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TRANSLATION OF SPANISH-ENGLISH AND ENGLISH-SPANISH DOCUMENTS OF THE HISTORY OF COSTA RICAN HEALTHCARE

Thesis Submitted to Obtain the Bachelor's Degree in English

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Dedication

To my family, for their unconditional love and support and the countless sacrifices they have made for me to live comfortably. I would like to thank them for always teaching me the importance of education. In particular, I would like to thank my mother, whom I treasure, for everything she has given me, and for the hardships she has endured in order to take care of me.

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Abstract

The purpose of this study is to provide information and accessibility about the beginnings of Costa Rican health care through a translation from English to Spanish and from Spanish to English that contrasts the documents while maintaining accuracy. A few surveys will be conducted to collect the data required to produce this document. In addition, the researcher will compile several studies from previous documents regarding medical translation as well. As a result, the information gathered from this search will be the primary foundation for this work, with analysis to ensure project correctness and rely on trustworthy sources. The investigator's idea to support the study's goal would be to gather many diverse perspectives and data from sites online provided by different authors that offer useful and essential information to contribute to this investigation in the healthcare field and the use of technical translation methods. Therefore, to acquire a deeper comprehension of the translation of medical documents and their corresponding approach, different points of view and statistical data were examined and analyzed by the researcher. This investigation considered the growth and development of Costa Rican health institutions over time and the terminology utilized in both national and international medical records. Hence, this analysis is carried out to give a deeper analysis and gathering in sequence to ensure that the translated material is accurate.

Resumen

El propósito de este estudio es proporcionar información y accesibilidad acerca de los inicios de la atención médica costarricense mediante una traducción del inglés al español y del español al inglés que contraste los documentos manteniendo su precisión. Se realizarán encuestas para recopilar los datos necesarios para elaborar este documento. Además, el investigador recopilará varios estudios de documentos anteriores relativos también a la traducción médica. Como resultado, la base principal de este trabajo será la información obtenida de la búsqueda, con análisis para garantizar la corrección del proyecto y basarse en fuentes confiables. La idea del investigador para apoyar el objetivo del estudio es reunir diversas perspectivas y datos de sitios en línea proporcionados por diferentes autores que ofrezcan información útil y esencial para contribuir a esta investigación en el campo de la atención médica y el uso de métodos de la traducción técnica. Por lo tanto, para adquirir una comprensión más profunda de la traducción de documentos médicos y su enfoque correspondiente, el investigador examinó y analizó distintos puntos de vista y datos estadísticos. En esta investigación se consideró el crecimiento y el desarrollo de las instituciones de salud costarricenses a lo largo del tiempo y la terminología utilizada en los registros médicos tanto nacionales como internacionales. Por lo tanto, este análisis se lleva a cabo para dar un análisis más profundo, y la recopilación en secuencia para garantizar que el material traducido sea preciso

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Chapter I

Introductory Framework

In Costa Rica, access to historical data about the development of the healthcare sector remains limited, presenting a significant challenge to understanding the evolution of its health system. This argument seeks to address this gap by exploring the key healthcare strategies that have shaped Costa Rica's effective health system focusing particularly on the evolution of the Caja Costarricense de Seguro Social (CCSS). By examining the historical context of the first implementation of medicine in the native cultures of Costa Rica the health reforms and the complex association between social and political factors in creating health institutions, this study's intention is to clarify the foundational requirements that led to a vital primary healthcare system. The significance of this research lies in the understanding that Costa Rica's healthcare system represents a fundamental right to an accessible and free medical service for its citizens. Along with these points highlighted before, this study aims to showcase the importance of ancestral practices used before Costa Rica was a nation.

To describe these documents, they discuss Costa Rica's primary health care system as one of the most effective in the world, providing comprehensive care to nearly all its citizens. These cases explore what choices the country implemented to develop its health system, with a focus on the integration of preventive and curative care models and the legal decisions taken by the government per decade. Likewise, these documents explain how the country has become economically stable and has a strong social development record despite being a middle-income nation. Moreover, the case study is structured into different sections. These examine the historical context that laid the foundation for the Costa Rican health system, tracing its development that set the political platform for subsequent reforms in the upcoming years.

This study highlights the laws that facilitated the establishment of healthcare institutions and the implementation of public services to promote the welfare of Costa Rican citizens. Moreover, this investigation has critically evaluated historical and cultural documents related to the inception of health institutions, emphasizing the need for precise translations of these records to preserve the integrity of Costa Rica's health history.

Accurate documentation is crucial, as it ensures that the messages conveyed through these texts are properly understood by the public. Furthermore, this study develops a glossary with the terminology used in the documents that has been essential to clarify their meanings and enhance accessibility to vital information. Lastly, this research aims to contribute to a clearer understanding of Costa Rica's health system and its evolution within the culture and sociality, ensuring that important historical insights are not lost in translation. As a result, many people can have access to this information.

1.1 Problem Statement

In translating key documents on the evolution of healthcare in Costa Rica—“Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica” and “Building a Thriving Primary Health Care System: The Story of Costa Rica”—it is essential to not only provide accurate translations but also to retain the cultural and technical nuances present in each text. Different challenges or nuances may interfere with the process of translation.

A major challenge in translation is ensuring the accuracy of the text. Medical terms are complex and differ significantly between languages, where small errors can result in misinterpretations that compromise the information which is crucial to obtain a good understanding of the statements. In the case of this study, the documents present a sociological view of Costa Rica over time and the development of medicine. Then, as medicine and healthcare become more modern, translators must be fluent in both languages and have a thorough understanding of the concepts and terminology specific to each language. Hence, translators must enhance their database with up-to-date information in the field. This often requires continuous learning and association with healthcare professionals or academic knowledge.

Cultural precision is essential in translation. Medical practices and beliefs about health can differ significantly widely between cultures, impacting how information is perceived and understood. Documents rooted in a particular culture highlight the importance of that culture and language within its community. For a translation to be effective, it’s vital to respect and accurately convey these cultural nuances, ensuring that the intended meaning is preserved. Translators must convey the same ideas as the original

author, even when there are no direct equivalents in the target language. Using incorrect or culturally inappropriate terms can lead to misunderstandings, especially when cultural differences in medical practices, beliefs, and traditions are involved. By ensuring cultural accuracy, translators help maintain the integrity of communication, promoting clearer and safer healthcare interactions.

Currently, much of the historical and primary healthcare information about Costa Rica remains inaccessible, limiting national and international understanding of the country's health advancements and restricting collaborative efforts. This investigation addresses the gap by exploring translation techniques and strategies to ensure these documents accurately convey specialized medical, cultural, and historical terminology.

This thesis' purpose is to examine how translation quality affects the accessibility and reliability of information for a diverse audience. In doing so, the study expects to contribute to the development of best practices for translating technical content, which can be applied across diverse sectors, ultimately promoting more inclusive communication and supporting global knowledge exchange.

1.2 Investigation Objectives

1.2.1 General Objective

- To analyze and apply specialized translation techniques to translate documents from Spanish-English and English-Spanish on Costa Rica's healthcare history, ensuring accuracy, cultural relevance, and accessibility for a bilingual audience

1.2.2 Specific Objectives

- To translate "Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica" by Alí García and Alejandro Rojas, and "Building a Thriving Primary Health Care System: The Story of Costa Rica" Madeline Pesec, Hannah Ratcliffe, and Asaf Bitton in their respective target languages
- To apply translation techniques that maintain technical accuracy and cultural relevance, focusing on the clarity and accessibility of the information
- To assess the translation quality by evaluating terminology, readability, and contextual accuracy in conveying Costa Rica's healthcare history

- To create a bilingual glossary of essential terms and concepts related to Costa Rica's health system, providing a valuable resource for future translations to the field of translation

1.3 Justification of the Study

This search aims to provide a comprehensive resource for individuals seeking to understand the development of health institutions in Costa Rica. It is particularly valuable for students, translators, and healthcare professionals who are investigating the country's medical history, as well as for those with a broader interest in Costa Rican history and its social development. This work aspires to narrow the gap between historical healthcare practices and their modern implications. Translators and researchers benefit from the information provided by this study by organizing information from different sources. It creates a cohesive narrative that explains the challenges of Costa Rica's healthcare system over time.

The study combines diverse perspectives—historical, cultural, and medical—contributing to a deeper understanding of the development of healthcare institutions in Costa Rica. This approach seeks to highlight the significance of healthcare within the broader historical context of the nation, providing more informed dialogue about its impact on Costa Rican society. By integrating multiple perspectives, this study aspires to contribute to a richer understanding of the development of healthcare in the country, ultimately fostering a more informed dialogue about its significance in a historical context.

This work attempts to create a connection between different times of the practice of medicine in Costa Rica. Therefore, the study is constructed on the beginnings of Costa Rican medicine in health institutions as well as in ancient times involving the indigenous communities of Costa Rica. This is to provide an understanding of the roots of medicine in ancient territories to when Costa Rican society established regulations to support citizens and their access to health care. The documents on which this investigation is based provide more than medical information since they explain Costa Rica's historical background. The texts share the context of the government's establishments and

organizations, which not only need to be accessible for health-related reasons but also for the preservation of Costa Rica's background.

1.4 Antecedents

In this investigation, the researcher analyzed documents written by different scholars, focusing on the principles of translation and examining their contributions to the field. Some of these studies are not based on the medical or historical field of any country but still contributed to this research because of the structure and techniques exemplified in them. The researcher aimed to assess the impact of these works on the development of translation studies as an academic discipline. Besides, the analysis considered the implications of these contributions by exploring how they have influenced translation theory and practice, and how they continue to shape the understanding of translation in both academic and professional contexts. Through this process, the researcher aimed to identify familiar differences and progress within the translation field and provide a comprehensive overview of the elaboration of translation studies.

A MEDICAL TRANSLATION AND ANALYSIS OF SOME DOCUMENTS FROM SPANISH TO ENGLISH AND FROM ENGLISH TO SPANISH - Mario Araya Roa (2023).

The document *A MEDICAL TRANSLATION AND ANALYSIS OF SOME DOCUMENTS FROM SPANISH TO ENGLISH AND FROM ENGLISH TO SPANISH* by Mario Araya is implemented in the investigation as a reliable source. The focus of the study carried by Araya explored how different translation methods and procedures affect the translation of medical documents between private medical practices in Costa Rica and United States in Spanish and English. It focuses on gathering and analyzing data to gain knowledge of concepts, opinions, and experiences to achieve high-quality technical translations of the documents.

The research includes an analysis of the source texts, and the translation processes involved, examining aspects such as grammatical structures, translation techniques, and others. Additionally, it evaluates the complexity of these documents as technical texts,

highlighting how translation techniques enhanced the quality of the translations. These translation techniques and processes are distinct from methods used to translate a full text and aim to maintain naturalness and prevent the translated text from sounding awkward or stilted. As a result, this document is relevant because it explains the translation process and how a translator must keep professionalism and accuracy, which is essential in technical translation. The outcome of the investigation creates a natural equivalent of the source language message in a medical communication context by recompiling data from different resources.

ANALYSIS OF PROCEDURES AND METHODS USED TO TRANSLATE SOME DOCUMENTS FROM ENGLISH TO SPANISH AND OTHERS FROM SPANISH INTO ENGLISH FOR UNIVERSIDAD NACIONAL DE COSTA RICA - Andrea Feliu Gonzalez (2020)

The research *ANALYSIS OF PROCEDURES AND METHODS USED TO TRANSLATE SOME DOCUMENTS FROM ENGLISH TO SPANISH AND OTHERS FROM SPANISH INTO ENGLISH FOR UNIVERSIDAD NACIONAL DE COSTA RICA* by Andrea Feliu aimed to understand the impact of applying technical translation methods and techniques relies on applied linguistics. To address this, the author selected the most effective translation methods and techniques for each translated document. Besides, the researcher created glossaries containing terminology measured as challenging or helpful for understanding the texts. Therefore, this suggests that by analyzing the texts and creating glossaries, the investigator demonstrated the effects of the chosen translation methods and techniques on the target texts. Similarly, the use of glossaries is highlighted so that the translator can further research the significant vocabulary needed to translate, as well as work as guidance for the translator or reader. This research is meant to enrich the field by emphasizing the importance of understanding the cultural context and the utilization of appropriate translation methods to achieve effective and empathetic communication in a multicultural and multilingual society.

Medical Translation English-Spanish. Theory, Difficulties, and Translation Proposal for a Research Article - Diego Jiménez Calvo (2019).

In the document *Medical Translation English-Spanish. Theory, Difficulties, and Translation Proposal for a Research Article* by Diego Jiménez explains that the exchange of information occurs globally and makes medical translation a crucial task within the health sciences field. This examination sought to analyze the field of medical translation by addressing the challenges and processes involved in a practical case. In addition, the study employs an examination of the text as a foundational tool for translating scientific documents whilst utilizing both English and Spanish parallel texts. The outcome of this project provided insights into several important considerations that are essential in the translation of medical or technical texts. The investigation aimed for the reader to recognize the significance of prior analysis and translation techniques in shaping the translation proposal. Hence, this study is a beneficial contribution in the sense that it provides information about the methods and processes used to release a correct translation. There is documentation tracking the importance of communication and the delivery of a message depending on the background provided on a text.

Analysis of the Effect of Procedures and Methods Used to Translate Various Documents from Spanish into English and from English into Spanish for Apartotel Don Francisco - Graciela Echavarría Silva (2016).

The investigation *Analysis of the Effect of Procedures and Methods Used to Translate Various Documents from Spanish into English and from English into Spanish for Apartotel Don Francisco* by Graciela Echavarría is intended to examine the impact of various translation procedures based on different types of texts. Although this research does not specifically focus on the medical or political fields, it contributes significantly to the broader body of translation research by detailing a suitable and legally proper translation process. The goal of the analysis was to demonstrate the significance of employing appropriate translation procedures to achieve a natural and accurate target text. Additionally, it is highlighted in the document that translation encompasses a range of methods designed to produce target texts that are both natural and faithful to the original

and appropriate for the target culture. This research is structured to provide condensed resources with relevant information about translation for future scholars. Besides, another key aspect of this study is the analysis of both source and target texts. Hence, this investigation is essential for understanding the nature of the text, its intent, its procedures, and its expected audience, among other principal characteristics of translation.

Translation and Analysis of the Documents Manual de Adscripción y Beneficio Familiar from Spanish into English for Caja Costarricense de Seguro Social and The Preliminary Plan of Language Café -- an Online Learning Platform from English into Spanish for Language Café. - Roy Shen Su (2018)

The research Translation and Analysis of the Documents Manual de Adscripción y Beneficio Familiar from Spanish into English for Caja Costarricense de Seguro Social and The Preliminary Plan of Language Café -- an Online Learning Platform from English into Spanish for Language Café by Roy Shen focused on translating important documents to improve communication and accessibility for English-speaking users with limited Spanish proficiency, particularly immigrants. This included the analysis and translation of the Manual de Adscripción y Beneficio Familiar for users of Caja Costarricense de Seguro Social (CCSS), which enabled them to understand healthcare services and requirements independently. This translation aimed to ensure that non-Spanish-speaking immigrants feel respected and treated equally and enhance their ability to navigate healthcare processes. Hence, this investigation is essential for the study not simply of its translations but for the analysis of the importance of translation in human communication and its development through history and modern times. As mentioned before, this document is applied in the thesis as a model for understanding the construction of a glossary and its structure, which is implemented in the ongoing research to complete the translation properly.

LA TRADUCCIÓN DEL NUEVO TESTAMENTO AL BRIBRI: ETAPAS, PROBLEMAS, SOLUCIONES Y COMPARACIÓN ENTRE LA REALIDAD Y LA TEORÍA DE LA TRADUCCIÓN BÍBLICA. – Natalia Acuña Naranjo (2008).

The thesis *THE TRANSLATION OF THE NEW TESTAMENT INTO BRIBRI: STAGES, PROBLEMS, SOLUTIONS AND COMPARISON BETWEEN REALITY AND BIBLICAL TRANSLATION THEORY* by Natalia Acuña examines translating the Bible into Bribri, an indigenous language of Costa Rica. It outlines the key stages of the translation process: the cultural adaptation of the translators, the development of a written form of the Bribri language, and the challenges encountered by the translators. It also explores how these challenges were addressed and overcome. The study highlights that indigenous languages are experiencing a significant decline, linked to the erosion of many cultural traits and practices of indigenous peoples.

Fortunately, there has been a growing awareness among Indigenous communities and academic institutions to reverse this process of language extinction. This emphasizes the importance of promoting the learning and use of Costa Rica's indigenous languages. Such efforts are not only crucial for preserving these languages but also for safeguarding the cultural identity of indigenous peoples. Additionally, enabling linguistic diversity contributes to a richer and more cultural landscape in Costa Rica. This research gives a background understanding of the importance of translating native languages into English and Spanish.

1.5 Scope

To carry out this research, the researcher has evaluated the information to be understood when producing the translation. Therefore, different studies have been examined on reliable websites and documents such as those of universities, companies, or professionals in the field of translation, medicine, or history. These sources may come from national or international authors who take part in the elaboration of similar studies. Some of the documents the researcher has reviewed focus specifically on the art and process of translation, guiding how to effectively transfer meaning between languages while maintaining clarity and fidelity.

Moreover, other sources are more specialized, offering technical content related to medical or historical topics. These had been particularly important for acquiring the precise vocabulary needed for translating documents related to healthcare services. The sources allow the researcher to become familiar with the medical and historical terminology used in the study along with the language conventions commonly used in the stated field. Moreover, the analysis means to create a readable and collected document to provide historical information about the history of Costa Rica.

This research focuses on the translation of medical documents between Spanish and English, analyzing the impact of different translation methods and techniques on the accuracy and quality of technical translations. The researcher examines several theses that provide insights into the challenges and strategies involved in translating specialized texts, particularly in the medical field. Most studies that were analyzed focused on things such as the role of grammatical structures and translation methods in producing accurate and culturally suitable medical texts. These were completed by identifying challenging terminology, and demonstrating the effectiveness of translation methods, processes, and challenges involved in translating scientific texts to produce natural and faithful translations and the importance of glossaries in technical translations.

Chapter II

Theoretical Framework

Outlining the main theories and ideas that support this investigation is the purpose of the theoretical framework. This section's main objective is to provide readers of this research with a better understanding of the translation process. According to the University of Southern California (2024), the theoretical framework is when theories are developed to explain, predict, and understand phenomena. These are often aiming to challenge and expand upon existing knowledge while working within specific assumptions or predictions about behavior. The theoretical framework serves as the foundation that supports a research study's theory. It includes not only the theory itself but also an explanation of how the researcher applies the theory and its assumptions to explore the research problem.

This framework brings together concepts, ideas, and theories from previous studies to provide a conceptual basis for analyzing and interpreting the research findings. The researcher takes part in research and thesis about traductology, and linguistics, exploring translation methods, techniques, and strategies in this chapter to explain translation theories in different languages. These studies influence the choice of analysis and methodology applied by the author of the research at the end of the investigation. As a result, there are several theories regarding diverse topics, processes, methods, and styles of translation in this framework that work as a contrast to give further enrichment to the analysis. In short, a theoretical framework supports the theories implemented in research because it acts as a basis for understanding it. It helps explain the connections between variables and hypotheses. A theoretical framework clarifies the key concepts and terminology in analysis, influences the methodology to guide data collection, and provides context for the existing theories.

Additionally, glossaries function as the subject of this chapter's last section. This is meant to explain how glossaries are made as part of the research and express their significance to the translator, the translation process, and the intended audience. In other words, this chapter simplifies the details of the translation process and its analysis to understand the decisions made by the translator when translating the main texts.

2.1 Text Analysis

First, text analysis in translation involves examining a text to understand its meaning, intent, and context to determine the most effective way to translate it into another language. This process usually includes a detailed reading of the text and research into its cultural, historical, and contextual background. According to Araya (2023), text analysis is a crucial initial step before beginning a translation. Translators focus on effective communication, so a thorough and systematic text analysis is necessary to achieve this goal. The first thing a translator must do is to read the entire text. By doing so, the translator acquires an overall understanding of the text, broadens their knowledge, identifies any historical or topical gaps, and assesses the scope of the work. The translator conducts detailed reading and pays closer attention to specific elements such as vocabulary, style, tone, methods, stylistic choices, conversions, and others.

Finally, the translator completes another reading of the text, which focuses on the cultural aspects of the source text (ST) that could impact the translation. This includes analyzing the text's function and highlighting elements like neologisms, metaphors, culturally specific terms, technical jargon, and untranslatable words. These steps of text analysis are essential for producing a high-quality translation and should not be skipped as they are integral to the translator’s process. Hence, texts should be comprehended correctly before beginning to translate the text itself. Text analysis is a vital part of the translation process due to the amount of attention the translator puts into identifying the major points of the text and its details. This is the stage where the translator identifies the terminology and structure that makes the text stand out.

2.1.1 Text Styles

As a translator, it is vital to recognize and understand the style of the source text for several reasons, such as the purpose of the text. First, knowing the style facilitates translators in determining the intended audience, which aids in selecting the right words to convey the message accurately while preserving its meaning in the target language. The four main types of text styles are narrative, descriptive, discursive, and dialogue. Sepúlveda (2021); and Nida (1988), there are four distinct types of texts, whether literary or non-literary, such as narrative, descriptive, discussion, and dialogue.

Nida (1998) introduces the first type, the narrative text, and explains that it is characterized by a dynamic sequence of events, with a focus on verbs, or in English, 'dummy' or 'empty' verbs, as well as verb-nouns or phrasal verbs (e.g., "He made a sudden appearance," "He burst in"). The use of action verbs structures a method of unfolding the events of a story through a "narration". The descriptive text is the second type, which is more static. This type emphasizes linking verbs, adjectives, and adjectival nouns. This static nature focuses on presenting detailed descriptions and settings to the audience instead of actions. The third type, the discussion, involves the treatment of ideas, focusing on abstract nouns (such as concepts), verbs related to thought and mental processes (like "consider" or "argue"), logical arguments, and connectives. These types of texts tend to analyze and debate more complex arguments, keeping communication clear and coherent to explain further ideas. Lastly, the dialogue text type emphasizes colloquialism and phatic expressions, reflecting conversational language. This means that the texts are used in a more natural and social communication, directed at reflecting a spoken language. This categorizes the types of texts based on their primary focus, whether it is on actions/events (narrative), descriptions (descriptive), ideas/arguments (discussion), or conversation (dialogue).

In summary, Nida uses these text classifications or categories to make people understand how various kinds of texts function, both in terms of their content and the language features that must be applied. First, the narrative is focused on events or actions. Second, descriptive is meant to provide detailed descriptions of people, places, or things. Third, the discussion is used with ideas, arguments, and abstract concepts. Lastly, dialogue is focused on conversational exchanges between people. Each type uses specific language features to achieve its purpose, from verbs and adjectives in narratives and descriptions to abstract nouns and connectives in discussions, and colloquial expressions in dialogue. Each classification uses different linguistic features to communicate its message effectively. In addition, the style would adjust the dynamic that the author is going for, the sequence the text must follow, and the emphasis it wants to make. This is possible due to the grammatical rules and approaches of each type of text style.

2.1.2 Stylistic Scales

When reading, it is essential for the reader to feel the text flow and sound natural. This is the reason style is necessary understandable way so it would guide translators in producing a valuable translation. The choice of specific words or phrases that a translator uses to convey formality throughout an assessment is known as text style. As a result, different texts call for different translation styles, and to apply the style correctly, the translator must carefully choose the vocabulary they may use in that text. Translators must be precise to the scales to guarantee that the target text reflects the intent of the source text, making the audience resonate with the linguistic nuances and cultural barriers the text may hold.

As stated by Araya, (2023) "Style is but one more tool that translators use to aid their work. It provides consistency throughout documents and projects so that the author's fingerprint transfers in a way from the ST to the TT." This conveys that the style of the text is just one of the tools translators utilize in their work. The style ensures consistency across documents and allows the author's voice to carry over from one language to another. As has been implied before, the voice and intention of the original author of the source text are transferred to the target text, which makes it possible for the audience to fully understand and feel the intention or situation of the document based on the way it is written. This means that the stylistic scale influences the way a document is understood, which is connected to the text style, and it is just as important. This also includes the implementation of correct grammar, syntax, tone, and word choice in the text.

Munday (2008) explains in one chapter of "*The Nature and Analysis of Style,"* that a translator must preserve their style while staying true to the author's ideas and voice from the original text. He emphasizes that "many translators use the term 'voice,' and 'ear,' and it must play a central role in the translation process." If translators neglect the author's style, they risk losing the essence of the original voice. Moreover, Munday further explains that the translator must be careful not to inject too much of their style into the translation, but instead, they should produce a new text that maintains the same meaning.

2.1.2.1 Scale of Formality

The Dictionary of Language Teaching and Applied Linguistics (Richards, Platt, & Platt, 1997) defines formal speech as “the type of speech used in situations when the speaker is very careful about pronunciation and choice of words and sentence structure. This type of speech may be used, for example, at official functions, and in debates and ceremonies". However, this description only provides an understanding of a formal situation, but it does not specifically define formal speech. Instead, it suggests what a speaker focuses on in contexts. Therefore, the key factor in determining formality in speech is non-linguistic.

Essay Company (2017); states that the scale of formality consists of eight categories, ranging from Officialese to Slang, as outlined by Newmark (1988). These categories represent different levels of formality in language use: Officialese refers to the language used in legal or highly formal governmental documents, often characterized by complex and rigid structures. Official language is similar to officialese but is primarily used for conveying information in a more straightforward, informative manner, typically in official communication. Formal language is used in more complex settings, such as business or corporate documents, where precise and professional language is required. Neutral language focuses on conveying a message that is understandable to a broad audience, regardless of their educational background. It aims for clarity and accessibility.

Informal language is similar to neutral language but tends to be more casual, often reflecting lower levels of formality or education. Colloquial language, a subset of informal language, includes expressions or phrases that are commonly used in everyday conversation, often specific to certain regions or communities. Slang, also informal, is more specialized, used by particular social groups, and often not understood outside those groups. In addition, Newmark (1988) also discusses two other stylistic scales: the scale of generality or difficulty, which relates to the complexity or accessibility of language, and the scale of emotional tone, which measures the emotional impact or tone conveyed by the language.

2.1.2.2 Scale of Generality or Difficulty

The scale of generality or difficulty measures the level of complexity in texts. According to Newmark (1988), this scale is divided into five categories: simple, popular, neutral, educated, and technical. The scales vary depending on the linguistic complexity that the text requires. Translators analyze the texts to understand their approach and use the scale range to adapt it to theirs.

a. Simple texts are characterized by their low level of difficulty by using basic vocabulary and terminology that are easy to understand. The vocabulary implemented in these texts is not complex, but straightforward.
b. Popular texts typically use language that reflects everyday life and or colloquial vocabulary, making them accessible to a wide audience. The vocabulary used is familiar and common.
c. Neutral complexity refers to texts that strike a balance between simplicity and complexity. These texts are neither too difficult nor too easy, aiming for a middle ground.
d. Educated texts are commonly more advanced and often used in academic or instructional settings. In these cases, it refers to the ones such as university or school materials, where a higher level of vocabulary and complexity is expected.
e. Technical texts are highly specialized as they contain specific terminology related to a particular field or profession, such as user manuals or technical documents. These texts are intended for audiences familiar with the subject matter.
f. Opaquely technical is the type that is highly specialized and logical to professionals who work in a specific field.

The scale for categorizing texts is based on their level of complexity, from simple to opaquely technical. Each one is meant to be classified based on the language and vocabulary of each text to understand it better. Some are meant to be basic and easy to understand whereas others are more complicated and advanced since they require a higher level of literacy. Each category represents a different level of language complexity, designed for audiences with varying degrees of expertise or familiarity with the subject

matter. Translators may encounter challenges with texts that contain highly technical and complex vocabulary. In such cases, the scale helps as a strategy to consider all the nuances the translator may encounter to accurately complete the text. The overall context of the text guides the translator in determining how the message should be conveyed. This scale not only impacts the choice of vocabulary but also helps determine the appropriate level of formality and accuracy needed during the translation. Ultimately, the ability to assess the complexity or difficulty of a text enables translators to balance fidelity to the original with clarity so that the message is effectively transmitted.

2.1.2.3 Scale of Emotional Tone

Preserving the emotional tone is essential as it influences the emotional response of the reader in translation. This can be difficult because emotional expressions in the language are more than just direct emotional terms; they also involve details like humor, sadness, hatred, and irony. Then, translators need to do more than find equivalent words; they must also consider the socio-cultural and emotional factors that shape how a message is understood in different languages, cultures, and contexts. The goal is to ensure that the audience catches both the intention and the depth of the words. The message and its intent may get distorted if the wrong vocabulary is used in the final translation. Therefore, the translator must balance the emotional impact of the original text while adapting it to the target language so that the tone fits the source text's intent and effect.

The scale of tone refers to the choice of vocabulary in a text. According to Newmark (1988), the tone of a text can be categorized into three levels: intense, warm, and factual. Each category requires the use of different approaches. As Nemark suggests, an intense emotional tone is “profuse use of intensifiers” and “'hot”. The intensity is remarked in the phrases “Absolutely wonderful”, “ideally dark bass”, “enormously successful”, and “superbly controlled” as way to show the intensity preserved in the target text. This tone is seen as a warm emotion, described as “'Gentle, soft, heart-warming melodies”. Additionally, a factual emotional tone has more of a “cool” intent. This tone involves using more serious terms to maintain a modest objective. The terms implied are “significant”, “exceptionally well judged”, “personable”, “presentable”, and “considerable”, as they hold a light level of emotion. Hence, translators must ensure to find the correct equivalents to preserve the emotional context of the original text.

> Note that there is some correlation between formality and emotional tone, in that an official style is likely to be factual, whilst colloquialisms and slang tend to be emotive. In translating, the effusiveness of Italian, the formality and stiffness of German and Russian, the impersonality of French, and the informality and understatement of English have to be taken into account in certain types of corresponding passages.

Hence, an intense tone uses strong language and intensifiers to convey a powerful message. Then, when expressing a warm tone, it employs gentler, more empathetic vocabulary to deliver a message with a softer approach. Lastly, a factual tone combines aspects of intense and warm tones. This intends to communicate the message clearly but with a more measured and less forceful expression in it. Moreover, the meaning and or feeling that the text is trying to express may change depending on the emotional tone that it is interpreted into. It is the job of translators to comprehend the overall view of the text and to translate the information in the correct tone.

2.1.3 Text Function

The function of a text refers to its primary purpose or intent. Newmark (1988) identifies three main functions of language: informative, vocative, and expressive. Feliu (2020), states that the main purpose of the text function is to offer the reader the subject matter and to understand the intention that the author intends to communicate the main objective of the text. For translation purposes, understanding the function of a text is essential, along with learning the content of it and what the author plans to convey in their work. Then, by identifying the text function, the translator can make the best fitting translation conclusions to be able to transmit the original message into the target text. Feliu cites Newmark, where he developed the theory of text types from Karl Bühler's functional theory of language. However, it was first expressed by Jakobson, Firth, and Wandruszka. As per Buhler, the three main functions of language are the expressive, the informative, and the vocative functions. These are the main purposes of using language.

2.1.3.1 Informative

This function focuses more on conveying knowledge about a specific subject or external reality, such as facts, ideas, or theories. Informative texts follow a standard format and are commonly found in newspapers, academic books, scientific reports, and other

similar documents that require important information. In addition, informative texts are often used by international organizations or translation agencies, and they may contain grammatical errors that the translator needs to address or correct. (Wang, 2023; Newmark, 1988). The focus of informative texts is on conveying confirmed or factual content about external reality, with the truth and clarity of the information being paramount. In these texts, the author's identity is less significant, and the core aim is to ensure the message is accurately transmitted to the audience.

For translating such texts, Newmark (1982) recommends the use of communicative translation, which strives to produce an effect in the target audience that is as similar as possible to the one achieved with the original audience in the first place. Moreover, the emphasis is on ensuring that the factual content is communicated clearly and accurately. This approach aligns with Nida's concept of functional equivalence, where the translated text should be comprehensible to the target readers in the same way it was understood by the original readers (Nida, 1993). Hence, the informative function prioritizes clear communication and information that requires specific and detailed evidence. In this case, the translator must specialize in the field or terminology of the material to produce a trustful and understandable translation.

2.1.3.2 Expressive

Expressive texts must prioritize the preservation of the original style. In these texts, the sender conveys a specific opinion or attitude toward an object or phenomenon. Texts that express emotions or feelings are characterized by an emotive subfunction. When an attitude is expressed, this subfunction can be evaluative. The expressive function is sender-focused, based on the assumption that the sender and receiver share similar values, allowing the message to be understood and accepted. In these types of texts, emotionally charged adjectives and nouns are typically dominant (Sgibneva, 2023; Nord).

Expressive texts reflect the thoughts, feelings, and personal viewpoints of the author, often without expecting a direct response from the reader. Newmark (1988) classifies expressive texts into three types: first, the serious imaginative literature, such as poetry, novels, and plays, where the author's expression is central. Second, authoritative statements are often found in official or governmental documents, where the text carries the

authority of the writer’s position or expertise. Lastly, the personal correspondence type includes letters or autobiographies, which are deeply personal and often reflect the writer’s emotions and experiences. In addition, in the case of expressive texts, the translators must maintain the elements of the original text, since as mentioned before, these types of documents (poetry, novels, biographies, and others) involve the voice of the author and the feeling they want to transmit to the audience.

(Wang, 2023; Newmark, 1988) emphasizes that the main element in translating expressive texts is the identity of the author and personal ideology, which are integral to these texts. Expressive texts reflect the voice of the author and personal style, often through their "idiolect," or unique way of using language to communicate themselves. To preserve these personal elements, Newmark suggests using semantic translation. This method aims to mirror the original text’s meaning, as much as the target language's grammar and structure allow, to maintain the text's original emotional and ideological content. Hence, the objective is to preserve the expressive function of the text, ensuring that the translated version closely reflects the original. In summary, when translating expressive texts, preserving the author's identity is crucial. To maintain these personal elements, Newmark recommends semantic translation, which focuses on reflecting the original meaning while adapting to the target language's grammar and structure. This means that the translated version remains true to the original.

2.1.3.3 Vocative

Vocative text’s objective is to persuade or produce a response from the reader. These texts encourage the audience to act or adopt a particular viewpoint. Examples may include advertisements, public notices, instructions, and persuasive writing in academics. The focus is on getting the reader to act, think or react in a specific way (Wang 2023; Newmark, 1988). The primary focus in vocative texts is the audience rather than the author. These texts are designed to provoke a strong response from the reader, such as encouraging them to think, act, or feel in a certain way. This is done by approaching the readers directly and making the message appealing to them. The communication must be clear and effective towards the audience so that they respond with the focus that the translator anticipated (from the original text.) Translators have the responsibility to structure the key elements

and use the correct approach so the audience can resonate with them and find the information relevant and relatable.

To achieve the intended effect, the translator must consider the audience's preferences, reading habits, and emotional responses, to adapt the text to be more engaging and relatable to them. This connects with the socio-cultural context these texts are adapted from, as many expressions may influence the way the meaning of the texts changes their connotation. The translator must create a balance between inspiring, influencing, and persuading the perspective of the audience to make them act in response. In translating vocative texts, Newmark (1982) suggests that the translator may prioritize explanation over literal reproduction. The translator has the flexibility to adjust awkward syntax, eliminate ambiguities or unnecessary repetition, and simplify the language, all to make the translation more natural, clear, and appealing to the target audience.

2.1.4 Translation Methods

Although various translation methods have been proposed, relying solely on one method is unlikely to result in a high-quality translation. Throughout the translation process, depending on the nature of the source text, the translator typically combines different methods to achieve the best outcome. As stated by McDonald, (2020):

> Translation Methods, the translation method is a particular way that the translator chooses or believes in an assignment. They reveal that several translation methods can be chosen, namely: interpretive communicative (translation of ideas or messages), literal (linguistic transcodification), free (modification of semiotic and communicative categories), and philological (academic translation or criticism). The translation method is divided into two major groups, namely (1) methods that emphasize the source language and (2) methods that emphasize the target language.

This means that translation methods refer to the approaches a translator selects to best convey meaning from a source language to a target language. These methods are guided by the translator’s understanding of the assignment, the context, and the desired outcome. Translation methods can generally be divided into two main categories: methods that emphasize the source language, which aspires to preserve the original form and meaning as closely as possible, and methods that emphasize the target language, which

prioritizes the naturalness, fluency, and cultural relevance of the translation in the target language. These distinctions help guide translators in selecting the most appropriate strategy for each translation task.

2.1.4.1 Semantic translation

A semantic translation intends to translate the source language's syntactic and semantic structures into the target language. This maintains context and culture while matching the original text in a foreign language. Mohamed (2023) declares that semantic translation is closely aligned with literal translation, as it focuses on preserving the meaning and form of the words and sentences in the source language. This approach seeks to keep the translation semantically and syntactically close to the original text, often preserving the cultural aspects of the source language and avoiding changes to local expressions. Such aspects include different idiomatic expressions and equivalents that help provide the meaning accurately. Lui (2004), views semantic translation as an art form because it captures language expression in an objective and precise manner.

Newmark (1998) also emphasizes that the specific language used by the speaker is as important as the content itself, since semantic translation aims to convey every detail of the source text, recreating its tone and flavor. This means that semantic translation respects the structure of the text whilst it also conveys the meaning truthfully. Additionally, the translator ought to make every effort to maintain the author's writing style and ways of expressing themselves. This type of translation is mostly supported by a specific context, such as a text that includes culturally rich backgrounds. In addition, semantic translation pretends to resonate with the reader more than to inform compared to other methods of translation. Semantic translation is the process of transferring meaning from one representation or data model to another, using the semantic information, or the meanings associated with data elements in the source system to guide the translation. This type of translation focuses on ensuring that the meaning of individual data elements in the source system is preserved and accurately represented in the target system.

In other words, semantic translation involves interpreting the meaning (or semantics) and putting them into equivalent elements in the target system. The goal is to maintain the same underlying meaning, even though the information may be expressed in

different formats, structures, or systems. This comes from "semantics", which refers to the study of meaning in language, specifically the meaning and interpretation of words, signs, and sentence structure.

2.1.4.2 Communicative translation

In contrast to semantic translation, communicative translation emphasizes ensuring that the translated text resonates with the target audience in a way that mirrors how the original text impacts its original readers. This approach focuses on adapting the message to the cultural and linguistic norms of the target language to ensure clarity and facilitate understanding. (Wang 2023; Newmark, 1988) state that the objective is to make the text more natural and relatable for the target audience, even if it means deviating from the original structure or phrasing. In essence, communicative translation leans more toward making the message accessible to the target readers, ensuring effective communication and minimizing any confusion. This suggests that communicative translation focuses on the reader, which expects to produce the same effect in the target audience as the original text does for its readers. This approach is particularly relevant for vocative texts, where the translator must consider not just the words of the source text but also the context given or expected by the target audience.

