Health and Indigenous People: Intercultural Health as a New Paradigm Toward the Reduction of Cultural and Social Marginalization?

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Abstract

The precarious socio-economic and health conditions of indigenous populations legitimize claims of marginalization and attest to the inherent inequality that indigenous groups suffer. In the last few years, advocates have urged the use of traditional indigenous health practices as more culturally fitting for most indigenous populations. An intercultural health program can reduce the conditions of social and cultural marginalization in an indigenous population. However, accepting and integrating indigenous medicine into a westernized health system presents a major challenge to intercultural healthcare in Latin America. The objective of this paper is to analyze the case of Makewe hospital, one of the first and few examples of intercultural health initiatives in Chile. The paper will examine the implementation of this initiative and the main challenges in creating an effective intercultural health program.

Introduction

Despite the political advances indigenous populations have made through political representation and autonomy, very few gains have been made in reducing poverty among these groups (Hall and Patrinos 2005). No systematic data on the health of these populations are available, but a few studies have reported worse indicators (infant mortality, life expectancy, maternal mortality) than

the national averages in their respective countries (Cass et al. 2002; Hall and Patrinos 2005; Pan American Health Organization [PAHO] 1999).

Chile has two health services systems. The unrecognized and unregulated traditional indigenous health system is widely distributed and utilized, whereas the formally recognized and regulated modern health system is significantly restricted in its accessibility and scope, particularly outside metropolitan areas. According to the Pan-American Health Organization (PAHO; 1998), Chile has more than 10,000 healers. Bussman et al. (2010) found that 71% of the Chilean population and 40% of the Colombian population have used traditional medicine. Modern medicine in each country has gone through a process of reforms during the last decade, most often moving toward decentralization and increased privatization.

Athough Chile has attempted to maintain a core of first-level services (primary healthcare) through insurance schemes and contract-based health centres and outposts, its social safety network has been substantially destabilized during this period. In some rural areas, a high proportion of the poor, including indigenous populations, are without adequate access to modern healthcare services. Pervasive economic and social inequality helps explain the differences in health between indigenous and non- indigenous Chilean people. A higher poverty rate hinders access to local health services for the Mapuche (Adler and Newman 2002; Johnson et al. 2004). It is important to point out that the Mapuche are not the only indigenous community in Chile. Although they represent the largest indigenous population, there were also small populations of Aymara, Atacameno, Rapa Nui and Kawaskhar in the country. In Chile, as well as in other South American countries, variations in health have been shown to be correlated with income and poverty. Lower income is associated with poorer health outcomes (Newacheck and Hung 2003; Scarpaci 1988; Shi and Stevens 2005).

Living in rural areas represents a problem in health outcomes, too. The interaction of identity with land in Chile also complicates the study of poverty among indigenous people; location and space available to a community can greatly affect the risk of poverty among indigenous and non-indigenous people alike (Adler and Newman 2002; Parse 2003). Empirical evidence has shown that those living in areas that depend on one major natural resource for economic well-being are disproportionately poor (Sapag and Kawachi 2007). Additionally, in rural areas the population is less likely to have adequate housing, health and sanitation.

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Responding to problems in healthcare, advocates are attempting to promote retention of traditional indigenous practices as more culturally fitting for significant portions (and sometimes majorities) of the population (Newacheck and Hung 2003; Reyes-Ortiz and Pelaez 2007; Shi and Stevens 2005). But to what extent do such intercultural health initiatives work in practice? What are the major challenges in implementing an effective form of intercultural healthcare that can also reduce social and cultural marginalization among the indigenous population?

To answer to these questions, I shall present the case study of Makewe Hospital. Makewe is one of the first examples of an intercultural healthcare delivery system in Chile. It is located in the middle of several Mapuche communities and serves approximately 20,000 people. According to the hospital, more than 90% of its patients belong to the indigenous Mapuche communities.

Intercultural Health and Indigenous People: A Challenging Issue

The rights claimed by indigenous people, especially the Mapuche, have become part of an international effort to encourage and pressure Latin American countries to recognize and grant these groups increased sovereignty. This effort has accelerated in the last few years as indigenous groups represent themselves at international meetings and summits. Uncertain economic and health conditions of

indigenous groups are the basis for their promoting change in the health system and transformation of relations with the state. As a consequence, the consensus among international organizations has been to link improvement of health conditions to indigenous self-determination[1] struggles.

