mortality remains considerably higher for Mayas than for Guatemala as a whole. The prevalence of low height for age in 2003 was 80 percent among Western Highlands Mayas and under 20 percent for non-Mayas. Persistent disparities in health are attributed to several interrelated processes, including the strong influence of neoliberal economic policies that emphasize free markets in the provision of service and promote individual responsibility in health, resulting in an emphasis on privatization and outsourcing of health care services primarily to NGOs; and the impact of postwar surges in racketeering, violence, and drug trafficking on these processes, echoing the analysis of some that Guatemala is now a failed state controlled by drug traffickers.

As a strategy to fulfill the mandate of the Peace Accords to extend health care services to rural Maya communities, the Ministry of Health created the Program for Expansion of Coverage, which enrolled NGOs as agents to provide minimum package of services to underserved regions. While this strategy increased the availability of minimum and preventative services it also restructured and deformed the historical roles of primary care and local health care workers by curtailing local services in favor of a system in which curative services were referred further up the chain of services and were essentially privatized. The proliferation of NGOs providing health care has also spawned an array of biomedical health promoters, community health care workers, and physicians and nurses.

In a particularly poignant paper, Jonathan Maupin (3–19) chronicles the shifting role and presence of the *Fundación Guatemalteca para el Desarrollo “Carroll Behrhorst”* in health care and presents it as a case study which can be extended to other NGOs. Founded in 1962, the foundation was a model of liberationist social development and health care in Latin America. Maupin documents the changes in the foundation as it formed strategic alliances with the state in order to survive. During the long civil war the foundation moved more toward providing health care services and away from the broader social development mission it had originally espoused. Maupin identifies the susceptibility of liberationist strategies to changing political and economic realities, and the impact of the particular and simultaneous extension of state control through privatization and regulation. The withdrawal of the Guatemalan state from the delivery of health services and the replacement of that role by NGOs was a driving force in the recruitment of NGOs as complicit partners in continuing health disparities. Even this was not a guarantee for survival of the organizations as, as a result of inadequate funding the state in 2015 pulled back contracts and support.

Chapters by Shom Dasgupta-Tsinikas and Paul Wise (19–34) on the Conditional Cash Transfer (CCT) program, and by Alejandra Colom (35–50) on the Thousand Days initiative (thousanddays.org), which focuses health care on the first thousand days of life (conception to two years of age), address how, in the context of government regulation and privatization, these programs both focus responsibility for child welfare on women as mothers, while erasing them as women. Both these papers echo the work of others in Latin America who have demonstrated that potentially transformative approaches to health, such as cash transfer programs and Thousand Days can be co-opted into tools of ongoing oppression as administered in a postcolonial privatized setting.

Section 2, “Commoditizing Care,” presents discussions of diabetes care (David Flood and Rohloff, 53–70) and the marketplace for quasi-pharmaceuticals (Rachel Hall-Clifford, 71–88) as case studies of the impact of the privatization and commodification of care. Mayas come to understand that, in a landscape in which fundamental primary care is available through NGOs, care for chronic illnesses such as diabetes places them in a world of private and sometime unscrupulous providers. Health must be purchased and only the wealthy can afford it. Hall-Clifford makes a similar argument drawing on a study of pharmaceuticals, especially quasi-pharmaceuticals provided by the Omnilife Company, organized as a pyramid marketing scheme.

The third section, “Navigating Resources,” continues the narratives of opportunity and loss in the contemporary health landscape. Carla Pezzia (91–106) addresses the task of seeking care for mental health problems in Panajachel. She highlights the array of options available and the critical nature serendipity can play in seeking care in a popular tourist destination. In Panajachel, health care seekers build rational (but not always effective) strategies based on serendipity. Anita Chary describes the “therapeutic anarchy” (121) of navigating cervical cancer treatment options. She effectively argues that in the Guatemalan context,

emblematic of several other Latin American countries, health seekers cannot and should not be expected to follow the rational health seeking envisioned in neoliberal approaches to health decision-making. Nora King, Chary, and Rohloff (125–142) demonstrate how lay indigenous midwives are able to leverage international attention, for example, by the Safe Motherhood Initiative and local NGOs, to find spaces in which they can access power. In this complex context, they are “post-modern midwives” (140) who have learned how to exploit biomedical technology and drugs and access specialty services for their clients while playing organizations off against each other in order to create strategies for resistance and empowerment.