It emphasizes a reader-centered approach and highlights the importance of the reader’s response and comprehension. Plus, given the diversity of readers, translators may need to adapt the text and keep on editing it to balance the cultural and linguistic context of the target language in the process. Translators should avoid relying on a single translation method and instead adapt their approach to the specific context based on the text's intent. This means that communicative translation aspires to create an effect on the target audience that closely reflects the impact the original text has on its readers. The focus is on conveying the same message, emotional tone, and response in the target language, rather than adhering strictly to the form or structure of the original text.

The intent is for the target audience to have a similar experience to the original audience, with the translation being natural and fluent in the target language while preserving the intent and effect of the original. This approach often prioritizes readability and cultural relevance over literal accuracy. As the name says, "communicative" translation

prioritizes communication by adapting the content of the translation to match the equivalent in different languages and cultures. To achieve this, the translator must comprehend the source text to transmit the same meaning to the target text.

2.2 Translation Procedures.

In this chapter, the translation methods and procedures employed in translating the texts mentioned earlier have been analyzed and justified based on the intended audience for these texts. These methods are meant to fit the approach of the translation. In these, is important to keep in mind the complexity of source text, its level of language, and how the information can be visualized to convey the meaning to the audience. These translation procedures are meant to be used by the translator so the text can sound natural in the target language.

Different procedures can be applied to texts. As mentioned by Ordudari (2007), there are various procedures that a translator might use depending on the situation. The procedures' importance and impact depend on the type of document, especially if it is about translating culture-specific concepts. These procedures support to management of the challenges posed by cultural differences in language and ensure that the meaning and context of the original text are preserved as much as possible. The distinction between translation methods (for whole texts) and translation procedures (for smaller units like sentences or words) is also highlighted when studying these concepts.

2.2.1 Transposition

This process involves changing the sequence of parts of speech when translating. Essentially, it is a shift in word class. The goal is to maintain the meaning of the sentence while adjusting it to fit the grammatical structure of the target language. Since grammatical structures vary between languages, this adjustment is necessary to ensure the sentence makes sense in the translated version. This means that one part of speech is exchanged for another without changing the implication of the message. This approach is useful when translating between languages with different syntactic structures, ensuring the translation sounds natural and fluent in the target language.

Catford (1978), identifies two types of transposition: level shifts and category shifts. A level shift refers to a change that occurs between the grammatical and lexical levels,

where the translation moves from one level of language structure to another. On the other hand, a category shift involves translating a word in the source language (SL) into a different linguistic form, such as a phrase, in the target language (TL).

Moreover, Král (2021), a simpler form of oblique (indirect) translation is transposition, which involves changing the word order within a phrase or sentence. Since languages have different rules regarding the placement of adjectives, nouns, and verbs, transposition adapts the structure to fit the target language. For instance, in English, adjectives typically come before nouns, while in French, they often follow the noun. Transposition addresses these differences, ensuring that words are arranged correctly in the target language while maintaining the original meaning of the phrase. This involves altering the grammatical structure when translating from the source language (SL) to the target language (TL). For example: (i) changing from singular to plural, (ii) making adjustments when a specific structure in the SL does not exist in the TL, and (iii) converting an SL verb to a TL word or an SL noun phrase to a TL noun, among other adjustments. This means that since languages have different rules for positioning the parts of speech, transposition changes the structure to suit the target language.

2.2.2 Modulation

Modulation, as referred to by (Saridaki 2021; Vinay & Darbelnet, 1995) is the change in the way a message is expressed, resulting from a shift in perspective or point of view. It involves altering the angle from which something is presented. This strategy is often used when a translation is grammatically correct but would be unacceptable or unnatural in the target language (TL). The original authors contrast between two types of modulation: obligatory and optional. An example of obligatory modulation is the phrase "the time when," which must be translated into French as “le moment où” (back-translated as "the moment when") rather than literally as "le moment where." This is applied by translators to make the texts sound more natural and clearer in the target language.

On the other hand, optional (or free) modulation involves transforming a negative expression in the source language into a positive one in the target language. For instance, "it is not easy" can be translated as "il est difficile" (which means "it is difficult"). Sometimes an optional modulation may fit the context so well that it becomes necessary.

By then, this modulation essentially became obligatory. This technique is used when the translator adjusts the message of the original text to match the norms or perspective of the target language (TL). Since the source language and the target language may differ in how they express certain ideas, modulation helps to convey the meaning in a way that is culturally and linguistically appropriate for the target language audience.

Modulation helps to highlight the difference between a literal translation and one that conveys coherent meaning. This is particularly useful when translating texts containing idioms or regional expressions that would sound awkward or incorrect if translated literally into the target language. Sometimes by altering the structure or pattern of the original text, the translation can be redesigned into a form that better expresses the intended meaning, rather than sticking to the original wording. This adjustment allows the translation to be more fluid and natural in the target language and ensures that the meaning is clear and accurate.

2.2.3 Omission

Omission in translation refers to where the translator removes or leaves out certain words, phrases, or sentences from the original text to make the translation more suitable for the target audience. This "omission" of words mostly happens when the information of the source language is either redundant or unnecessary in the target language context. Omission can also be used to simplify or align with the grammatical structure of the target language. For instance, there are some languages where the subject of a second or third clause in a compound sentence is the same as the subject of the first clause. In this case, it may be omitted for conciseness and clarity. This helps to create a smoother and more natural translation by adjusting to the grammatical rules of the target language. Delisle, Lee-Jahnke, and Cormier (2004), describe omission as "a translation error where the translator fails to render a necessary element of information from the source text in the target text".

According to Vázquez-Ayora, (1977), inexperienced translators usually do not dare to recur to procedures that have to do with expansion because of their inclination to literalism and unfamiliarity. This is out of respect for the ideas of the original author. The omission is sometimes ignored and poorly employed, even though it allows the achievement of an oblique translation. The omission is usually used in a sentence, for

example, when the direct subject is used in English and is repeated many times. On the contrary, in this case, if translated into Spanish, the tacit subject is used, and the word is omitted following the grammatical rules of Spanish. Therefore, to avoid redundancy, translators often use the omission method to simplify the text, eliminating repetitive ideas and expressing them more concisely in the target language.

On the other hand, omission in translation is often considered negative because it can be seen as violating the principle of "faithfulness" by not conveying the full message to the target audience. Nevertheless, faithfulness does not require a word-for-word translation, and some argue that literal translation is not always the best approach. This is supported by Baker (2000), who specifically highlights that translation by omission is a strategy that professional translators can use when faced with non-equivalence issues at or above the word level. Many studies on omission focus on structural and syntactic aspects, with few considering the socio-cultural factors influencing these decisions taken by translators.

2.2.4 Amplification

Molina and Hurtado (2002), compare in *A Dynamic and Functionalist Approach*, amplification vs. economy: these two procedures are similar to the concepts of concentration and dissolution. Amplification occurs when the target language (TL) uses more words to fill in syntactic or lexical gaps. The authors also cite Vinay and Darbelnet, claiming that dissolution is about adapting the structure of the source language (SL) to fit the target language, such as in the example “He talked himself out of a job” being translated to “Il a perdu sa chance pour avoir trop parlé” (He lost his chance by talking too much). In contrast, economy involves using fewer words in the target language (TL), as shown in the example “We’ll price ourselves out of the market” being translated as “Nous ne pourrons plus vendre si nous sommes trop exigeants” (We won’t be able to sell if we are too demanding). In other words, amplification is where additional information is included in the text of the target language to enhance clarity or understanding.

This may involve making implicit details explicit, filling in grammatical gaps between languages, or providing explanations for culturally specific terms. The additional information seeks to ensure that the meaning of the original text is completely conveyed and easily understood in the target language. Amplification is often guided by the nuances

of the target language along with the most current research or knowledge about the subject matter. This is done by the translator to produce a more accurate and contextually appropriate translation so the audience that is unfamiliar with the context can comprehend the content of the text. The translator includes amplification as a procedure if there is not an equivalent in the target language by adding explanations and details to the context so the audience can comprehend the original meaning of the source text.

2.2.5 Explicitation

Molina and Hurtado, (2002), also explain the difference between explicitation and implicitation: explicitation involves making implicit information from the source text (ST) clear or explicit in the translation, such as clarifying the patient's sex when translating his patient into French. On the other hand, implicitation allows the context or situation to reveal information that is explicit in the source text.

The authors make these comparisons for the translator or reader to have a clearer understanding of these meanings. As an example, the meaning of the French word *sortez* ("go out" or "come out") depends on the situation in which it is used. Involves making implicit information from the source text (ST) clear or explicit in the translation, such as clarifying the patient's sex when translating his patient into French. In other words, it is the process of making elements of meaning understood but not directly stated in the source text clearer or more explicit in the translation. Translators tend to add more elements explicitation to clarify the meaning and give more context to the situation.

These implicit elements are commonly assumed by the writer and reader, but not actually written or spoken out loud. Explicitation is a shift from implicit meaning in the source language to explicit meaning in the target language. This is often necessary due to differences in how languages structure information or how certain ideas are understood differently across cultures. For example, this happens because different cultures and languages may not have the same clarification about someone's gender or subject. However, despite its prevalence in translation texts, few studies have deeply examined the very concept of explicitation itself, especially about the complex relationship between what is stated clearly and what is understood without being directly stated (explicit and implicit). In summary, explicitation involves making implicit details from the source text clearer in

the translation, ensuring that nothing essential is left for the reader, especially when such inferences might not be obvious in the target language.

2.2.6 Literal Translation

In literal translation, linguists convert the source text's grammatical structures into near equivalents when translating literally. This method works for some technical translations due to the complexity of a word or meaning that means to be described literally. As stated by McDonald, (2020):

> At first, literal translation is carried out like word-for-word translation, but the translator then adjusts the word order in the translated sentence according to the word order in the target language sentence. This method is usually applied when the sentence structure of the source language is different from the sentence structure of the target language.

This suggests that literal translation is like word-by-word translation, but it can vary depending on the structure of the target text to be translated. Furthermore, the connotations between words are not considered when translating them in literal translation. Finding metaphorical equivalents in the target language is the goal of literal translation, which prioritizes context. The term "literal translation" refers to a kind of word-for-word translation from one language to another. This happens when each word is directly substituted with its counterpart or almost equivalent in the target language, without considering the broader meaning or context of the entire text.

However, many translators often think of this practice as leading the text to have unnatural-sounding sentences in the target language, as sometimes it fails to account for differences in grammar, syntax, and idiomatic expressions between the two languages. As a result, literal translations can be difficult to read or may be grammatically incorrect, as they fail to accurately convey the intended meaning of the original text. While it may preserve the individual words, it often lacks coherence and fluency, making it unsuitable for effective communication. Still, other translators may find this an approachable way to translate technical texts that sometimes require this technique to justify the information provided. This results in a way to maintain the fidelity of the text in legal cases.

(Chironova 2014; Chukovsky 1964) States that one ongoing debate in translation revolves around how closely a target text (TT) should align with the source text (ST). This issue has been a dilemma for both professional translators and scholars in translation studies. In academic discussions, researchers from literary theory and linguistic translation theory contrast word-for-word, literal, or source-centered translations with sense-for-sense, free, or target-centered translations.

In Russia, the extremes of formal literalism and excessive translator discretion have been central to critical discourse in literary translation studies. The distinction between these two translation approaches is so clear to critics that they rarely question or explore the dichotomy, instead using it as a basis for further discussion. The term "literal translation" is used to criticize translations done mechanically, where translators transfer the TT into the ST word by word, which can distort the original text's intent and the source language (SL). This focus on the negative impact of literalism on the literary process tends to highlight its harmful aspects and is inherently judgmental.

2.2.7 Punctuation changes

Punctuation changes in translation involve modifying the punctuation marks of the source language (SL) to suit the target language (TL). These adjustments are crucial for ensuring that the translated text flows naturally and adheres to the grammatical conventions of the target language, which may differ from those of the source language. This implies that the purpose and usage of punctuation change across languages. Punctuation serves different functions in each language, so when translated, it can convey different meanings.

According to Newmark (1988), punctuation is a powerful tool, but it is often overlooked. He suggests translators do a separate comparison between the punctuation in their translation and that of the original text. For example, in French, dashes are used to list items (a, b, c, or 1, 2, 3), and dialogue is sometimes marked with inverted commas, which are less common in French than in English. Parentheses in French are often translated as brackets. French and Italian also use semi-colons more frequently than English to indicate a series of simultaneous actions or events, which aren't significant enough to be separated by full stops or exclamation marks. The translator must decide whether to keep or omit these punctuation marks.

Newmark also cites E. W. Baldick and expresses that when translating L'Education sentimentale, tends to remove these semi-colons and unnecessarily connects sentences for the sake of smoother, more natural flow, which is regrettable for such an important text. However, many other important punctuation marks make a difference and are influential when translating texts from one language to another. Still, not all punctuation marks can be mentioned since many of them are not commonly used in different languages, just as exemplified before. Punctuation plays a crucial role in discourse analysis because it signals the semantic relationship between sentences and clauses, which can differ across languages. For instance, in Spanish, written questions start with an inverted question mark, whereas in English, it does not exist.

One if not the most distinctive punctuation differences is the use of inverted question marks (¿) and inverted exclamation points (¡), a feature that is mostly exclusive to Spanish. These inverted punctuation marks are placed at the beginning of a question or exclamation, complementing the standard punctuation at the end with a regular question mark. In Spanish, these inverted marks work to indicate the start of a question or exclamation, providing the reader with an early indication of the tone or intent of the sentence. This practice helps the reader prepare for the shift in tone as they read the rest of the sentence. The inverted marks should be used within a sentence if only part of the sentence contains the question or exclamation.

As for an example, ¿Cómo estás? In Spanish would be written as "How are you?" in English, which adds the inverted punctuation mark in the beginning. Another example would be that in English it is very common to have a dash to form compound nouns or compound adjectives. These are often hyphenated to avoid confusion when multiple adjectives appear before a noun. Some of these can be words such as the compound adjective "well-known" or a compound known as "sister-in-law." These are not translated into Spanish with hyphens since they have their own words in the language, "conocido" and "cuñada".

Punctuation plays a key role in discourse analysis, signaling the relationship between sentences and clauses, which vary across languages. Translators compare the punctuation in the original text with that of the translation.

2.3 Glossaries

As stated at the beginning of this research, one of the essential parts of it is to create a bilingual glossary. This is not only represented to provide a resource for future translations in the field, but for all the readers to fully understand the denotation of the terminology. In addition, this glossary aims to work as a guide or data collected for the translator after searching for the meaning of terms and concepts employed in the translations. Two glossaries have been developed, one of the terminologies from English to Spanish, and the other from Spanish to English.

2.3.1. Relevance for the translator

Creating a glossary is a fundamental practice for translators working on any new project. According to Gapper, (2008), those with less experience often struggle to find an appropriate approach for analyzing terminology and utilizing available resources to meet translation needs. However, this absence of guidance may lead to improvised solutions when encountering unfamiliar terms in the text. This can interrupt or slow the fluency of the text and lower the quality of the translation. It also contributes to the improper use of specialized language, incorrect vocabulary, and the ineffective use of foreign terms, such as anglicisms or borrowing despite having an equivalent word in the target language.

Glossaries not only guide readers but also simplify the translator's work in the translation process. They provide a reference guide for specialized terminology, speeding up the translation process by offering quick access to definitions and phrases. This is especially useful in fields like medicine, economics or politics, where technical terms may vary significantly between languages and are sometimes unknown to the public. According to Sepúlveda (2021), glossaries are crucial for translation as they aid both the translator and the reader in fully understanding the content of the document. While glossaries may have once been viewed as a luxury, and some may still not see them as essential, the truth is that they have never been more important than they are today. In a globalized world, it is vital to understand how terms can vary depending on the region in which they are used since the idiolect can change even within the same country. Another aspect when creating a glossary is that it requires attention to detail and organization. The translator should identify difficult or specialized terms during the reading of the document and compile them into a glossary.

2.3.2. Relevance for the translation process

A glossary is an important tool for translators, providing definitions and explanations of specialized terms used in a text. Developing a glossary requires organization and thorough research so the translator can ensure that the meaning of terminology is conveyed accurately. According to the Cambridge Dictionary, a glossary is "an alphabetical list, with meanings, of the words or phrases in a text that are difficult to understand" or "an alphabetical list of difficult, technical, or foreign words in a text along with explanations of their meanings." Glossaries play a crucial role in the translation process by ensuring that the terminology used is accurate and consistent in the text. Glossaries help to maintain the truthfulness of the translation by providing a reference for specific terms. This makes sure that specialized vocabulary is applied accordingly to the text's field.

Moreover, the terms in the glossary must be carefully selected to reflect the most accurate and naturally accepted usage within the specialization. This confirms that the translated text conveys the intended meaning without confusion or ambiguity. A well-constructed glossary not only assists the translator in maintaining consistency but also improves the quality and efficiency of the translation process, helping to avoid errors that may occur from misunderstanding or misusing field-specific terms.

2.3.3. How to create a glossary

According to Gapper (2008), in her book *Manual de gestión terminológica,* once the information is systematically collected, a glossary is prepared according to the defined requirements and users of the project. Then, the content and its format are defined. When analyzing each case, both the macrostructure and the microstructure are defined. By then, decisions must be made about the general organization of the glossary.

When creating a specialized glossary, it is important to carefully consider its structure, content, and target audience. The glossary can be organized by language (in this case, Spanish to English or English to Spanish) or by topic, depending on the intended use. Each entry should include the term itself, a clear definition, its translation (if applicable), contextual examples, and any relevant synonyms or related terms. For bilingual glossaries, it is crucial to ensure the accuracy of the translation by consulting multiple sources,

comparing the term's meaning across different contexts and periods, and being aware of regional variations.

In cases where a word lacks a direct equivalent in the target language, the glossary should provide a detailed explanation or adaptation of the term. Additionally, reviewing various sources from different years helps capture any shifts in meaning, ensuring that the glossary remains up to date. In situations where is not, then the translator must check that the denotation of the word has not changed. Finally, the glossary's design should be tailored to its users whether they are language learners, professionals, or general readers and it should be regularly updated to reflect new terms or evolving usage.

Chapter III

Methodological Framework

This examination by carried by the researcher to gather the most relevant information about translation to evaluate the methods and techniques thorough theories exemplified by different authors. This chapter is constructed to support a structure of the translation methodology applied in the thesis by ensuring that the process achieves fluency, fidelity, and coherence. (Shafer Library 2024; Dawson 2019), suggests that a research methodology is the foundational framework that guides the entire research process. It represents the approach a researcher uses to investigate the topic and influences the choice of specific research methods used to collect data. A research methodology defines the strategy for inquiry, while research methods are the tools or techniques employed to gather data (e.g., surveys and experiences).

Furthermore, when selecting the most appropriate methodology for a research project, several key factors must be considered, such as potential research limitations (e.g., time and resources) and ethical considerations that could affect the integrity and validity of the study. All these considerations are necessary to the investigation because they directly influence the methodology chosen and the quality of the research outcomes. This examination was conducted to investigate several factors that affect the information related to the medical field in technical translation. The examiner analyzed different theories used to organize the correct approach of a translation and provide limitless access to different documents regarding medical and cultural terms regarding the history of Costa Rica.

3.1 Research Approach

This research explores the translation of medical, historical, and cultural aspects of Costa Rica, putting emphasis on a qualitative method to comprehend and explain the result of the research. By using this qualitative approach, the study seeks to elaborate clear, coherent, and accurate translations. This research investigates the socio-cultural nuances and terminology in the texts. This investigation examines the translation process of two texts, “Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica” and “Building a Thriving Primary Health Care System: The Story of Costa Rica.” By

analyzing these texts, the research identifies challenges such as dealing with technical, medical, and cultural terminology, colloquial expressions, and cultural nuances. It aims to establish a comprehensive guide to essential technical terms to ensure reliability in translations. This approach provides detailed insights into the translation process, promoting a deeper understanding of the strategies and decisions made to manage linguistic and cultural obstacles.

According to Fulton Library (2024), The primary objective of qualitative research methodologies is to collect data that is often difficult to measure. As they gather information through observation, codified survey or interview responses, and other means, these approaches frequently involve some degree of interpretation on the part of the researchers. In a single investigation, researchers may employ a variety of qualitative techniques in addition to a theoretical or critical framework to assist in the interpretation of the results they obtain. In addition, these techniques often require researchers to interpret the data, identifying patterns, themes, or narratives that provide deeper understanding. In many studies, such as in this one, researchers may use qualitative and quantitative methods together to gain a more comprehensive view of the subject. Additionally, qualitative research is often framed by a theoretical or critical perspective, which helps guide the interpretation of the data and ensures that the findings are analyzed within a broader social, cultural, or conceptual context.

3.2 Research Design

Bouchrika (2024), explains that the type of research design plays a crucial role in shaping the quality, relevance, and accuracy of research findings. Before undertaking a study, it is essential to clearly define the research design, as it establishes the framework for how the research will be conducted. Research design is distinct from research methods: while the design refers to the overall strategy guiding the research, research methods are the specific tools or techniques used to gather data. However, the distinctions between design types and methods can sometimes be blurred, as highlighted by various scholars (Abutabenjeh, 2018), with earlier references even categorizing designs as "fixed" or "flexible". To simplify the process of selecting an appropriate research design, it is often broken down into four main types, each serving different research objectives.

One key type is the descriptive research, which is used when the researcher is interested in understanding and describing a phenomenon or situation. Descriptive research focuses on answering the how, what, when, and where of a topic, but typically does not address why something happens. It serves as an initial step to understanding a research problem before reaching deeper causes. In terms of approaches to research design, there are three methodologies: quantitative, qualitative, and a mixed-methods approach that combines elements of both. It is important to recognize that quantitative and qualitative research methods should not be viewed as strict opposites. Instead, they represent different ends of a range. By understanding the characteristics, advantages, and limitations of each approach, researchers can select the design that best suits their research goals, ensuring the findings are both reliable and relevant.

This research uses a qualitative approach specialized in technical and cultural documents. This design seeks to investigate the difficulties of medical and cultural translation. The first two sections, which analyze external and internal factors, are based on Christiane Nord's text analysis model in translation (1991). However, the current analysis deviates slightly from Nord's model because there is no need to develop separate target text (TT) profiles, as both the source texts (STs) and the final TTs are in the same language and should adhere to the same cultural norms. The primary goal of the analysis is, therefore, to identify any deviations from the original STs. At the heart of this analysis is the concept that both the translator and the reviewer must first create a profile for the ST, then for the TT, and finally compare the two. The translator's role is to "place a cultural filter between ST and TT" (1991). While this model may seem straightforward, it is quite complex.

The research focuses on qualitative analysis using Nord's text analysis model to study extratextual and intertextual factors of the source texts. Extratextual factors include the purpose of the text, its target audience, and the cultural context based on the content, while intertextual factors study linguistic features, style, and tone and its intention. This considers the translators' experiences, interpretations of the text, and decision-making processes during the translation. This research investigates how translators understand technical concepts and cultural nuances, as well as reflecting on how their choices impact the final translation. This happens because translators have different idiolects and ways of

perceiving and expressing information. Then, the two selected texts to be translated are labeled, “Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica” and “Building a Thriving Primary Health Care System: The Story of Costa Rica.”, and the researcher creates a glossary to ensure terminological consistency and accuracy. Later, the translator explores "why" and "how" the techniques are employed, analyzing the translators' cause for selecting different approaches and how these choices shape the meaning and impact of the translated texts. The evaluation considers the effects of the translations on the target audience, examining how different translation choices might be understood perceived and interpreted by the target audience.

By employing Nord’s model, the analysis emphasizes the importance of conveying the meaning of the texts, ensuring accuracy and clarity, which are crucial for creating reliable information for professionals and readers. Glossary addresses the need for consistency in technical and medical fields. This research design provides a comprehensive framework for studying the nuances involved in translating medical and socio-cultural documents. By integrating a qualitative approach, the study captures a range of linguistic, cultural, and technical factors, contributing valuable perceptions to the field of translation and history of Costa Rica.

3.3 Information Sources

Information sources are categorized into a three-level scale, which includes primary, secondary, and tertiary sources. These sources provide the necessary information to address the research questions and theories presented in a thesis.

Primary sources offer first-hand accounts or direct evidence related to the subject being studied. These sources are created by individuals who directly witness or record events at or near the time they occur. They have not undergone additional interpretation or analysis, providing an unmediated view of the event or topic (UC Merced Library, 2024). The researcher used the information from the texts to be translated used in this research, which are “Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica” by Alí García and Alejandro Rojas, and “Building a Thriving Primary Health Care System: The Story of Costa Rica” Madeline Pesec, Hannah Ratcliffe, and Asaf Bitton. The data and information translated is based on these two main documents.

Secondary sources are more difficult to define than primary sources. In general, they are written accounts created after an event, offering the benefit of hindsight. These sources provide interpretations, analyses, or evaluations of primary sources rather than presenting direct evidence. Secondary sources serve as commentary or discussion about the evidence but are not considered evidence themselves. It is important to note that while some classify as a secondary source, others may consider a tertiary source, emphasizing that context plays a key role in determining the classification (University of Utah, 2020). This thesis includes the secondary sources such as:

a. Molina & Hurtado (2002). *Translation Techniques Revisited: A Dynamic and Functionalist Approach,* which discusses several translation procedures and approaches.
b. Sherry Gapper (2008). *Manual de gestión terminológica.* This document explains in detail the importance of and guidelines for producing an effective glossary.
c. Peter Newmark (1988). *A Textbook of Translation.* A significant part of this research is based on studies developed by Newmark and his relevance in traductology.
d. Christiane Nord (1991). *Text analysis in translation: Theory, Methodology, and Didactic Application of a Model for Translation-Oriented Text Analysis,* which explores different theories, and the approach used in this investigation.

Examples of tertiary sources include library catalogues, reading lists, bibliographies, indexes, and directories. These sources are not cited in the bibliography of a research paper for college credit and are primarily used for background information. Tertiary sources consist of subject-specific reference materials, handbooks, textbooks, general encyclopedias, and bibliographies, which provide an overview or summary of a topic rather than an in-depth analysis or original research (Lera, 2024).

In this case, the investigator made use of different reliable online dictionaries as Cambridge Dictionary and Merriam-Webster for the English Language and the website of RAE (Real Academia Española) for Spanish, as well as different glossaries specialized in

technical and medical terminology. In addition, the examiner conducted research on different Costa Rican terminologies or names of different institutions to translate their respective terms accordingly.

Hence, primary sources serve as the foundation of the investigation, as they are the texts to be translated and are the most crucial documents in the study. Secondary sources assist the researcher in developing the theories, methodology, and translation process for the thesis, supporting the primary documents. Finally, tertiary sources function as dependable references to gather additional information on the meanings and content of the texts, offering a broader context to support the research.

3.4 Analysis Categories

The analysis categories are used to organize and categorize key aspects of the investigation, providing structure to the research process. In the previous chapters in this study, the following categories have been identified:

1. Translation: This focuses on the ability to transfer not just the literal meaning of words, but also the style, tone, and cultural nuances from one language to another. It involves ensuring that the overall message and intent of the original text are preserved in the translation. Several types of translation may be exemplified in the document.
2. Translation Procedures: This refers to the methods applied by translators to find equivalences that accurately convey the meaning of the source text into the target text. These procedures can include various strategies, such as literal translation, modulation, or adaptation, depending on the nature of the text and its intended audience.
3. Glossary: In the context of translation, a glossary is an alphabetical list of difficult or specialized terms, often including definitions, to aid understanding. It serves as a reference tool for both translators and readers, particularly when dealing with terminology that may not have direct equivalents in the target language.

These categories help structure the investigation by addressing the different components of the translation process.

3.5 Data collection Instruments

In this research the use of different tables is made to compare the use of the procedures used in translation. They are categorized according to the analysis of the text and its functions, the procedure of translation and the glossary after searching for the meaning of the unfamiliar vocabulary. These instruments are used to maintain a specific order in this research and to analyze the meaning of these instruments without any problem. Their coding is divided by the term exemplified in each text analysis. When presenting the translation procedures, they are divided by their format, either underlined, highlighted, or colored in distinct colors so that the reader can distinguish between them.

This first table facilitates a comparison between the source text and the translated text by analyzing elements such as text style, text function, and the stylistic scale (including formality, generality, and emotional tone). The purpose of this table is to examine the linguistic equivalents between the two languages and assess how effectively the translation mirrors the original text's characteristics.

Text Analysis	**Building a Thriving Primary Health Care System: The Story of Costa Rica**	**Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica**
Text Style		
Text Function		
Scale of Formality		
Scale of Generality		
Scale of Emotional Tone		

Table 1 Illustrates one of the data collection instruments for the text analysis. Researcher's creation.

The second table uses a color-coding method to organize the translation procedures, with each procedure assigned a unique format or color to distinguish it from the others. This approach makes it easy to identify and analyze the purpose of each procedure in the translation process. By examining this table, the reader can understand the decisions made by the translator throughout the process. Each color represents a specific format corresponding to the procedures applied in the translation and creates the structure for the final product.

Procedure	**Format or Color**
Transposition	Blue
Modulation	Dark red
Omission	Highlighted in cyan
Amplification	Highlighted in yellow
Explicitation	Green
Literal Translation	Purple

Table 2 Illustrates the color of the text and its procedure for the color-coding instrument. Researcher's creation.

The final table is the glossary, which contains specialized terminology. The glossary serves as a valuable resource for both the translator and the audience reading the document. In this case, it provides explanations of word equivalents and meanings to help the audience better understand the concepts. This implementation is especially crucial in technical translations, as it offers additional clarification on the terms used in the document, ensuring clear communication of complex concepts.

English Term	**Spanish Term**	**Grammatical Category**	**Definition**

Table 3 Illustrates the table used for the glossaries. Researcher's creation.

All these tools allow the researcher to organize the data collected by the researcher. Each table outlines the methods and procedures used by the examiner to ensure a complete and accurate investigation and translation of the documents. They provide a structured approach, making it easier to understand the decisions and strategies employed throughout the translation process.

3.6 Collection data process and data analysis

The data exemplified results have been recollected through an investigation by comparing the meaning of the concepts and comparing them with their respective implementation in the text. These are based on the usage of different translation methods and techniques. In addition, three tables are implemented in the research as a way of comparing the information in the two translated documents. The first table exemplifies the text analysis between the documents and their similarities or differences. This was done to differentiate the ways of translating each text and determine the best approach to fulfill the accurate meaning in the target language of each text. By researching these details, the translator intends to find the right information to appeal the information to the audience.

The chosen texts “Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica” from Spanish to English and “Building a Thriving Primary Health Care System: The Story of Costa Rica” from English to Spanish were selected to the relevance of preserving part of the history of Costa Rica. These texts are significant to the

socio-cultural and medical fields, providing valuable understanding for professionals and translators. They address the challenges faced by Costa Rican society, from its early traditions and struggles to the establishment of health institutions.

The thesis includes a theoretical framework that explains the foundational concepts of the study and the theories supporting its claims. This framework aims to clarify the various methods, procedures, stylistic features, and other aspects that the translation process entails, particularly how it addresses different linguistic elements. This approach helps in determining the most suitable translation strategy for each text. Additionally, several tools are used to assist the examiner in analyzing the information and procedures, ensuring an effective translation. Lastly, a glossary is included in the research to guide both the researcher and readers, serving as a reliable reference for both the source and target languages.

Chapter IV

4.1 Translation from Spanish to English

Concepts and Cultural Practices of Ancestral Bribri and Cabecar Medicine in Costa Rica

Alí García Segura, Alejandro Jaén Rojas

Introduction

Since the 16th century, the native peoples of the Americas have faced one of the worst demographic catastrophes in living memory in the world because of contagious diseases brought by Europeans and for which they (the people of the region) lacked immunity. Diseases such as influenza, smallpox, measles, whooping cough, typhus, among many others, wreaked havoc on the indigenous population (Ibarra, 1998).

Although it is very difficult to reconstruct in detail the phenomena that occurred more than 400 or 500 years ago, the most recent research suggests that between the 16th and early 17th centuries over 90% of the populations of the native peoples of the American continent disappeared (Koch, Brierley, Maslin and Lewis, 2019).

Such a dramatic event deeply marked the societies of the native peoples at all levels, to the extent that some communities such as the Bribri and Cabecar still maintain healing practices and sociocultural care, medical knowledge and a conception of the world that, in essence, prevent them from powerful invisible beings: diseases.

The Bribri and the Cabecar are two native communities of southern Costa Rica, socioculturally and linguistically related. According to the 2011 census, the Bribri are in the territories of Salitre, Cabagra, Talamanca Bribri and Kekoldi. In 2011, there were 16,938 people living in these territories, with a non-indigenous percentage of 24.5% (Fuentes, 2011, p. 9).

The Cabecar are in the territories of Chirripó, Ujarráz, Tayni, Talamanca Cabecar, Telire, Bajo Chirripó, Nairi Awari, and China Kicha. In 2011, there were 13,993 people living in these territories, with a non-indigenous percentage of 18.5% (Fuentes, 2011, p. 9).

The COVID-19 pandemic has put us all to the test, whether at the individual, familiar or collective level. This uncertainty about health and disease has revealed new dimensions, or new perceptions, of our daily lives. It is these new perceptions that, curiously, come to our aid to venture with a new vision into some passages of the ancestral history of the Bribri and Cabecar peoples that were interpreted as superstitions, but which, in the light of this pandemic, could be reinterpreted. They are, in a way, the links of ancient medical concepts, the value of which we can only elucidate under the pressure of a health emergency of planetary proportions.

We will try to focus exclusively on the concepts of the bribri and cabecar medicine of southern Costa Rica, alluding to some historical data from Mesoamerica, which we consider relevant to support our analysis and reflections.

Two Views of Medicine

Pre-Columbian American medicine had diverse systems and approaches to health. However, despite its diversity, it evolved and developed over many centuries without contact with other regions of the world. For this reason, when there was contact, communication, and cultural diffusion, it occurred within the American continent. This means that we are not only dealing with sui generis knowledge, but that the whole conceptual body of medicine largely differs from that of other regions of the world. The concepts of medicine, disease, doctor, and treatment exist, as is logical, but they respond to another worldview, even to another logical system of approaching knowledge.

Although there were attempts at understanding the scope and development of the medical tradition of the native peoples during the conquest and colonization, the truth is that it has not been an easy task as there are more misunderstandings than fortunate situations. Since the healing system of the physicians of the native peoples is not understood, conceptual errors are common. The doctors of these peoples have been called “witches”, “quacks” (matasanos) and all sorts of derogatory appellatives. Even in cases where some authors (Lines, 1945, p. 1) recognize the importance of the physicians of the native peoples, we find derogatory allusions or confusion when describing the concepts of bribri-cabecar medicine.

These confusions regarding the medicine of indigenous people continue to the present day, where Western doctors often end up believing that all medical knowledge belongs to their culture. Thus, when it comes to transmitting and applying medical science, there is only one way from the health institutions to the native peoples. Consequently, the native peoples end up being passive and simple depositaries of concepts, protocols and knowledge that they barely understand, which leaves them at a great vulnerability and disadvantage in the face of an emergency such as COVID-19. Not only is there the language difference, but even if we have literal translations of the medical protocols, we face other problems, which have to do with the conception of the world, the concept of health, disease, cultural practices, among others.

Such important things as understanding that native people have an oral tradition and that when establishing protocols, orality should be favored over written language, are aspects that will be considered.

This usually results in communication conflicts and sometimes in outright rejection of the knowledge imposed by the health teams, which is perceived as exogenous to the communities of these peoples, or even as contrary to their beliefs and prevention-healing practices.

Indigenous peoples' medicine must be understood in its broadest context, bearing in mind that their medical concepts differ profoundly from Western concepts. In essence, they have the same purposes: to prevent disease, to cure the sick, or to reflect on medical practices and possible treatments. When working with native communities, although it may seem strange in this pandemic, the starting point in terms of health should be their own ancestral medical knowledge. If this is considered, not only would communication be improved, but the process of appropriation of knowledge would be more profound. This could lead to the construction of shared knowledge, the reformulation of the interpretation of medical concepts in pluri-ethnic and pluricultural territories. Not only do these traditions respond to different cultures, but they are also practiced in different languages and where the concepts of medicine, illness, doctor, and treatment are expressed in systems whose paradigms develop and evolve in completely different worlds.

Some Preliminary Clarifications

Among the Bribri and Cabecars, both women and men could practice medicine. The term in Bribri language to refer to the doctor is *awá*, and in plural is *awápa*. In the Cabecar language it is *jawá* and in plural *jawáwá*. When referring to the doctors of the native people, we will respect the terms *awá* for the singular and *awápa* for the plural. When references are made to the medicine of these groups, it generally refers to the use of medicinal plants. This is even though the *awápa* tell us that plants, although very necessary in the healing process, are not the most important thing because what is essential is the ancestral history. In this article, we will be guided by the words of the a*wápa* and we will emphasize concepts and knowledge that come from the oral tradition, the ancestral history, without touching on medicinal plants. This would be the subject of another work and which Alí García has previously dealt with in his book *Plantas de la Medicina Bribri* (1994). The Bribri-Cabecar communities have kept in their oral tradition, in their ancestral stories, the memories of *enfermedades viajeras (duwè shkál),* diseases that come and go, those that pass, that is epidemics or pandemics. They are illnesses that can be transferred from one person to another or from animals to people are referred to as infectious diseases or communicable diseases. In general, these ancestral stories are categorized as mythology or magical thinking, that is, as a fantastic, unreal, or false legend. The concept of mythology has other meanings and has been varying as Leonardo Ordóñez points out:

> Although myths for a long time were seen as stories about imaginary beings or fables lacking rationality, mythical thinking has been revalued since the mid-20th century as a legitimate form of knowledge and an essential dimension of the human experience (Ordóñez Díaz, 2016, p. 5).

However, despite the changes that occurred in the 20th century in conceptual terms, the prevailing meaning is to see the myth associated with a story. This is generally devoid of any reality, which is why in this article we have preferred not to use terms such as myth or mythology and instead use the term *suwõ'*, which in the Bribri language means wind or history, while in a different meaning is knowledge, wisdom. The Bribri dictionary of mythology defines *suwõ'* as: “Wind, soul, history. The Bribri oral tradition is designated by this term.” (Jara and García, 2003, p. 201). It refers to ancestral history, knowledge, Bribri

and Cabecar cosmogony. The *suwõ'* is associated with the wind because it symbolizes the word, the story. In many texts (Bozzoli, 1982), *suwõ'* is known as the chant because *suwõ'* is a specific language (different from Bribri and Cabecar) used only by the *awápa*, the *Óköm*, and other masters for their healings and ceremonies. When the *awápa* do their healings, one hears a soft chant that often lasts several hours and is repeated over the course of 2 or 4 nights.