Indigenous health policy in Chile focuses on cultural differences expressed through the discourse of intercultural practices and intercultural health (Cuijema and Ochoa Davila 2003; Cunningham 2002; Orellana Salvador 2003; PAHO 1998). Intercultural practices are meant to convey acceptance, respect, horizontal relations, inclusion, equity, reciprocity and solidarity (Almaguer et al. 2002; Morgan 2001; PAHO 1998). According to PAHO's definition (1998: 36), intercultural practices "involve the equal and respectful inter-relationships of the political, economic, social, cultural, linguistic and gender differences, established in a particular space between different cultures." In many instances in Latin America, intercultural health is linked with indigenous forms of medicine (Centro Interamericano de Estudios de Seguridad Social and Reyes-Heroles 1987; Fernández Juárez 1999; Montenegro and Stephens 2006). It is important to point out that intercultural approaches to health are not only related to the indigenous medical systems. The term "intercultural practices" on one hand emphasizes the importance of cultural rights, and on the other points to the government's responsibility to provide adequate healthcare through access to institutional medicine. Cunningham et al. (2003) argue that intercultural practices emerge from 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."

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Recognizing these different rights in the concept of "intercultural health" and the need for different policies to deal with indigenous peoples is at the core of the advocacy for decentralizing the health system for numerous indigenous populations (Cujilema and Ochoa Davila 2003; Cunningham 2002; Murray-Garcıa et al. 2000; PAHO 1999). In Chile, the recent expansion of decentralization policies is part of a broader process of political, economic and technical reform (World Bank 1998). These policies include democratization and an effort to give voice to indigenous communities, as well as the neo-liberal modernization of the state.

Because of its long history as a centralist state, Chile is an interesting case of decentralization in health services (Angell et al. 2001; Nigenda et al. 2001). This history brings inevitable challenges for the state in reducing its own power and control over social policy. While the Chilean state is the main actor of reform in social programs and intends to maintain its centralist control over the social sector, the policy of decentralization in health sector has mainly relied on non-governmental organizations (NGOs) or civil organizations (Johnson et al. 2004; Mable and Marriott 2001; Nierkens et al. 2002). The intercultural health program emphasizes participation from indigenous communities as its key element.

These efforts at decentralization endeavour to blend intercultural practices with political action. Decentralization is explained as more than an intercultural preoccupation; it must be seen within a broader context of concerns about efficiency and local responsiveness (Birn et al. 2000; Bossert et al. 2000; Lillie-Blanton et al. 2000).

The characteristics, rationale and expected results of decentralization are aligned with the goals of the indigenous rights movement. The rationale is that local autonomy in decision-making, with input from the local population, will lead to increased responsiveness of healthcare to local needs, better quality healthcare and social empowerment. In evaluating decentralization, Bossert et al. (2000) outline the need for ways to assess improvement in equity and the democratic process. For

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the indigenous movement, control over resources and autonomy in issues related to health are closely aligned with the goals of political autonomy and self-determination for indigenous groups. Cunningham (2002), for example, sees decentralization as the key to effecting an intercultural health system.

The Case Study

The Makewe hospital is situated in Makewe-Pelale, a rural Mapuche territory 25 km south of Temuco in the municipalities of Padre Las Casas and Freire. The territory includes 80 Mapuche communities with a population of approximately 10,000 persons. The vast majority of people living in these indigenous communities are small-scale farmers; the average land distribution is 1.5 hectares per capita.

As well as its intercultural health program, an unusual feature of Makewe Hospital is the strong participation of Mapuche communities in its administration. Participation is through the Indigenous Association, created in 1997 following the mobilization of the communities around the Makewe-Pelale area. The Association took control of the hospital in 1999; previously, it had been administered by the local Anglican church.

The Indigenous Association has developed mechanisms to enhance the communities' participation in the administration of the hospital. First, it has committees dedicated to gathering input from the communities. One is the Committee of the Wise (Comidad de los Sábios), which consists of lonkos, or elders, who have legal and social authority in their communities. The Committee of the Wise plays an important role in shaping the health model of the hospital and in supporting the proposals of the Indigenous Association. The director of Makewe and some of the hospital doctors interviewed emphasized this role heavily.