Peter Benson (143–156) draws together all of the arguments and places them in a clear and coherent framework that demonstrates the impact of long-term postcolonial structures of power with the superimposition of neoliberal economic policies and the impact of drug trafficking on the conduct of the state. The benefits of the neoprivatization of health care delivery is counterbalanced by the ways in which it deforms the NGO sector charged with the delivery of care, and creates a maze of options that provide opportunities for both improved health care and predatory marketing by companies and providers. While I feel that the volume ends on an idealistic note that may overpromise the impact of detailed, reflective ethnography, this is a successful volume. The story told here is both unique to the history of Guatemala and generalizable to other settings in Latin America. It reexamines the meaning of medical pluralism and choice, the impact of postcolonial structures, and the ways in which therapeutic anarchy provides both effective and ineffective strategies for agency.

Edward Fischer is one of a number of theorists in anthropology currently advocating a turn from the “anthropology of the dark” to an “anthropology of the good,” or in his terms “a positive anthropology” (*The Good Life*, 17). He represents a movement away from purely critical theoretical approaches that emphasize structural violence, racism, and other oppressive structures of power, to one that also incorporates an understanding of agency and motivation and that can theoretically accommodate observations of the pursuit of strategies for positive action. In *The Good Life: Aspiration, Dignity and the Anthropology of Wellness*, Fischer addresses his interest in the scholarly study of well-being and the ways in which people can, and do, achieve perceived well-being even under constraints on resources and power. He argues, “we should understand the ends of economics, as well as politics, to be provisioning the good life as widely as possible for people as they themselves conceive it” (1). Moreover, he is interested in the ways in which people use the market to achieve these ends.

For Fischer, “the good life” is best understood from the ground up by drawing on empirical ethnographic research and the dialectic of fieldwork to understand the meanings and values that inform aspirations and motivate peoples’ strategies to achieve the good life. To explore this, Fischer draws data from Germany and Guatemala. In Germany his starting point is the purchase of eggs in Hannover, where German consumers express a desire to purchase more expensive organic and biodynamically produced eggs, but often actually purchase less expensive conventionally produced eggs. In Guatemala he examines the strategies of Guatemalan Maya coffee farmers to achieve *algo más* (something more) in a market that is increasingly interested in high-quality coffee.

The German case study highlights issues related to the value of virtue, and consumers’ calculations that draw on moral economies as well as economic ones. It draws on theories of stated and revealed preferences to understand how value such as solidarity, dignity, and opportunity are embedded in German approaches to well-being and add meaning and value to the behavior of German consumers.

Fischer lays out the historical and contemporary background of coffee production in Guatemala, documenting how in the postwar era, a number of small, previously landless or subsistence farmers were able to enter into an increasingly segmented market as producers of high-value coffee. As many as 50 percent of the producers of coffee in Guatemala are small Mayan farmers in the highlands who are able to exploit their high-altitude landholdings and household labor to produce high-quality beans. To understand the interplay between agency and access to opportunity Fischer draws heavily on Amartya Sen’s concept of “unfreedom,” but he also incorporates a range of concepts from contemporary and classical economics to build a model that places neoclassical notions of rationality and rational economic behavior within the context of a more ontological understanding of the varying values and aspirations of people in different settings.

Data that Fischer and collaborator Bart Victor collected in a survey of coffee producers across the coffee producing regions of Guatemala in 2011 suggest that coffee farmers aspire to “something more” (*algo más*) and, while overall satisfied with their lives, see themselves as constrained by access to resources such as credit, educational opportunities, and political influence, which Fischer uses to illustrate his notion of “frustrated freedom” and add it to the discussion of “unfreedom.” Fischer and Victor also used the tools of experimental economics, including the use of the Ultimatum Game to demonstrate the degree to which

Maya coffee producers from several communities privilege the values of fairness and dignity. Beginning with the observation that “If Job were a country, it would have to be Guatemala” (181), Fischer documents the further constraints placed on farmers by a failed political system dominated by narco violence and broad insecurity. In this analysis, Fischer has provided a nuanced and intellectually stimulating counterpoint to overdetermined structural models by redirecting our attention to the goals, aspirations, and actions of people, and reconnected theories of economic rationality with locally held values and expectations.