We have also tried to refer to the concept of medicine of native people, and avoid confusing it with superstitions associated with sorcerers, witchdoctors or charlatans, as is often the case. Following the teachings of Miguel León Portilla, in *La filosofía náhuatl estudiada en sus fuentes* (1966), we have preferred to speak of the philosophy or knowledge of native people, and not of simple legends or myths. In the *suwõ'*, the oral tradition of the native Bribri and Cabecar peoples of Costa Rica, there are coherent explanations of their own conception of the world. It is not just one, but several interwoven, intertwined, synchronic worlds. In this knowledge we find a deep reflection on life and death, on healing practices or on the various worlds that are interwoven here and now, in our own world, and whose existence is intrinsically linked to their conception of medicine and disease.

Methodology and Information Gathering

In general, almost all the information on medicine and cosmogony that supports this text was compiled through original audio interviews we conducted with the *awápa* (doctors) and bribri-cabecar knowledge specialists in different traditional positions over many years.

Among this group, the *awá* don Francisco García (1902-1996) deserves special attention, from whom we gathered much of his knowledge and included some of his words in this article. Don Francisco thought that the *suwõ'* should be recorded, translated, and then published to make known the true knowledge of the Bribri and Cabecar peoples.

Therefore, it is convenient to clarify that this article is not the result of a specific research work, of an undergraduate or doctoral thesis, but of a continuous effort over more than 30 years. In which we have participated several researchers and people from the bribri-

cabecar peoples to make known the knowledge of the *suwõ'* and strengthen the cultural identity of these communities.

The knowledge stored in the *suwõ'*, being of great importance, is traditionally kept in a language considered sacred, different from Bribri and Cabecar. Thus, it was necessary to resort to a double translation to know the information stored in the *suwõ'*. Several pieces of knowledge, for example, were first translated from *Suwõ'* into Bribri and then from Bribri into Spanish. It was necessary not only to count on the *awápa* who narrated the stories, but also on people who collaborated on the various translations.

Part of these materials were reflected in very diverse works (articles, books, interviews, radio plays, videos) made by various researchers, among which we count ourselves. A good synthesis of what this process of cultural revitalization means was made by our friend Marcos Guevara Berger (1958-2021) in an interview he conducted with Alí García and published this same year (Guevara, 2021).

Some of these publications are cited in this article, such as: Plantas de la Medicina Bribri (1994) by Alí García; Ies Sá Yilite. Our Origins. Historias Bribri (1996) by Alí García and Alejandro Jaén.

Jaén; Diccionario de Mitología Bribri (2003) by Carla Jara and Ali García; among others. Another part of the information was obtained from various historical texts related to the contagious diseases that affected the indigenous people since the 16th century, both for Costa Rica (Ibarra, 1998) and Mesoamerica (Guevara, 2020). For this article we reflect on those concepts of bribri-cabecar medicine. These were collected by other researchers at different times and presented as myths, but against the backdrop of the COVID-19 pandemic, they could be reinterpreted as medical protocols or social isolation measures, which maintain not only their validity, but their socio-cultural validity today.

To make concepts such as *buklú*, *buklú bisok* or *Wiköl*, which we will analyze later, understandable to a wide public, we emphasize those elements of cosmogony that have a close relationship with medicine, the origin of diseases and protection against them.

The Diverse Perceptions of the World

In the *suwõ'*, in one of the bribri-cabecar stories, there is talk of the paths, both of diseases and of the paths of human beings: "our paths are the rivers of diseases, and our rivers are the paths of them. They see the world differently from ours" (García and Jaén, 1996, p. 18).

It seems a simple play on words, a poetic expression, but this quote is of great depth, since it begins by answering a question, we had previously asked ourselves: how do diseases move? Thus, we learn that diseases have their own paths, and these differ from ours, because what we, human beings, perceive as a river, for them constitutes their usual path.

Everything seems to indicate that in the *suwõ'*, the oral history, a practical observation of the first order was recorded: many diseases are transmitted by water. It is possible that the Bribri-Cabecar peoples did not develop as in the West, a concept of drinking water, but they did develop the concept of the place where diseases travel and associated it with rivers with water.

In all the teachings of *suwõ'*, diseases not only have their own world, but that they perceive ours in a different way. It is another logical, complex, and dynamic system that seeks to explain through the images of *suwõ'*. The relationships, the changes, and the points where various worlds converge. Proportions, forms, meanings, the use given to things, strength, energy, and others, change. What in our world is small, in the world of darkness can be big. The clearest example is a hummingbird, which in our world we see as a small and fragile being, but in the world of darkness it is a very big and powerful being. All of this has a purpose, a fundamental meaning. It is intended to answer the questions: how does the world perceive disease, how are we perceived?

> If the flu passes it sees us as if we were fish and our house a big pond. But if another disease passes it sees us as if we were birds and our house a leafy tree. Another illness may see us as if we were wild pigs and our house a small forest (García and Jaén, 1996, p. 16).

Each disease has its own perception of the world. Not only does it see us differently from the way we are, but every human being, every plant, every mountain or every tree perceives it differently because they have another way of looking at and interpreting their own world. That is why we say that there are other worlds that are also in our own world.

Don Francisco told us “We must never believe only the things that our eyes see, but we must see as the elders do: see the things that are beyond our eyes" (García and Jaén, 1996, p. 22). This phrase clearly expresses the method followed by the *awápa* in their reflections and knowledge about diseases. In this specific case, they refer to not trusting the information that is presented to our sight, but in other occasions they refer to not trusting our senses. Even not trusting the information of our world at all because the essential happens in the world of darkness, where there are beings that we do not see, beings that do not make noise, but that sometimes interact with us and manifest themselves as diseases.

The knowledge of our own world does not allow us to understand what a disease is like, what it thinks, or what the world where it lives is like. The awá doctors go even further and delve into the elements of perception, but not from our own perception, but from the perception and look of each disease as a character, as a living being. If we see the world through the eyes of this disease, we must ask ourselves: how does it perceive us, when do we become visible?

Tuàlia: The Lord of the Flu

Amid the COVID-19 pandemic, references to other pandemics have proliferated in the media, such as the Spanish flu pandemic that ravaged Europe in 1918, at the end of the First World War. Among the Bribri and Cabecars, the flu is called *Tuàlia*, and in the *suwõ'* there are multiple stories related to this character (Bozzoli, 1982, p. 4).

Some of these stories we collected from the *suwõ'* almost 30 years ago from the words of the *awá* don Francisco García, who when referring to the flu disease told us: "[...] the king of the flu was sent by *Sib*, there behind where the sun rises." (García and Jaén, 1996, p. 18). That was his way of telling us that the flu was one of the diseases that came from the east, that it was brought by the Spaniards, and that *Tuàlia* (the flu) was a powerful lord.

Bribris and Cabecars, faithful to their tradition, also personified the flu, and all the new diseases that were brought by the Spaniards for a better understanding of them. By personifying them and by giving them human characteristics, they were able to gather information about those beings they could not see and made visible phenomena that are

otherwise invisible. In this regard, Bozzoli warns that: "The cures of the /*awápa*/ require that they know the history of each disease, the origin of the patient's clan and the aids (plants, stones, waters, others.)" (Bozzoli, 1982, p. 75).

Regarding *Tuàlia* (the flu), the *awápa* tell us that: "*Tuàlia*, the king of the flu. It (he) has a great importance since the flu is a disease that is difficult for indigenous doctors to treat." (Jara and García, 2003, p. 215). In general, when the *awápa* refer to the diseases that were brought by the Spanish and other Europeans, they tell us that they are diseases whose origin is unknown, and therefore it is difficult to cure them.

When Don Francisco referred to Tuàlia, the lord of the flu, he was referring not only to the seasonal flus that arrive every year, but also and especially to those flus that arrived and almost exterminated many of the clans, both Bribri and Cabecar (Bozzoli, 1982, p. 4).

In general, the *suwõ'* stories do not determine the exact years in which *Tuàlia*, the lord of the flu wreaked havoc on the Bribri-Cabecar population, because the rules and codes for keeping information in the *suwõ'* are strange and complex. We do not know if he was referring to the Spanish flu of 1920, or to previous situations, even those that occurred during the 16th and 17th centuries. It would not be surprising that Don Francisco García and other *awápa* kept memories of the Spanish flu that arrived in Costa Rica around February 1920, which is why we decided to delve deeper into that historical moment.

According to the information recorded in the 1920 Statistical Yearbook, the total population of Costa Rica was 468,373 inhabitants on December 31, 1919 (Lizano, 1922, p. 16). Based on these statistics, in 1919, 170 people died of influenza (flu) in Costa Rica, while in 1920, 2,298 people died of the same cause (Lizano, 1922, p. 19). This means that from 1919 to 1920 there was a 13-fold increase in the number of cases of mortality due to influenza.

In 1920, Costa Rica was still a huge forest, with poor communications and lousy roads. Without discrediting the work done in collecting information for the *Anuario Estadístico de 1920*, it is difficult to believe that reliable data could have been collected in areas inhabited by indigenous peoples. This is not only due to the rugged geography but,

above all, due to sociocultural and linguistic barriers. In fact, when we look at the mortality data by province, our hypothesis seems to be confirmed.

According to the cited document, in the province of Limón—where most of the indigenous population is located—10 deaths from influenza were reported in 1919, while in 1920 only eight deaths were reported (Lizano, 1922, p. 19). It seems that the Spanish flu did not affect the province of Limon. This is extremely unlikely, especially since the port of Limon is in that province, which in 1920 guaranteed the export of coffee to Europe, Costa Rica's main export at the time.

In this sense, the information stored in the *suwõ'* takes on greater relevance because it allows us to fill a gap in the history of indigenous peoples and bring us closer to the moment when they experienced a situation as critical as a pandemic. The Bribri-Cabecar peoples stored in the *suwõ'*, in their oral memory, those moments of extreme difficulty, where a *duwè shkál*, (an infectious disease) greatly affected the lives of indigenous peoples. The exact dates and death toll are not specified, but they express it with enormous clarity when they say: *Ta i duwè tö se' ẽ' owã*, which means: "Diseases almost exterminate us."

Tuàlia, the lord of the flu, had wreaked havoc in the indigenous Talamanca of Costa Rica, but he was not the only powerful lord spoken of in the *suwõ'*. Many beings of diverse nature still pass through the world of darkness.

Ancient Duwè Shkál (Infectious Diseases)

Everything seemed to indicate that ancient stories were preserved in the *suwõ'*, which are what support the deepest medical knowledge and Bribri-Cabecar cosmogony. This meant that the search had to continue, delving into the secrets of the *suwõ'* and the colonial chronicles.

Some enigmatic phrases from the *awápa* seemed to refer to the most ancient *duwè shkál,* expressed from their knowledge and understanding, from their perspective. Frequently, in their stories, they say: “many of the illnesses come from the East.” 2 Thus, we learn that illnesses come with the rising of the sun and leave in the West with the setting of the sun. The *awápa* always seemed to refer to the illnesses brought by the Spanish, as documented in various colonial chronicles (Ibarra, 1998).

The *awápa*, in general, and Don Francisco in particular, said that curing the descendants of Europeans was simple, while curing indigenous peoples was more difficult. This seemed a contradiction with the previous statement, which stated that indigenous peoples' illnesses were easy to cure, while, conversely, diseases that came from the east were difficult. This is how we discovered that Don Francisco made the difference between the healing process and the disease itself. He also referred to how an illness "brought by the Spanish," the *duwè shkál*, affected indigenous peoples, or people of Spanish or European descent, because the effects and consequences were not the same. What Don Francisco and the *awápa* described so clearly in the forests of *Talamanca* is precisely the information collected in colonial chronicles throughout the Americas.

> According to Friar Bartolomé de las Casas, in December 1518 or January 1519, a disease identified as smallpox appeared among the Indians of the island of Santo Domingo. Few Spaniards were affected, with the Indians suffering the most. According to the Spanish, it exterminated between one-third and one-half of the indigenous population (Guevara, 2020, p. 3).

What Fray Bartolome de las Casas describes in detail for the year 1518 would be repeated over and over throughout the Americas, as we will see later. For us, it was of additional value to discover that in the *suwõ'*, the oral memory, the *awápa* had stored information that coincided with that collected in the oldest chronicles, such as the chronicles that narrated the development of contagious diseases that decimated hundreds or thousands of towns throughout indigenous America, between the 16th and 17th centuries (Koch et al., 2019).

One idea appeared repeatedly in both colonial chronicles and the *suwõ'*: when faced with certain contagious diseases, although the Spanish population fell ill, they did not end up in critical situations and died at the same rate as the indigenous population. Suárez de Peralta wrote in 1589:

> A great pestilence befell the Indians, which was smallpox, and no one escaped its victim." According to Fray Bernardino de Sahagún, the epidemic began in the month of Tepeilhuitl (September 10, 1520), causing people to become covered in pustules or rashes all over (Guevara, 2020, p. 2).

Smallpox then spread throughout the region, even affecting the capital of the Aztec Empire. The fall of Tenochtitlan occurred precisely as smallpox was ravaging Mexico's indigenous population (Guevara, 2020, p. 2). Reports of major epidemics continue throughout the 16th and 17th centuries, not only in Mexico but throughout the continent.

Although there is much controversy surrounding the population figures for the indigenous people of the Americas in the 16th and 17th centuries, what is not controversial is the assertion that the mortality rate among them was enormous. In most cases, it exceeded 80% or 90% of the population and, in many cases, resulting in the total extermination of many people. Recent research (Koch et al., 2019) states that the population of indigenous people declined in less than 100 years, between the 16th and 17th centuries, from about 60.5 million to only 4.5 or 6 million. In this article, the authors (Koch et al., 2019) hypothesize that the death of approximately 56 million Indigenous people throughout the 16th century transformed the Earth's climate due to the decrease in atmospheric CO2. When millions of hectares of cultivated land throughout Indigenous America were abandoned by the "Great Dying," they were transformed into forested areas. These changes apparently contributed, among other factors, to the development of the Little Ice Age in Europe, which lasted from the mid-17th to the early 18th century, approximately from 1645 to 1715 (Koch et al., 2019).

It is not unusual to conclude that a demographic catastrophe that occurred 500 years ago could have influenced climate change on a global scale. It is an idea that allows us to understand the impact and enormous dimensions of the conquest and colonization of Indigenous America.

The same impact we can study and reconstruct today on the Earth's climate in the 16th and 17th centuries must also be imagined, in psychological, economic, political, and cultural terms, on the surviving indigenous populations. The traces of these events, these marks, must have remained in their worldview in general and, very specifically, in their conceptions of health, illness, and healing practices.

Costa Rica in the 16th and 17th centuries was no exception, and indigenous peoples were profoundly affected, as Eugenia Ibarra notes:

> Currently, specialists in the field of demographic history acknowledge that it is impossible to know with certainty the population of Costa Rica in the 16th century, but they consider the figure of 400.000 inhabitants, calculated using specialized techniques and methods, to be acceptable. The figure offered by these studies for 1569 is 120,000 inhabitants, and for the year 1611, or at the beginning of the 17th century, they estimate that there were only 10,000 Indigenous peoples (Ibarra, 2002, p. 45).

According to these data, 97.5% of the indigenous population disappeared from Costa Rican territory in less than a century. This depopulation occurred even before the conquest of Costa Rica, which began late in 1561 (Ibarra, 1998).

This means that Costa Rica was practically depopulated before the first colonial chronicles could be written. This lack of written documentation makes oral tradition, the information stored in the *suwõ'*, the only source of information we have access to about this period.

This brutal depopulation of Costa Rica, and overall, of indigenous America, must have caused enormous changes in the surviving population at all levels: economic, cultural, psychological, among many others. Strictly speaking, in terms of addressing health and disease issues, these changes must have been reflected in multiple ways. In the face of such a tragedy, it is very likely that many healing practices abandoned the scope of everyday protocol, amid the pandemic, to become deeply embedded as permanent cultural practices. If this hypothesis is correct, we will not be trying to follow an improbable trail of an ancient health protocol lost in time. Instead, we can investigate by studying *suwõ'*, the way in which ancient practices persist to prevent and treat *duwè shkál* (infectious illnesses). It is, if you will, a journey through *suwõ'*, the eternal return, an ancient knowledge that returns to fill the present time with meaning and wisdom.

From experience, we know that oral tradition, *suwõ'*, allows for the feats of preserving knowledge for centuries. However, our purpose is not to venture into speculation, but rather to understand the scope of these ancient concepts and practices, in the health and disease systems developed by indigenous people. Concepts such as *buklú, buklúbitsok,* and *Wiköl*, and others can help us understand some of the reflections of the Bribri-Cabecar people regarding disease. The COVID-19 pandemic is an ideal time to

begin analyzing the concept of *buklú*. This term was translated as "bad omen," meaning a set of superstitious practices, but given the prevailing winds, this is a good time to dive deeper into it.

Buklú or Bukulú

The concept of *buklú* has several meanings, one of them being defined as: “Powerful devil, guardian of certain animals. Evil spirit” (Jara and García, 2003, p. 34). Seen in this way, it gives the impression of being a simple superstition, which is why it is so often associated with bad omens. However, when we delve deeper into this concept, we discover several important points. First, we know that it is a powerful being, guardian of certain animals, in other words, associated with the diseases that certain animals can transmit to us. It is possible that what the West called zoonosis, the Bribri and Cabecar people would call *íyiwak dàli* (diseases of animal origin or produced by some animal.) Then, we have several characteristics of this character:

> Evil that is produced by contact with something that by disuse has acquired the spirit of some disease. It is seen as a contaminating dirt of objects that after having been touched by human hands remains unused for some time. It is seen as the maximum expression of impurity (Jara and García, 2003, p. 34).

Now we know that the *buklú* or *bukulú* is not only a powerful spirit, guardian of certain animals, but it has the strange quality of impregnating things, of remaining adhered to things that have been in disuse for a certain time, after having been touched by human hands. In this case, bribris and cabecars use not only the concept of buklú but also the concept of *íyi dàli.* They specify with great clarity the diseases produced, no longer by animals, but by certain things. “Objects acquire this condition when they have been touched by a human being and spend five days without being touched again. After twenty days the object loses the power to produce the disease” (Jara and García, 2003, p. 34). According to this definition, things can acquire the spirit of a disease, but not all things, only those that have four very clear characteristics:

1. They were touched by human hands.
2. They are things that remained several days in disuse.

3. The *buklú* does not remain permanently attached to things.

4. According to Bribri knowledge, *buklú* disappears approximately after 15 to 20 days.

Buklú Bitsö`k: to Protect Oneself Against Diseases

The concept of *buklú bitsö`k* is explained, textually in the Bribri language in this way: "that the beings from beyond the earth do not see you". This means that the diseases [may] do not find you, do not discover you—because your actions when well carried out, can hide you, and make you invisible to the diseases. These are various measures of social isolation, expressed as a cultural practice of protection. The words *buklú bitsok* are complex because they do not apply to the care of all diseases, but only to those in which the *awápa* recommend isolation or quarantine of the sick person. Isolation is expressed on two levels, from outsiders (relatives, neighbors, friends), or from within the family itself. The family of the sick person puts an obstacle in the entrance way to the house to indicate not to pass. Two pitchforks and a crossbeam are placed, and banana leaves are hung across the width of the road, as if they were hanging clothes. In this way, neighbors, relatives and friends know that this house is not to be entered because there is a gravely ill person who must be isolated.

Within the family there are also very specific rules of distance and social isolation. Only one or two people in the family can attend to the sick person, who has his own crate, glass or spoon, among other things. When the sick person must go to the bathroom, banana leaves are placed on the floor, so that the sole of the sick person's foot does not touch the floor, which will be stepped on by the other people in the family. The justification for this practice is that the energy of the sick person can be impregnated in the things they touch so that they can make other people in the house sick. In the indigenous communities, bathrooms are built 30 or 40 meters from each house, so the task of covering the floor with banana leaves was not easy. It is also surprising in terms of its reflection on the ways of getting infected. In this case, the energy of the sick person passes immediately to the objects the person touches.

E 'iyáuk means in the Bribri language [textually], "to get muddy", but it is the expression used to say that someone was infected by something. In the popular language of these peoples, it is said: "it is as if something that we do not see was covered [with dirt] on things". The *buklú bisok* is established as a cultural practice of behavior, but also as an ethical rule. It is necessary to respect the patient's house in order not to make that person sicker, if one is carrying *buklú*, something that causes illness or in order not to make other people in the community sick. If someone does not respect the practice of *buklú bisok* and enters the sick person's house without permission, the patient's family is deeply offended. It is interpreted as an act of aggression against the patient and his family.

The *bisok* even embraces a system of cultural practices that were called diets. They go beyond abstaining from eating certain foods, and should be understood in a much broader sense: *bisok* can comprise not eating certain foods (fasting), not eating the meat of certain animals (diet), prohibit the visit of people to the house (isolation), stop traveling (break in mobility and social isolation), do not go to parties or dances (social isolation), only eat roasted plantains (diet), do not eat fat, chili, red meat, do not eat salt (diet), not to eat certain birds, palms, peach palm/pejibayes (diet), not to be exposed to the sun for several days or weeks (diurnal isolation), not to have sexual relations for a certain period of time (conjugal isolation), not to cook or touch food (prevention against *buklú*), among others. Behind the word "diet" there is a system that includes abstinence from a set of actions, practices or meals, which will have to be studied in greater detail according to the types of disease. Not being exposed to the sun for one or two weeks could be interpreted as a norm of social distancing during the day, but it could be an observation related to the inconvenience of sunbathing when one has certain illnesses, as in the case of allergies, or others.

These behavioral norms, which possibly developed during the great epidemics, and today we would recognize as sanitary protocols, remained as permanent cultural practices, and are incorporated, in the social imaginary, to the practical reflection (conception of the world) as knowledge of the origins and characteristics of the different types of diseases and preventive and curative practices. There are other practices that, without having developed conceptually in the same way as *buklú*, are important because they favor social distancing.

For example, Bribri and Cabecar villagers do not shake hands to greet each other, do not kiss each other on the cheek, and even, among couples in love, do not kiss each other on the mouth. To outsiders, these practices are seen as colder or unromantic relationships, but their main objective seems to be to avoid the transmission of some evils between people.

The Origin of the Diseases

Conceptually, in bribri-cabecar medicine, every disease is a being that lives in the beyond the earth, in a world we cannot see. That is, they live in the world of darkness, in the world of origin. The world of light, the world we inhabit, the world that was created for the seed (human beings), is a false and deceptive world, only a reflection of the true reality, which is found precisely in the world of darkness, the world where all diseases dwell.

Diseases are the original beings, beings that in their world have enormous power and on certain occasions manifest themselves in our world. In the ancestral stories the battles between the beings of the time of darkness are narrated. Often, the *awápa* say that whoever wins the battle is a healing plant, because the healing plants are considered the *awápa* in the afterlife of the earth. Hence, in bribri-cabecar knowledge and wisdom, human beings are not superior, but on the same level as plants and animals. Animals may even appear to be superior to us, in the sense that they can transmit various diseases to us. Animals are in this world, but their real owners, the beings they represent, the diseases, are in the other world—the world of darkness. The plants and animals that are on this earth are only representations of the true beings that inhabit the other dimension, even with greater power, with greater wisdom, with greater intelligence than us human beings. These beings (plants and animals) are more "educated" than us since they know how to act in this world and have more protection against diseases.

The current pandemic is the product of a being that we do not see and that literally has put the entire planet in a state of emergency. It is possible that in ancestral stories when they talk about the power of disease, they were referring to situations like the current one [COVID-19], to situations like those experienced by indigenous peoples in the 16th and 17th centuries, when they lost more than 90% of their populations (Koch et al., 2019).

So far, we have referred to cultural practices of social behavior, for acting and protecting oneself in the event of contagious diseases. However, we have not said anything about each person, their individual protection system. In the Bribri and Cabecar medical tradition, there is also a set of cultural practices of individual behavior, the purpose of which is to prevent disease, to keep the person healthy. All of this is expressed in its paradigmatic space, between the world of light and the world of darkness. Between what we see and is of no use to us because it is unreal and what we do not see, what is hidden from our eyes and where true reality lies. When it comes to preventing disease, when it comes to warning us of future events, *Wiköl* comes into play. It is our soul outside the body, our protective shield.

Wiköl: The Soul Outside the Body (Our Protective Shield)

Conceptually, *Wiköl* is a complex being. There is no doubt that it is a human being, but not just any human being; it is us in the other world, in the other dimension, in the world of darkness. *Wiköl* is represented as a kind of halo that surrounds our entire body (in the other dimension), which is why it is called the protective shield or soul outside the body. Its mission is to protect us, and to do so, it makes us invisible to illness. Illnesses can be right next to us, but they cannot see us because *Wiköl* envelops our entire body with its halo and hides us from all harmful beings (García and Jaén, 1996, p. 4).

Keeping cultural distance and knowing that this is a different paradigm in terms of worldview and health, it gives the impression that *Wiköl* resembles what Western medicine calls "our immune system." True to their tradition and their way of seeing the world, the Bribri and Cabecar peoples do not place their defences inside our own bodies, but outside of them. This is like a halo that surrounds us, but in another dimension, in the world of darkness. Only when our protective shield is broken do we become visible, not to one, but to all illnesses. It is there that *Wiköl* sends us his messages through dreams, to warn us of approaching danger.

Dreams are the language *Wiköl* uses to communicate with us in his own language, the language of the origins of time. That is why dreams are so complex to interpret, because

they are expressed in the language spoken by beings from beyond the earth, beings from the world of darkness: illnesses. The world of dreams is enormously complex, requiring a separate study. In this article, we only touch on it tangentially to refer to *Wiköl* as a character, as our own being in the beyond the earth.

All things happen to *Wiköl*, our protective shield, before they happen to ourselves. If a person is sick, it is because their shield was previously attacked by an illness in the other dimension, beyond the earth. Thus, we learn that the various worlds are intertwined, like the threads in the weave of a hammock, but that actions happen first in the world we cannot see, in the world of darkness.

There are many reasons why our protective shield can crack or break, and this is where cultural practices of individual behavior come into play. There are animals that should not be eaten because contact with the animal, its meat, its skin, could make us sick. Cultural practices are so specific and complex that they might tell us that this clan cannot eat tapir meat, but that other clan can eat it. These practices were very often presented or studied (in the West) as a system of taboos. However, for them, there is a strict classification of diseases that can be caused by various animals or sometimes several things.

Our indigenous peoples inhabited forests and jungles for millennia, occupying the same territories. It is not surprising that they had very specific knowledge about the diseases that certain animals can cause. What in the West is recognized as zoonosis and studied in medical or veterinary schools, the Bribri-Cabecar learned from childhood.

When something happens in the world of darkness, *Wiköl* warns us in his language, which is different from ours and is a language of images, the language of dreams. Almost all dreams come from the protective shield, *Wiköl*. Thus, in dreams, *Wiköl* warns us about what will happen in our future, in terms of health and illness. It is through dreams that we receive messages from beyond the earth. In a highly complex process, not only Wiköl, the soul outside the body, but also three other souls: the soul of the liver, the soul of the eyes, and the soul of the bones. Together, all these beings make up the being that “I am” in the various worlds “I” inhabit simultaneously. This is true for every human being because, in

Bribri-Cabecar knowledge, we all have four souls and simultaneously inhabit several worlds.

The world of dreams, in the knowledge, wisdom, and health systems of these peoples, is highly complex because every animal, every image that appears in a dream is associated with a specific disease in this world. The concept of dreams differs even from our own concept of dreams because, paradoxically, in *suwõ'*, not everything we dream can be conceived as a real dream. For these native communities, who have apparently lived in the same forests for several thousand years, their contact with the animals and plants of these jungles has shaped not only their way of life, in terms of survival, but also their entire body of knowledge.

Conclusion

This pandemic, among all the changes it has brought about, allows us to highlight and bring to light the cultural practices and knowledge of the Bribri-Cabecar peoples. These have enormous validity, not only in practical terms, but because they allow us to understand how far they have advanced in their knowledge in the field of health from another paradigm and another way of seeing the world. It is a fact that these peoples faced major pandemics to which they had no immunity and developed a series of knowledge and practices to confront them. This knowledge constitutes the first pages of the history of Costa Rican medicine. Expressed in other languages, in another conception of the world, in other paradigms, but whose purpose was the same as current medicine: to prevent diseases and cure the sick on an individual and collective level.

The analysis of concepts such as *buklú, buklú bitsok,* and *Wiköl* allows us to approach those worlds we cannot see. These dark worlds where diseases dwell and understand a small part of the cultural practices that allowed these peoples to survive one of the worst demographic catastrophes in living memory: the pandemics and epidemics of the 16th and 17th centuries.

Finally, we believe that the knowledge and wisdom accumulated over centuries can help those of us who work with Indigenous peoples create or formulate alternative and innovative public health actions in the territories of the Bribri-Cabecar peoples. This is to

address this pandemic with an intercultural approach and greater respect for the cultural traditions of these Indigenous peoples.

4.2 Translation from English to Spanish

La construcción de un próspero sistema de atención integral: la historia de Costa Rica

Madeline Pesec, Hannah Ratcliffen y Asaf Bitton

Atención Integral antes de los años 90

Antes de 1960: la creación de instituciones de salud

Costa Rica se independizó de España en 1821 y de México en 1838, antes de establecerse como democracia en 1869. Antes de la creación de los hospitales y la introducción de los médicos como únicos proveedores de servicios médicos autorizados, los costarricenses confiaban en la higiene personal, los curanderos indígenas y las terapias a base de hierbas de los diversos bosques tropicales de Costa Rica para prevenir y tratar enfermedades. En la década de 1850, muchos médicos costarricenses viajaron a Europa para formarse y más tarde regresaron a Costa Rica y trajeron consigo las prácticas biomédicas occidentales. El Hospital San Juan de Dios, primer hospital de Costa Rica fue fundado en la capital, San José, por propietarios de una plantación de café en 1845.

Una ley en 1865 creó un sistema de "médicos del pueblo", cada uno de los cuales atendía a la población de una ciudad determinada en virtud de un contrato con un municipio concreto. Los "médicos del pueblo" se encargaban de prevenir brotes de enfermedades y de tratar a la población indigente. El sistema de "médicos de pueblo" persistió en las zonas urbanas y en las ciudades bien pobladas hasta finales del siglo XIX y principios del XX. El ejercicio de la medicina quedó restringido a los biomédicos en 1887, cuando una ley anuló todas las licencias de curandero expedidas anteriormente. Durante este periodo, el sistema sanitario costarricense se basó cada vez más en la biomedicina occidental.

La mayor parte de la asistencia sanitaria fuera de los centros urbanos era proporcionada por las compañías bananeras y cafetaleras. Por ejemplo, en la provincia rural atlántica de Limón, la United Fruit Company fue el único proveedor de atención médica durante 30 años. Además de establecer hospitales, la United Fruit Company creó programas de prevención, por ejemplo, para eliminar la malaria con el fin de incentivar la productividad de sus trabajadores. Como la mano de obra era relativamente escasa en Costa Rica, la inversión en la salud de los trabajadores era una importante estrategia empresarial.

A principios de la década de 1920, el gobierno creó una serie de instituciones sociales clave, como la Subsecretaría de Higiene y Salud Pública en 1922 (precursora del Ministerio de Salud, que supervisaría los hospitales y prestaría algunos servicios de salud pública) y el Instituto Nacional de Seguros en 1924. Su creación y sus primeros éxitos sirvieron de impulso político para crear otros programas sociales.

Uno de ellos fueron las Unidades Sanitarias, creadas en 1934 por el Dr. Solón Núñes Frutos en la ciudad rural de Turrialba. Este programa condujo al establecimiento de centros de salud, los cuales normalmente se ubicaban en la ciudad capital de diferentes provincias y eran atendidos por un médico general, una enfermera, algunos auxiliares de enfermería, un técnico de laboratorio y un farmacéutico. Estas Unidades Sanitarias tenían un compromiso con la prevención y seguían el modelo de las Unidades Sanitarias de condado que se estaban estableciendo en las zonas rurales de Estados Unidos durante la misma época. Además de su compromiso con la prevención, estos centros sanitarios rurales estaban anclados a una zona geográfica, lo que tal vez representaba los primeros presagios de la organización geográfica del sistema sanitario. Estas Unidades Sanitarias fueron un modelo de atención muy popular y siguieron creciendo en número a lo largo de la primera mitad del siglo XX.

En la década de 1930 se produjo una mayor expansión de la atención biomédica en los hospitales y el desarrollo de la atención preventiva dispersa en programas comunitarios gestionados por organizaciones filantrópicas internacionales. A medida que se construían más hospitales durante este periodo, la mayor parte de la atención a la población urbana se trasladó al ámbito hospitalario. La capital, San José, contaba con tres hospitales principales gestionados por órdenes religiosas. Junto a los hospitales, varias organizaciones filantrópicas internacionales, como la Fundación Rockefeller, empezaron a invertir en el sistema sanitario costarricense, sobre todo en programas de erradicación de la anquilostomiasis.

Muchos costarricenses viajaron a Europa en las décadas de 1920 y 1930 para formarse y muchos futuros médicos vieron las ventajas de los incipientes programas de seguridad social. Los programas sociales se utilizaban en todo el mundo como barómetro de la eficacia de un gobierno. En América Latina también se estaban creando organismos

de seguridad social en muchos países que, en última instancia, guiarían el desarrollo de sus respectivos sistemas sanitarios a lo largo de la era moderna.

Estas tendencias internacionales dirigidas al establecimiento de sistemas de seguridad social tuvieron eco en Costa Rica, donde la población (en particular los trabajadores y los sindicatos) empezaba a reclamar que el gobierno iniciara una reforma integral de la atención de salud para satisfacer mejor sus necesidades. Esto se vio impulsado por la sobrecarga del sistema de la Unidades Sanitarias y el mal estado de salud atribuido a las infecciones parasitarias, las enfermedades diarreicas y respiratorias, las lesiones traumáticas, la desnutrición y la mortalidad infantil y materna. En aquel momento, se trataba de un perfil sanitario bastante típico de un país latinoamericano: Las principales preocupaciones sanitarias giraban en torno a las enfermedades infecciosas y la asistencia sanitaria era prestada de forma heterogénea por hospitales públicos, organizaciones filantrópicas internacionales y curanderos tradicionales locales.

Este impulso para que el estado costarricense se implicara más en el bienestar social de sus ciudadanos llevó a al menos media docena de intentos entre 1907 y 1936 para establecer una administración de la seguridad social. Finalmente, en 1941, el presidente Calderón Guardia dirigió el establecimiento de la Caja Costarricense de Seguridad Social (CCSS), un organismo de seguridad social diseñado inicialmente para proporcionar asistencia sanitaria y pensiones a los trabajadores asalariados. La importancia de la CCSS en la historia de Costa Rica como país y de su sistema de asistencia sanitaria en particular no puede exagerarse; se convertiría en uno de los pilares clave del Estado de Bienestar costarricense. La institución se fundó sobre los principios de solidaridad, equidad, justicia, universalidad e igualdad; valores que seguirían guiando el sistema sanitario costarricense durante décadas.

Tras la Guerra Civil de 1948 que duró 44 días, el derecho a la asistencia sanitaria administrada por la CCSS se reincorporó a la nueva Constitución de 1949 y la CCSS creció constantemente durante la década de 1950. No sólo se convirtió en un elemento importante de la incipiente democracia costarricense, sino que también amplió la capacidad de prestación de la asistencia sanitaria del país.

Más allá de la CCSS, la década de 1950 en Costa Rica trajo consigo una miríada de esfuerzos de salud pública, incluyendo la aprobación de leyes de saneamiento, la implementación de esfuerzos de control de enfermedades venéreas y campañas de erradicación de la malaria, y el establecimiento del Ministerios de Salud. En 1959, se produjo un cambio en el sistema de financiación y prestación de asistencia sanitaria de Costa Rica, que pasó de depender de organizaciones filantrópicas internacionales a un control estatal cada vez mayor de las funciones sanitarias del país.

1960s: Profundizar en el compromiso con el acceso universal a la sanidad

En la década de 1960 se redobló el compromiso de Costa Rica de atender las necesidades de las poblaciones vulnerables y empobrecidas, incluida la ampliación de la cobertura de la CCSS más allá de la clase trabajadora para la que se había establecido originalmente. En 1961, en un punto de inflexión importante, Costa Rica aprobó una enmienda constitucional que exigía la universalización de los servicios de la CCSS, incluidas las pensiones y la cobertura de la atención sanitaria curativa, en el transcurso de una década. Con el tiempo, esta enmienda ampliaría la cobertura de la CCSS para incluir a los dependientes de los trabajadores y a las poblaciones desprotegidas, como los grupos de bajos ingresos, rurales y vulnerables. Más allá de los beneficios inmediatos de la ampliación de la cobertura, la enmienda de 1961 estableció la Cobertura Sanitaria Universal (CSU) como el rasgo definitorio de las actitudes costarricenses hacia la atención sanitaria y un componente clave de la autopercepción del país. En efecto, los analistas del sistema sanitario Juan Rafael Vargas y Jorine Muiser sostienen que el derecho a los servicios sanitarios se ha convertido en "sinónimo de ser costarricense y probablemente representa la característica más importante del tejido social costarricense". Para los costarricenses, la prestación equitativa de servicios sanitarios se convirtió en un imperativo moral relacionado con el concepto de que la bondad de un Estado puede medirse en función de la atención sanitaria que presta a sus ciudadanos. Aunque no se alcanzó el objetivo de lograr el acceso universal a los servicios de la CCSS en 1971, la articulación de la CSU como un objetivo político y constitucional explícito dio al concepto una longevidad que aún hoy propulsa el sistema de salud costarricense. Además, el concepto de expansión de los

servicios de la CCSS se asoció específicamente con el ideal de cobertura sanitaria para todos.

Durante la década de 1960, la CCSS funcionó principalmente como un comprador estratégico de servicios y la estrategia predominante para la prestación de atención fue que la CCSS comprara la atención médica para sus beneficiarios en diferentes hospitales. Para acelerar el proceso de universalización de la cobertura de los servicios de salud, en 1961 se creó la Facultad de Medicina para que los médicos se formaran en el país y Costa Rica pudiera así controlar la oferta de médicos. A finales de los sesenta, el 47% de la población tenía cobertura sanitaria a través de la CCSS, frente al 18% de 1961.

En esta década las Unidades Sanitarias continuaron prestando asistencia sanitaria a los ciudadanos costarricenses fuera de las principales ciudades metropolitanas. Además de programas de prevención como vacunación, control del crecimiento y planificación familiar, las unidades sanitarias también llevaron a cabo cuatro “campañas” contra las enfermedades venéreas, la tuberculosis, los parásitos y la malaria. Los centros de salud móviles también desempeñaron un papel importante en la década de 1960 en la prestación de asistencia a las zonas rurales de Costa Rica. El primer centro móvil se estableció en 1963 y a finales de la década había doce funcionando por todo el país. Estas unidades móviles funcionaban como equipos de atención sanitaria, con funciones similares a las de las Unidades Sanitarias.