Methods

I contacted fieldwork for this study in Chile between February and April of 2008 at Makewe Hospital. The research is based on a sample of 42 semi-structured and open-ended interview conducted with Mapuche patients and doctors and nurses from the Makewe hospital. I interviewed four traditional Mapuche healers (machis). I selected the respondents based on their representativeness and willingness to participate. Patients were selected through parameters such as age and gender. I conducted in-depth interviews with the main actors of each intercultural health program; they included health officials from regional and municipal governments in Temuco with whom the Makewe hospital interact and negotiate, as well as Mapuche leaders in Makewe. I also conducted observations in the hospital and of participants. Interaction between the health workers and patients in the lobby, the waiting area and doctors' offices was observed, with permission from doctors. I attended seminars on intercultural health programs in Makewe, as well as various community meetings and governmental workshops in Temuco. In order to ensure the confidentiality of the data, I omitted the interviewee names.

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How Intercultural Health Is Put into Practice

The staff of the Makewe hospital is composed of 30 members, including two doctors, one dentist, three midwives, one kinesiologist, six paramedics, four custodial workers, three secretaries, three cooks, three drivers and one assistant for the dental service (PAHO 2001). A unique feature of this hospital is its relationships with traditional health specialists such as machis, who are religious, spiritual and medical authorities in Mapuche culture. These traditional healers take an active part in several events at the hospital and advise the Indigenous Association on how to formulate and

implement intercultural healthcare practices. One of the most important initiatives is collaboration between doctors and traditional healers in the diagnostic and therapeutic phases of treatment. Patients who doctors believe will benefit from traditional Mapuche healthcare are transferred to machis. In terms of intercultural health, this hospital is one of the most advanced in Chile and has the longest history with such practices.

Although the machis are linked to the work of the hospital, patients pay them directly. This aspect is particularly important, as it creates an access barrier for some. Nevertheless, from the interviews it emerged that the traditional healers' fee is generally lower than that of a medical specialist. The Indigenous Association's rational for the fees is that each type of treatment should be provided within its own cultural context. According to this vision, the machis should be validated by the community where they live, not by official entities such as the government. The Makewe hospital helps create links between the patients and the machis of the local communities. Collaboration between physicians and an intercultural worker helps determine if the patient suffers from a Mapuche (spiritual or emotional) or winka (western-based, psychological) illness. Patients diagnosed by either a western physician or a machi can use traditional or western medicine, or a combination.

The need for a culturally diverse hospital can be partially explained by the limited resources of the state to build new hospitals or clinics. Due to the paucity, and sometimes absolute lack, of hospitals and clinics in rural areas, the central question became how to make existing facilities more appropriate for indigenous people.

According to the director of SSAS (Health Service of Araucania), this can explain why the state-sponsored intercultural programs have focused on educating health workers about indigenous culture and on installing a bilingual service centre in the hospital. This initiative is also linked with reducing social discrimination, a priority for Mapuche communities. Institutionalized racism against the Mapuche in education, health and labour markets has attracted national attention to growing conflicts between Mapuche communities and the state. To foster cultural sensitivity as well as diversity of services, the Indigenous Association highlights the importance of changing health workers' attitudes to Mapuche patients and culture. As the director of Makewe emphasized in an interview, "… Intercultural health is not just about the combination of medicine. It is about respect for both cultures."

Respect for Mapuche culture is reflected in the administration of the hospital. For instance, all signs appear in both Mapudungun, the Mapuche language, and in Spanish. The hospital recognizes the religious holidays of Mapuche culture such as We Tripantü (New Year's Day for Mapuche), and religious ceremonies are celebrated within the hospital. Respect for traditional culture is also seen in the hospital grounds, which contain a ruka, a traditional Mapuche house, used by the Association as a meeting place. A rehue,[2] the most important symbol of Mapuche religion, is maintained in the front yard.

As part of the hospital's intercultural health program, the Indigenous Association encourages health workers to acquire knowledge about Mapuche culture, particularly its medicine. Programs aim to blend Western and non-Western medical knowledge. However, Chilean government documents do not present this blending as the intercultural program's main objective.