Prompted by a Guatemalan man infected with HIV who posed the question: “Why would your congress make it harder for me to get my medicine?” Angelina Snodgrass Godoy embarked on a careful, detailed study of the impact of Chapter 15 of the Central American Free Trade Agreement (CAFTA), which includes the provision for the protection of intellectual property, on the availability and price of drugs in Central America. *Of Medicines and Markets: Intellectual Property and Human Rights in the Free Trade Era* builds on her work on human rights activism in Guatemala to address the impact that intellectual property rights protectionism has on access to health care, particularly pharmaceuticals in Central America. In contrast to other books discussed in this essay, Godoy is not interested in the impact of CAFTA on individuals. She is more generally concerned with the impact of CAFTA on the right to health, specifically on the availability of affordable medications. She uses this example to more broadly analyze human rights activism in a neoliberal global economic environment. Godoy sees intellectual property rights in drugs as a unique window into the broader discussion of the inherent conflicts between free trade and human rights in a globalized economy. Her focus is the effect of intellectual property regimes embedded in CAFTA on the availability of affordable generic drugs for the people of Central America in general and Guatemala in particular. She is especially concerned with the challenges that the exercise of power through CAFTA poses for the conventional human rights advocates in Central America, who she sees as focused on civil and human rights rather than on social and economic rights, and thus as ill prepared to deal with the subtler forms of rights abuses that the impact of intellectual property regimes place on the right to health, with specific reference to poor and indigenous peoples.

As Godoy points out, Chapter 15 was presented by US negotiators as a nonnegotiable provision. At the time of the negotiations both the Central American negotiators and advocacy groups saw a clear tradeoff between the protection of intellectual property and public health.

Godoy reviews central concerns in the application of intellectual property regimes to pharmaceuticals and discusses basic information on the nature of patents in the drug industry and the role of test data in moving new drugs to patent, and then maintaining patents through the extension of testing data. This is not new information for any reader with some familiarity with the ways in which pharmaceutical companies manage and maintain patent rights. However, it does set the stage for a better understating of the implications for the application of Chapter 15 of CAFTA to the Central American case. Conventional approaches to advocacy developed under foci on civil and political rights can be manipulated and marshalled to serve the interests of global capital, as when health care advocates, especially for people with chronic illnesses such as HIV infection, advocate for the availability of branded drugs over generic drugs, which are often seen as less effective. Human rights advocacy in Central America was shaped by the resistance to a series of wars and, in Guatemala, the genocide perpetrated against the Maya. “Human rights tactics are still drawn from a tool kit first developed to stop civil and political rights abuses” (47). Godoy’s analysis shows how conventional human rights advocates were in a position to be co-opted by multinational pharmaceutical interests as they moved to address health in a neoliberal global economic system.

Tarahumara Medicine draws on the experiences of Fructuoso Irigoyen-Rascón as a physician and observer of the Rarámuri (Tarahumara), beginning with his time as a medical graduate carrying out his year of service with the Rarámuri, followed by five years as a medical professional in the Clínica San Carlos, a medical mission in Norogachi, and subsequent years of practice. In this monograph he takes a cultural ecology approach, examining the ethnomedical practices of the Rarámuri as cultural and biological responses to challenging physical and external cultural and political environments. The book is organized in classic ethnographic structure. It is written from the point of view of the omniscient observer and summarizes the authors’ knowledge of Rarámuri healing with little descriptive detail. In a format more common before 1970, Irigoyen-Rascón presents a description/discussion of the “ecological habitat” of the contemporary and historical Tarahumara with chapters on the history of the Rarámuri; the land, climate soils, plants, and animals of the land inhabited by the Rarámuri; Rarámuri history beginning with the early Clovis Complex settlements; a critical discussion of the impact of introduced disease; and the resistance of the Rarámuri and others to colonial and postcolonial domination. The focus is on the structural elements of a culture presented as though it is frozen in time and essentially ahistorical.

Rarámuri as actors are curiously absent here. The discussion of Tarahumara medicine is presented in the kind of ahistorical terms that was common in medical anthropology before the middle of the twentieth century. The author describes local health knowledge and healing practices in generalized terms. It is not that the information contained here is inaccurate, but that it is presented as static, essentialized, and atheoretical. Compared to the work described above, the book presents an unnuanced view of medical pluralism that sees ethnomedical systems as anachronisms and spends little time describing health-seeking behavior or the factors that influence the choices that Rarámuri make with respect to health.