Además de la atención sanitaria preventiva y curativa prestada en hospitales, Unidades Sanitarias y centros de salud móviles, Costa Rica también invirtió mucho en el saneamiento de todo el país. En 1961, Costa Rica creó el Instituto Costarricense de Acueductos y Alcantarillados, dónde de 1961 a 1964, este organismo gastó 12,6 millones de dólares estadounidenses en estudios y en la ampliación de las prácticas de agua potable y alcantarillado en todo el país, principalmente en las zonas rurales. Estos esfuerzos de saneamiento tuvieron un impacto especial en la mejora de la salud del país, por ejemplo, en la reducción de la mortalidad infantil.

1970s: Legislación sanitaria fundacional y establecimiento de modelos sanitarios rurales

A principios de la década de 1970, el presidente social demócrata costarricense José Figueres, un destacado militar de la guerra civil de 1948 que había supervisado la ratificación de la constitución de 1949, se comprometió a ampliar los programas sociales junto con un impulso al crecimiento económico más rápido. Durante su mandato, el presidente Figueres se comprometió con la erradicación de la pobreza extrema y la universalización de los servicios sanitarios a través de la CCSS. A principios de la década de 1970, el presidente Figueres contaba con un amplio apoyo político para las reformas sanitarias y consideraba que la sanidad era una forma importante de lograr su programa izquierdista contra la pobreza. Figueres fue una figura clave en el establecimiento del Estado del bienestar costarricense, en el que la universalidad, la solidaridad y la igualdad se convirtieron en los principios fundamentales no sólo de las instituciones sanitarias, sino también de las políticas públicas en general.

Como parte de su estrategia, el presidente Figueres abogó por la Ley de Transferencia Hospitalaria de 1973, la cual transfirió la mayoría de los hospitales que operaban en el país (incluidos aquellos administrados por el Ministerio de Salud, los que pertenecían a las empresas agrícolas y los hospitales religiosos) al control de la CCSS. Hasta ese momento, la CCSS era únicamente un comprador estratégico; después de la implementación de esta ley, la CCSS comenzó también a dirigir y administrar sus propios hospitales y clínicas, lo que transformó a la agencia en un sistema combinado de pago y prestación. Tras la Ley de Transferencia de Hospitales, la CCSS controlaba 33 hospitales y 69 clínicas. Al colocar los hospitales bajo el control de la CCSS, Costa Rica convirtió la atención sanitaria clínica en un bien público.

Como complemento de la Ley de Traspaso de Hospitales, la Ley General de Salud de 1973 redefinió la responsabilidad del gobierno nacional en la protección de la salud de todos los costarricenses, lo que otorgó al gobierno el poder explícito de actuar en nombre del bienestar de sus ciudadanos durante emergencias sanitarias, principalmente a través del Ministerio de Salud. La Ley General de Salud definió los derechos y obligaciones de todos los agentes que ejecutan actividades que repercuten en la salud de la población. Una tercera

ley adoptada ese mismo año fue la Ley Orgánica del Ministerio de Salud, que estableció la "función rectora del sistema de salud" del Ministerio de Salud y también estableció al Ministerio de Salud como delegado del estado en materia de salud. Estas leyes permitieron al Ministerio de Salud costarricense vigilar la salud de la población e hicieron explícita la función de planificación y coordinación del MSP. Sin embargo, también establecieron que el MSP no podía actuar en contra de los intereses de las instituciones autónomas del sector salud (por ejemplo, la CCSS), limitando así la eficacia de su función rectora.

Basándose en su nueva función ampliada, el Ministerio de Salud estableció dos nuevos programas de atención integral en la década de 1970: el Programa de Salud Rural (PSR) y el Programa de Salud Comunitaria (PSC). Hasta entonces, la mayoría de los recursos de atención sanitaria (con la excepción de las clínicas móviles) se encontraban en los centros urbanos y provinciales con poblaciones que superaban las 1.000 personas. Tras un análisis de los datos de mortalidad organizados geográficamente, los dirigentes del Ministerio de Salud se dieron cuenta de que la mayoría de las muertes del país procedían de zonas rurales pequeñas y se debían en gran medida a la mortalidad infantil y a otras causas evitables. En 1973 se creó el Programa de Salud Rural para reducir esta mortalidad y llevar los servicios de atención integral a las zonas rurales marginadas del país. El programa se dirigía a las comunidades con menos de 500 habitantes, en particular a las que no tenían acceso a los hospitales de la CCSS y se encargó de recopilar datos epidemiológicos, proporcionar vacunas y tratamientos sencillos, promover la planificación familiar, organizar a las comunidades en torno a actividades de promoción de la salud y facilitar la derivación a hospitales secundarios en caso de afecciones graves. El PSR utilizaba enfermeras auxiliares recién formadas, llamadas asistentes sanitarias, seleccionadas entre la población local y supervisadas por una enfermera para educar a la población e identificar enfermedades. Para 1978, Costa Rica había construido 218 dispensarios rurales y en 1987 el programa cubría el 60% de la población rural. Los principios de prevención ensalzados por el PSR, como garantizar el acceso a los servicios básicos de salud, lo que llevó estos servicios a las comunidades y proporcionó una educación sanitaria integral, se convirtieron en conceptos fundacionales para el posterior desarrollo del sistema sanitario costarricense.

A fin de organizar los programas de salud rural, el Ministerio de Salud dividió el campo en distintas regiones geográficas de salud. Esta delimitación geográfica permitió el seguimiento de los resultados sanitarios por zonas a lo largo del tiempo, lo que adquirió importancia para el establecimiento de prioridades y la gestión de la salud de la población en la década de 1970 y años posteriores. Los trabajadores del sector sanitario recorrían el país a pie, en carro, a caballo, en barco o en bicicleta para así llevar la atención primaria a las poblaciones de las que eran responsables. Estas áreas de salud definidas, también permitieron la participación comunitaria y ciudadana a través de los comités locales de salud responsables de la administración y el mantenimiento de los dispensarios donde funcionaban los programas de salud rural. Los comités locales de salud se instituyeron con distintos grados de eficacia en todo el país. En algunas zonas, un comité local de salud elegido democráticamente dirigía activamente la atención sanitaria, pero en muchas otras la participación de la comunidad era limitada y los comités locales de salud no se creaban o se reunían en contadas ocasiones.

A partir de la entusiasta aceptación del PSR, el Ministerio de Salud estableció el Programa de Salud Comunitaria (PSC) en 1976. El PSC utilizaba el mismo concepto de agentes de salud comunitarios empleado en el PSC, pero añadía un componente de visitas domiciliarias y estaba orientado a las poblaciones urbanas empobrecidas. El PSC funcionaba en aproximadamente 250 Áreas de Salud, con una población aproximada de 2.000 personas cada una y cubría el 57% de las poblaciones urbanas empobrecidas. El PSC utilizó un protocolo de ejecución riguroso que implicaba la selección inicial de un área geográfica, la creación de programas de salud basados en las aportaciones de la comunidad a nivel local y una sólida medición para evaluar los resultados. Este protocolo de aplicación formalizó la participación de la comunidad y el seguimiento y la evaluación continuos como componentes prácticos básicos de la prestación de atención primaria en Costa Rica.

Tanto el PSR como el PSC aplicaron un enfoque de salud comunitaria centrado en estrategias básicas de salud pública preventiva, como la promoción de la higiene y el saneamiento, el lavado de manos, la educación sanitaria comunitaria, la atención prenatal, la lactancia materna, el seguimiento del crecimiento y el desarrollo infantil, la nutrición, la terapia de rehidratación oral, el tratamiento de la tuberculosis, la vigilancia de las

enfermedades infecciosas, la vacunación y los medicamentos antiparasitarios. Ambos programas lograron un éxito notable. De 1974 a 1977, el PSR y el PSC aumentaron el número de niños bajo vigilancia de 900 a 125.000 y el número de mujeres embarazadas bajo vigilancia de 350 a 10.000, y un estudio retrospectivo descubrió una asociación entre el tiempo que una población estuvo bajo la atención del PSC y el aumento de la esperanza de vida al nacer. Se cree que los eficaces trabajadores sanitarios comunitarios empleados por el PSR y el PSC son el elemento que permitió que los programas tuvieran un impacto positivo tan profundo y rápido en la salud de las poblaciones a las que atendían. A diferencia de muchos programas de TCS que se estaban implementando en todo el mundo en ese momento, en Costa Rica se supervisaba de cerca la calidad de los trabajadores de salud comunitarios. Los gobiernos locales recibieron formación en distintos mecanismos de garantía de calidad para asegurarse de que los trabajadores ejecutaban correctamente las técnicas de vigilancia médica, educaban a la población en determinados temas de salud y le proporcionaban materiales esenciales como alimentación suplementaria y tablas de crecimiento. Los agentes de salud comunitarios fueron un enlace eficaz entre la población y el sector sanitario de orientación biomédica y facilitaron la integración de los servicios sanitarios con la comunidad.

En 1978, el PSR y el PSC se combinaron para crear la División de Atención Primaria de Salud dentro del Ministerio de Salud. Esta unidad se encargó de proporcionar atención primaria a todas las familias empobrecidas y a principios de la década de 1980 el programa cubría al 70% de los “habitantes urbanos marginados” y también a la mayoría de la población rural. Los logros del PSR y el PSC fueron significativos, sobre todo si se consideran en relación con la histórica Conferencia y Declaración de Alma-Ata de 1978, en la que se pedía el acceso integral a unos servicios sanitarios amplios y equitativos. Costa Rica era un país ejemplar dentro de la Conferencia de Alma-Ata y ya estaba defendiendo esos principios y prestando servicios de atención primaria de salud bastante similares a las recomendaciones finales de la Declaración. De hecho, se consideró a San José como una de las ciudades candidatas para albergar el evento, pero consideraciones políticas entre la URSS, Estados Unidos, China y la OMS llevaron a la selección de Alma-Ata en su lugar.

Durante el mandato de Rodrigo Carazo Odio (1978-1982), la División de Atención Primaria floreció. Aunque el partido del presidente Carazo era conservador y promovía reformas de libre mercado, la administración utilizó el fortalecimiento de la atención primaria de salud para reforzar el apoyo nacional al partido en las zonas rurales. Además, las agencias internacionales de desarrollo apoyaron el programa de atención primaria de salud, ya que había un creciente apoyo y entusiasmo en torno a la atención primaria de salud después de la Declaración de Alma-Ata. La Agencia de los Estados Unidos para el Desarrollo Internacional (USAID), por ejemplo, cambió su enfoque hacia programas de prestación de atención sanitaria de bajo coste y promocionó Costa Rica como un estándar eficaz de atención primaria. La Organización Panamericana de la Salud (OPS), se comprometió a ampliar los servicios de atención sanitaria a las poblaciones desatendidas mediante la expansión de la atención primaria y la participación comunitaria en la década de 1970.

Los años setenta fueron una década crucial y formativa para la atención primaria de salud costarricense. Además de incrementar la financiación, las tres leyes sanitarias complementarias de 1973 pusieron la prestación de asistencia sanitaria curativa y hospitalaria bajo la responsabilidad de la seguridad social y otorgaron al gobierno, y en consecuencia al Ministerio de Salud, el deber de dirigir el proceso de la política sanitaria. A lo largo de los años, a través del PSR, el PSC y la División de Atención Primaria de Salud, se logró que la atención primaria de salud se convirtiera en el núcleo del sistema sanitario costarricense. A finales de la década de 1970, Costa Rica contaba con un sólido sistema de atención primaria de salud centrado en gran medida en la promoción de la salud, el saneamiento, la salud infantil y la erradicación de enfermedades infecciosas y este sistema ya se estaba reflejando en una mejora del estado de salud. De 1970 a 1980, la tasa de infección parasitaria de Costa Rica disminuyó significativamente y la tasa de mortalidad infantil bajó de 61 muertes por cada 1.000 nacidos vivos a 18 muertes por cada 1.000 nacidos vivos. Un análisis realizado en 1985 por el demógrafo Luis Rosero Bixby demostró que el 41% de este descenso se debía a los esfuerzos de la atención primaria de salud; en otras palabras, la atención primaria había reducido la mortalidad infantil en 17 muertes por cada 1.000 nacidos vivos. Al capitalizar su agenda política nacional y el compromiso existente con la atención sanitaria, Costa Rica fue capaz de construir un amplio sistema de

atención primaria basado en los valores de solidaridad financiera, provisión pública, compromiso con la atención preventiva y curativa, igualdad y universalidad.

1980s: Estancamiento relativo de la atención primaria

En la década de 1980, las turbulencias financieras asolaron Costa Rica y pusieron en peligro el sólido sistema de atención primaria. Esta grave crisis financiera fue consecuencia de la caída de los precios del café, el aumento de los costos del combustible y el incremento del déficit comercial del país. La decadencia económica de Costa Rica reflejó la recesión de Estados Unidos y de muchos otros países del mundo. De 1980 a 1982, la economía costarricense se contrajo un 10%, la inflación aumentó hasta el 90% y la proporción de ciudadanos pobres se disparó del 20% al 54%. En 1982, Costa Rica tenía una deuda pública de 3.000 millones de dólares.

Para hacer frente a esta creciente deuda pública, Costa Rica recurrió a organizaciones financieras internacionales. En aquel momento, estas organizaciones se centraban en la austeridad fiscal, y el Fondo Monetario Internacional (FMI) convenció a Costa Rica de que limitara el gasto en programas sociales (incluida la sanidad) para pagar sus deudas. La promoción de las reformas de libre mercado por parte del presidente de los Estados Unidos Ronald Reagan tuvo un profundo impacto en la política de las agencias internacionales de desarrollo, lo que llevó a la mayoría a empezar a recomendar la privatización de los servicios sanitarios y el abandono de la prestación de asistencia sanitaria controlada por el gobierno. Debido a la creciente dependencia financiera de Costa Rica respecto a estas organizaciones internacionales, el país se convirtió en deudor al menos parcialmente de ellas y de la dirección que querían tomar.

Junto con las recomendaciones de las organizaciones financieras internacionales, en la década de 1980 la Atención Primaria de Salud Selectiva (APS) fue ganando popularidad entre la comunidad mundial del desarrollo. La APS, descrita por primera vez en el New England Journal of Medicine en 1979, fue una respuesta a la visión de la atención primaria de salud integral (APS-I) presentada en la Conferencia de Alma-Ata. En general, la APS-I descartaba la integralidad por considerarla demasiado costosa y, a la larga, inalcanzable para los países de renta baja y sugería concentrar los recursos en intervenciones técnicas de bajo coste para las enfermedades más responsables de la morbilidad y la mortalidad. Los

programas de atención sanitaria primaria a menudo se centraban en tres o cuatro programas: por ejemplo, control del crecimiento, terapia de rehidratación oral, lactancia materna e inmunización. Se ignoraban en gran medida otros servicios curativos y preventivos, independientemente de las prioridades de la comunidad. Las organizaciones internacionales como el Fondo de las Naciones Unidas para la Infancia (UNICEF) y la Organización Mundial de la Salud (OMS) pregonaban la APS-I como la forma de atención primaria más rentable y viable para el mundo en desarrollo. Sin embargo, la APS-I se oponía directamente, tanto desde el punto de vista conceptual como práctico, a la visión y el modelo de prestación de servicios que la División de Atención Primaria de Costa Rica había construido durante la última década.

A medida que las organizaciones internacionales acogían cada vez más la APS-I, el presidente conservador de Costa Rica, Luis Alberto Monge, también adoptó una perspectiva neoliberal de la atención sanitaria y redujo drásticamente el presupuesto asignado a la atención primaria a principios de la década de 1980. Los programas integrales de atención primaria de salud que habían sido el *statu quo* en la década de 1970 cayeron en desgracia política y sufrieron un “abandono deliberado”. Mientras tanto, los programas de atención primaria del Ministerio de Salud perdieron financiación y disminuyeron la intensidad de sus esfuerzos de prestación de servicios (Muiser 2013). Durante este periodo, los programas “verticales”, o específicos de una enfermedad, dentro del Ministerio de Salud ganaron adeptos y quedaron algo protegidos de los recortes de financiamiento. Sin embargo, con el tiempo, el modelo de APS-I con muchos programas verticales, más los costes administrativos de cada uno, demostró ser tan costoso como la APS-I, y los programas selectivos para enfermedades específicas se abandonaron lentamente en Costa Rica.

Durante la década de 1980, la crisis económica provocó una disminución de la financiación del Ministerio de Salud, lo que hizo que éste redujera la prestación de servicios en algunas zonas geográficas. Sin embargo, la CCSS estaba mejor aislada de los recortes de financiación derivados de la crisis financiera, ya que gran parte de sus ingresos procedían de los pagos de seguros de empleadores y empleados. Por lo tanto, en muchas zonas en las que el Ministerio de Salud estaba reduciendo los servicios, la CCSS empezó a

intervenir. Aunque la CCSS se había centrado tradicionalmente en los servicios de atención curativa, la ausencia de servicios de atención primaria prestados por el Ministerio de Salud la llevó a empezar a prestar también atención preventiva. Aunque este arreglo puede haber ayudado a garantizar el acceso a la atención, también complicó aún más la delimitación de responsabilidades entre el Ministerio de Salud y la CCSS y condujo a la duplicación de la prestación de atención en algunas zonas. Esto empeoró la oferta de recursos existente y contribuyó a la escasez de productos farmacéuticos y de enfermería en el país. La escasez y la disminución general del presupuesto redujeron la calidad de la atención primaria de salud en todo el país, lo que llevó a la percepción pública de que los servicios de atención primaria carecían de los recursos básicos y eran un mal lugar para recibir atención sanitaria.

En consecuencia, la demanda de servicios de atención primaria disminuyó y la demanda de atención secundaria y terciaria aumentó significativamente; de 1985 a 1990, las visitas de atención primaria disminuyeron un 17%. Los tiempos de espera para la atención secundaria y terciaria se convirtieron en un grave problema, ya que muchos pacientes esperaban entre 12 y 18 meses para acceder a servicios de atención especializada como cardiología, oftalmología, dermatología y ginecología. La disminución de la utilización de la atención primaria y la mayor dependencia de la atención secundaria y terciaria también provocaron un aumento de los costes, lo que supuso una mayor presión financiera sobre el sistema. Además de esta limitación de recursos, la población estaba experimentando simultáneamente una transición epidemiológica. Los costarricenses que antes habrían muerto a una edad más temprana vivían más tiempo y desarrollaban enfermedades no transmisibles (como hipertensión, obesidad, diabetes y demencia), lo que aumentaba aún más las necesidades de atención de la población.

A finales de la década de 1980, el sistema de atención primaria de Costa Rica estaba en grave peligro. La insatisfacción de los pacientes con la calidad de la atención primaria y con los largos tiempos de espera para la atención secundaria y terciaria, así como la presión financiera de la duplicación y la creciente demanda de servicios, pesaban mucho sobre el sistema sanitario. Los fracasos de los experimentos con la APSF quizás consolidaron el compromiso de Costa Rica con la integralidad y dejaron al país escéptico sobre la utilidad de las recomendaciones de las organizaciones internacionales. Había incertidumbre en

torno al futuro de la atención primaria de salud y la preocupación de que se abandonaran los programas del Ministerio de Salud de los años setenta. Aunque no desaparecieron los valores de integralidad y bienestar general establecidos en la década de 1970, las turbulencias presupuestarias eclipsaron todas las demás preocupaciones políticas; tanto desde el interior del país como desde la comunidad internacional de donantes se hicieron fuertes llamamientos a la privatización y a la reducción del sistema sanitario. Mientras tanto, muchos profesionales sanitarios costarricenses sostenían que Costa Rica, ante las transiciones demográfica y epidemiológica, no podía permitirse carecer de una atención primaria de salud más completa. El resultado fue un sistema de atención primaria que necesitaba desesperadamente una reforma para mejorar la prestación de servicios y satisfacer mejor las necesidades de la población, pero de una forma fiscalmente sostenible y viable.

Reformas estructurales de la atención primaria

El descontento del público con el sistema sanitario costarricense alcanzó su punto máximo en 1991 durante un brote de sarampión. Los empleadores se vieron obligados a pagar por atención médica privada porque el sistema público no podía hacer frente al número de pacientes que provocó la epidemia. Ante la amenaza de los empresarios de retener sus cotizaciones obligatorias a la CCSS, la necesidad de reformar el sistema sanitario era clara y urgente. Además, había problemas con el saneamiento y el suministro de agua debido a los recortes de personal en esas organizaciones estatales ordenados por los organismos internacionales de financiación. El experimento de los años ochenta sobre reducir el tamaño del gobierno y más concretamente el sector sanitario, no se ajustó a las expectativas de prestación de servicios de muchos costarricenses.

Desarrollo de una estrategia nacional de atención primaria de salud

En marzo de 1990, el presidente Rafael Calderón Fournier del partido Unidad Social Cristiana estableció una comisión para la Reforma del Estado Costarricense, no sólo para el sector de la salud, pero para todo el gobierno de Costa Rica. Como parte de esta, los funcionarios de la CCSS y del Ministerio de Salud se reunieron para elaborar un plan de la reforma sanitaria, la cual tenía dos objetivos principales:

1) Ampliar la cobertura.

2) Proporcionar una atención más integral a los costarricenses.

Un equipo de proveedores de atención sanitaria formado por el Dr. Fernando Marín, el Dr. Herman Weinstock, Luis B. Sáenz, la Dra. Xinia Carvajal, Norma Ayala y el Dr. Álvaro Salas, entre otros, trabajó conjuntamente para desarrollar el modelo de atención primaria que guiaría la reforma. A partir de su análisis y experiencia colectiva con el Programa de Salud Rural de la década de 1970 y otros modelos de atención primaria en todo el país, surgió un nuevo modelo de prestación de servicios.

Este nuevo modelo, Equipos Básicos de Atención Integral de Salud (EBAIS), tenía como objetivo crear equipos de atención primaria de salud que atendieran de forma holística a un grupo específico y geográficamente ordenado de ciudadanos (pacientes empanelados). El concepto de EBAIS fue diseñado para ser un modelo de equipo multidisciplinario capaz de brindar un manejo integral de enfermedades preventivas, agudas y crónicas a los costarricenses a lo largo de sus vidas. Cada clínica EBAIS estaría dirigida por un equipo EBAIS compuesto por un médico, una enfermera, un asistente técnico (ATAP), un empleado médico (REDES) y un farmacéutico certificado, los cuales juntos atenderían a una población geográficamente empanelada de aproximadamente 4.000 a 5.000 pacientes. Cada clínica EBAIS tendría su propia farmacia dirigida por un farmacéutico certificado. La composición de los equipos EBAIS es notable por la forma en que promueve la integración entre la atención clínica, proporcionada por médicos y farmacéuticos, y la atención preventiva, proporcionada por asistentes técnicos. Las enfermeras podrían reducir la brecha entre la prevención y la atención clínica al brindar asistencia en el manejo de enfermedades y educación sanitaria.

Además del modelo de atención básica, se propusieron otras reformas administrativas. Para consolidar la atención primaria de salud, los reformadores propusieron que el departamento de atención primaria de salud se integrara completamente en la CCSS, para así eliminar la función de prestación de servicios del Ministerio de Salud. Otros componentes de la reforma recomendada apoyaron una mayor descentralización e independencia administrativa, en especial para los hospitales.

Negociaciones con el grupo del banco mundial

Una vez finalizada esta propuesta de reforma, Costa Rica inició negociaciones con el Grupo del Banco Mundial (GBM) para financiarla. Durante las negociaciones, se observó un resurgimiento del apoyo internacional a la atención primaria de salud. Los políticos costarricenses se mostraron abiertos a la asistencia del GBM y confiaron el proceso de negociación al Ministerio de Salud y a la CCSS. A diferencia de otras reformas, el Poder Ejecutivo costarricense se mantuvo prácticamente al margen de las negociaciones, permitiendo que altos funcionarios de políticas sanitarias del Ministerio de Salud y la CCSS impulsaran el proceso con menor influencia de otras áreas del gobierno. El trabajo se centró en construir un sistema de atención primaria de salud sólido y fiscalmente sostenible.

El GBM llegó a las negociaciones con el compromiso explícito de reducir costos, privatizar los servicios de salud y establecer una división entre comprador y proveedor. Esta división se produce cuando diferentes organizaciones pagan y prestan la atención médica, un acuerdo que contradice el modelo vigente en ese momento de la CCSS, que financiaba y prestaba la mayor parte de la atención médica en el país. Costa Rica, por otro lado, se sentó a la mesa de negociaciones con el objetivo de financiar su visión del modelo EBAIS.

Las diferencias de opinión entre el Grupo del Banco Mundial y los costarricenses hicieron que el proceso de negociación fuera prolongado y complejo. En primer lugar, el GBM propuso la privatización y descentralización de todo el sistema de salud costarricense. Esta propuesta fue rechazada por Costa Rica, ya que implicaba una reforma constitucional y no se alineaba con el modelo que el país había conceptualizado durante los dos años anteriores. Los costarricenses, a su vez, propusieron su nuevo modelo EBAIS, basado en la integración de la atención primaria de salud en la CCSS.

Cuando la delegación del Grupo del Banco Mundial leyó la propuesta costarricense, la acogió en gran medida; se mostraron de acuerdo con revitalizar la salud comunitaria, aumentar el número de visitas domiciliarias y fortalecer la vacunación y la nutrición, entre otros aspectos. El GBM también apoyó la consolidación de la prestación de servicios de salud, tanto del Ministerio de Salud como de la CCSS, a cargo únicamente de la CCSS. Además de su eficiencia, el GBM apoyó esto porque prefería alejarse de la provisión

directa de servicios por parte de instituciones gubernamentales y, si bien la CCSS es una institución pública, es autónoma y no está bajo el control directo de un ministerio gubernamental.

Sin embargo, el GBM consideró que la incorporación de un médico al equipo de atención primaria no era necesaria y resultaría demasiado costosa para Costa Rica. El equipo costarricense de reforma insistió en que los médicos eran clave para el modelo; sin ellos, no sería posible ampliar el acceso a la atención médica curativa ni eliminar las largas listas de espera para ser atendidos por un médico, dos prioridades de la reforma. Con base en este punto de discordia, Costa Rica casi se retiró de las negociaciones. Cuando el GBM cuestionó al equipo de reforma llamando directamente al presidente, este se puso del lado del equipo, reiterando el compromiso de Costa Rica de incluir médicos en cada equipo de atención. Con esta muestra de compromiso con el modelo desde las más altas esferas políticas, el GBM aceptó el programa EBAIS, con varias condiciones. Estas condiciones incluían una división entre compradores y proveedores dentro de la CCSS, un esquema moderado de modernización de pagos y la supervisión de la implementación de la reforma por parte del GBM en el país.

Al final, el Grupo del Banco Mundial prestó a Costa Rica 22 millones de dólares que debía reembolsarse en 17 años. En poder adquisitivo de 2015, 22 millones de dólares equivalen a 37 millones de dólares. Con el apoyo del Grupo Banco Mundial y la OPS, Costa Rica pudo recaudar un total de 123 millones de dólares de varias organizaciones internacionales de desarrollo para apoyar sus reformas de la atención primaria de salud. El Banco Interamericano de Desarrollo aportó 42 millones de dólares y los gobiernos de España y Suecia también otorgaron préstamos. El BID y el GBM coordinaron sus préstamos para crear un préstamo integral para la reforma costarricense. La OPS asesoró a Costa Rica durante todo el proceso y coordinó la contribución costarricense que complementaría los préstamos recibidos.

El préstamo del GBM tuvo tres componentes principales. Primero, la reforma y el desarrollo institucional de la CCSS fortalecerían la organización de la CCSS en su conjunto y transferirían la responsabilidad de la atención primaria de salud del Ministerio de Salud a la CCSS. El Ministerio de Salud tendría la responsabilidad de administrar el sector de la

salud, excepto para algunos programas específicos en nutrición infantil y control de vectores de enfermedades que el Ministerio de Salud ofrece hasta el día de hoy. Segundo, la reforma apoyaría el nuevo modelo de atención primaria de salud EBAIS, que facilitaría la integración de tratamientos preventivos y curativos para grupos específicos de ciudadanos organizados geográficamente o pacientes censados. Tercero, la reforma proporcionó fondos para que los costarricenses implementaran sistemas de pago alternativos y más sostenibles. El programa de modernización de pagos incluyó un plan para aumentar el número de costarricenses afiliados al seguro de salud de la CCSS, un proceso presupuestario mejorado, la reducción de la duplicación en la prestación de servicios de salud y la mejora de los procesos de distribución farmacéutica.

Aunque fueron complicadas, las negociaciones del Grupo del Banco Mundial finalmente permitieron a Costa Rica implementar y financiar una reforma que creó un modelo de atención primaria de salud adaptado a los valores del país de la salud como un derecho humano y la importancia de promover el bienestar general y la atención integral.

Aprobación de la reforma por el congreso

Cuando el equipo costarricense encargado de la reforma llegó a un acuerdo con el GBM sobre los términos del préstamo, la reforma estaba lejos de estar finalizada, ya que todos los préstamos internacionales deben ser aprobados por el Congreso costarricense. En palabras de Álvaro Salas, un miembro clave del equipo de reforma, “la discusión técnica había terminado, pero la discusión política apenas comenzaba”.

En ese momento, el congreso costarricense tenía dos partidos principales. La reforma se desarrolló bajo el liderazgo político del presidente Calderón y su partido, el Partido Unidad Social Cristiana (PUSC), por lo que contaba con el apoyo del Congreso. El otro partido mayoritario era el Partido Liberación Nacional (PLN), un partido socialista democrático. El apoyo del PLN se debió principalmente a Álvaro Salas, quien colaboró estrechamente con el candidato presidencial del PLN, José Figueres, para convencerlo de que apoyara la reforma, a pesar de que se desarrolló bajo la administración de un partido diferente. Juntos, y a lo largo de un año, Figueres y Salas lograron conseguir el apoyo de los miembros del partido PLN.

Sin embargo, durante este año de diálogo con Figueres y el PLN, muchos otros actores internos expresaron serias inquietudes sobre la reforma. En primer lugar, los sindicatos temían que la CCSS fuera privatizada o disuelta bajo la reforma. Una vez que el equipo de reforma logró asegurarles que la CCSS seguiría siendo una organización pública autónoma, estas inquietudes finalmente se disiparon.

En segundo lugar, la transferencia de empleados del Ministerio de Salud (un ministerio nacional) a la CCSS (un instituto autónomo) generó una serie de problemas laborales. La Asociación Nacional de Empleados Públicos (ANEP) estaba preocupada por la pérdida de electores, ya que no representaba a los trabajadores de la CCSS. Los empleados del Ministerio de Salud exigieron que la CCSS los recontratara de acuerdo con la normativa vigente en ese momento, que exigía que cualquier empleado público despedido fuera reembolsado con una generosa pensión. Los reformadores argumentaron que no estaban realmente despidiendo al personal, sino simplemente transfiriéndolo a otra organización. A este problema se sumó el hecho de que muchos empleados del Ministerio de Salud no querían unirse a la CCSS; ambas instituciones tenían culturas diferentes. Este problema desencadenó protestas por parte de los empleados del Ministerio de Salud. Un factor que finalmente motivó a los empleados del Ministerio de Salud a trasladarse a la CCSS fue que la escala salarial de las organizaciones autónomas era significativamente más alta (lo que implicaba un aumento salarial promedio del 30%) que la de las instituciones públicas. Con el tiempo, los empleados de atención primaria de salud del Ministerio de Salud aceptaron transferirse a la CCSS sin ser reembolsados de sus cargos públicos, pero esta cuestión tardó meses en negociarse con el sindicato del Ministerio de Salud.

Otros ministerios también tuvieron dificultades para aceptar la reforma. El Ministerio de Hacienda se opuso porque no quería comprometer la contribución local necesaria para los préstamos internacionales. El Ministerio de Planificación Interna y el presidente del Banco Central también se opusieron a la reforma debido a preocupaciones sobre la sostenibilidad financiera. Finalmente, el apoyo del presidente Calderón convenció a estos actores a apoyar el proyecto. Después de casi un año de reunir apoyo político para la reforma, en 1994 el Congreso aprobó el préstamo por unanimidad.

Modelos de atención primaria

En los últimos 70 años se han definido muchos tipos de atención primaria. Tres de los modelos más destacados de atención primaria son la integral (APS-I), la orientada a la comunidad (APOC) y la selectiva (APS-S).

Antes de la década de 1970, gran parte de la atención prestada en los países de renta baja y media dependía de las agencias internacionales de desarrollo y existían muchos programas específicos contra enfermedades como la malaria, la viruela y la tuberculosis. En estos programas específicos se utilizaban enfoques descendentes con altos niveles de tecnología médica y, a con frecuencia, productos farmacéuticos de nuevo desarrollo.

Sin embargo, en los años setenta, cuando muchos países empezaron a nacionalizar la atención sanitaria y a establecer servicios públicos de atención sanitaria, el alcance de los servicios sanitarios se amplió. La APS-I surgió como un modelo holístico de atención primaria que abarcaba todas las enfermedades, hacía hincapié en la prevención e incluía los determinantes sociales de la salud. Partiendo de un compromiso con la igualdad social y de la idea de que la salud es un derecho humano fundamental, la APS-I adopta un enfoque ascendente que sitúa la salud en la vida y el contexto social de los pacientes. La accesibilidad universal y la distribución equitativa de los recursos sanitarios son principios fundamentales de la APS-I.

La estrategia de la APS-I consiste en reforzar los sistemas generales de atención sanitaria de forma sostenible mediante una acción multisectorial que haga hincapié en la participación de la comunidad, la prevención de enfermedades y la promoción de la salud. A diferencia de otras estrategias de atención primaria de salud, la APS-I incluye el desarrollo de instalaciones de sanidad, agua limpia y disponibilidad de alimentos. La APS-I consta de ocho elementos clave: 1) educación sanitaria y alfabetización; 2) suministro de alimentos y nutrición; 3) agua potable y sanidad; 4) planificación familiar y salud materna e infantil; 5) vacunación; 6) prevención y control de enfermedades infecciosas; 7) tratamientos curativos de enfermedades y lesiones; y 8) suministro de medicamentos.

Muy relacionada con la APS-I, la APS-I surgió en Sudáfrica en la década de 1940, a partir del trabajo seminal de Sidney y Emily Kark. La APS-I se basa en la integración de la

salud pública y los servicios médicos básicos para proporcionar una atención integral a una comunidad. Como indica su nombre, da prioridad a las necesidades de la comunidad e incorpora a sus miembros en la asignación de los recursos sanitarios y la ejecución de los programas de salud. Aunque la APS-I y la APS-I están relacionadas, son distintas. Un programa de APS-I puede abarcar las mismas funciones de salud pública y atención primaria que la APS-I, pero carece de participación comunitaria; por el contrario, se crearon algunos programas de APS-I específicos para una enfermedad (y por ello no integrales).

En el momento de la Declaración de Alma-Ata de 1978, también se habían realizado experimentos con APS-I en India, Nicaragua, Bangladesh, Filipinas, China y Mozambique. La APS-I funcionaba en Sudáfrica e Israel. La Declaración de Alma-Ata incorporó elementos tanto de la APS-I como de la APS-C, abogando por una atención integral basada en la comunidad que integrara medidas preventivas y tratamientos curativos. Sin embargo, más tarde se consideró que la APS-I y la APS-C eran inviables, inalcanzables y demasiado costosas para la mayoría de los países en desarrollo, por lo que las organizaciones internacionales de desarrollo buscaron estrategias alternativas.

En 1979, los médicos de la reunión internacional sobre Salud y Población en los Países en Desarrollo, celebrada en el Lago Como (Italia), presentaron la APS-I como una teoría alternativa a la APS-I.La APS-I se presentó como una "estrategia provisional" (interina) para ayudar a los países a establecer servicios de atención primaria. Al hacer énfasis selectivamente en unas pocas enfermedades, los proponentes esperaban reducir el alcance de la atención sanitaria prestada y ofrecer "ganancias" rápidas a los donantes. La tuberculosis, la neumonía y las infecciones helmínticas eran algunas de las enfermedades que se consideraba que los países en desarrollo no podían cubrir. En los años ochenta, como consecuencia de la recesión mundial, el coste de la APS-I parecía abrumador y la APS-S parecía cada vez más atractiva y las organizaciones internacionales adaptaron rápidamente el modelo de APS-I. En 1982, el Gobierno de los Estados Unidos (USAID) ordenó a todas las oficinas sobre el terreno que implantaran la APS-I; el GBM y UNICEF también aprobaron la APS-I en 1982.

La APS-I adoptó la maximización de recursos y la rentabilidad. Cuando se compara con el lenguaje de equidad de la APS-I, el marcado contraste entre ambos enfoques resulta evidente. Con un enfoque de APS-I, hay diferentes formas de seleccionar las enfermedades prioritarias, pero todas se basan en un cálculo de rentabilidad. Un método descrito en la literatura usa cuatro factores para guiar la selección de las enfermedades objetivo: 1) prevalencia, 2) morbilidad, 3) mortalidad y 4) factibilidad de control. La «factibilidad de control» se mide en función de la eficacia del tratamiento y del coste de este. Otro método determina la prioridad del tratamiento de la enfermedad sumando las puntuaciones de la importancia de la enfermedad (mortalidad, incidencia y discapacidad) y la probabilidad de éxito (compromiso gubernamental, factores técnicos y respuesta pública).

Los programas SPHC se centraron en dos oleadas principales. La primera se centró en los tratamientos GOBI. GOBI son las siglas de *Growth Monitoring* (control del crecimiento), *Oral Rehydration Therapy* (ORT) (terapia de rehidratación oral), *Breastfeeding* (lactancia materna) e *Immunization* (inmunización). La segunda oleada añadió la FFF a los programas de APS-I, donde la FFF incluye la planificación familiar, la educación de la mujer y los suplementos alimentarios *(Family planning, Female education, and Food supplementation).* Con el tiempo, los estudios empezaron a demostrar que el modelo de APS-I no era tan rentable como se esperaba y no satisfacía la demanda de la población, por lo que el modelo empezó a perder adeptos.

La APS-I ha resurgido en la década de 2000, y el Informe sobre la Salud en el Mundo 2008 de la OMS afirma su importancia como estrategia sanitaria mundial. Costa Rica también reafirmó su compromiso con la APS-I en las décadas de 1990 y 2000 como su principal estrategia de atención primaria.