The intercultural health program promoted by the state seeks to recognize indigenous people's needs in the health sector, redefining the state as democratic, humanitarian and pro cultural rights (Laveist and Nuru-Jeter 2002; Montenegro and Stephens 2006). To improve health service for indigenous peoples, the Chilean health system introduced Bilingual Information Services to serve the Mapuche population in the IX Region, and Patient Care Services designed to greet and accompany patients and their families from hospital admission to discharge.

From the state's perspective, a bilingual office within hospitals, hiring indigenous health workers and allowing some input from indigenous communities in hospital administration was expected to improve access and reduce inequality between indigenous and non-indigenous populations. This is the key aspect of the intercultural health program and remains the key target for multicultural social policy. The state's multicultural social policy remains focused on expanding the social rights of the indigenous population rather than on promoting their cultural rights (Kim et al. 2000; Morgan 2001).

National health officials view culture in the context of values and beliefs. Intercultural practices are therefore mainly a process of communication in which those cultural values and beliefs are understood and recognized (Almaguer et al. 2002; Anderson et al. 2003; Ferguson and Candib 2002).

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. Policy recommendations therefore are limited to adding elements of "cultural competence" to staff training in the health system through workshops and education.

Local health officials have a different conception of intercultural practices and health policy. The latter conforms to the model of political action previously presented by Cunningham (2002). According to this vision, intercultural practices represent an epistemological concept, one that brings together different forms of knowledge that have been placed in a hierarchy through differential access to power. As such, the goals of intercultural practices must not only be improved communication, but also political action and redressing questions of historical inequality.

There are eleven machis in the area of Makewe-Pelale, and six of them have strong collaborative ties with the Makewe hospital. If necessary, doctors may transfer a patient to a machi, while machis of the area transfer their patients to Makewe if they believe that Western medicine is needed. Once the transfer takes place, doctors and machis generally interact and discuss the patient. The hospital offers transportation for patients who wish to see a machi (PAHO 2001).

Interviews with Makewe patients revealed a high level of satisfaction with the hospital and its services. The majority of patients interviewed, 25 out of 32, answered that they chose the hospital because of the high quality of its service. Fourteen patients, mostly middle-aged women, stated that they chose to come to the Makewe hospital because of its proximity to their village. Four patients responded that they chose Makewe because of lower cost, compared to other hospitals in Temuco.

A reason that could explain patients' positive reaction to the hospital's service is that the hospital not only tackles problems related to social service delivery but also addresses cultural issues inside the service delivery system. This is illustrated by the issue of clarity in doctors' explanations of an illness. When asked how clear the doctor's explanation of their health problem was, 17 out of 32 patients answered that it was comprehensible and satisfactory. Only four patients, mostly older ones, answered that communication between doctors and patients was not completely satisfactory. Only one patient answered that the explanation lacked clarity.

Although little is known about the exact causes of the communication problems in Chilean hospitals, this is not only due to a language problem, but also to a cultural difference expressed in the way different ethnic groups think about health, disease and healthcare (Ahmad et al. 1990; Angell et al. 2001; de Haes and Koedoot 2003). The health beliefs of modern physicians are shaped by their own cultural background and biomedical and clinical training and are based on a scientific medical paradigm (Penn et al. 1995).

Many indigenous people have little education and thus have difficulty understanding information given by healthcare professionals. Kleinman (1980) argued that healthcare outcomes (compliance, satisfaction, and so forth) are directly related to the degree of cognitive disparity between the explanatory models of practitioner and patient and to the effectiveness of clinical communication.

Generally in Chilean hospitals the Mapuche patients' perception that the doctors' explanations are clear could derive from the fact that doctors have been trained to try and better understand Mapuche culture. Three out of five doctors interviewed emphasized that they have spent a long time interacting with Mapuche leaders and are familiar with Mapuche culture. For instance, one doctor from the Makewe hospital spoke Mapudungun fluently.

Outstanding Issues in This Experience of Intercultural Health

The Makewe Hospital is often cited as a successful example of the implementation of intercultural health, both by government representatives and among the Mapuche themselves. This does not mean that the project is without difficulties.