Finally, this book sidesteps a number of issues of intellectual property regarding the knowledge held by indigenous peoples concerning their environments and the useful species that they contain. The last half of this volume (155–283) comprises a “Compendium of Tarahumara Herbal Remedies and Health Practices” in which the Rarámuri, Spanish, and Linnaean names for the species are linked with their uses by the Tarahumara and, when available, the demonstrated or likely pharmacological effects recognized by science. It has become common in recent decades to avoid this level of identification in order to protect the intellectual property of indigenous or other local communities from blatant medical prospecting.

This work stands in stark contrast with the analysis presented in the volumes of Briggs et al., Fischer, and Chary and Rohloff discussed earlier. The reader has no real feel for the ways in which contemporary Rarámuri manage their health or the constraints and opportunities that a complex Mexican health care landscape affords. It can also be contrasted with the work of Godoy, who directly confronts issues of intellectual property in Central America, albeit focused on the production of biomedical pharmaceuticals.

These books illustrate several themes currently discussed in the wider literature on medical pluralism and health equity in Latin America. Most of these works directly confront the health and medical concerns of indigenous peoples and other ethnic minorities as the clear consequences of postcolonial structures of power and the resistance to those structures. Even across several different health care systems (Venezuela, Guatemala, and even Mexico) the impact of neoliberal economic policies is played out as an extension of the constraints and inequities imposed in colonial and postcolonial regimes. The current critique of humanitarian care can be applied to policies aimed sometime naively at empowerment, such as conditional cash transfer programs, the Thousand Days initiative, and international NGOs providing “free care.”⁴

Briggs and colleagues place the responses of both the families that lost children and the health care workers who interacted with them squarely within the domain of postcolonial structures of power. While Godoy is concerned primarily with the newer realities engendered by global economic change and global neoliberal economic regimes translated into the availability of and access to drugs in Central America, Briggs and Mantini-Briggs develop a conceptual framework for the ways in which the national health care system responds in long-established ways to the health needs of indigenous peoples.

Godoy’s approach to the questions of health and human rights that crosscut many of the works discussed here provides a distinctive view of the some broader questions. Her ability to link the concerns of global neoliberal economic regimes, as seen through the lens of intellectual property rights, with a bottom-up approach to examining the potential impacts on real people adds a dimension to the discussion that is not as well addressed by the authors in Chary and Rohloff or by Briggs and coauthors and is quite distinct from the approach of Fischer. While these other works focus most closely on the impact of policy on the lived experience of people, Godoy’s analysis is more aimed at the implications of this case for the fundamental issues in the philosophy of human rights discourses. Her analysis of the ways in which this particular area highlights the degree to which rights advocacy discourse can be manipulated suggests a need for a fundamental change in the way in which advocacy for social and economic rights is organized. The papers included in the volume edited by Chary and Rohloff include narratives of choice and agency in a chaotic and nonrational landscape of health care alternatives that both confounds some health seekers and provides opportunities for others; Fischer more pointedly examines agency in service of the achievement of the actors’ own desires in both Germany and Guatemala. The data on the aspirations of Guatemalan Maya coffee farmers and their perception of the opportunities and constraints they face to achieve them presents a more optimistic view of the ways in which individuals, households, and communities develop strategies to achieve goals even in the face of violence, racism, and neoliberal policy regimes.

Finally, all of these books draw on empirical research using qualitative research methods and the tools of ethnography to bring a grounded understanding of the points of view of the participants, and to move the sequence of models into a new, more nuanced and broader discussion. The reader hears the voices of health

⁴ See, for example, Miriam I. Ticktin, *Casualties of Care: Immigration and the Politics of Humanitarianism in France* (Berkeley: University of California Press, 2011).

care personnel, Ministry of Health officials, indigenous families, indigenous healers, and human rights activists, as well as the voices of the researchers who have collected and analyzed the data. Many though not all of these books take a situated and reflexive approach to analysis. They incorporate understandings of agency and action that go beyond the critical theoretical approaches of the late twentieth and early twenty-first century. The privatization of health care delivery helped create a dizzying, nontransparent, difficult-to-navigate array of options for indigenous Guatemalans. It also created new opportunities for accessing health care for those who have been able to manage the new reality. These volumes call on us to rethink the consensus around the salience of structural approaches to health equity (structural violence, critical medical anthropology) and the emphasis on agency (historical approaches to medical pluralism, health choice models). Each of these works focuses on a different aspect of these concerns and suggests a somewhat different answer.

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