Tabla 2: Comparación de la APS integral, la APS orientada a la comunidad y la APS selectiva

	Atención Primaria Integral	Atención primaria orientada a la comunidad	Atención primaria de salud selectiva
Visión de la salud	Bienestar positivo	Bienestar positivo de las comunidades	Ausencia de enfermedad
Locus de control (psicología)	Comunidades e individuos	Comunidades	Proveedores de atención sanitaria
Objetivo principal	Salud mediante la equidad y el fortalecimiento del sistema sanitario global	Salud mediante la capacitación de la comunidad y los sistemas sanitarios integrados	Salud mediante tratamientos médicos
Proveedores de atención sanitaria	Equipo multidisciplinar formado por médicos, enfermeras, agentes de salud comunitarios y otros profesionales clínicos	Miembros de la comunidad, trabajadores sanitarios comunitarios, funcionarios de salud pública y personal clínico	Médicos y otros profesionales clínicos
Estrategias para la salud	Apoyo social, prevención y tratamientos curativos	Combinación de servicios de salud pública y atención primaria	GOBI, FFF
Consideraciones financieras	Distribución equitativa de los recursos	Distribución equitativa de los recursos	Rentabilidad

Table 4 Illustrates the comparison of the APS (CPHC) and its respective primary healthcare services. Researcher's creation.

A medida que las organizaciones internacionales acogían cada vez más la APS-I, el presidente de Costa Rica, Luis Alberto Monge, adoptó también una perspectiva neoliberal de la atención sanitaria y redujo drásticamente el presupuesto asignado a la atención primaria a principios de los años ochenta. Los programas integrales de atención primaria de salud que habían sido el statu quo en la década de 1970 cayeron en desventaja política y sufrieron un "abandono deliberado". Mientras tanto, los programas de atención primaria del Ministerio de Salud perdieron financiación y disminuyeron la intensidad de sus esfuerzos de prestación de servicios (Muiser 2013). Durante este periodo, los programas "verticales" o específicos de una enfermedad dentro del Ministerio de Salud ganaron adeptos y quedaron algo protegidos de los recortes de financiación. Sin embargo, con el tiempo se demostró que el modelo de APS-I con muchos programas verticales, más los costes administrativos de cada uno era tan costoso como la APS-I, y los programas selectivos para enfermedades específicas se abandonaron lentamente en Costa Rica.

Durante la década de 1980, la crisis económica provocó una disminución de la financiación del Ministerio de Salud, lo que hizo que éste redujera la prestación de servicios en algunas zonas geográficas. En cambio, la CCSS estaba mejor aislada de los recortes de financiación derivados de la crisis financiera puesto que gran parte de sus ingresos procedían de los pagos de seguros de empleadores y empleados. Por lo tanto, la CCSS empezó a intervenir en muchas zonas en las que el Ministerio de Sanidad estaba reduciendo los servicios. Aunque la CCSS se había centrado tradicionalmente en los servicios de atención curativa, la ausencia de servicios de atención primaria prestados por el Ministerio de Salud llevó a la CCSS a empezar a prestar también atención preventiva. Aunque este acuerdo puede haber ayudado a garantizar el acceso a la atención, también complicó aún más la delimitación de responsabilidades entre el Ministerio de Salud y la CCSS, lo que condujo a la duplicación de la prestación de atención en algunas zonas. Esto empeoró la oferta de recursos existente y contribuyó a la escasez de productos farmacéuticos y de enfermería en el país. La escasez y la disminución general del presupuesto redujeron la calidad de la atención primaria de salud en todo el país, lo que provocó la percepción pública de que los servicios de atención primaria carecían de los recursos básicos y eran un mal lugar para recibir atención sanitaria. Como resultado, la demanda de servicios de atención primaria disminuyó y la demanda de atención secundaria

y terciaria aumentó significativamente; entre 1985 y 1990, las visitas de atención primaria disminuyeron un 17%. Los tiempos de espera para la atención secundaria y terciaria se convirtieron en un grave problema, ya que muchos pacientes esperaban entre 12 y 18 meses para recibir servicios de atención especializada como cardiología, oftalmología, dermatología y ginecología. La disminución de la utilización de la atención primaria y la mayor dependencia de la atención secundaria y terciaria también provocaron un aumento de los costes, lo que supuso una mayor presión financiera sobre el sistema. Además de esta limitación de recursos, la población estaba experimentando simultáneamente una transición epidemiológica. Los costarricenses que antes habrían muerto a una edad más temprana vivían más tiempo y desarrollaban enfermedades no transmisibles, tales como hipertensión, obesidad, diabetes y demencia, lo que aumentaba aún más las necesidades de atención de la población.

A finales de la década de 1980, el sistema de atención primaria de Costa Rica estaba en grave peligro. La insatisfacción de los pacientes con la calidad de la atención primaria y con los largos tiempos de espera para la atención secundaria y terciaria, así como la presión financiera de la duplicación y la creciente demanda de servicios eran una pesada carga para el sistema sanitario. Los fracasos de los experimentos con la APSF quizás reafirmaron el compromiso de Costa Rica con la integralidad y dejaron al país escéptico sobre la utilidad de las recomendaciones de las organizaciones internacionales. Había incertidumbre en torno al futuro de la atención primaria de salud y la preocupación de que se abandonaran los programas del Ministerio de Salud de los años setenta. Aunque los valores de integralidad y bienestar general establecidos en la década de 1970 no desaparecieron, las turbulencias presupuestarias eclipsaron todas las demás preocupaciones políticas; tanto desde dentro del país como desde la comunidad internacional de donantes se hicieron fuertes llamamientos a la privatización y a la reducción del sistema sanitario. Mientras tanto, muchos profesionales del sector sanitario costarricense sostenían que Costa Rica ante la transición demográfica y epidemiológica, ya no podía permitirse prescindir de una atención primaria de salud más completa. El resultado fue un sistema de atención primaria que necesitaba desesperadamente una reforma para mejorar la prestación de servicios y satisfacer mejor las necesidades de la población, pero de una forma fiscalmente sostenible y viable.

Chapter V

Data Analysis

After completing the translation, data analysis becomes a crucial aspect of the investigator's research. The next chapter focuses on analyzing the finished documents, including revisiting and examining data from the translated text. It provides an analysis of the source text, categorizing its type, and other relevant factors. This chapter also includes the application of the tools mentioned in chapter three, such as color-coding analysis and the glossary. It presents the results obtained after translating the documents, alongside the implementation of instruments like the text analysis chart, which offers a detailed explanation of the characteristics of each translated text. Additionally, the color-coding chart illustrates the translation techniques used to convey the message accurately. Lastly, it presents the glossaries in both languages, which were created during the investigation. These glossaries are vital for the translation process and serve as a reference for the translator and future readers.

5.1 Analysis and interpretation of the results

This section presents the results of the analysis, which include the color-coding of the text to highlight various translation procedures, the text analysis based on Peter Newmark's method, and the glossary of relevant terms or phrases. The text analysis chart helps the translator define key characteristics of each document, such as style, function, and stylistic elements, ensuring an accurate translation. The color-coding chart is used to identify and analyze the translation procedures employed throughout the texts. Finally, glossaries for each language are essential in tracking important terminology, ensuring consistency and coherence in the translation process. This section also includes an analysis of the translated texts from Spanish to English and English to Spanish, along with an interpretation of the results.

5.1.1 Text Analysis

The text analysis will focus on the source texts, considering several aspects based on Newmark's (1988) approach. These aspects include style, stylistic scale, generality or difficulty level, emotional tone, function, and the type of translation used. A table will illustrate this analysis. According to the theory discussed in Chapter II, the text analysis

table will include elements such as the purpose, text type, emotional tone, and different scales of formality and difficulty. These elements should be carefully identified by the translator and considered during the translation process. Maintaining the integrity of these elements is crucial to achieving fidelity in the translation, which is a primary goal of this research. Moreover, it is the translator's responsibility not to alter these key elements from the source text during the translation.

Text Analysis	Building a Thriving Primary Health Care System: The Story of Costa Rica	Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica
Text Style	Descriptive	Descriptive
Text Function	Informative	Informative
Scale of Formality	Formal	Informal
Scale of Generality	Technical	Educated
Scale of Emotional Tone	Factual	Factual

Table 5 Illustrates the text analysis of the translated texts. Researcher's creation.

5.1.2 Color Coding

The color-coding system is a data collection tool designed to help the researcher identify the different translation techniques applied in the translations. The system is used to analyze fifteen paragraphs from Spanish-to-English and English-to-Spanish translations. The color-coding chart records how frequently each translation technique is used across the texts. The instrument involves two paragraphs: the first represents the source text, and the second corresponds to the target language. The color-coding technique is applied in the second paragraph to highlight the specific techniques used for translating the text.

Procedure	Format or Color
Transposition	Blue
Modulation	Dark red
Omission	Highlighted in yellow
Amplification	Highlighted in cyan
Explicitation	Green
Literal Translation	Purple

Table 6 Illustrates the colors and their respective format for the color-coding chart as applied by the researcher. Researcher's creation.

5.1.2.1 English to Spanish Text

Paragraph 1

Primary Health Care Before the 1990s

PRE-1960: ESTABLISHMENT OF HEALTH INSTITUTIONS

Costa Rica gained independence from Spain in 1821 and full independence from Mexico in 1838 before it was established as a democracy in 1869. Before the creation of hospitals and the introduction of physicians as the solely licensed medical providers, Costa Ricans relied on personal hygiene, indigenous healers, and herbal therapies from the diverse Costa Rican rain forests to prevent and treat disease. In the 1850s, many Costa Rican doctors went to Europe for training and later returned to Costa Rica, bringing with them Western biomedical practices. The first hospital in Costa Rica, Hospital San Juan de Dios, was established in the capital, San José, by coffee plantation owners in 1845.

Atención Integral antes de los años 90

Antes de 1960: la creación de instituciones sanitarias

Costa Rica se independizó de España en 1821 y de México en 1838, antes de establecerse como democracia en 1869. Antes de la creación de hospitales y la introducción de los médicos como únicos proveedores de servicios médicos autorizados, los costarricenses

confiaban en la higiene personal, los curanderos indígenas y las terapias a base de hierbas de los diversos bosques tropicales de Costa Rica para prevenir y tratar enfermedades. En la década de 1850, muchos médicos costarricenses viajaron a Europa para formarse y más tarde regresaron a Costa Rica y trajeron consigo las prácticas biomédicas occidentales. El Hospital San Juan de Dios, primer hospital de Costa Rica fue fundado en la capital, San José, por propietarios de una plantación de café en 1845.

Paragraph 2

An 1865 law created a system of "town doctors," or "medicos del pueblo," each of whom treated the population of a given city based on a contract with a particular municipality. The town doctors were responsible for preventing disease outbreaks and treating indigent populations. The town doctor system persisted in urban areas and well-populated cities through the end of the 19th century and the beginning of the 20th century. Medical practice was restricted to biomedical practitioners in 1887, when a law canceled all previously issued indigenous healer (curandero) licenses. During this time, Costa Rica's health care system became increasingly based on Western biomedicine.

Una ley en 1865 creó un sistema de "médicos del pueblo", cada uno de los cuales atendía a la población de una ciudad determinada basándose en un contrato con un gobierno municipal determinado. Los "médicos del pueblo" se encargaban de prevenir brotes de enfermedades y de tratar a la población indigente. El sistema de "médicos de pueblo" persistió en las zonas urbanas y en las ciudades bien pobladas hasta finales del siglo XIX y principios del XX. El ejercicio de la medicina quedó restringido a los biomédicos en 1887, cuando una ley anuló todas las licencias de curanderos (indígenas) otorgadas anteriormente. Durante este periodo, el sistema sanitario costarricense se basó cada vez más en la biomedicina occidental.

Paragraph 3

Most health care outside of urban city centers was provided by banana and coffee companies. For example, in the rural Atlantic province of Limon, the United Fruit Company was the sole provider of medical care for 30 years. In addition to establishing hospitals, the United Fruit Company created prevention programs, for example to eliminate

malaria, to boost the productivity of its workers. Because labor was relatively scarce in Costa Rica, investing in workers' health was an important business strategy.

La mayor parte de la asistencia sanitaria fuera de los centros urbanos era proporcionada por las compañías bananeras y cafetaleras. Por ejemplo, en la provincia rural atlántica de Limón, el único proveedor de atención médica durante 30 años fue la United Fruit Company. Además de establecer hospitales, la United Fruit Company creó programas de prevención, por ejemplo, para eliminar la malaria con el fin de incentivar la productividad de sus trabajadores. Como la mano de obra era relativamente escasa en Costa Rica, la inversión en la salud de los trabajadores era una importante estrategia empresarial.

Paragraph 4

In the early 1920s, the government established a number of key social institutions including the sub-secretariat of Hygiene and Public Health in 1922 (a precursor to the Ministry of Health, which would supervise the hospitals and provide some public health services) and the National Insurance Agency (Instituto Nacional de Seguro) in 1924. Their creation and early successes provided political momentum to create other social programs.

A principios de la década de 1920, el gobierno creó una serie de instituciones sociales clave, como la Subsecretaría de Higiene y Salud Pública en 1922 (precursora del Ministerio de Salud, que supervisaría los hospitales y prestaría algunos servicios de salud pública) y el Instituto Nacional de Seguros en 1924. Su creación y sus primeros éxitos sirvieron de impulso político para crear otros programas sociales.

Paragraph 5

One such program was Health Units (Unidades Sanitarias) established in 1934 by Dr. Solón Núñes Frutos in the central, rural city of Turrialba. This program led to the establishment of health centers, which typically were placed in the capital city of different provinces and staffed by a general physician, a nurse, a few nursing assistants, a laboratory technician, and a pharmacist. These Health Units had a commitment to prevention and were modeled on the county health units that were being established in rural areas of the United States during the same time. In addition to their commitment to prevention, these rural health centers were anchored to a geographical area, perhaps representing early portents of

geographic organization of the health care system. These Health Units were a very popular model of care and continued to grow in numbers throughout the first half of the 20th century.

Uno de ellos fueron las Unidades Sanitarias, creadas en 1934 por el Dr. Solón Núñes Frutos en la ciudad rural de Turrialba. Este programa condujo al establecimiento de centros de salud, los cuales normalmente se ubicaban en la ciudad capital de diferentes provincias y eran atendidos por un médico general, una enfermera, algunos auxiliares de enfermería, un técnico de laboratorio y un farmacéutico. Estas Unidades Sanitarias tenían un compromiso con la prevención y seguían el modelo de las Unidades Sanitarias de condado que se estaban estableciendo en las zonas rurales de Estados Unidos durante la misma época. Además de su compromiso con la prevención, estos centros sanitarios rurales estaban anclados a una zona geográfica, lo que tal vez representaba los primeros presagios de la organización geográfica del sistema sanitario. Estas Unidades Sanitarias fueron un modelo de atención muy popular y siguieron creciendo en número a lo largo de la primera mitad del siglo XX.

Paragraph 6

The 1930s saw further expansion of biomedical care in hospitals and the development of scattered preventive care in community-based programs operated by international philanthropic organizations. As more hospitals were constructed during this time period, the majority of care for the urban populations shifted to the hospital setting. The capital, San José, had three main hospitals run by religious orders. In addition to hospitals, several international philanthropic organizations, such as the Rockefeller Foundation, began to invest in the Costa Rican health system, mostly in hookworm eradication programs.

En la década de 1930 se produjo una mayor expansión de la atención biomédica en los hospitales y el desarrollo de la atención preventiva dispersa en programas comunitarios gestionados por organizaciones filantrópicas internacionales. A medida que se construían más hospitales durante este periodo, la mayor parte de la atención a la población urbana se trasladó al ámbito hospitalario. La capital, San José, contaba con tres hospitales principales gestionados por órdenes religiosas. Junto a los hospitales, varias organizaciones filantrópicas internacionales, como la Fundación Rockefeller, empezaron a invertir en el

sistema sanitario costarricense, sobre todo en programas de erradicación de la anquilostomiasis.

Paragraph 7

During the 1920s and 1930s, many Costa Ricans traveled to Europe to receive their education, where many prospective physicians saw the benefits of nascent social security programs. Around the world, social programs were being used as a barometer of the efficacy of a government. In Latin America, too, social security agencies were being established in many countries that would ultimately guide the development of their respective health systems through the modern era.

Muchos costarricenses viajaron a Europa en las décadas de 1920 y 1930 para formarse y muchos futuros médicos vieron las ventajas de los incipientes programas de seguridad social. Los programas sociales se utilizaban en todo el mundo como barómetro de la eficacia de un gobierno. En América Latina también se estaban creando organismos de seguridad social en muchos países que, en última instancia, guiarían el desarrollo de sus respectivos sistemas sanitarios a lo largo de la era moderna.

Paragraph 8

These international trends toward the establishment of social security systems were echoed back in Costa Rica, where the population—particularly workers and labor unions—was beginning to clamor for the government to initiate comprehensive health care reform to better meet their needs. This domestic push was fueled by the over stretching of the Health Unit system and poor health status attributed to parasitic infections, diarrheal and respiratory illnesses, traumatic injuries, childhood malnutrition, and infant and maternal mortality. At the time, this was a fairly typical health profile of a Latin American country: major health concerns were centered around infectious diseases, and health care was provided in a heterogeneous fashion by public hospitals, international philanthropic organizations, and local traditional healers.

Estas tendencias internacionales dirigidas al establecimiento de sistemas de seguridad social tuvieron eco en Costa Rica, donde la población (en particular los trabajadores y los sindicatos) empezaba a reclamar que el gobierno iniciara una reforma integral de la

atención de salud para satisfacer mejor sus necesidades. Esto se vio impulsado por la sobrecarga del sistema de la Unidades Sanitarias y el mal estado de salud atribuido a las infecciones parasitarias, las enfermedades diarreicas y respiratorias, las lesiones traumáticas, la desnutrición y la mortalidad infantil y materna. En aquel momento, se trataba de un perfil sanitario bastante típico de un país latinoamericano: Las principales preocupaciones sanitarias giraban en torno a las enfermedades infecciosas y la asistencia sanitaria era prestada de forma heterogénea por hospitales públicos, organizaciones filantrópicas internacionales y curanderos tradicionales locales.

Paragraph 9

This push for the Costa Rican state to become more involved in the social well-being of its citizens led to at least a half-dozen attempts between 1907 and 1936 to establish a social security administration. Finally, in 1941, President Calderón Guardia led the establishment of the Caja Costarricense de Seguridad Social (CCSS), a social security agency initially designed to provide health care and pensions to salaried workers. The importance of the CCSS in the history of Costa Rica as a country and its health care system in particular cannot be overstated; it would become one of the key pillars of Costa Rica's Welfare State (Estado de Bienestar). The institution was founded on the principles of solidarity, equity, justice, universality, and equality; values that would continue to guide the Costa Rican health system for decades.

Este impulso para que el estado costarricense se implicara más en el bienestar social de sus ciudadanos llevó a al menos media docena de intentos entre 1907 y 1936 para establecer una administración de la seguridad social. Finalmente, en 1941, el presidente Calderón Guardia dirigió el establecimiento de la Caja Costarricense de Seguridad Social (CCSS), un organismo de seguridad social diseñado inicialmente para proporcionar asistencia sanitaria y pensiones a los trabajadores asalariados. La importancia de la CCSS en la historia de Costa Rica como país y de su sistema de asistencia sanitaria en particular no puede exagerarse, por lo que se convertiría en uno de los pilares del Estado de Bienestar costarricense. La institución se fundó sobre los principios de solidaridad, equidad, justicia, universalidad e igualdad; valores que seguirían guiando el sistema sanitario costarricense durante décadas.

Paragraph 10

After the 44-day Civil War of 1948, the right to health care administered by the CCSS was reincorporated into the new constitution of 1949, and the CCSS grew steadily during the 1950s. In addition to becoming an important fixture of the fledgling Costa Rican democracy, it also expanded the country's health care delivery capacity.

Tras la Guerra Civil de 1948 que duró 44 días, el derecho a la asistencia sanitaria administrada por la CCSS se reincorporó a la nueva Constitución de 1949 y la CCSS creció constantemente durante la década de 1950. No sólo se convirtió en un elemento importante de la incipiente democracia costarricense, sino que también amplió la capacidad de prestación de la asistencia sanitaria del país.

Paragraph 11

Beyond the CCSS, the 1950s in Costa Rica brought a myriad of public health efforts, including the passage of sanitation laws, implementation of venereal disease control efforts and malaria eradication campaigns, and the establishment of public health ministries. By 1959, there was a shift in Costa Rica's health care financing and provision system, away from dependence on international philanthropic organizations to ever-increasing state control of the country's health care functions.

Más allá de la CCSS, la década de 1950 en Costa Rica trajo consigo una miríada de esfuerzos de salud pública, incluyendo la aprobación de leyes de saneamiento, la implementación de esfuerzos de control de enfermedades venéreas y campañas de erradicación de la malaria, y el establecimiento del Ministerios de Salud. En 1959, se produjo un cambio en el sistema de financiación y prestación de asistencia sanitaria de Costa Rica, que pasó de depender de organizaciones filantrópicas internacionales a un control estatal cada vez mayor de las funciones sanitarias del país.

Paragraph 12

1960s: DEEPENING A COMMITMENT TO UNIVERSAL HEALTH CARE ACCESS

The 1960s saw a redoubling of Costa Rica's commitment to addressing the needs of vulnerable and impoverished populations, including expansion of CCSS coverage beyond

the working-class population for whom the CCSS had originally been established. In a major turning point, in 1961, Costa Rica passed a constitutional amendment calling for universalization of CCSS services, including pensions and curative health care coverage, within a decade. This amendment would over time expand the coverage of the CCSS to include workers' dependents and underprotected populations such as low-income, rural, and vulnerable groups. Beyond the immediate benefits of expanded coverage, the 1961 amendment established Universal Health Coverage (UHC) as the defining feature of Costa Rican attitudes towards health care and a key component of the country's self-perception. Indeed, health system analysts Juan Rafael Vargas and Jorine Muiser argue that entitlement to health services has become "synonymous with being a Costa Rican and represents probably the single most important feature of the Costa Rican social fabric." For Costa Ricans, equitable provision of health services became a moral imperative related to the concept that a state's goodness can be measured on the basis of the health care it provides to its citizens. Although the goal to achieve universal access to the CCSS services by 1971 was not achieved, articulation of UHC as an explicit political and constitutional goal gave the concept longevity that propels Costa Rica's health care system even today. Additionally, the concept of expansion of the CCSS services, specifically, became associated with the ideal of health coverage for all.

1960s: profundizar en el compromiso con el acceso universal a la sanidad

En la década de 1960 se redobló el compromiso de Costa Rica de atender las necesidades de las poblaciones vulnerables y empobrecidas, incluida la ampliación de la cobertura de la CCSS más allá de la clase trabajadora para la que se había establecido originalmente. En 1961, en un punto de inflexión importante, Costa Rica aprobó una enmienda constitucional que exigía la universalización de los servicios de la CCSS, incluidas las pensiones y la cobertura de la atención sanitaria curativa en el transcurso de una década. Con el tiempo, esta enmienda ampliaría la cobertura de la CCSS para incluir a los dependientes de los trabajadores y a las poblaciones desprotegidas, como los grupos de bajos ingresos, rurales y vulnerables. Más allá de los beneficios inmediatos de la ampliación de la cobertura, la enmienda de 1961 estableció la Cobertura Sanitaria Universal (CSU) como el rasgo definitorio de las actitudes costarricenses hacia la atención sanitaria y un componente clave

de la autopercepción del país. En efecto, los analistas del sistema sanitario Juan Rafael Vargas y Jorine Muiser sostienen que el derecho a los servicios sanitarios se ha convertido en "sinónimo de ser costarricense y probablemente representa la característica más importante del tejido social costarricense". Para los costarricenses, la prestación equitativa de servicios sanitarios se convirtió en un imperativo moral relacionado con el concepto de que la bondad de un Estado puede medirse en función de la atención sanitaria que presta a sus ciudadanos. Aunque no se alcanzó el objetivo de lograr el acceso universal a los servicios de la CCSS en 1971, la articulación de la CSU como un objetivo político y constitucional explícito dio al concepto una longevidad que aún hoy propulsa el sistema de salud costarricense. Además, el concepto de expansión de los servicios de la CCSS se asoció específicamente con el ideal de cobertura sanitaria para todos.

Paragraph 13

During the 1960s, the CCSS primarily functioned as a strategic purchaser of services, and the predominant strategy for care provision was for the CCSS to purchase health care for its beneficiaries from different hospitals. To accelerate the process of universalizing health care service coverage, in 1961 the Faculty of Medicine was established so medical doctors could be trained in the country and Costa Rica could thereby control the supply of physicians. By the end of the 1960s, 47 percent of the population had health cover age through the CCSS, up from 18 percent in 1961.

Durante la década de 1960, la CCSS funcionó principalmente como un comprador estratégico de servicios y la estrategia predominante para la prestación de atención fue que la CCSS comprara la atención médica para sus beneficiarios en diferentes hospitales. Para acelerar el proceso de universalización de la cobertura de los servicios de salud, en 1961 se creó la Facultad de Medicina para que los médicos se formaran en el país y Costa Rica pudiera así controlar la oferta de médicos. A finales de los sesenta, el 47% de la población tenía cobertura sanitaria a través de la CCSS, frente al 18% de 1961.

Paragraph 14

During the 1960s, Health Units continued to provide health care to Costa Rican citizens outside the major metropolitan cities. In addition to prevention programs such as

vaccination, growth monitoring, and family planning, Health Units also conducted four "campaigns" against venereal disease, tuberculosis, parasites, and malaria. In addition to the Health Units, mobile health centers also came to play an important role during the 1960s in providing care to the rural areas of Costa Rica. The first mobile center was established in 1963, and by the end of the decade there were 12 functioning throughout the country. These mobile units worked as health care teams, similar in function to the Health Units.

En esta década las Unidades Sanitarias continuaron prestando asistencia sanitaria a los ciudadanos costarricenses fuera de las principales ciudades metropolitanas. Además de programas de prevención como vacunación, control del crecimiento y planificación familiar, las Unidades Sanitarias también llevaron a cabo cuatro "campañas" contra las enfermedades venéreas, la tuberculosis, los parásitos y la malaria. Los centros de salud móviles también desempeñaron un papel importante en la década de 1960 en la prestación de asistencia a las zonas rurales de Costa Rica. El primer centro móvil se estableció en 1963 y a finales de la década había doce funcionando por todo el país. Estas unidades móviles funcionaban como equipos de atención sanitaria, con funciones similares a las de las Unidades Sanitarias.

Paragraph 15

In addition to the preventive and curative health care provided in hospitals, Health Units, and mobile health centers, Costa Rica also invested heavily in sanitation throughout the country. In 1961, Costa Rica established the Servicio Nacional de Acueductos y Alcantarillados (National Service of Aqueducts and Sewers). From 1961 to 1964, the agency spent USD $12.6 million for studies and expansion of potable water and clean sewage practices throughout the country, especially in rural areas. These sanitation efforts were particularly impactful in improving the country's health outcomes, specifically in decreasing infant mortality.

Además de la atención sanitaria preventiva y curativa prestada en hospitales, Unidades Sanitarias y centros de salud móviles, Costa Rica también invirtió mucho en el saneamiento de todo el país. En 1961, Costa Rica creó el Instituto Costarricense de Acueductos y Alcantarillados, dónde de 1961 a 1964, este organismo gastó 12,6 millones de dólares

estadounidenses en estudios y en la ampliación de las prácticas de agua potable y alcantarillado en todo el país, principalmente en las zonas rurales. Estos esfuerzos de saneamiento tuvieron un impacto especial en la mejora de la salud del país, por ejemplo, en la reducción de la mortalidad infantil.

5.1.2.2 Spanish to English Text

Paragraph 1

Conceptos y prácticas culturales de la medicina ancestral bribri y cabecar en Costa Rica

Introducción

Los pueblos originarios de América se enfrentaron desde el siglo XVI a una de las peores catástrofes demográficas de las que tenemos memoria en el mundo, producto de las enfermedades contagiosas que trajeron los europeos y para las cuales ellos (las personas de dichos pueblos) carecían de inmunidad. Enfermedades como la gripe, la viruela, el sarampión, la tosferina, el tifus, entre muchas otras, produjeron estragos en la población indígena (Ibarra, 1998).

Concepts and Cultural Practices of Ancestral Bribri and Cabecar Medicine in Costa Rica

Introduction

Since the 16th century, the native peoples of the Americas have faced one of the worst demographic catastrophes in living memory in the world because of contagious diseases brought by Europeans and for which they (the people of the region) lacked immunity. Diseases such as influenza, smallpox, measles, whooping cough, typhus, among many others, wreaked havoc on the indigenous population (Ibarra, 1998).

Paragraph 2

Aunque es muy difícil reconstruir a detalle los fenómenos que sucedieron hace más de 400 o 500 años, las investigaciones más recientes apuntan a que entre el siglo XVI y principios

del siglo XVII desapareció más del 90 % de las poblaciones de los pueblos originarios del continente americano (Koch, Brierley, Maslin y Lewis, 2019).

Although it is very difficult to reconstruct in detail the phenomena that occurred more than 400 or 500 years ago, the most recent research suggests that between the 16th and early 17th centuries over 90% of the populations of the native peoples of the American continent disappeared (Koch, Brierley, Maslin and Lewis, 2019).

Paragraph 3

Semejante drama marcó profundamente a las sociedades de los pueblos originarios, en todos los planos, al extremo de que algunos pueblos como los bribri y cabécar mantienen aún prácticas curativas y de cuidado sociocultural, conocimientos médicos y una concepción de mundo que, en esencia, los previenen sobre poderosos seres invisibles: las enfermedades.

Such a dramatic event deeply marked the societies of the native peoples at all levels, to the extent that some communities such as the Bribri and Cabecar still maintain healing practices and sociocultural care, medical knowledge and a conception of the world that, in essence, prevent them from powerful invisible beings: diseases.

Paragraph 4

El bribri y el cabécar son dos pueblos originarios del sur de Costa Rica, emparentados sociocultural y lingüísticamente. Según el censo del 2011, los bribris se localizan en los territorios de Salitre, Cabagra, Talamanca bribri y Kekoldi. En el 2011 habitaban 16 938 personas en estos territorios, con un porcentaje no indígena del 24.5 % (Fuentes, 2011, p. 9).

The Bribri and the Cabecar are two native communities of southern Costa Rica, socioculturally and linguistically related. According to the 2011 census, the Bribri are in the territories of Salitre, Cabagra, Talamanca Bribri and Kekoldi. In 2011, there were 16,938 people living in these territories, with a non-indigenous percentage of 24.5% (Fuentes, 2011, p. 9).

Paragraph 5

Los cabécares se localizan en los territorios de Chirripó, Ujarráz, Tayni, Talamanca cabécar, Telire, Bajo Chirripó, Nairi Awari y China Kicha. En el 2011 habitaban 13 993 personas en dichos territorios con un porcentaje no indígena del 18.5 % (Fuentes, 2011, p. 9).

The Cabecar are in the territories of Chirripó, Ujarráz, Tayni, Talamanca Cabecar, Telire, Bajo Chirripó, Nairi Awari, and China Kicha. In 2011, there were 13,993 people living in these territories, with a non-indigenous percentage of 18.5% (Fuentes, 2011, p. 9).

Paragraph 6

La pandemia de COVID-19 nos ha puesto a prueba a todos, tanto a nivel individual, como familiar y colectivo. Esta incertidumbre sobre la salud y la enfermedad nos ha revelado nuevas dimensiones, o nuevas percepciones, de nuestro trajinar diario. Son estas nuevas percepciones las que, curiosamente, acuden en nuestra ayuda para aventurarnos con una nueva visión en algunos pasajes de la historia ancestral de los pueblos bribri y cabécar que fueron interpretados como supersticiones, pero que, a la luz de esta pandemia, podrían reinterpretarse. Son, si se quiere, los eslabones de antiguos conceptos médicos, cuyo valor solo alcanzamos a dilucidar ante la presión de una emergencia sanitaria de proporciones planetarias.

The COVID-19 pandemic has put us all to the test, whether at the individual, familiar or collective level. This uncertainty about health and disease has revealed new dimensions, or new perceptions, of our daily lives. It is these new perceptions that, curiously, come to our aid to venture with a new vision into some passages of the ancestral history of the Bribri and Cabecar peoples that were interpreted as superstitions, but which, in the light of this pandemic, could be reinterpreted. They are, in a way, the links of ancient medical concepts, the value of which we can only elucidate under the pressure of a health emergency of planetary proportions.

Paragraph 7

Trataremos de enfocarnos, exclusivamente, en los conceptos de la medicina bribri y cabécar del sur de Costa Rica, haciendo alusión a algunos datos históricos de Mesoamérica, que consideremos relevantes para cimentar nuestros análisis y reflexiones.

We will try to focus exclusively on the concepts of the bribri and cabecar medicine of southern Costa Rica, alluding to some historical data from Mesoamerica, which we consider relevant to support our analysis and reflections.

Paragraph 8

Dos visiones de la medicina

La medicina de la América precolombina tuvo muy diversos sistemas y enfoques de salud, sin embargo, a pesar de su diversidad, evolucionó y se desarrolló durante muchos siglos, sin tener contacto con otras regiones del mundo, razón por la cual, en los casos que hubo contacto, comunicación y difusión cultural, se dio dentro del continente americano. Eso significa que no solo se trata de conocimientos sui géneris, sino que en gran medida todo el cuerpo conceptual relativo a la medicina difiere del de otras regiones del mundo. Existen, como es lógico, los conceptos de medicina, enfermedad, médico y tratamiento, pero estos responden a otra visión de mundo, incluso a otro sistema lógico de abordar el conocimiento.

Two Views of Medicine

Pre-Columbian American medicine had diverse systems and approaches to health. However, despite its diversity, it evolved and developed over many centuries without contact with other regions of the world. For this reason, when there was contact, communication, and cultural diffusion, it occurred within the American continent. This means that we are not only dealing with sui generis knowledge, but that the whole conceptual body of medicine largely differs from that of other regions of the world. The concepts of medicine, disease, doctor, and treatment exist, as is logical, but they respond to another worldview, even to another logical system of approaching knowledge.

Paragraph 9

Aunque durante la conquista y colonización se hicieron esfuerzos por comprender los alcances y desarrollo de la tradición médica de los pueblos originarios, lo cierto es que no ha sido una tarea fácil y hay más desencuentros que situaciones afortunadas. Al no entenderse el sistema curativo de los médicos de los pueblos originarios, son corrientes los errores conceptuales. A los médicos de dichos pueblos se les llamó “brujos”, “matasanos”,

y toda suerte de apelativos despectivos. Incluso en los casos que algún autor (Lines, 1945, p. 1) reconoce la importancia de los médicos de los pueblos originarios, encontramos alusiones despectivas o confusiones a la hora de describir los conceptos de la medicina bribri-cabecar.

Although there were attempts at understanding the scope and development of the medical tradition of the native peoples during the conquest and colonization, the truth is that it has not been an easy task as there are more misunderstandings than fortunate situations. Since the healing system of the physicians of the native peoples is not understood, conceptual errors are common. The doctors of these peoples have been called “witches”, “quacks” (matasanos) and all sorts of derogatory appellatives. Even in cases where some authors (Lines, 1945, p. 1) recognize the importance of the physicians of the native peoples, we find derogatory allusions or confusion when describing the concepts of bribri-cabecar medicine.

Paragraph 10

Estas confusiones relativas a la medicina de los pueblos originarios se mantienen hasta la actualidad, donde con frecuencia los médicos occidentales terminan creyendo que todos los conocimientos médicos pertenecen a su cultura. Así, entonces, cuando se trata de transmitirlos y aplicar la ciencia médica solo existe una única vía que va desde las instituciones de salud hacia los pueblos originarios. En consecuencia, los pueblos originarios terminan siendo pasivos y simples depositarios de conceptos, protocolos y conocimientos que apenas entienden, y que frente a una emergencia como la de COVID-19 los deja en una gran vulnerabilidad y desventaja. No solo se encuentra la diferencia de idiomas, sino que incluso aunque se tengan traducciones literales de los protocolos médicos, enfrentamos otros problemas, que tienen que ver con concepción de mundo, el concepto de salud, enfermedad, prácticas culturales, entre otros.

These confusions regarding the medicine of indigenous people continue to the present day, where Western doctors often end up believing that all medical knowledge belongs to their culture. Thus, when it comes to transmitting and applying medical science, there is only one way from the health institutions to the native peoples. Consequently, the native peoples end up being passive and simple depositaries of concepts, protocols and knowledge that

they barely understand, which leaves them at a great vulnerability and disadvantage in the face of an emergency such as COVID-19. Not only is there the language difference, but even if we have literal translations of the medical protocols, we face other problems, which have to do with the conception of the world, the concept of health, disease, cultural practices, among others.

Paragraph 11

Cosas tan importantes como el entender que los pueblos originarios tienen una tradición oral y que, a la hora de establecer protocolos, se debería privilegiar la oralidad más que el lenguaje escrito, son aspectos que habrá que tomar en cuenta.

Such important things as understanding that native people have an oral tradition and that when establishing protocols, orality should be favored over written language, are aspects that will be considered.

Paragraph 12

Todo ello, por lo general, termina provocando conflictos de comunicación y, a veces, en franco rechazo de los conocimientos impuestos por los equipos de salud, que son percibidos como exógenos a las comunidades de estos pueblos, o incluso como contrarios a sus creencias y prácticas de prevención-curación.

This usually results in communication conflicts and sometimes in outright rejection of the knowledge imposed by the health teams, which is perceived as exogenous to the communities of these peoples, or even as contrary to their beliefs and prevention-healing practices.

Paragraph 13

La medicina de los pueblos originarios debe entenderse en su contexto más amplio, teniendo claro que sus conceptos médicos difieren profundamente de los conceptos occidentales, aunque en el fondo tienen los mismos propósitos: prevenir enfermedades, curar enfermos, o reflexionar sobre las prácticas médicas y posibles tratamientos. Al trabajar con los pueblos originarios, aunque parezca extraño en esta pandemia, el punto de partida en términos de salud deben ser los propios conocimientos médicos ancestrales. De

tomarse en cuenta lo anterior, no solo se mejoraría la comunicación, sino que el proceso de apropiación de los conocimientos sería más profundo y podría dar lugar a la construcción de conocimientos compartidos, la reformulación de la interpretación de conceptos médicos en territorios pluriétnicos y pluriculturales. Todo ello permitiría reflexionar y reducir la enorme brecha que existe entre dos tradiciones médicas, que no solo responden a culturas diferentes, sino que se practican en distintas lenguas y donde los conceptos de medicina, enfermedad, médico y tratamiento se expresan en sistemas cuyos paradigmas se desarrollan y evolucionan en mundos completamente diferentes.