Challenges in Harmonizing Different Religious Beliefs

Study interviews highlighted how evangelical churches in the region have condemned Mapuche medical ceremonies. People who are evangelical or belong to a Protestant church tendency to not to visit machis, largely because of religious beliefs. Evangelical or Protestant nurses and workers in the hospital had nothing against the study of herbal medicine or its use in the hospital. However, they expressed uneasy feelings about the machis, whom they often associate with evil forces and witchcraft.

The Contentious Concept of Intercultural Health

Although Mapuche leaders and Indigenous Association members interviewed were active in political discussions on intercultural health or were working in this field, some expressed strong negative views about the concept itself. This was especially true in the case of elderly Mapuche, who remain sceptical of initiatives involving the Chilean government. This mistrust is based on the current and historical relationship between the Mapuche and the Chilean state and dominant culture.

The history of the indigenous population in Chile has been one of repression, discrimination and subjugation (Melissa and David 2008). Segregation and forced assimilation became the twin tools of domination by the European-origin population (Rector 2003). Indigenous people were forced to assimilate or face isolation. They were subjected to social oppression through legislation, social policies and other official and quasi-official means (Jeffery 2007). These laws created formal mechanisms such as slavery and a reservation system that legitimized discrimination against indigenous people. One example was the forcing of indigenous communities onto reservations that were smaller than their traditional ancestral lands (Ray 2007).

This resistance to state-sponsored initiatives is not generally shared by younger Mapuche leaders, who see intercultural health as a way to express the Mapuche identity and as a more balanced and egalitarian relationship with mainstream Chilean society.

Pablo, a Mapuche community leader in his early forties, explained,

> Through this experience at the Makewe hospital we have shown that Mapuche medicine can be as good as the Chilean one. We have been obliged to live in an intercultural context since our childhood. It is the time now that Chileans learn to do the same thing.

Some interviewees also argued that the concept of intercultural health does not necessarily provide equality, which can be achieved only if the fundaments of interculturality are implemented on a broader level. This involves social and political equality, legal recognition and the elevation of Mapuche medicine and culture in development programs. As long as inequality and discrimination remain unchallenged, a "relationship based on respect" will not be developed. A patient at the hospital stated,

> Traditional medicine represents an important aspect of our culture.... When people make fun of our beliefs they are not respecting the culture of the Mapuche. The fact that we have indigenous medicine included in the health system means that our culture is respected and recognized.

A machi interviewed argued that from his point of view, there were no examples of intercultural health systems in Chile. Asked about the significance of the concept of intercultural health, he explained,

> Intercultural health does not yet exist, and it will not exist as long as there are unequal conditions for the individual … the Mapuche people and other indigenous people are not recognized.

These comments are particularly meaningful as they reflect the importance of political issues in health policy. The growing grassroots demand for political recognition of culturally differentiated groups, and the apparent willingness by the government to recognize these groups, are significant

political as well as social issues. They can be understood as a problem of how to expand citizenship to realize multicultural citizenship (DiClemente et al. 2002; Kymlicka 1995) or how to modify liberal democracy to combine its universalist approach with the pluralist reality of a society (O'Neil et al. 2006; Taylor et al. 1994).

As Habermas (1994) points out, multicultural society necessarily involves the struggle of oppressed ethnic and cultural minorities. This struggle is certainly not a uniform phenomenon. Different ethnic groups have different goals, derived from different historical and political conditions. Multiculturalism draws either from the indigenous minorities who become aware of their identity and demand recognition, or from the new minorities who are a result of migrations in this globalized world (Ashton et al. 2003; Habermas 1994; Paley 2001).

These fundamental issues remain unresolved and are not currently recognized in healthcare policies. So far, governmental planning has focused on improving communication and interaction between Mapuche patients and health workers.

Inadequate Regulatory Framework

In Chile, regulations concerning how the healthcare system might best interact with traditional indigenous practitioners are minimal. The legal system hinders harmonization of the two systems because the government's Sanitary Code makes it illegal to practice medicine without holding a license. Traditional healers such as the machis do not possess a license, exposing both traditional healers and western doctors to the risk of litigation when adopting intercultural health practices. Traditional Mapuche healers practice extensively throughout rural areas in Chile, and in particular in Region IX (Araucanía), which has many Mapuche residents. The conflicts between the Mapuche and the government make implementing intercultural health difficult and hinder constitutional or legal changes that recognize traditional medicine. However, lack of recognition for the field of intercultural health does not seem to favour tendencies to identity change or cultural assimilation. Instead, the conflicting interests between the Mapuche and the dominant society accentuate ethnic difference (Almaguer et al. 2002; Cooper et al. 2003; O'Neil et al. 2006).