Indigenous peoples' medicine must be understood in its broadest context, bearing in mind that their medical concepts differ profoundly from Western concepts. In essence, they have the same purposes: to prevent disease, to cure the sick, or to reflect on medical practices and possible treatments. When working with native communities, although it may seem strange in this pandemic, the starting point in terms of health should be their own ancestral medical knowledge. If this is considered, not only would communication be improved, but the process of appropriation of knowledge would be more profound. This could lead to the construction of shared knowledge, the reformulation of the interpretation of medical concepts in pluri-ethnic and pluricultural territories. Not only do these traditions respond to different cultures, but they are also practiced in different languages and where the concepts of medicine, illness, doctor, and treatment are expressed in systems whose paradigms develop and evolve in completely different worlds.

Paragraph 14

Algunas aclaraciones previas

Entre los bribris y cabécares, tanto mujeres como hombres podían ejercer la medicina. El término en lengua bribri para referirse a la o el médico es awá, y en plural es *awápa*. En lengua cabecar es *jawá* y en plural *jawáwá*. A la hora de referirnos a las o los médicos de los pueblos originarios, respetaremos los términos awá para el singular y *awápa* para el plural. Cuando se hacen referencias a la medicina de estos pueblos, generalmente todo nos remite al uso de plantas medicinales, pese a que las y los *awápa* nos dicen que las plantas, aunque muy necesarias en el proceso curativo, no son lo más importante, porque lo esencial es la historia ancestral. Nosotros, en este artículo, nos guiaremos por las palabras de las y

los *awápa* y pondremos el énfasis en conceptos y conocimientos que vienen de la tradición oral, la historia ancestral, sin tocar lo relativo a plantas medicinales, que sería motivo de otro trabajo, y que previamente Alí García ha tratado en su libro Plantas de la Medicina Bribri (1994).

Some Preliminary Clarifications

Among the Bribri and Cabecars, both women and men could practice medicine. The term in Bribri language to refer to a doctor is *awá*, and in plural is *awápa*. In the Cabecar language it is jawá while in plural *jawáwá*. When referring to the doctors of the native people, we will respect the terms *awá* for the singular and *awápa* for the plural mentions. When references are made about the medicinal practices of these groups, it generally refers to the use of medicinal plants. This is even though the *awápa* tell us that plants, although very necessary in the healing process, they are not considered the most important thing. What is essential is the ancestral history. In this article, we will be guided by the words of the *awápa*, and we will emphasize concepts and knowledge that come from the oral tradition, the ancestral history, without touching on medicinal plants. This would be the subject of another work and which Alí García has previously addressed in his book *Plantas de la Medicina Bribri* (1994).

Paragraph 15

Los pueblos bribri-cabecar guardaron en su tradición oral, en sus historias ancestrales, los recuerdos de las enfermedades viajeras *(duwè shkál),* las enfermedades que vienen y van, las que pasan, es decir, las epidemias o las pandemias. Estas historias ancestrales, en general, son catalogadas como mitología o pensamiento mágico, es decir, como una leyenda fantástica, irreal o falsa.

The Bribri-Cabecar communities have kept in their oral tradition, in their ancestral stories, the memories of *enfermedades viajeras (duwè shkál),* diseases that come and go, those that pass, that is epidemics or pandemics. They are illnesses that can be transferred from one person to another or from animals to people are referred to as infectious diseases or communicable diseases. In general, these ancestral stories are categorized as mythology or magical thinking, that is, as a fantastic, unreal, or false legend.

5.1.3 Glossary

A glossary is a crucial component of any translation, especially in the medical field, where accuracy is essential. Without it, translations could lead to misunderstandings and inconsistencies in the information. A glossary helps maintain consistency in technical terms and ensures the quality of the translation. It should be frequently referenced throughout the translation process. In technical translations, the glossary works as a vital tool for the translator, offering a consistent reference for key terms in English and Spanish, which improves the overall quality and coherence of the document. By using a glossary, translators avoid errors, maintain the pace of their work, and prevent unnecessary research on complex terms. Additionally, it aids readers in understanding technical language and provides the translator with a valuable terminology resource for future projects. For this study, two glossaries have been created: one for English to Spanish, with columns for English terms, Spanish equivalents, grammatical categories, and definitions.

5.1.3.1 English to Spanish Glossary

English Term	Spanish Term	Grammatical Category	Definition
Advocate	Abogar	Verb	Defender en juicio, por escrito o de palabra. Interceder, hablar en favor de alguien o de algo.
Alma-Ata	Alma-Ata	Noun	La Conferencia Internacional sobre Atención Primaria de Salud, un evento de trascendencia histórica ocurrió en 1978. Convocada por la Organización Mundial de la Salud (OMS) y el Fondo de las Naciones Unidas para la Infancia (UNICEF), contó con la presencia de 134 países, 67 organismos internacionales, y muchas organizaciones no gubernamentales.
ANEP	ANEP	Noun	Asociación Nacional de Empleados Públicos, es una organización sindical de tipo industrial en la República de Costa Rica.

CPHC Comprehensive Primary Health Care	APS-I	Noun	Modelo de Atención Primaria de Salud Integral e Integrada Modelo de salud que incluye todos los niveles de atención del sistema de salud, la cual promueve la prevención, la curación, la rehabilitación y la atención paliativa. Su objetivo es garantizar el mayor nivel posible de salud y bienestar para toda la sociedad.
ATAP	ATAP	Noun	Asistente Técnico de Atención Primaria.
Fiscal austerity	Austeridad fiscal	Noun	Política económica que reduce el gasto público para disminuir el déficit y la deuda. Austeridad: Mortificación de los sentidos y pasiones.
National Service of Aqueducts and Sewers	AyA	Noun	Instituto Costarricense de Acueductos y Alcantarillados. Institución autónoma del Estado Costarricense que vela por el acceso al agua potable de la población.
IADB	BID	Noun	Banco Interamericano de Desarrollo es una organización financiera que apoya el desarrollo de América Latina y el Caribe para promocionar la integración regional y reducir la desigualdad.
CCSS	CCSS Caja Costarricense de Seguro Social	Noun	Caja Costarricense de Seguro Social una institución pública que se encarga de la seguridad social en Costa Rica.
Contribution	Cotización	Noun	Acción y efecto de cotizar. Es la cuota que pagan empleados y empleadores al Estado como aportación al sistema de la Seguridad Social.

UHC Universal Health Coverage	CSU	Noun	Cobertura Sanitaria Universal reforma apuesta de modo decidido por el principio de universalidad en la atención sanitaria que consiste en que todas las personas tengan acceso al conjunto de servicios de salud de calidad que necesiten, cuando y donde los necesiten, sin sufrir dificultades económicas por ello.
EBAIS	EBAIS	Noun	Equipos Básicos de Atención Integral de Salud. Estado de Bienestar de Costa Rica conjunto de políticas públicas que buscan mejorar las condiciones de vida de los ciudadanos. Se caracteriza por ser universal, igualitario y equitativo.
Amendment	Enmienda	Noun	Acción y efecto de enmendar. Corrección, rectificación, subsanación, reparación, arreglo, reforma, revisión. Propuesta de variante, adición o reemplazo de un proyecto, dictamen, informe o documento análogo.
Extol	Ensalzar	Verb	Engrandecer (‖ elevar a grado o dignidad superior). elogiar, ponderar, encomiar.
IMF International Monetary Fund	FMI	Noun	Fondo Monetario Internacional es una organización financiera internacional de las Naciones Unidas. Su objetivo es lograr un crecimiento y una prosperidad sostenibles para cada uno de sus 191 países miembros. Respalda políticas económicas que promueven la estabilidad financiera y la cooperación monetaria, que son esenciales para la productividad, la

			creación de puestos de trabajo y el bienestar económico.
Nascent	Incipiente	Adjective	Que empieza. Naciente, inicial, embrionario, rudimentario, nuevo, primerizo, principiante.
National Insurance Agency	INS	Noun	Instituto Nacional de Seguros Institución estatal de Costa Rica. Brinda seguros y servicios a nivel nacional e internacional, además de promover la prevención de riesgos para el trabajo, el hogar y el tránsito de vehículos.
Legislation	Legislación	Noun	Conjunto o cuerpo de leyes por las cuales se gobierna un Estado, o una materia determinada.
MOH Ministry of Health	MINSA	Noun	Ministerio de Salud de Costa Rica es el ministerio de gobierno encargado de dirigir a los factores sociales para el desarrollo de acciones que protejan y mejoren el estado de la salud pública.
Myriad	Miríada	Noun	Cantidad muy grande e indefinida.
WHO	OMS	Noun	Organización Mundial de la Salud
PAHO Pan-American Health Organization	OPS	Noun	La Organización Panamericana de la Salud, es la agencia de salud pública internacional más antigua del mundo. Brinda cooperación técnica y moviliza asociaciones para mejorar la salud y la calidad de vida en los países de las Américas.
PNL	PNL	Noun	Partido Liberación Nacional es el partido político de Costa Rica fundado en 1951. Es de tendencia socialdemócrata.

CMP Community Health Program	PSC	Noun	Programa de Salud Comunitaria
RHP Rural Health Program	PSR	Noun	Programa de Salud Rural
Unanimously	Por unanimidad	Adverb	Sin discrepancia, unánimemente. Es la construcción adecuada para indicar que existe un acuerdo sin discrepancia.
PUSC	PUSC	Noun	Partido Unidad Social Cristiana es un partido político costarricense que se sitúa en la derecha del espectro político fundado en 1983.
REDES	REDES	Noun	Registros de Salud
The status quo	Statu quo	Noun	Estado de cosas en un determinado momento.
UNICEF United Nations Children's Fund	UNICEF	Noun	Organismo de las Naciones Unidas encargado de proteger los derechos de todos los niños, especialmente de los más desfavorecidos. Organización a la cual la Convención sobre los Derechos del Niño se refiere concretamente como fuente de asistencia y asesoramiento especializados.
USAID United States Agency for International Development	Agencia de los Estados Unidos para el Desarrollo Internacional	Noun	Agencia federal independiente responsable de planificar y administrar la asistencia económica y humanitaria en el mundo.

Table 7 Illustrates the glossary from the translation of Building a Thriving Primary Health Care System: The Story of Costa Rica. Researcher's creation.

5.1.3.2 Spanish to English Glossary

English Term	Spanish Term	Grammatical Category	Definition
Awá	Awá	Noun	Term in Bribri language to refer to a singular doctor.
Awápa	Awápa	Noun	Term in Bribri language to refer to doctors (in plural).
Aztec Empire	Emperio Azteca	Noun	Nahuatl-speaking people who in the 15th and early 16th centuries ruled a large empire, now central and southern Mexico. Translated as “White Land,” “Land of White Herons,” or “Place of Herons”.
Bribri	Bribri	Noun	One of the largest indigenous ethnic groups in Costa Rica. They settled in the Talamanca Mountain range. Their social system was based on chiefdoms. Bribriwak is a Chibchan language from a language family native to the Isthmo-Colombian Area.
Buklú – bukulú	Buklú – bukulú	Noun	A powerful devil, guardian of certain animals. An evil spirit or bad omen is associated with the diseases that animals can transmit to humans.
Buklú bisok	Buklú bisok	Noun	Beings from beyond the earth that do not see you.

Cabecar	Cabécar	Noun	(Kabekwa) An indigenous ethnic group of Costa Rica. They live between the provinces of Cartago, Limón, and Puntarenas. The Cabecar language belongs to the Chibcha-Talamanca family.
COVID-19	COVID-19 (Corona virus)	Noun	An infectious disease caused by the SARS-CoV-2 virus. The virus can spread from an infected person's mouth or nose in small liquid particles. Covid-19 Pandemic.
Disease	Enfermedad	Noun	The condition of the living animal, plant, body or of one of its parts that impairs normal functioning and is typically manifested by distinguishing signs and symptoms.
Duwè shkál	Duwè shkál	Noun	Infectious illnesses. Traveling diseases. Diseases that come and go, those that pass, that are epidemics or pandemics.
E 'iyáuk	E 'iyáuk	Verb	"To get muddy" in the Bribri language. An expression used to say that someone is infected by something (that can probably not be seen)
Great Dying	La Gran Mortandad	Noun	Permian–Triassic extinction event was an extinction event that occurred approximately 251.9 million years ago. It is Earth's most severely known extinction event.

Illness	Enfermedad (condición)	Noun	An unhealthy condition of body or mind, the state of being ill.
Influenza	Influenza	Noun	An acute, highly contagious, respiratory disease caused by any of three orthomyxoviruses. Any of various human respiratory infections of undetermined cause.
Iyi dàli	Iyi dàli	Noun	Refers, as (Íyiwak dàli), to the forms of contagion and in this case, exclusively to the diseases that certain objects can produce in certain circumstances.
Íyiwak dàli	Íyiwak dàli	Noun	Recognized in the West as zoonosis, but the Bribri and Cabecar people would call íyiwak dàli (diseases of animal origin or produced by some animal.) When things acquire the spirit of a disease after being by human hands.
Jawá	Jawá	Noun	Term in Cabecar language to refer to a singular doctor.
Jawáwá	Jawáwá	Noun	Term in Cabecar language to refer to doctors (in plural).
Measles	Sarampión	Noun	An acute contagious disease that is caused by a morbillivirus (species Measles morbillivirus) and is marked especially by an eruption of distinct red circular spots.
Mesoamerica	Mesoamérica	Noun	Complex indigenous cultures developed in parts of Mexico and

			Central America prior to Spanish exploration and conquest in the 16th century. Recognized by the organization of its kingdoms and empires, and the sophistication of its monuments and cities.
Native (people)	Nativo(s)	Noun	Living or growing naturally in a particular region: indigenous one born or reared in a particular place. An original or indigenous inhabitant or something indigenous to a particular locality.
Quacks	Matasanos	Noun	An ignorant, misinformed, or dishonest practitioner of medicine (impostor).
Sib	Sib, Sibo	Noun	Sibú is the principal deity of Talamancan mythology, as he was the creator of the earth and human beings. Considered the creator god of indigenous wisdom, values, and customs. Sibö̀ is known to the Bribri, Sibú to the Cabécar, Sibö to the Telibes, and Zipoh to the Boruca.
Smallpox	Viruela	Noun	An acute contagious febrile disease of humans that is caused by a poxvirus (species Variola virus of the genus Orthopoxvirus), is characterized by a skin eruption with pustules, sloughing, and scar formation.

Suwõ'	Suwõ'	Noun	Refers to wind, history, knowledge, and wisdom in Bribri. Suwõ' is known as the chant because it is a specific language used only by the awápa, the Ókŏm, and other masters for their healings and ceremonies.
Tenochtitlan	Tenochtitlan	Noun	Ancient capital of the Aztec empire. Located at the site of modern Mexico City,
Tuàlia	Tuàlia	Noun	The Lord of the Flu sent by Sibo. One of the diseases that came from the east brought by the Spaniards flus that arrived and almost exterminated many of the clans.
Typhus	Typhus	Noun	A severe human febrile disease that is caused by one (Rickettsia prowazekii) transmitted especially by body lice and is marked by high fever, stupor alternating with delirium, intense headache, and a dark red rash.
Whooping cough	Tos ferina	Noun	An infectious respiratory disease especially in children caused by a bacterium (Bordetella pertussis) and marked by a convulsive spasmodic cough sometimes followed by a crowing intake of breath.
Wiköl	Wiköl	Noun	The soul outside the body or a protective shield. Refers to ourselves in the other world or dimension. Wiköl is represented as a halo that

			surrounds the entire body in the dimension, the reason why it is called the protective shield or soul outside the body. This means to protect the body and make it invisible to illness.
Zoonosis	Zoonosis	Noun	An infection or disease that is transmissible from animals to humans under natural conditions

Table 8 Illustrates the glossary from the translation made of Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica. Researcher's creation.

Chapter VI

This chapter reflects on the complex process the investigator underwent to accurately convey meaning, tone, terminology, and cultural elements from the source language (SL) to the target language (TL). Additionally, this section restates the research question introduced in Chapter I, discusses any unexpected findings encountered during the research, and provides recommendations for future studies in similar areas. The conclusions are drawn from the results gathered using the tools described in Chapter V. Lastly, the researcher offers suggestions for future research in this field, aiming to support others working on similar investigations.

6.1 Purpose of the Conclusion

The purpose of the conclusions in a research study is to present the results and demonstrate how the objectives were achieved. In this investigation, the researcher will show the impact of analyzing translation procedures in two texts: one translated from Spanish to English and the other from English to Spanish. This chapter aims to summarize the research and present the findings related to the specific and general objectives. Additionally, it includes a section dedicated to highlighting key recommendations for future research in this area.

6.2 Conclusions

6.2.1 To translate "Conceptos y prácticas culturales de la medicina ancestral bríbri y cabécar en Costa Rica" by Alí García and Alejandro Rojas, and "Building a Thriving Primary Health Care System: The Story of Costa Rica" Madeline Pesec, Hannah Ratcliffe, and Asaf Bitton in their respective target languages

To begin translating a text, it is essential to first read and analyze it. According to Newmark (1988), the process starts with a general reading to grasp the main topic of the document. The translator then consults textbooks and technical documents to better understand the source text's content. After this, a close reading is necessary to analyze specific elements of the text. Then, the translator can identify potential challenges that require special attention. With this analysis, the translator can then choose the most suitable translation method and procedures to ensure the translation is both accurate and natural.

One of the main objectives of this work is to translate different medical and cultural documents and analyze them to create high-quality translations. Different techniques and

processes were applied to the texts for analytical purposes. In addition to analyzing translation procedures and using a color-coded chart to track them, it is important to emphasize the initial analysis of the source texts. It is important for the translator to thoroughly grasp the material to ensure proper and complete work. This understanding can be further improved by reading medical or culturally based books, journals, and forms typically used in the field, as working with specific terminology can be challenging without sufficient knowledge. As students, is better to prepare fully to handle the complexities of any field of translation.

6.2.2 To apply translation techniques that maintain technical accuracy and cultural relevance, focusing on the clarity and accessibility of the information

As discussed throughout the research, one of the main goals was to maintain the accuracy of the documents during translation. Various translation techniques and methods were applied to ensure the quality of the translation. These techniques help ensure that the message is accurately adapted to the target language, preserving both structural and stylistic equivalence while conveying the intended meaning. As demonstrated in the study, the researcher accomplished this goal by using the color-coding instrument, which highlights how different technical translation techniques were applied across the texts to guarantee an effective translation.

Maintaining the cultural and historical context was essential to ensuring the translation accurately conveyed the nuances and significance of the original content. To achieve this, the translator carefully considered the historical and cultural references in the source text and sought to reflect them in the target language while retaining their original meaning and impact. Additionally, the translator focused on finding precise word equivalents that would make the texts clear and comprehensible in the target language. This involved identifying terms that best matched the specific terminology used in the source text, particularly those with strong cultural or historical connotations. By carefully selecting these equivalents, the translator worked to bridge any gaps between the two languages while maintaining the accuracy, clarity, and integrity of the source material.

6.2.3 To assess the translation quality by evaluating terminology, readability, and contextual accuracy in conveying Costa Rica's healthcare history

The researcher made use of specialized medical and historical terms by carefully examining the equivalents in both languages. This was made to ensure they accurately reflected the original meaning and were appropriate for the target language. This was especially important given the historical and cultural significance of the subject matter. Correctly selecting terms related to Costa Rican healthcare history helped maintain precision and relevance. Moreover, the translation's readability was assessed to ensure that the text was clear and easy to understand for the target audience. The language used needed to be accessible and appropriate for the intended readership, without sacrificing the technical accuracy required in healthcare-related texts. In addition, the ability to convey the cultural and historical context of Costa Rica's healthcare system was crucial. The translation was evaluated to ensure that the specific cultural and historical nuances were preserved, allowing the target audience to fully understand the context of the original text. This included accurate representation of Costa Rican healthcare policies, practices, and historical developments. All the terminology was checked through different national and international sources to make sure the equivalents were correct in the source and target languages.

6.2.4 To create a bilingual glossary of essential terms and concepts related to Costa Rica's health system, providing a valuable resource for future translations to the field of translation

The development of two glossaries was successful and played a crucial role in the translation process. In terms of terminology, the glossaries served as an essential guide for the translator, ensuring consistency and accuracy throughout the translation. By providing a comprehensive list of the key terms and their corresponding equivalents, the glossaries helped the translator maintain uniformity in language use, particularly with specialized medical and historical terms. They acted as a reference tool to prevent distinctions or misunderstandings in terminology, thereby contributing to a more precise and coherent translation. This was particularly important when translating texts related to Costa Rican healthcare history, where specific cultural and historical terms needed to be accurately conveyed.

6.3 Restatement of the Research Question

When translating important documents on the evolution of healthcare in Costa Rica, such as “Conceptos y prácticas culturales de la medicina ancestral Bríbri y Cabécar en Costa Rica” and “Building a Thriving Primary Health Care System: The Story of Costa Rica,” it is crucial to ensure that the translations are both accurate and reflective of the cultural and technical nuances within each text. Various challenges or subtleties may arise during the translation process, potentially complicating the task.

The translation process may be slowed by a variety of challenges. For example, cultural-based terminology may not have direct equivalents in the target language, requiring the translator to find the most accurate terms or provide explanations. Additionally, cultural concepts or practices, such as the traditional healing methods of the Bribri and Cabecar people might be unfamiliar to the target audience and could require additional context or clarification to maintain their significance. Similarly, the technical details of Costa Rica’s healthcare system may present difficulties in terms of language and context, as some terms or systems may be specific to the country and need to be adapted carefully for clarity without losing their original meaning.

Moreover, the translator had to maintain the emotional tone and style of each text. For instance, the historical and cultural depth of the document focusing on indigenous medicine requires a sensitive and accurate translation that respects the traditions being described. On the other hand, the document which discusses Costa Rica's modern healthcare system, calls for a precise, professional tone that communicates technical details clearly while also conveying the story of the country’s healthcare success. By carefully addressing these challenges, the translator ensured that the essence of the original documents was preserved and accurately communicated to the target audience.

6.4 Recommendations

In this section, the researcher offers recommendations for future similar studies. The aim is to draw from the researcher’s own experiences to highlight aspects that could be improved or considered in future research. These recommendations serve as guidance for researchers undertaking similar projects, helping them refine their methods and approaches based on insights gained during this investigation.

For future research focused on the culture or history of Costa Rica, it is recommended to entirely study the specific or regional culture from which the text is being translated. Understanding the culture from the perspective of the people who are part of that community is essential, as it provides respect and accurate representation of their values and practices. Additionally, extensive reading on the equivalents and terminology used in the documents is crucial. It would be beneficial to refer to specialized texts or resources that outline the specific vocabulary and terms related to the subject matter of the translation, as this will enhance the accuracy and contextual appropriateness of the translation.

I would recommend looking for specific documents related to the topic, focusing on regional sources rather than foreign ones. If necessary, do not hesitate to reach out to professionals for assistance, as there are often when there is incomplete information available to compare or evaluate the content in another language. Gaining access to accurate and relevant regional information is crucial, as it allows the researcher to conduct a thorough analysis and ensure the translation is accurate and contextually sound.

References

Abutabenjeh, S., Jaradat, R. (2018). Clarification of research design, research methods, and research methodology: A guide for public administration researchers and practitioners. SAGE Journals (36) 3, 237-258. https://doi.org/10.1177%2F0144739418775787

Acuña, N. (2008). La traducción del nuevo testamento al Bribri etapas, problemas, soluciones y comparación entre la realidad y la teoría de la traducción bíblica. Repositorio UNA. https://repositorio.una.ac.cr/items/1f9a8cbf-b133-44e2-82fb-0857979b612b

Araya Roa, M. (2023). A MEDICAL TRANSLATION AND ANALYSIS OF SOME DOCUMENTS FROM SPANISH TO ENGLISH AND FROM ENGLISH TO SPANISH. Repositorio UIA. http://repositorio.uia.ac.cr:8080/server/api/core/bitstreams/f140a6a9-c65c-4407-ba33-529da957277a/content

Bouchrika, I. (2024). Types of Research Design in 2024: Perspective and Methodological Approaches. Research.com. https://research.com/research/types-of-research-design#:~:text=However%2C%20what%20is%20research%20design,in%20building%20a%20thesis%20statement.

Baker, M. (2000). In Other Words: A Coursebook on Translation. Beijing: Foreign Language Teaching and Research Press.

Catford, J. C. (1978). A linguistic theory of translation. Oxford: Oxford University Press.

Chironova, I. 2014. Literalism in Translation: Evil to Be Avoided or Unavoidable Reality. SKASE Journal of Translation and Interpretation 7(1). http://www.skase.sk/Volumes/JTI08/pdf_doc/03.pdf

Delisle, J., Lee-Jahnke, H., & Cormier, M. (2004). Translation Terminology. Beijing: Foreign Language Teaching and Research Press.

Echavarría Silva, G. (2016). Analysis of the Effect of Procedures and Methods Used to Translate Various Documents from Spanish into English and from English into Spanish for Apartotel Don Francisco. Repositorio UIA. http://repositorio.uia.ac.cr:8080/server/api/core/bitstreams/94f9be1f-578a-47d2-a3cf-b143e0bb3355/content

Essay Company. (2017). Scale Of Generality Or Difficulty. https://www.essaycompany.com/essays/english-language/scale-of-generality-or-difficulty-english-language-essay

Feliu González, A. (2020). ANALYSIS OF PROCEDURES AND METHODS USED TO TRANSLATE SOME DOCUMENTS FROM ENLISH TO SPANISH AND OTHERS FROM SPANISH INTO ENGLISH FOR UNIVERSIDAD NACIONAL DE COSTA RICA. Repositorio UIA. http://repositorio.uia.ac.cr:8080/server/api/core/bitstreams/22c51f57-5ddb-4c4d-b88a-2ea0fcd79b89/content

Fulton Library. (2024). Research Methodologies. https://uvu.libguides.com/methods/home

Gapper, S. E. (2008). Manual de gestión terminológica. Editorial Universidad Nacional de Costa Rica.

glossary. 2024. In Merriam-Webster.com. https://dictionary.cambridge.org/es/diccionario/ingles/glossary

Jiménez Calvo, D. (2019). Medical Translation English-Spanish. Theory, Difficulties and Translation Proposal for a Research Article. Universidad de Valladolid. https://uvadoc.uva.es/bitstream/handle/10324/39487/TFG_F_2019_182.pdf?sequence=1&isAllowed=y

Král, D. (2021). Types of Translation Techniques and Methods. Lexica. https://www.lexika-translations.com/blog/types-of-translation-techniques-and-methods/

McDonald, S.V. (2020). Accuracy, readability, and acceptability in translation. Yale University. https://media.neliti.com/media/publications/343982-accuracy-readability-and-acceptability-i-ed24ad76.pdf

Mohamed, E. (2022). Translation Methods: A Comparison Study between Semantic and Communicative Translation. International Journal of Linguistics, Literature and Translation. https://media.neliti.com/media/publications/554044-translation-methods-a-comparison-study-b-f55fdc92.pdf

Molina, L., & Hurtado, A. (2002). Translation Techniques Revisited: A Dynamic and Functionalist Approach. Universitat Autònoma de Barcelona, Barcelona, Spain. https://www.uv.es/tronch/TradEspII/Trans-Techn-Molina-Hurtado.pdf

Munday, J. (2008). Style and Ideology in Translation. (Fuentes, C. (2013)). https://www.researchgate.net/publication/274127231_Style_and_Ideology_in_Translation

Newmark, P. (1988). A Textbook of Translation. Newmarkhttp://ilts.ir/Content/ilts.ir/Page/142/ContentImage/A%20Textbook%20of%20Translation%20by%20Peter%20Newmark%20(1).pdf

Nord, C. (1991). Text analysis in translation: theory, methodology, and didactic application of a model for translation-oriented text analysis.

Lera, Bianca. (2024). Professional text, Reliable sources, Primary sources, Secondary sources, Tertiary sources. https://www.researchgate.net/publication/381311766_SOURCES_USED_IN_PROFESSIONAL_TRAINING_AND_PRACTICE

Ordudari, M. (2007). Translation procedures, strategies and methods. Translation Journal. https://translationjournal.net/journal/41culture.htm

Richards, J. Platt, J. & Platt, H. (1997). Dictionary of Language Teaching and Applied Linguistics.

Saridaki, E. (2021). Vinay & Darbelnet's Translation Techniques: A Critical Approach to their Classification Model of Translation Strategies. International Journal of Latest Research in Humanities and Social Science (IJLRHSS). http://www.ijlrhss.com/paper/volume-4-issue-11/14-HSS-1186.pdf

Sepúlveda Aguilar, I. (2021). ANALYSIS OF PROCEDURES AND METHODS USED TO TRANSLATE SOME DOCUMENTS FROM ENGLISH INTO SPANISH AND FROM SPANISH INTO ENGLISH. Repositorio UIA. http://repositorio.uia.ac.cr:8080/server/api/core/bitstreams/3396e1fb-02ef-4b45-9d98-fc71bc002b71/content

Sgibnera, N. (2023). A Functional Typology by Christiane Nord in Corporate Newsletters' Translation (English to Spanish). ResearchGate. https://www.researchgate.net/publication/371768145_Functional_Typology_by_Christiane_Nord_in_Corporate_Newsletters'_Translation_English_to_Spanish

Shafer Library. (2024). Research Methodologies: Research Methodologies. University of Findlay. https://findlay.libguides.com/c.php?g=1325374&p=9755136

Shen Su, R. (2018). Translation and Analysis of the Documents Manual de Adscripción y Beneficio Familiar from Spanish into English for Caja Costarricense de Seguro Social and The Preliminary Plan of Language Café -- an Online Learning Platform from English into Spanish for Language Café. Repositorio UIA. http://repositorio.uia.ac.cr:8080/server/api/core/bitstreams/a05960c2-4f7f-4b9b-a1d0-82db436fdd09/content

UC Merced Library. (2024). Primary, Secondary and Tertiary Sources. https://libguides.ucmerced.edu/source-types

University of Southern California. (2024). Research Guides - Organizing Your Social Sciences Research Paper. USC Libraries. https://libguides.usc.edu/writingguide/theoreticalframework

University of Utah. (2020). Primary, Secondary and Tertiary Sources. ULibraries. https://campusguides.lib.utah.edu/PrimarySecondayAndTertiarySources

Vázquez-Ayora, G. (1977). Introducción a la Traductología. Washington, D.C.: George Town University.

Wang. Z. (2023). A Comparative Analysis of Eugene Nida's and Peter Newmark's Perspectives on Cultural Context in Translation. Journal of Education and Educational Research. https://www.researchgate.net/publication/378317742_A_Comparative_Analysis_of_Eugene_Nida's_and_Peter_Newmark's_Perspectives_on_Cultural_Context_in_Translation

Annexes

1. **Annex Building a Thriving Primary Health Care System: The Story of Costa Rica by Madeline Pesec, Hannah Ratcliff, and Asaf Bitton.**

BUILDING A THRIVING PRIMARY HEALTH CARE SYSTEM: THE STORY OF COSTA RICA

Madeline Pesec, Hannah Ratcliffe MSc, and Asaf Bitton MD, MPH

Primary Health Care Before the 1990s

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PRE-1960: ESTABLISHMENT OF HEALTH INSTITUTIONS

Costa Rica gained independence from Spain in 1821 and full independence from Mexico in 1838 before it was established as a democracy in 1869.[8] Before the creation of hospitals and the introduction of physicians as the solely licensed medical providers, Costa Ricans relied on personal hygiene, indigenous healers, and herbal therapies from the diverse Costa Rican rain forests to prevent and treat disease.[9] In the 1850s, many Costa Rican doctors went to Europe for training and later returned to Costa Rica, bringing with them Western biomedical practices.[9] The first hospital in Costa Rica, Hospital San Juan de Dios, was established in the capital, San José, by coffee plantation owners in 1845.[9]

An 1865 law created a system of "town doctors," or "*medicos del pueblo*," each of whom treated the population of a given city based on a contract with a particular municipality.[10] The town doctors were responsible for preventing disease outbreaks and treating indigent populations.[11] The town doctor system persisted in urban areas and well-populated cities through the end of the 19th century and the beginning of the 20th century. Medical practice was restricted to biomedical practitioners in 1887, when a law canceled all previously issued indigenous healer (*curandero*) licenses.[9] During this time, Costa Rica's health care system became increasingly based on Western biomedicine.

Most health care outside of urban city centers was provided by banana and coffee companies.[12] For example, in the rural Atlantic province of Limon, the United Fruit Company was the sole provider of medical care for 30 years.[9] In addition to establishing hospitals, the United Fruit Company created prevention programs, for example to eliminate malaria, to boost the productivity of its workers.[9] Because labor was relatively scarce in Costa Rica, investing in workers' health was an important business strategy.

In the early 1920s, the government established a number of key social institutions including the sub-secretariat of Hygiene and Public Health in 1922 (a precursor to the Ministry of Health, which would supervise the hospitals and provide some public health services) and the National Insurance Agency (*Instituto Nacional de Seguro*) in 1924.[9,13] Their creation and early successes provided political momentum to create other social programs.

One such program was Health Units (*Unidades Sanitarias*) established in 1934 by Dr. Solón Núñes Frutos in the central, rural city of Turrialba.[14] This program led to the establishment of health centers, which typically were placed in the capital city of different provinces and staffed by a general physician, a nurse, a few nursing assistants, a laboratory technician, and a pharmacist.[14] These Health Units had a commitment to prevention and were modeled on the county health units that were being established in rural areas of the United

States during the same time.[9] In addition to their commitment to prevention, these rural health centers were anchored to a geographical area, perhaps representing early portents of geographic organization of the health care system. These Health Units were a very popular model of care and continued to grow in numbers throughout the first half of the 20th century.[15]

The 1930s saw further expansion of biomedical care in hospitals and the development of scattered preventive care in community-based programs operated by international philanthropic organizations. As more hospitals were constructed during this time period, the majority of care for the urban populations shifted to the hospital setting.[16] The capital, San José, had three main hospitals run by religious orders.[12] In addition to hospitals, several international philanthropic organizations, such as the Rockefeller Foundation, began to invest in the Costa Rican health system, mostly in hookworm eradication programs.[17]

During the 1920s and 1930s, many Costa Ricans traveled to Europe to receive their education, where many prospective physicians saw the benefits of nascent social security programs.[18] Around the world, social programs were being used as a barometer of the efficacy of a government. In Latin America, too, social security agencies were being established in many countries that would ultimately guide the development of their respective health systems through the modern era.[18]

These international trends toward the establishment of social security systems were echoed back in Costa Rica, where the population—particularly workers and labor unions—was beginning to clamor for the government to initiate comprehensive health care reform to better meet their needs.[10,18] This domestic push was fueled by the overstretching of the Health Unit system and poor health status attributed to parasitic infections, diarrheal and respiratory illnesses, traumatic injuries, childhood malnutrition, and infant and maternal mortality.[14] At the time, this was a fairly typical health profile of a Latin American country: major health concerns were centered around infectious diseases, and health care was provided in a heterogeneous fashion by public hospitals, international philanthropic organizations, and local traditional healers.[11]

This push for the Costa Rican state to become more involved in the social well-being of its citizens led to at least a half-dozen attempts between 1907 and 1936 to establish a social security administration.[11] Finally, in 1941, President Calderón Guardia led the establishment of the *Caja Costarricense de Seguridad Social* (CCSS),[11] a social security agency initially designed to provide health care and pensions to salaried workers.[16,19] The importance of the CCSS in the history of Costa Rica as a country and its health care system in particular cannot be overstated; it would become one of the key pillars of Costa Rica's Welfare State (*Estado de Bienestar*).[18] The institution was founded on the principles of solidarity, equity, justice, universality, and equality; values that would continue to guide the Costa Rican health system for decades.[11]

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After the 44-day Civil War of 1948, the right to health care administered by the CCSS was reincorporated into the new constitution of 1949, and the CCSS grew steadily during the 1950s. In addition to becoming an important fixture of the fledgling Costa Rican democracy, it also expanded the country's health care delivery capacity.[8]

Beyond the CCSS, the 1950s in Costa Rica brought a myriad of public health efforts, including the passage of sanitation laws, implementation of venereal disease control efforts and malaria eradication campaigns, and the establishment of public health ministries.[11] By 1959, there was a shift in Costa Rica's health care financing and provision system, away from dependence on international philanthropic organizations to ever-increasing state control of the country's health care functions.

1960s: DEEPENING A COMMITMENT TO UNIVERSAL HEALTH CARE ACCESS

The 1960s saw a redoubling of Costa Rica's commitment to addressing the needs of vulnerable and impoverished populations, including expansion of CCSS coverage beyond the working-class population for whom the CCSS had originally been established. In a major turning point, in 1961, Costa Rica passed a constitutional amendment calling for universalization of CCSS services, including pensions and curative health care coverage, within a decade.[10] This amendment would over time expand the coverage of the CCSS to include workers' dependents and underprotected populations such as low-income, rural, and vulnerable groups.[20] Beyond the immediate benefits of expanded coverage, the 1961 amendment established Universal Health Coverage (UHC) as the defining feature of Costa Rican attitudes towards health care and a key component of the country's self-perception. Indeed, health system analysts Juan Rafael Vargas and Jorine Muiser argue that entitlement to health services has become "synonymous with being a Costa Rican and represents probably the single most important feature of the Costa Rican social fabric."[13] For Costa Ricans, equitable provision of health services became a moral imperative related to the concept that a state's goodness can be measured on the basis of the health care it provides to its citizens.[9,21] Although the goal to achieve universal access to the CCSS services by 1971 was not achieved, articulation of UHC as an explicit political and constitutional goal gave the concept longevity that propels Costa Rica's health care system even today.[22] Additionally, the concept of expansion of the CCSS services, specifically, became associated with the ideal of health coverage for all.

During the 1960s, the CCSS primarily functioned as a strategic purchaser of services, and the predominant strategy for care provision was for the CCSS to purchase health care for its beneficiaries from different hospitals.[18] To accelerate the process of universalizing health care service coverage, in 1961 the Faculty of Medicine was established so medical doctors could be trained in the country and Costa Rica could thereby control the supply of physicians.[23] By the end of the 1960s, 47 percent of the population had health coverage through the CCSS, up from 18 percent in 1961.[13]

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During the 1960s, Health Units continued to provide health care to Costa Rican citizens outside the major metropolitan cities.[14] In addition to prevention programs such as vaccination, growth monitoring, and family planning, Health Units also conducted four "campaigns" against venereal disease, tuberculosis, parasites, and malaria.[14] In addition to the Health Units, mobile health centers also came to play an important role during the 1960s in providing care to the rural areas of Costa Rica. The first mobile center was established in 1963, and by the end of the decade there were 12 functioning throughout the country.[14] These mobile units worked as health care teams, similar in function to the Health Units.

In addition to the preventive and curative health care provided in hospitals, Health Units, and mobile health centers, Costa Rica also invested heavily in sanitation throughout the country. In 1961, Costa Rica established the *Servicio Nacional de Acueductos y Alcantarillados* (National Service of Aqueducts and Sewers).[9] From 1961 to 1964, the agency spent USD $12.6 million for studies and expansion of potable water and clean sewage practices throughout the country, especially in rural areas. These sanitation efforts were particularly impactful in improving the country's health outcomes, specifically in decreasing infant mortality.[24]

At the end of the 1960s, the universalization of access to services covered by the CCSS had become the government's health priority. Over the course of the decade, the CCSS had become increasingly dominant not only financially but also in political and cultural terms, as it represented Costa Rica's emerging identity as a Welfare State (*Estado de Bienestar*). While there was an organizational split between curative care provided in hospitals and preventive care provide in the Health Units during this decade, the establishment of both as government-based health care activities and the progress both sectors achieved were critical for Costa Rica's future directions.

1970s: FOUNDATIONAL HEALTH LEGISLATION AND ESTABLISHMENT OF RURAL HEALTH MODELS

In the early 1970s, the leftist Costa Rican President José Figueres, a prominent military figure in the 1948 civil war who had overseen ratification of the 1949 constitution, committed to the expansion of social programs alongside a push to more rapid economic growth. President Figueres was committed during his terms to the eradication of extreme poverty and the universalization of health services through the CCSS.[8] By the early 1970s, President Figueres had broad-based political support for health care reforms and saw health care as one important way to achieve his leftist anti-poverty agenda.[9,10] He proved a key figure in establishing Costa Rica's welfare state in which universality, solidarity, and equality became the main principles of not only health institutions but also public policies more generally.[22]

As part of his strategy, President Figueres advocated for the Hospital Transfer Act of 1973, which transferred most of the hospitals operating in the country (including those run by the Ministry of Health, those that belonged to the agriculture companies, and religious hospitals) to the control of the CCSS.[22] Until this point, the CCSS was solely a strategic purchaser; after implementation of this law, the CCSS began to also run and manage its own hospitals and clinics, transforming the agency into a combined payer and delivery system.[18] After the Hospital Transfer Act, the CCSS controlled 33 hospitals and 69 clinics.[25] By bringing hospitals under CCSS control, Costa Rica made clinical health care a public good.

Supplementing the Hospital Transfer Act, the General Health Act of 1973 redefined the responsibility of the national government in protecting the health of all Costa Ricans, giving the government explicit power to act on behalf of its citizens' welfare during health emergencies, mainly through the Ministry of Health.[22] The General Health Act defined the rights and obligations of all agents who implement activities that have an impact on the health of the population. A third law adopted in that same year was the Organic Health Ministry Act, which established the "health system steward function" of the MOH and also established the MOH as a delegate of the states in health matters.[13] These acts allowed the Costa Rican Ministry of Health to monitor the health of the population and made explicit the MOH's planning and coordination role. However, they also established that the MOH could not act against the interests of autonomous institutions in the health sector (the CCSS, for example), thus limiting the effectiveness of its stewardship function.[18]

Based on its newly expanded role, the MOH established two new primary health care programs in the 1970s: the Rural Health Program (RHP) and the Community Health Program (CHP). Until that point, the majority of health care resources (with the exception of the mobile clinics) were found in city and province centers with populations greater than 1,000 people.[11] After an analysis of geographically organized mortality data, MOH leaders realized that most of the deaths in the country were coming from small, rural areas and were largely due to infant mortality and other preventable causes.[26] The Rural Health Program was established in 1973 to decrease this mortality and bring primary health care services to marginalized, rural areas of the country.[16,27] The program targeted communities with fewer than 500 people, in particular those with no access to CCSS hospitals, and it was tasked with collecting epidemiological data, providing vaccinations and simple treatments, promoting family planning, organizing communities around health promotion activities, and facilitating referral to secondary hospitals for serious conditions.[10] The RHP used newly trained auxiliary nurses, called health assistants, selected from the local population and supervised by a nurse to educate the population and identify illnesses. By 1978, Costa Rica had constructed 218 rural health clinics, and by 1987 the program covered 60 percent of the rural population.[9,10] The prevention principles extolled by the RHP, such as ensuring access to basic health services by bringing these services to communities and providing comprehensive health education, became foundational concepts for later Costa Rican health care system development.

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PRIMARY HEALTH CARE BEFORE THE 1990s

To organize rural health programs, the MOH divided the countryside into distinct geographic health regions. This geographic delineation enabled the tracking of health outcomes by areas over time, which became important for priority setting and population health management in the 1970s and beyond.[9] Health workers traveled across the country on foot, by cars, horses, boats, or bikes, bringing primary health care to the populations for which they were responsible.[18] These defined Health Areas also enabled community and citizen engagement via local health committees, which were responsible for the administration and maintenance of the clinics where the rural health programs operated.[10] The local health committees were instituted to varying degrees of efficacy throughout the country. In some areas a democratically elected local health committee actively directed health care, but in many others, community participation was limited and local health committees were not established or met rarely.[9]

Based on the enthusiastic acceptance of the RHP, the Ministry of Health established the Community Health Program (CHP) in 1976. The CHP used the same concept of community health workers employed in the RHP, but added a home visitation component and was oriented toward impoverished urban populations.[16,10] The CHP operated in approximately 250 Health Areas, each with a population of approximately 2,000 people, and covered 57 percent of the impoverished urban populations.[10] The CHP used a rigorous implementation protocol that entailed an initial selection of a geographic area,the creation of health programming based on community input at the local level, and robust measurement to assess the performance.[10] This implementation protocol formalized community engagement and continual monitoring and assessment as core practical components of primary health care delivery in Costa Rica.

Both the RHP and CHP employed a community health focus on basic preventive public health strategies such as promoting hygiene and sanitation, handwashing, community health education, prenatal care, breastfeeding, child growth and development monitoring, nutrition, oral rehydration therapy, tuberculosis treatment, infectious disease surveillance, vaccination, and deworming medications.[9,18] Both programs achieved remarkable success. From 1974 to 1977, the RHP and CHP increased the number of children under surveillance from 900 to 125,000 and the number of pregnant women under surveillance from 350 to 10,000, and a retrospective study found an association between the duration that a population was under CHP care and an increase in life expectancy at birth.[10] The effective community health workers employed by the RHP and CHP are believed to be the element that allowed the programs to have such a profound and rapid positive impact on the health of the populations they served.[10] Contrary to many CHW programs that were being implemented around the world at this time, the quality of community health workers was closely monitored in Costa Rica. Local governments were trained in different quality assurance mechanisms to ensure that the workers were correctly executing medical surveillance techniques, educating the population on given health issues, and providing the population with essential materials such as supplementary feeding and

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growth charts.[28] Community health workers were an effective liaison between the people and the biomedically oriented health sector, facilitating the integration of health services with the community.

In 1978, the RHP and CHP were combined to create the Division of Primary Health Care within the MOH.[16] The unit was responsible for providing primary health care to all impoverished families, and by the early 1980s the program covered 70 percent of "marginalized urban dwellers" and the majority of the rural population as well.[10] The achievements of the RHP and CHP were significant, especially when considered in relation to the landmark international 1978 Alma-Ata Conference and Declaration which called for comprehensive access to broad and equitable health services.[29] Costa Rica was an exemplar country within the Alma-Ata conference and was already upholding those principles and delivering primary health care services quite similarly to the Declaration's ultimate recommendations. Indeed, San José was considered as one of the front-running cities to host the event, but political considerations between the USSR, United States, China, and WHO led to the selection of Alma-Ata instead.[30]

Under the presidency of Rodrigo Carazo Odio (1978-1982), the Division of Primary Health Care flourished.[9] While President Carazo's party was conservative and promoted free market reforms, the administration used primary health care strengthening to bolster national party support in rural areas.[31] Additionally, international development agencies supported the primary health care program, as there was growing support and excitement around primary health care after the Alma-Ata Declaration.[9] The United States Agency for International Development (USAID), for example, changed its focus to low-cost health care delivery programs and promoted Costa Rica as an effective primary health care standard.[9] The Pan-American Health Organization (PAHO), too, committed to extending health care services to underserved populations through the expansion of primary health care and community participation in the 1970s.[32]

The 1970s was thus a crucial, formative decade for Costa Rican primary health care. In addition to increased financing, the three complementary health laws of 1973 brought the provision of curative, hospital-based health care under the responsibility of the social security agency and gave the government, and consequentially the MOH, the duty to steer the health policy process. Through the RHP, CHP, and, eventually, the Division of Primary Health Care, primary health care became woven into the core fabric of Costa Rica's health care system. At the close of the 1970s, Costa Rica had a strong primary health care system largely focused on health promotion, sanitation, child health, and infectious disease eradication, and this system was already resulting in improved health status. From 1970 to 1980, Costa Rica's parasite infection rate decreased significantly and the infant mortality rate dropped from 61 deaths per 1,000 live births to 18 deaths per 1,000 live births.[1] A 1985 analysis by demographer Luis Rosero Bixby showed that 41 percent of this decrease was due to primary health care efforts; in other words, primary

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care had decreased infant mortality by 17 deaths per 1,000 live births.[24] By capitalizing on its national political agenda and extant commitment to health care, Costa Rica was able to build an extensive primary health care system based on the values of financial solidarity, public provision, commitment to both preventive and curative care, equality, and universality.

1980s: RELATIVE STAGNATION OF PRIMARY HEALTH CARE

In the 1980s, financial turmoil struck Costa Rica and jeopardized the strong primary health care system. This significant financial crisis resulted from a decline in coffee prices, rising fuel costs, and an increase in the country's trade deficit.[33] Costa Rica's economic downturn mirrored the recession in the United States and many other countries around the world.[34] From 1980 to 1982, Costa Rica's economy shrank by 10 percent, inflation increased to 90 percent, and the proportion of citizens in poverty soared from 20 percent to 54 percent.[35] By 1982, Costa Rica had USD $3 billion public sector debt.[33]

To deal with this growing public debt, Costa Rica turned to international financial organizations. At the time, these organizations were focused on fiscal austerity, and the International Monetary Fund (IMF) convinced Costa Rica to limit spending on social programs—including health—to pay off its debts.[9] U.S. President Ronald Reagan's promotion of free market reforms had a profound impact on the politics of international development agencies, leading most to begin recommending the privatization of health services and movement away from government-controlled delivery of health care. Because of Costa Rica's increased financial reliance on these international organizations, the country became beholden, at least in part, to them and the directions they wanted to take.

Concurrent with the recommendations of the international financial organizations, during the 1980s Selective Primary Health Care (SPHC) increased in popularity among the global development community.[18] SPHC, first described in the *New England Journal of Medicine* in 1979, was a response to the vision of comprehensive primary health care (CPHC) presented at the Alma-Ata Conference.[36] In general, SPHC dismissed comprehensiveness as too costly and ultimately unattainable for low-income countries, and suggested that concentrated resources be focused on low-cost technical interventions for those diseases most responsible for morbidity and mortality.[16] SPHC often focused on three or four programs: for example, growth monitoring, oral rehydration therapy, breastfeeding, and immunization. Other curative and preventive services were largely ignored, regardless of community priorities. International organizations such as the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) touted SPHC as the most cost-effective, feasible form of primary health care for the developing world. However, SPHC was both conceptually and practically in direct opposition to the vision and model of service delivery that Costa Rica's Division of Primary Health Care had built during the previous decade.

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PRIMARY HEALTH CARE MODELS

Over the past 70 years, many types of primary health care have been defined. Three of the most prominent models of primary health care include comprehensive (CPHC), community-oriented (COPHC), and selective (SPHC).[39]

Before the 1970s, much of the care provided in low- and middle-income countries was dependent on international development agencies, and there were many disease-specific programs against illnesses like malaria, smallpox, and tuberculosis.[40] These disease-specific programs used top-down approaches with high levels of medical technology and, often, newly developed pharmaceuticals.[40]

However, by the 1970s, as many countries began to nationalize health care and establish public health care services, the scope of health services broadened. CPHC emerged as a holistic model of primary health care that extended across all diseases, emphasized prevention, and included social determinants of health.[39] Rooted in a commitment to social equality and the view that health is a fundamental human right, CPHC espouses a bottom-up approach that situates health within patients' lives and social contexts.[40] Universal accessibility and equitable distribution of health resources are fundamental principles of CPHC.[40]

The strategy of CPHC is to strengthen overall health care systems in a sustainable manner through multi-sectorial action that emphasizes community participation, disease prevention, and health promotion. [40,41] Different from other primary health care strategies, CPHC includes development of sanitation facilities, clean water, and available food supply.[39] There are eight key elements of CPHC: 1) health education and literacy; 2) food supply and nutrition; 3) safe water and sanitation; 4) family planning, maternal and child health; 5) vaccination; 6) prevention and control of infectious disease; 7) curative health treatments for disease and injury; and 8) provision of medication.[40]

Closely related to CPHC, COPHC emerged out of South Africa in the 1940s, based on seminal work by Sidney and Emily Kark.[42] COPHC is based on the integration of public health and basic medical services to provide comprehensive care to a community. As the name suggests, it places the needs of the community first and incorporates community members in the allocation of health resources and execution of health programs. While COPHC and CPHC are closely related, they are distinct. A CPHC program could cover the same public health and primary care functions as COPHC, but lack community involvement; conversely, some disease-specific (and thus not comprehensive) COPHC programs were created.

At the time of the Alma-Ata Declaration in 1978, there had also been experiments with CPHC in India, Nicaragua, Bangladesh, the Philippines, China, and Mozambique.[39,40] COPHC was oper-

ating in South Africa and Israel.[42] The Alma-Ata Declaration incorporated elements from both CPHC and COPHC, calling for comprehensive, community-based care that integrated preventive measures and curative treatments. However, COPHC and CPHC were later deemed unfeasible, unattainable, and too costly for most developing countries; and international development organizations sought alternate strategies.[39]

In 1979, physicians at the international meeting on Health and Population in Developing Countries in Lake Como, Italy presented SPHC as an alternate theory to CPHC.[36] SPHC was presented as an "interim strategy" to help countries establish primary health care services.[39,40] By selectively emphasizing a few diseases, proponents hoped to reduce the scope of health care provided and deliver quick "wins" to donors.[39] Some of the diseases deemed not feasible for developing countries to cover were tuberculosis, pneumonia, and helminthic infections.[39] In the 1980s, due to the global recession, the cost of CPHC seemed overwhelming and SPHC appeared increasingly attractive.[43] International organizations quickly adapted the SPHC model. In 1982, USAID told all field offices to implement SPHC; the WBG and UNICEF also endorsed SPHC in 1982.[39]

SPHC embraced resource maximization and cost-effectiveness.[40,44] When compared to the equity language of CPHC, the stark contrast between the two approaches becomes clear. With an SPHC approach, there are different ways to select target diseases, but all rely on a calculation of cost-effectiveness. One method described in the literature uses four factors to guide selection of target diseases: 1) prevalence, 2) morbidity, 3) mortality, and 4) feasibility of control.[40] "Feasibility of control" is measured as a function of treatment efficacy and cost per treatment.[40] Another method determines priority of disease treatment by adding up scores of the importance of the disease (mortality, incidence, and disability) and the likelihood of success (governmental commitment, technical factors, and public response).[39]

There were two main waves of focus for SPHC programs. The first wave focused on GOBI treatments. GOBI stands for Growth monitoring, Oral rehydration therapy (ORT), Breastfeeding, and Immunization.[40] The second wave added FFF to SPHC programs; FFF includes Family planning, Female education, and Food supplementation.[40] Over time, studies began to show that the SPHC model was not as cost-effective as anticipated and did not meet population demand, and the model began to lose favor.[39]

CPHC has made a comeback in the 2000s, with the 2008 WHO's World Health Report affirming its importance as a global health strategy.[43] Costa Rica also reaffirmed its commitment to CPHC in the 1990s and 2000s as its main primary health care strategy.

Table 2: A Comparison of Comprehensive PHC, Community-Oriented PHC, and Selective PHC

	COMPREHENSIVE PRIMARY HEALTH CARE	COMMUNITY-ORIENTED PRIMARY HEALTH CARE	SELECTIVE PRIMARY HEALTH CARE
View of Health	Positive well-being	Positive well-being of communities	Absence of disease
Locus of control	Communities and individuals	Communities	Health care providers
Major focus	Health through equity and strengthening of the overall health care system	Health through community empowerment and integrated health systems	Health through medical treatments
Health care providers	Multidisciplinary team includes physicians, nurses, community health workers, and other clinicians	Community members, community health workers, public health officials, and clinicians	Physicians and other clinicians
Strategies for health	Social support, prevention, and curative treatments	Combination of public health and primary health care services	GOBI, FFF
Financial considerations	Equitable distribution of resources	Equitable distribution of resources	Cost-effectiveness

Source: *Adapted from Mullan and Epstein[42] and Rogers and Veale[44]*

As international organizations increasingly embraced SPHC, Costa Rica's conservative President Luis Alberto also embraced a neo-liberal perspective on health care and dramatically decreased the budget allotted to primary care in the early 1980s.[16,37] The comprehensive primary health care programs that had been the status quo in the 1970s fell out of political favor and suffered from "deliberate neglect."[9,38] Meanwhile, MOH primary care programs lost funding and decreased the intensity of their service provision efforts (Muiser 2013). During this period, "vertical", or disease-specific, programs within the MOH gained favor and were somewhat sheltered from funding cuts. However, over time, the SPHC model with many vertical programs, plus administrative costs for each, was shown to be as costly as CPHC, and the selective disease-specific programs were slowly abandoned in Costa Rica.[37,39]

During the 1980s, the economic crisis led to a decline in the funding for the MOH, which caused the ministry to reduce service provision in some geographic areas. The CCSS, however, was better insulated from funding cuts arising from the financial crisis since a large portion of its revenue came from employer and employee insurance payments. Therefore, in many areas where the MOH was reducing services, the CCSS began to step in. Although the CCSS had traditionally focused on curative care services, the absence of MOH-provided primary care services led the CCSS to begin providing preventive care as well.[45,18] While this arrangement may have helped ensure access to care, it also further complicated the delineation of responsibilities between the MOH and CCSS and led to the duplicative provision of care in some areas. This worsened the existing supply of resources and contributed to pharmaceutical and nursing shortages in the country.[45] Shortages and overall budget decreases led to reduced quality primary health care throughout Costa Rica,[45] which led to the public perception that primary care services lacked basic resources and were a poor place to receive health care.[45] Consequently, the demand for primary care services decreased and the demand for secondary and tertiary care increased significantly; from 1985 to 1990, primary care visits decreased by 17 percent.[45] Waiting times for secondary and tertiary care became a serious problem, with many patients waiting 12-18 months for specialty care services such as cardiology, ophthalmology, dermatology, and gynecology.[46,47] The decrease of primary care utilization and increased reliance on secondary and tertiary care also led to increasing costs, putting further financial strain on the system.[47,48] Adding to this resource constraint, the population was simultaneously undergoing an epidemiological transition. Costa Ricans who once would have died at a younger age were living longer and developing noncommunicable diseases—such as hypertension, obesity, diabetes, and dementia—which further increased the populations' care needs .[49]

At the close of the 1980s, Costa Rica's primary health care system was in great peril. Patient dissatisfaction with the quality of primary care and with long waiting times for secondary and tertiary care, and the financial strain of duplication and increasing demand for services all weighed heavily on the health care system.[46] Failed experiments with

SPHC perhaps cemented Costa Rica's commitment to comprehensiveness and left the country skeptical about the utility of recommendations from international organizations. There was uncertainty around the future of primary health care and a concern that the MOH programs of the 1970s would be abandoned. While the values of comprehensiveness and overall well-being established in the 1970s did not disappear, budgetary turmoil overshadowed all other policy concerns; loud calls for privatization and the scaling back of the health care system came from within the country as well as from the international donor community. Meanwhile, many Costa Rican health professionals argued that Costa Rica, in the face of the demographic and epidemiologic transitions, could not afford to do without more comprehensive primary health care. The result was a primary health care system desperately in need of reform to improve service delivery and better meet the needs of the population, but in a fiscally sustainable and feasible manner.

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Public dissatisfaction with the Costa Rican health care system came to a head in 1991 during an outbreak of measles, when employers were forced to pay for private medical care because the public system could not handle the volume created by the epidemic.[50] With business owners threatening to withhold their mandatory CCSS contributions, the need for health system reform was clear and urgent. In addition, there were problems with sanitation and the water supply because of the personnel cuts to those state-run organizations mandated by the international financing agencies.[49] The 1980s experiment with shrinking the size of the government, specifically the health care sector, did not match many Costa Rican's expectations for service delivery.[49]

DEVELOPMENT OF A NATIONAL PRIMARY HEALTH CARE STRATEGY

In March of 1990, President Rafael Calderón Fournier of the Social Christian Unity Party established a Commission for the Reform of the Costa Rican State, not only for the health sector but for the entire Costa Rican government.[11] As part of this commission, officials from the CCSS and the MOH met together to develop a plan for health care reform.

The health care reform had two main goals: 1) to extend coverage and 2) to provide more comprehensive care to Costa Ricans.[49] A team of health care providers including Dr. Fernando Marín, Dr. Herman Weinstock, Luis B. Saenz, Dr. Xinia Carvajal, Norma Ayala, and Dr. Alvaro Salas, among others, worked together to develop the primary care model that would guide the reform.[11,49] Out of their analysis and collective experience with the Rural Health Program of the 1970s and other primary care models throughout the country, a new primary health care service delivery model emerged.

This new model, *Equipos Básicos de Atención Integral de Salud* (EBAIS), or Integrated Primary Health Care Teams, aimed to create primary health care teams that cared holistically for a specific, geographically ordered group of citizens (empaneled patients). The EBAIS concept was designed to be a multidisciplinary team model able to deliver comprehensive preventive, acute, and chronic disease management to Costa Ricans throughout the course of their lives.[12,50] The EBAIS clinics would each be run by an EBAIS team consisting of one physician, one nurse, one technical assistant (ATAP), one medical clerk (REDES), and one certified pharmacist; together they would care for a geographically empaneled population of approximately 4,000-5,000 patients. Each EBAIS clinic would have its own pharmacy run by a certified pharmacist. The composition of EBAIS teams is notable for the way it promotes integration between clinical care—provided by physicians and pharmacists—and preventive care—provided by technical assistants. Nurses would bridge the gap between prevention and clinical care by providing both disease management assistance and health education.

In addition to the basic care provision model, other administrative reforms were also proposed. To consolidate the provision of primary health care, the reformers proposed that the primary health care department be housed entirely in the CCSS, taking away the MOH's health care delivery function. Other components of the recommended reform supported increased decentralization and administrative independence, especially for hospitals.[46]

NEGOTIATIONS WITH THE WORLD BANK GROUP

Once this reform proposal was finalized, Costa Rica entered into negotiations with the World Bank Group (WBG) to finance it. At the time of the negotiations, there was a resurgence of international support for primary health care.[15] Costa Rican politicians were open to assistance from the WBG and entrusted the negotiation process to the MOH and CCSS. Unlike other reforms, the Costa Rican executive branch largely stayed out of the negotiations, allowing high-ranked health policy officials from the MOH and CCSS to drive the process with less influence from other parts of the government.[15,50] The focus of the work was on building a robust and fiscally sustainable primary health care system.

The WBG came to the negotiations with an explicit commitment to reducing costs, privatizing health care services, and establishing a purchaser-provider split.[16,50] A purchaser-provider split occurs when different organizations pay for and deliver health care, an arrangement at odds with the then-current CCSS model of paying for and delivering most of the health care in the country. Costa Rica, on the other hand, came to the negotiating table with the goal of financing their vision of the EBAIS model.

The differences in view between the WBG and the Costa Ricans made the negotiation process protracted and complex. First, the WBG proposed privatization and decentralization of the entire Costa Rican health care system. This proposal was rejected by Costa Rica, as it implied a reform of the Constitution and was not aligned to the model the country had conceptualized over the preceding two years.[18,49] The Costa Ricans in turn proposed their new EBAIS model, based on the integration of primary health care within the CCSS.[48]

When the WBG delegation read the Costa Ricans' proposal, they embraced much of it; they were in agreement with reinvigorating community health, increasing the number of home visits, and strengthening vaccination and nutrition, among other aspects.[49] The WBG also liked the consolidation of health care delivery from both the MOH and the CCSS to solely the CCSS. In addition to its efficiency, the WBG supported this because they preferred moving away from direct provision of services by governmental institutions and, while the CCSS is a public institution, it is autonomous and not under direct governmental ministry control.

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However, the WBG believed that the addition of a physician to the primary care team was not necessary and would be too expensive for Costa Rica.[49] The Costa Rican reform team insisted that doctors were key to the model; without them, it would not be possible to extend access to curative health care or to eliminate the long waiting lists to see a physician, two priorities of the reform.[49] Based on this point of contention, Costa Rica almost walked away from the negotiations. When the WBG challenged the reform team by calling the president directly, the president sided with the reform team, reiterating Costa Rica's commitment to including physicians in each care team.[49] With this show of commitment to the model from the highest political levels, the WBG agreed to the EBAIS program, on several conditions.[50] Those conditions included a purchaser-provider split within the CCSS, a moderate payment modernization scheme, and in-country WBG supervision of the reform's implementation.[45,51]

Ultimately, the WBG loaned Costa Rica USD $22 million to be repaid over 17 years.[45] In 2015 purchasing power, USD $22 million is equivalent to USD $37 million.[52] With the support of the WBG and PAHO, Costa Rica was able to raise a total of USD $123 million from various international development organizations to support its primary health care reforms.[53] The Inter-American Development Bank provided USD $42 million, and the Spanish and Swedish governments also provided loans. The IADB and the WBG coordinated their loans to create an overarching Costa Rican reform loan.[45] PAHO advised Costa Rica throughout the process and coordinated the Costa Rican contribution that would complement the loans they received.[11]

The WBG loan had three main components. First, CCSS institutional reform and development would strengthen the CCSS organization as a whole and transfer responsibility for primary health care from the MOH to the CCSS. MOH would hold responsibility as health sector steward, except for some specific programs in child nutrition and disease vector control that the MOH provides to this day.[18] Second, the reform would support the new EBAIS primary health care model, which would facilitate the integration of preventive and curative treatments for specific, geographically organized groups of citizens, or empaneled patients. Third, the reform provided funds for the Costa Ricans to initiate alternate and more sustainable payment systems. The payment modernization program included a plan to increase the number of Costa Ricans enrolled in CCSS health insurance, an improved budgeting process, reduced duplication in the provision of health care services, and improved pharmaceutical distribution processes.[45]

Though complicated, the WBG negotiations ultimately allowed Costa Rica to implement and pay for a reform which created a primary health care model tailored to the country's values of health as a human right and the importance of promoting overall well-being and comprehensive care.

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CONGRESSIONAL APPROVAL OF THE REFORM

When the Costa Rican reform team came to an agreement with the WBG on the terms of the loan, the reform was far from finalized, as all international loans must be approved by the Costa Rican congress. In the words of Alvaro Salas, a key member of the reform team, "the technical discussion was over, but the political discussion was just beginning."[49]

At that time, the Costa Rican congress had two major parties. The reform was developed under the political leadership of President Calderon and his party, the Social Christian Unity Party, and thus had their congressional support. The other major party was the *Partido Liberación Nacional* (PLN), or Party for National Liberation, which was a democratic socialist party. The support of the PLN was garnered largely by Alvaro Salas, who worked closely with PLN presidential candidate José Figueres to convince him to support the reform, even though it was developed under a different party's administration.[50] Together, and over the course of a year, Figueres and Salas were able to secure the support of the members of the PLN party.[50]

Throughout this year of discussion with Figueres and the PLN, however, there were many other internal stakeholders who had major concerns with the reform. First, the unions were worried that the CCSS would be privatized or disbanded under the reform. Once the reform team was able to reassure them that the CCSS would stay an autonomous public organization, these concerns were eventually quelled.[50]

Second, the transfer of employees from the MOH (a national ministry) to the CCSS (an autonomous institute) created a slew of labor issues. The *Asociación Nacional de Empleados Públicos* (National Association of Public Employees) was concerned because they would lose constituents, as they did not represent workers in the CCSS.[50] MOH employees demanded that the CCSS buy them out of their public positions and then rehire them to the CCSS, in line with regulations at the time that any public employee whose position was terminated had to be bought out of their position with a generous pension.[49] The reformers argued they were not truly terminating the position, simply transferring the personnel to another organization. Adding to this issue was the fact that many MOH employees did not want to become a part of the CCSS; the two institutions had different cultures. This issue erupted into protests by the MOH employees.[49] One factor that ultimately helped motivate MOH employees to move to the CCSS was that the pay scale of autonomous organizations was significantly higher (yielding an average 30 percent increase in salary)[49] than public institutions. Over time, the MOH primary health care employees agreed to transfer to the CCSS without being bought out of their public positions, but this issue took months to negotiate with the MOH's union.[49]

eOther governmental ministries also struggled to accept the reform. The Treasury Department was opposed because it did not want to commit the necessary local contribution to the international loans.[49] The Ministry of Internal Planning and the president of the

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central bank were also against the reform due to financial sustainability concerns.[49] Ultimately, the support of President Calderon convinced these stakeholders to support the project.

After almost a year of gathering political support for the reform, in 1994 congress passed the loan unanimously.[50]

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2. **Annex Conceptos y prácticas culturales de la medicina ancestral bribri y cabecar en Costa Rica by Alí García Segura and Alejandro Jaén Rojas.**

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Conceptos y prácticas culturales de la medicina ancestral bribri y cabecar en Costa Rica

Alí García Segura
Alejandro Jaén Rojas

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Introducción

Los pueblos originarios de América se enfrentaron desde el siglo XVI a una de las peores catástrofes demográficas de las que tenemos memoria en el mundo, producto de las enfermedades contagiosas que trajeron los europeos y para las cuales ellos (las personas de dichos pueblos) carecían de inmunidad. Enfermedades como la gripe, la viruela, el sarampión, la tosferina, el tifus, entre muchas otras, produjeron estragos en la población indígena (Ibarra, 1998).

Aunque es muy difícil reconstruir a detalle los fenómenos que sucedieron hace más de 400 o 500 años, las investigaciones más recientes apuntan a que entre el siglo XVI y principios del siglo XVII desapareció más del 90 % de las poblaciones de los pueblos originarios del continente americano (Koch, Brierley, Maslin y Lewis, 2019).

Semejante drama marcó profundamente a las sociedades de los pueblos originarios, en todos los planos, al extremo de que algunos pueblos como los bribri y cabecar mantienen aún prácticas curativas y de cuidado sociocultural, conocimientos médicos y una concepción de mundo que, en esencia, los previenen sobre poderosos seres invisibles: las enfermedades.

El bribri y el cabecar son dos pueblos originarios del sur de Costa Rica, emparentados sociocultural y lingüísticamente. Según el censo del 2011, los bribris se localizan en los territorios de Salitre, Cabagra, Talamanca bribri y Kekoldi. En el 2011 habitaban 16 938 personas en estos territorios, con un porcentaje no indígena del 24.5 % (Fuentes, 2011, p. 9).

Los cabécares se localizan en los territorios de Chirripó, Ujarráz, Tayni, Talamanca cabecar, Telire, Bajo Chirripó, Nairi Awari y China Kicha. En el 2011 habitaban 13 993 personas en dichos territorios con un porcentaje no indígena del 18.5 % (Fuentes, 2011, p. 9).

La pandemia de COVID-19 nos ha puesto a prueba a todos, tanto a nivel individual, como familiar y colectivo. Esta incertidumbre sobre la salud y la enfermedad nos ha revelado nuevas dimensiones, o nuevas percepciones, de nuestro trajinar diario. Son estas nuevas percepciones las que, curiosamente, acuden en nuestra ayuda para aventurarnos con una nueva visión en algunos pasajes de la historia ancestral de los pueblos bribri y cabecar que fueron interpretados como supersticiones, pero que, a la luz de esta pandemia, podrían reinterpretarse. Son, si se quiere, los eslabones de antiguos conceptos médicos, cuyo valor solo alcanzamos a dilucidar ante la presión de una emergencia sanitaria de proporciones planetarias.

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Trataremos de enfocarnos, exclusivamente, en los conceptos de la medicina bribri y cabecar del sur de Costa Rica, haciendo alusión a algunos datos históricos de Mesoamérica, que consideremos relevantes para cimentar nuestros análisis y reflexiones.

Dos visiones de la medicina

La medicina de la América precolombina tuvo muy diversos sistemas y enfoques de salud, sin embargo, a pesar de su diversidad, evolucionó y se desarrolló durante muchos siglos, sin tener contacto con otras regiones del mundo, razón por la cual, en los casos que hubo contacto, comunicación y difusión cultural, se dio dentro del continente americano. Eso significa que no solo se trata de conocimientos sui géneris, sino que en gran medida todo el cuerpo conceptual relativo a la medicina difiere del de otras regiones del mundo. Existen, como es lógico, los conceptos de medicina, enfermedad, médico y tratamiento, pero estos responden a otra visión de mundo, incluso a otro sistema lógico de abordar el conocimiento.

Aunque durante la conquista y colonización se hicieron esfuerzos por comprender los alcances y desarrollo de la tradición médica de los pueblos originarios, lo cierto es que no ha sido una tarea fácil y hay más desencuentros que situaciones afortunadas. Al no entenderse el sistema curativo de los médicos de los pueblos originarios, son corrientes los errores conceptuales. A los médicos de dichos pueblos se les llamó "brujos", "matasanos", y toda suerte de apelativos despectivos. Incluso en los casos que algún autor (Lines, 1945, p. 1) reconoce la importancia de los médicos de los pueblos originarios, encontramos alusiones despectivas o confusiones a la hora de describir los conceptos de la medicina bribri-cabecar.

Estas confusiones relativas a la medicina de los pueblos originarios se mantienen hasta la actualidad, donde con frecuencia los médicos occidentales terminan creyendo que todos los conocimientos médicos pertenecen a su cultura. Así, entonces, cuando se trata de transmitirlos y aplicar la ciencia médica solo existe una única vía que va desde las instituciones de salud hacia los pueblos originarios. En consecuencia, los pueblos originarios terminan siendo pasivos y simples depositarios de conceptos, protocolos y conocimientos que apenas entienden, y que frente a una emergencia como la de COVID-19 los deja en una gran vulnerabilidad y desventaja. No solo se encuentra la diferencia de idiomas, sino que incluso aunque se tengan traducciones literales de los protocolos médicos, enfrentamos otros problemas, que tienen que ver con concepción de mundo, el concepto de salud, enfermedad, prácticas culturales, entre otros.

Cosas tan importantes como el entender que los pueblos originarios tienen una tradición oral y que, a la hora de establecer protocolos, se debería privilegiar la oralidad más que el lenguaje escrito, son aspectos que habrá que tomar en cuenta.

Todo ello, por lo general, termina provocando conflictos de comunicación y, a veces, en franco rechazo de los conocimientos

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impuestos por los equipos de salud, que son percibidos como exógenos a las comunidades de estos pueblos, o incluso como contrarios a sus creencias y prácticas de prevención-curación.

La medicina de los pueblos originarios debe entenderse en su contexto más amplio, teniendo claro que sus conceptos médicos difieren profundamente de los conceptos occidentales, aunque en el fondo tienen los mismos propósitos: prevenir enfermedades, curar enfermos, o reflexionar sobre las prácticas médicas y posibles tratamientos. Al trabajar con los pueblos originarios, aunque parezca extraño en esta pandemia, el punto de partida en términos de salud deben ser los propios conocimientos médicos ancestrales. De tomarse en cuenta lo anterior, no solo se mejoraría la comunicación, sino que el proceso de apropiación de los conocimientos sería más profundo y podría dar lugar a la construcción de conocimientos compartidos, la reformulación de la interpretación de conceptos médicos en territorios pluriétnicos y pluriculturales. Todo ello permitiría reflexionar y reducir la enorme brecha que existe entre dos tradiciones médicas, que no solo responden a culturas diferentes, sino que se practican en distintas lenguas y donde los conceptos de medicina, enfermedad, médico y tratamiento se expresan en sistemas cuyos paradigmas se desarrollan y evolucionan en mundos completamente diferentes.

Algunas aclaraciones previas

Entre los bribris y cabécares, tanto mujeres como hombres podían ejercer la medicina. El término en lengua bribri para referirse a la o el médico es *awá*, y en plural es *awápa*. En lengua cabecar es *jawá* y en plural *jawáwá*. A la hora de referirnos a las o los médicos de los pueblos originarios, respetaremos los términos *awá* para el singular y *awápa* para el plural. Cuando se hacen referencias a la medicina de estos pueblos, generalmente todo nos remite al uso de plantas medicinales, pese a que las y los *awápa* nos dicen que las plantas, aunque muy necesarias en el proceso curativo, no son lo más importante, porque lo esencial es la historia ancestral. Nosotros, en este artículo, nos guiaremos por las palabras de las y los *awápa* y pondremos el énfasis en conceptos y conocimientos que vienen de la tradición oral, la historia ancestral, sin tocar lo relativo a plantas medicinales, que sería motivo de otro trabajo, y que previamente Alí García ha tratado en su libro *Plantas de la Medicina Bribri* (1994).

Los pueblos bribri-cabecar guardaron en su tradición oral, en sus historias ancestrales, los recuerdos de las enfermedades viajeras (*duwè shkál*), las enfermedades que vienen y van, las que pasan, es decir, las epidemias o las pandemias. Estas historias ancestrales, en general, son catalogadas como mitología o pensamiento mágico, es decir, como una leyenda fantástica, irreal o falsa.

El concepto de mitología tiene otras acepciones y ha ido variando como lo dice Leonardo Ordóñez:

> Si bien los mitos durante largo tiempo fueron vistos como relatos sobre seres imaginarios o fábulas carentes de racionalidad, desde mediados del siglo XX

> el pensamiento mítico ha sido revalorizado como una forma de conocimiento legítima y una dimensión esencial de la experiencia humana (Ordóñez Díaz, 2016, p. 5).

Sin embargo, a pesar de los cambios que se producen en el siglo XX en términos conceptuales, la acepción que prevalece es la de ver el mito asociado a un relato, generalmente desprovisto de toda realidad, razón por la cual, en este artículo hemos preferido no utilizar términos como mito o mitología sino el término suwö', que en lengua bribri significa viento o historia, pero que en otra de sus acepciones significa conocimiento, sabiduría. En el diccionario de mitología bribri se define suwö' como: "Viento, alma, historia. En su conjunto la tradición oral bribri se designa con este término" (Jara y García, 2003, p. 201). Se refiere a la historia ancestral, a los conocimientos, a la cosmogonía bribri y cabecar.

El suwö' se asocia al viento porque el viento simboliza la palabra, el relato. En muy diversos textos (Bozzoli, 1982), el suwö' se conoce como el canto, porque el suwö' es una lengua específica (diferente del bribri y el cabecar) que solo utilizan las y los awápa, los Ököm y otros maestros para sus curaciones y ceremonias. Cuando las y los awápa hacen sus curaciones se escucha como un canto suave que con frecuencia dura varias horas y se repite a lo largo de 2 o 4 noches.