Economic Sustainability of the Makewe Initiative

The Makewe initiative required a new discussion on the value and role of traditional medicine, the responsibility of community health leaders, and the role of the state in intercultural health. Economic support from the government appears insufficient to ensure the sustainability of this intercultural health initiative. Currently, the Makewe Hospital is a private health institution managed and run by the Mapuche Indigenous Association. If the state's intercultural development program receives funding for intercultural healthcare, the hospital will be obliged to accept government interference in administration in exchange for economic support.

Chile's government currently provides some funding for intercultural health programs, although it is minimal (Rivadeneyra et al 2000; Sapag and Kawachi 2007; Schouten and Meeuwesen 2006). Government agencies have given no indication that the intercultural health program will be maintained once current funding is over. As the ministry's budget and resources available for indigenous health programs are limited, it is not clear how the Mapuche projects could be replicated on a broader scale.

Conclusion

The intercultural health program in Makewe presents an important case of multicultural social policy based on strong community participation with a little intervention from the state. This relatively autonomous status of the Indigenous Association has made a positive impact on intercultural health policy. The Association could enhance cultural diversity as well as health workers' cultural sensitivity. Furthermore, the Indigenous Association's intercultural health model has created a new way of combining Mapuche medicines with Western medicine; it is innovative but does not necessarily conflict with the current Chilean legal system.

The Makewe hospital has been successful in expanding cultural rights in its healthcare model. Many patients stated their satisfaction not only because the care itself is effective and speedy, but also because they do not need to worry about discrimination. The case study shows the importance of achieving multiple goals of multicultural social policy. Such policy aims at accomplishing both social rights and cultural rights. The improvement in social rights needs to accompany the expansion of cultural rights, and vice versa.

The state initiative for implementation of intercultural healthcare practices has opened new opportunities for the Mapuche in the IX Region. Using the framework of the intercultural health system, these indigenous communities have implemented local projects combining both Mapuche and western medicine in this rural area. Within these projects, the Mapuche struggle to reinstate their medicine as a recognized health system. Simultaneously, they express their culturally defined needs in a broader socio-political perspective, stressing a wider holistic view within these projects.

The concept of intercultural heath is large and vague, opening it to multiple interpretations and degrees of control from various sectors of society (Sleath and Rubin 2002; Sleath et al. 2003). Therefore, the use of these terms can provide an illusion of agreement, despite radically different interpretations and practice (Morgan 1993; Paley 2001; Triandis and Trafimow 2001).

Intercultural practices can be understood as a framework that deals with bridging cultural differences based on knowledge systems, values and practices; it can be seen as a concept that encompasses cultural differences from the perspective of unequal power relations as historically constituted in society. As is shown in this paper, from the viewpoint of the Mapuche communities, the concept of intercultural practices encompasses both.

It is very important, however, to ensure that community participation represents the wider community, not the small groups that might have a vested interest in continuing traditional practices (Morgan 1993; Paley 2001; van Wieringen et al. 2002). One can question up to which point the Mapuche Indigenous Association and the Committee of the Wise represent the views of the whole Mapuche community. The Association is elected in the community and attempts to represent its members through age and gender, but the Committee of the Wise is composed mainly of elderly people.

Community participation initiatives provide avenues for real political action, but their success depends on both the capacity of the community to ensure democratically functioning mechanisms in its organizations and the openness of governments and states to accept the political demands and consequences that these initiatives engender.

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41

Endnote

1. The increase interest towards indigenous people has been the result 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). In one way or another, these international meetings have addressed the issue of health of indigenous peoples, and they have been linked to rights to self-determination, education and land.

2. A rehue is a tree trunk set in the ground and surrounded by canes of colihue, a perennial plant similar to bamboo, located in row and adorned with white, blue or yellow flags and branches of trees. The rehue has seven steps rising up from the earth to the summit. On the summit is a representation of a human face. The rehue symbolizes the connection with the cosmos. This rehue is a symbol of great importance, used in important celebrations like the Machitun, Guillatun, We Tripantu (Mapuche New Year) and others.