También, hemos procurado referirnos al concepto de medicina de los pueblos originarios, y evitar que se confunda con supersticiones asociadas a brujos, matasanos o charlatanes, como sucede a menudo. Siguiendo las enseñanzas de Miguel León Portilla, en *La filosofía náhuatl estudiada en sus fuentes* (1966), hemos preferido hablar de la filosofía o los saberes de los pueblos originarios, y no de simples leyendas o mitos.

En el suwö', la tradición oral de los pueblos originarios bribri y cabecar de Costa Rica, hay explicaciones coherentes de su propia concepción de mundo, que no es uno solo, sino varios mundos entretejidos, entrelazados, sincrónicos. En dichos conocimientos encontramos una profunda reflexión sobre la vida y la muerte, sobre prácticas curativas o sobre los diversos mundos que se entretejen, aquí y ahora, en nuestro propio mundo y cuya existencia está intrínsecamente ligada a su concepción de medicina y enfermedad.

Metodología y recopilación de la información

En general, casi todas las informaciones sobre la medicina y la cosmogonía que dan sustento a este texto las recopilamos por medio de entrevistas de audio originales, que realizamos a los awápa (médicos) y especialistas del conocimiento bribri-cabecar con diversos cargos tradicionales, a lo largo de muchos años. Especial atención merece en este grupo el *awá* don Francisco García (1902-1996), de quien recogimos muchos de sus conocimientos e incluimos algunas de sus palabras en este artículo. Don Francisco pensaba que el suwö' debía grabarse, traducirse y luego publicarse para dar a conocer el verdadero conocimiento de los pueblos bribri y cabecar.

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Por lo tanto, es conveniente aclarar que este artículo no responde a un trabajo de investigación específico, de una tesis de licenciatura o doctoral, sino de un esfuerzo continuado a lo largo de más de 30 años, donde hemos participado diversos investigadores y personas de los pueblos bribri-cabecar para dar a conocer los conocimientos del suwö' y fortalecer la identidad cultural de dichos pueblos.

Los conocimientos guardados en el suwö', por tratarse de conocimientos de gran importancia, de manera tradicional se guardan en una lengua considerada sagrada, diferente del bribri y del cabecar. Así, de esta manera fue necesario recurrir a una doble traducción para poder conocer la información guardada en el suwö'. Diversos conocimientos, por ejemplo, se tradujeron primero del suwö' al bribri y luego del bribri al español. Fue necesario contar, no solo con los awápa que narraban las historias sino con las personas que colaboraran en las diversas traducciones.

Parte de estos materiales quedaron plasmados en muy diversas obras (artículos, libros, entrevistas, radioteatros, videos) realizados por diversos(as) investigadores(as), entre los cuales nos contamos nosotros. Una buena síntesis de lo que significa este proceso de revitalización cultural lo realizó nuestro amigo Marcos Guevara Berger (1958-2021) en una entrevista que le realizó a Alí García y salió publicada este mismo año (Guevara, 2021).

Algunas de estas publicaciones las citamos en este artículo, como son: *Plantas de la Medicina Bribri* (1994) de Alí García; *Ies Sá' Yilite. Nuestros Orígenes. Historias Bribri* (1996) de Alí García y Alejandro Jaén; *Diccionario de Mitología Bribri* (2003) de Carla Jara y Ali García; entre otros. Otra parte de la información la obtuvimos de diversos textos históricos relativos a las enfermedades contagiosas que afectaron a los indígenas desde el siglo XVI, tanto para Costa Rica (Ibarra, 1998) como para Mesoamerica (Guevara, 2020).Para este artículo reflexionamos sobre aquellos conceptos de la medicina bribri-cabecar, que fueron recogidos por otros investigadores en diversas épocas, y presentados como mitos, pero que con el telón de fondo de la pandemia del COVID-19, podrían reinterpretarse como protocolos médicos o medidas de aislamiento social, que mantienen no solo su validez, sino su vigencia sociocultural en la actualidad.

Para que conceptos como buklú, buklú bisö̀k o Wiköl, que analizaremos posteriormente, sean comprensibles a un gran público, enfatizamos en aquellos elementos de la cosmogonía que tienen una estrecha relación con la medicina, el origen de las enfermedades y la protección contra ellas.

Las diversas percepciones del mundo

En el suwö', en una de las historias bribri-cabecar, se habla de los caminos, tanto de las enfermedades, como de los caminos de los seres humanos: "nuestros caminos son los ríos de las enfermedades y nuestros ríos son los

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caminos de ellas. Ellas ven el mundo diferente del nuestro" (García y Jaén, 1996, p. 18).

Parece un simple juego de palabras, una expresión poética, pero esta cita es de una gran profundidad, ya que empieza por responder a una pregunta que nos habíamos hecho anteriormente: ¿cómo se mueven las enfermedades? Así aprendemos que las enfermedades tienen sus propios caminos, y estos difieren de los nuestros, porque lo que nosotros, los seres humanos, percibimos como un río, para ellas constituye su camino habitual.

Todo parece indicar que en el suwö', la historia oral, se registró una observación práctica de primer orden: muchas enfermedades viajan en el agua. Posiblemente, los pueblos bribri-cabecar no desarrollaron como en occidente, un concepto de agua potable, pero sí desarrollaron el concepto del lugar por donde viajan las enfermedades y lo asociaron a los ríos, al agua.

En todas las enseñanzas del suwö', queda claro que las enfermedades no solo tienen su propio mundo, sino que el nuestro lo perciben de otra manera. Es otro sistema lógico, complejo y dinámico que pretende explicar por medio de las imágenes del suwö'. Las relaciones, los cambios y los puntos donde confluyen varios mundos. Cambian las proporciones, las formas, los significados, el uso que se le da a las cosas, la fuerza, la energía, entre otros. Lo que en nuestro mundo es pequeño, en el mundo de la oscuridad puede ser grande. El ejemplo más claro es un colibrí, que en nuestro mundo lo vemos como un ser pequeño y frágil, pero que en el mundo de la oscuridad se trata de un ser muy grande y poderoso. Todo ello tiene un propósito, un significado fundamental. Pretende responder a las preguntas: ¿cómo perciben el mundo las enfermedades?, ¿cómo nos perciben a nosotros?

> Si pasa la gripe nos ve como si fuéramos peces y nuestra casa una gran poza. Pero si pasa otra enfermedad nos ve como si fuéramos aves y nuestra casa un árbol frondoso. Otra enfermedad nos puede ver como si fuéramos chanchos de monte y nuestra casa un pequeño bosque (García y Jaén, 1996, p. 16).

Cada enfermedad tiene su propia percepción del mundo. No solo nos ve diferentes a como nosotros somos, sino que, cada ser humano, cada planta, cada montaña o cada árbol lo percibe de otra manera, porque ellas tienen otra forma de mirar e interpretar su propio mundo. Por eso decimos que existen otros mundos que también están en nuestro propio mundo.

Don Francisco nos decía: "nunca hay que creer solo las cosas que ven los ojos, sino que hay que ver como lo hacen los mayores: ver las cosas que están más allá de los ojos" (García y Jaén, 1996, p. 22). Esta frase expresa con nitidez el método que siguen los awápa en sus reflexiones y saberes sobre las enfermedades. En este caso específico se refieren a no confiar en la información que se nos presenta a la vista, pero en otras ocasiones se refieren a no confiar en nuestros sentidos, incluso a no confiar en absoluto en la información de nuestro mundo, porque lo esencial sucede en el mundo de la oscuridad, donde hay seres que no vemos, seres que no

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hacen ruido, pero que en algunas ocasiones interactúan con nosotros y se manifiestan como enfermedades.

El conocimiento de nuestro propio mundo no nos permite entender cómo es una enfermedad, qué piensa, ni cómo es el mundo donde habita. Los médicos awá van aún más lejos y profundizan en los elementos de la percepción, pero no de la nuestra, sino desde la percepción y mirada de cada enfermedad como personaje, como ser viviente. Si vemos el mundo desde los ojos de esta enfermedad, tenemos que preguntarnos: ¿cómo es que ella nos percibe a nosotros?, ¿cuándo nos volvemos visibles?

Tuàlia: el señor de la gripe

En medio de la pandemia del COVID-19 han proliferado en los medios de comunicación las referencias a otras pandemias, como la de la gripe española que asoló Europa en 1918, a finales de la Primera Guerra Mundial. Entre los bribris y los cabécares a la gripe se le llama Tuàlia, y en el suwö' hay múltiples relatos relativos a dicho personaje (Bozzoli, 1982, p. 4).

Algunos de estos relatos los recogimos del suwö' hace casi 30 años de las palabras del awá don Francisco García, que cuando se refería a la enfermedad de la gripe nos decía: "[...] el rey de la gripe fue enviado por Sibö̀, allá detrás de donde nace el sol" (García y Jaén, 1996, p. 18). Esa era su forma de decirnos que la gripe era una de las enfermedades que vino del este, que fue traída por los españoles y que Tuàlia (la gripe) era un señor poderoso.

Bribris y cabécares, fieles a su tradición, también personificaron la gripe y todas las nuevas enfermedades que fueron traídas por los españoles, para mejor comprenderlas. Al personificarlas, al otorgarles características humanas, pudieron recoger informaciones sobre esos seres que no podían ver, e hicieron visibles fenómenos que de otra forma resultan invisibles. Al respecto, Bozzoli advierte que: "Las curaciones de los /awápa/ exigen que estos conozcan la historia de cada enfermedad, del origen del clan del paciente y de los auxiliares (plantas, piedras, aguas, etc.)" (Bozzoli, 1982, p. 75).

Relativo a Tuàlia (la gripe), los awápa nos dicen que: "Tuàlia, el rey de la gripe. Tiene una gran importancia ya que la gripe es una enfermedad que para los médicos indígenas es difícil de curar" (Jara y García, 2003, p. 215). En general, cuando los awápa se refieren a las enfermedades que fueron traídas por los españoles y otros europeos, nos dicen que son enfermedades a las que no se les conoce su origen, y por lo tanto cuesta curarlas.

Cuando don Francisco se refería a Tuàlia, al señor de la gripe, se refería no solo a las gripes estacionarias que llegan todos los años, sino también y sobre todo a aquellas gripes que llegaron y por poco exterminan a muchos de los clanes, tanto de los bribri como de los cabécares (Bozzoli, 1982, p. 4).

En general, los relatos del suwö' no determinan los años exactos en los cuales Tuàlia, el señor de la gripe causó estragos en la población bribri-

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cabecar, porque las normas y códigos para guardar la información en el suwõ' son extrañas y complejas. No sabemos si se refería a la gripe española de 1920, o a situaciones anteriores, incluso a las ocurridas durante el siglo XVI y XVII. No sería de extrañar que don Francisco García y otros awápa guardaran memoria de la gripe española que llegó a Costa Rica hacia febrero de 1920, razón por la cual decidimos profundizar en ese momento histórico.

Según la información que registró el *Anuario Estadístico de 1920*, la población total de Costa Rica era de 468 373 habitantes al 31 de diciembre de 1919 (Lizano, 1922, p. 16). Con base en dichos datos estadísticos, en 1919, en Costa Rica murieron por la influenza (gripe) 170 personas, mientras que en 1920 murieron 2 298 personas por la misma causa (Lizano, 1922, p. 19). Eso significa que de 1919 a 1920 se multiplicaron por 13 los casos de mortalidad por influenza.

En 1920, Costa Rica era aún un enorme bosque, con malas comunicaciones y pésimos caminos. Sin desmeritar el trabajo realizado en la recolección de la información del *Anuario Estadístico de 1920*, nos es difícil pensar que se pudieran recoger datos confiables en zonas donde habitaban los pueblos originarios, no solo por lo agreste de la geografía sino, además y, sobre todo, por las barreras socioculturales y lingüísticas. De hecho, cuando vemos la información de mortalidad por provincias parece confirmarse nuestra hipótesis.

Según el documento citado en la provincia de Limón –donde se encuentra la mayor parte de la población de los pueblos originarios–, para 1919 reporta 10 muertos por influenza, mientras que para 1920 se reportan solo 8 muertos (Lizano, 1922, p. 19). Da la impresión de que la gripe española no tocó la provincia de Limón, cosa en extremo improbable, máxime que en dicha provincia se encuentra el puerto de Limón, que en 1920 garantizaba la exportación del café a Europa, principal producto de exportación de Costa Rica en su momento.

En tal sentido, la información guardada en el suwõ' cobra una mayor relevancia, porque nos permite llenar un vacío en la historia de los pueblos originarios y acercarnos al instante en que vivieron una situación tan crítica como una pandemia. Los pueblos bribri-cabecar guardaron en el suwõ', en la memoria oral, aquellos momentos de extrema dificultad, donde una *duwè sbkál*, una enfermedad viajera, afectó enormemente la vida de los pueblos indígenas. No se especifican las fechas exactas, ni las cantidades de muertos, pero lo expresan con enorme claridad cuando dicen: Tã̀ ĩ duwè tö se' ẽ' õ̀wã, que significa: "Las enfermedades casi nos exterminan" [1].

Tuàlia, el señor de la gripe, había hecho estragos en la Talamanca indígena de Costa Rica, pero no era el único señor poderoso del que se habla en el suwõ'. En el mundo de la oscuridad aun transitan muchos seres, de diversa naturaleza.

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Las *duwè shkál* (enfermedades viajeras) antiguas

Todo parecía indicar que en el suwō' se guardaron relatos de una gran antigüedad, que son los que le dan sustento al conocimiento médico más profundo y la cosmogonía bribri-cabecar. Eso significaba que había que continuar la búsqueda, adentrándose en los secretos del suwō' y las crónicas coloniales.

Algunas enigmáticas frases de las y los *awápa* parecían referirse a las *duwè shkál* (enfermedades viajeras) más antiguas, expresadas desde su conocimiento y comprensión, desde su perspectiva. Con frecuencia, en sus relatos dicen: "muchas de las enfermedades vienen del Este" [2] . Así aprendemos que las enfermedades vienen con el nacimiento del sol y se van por el Oeste con la puesta del sol. Las y los awápa parecían referirse siempre a las enfermedades que fueron traídas por los españoles, tal como se documentó en diversas crónicas coloniales (Ibarra, 1998).

Las y los *awápa*, en general, y don Francisco, en particular, decían que curar a los descendientes de los europeos era algo sencillo, que era más difícil curar a las personas de los pueblos originarios. Parecía una contradicción con la frase anterior, con la que decía que las enfermedades de los pueblos originarios eran fáciles de curar y que, por el contrario, las enfermedades que vinieron del este eran difíciles. Así fue como descubrimos que don Francisco hacía la diferencia entre el proceso curativo y la enfermedad en sí. También, hacía referencias sobre la forma en que una enfermedad "de las traídas por los españoles", las *duwè shkál* (enfermedades viajeras), afectaba a las personas de los pueblos originarios, o a las personas descendientes de españoles o europeos, porque los efectos y las consecuencias no eran las mismas. Eso que don Francisco y las y los *awápa* narraban con tanta claridad en los bosques de Talamanca es, precisamente, la información que recogieron las crónicas coloniales a todo lo largo y ancho de América.

> Acorde a Fray Bartolomé de las Casas, en diciembre de 1518 o enero de 1519 apareció entre los indios de la isla de Santo Domingo, una enfermedad que fue identificada como viruela. Pocos españoles fueron afectados, siendo los indios quienes más padecieron. Según informaron los españoles, exterminó entre un tercio y la mitad de la población indígena (Guevara, 2020, p. 3).

Lo que Fray Bartolomé de las Casas narra en detalle para el año de 1518, se repetirá una y otra vez a lo largo de toda América, como veremos luego.

Para nosotros, tenía un valor suplementario el descubrir que en el suwō', la memoria oral, las y los awápa habían guardado informaciones que coincidían con las recogidas en las crónicas más antiguas, como las crónicas que narraban el desarrollo de enfermedades contagiosas que diezmaron cientos o miles de pueblos en toda la américa indígena, entre el siglo XVI y XVII (Koch et al., 2019).

Una idea aparecía de manera reiterada tanto en las crónicas coloniales como en el suwō': frente a ciertas enfermedades contagiosas, la población de españoles, aunque se enfermaban, no terminaba en situaciones críticas

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y morían en la misma proporción que la población de los pueblos originarios. Suárez de Peralta escribió en 1589:

> Le sucedió a los indios una gran pestilencia, que fueron viruelas, que ninguno escapaba a quien daba". Acorde a Fray Bernardino de Sahagún, la epidemia inició en el mes de Tepeilhuitl (10 de septiembre de 1520), haciendo que las personas se cubrieran de pústulas o ronchas por todas partes (Guevara, 2020, p. 2).

Luego la viruela se difundió por toda la región afectando incluso la capital del Imperio azteca. La caída de Tenochtitlan se dio precisamente mientras la viruela hacía estragos en la población indígena de México (Guevara, 2020, p. 2). Los relatos de grandes epidemias continúan durante todo el siglo XVI y XVII, ya no solo en México sino en todo el continente.

Aunque hay mucha controversia en las cifras sobre la población de los pueblos originarios de América en el siglo XVI y XVII, en lo que sí no hay ninguna controversia es en la afirmación de que la mortalidad de dichos pueblos fue enorme, en la mayoría de los casos superior al 80 % o 90 % de la población y, en muchos casos, con el exterminio total de muchos pueblos. Una reciente investigación (Koch et al., 2019) afirma que la población de los pueblos originarios, se redujo en menos de 100 años, entre los siglos XVI y XVII, de unos 60.5 millones a solo 4.5 o 6 millones. En dicho artículo, los autores (Koch et al., 2019) plantean la hipótesis de que la muerte de, aproximadamente, unos 56 millones de personas de los pueblos originarios, a lo largo del siglo XVI, transformó el clima terrestre, por la disminución del CO2 atmosférico. Cuando millones de hectáreas de cultivo en toda la América de los pueblos originarios, quedaron abandonadas por la "la gran muerte", se transformaron en zonas boscosas. Aparentemente, dichos cambios contribuyeron, entre otros factores, al desarrollo de la pequeña edad de hielo en Europa, que se desarrolló de mediados del siglo XVII a principios del siglo XVIII, aproximadamente de 1645 a 1715 (Koch et al., 2019).

No es para nada usual que se concluya que una catástrofe demográfica sucedida hace 500 años haya podido influir en un cambio climático a escala planetaria. Es una idea que nos permite comprender el impacto y las enormes dimensiones que tuvo la conquista y la colonización de la América de los pueblos originarios.

Ese mismo impacto que hoy podemos estudiar y reconstruir sobre el clima terrestre de los siglos XVI y XVII, tenemos que imaginarlo también, en términos psicológicos, económicos, políticos y culturales, en la población de los pueblos originarios sobreviviente. Las huellas de esos acontecimientos, estos trazos, tienen que haber quedado en la concepción de mundo en general y, de manera muy específica, en sus concepciones de salud, enfermedad y las prácticas curativas.

La Costa Rica del siglo XVI y XVII no es la excepción y, los pueblos originarios, fueron profundamente afectados, como lo expresa Eugenia Ibarra:

> En la actualidad, especialistas en el campo de la historia demográfica reconocen que no se puede saber con certeza a cuanto ascendía la población de Costa Rica en

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> el siglo XVI, pero consideran aceptable la cifra de 400,000 habitantes, calculada por medio de técnicas y métodos especializados.
>
> La cifra que ofrecen esos estudios, para 1569 es de 120,000 habitantes, y para el año de 1611, o sea a principios del siglo XVII, calcula que era solamente de 10,000 indios (Ibarra, 2002, p. 45).

Según dichos datos, en menos de un siglo desapareció del territorio costarricense el 97,5 % de las poblaciones de los pueblos originarios. Este despoblamiento se dio incluso antes de que se desarrollara la conquista de Costa Rica que se inicia de manera tardía en 1561 (Ibarra, 1998).

Todo ello significa que Costa Rica quedó prácticamente despoblada antes de que se pudieran escribir las primeras crónicas coloniales. Esta ausencia de documentación escrita convierte a la tradición oral, la información guardada en el suwö', en la única fuente de información a la cual podemos tener acceso sobre dicho periodo.

Ese despoblamiento tan brutal de Costa Rica, y en general de la América de los pueblos originarios, tuvo que haber provocado, en la población sobreviviente, enormes cambios en todos los planos: económicos, culturales, psicológicos, entre muchos otros. Estrictamente en términos del abordaje de los temas de salud-enfermedad, esos cambios tuvieron que reflejarse de múltiples maneras. Ante semejante tragedia es muy probable que muchas prácticas curativas abandonaran el ámbito del protocolo cotidiano, en medio de la pandemia, para insertarse profundamente como prácticas culturales permanentes. Si esta hipótesis es acertada, no trataremos de seguir un rastro improbable de un antiguo protocolo de salud, que se pierde en el tiempo, sino que podemos indagar, aquí y ahora, estudiando el suwö', la forma en que persisten antiguas prácticas para prevenir y tratar las *duwè shkál* (enfermedades viajeras o de temporada). Es, si se quiere, un viaje a través del suwö', el eterno retorno, un conocimiento antiguo que regresa para llenar de sentido y de saber el tiempo actual.

Por experiencia, sabemos que la tradición oral, el suwö', permite realizar las proezas de guardar conocimientos durante siglos, pero nuestro propósito no es aventurarnos en la especulación, sino comprender los alcances de esos antiguos conceptos y prácticas, en los sistemas de salud y la enfermedad, que elaboraron estos pueblos originarios. Conceptos como el buklú, el buklúbitsö̀k y Wiköl, entre otros, pueden ayudarnos a comprender algunas de las reflexiones de los pueblos bribri-cabecar relativos a las enfermedades. La pandemia del COVID-19 es ideal para iniciar con el análisis del concepto de *buklú*. Dicho término fue traducido como el mal agüero, es decir, un conjunto de prácticas de carácter supersticioso, pero, por los vientos que corren, este es un buen momento para profundizar en el mismo.

Buklú o bukulú

El concepto de *buklú* tiene diversas acepciones, y en una de ellas es definido como: "Diablo poderoso, guardián de ciertos animales. Espíritu maligno" (Jara y García, 2003, p. 34). Visto así, da la impresión de tratarse

de una simple superstición, por ello, con gran frecuencia es asociado con el mal agüero. Sin embargo, al profundizar en dicho concepto descubrimos varios puntos importantes. Primero, sabemos que se trata de un ser poderoso, guardián de ciertos animales, es decir, asociado a las enfermedades que pueden provocarnos determinados animales. Es posible que lo que occidente llamó zoonosis, los pueblos bribri- y cabecar le llamaran *ïyiwak dàli* (enfermedades de origen animal o producidas por algún animal) [3] . Luego, tenemos diversas características de dicho personaje:

> Mal que se produce por el contacto con alguna cosa que por desuso ha adquirido el espíritu de alguna enfermedad. Se ve como una suciedad contaminante de objetos que después de haber sido tocadas por manos humanas permanece sin uso por algún tiempo. Se ve como la expresión máxima de la impureza (Jara y García, 2003, p. 34).

Ahora sabemos que el *buklú* o *bukulú* no solo es un espíritu poderoso, guardián de ciertos animales, sino que tiene la extraña cualidad de impregnar las cosas, de quedarse adherido a las cosas que quedaron en desuso por cierto tiempo, después de haber sido tocadas por manos humanas. En este caso, bribris y cabécares utilizan no solo el concepto de *buklú* sino también el concepto de *ïyi dàli*, es decir, especifican con gran claridad las enfermedades que producen, ya no los animales, sino las que producen ciertas cosas [4] . "Los objetos adquieren esta condición cuando han sido tocados por un ser humano y pasan cinco días sin volver a ser tocados. Después de veinte días el objeto pierde el poder de producir la enfermedad" (Jara y García, 2003, p. 34). Según esta definición, las cosas pueden adquirir el espíritu de una enfermedad, pero no todas las cosas, sino aquellas que tienen cuatro características muy claras:

1. fueron tocadas por manos humanas.
2. Son cosas que permanecieron varios días en desuso.
3. El *buklú* no se queda adherido a las cosas de manera permanente.
4. Según el conocimiento bribri, el *buklú* desaparece aproximadamente después de los 15 o 20 días.

Buklú bitsö̈k. Resguardarse ante las enfermedades

El concepto del buklú bitsö̈kse explica, textualmente en lengua bribri de esta manera: "que los seres del más allá de la tierra no te vean". Es decir, que las enfermedades no te encuentren, no te descubran, porque tus acciones, bien llevadas, te pueden ocultar, te pueden volver invisible a las enfermedades. Son diversas medidas de aislamiento social, expresadas como una práctica cultural de protección. Las palabras buklú bitsö̈k son complejas porque no se aplican para la atención de todas las enfermedades, sino que es solo para aquellas en las cuales las y los *awápa* recomiendan el aislamiento o la cuarentena del enfermo. El aislamiento se expresa en dos niveles, tanto de las personas que vienen de afuera (familiares, vecinos,

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amigos), como al interior de la misma familia. La familia de la persona enferma coloca un obstáculo en el camino de entrada a la casa, para indicar que no se debe pasar. Se ponen dos horquetas y un travesaño y cuelgan hojas de banano, como si hubieran tendido ropa, a lo ancho del camino. Así, vecinos(as), familiares y amigos(as), saben que a esa casa no se debe entrar, porque hay una persona enferma y muy grave, que debe estar aislada.

Al interior de la familia también hay normas de distanciamiento y de aislamiento social muy concretas. Solo una o dos personas de la familia pueden atender al enfermo, quien tiene su propio guacal, su vaso o su cuchara, entre otros. Cuando el enfermo tiene que ir al baño se colocan hojas de banano en el suelo, de manera que la planta del pie del enfermo no toque el suelo, que pisarán las otras personas de la familia. La justificación para esta práctica es que la energía del enfermo puede impregnarse en las cosas que toca y, de paso, puede enfermar a otras personas de la casa. En las comunidades indígenas, los baños se construyen a 30 o 40 metros de cada casa, por lo que la tarea de cubrir el piso con hojas de banano no era fácil, y además resulta sorprendente en términos de su reflexión sobre las formas de contagiarse. Debe entenderse que en este caso, la energía de la persona enferma pasa inmediatamente a los objetos que toca.

Ë ́iyâûk significa en lengua bribri, textualmente, "embarrarse", pero es la expresión que se utiliza para decir que alguien se contagió con alguna cosa. En el lenguaje popular de estos pueblos se dice: "es como si algo que no vemos quedó embarrado en las cosas". El buklú bisö̀k se establece como una práctica cultural de comportamiento, pero también como una norma ética. Hay que respetar la casa del paciente para no enfermarlo más, si es que uno porta *buklú*, algo que provoca enfermedad, o para no enfermar a otras personas de la comunidad. Si alguien no respeta la práctica del buklú bisö̀k y entra a la casa del enfermo sin permiso, la familia del paciente se ofende profundamente. Se interpreta como un acto de agresión contra el paciente y su familia.

El bisö̀k comprende incluso un sistema de prácticas culturales a las que se les llamó dietas, pero que van más allá de abstenerse de comer ciertos alimentos, y debe entenderse en un sentido mucho más amplio: el bisö̀k puede comprender el dejar de comer algunos alimentos (ayuno), dejar de comer la carne de determinados animales (dieta), prohibir la visita de personas a la casa (aislamiento), dejar de viajar (ruptura de la movilidad y aislamiento social), no ir a fiestas ni a bailes (aislamiento social), solo comer plátanos asados (dieta), no comer grasa, chile, carnes rojas, no comer sal (dieta), no comer algunas aves, palmas, pejibayes (dieta), no recibir sol durante varios días o semanas (aislamiento diurno), no tener relaciones sexuales durante cierto tiempo (aislamiento conyugal), no cocinar o tocar alimentos (prevención contra el *buklú*), entre otros. Es claro que detrás de la palabra "dieta" existe un sistema que comprende la abstinencia de un conjunto de acciones, prácticas o comidas, que habrá que estudiar con mayor detalle de acuerdo con los tipos de enfermedad. El no recibir sol durante una o dos semanas podría interpretarse como una norma de distanciamiento social diurno, pero podría tratarse de una

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observación relativa a la inconveniencia de asolearse cuando se tienen ciertas enfermedades, como en el caso de alergias, u otros.

Estas normas de comportamientos, que posiblemente se desarrollaron durante las grandes epidemias, y en la actualidad reconoceríamos como protocolos sanitarios, se quedaron como prácticas culturales permanentes, y se incorporan, en el imaginario social, a la reflexión práctica (concepción de mundo) como conocimiento de los orígenes y características de los distintos tipos de enfermedades y prácticas preventivas y curativas. Hay otras prácticas que, sin haberse desarrollado conceptualmente de la misma manera que el *buklú*, son importantes ya que favorecen el distanciamiento social. Por ejemplo, los habitantes de los pueblos bribri y cabécares no se dan la mano para saludarse, no se saludan de beso en la mejilla, e incluso, entre las parejas de enamorados, no se besan en la boca. Para las personas que vienen de afuera, estas prácticas son vistas como relaciones más frías o poco románticas, pero su objetivo principal parece ser el evitar la transmisión de algunos males entre las personas.

Origen de las enfermedades

Conceptualmente, en la medicina bribri-cabecar, toda enfermedad es un ser que vive en el más allá de la tierra, en un mundo que no podemos ver, es decir, viven en el mundo de la oscuridad, en el mundo del origen. El mundo de la luz, el mundo en que habitamos, el mundo que fue creado para la semilla (los seres humanos), es un mundo falso, engañoso, solo un reflejo de la verdadera realidad, que se encuentra precisamente en el mundo de la oscuridad, el mundo donde habitan todas las enfermedades. Las enfermedades son los seres originales, seres que en su mundo tienen un enorme poder y en ciertas ocasiones se manifiestan en nuestro mundo.

En las historias ancestrales se narran las batallas entre los seres del tiempo de la oscuridad y, con frecuencia, las y los *awápa* dicen que quien gana la batalla es una planta curativa, porque las plantas curativas son consideradas como las y los *awápa* en el más allá de la tierra. Por eso, en el conocimiento y los saberes bribri-cabecar, los seres humanos no somos superiores, sino que estamos al mismo nivel que plantas y animales. Los animales, incluso, podrían aparecer como seres superiores a nosotros, en el sentido de que ellos pueden transmitirnos diversas enfermedades. Los animales están en este mundo, pero sus verdaderos dueños, los seres que representan, las enfermedades, están en el otro mundo, en el mundo de la oscuridad. Las plantas y animales que están en esta tierra son solo representaciones de los verdaderos seres que habitan en la otra dimensión, incluso con mayor poder, con mayor sabiduría, con mayor inteligencia que nosotros los seres humanos. Estos seres (plantas y animales) son más "educados" que nosotros, porque saben cómo actuar en este mundo y tienen más protección ante las enfermedades.

La pandemia actual es producto de un ser que no vemos y que, literalmente, ha puesto al planeta entero en estado de emergencia. Posiblemente, en las historias ancestrales, cuando se habla del poder de las enfermedades, se referían a situaciones como la actual, a situaciones como

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las que los pueblos originarios vivieron en el siglo XVI y XVII, cuando perdieron más del 90 % de sus poblaciones (Koch et al., 2019).

Hasta ahora nos hemos referido a las prácticas culturales de comportamiento social, para actuar y protegerse en caso de enfermedades contagiosas, pero no hemos dicho nada con respecto a cada persona en sí, a su sistema de protección individual. En la tradición médica bribri y cabecar. también existe un conjunto de prácticas culturales de comportamiento individual, cuyo propósito es el de prevenir las enfermedades, el de mantener a la persona con salud. Naturalmente, todo ello se expresa en su espacio paradigmático, entre el mundo de la luz y el mundo de la oscuridad, entre aquello que vemos y no nos sirve porque es irreal y aquello que no vemos, lo que está oculto a nuestros ojos y que es donde se encuentra la verdadera realidad. Y cuando se trata de prevenir enfermedades, cuando se trata de avisarnos de los acontecimientos futuros, entra en escena *Wiköl*, nuestra alma exterior al cuerpo, nuestro escudo protector.

Wiköl, el alma exterior al cuerpo (nuestro escudo protector)

En términos conceptuales, *Wiköl* es un ser complejo, porque no hay duda de que es un ser humano, pero no cualquier ser humano, sino que somos nosotros mismos en el otro mundo, en la otra dimensión, en el mundo de la oscuridad. A *Wiköl* lo representan como una especie de halo que rodea todo nuestro cuerpo (en la otra dimensión) y por ello se le llama el escudo protector, o el alma exterior al cuerpo. Su misión es la de protegernos y, para ello, nos hace invisibles a las enfermedades. Las enfermedades pueden estar justo al lado nuestro, pero no pueden vernos porque *Wiköl* envuelve todo nuestro cuerpo con su halo y nos oculta de todo ser dañino (García y Jaén, 1996, p. 4).

Guardando las distancias culturales y a sabiendas de que se trata de otro paradigma en términos de concepción de mundo y términos de salud, da la impresión de que *Wiköl* se parece a lo que la medicina occidental llama "nuestro sistema inmunológico". Fieles a su tradición, a su forma de ver el mundo, los pueblos bribri y cabecar no colocan las defensas al interior de nuestro propio cuerpo, sino fuera de él, justo como un halo que nos rodea pero en otra dimensión, en el mundo de la oscuridad. Solo cuando nuestro escudo protector se rompe nos volvemos visibles, no a una, sino a todas las enfermedades, y es allí donde *Wiköl* nos envía sus mensajes, por medio de los sueños, para prevenirnos del peligro que se aproxima.

Los sueños son, literalmente, el lenguaje que utiliza *Wiköl* para comunicarse con nosotros en su propia lengua, en la lengua de los orígenes del tiempo. Por eso, los sueños son tan complejos de interpretar, porque se expresan en la lengua que hablan los seres del más allá de la tierra, los seres del mundo de la oscuridad: las enfermedades. El mundo de los sueños tiene una enorme complejidad que requiere de un estudio aparte, y en este artículo solo lo tocamos tangencialmente para referirnos a *Wiköl* como personaje, como nuestro propio ser en el más allá de la tierra.

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A *Wiköl*, a nuestro escudo protector, le suceden todas las cosas antes de que nos sucedan a nosotros mismos. Si una persona se encuentra enferma es porque, con anterioridad, su escudo fue atacado por una enfermedad en la otra dimensión, en el más allá de la tierra. Así aprendemos que los diversos mundos se encuentran entrelazados, como los hilos en el tejido de una hamaca, pero que las acciones suceden primero en el mundo que no vemos, en el mundo de la oscuridad.

Hay muchas causas por las cuales nuestro escudo protector puede sufrir una fisura o se puede romper y, allí es donde intervienen las prácticas culturales de comportamiento individual. Se contemplan animales que no se deben comer porque el contacto con el animal, su carne, su piel, podría enfermarnos. Las prácticas culturales son tan específicas y complejas que podrían indicarnos que este clan no puede comer la carne de danta, pero aquel otro clan sí puede comerla. Con gran frecuencia estas prácticas fueron presentadas o estudiadas (en occidente) como un sistema de tabús. Sin embargo, para ellos, hay una clasificación estricta de las enfermedades que pueden producir los diversos animales, o en ocasiones, las diversas cosas.

Nuestros pueblos originarios habitaron bosques y selvas durante milenios, ocupando los mismos territorios, y no es de extrañar que tuvieran un conocimiento muy concreto sobre las enfermedades que pueden producir tales o cuales animales. Lo que en occidente se reconoce como zoonosis y se estudia en las facultades de medicina o veterinaria, en el mundo bribri-cabecar pertenece a los conocimientos que se aprenden desde la infancia.

Cuando algo sucede en el mundo de la oscuridad, *Wiköl* nos avisa en su lenguaje, que es diferente del nuestro y es un lenguaje de imágenes, el lenguaje de los sueños. Casi todos los sueños vienen del escudo protector, de *Wiköl*. Así, en los sueños, *Wiköl* nos avisa sobre lo que acontecerá en nuestro futuro, en términos de salud y enfermedad. Por medio de los sueños es como recibimos los mensajes del más allá de la tierra. En un complejísimo proceso intervienen no solo *Wiköl*, el alma exterior al cuerpo, sino que intervienen tres almas más: el alma del hígado, el alma de los ojos y el alma de los huesos. Juntos, todos estos seres, conforman el ser que yo soy en los diversos mundos que habito de manera simultánea. Es así para cada ser humano porque, en los saberes bribris-cabécares, todos tenemos cuatro almas y habitamos de manera simultánea en varios mundos a la vez.

El mundo de los sueños, en el conocimiento, en la sabiduría y en los sistemas de salud de estos pueblos, son de gran complejidad, porque cada animal, cada imagen que aparece en un sueño está asociado con alguna enfermedad concreta en este mundo. El concepto de sueño difiere incluso de nuestro propio concepto de sueño, porque paradójicamente, en el suwö', no todo lo que soñamos puede concebirse como un sueño real. Para estos pueblos, que aparentemente han vivido varios miles de años en los mismos bosques, su contacto con los animales y las plantas de estas selvas no solo ha moldeado su forma de vida, en términos de sobrevivencia, sino también el conjunto de sus saberes.

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Conclusión

Esta pandemia, entre todos los cambios que ha provocado, permite evidenciar y sacar a flote prácticas culturales y saberes de los pueblos bribri-cabecar, que tienen una enorme validez, no solo en términos prácticos, sino porque permiten, desde otro paradigma, desde otra forma de ver el mundo, comprender hasta dónde avanzaron en sus saberes en el ámbito de la salud. Es un hecho que estos pueblos enfrentaron grandes pandemias para las cuales no tenían inmunidad y desarrollaron una serie de conocimientos y prácticas para poder enfrentarlas. Estos saberes constituyen las primeras páginas de la historia de la medicina costarricense, expresada en otros idiomas, en otra concepción de mundo, en otros paradigmas, pero cuyo propósito era el mismo que la medicina actual: prevenir enfermedades y curar enfermos, tanto en el plano individual como en el colectivo.

El análisis de algunos conceptos como el buklú, el buklú bitsö̀k y Wikö̀l, nos permite aproximarnos a esos mundos que no vemos, a esos mundos oscuros donde habitan las enfermedades y comprender una pequeña parte de las prácticas culturales que le permitieron a estos pueblos sobrevivir a una de las peores catástrofes demográficas de las que tenemos memoria: las pandemias y epidemias de los siglos XVI y XVII.

Para finalizar, pensamos que los conocimientos y saberes acumulados durante siglos pueden servirnos, a quienes trabajamos con pueblos originarios, para crear o formular acciones alternativas y novedosas de salud pública, en los territorios de los pueblos bribri-cabecar, con el fin de enfrentar esta pandemia, con un enfoque intercultural y con mayor respeto para las tradiciones culturales de estos pueblos originarios.

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