Weaving life: Vivencias Paving the Way for The *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercultural Indigenous Health System] in Colombia's Departamento of Vaupés

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Abstract

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Colonization adversely affected the health of the Indigenous Peoples in Colombia. The European colonizers stripped these communities of their lands and sought to eliminate them both physically and in identity. Such oppressive colonial frameworks continue to exist, jeopardizing the Indigenous philosophy of "Buen Vivir" [Good Living], a cornerstone for Indigenous health. Nevertheless, Indigenous Peoples in Colombia have ardently advocated for community-based health practices in the face of colonial adversities. Consequently, the creation of the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercultural Indigenous Health System] symbolized the Indigenous resistance and resilience to safeguard and apply their ancestral health wisdom.

Given the stark disparities in Indigenous health in Colombia, understanding the SISPI process and the relationships among the different actors that are part of it is crucial. Therefore, this research is a collaborative effort to answer the research questions: How can the SISPI support

local communities to build or strengthen their health models? Can bridges be constructed between Indigenous and "Western" medicine to provide more comprehensive and culturally appropriate healthcare access to Indigenous communities? And if such a bridge is possible, how could these bridges be built through the SISPI? This research explores the feasibility of establishing connections between various medical systems, focusing on Indigenous health, to integrate Indigenous principles while fostering collaboration and dialogue to inform the ongoing SISPI implementation process further. Specifically, the intention is to provide embodied experiences accompanying the SISPI to inform strategies for improving health services for the Indigenous population in the Departamento of Vaupés.

Employing Participatory Action Research principles and Indigenous methodologies through vivencias (embodiment of life experiences) and oral tradition, I emphasize the need to incorporate Indigenous knowledge into mainstream health initiatives. Grounded in vivencias of the actors involved in the SISPI process, the narrative advocates for a comprehensive, intercultural approach to Indigenous health. I utilize a sentipensante [feel-thinker] analysis through Chris Andersen's concept of "*density*," delving into the intricacies of human vivencias, challenging stereotypical categorizations created by the dominant paradigm about Indigenous Peoples. The research concludes by laying out the different ways *density* manifests across these vivencias and providing my recommendations, as requested by the elders who contributed to the study.

In the loving memory of Grandpa José Crispin Pineda, Grandma Dilma Villamil, and Ñeco.

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This dissertation would not have been possible without the constant support, collaboration, and accompaniment of the Colombian NGO Sinergias. The tireless and important work that Sinergias does for Indigenous Health in Colombia is admirable. I feel very fortunate to have shared with people with great knowledge and commitment to social and health justice. From my first visit, the

Sinergias team made me feel welcome. What I learned alongside all of you is priceless. In particular, I want to thank Pablo Montoya, who, besides being an academic mentor, was my main reference in the contexts I navigated and the facilitator of important relationships that developed during this project.

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To my love, best friend, partner, and conscious voice, Andrea, you are my rock, and I cannot imagine how I would have gone through this work without you. Thank you, my love. I am deeply thankful for my kids; they taught me that taking breaks and enjoying life with them is okay. I cannot be more grateful for that. To my mom (Gloria), thank you for always being there for me and reminding me that every experience in life has a teaching. I am also grateful for the unconditional love and support of the rest of my family: Cesar, Chuck, Rose, Vanessa, Ben, Nick, Allison, Stephen, Angelica, Gloria, Mami Raquel, Tia Mery, Tia Hilda, Tio Nelson, my nephew Nicolas and my father (Hugo).

Abbreviations and Acronyms

AATI	Asociación de Autoridades Tradicionales Indígenas [Association of Indigenous Traditional Authorities]
AATIAM	Asociación de Autoridades Tradicionales Indígenas [Association of Traditional Indigenous Authorities]
APIS	Atención Primaria Integral de Salud [Comprehensive Primary Health Care]
CAOI	Coordinadora Andina de Organizaciones Indígenas [Andean Coordinator of Indigenous Organizations]
CBPR	Community-Based Participatory Research
COVID-19	COronaVIrus Disease of 2019
CRIC	Consejo Regional Indígena del Cauca [Cauca Regional Indigenous Council]
DANE	Departamento Administrativo Nacional de Estadística [National Administrative Department of Statistics]
EAPB	Empresas Administradoras de Planes de Beneficios [Companies Managing Benefit Plans]
ELN	Ejército de Liberación Nacional [National Liberation Army]
ENS	Escuela Normal Superior [Superior Normal School]
EPSs	Entidades Promotoras de Salud [Health Promoting Entities]
ETIs	Entidades Territoriales Indígenas [Indigenous Territorial Entities]
FARC	Fuerzas Armadas Revolucionarias de Colombia [Revolutionary Armed Forces of Colombia]
HAI	Health Alliance International
ICU	Intensive Care Units
IEN	Instituto Nacional Etnológico [National Ethnological Institute]
IIRB	Indigenous Institutional Review Board
ILO	International Labor Organization
IPSs	Instituciones de Prestación de Servicios [Health Providers Institutions]
M-19	Movimiento 19 de Abril [April 19 Movement]
MAITE	Modelo de Acción Integral Territorial [Comprehensive Territorial Action Model]

MIAS	Modelo Integral de Atención en Salud [Comprehensive Health Care Model]
NGO	Non-Governmental Organization
ONIC	Organización Nacional Indígena de Colombia [National Indigenous Organization of Colombia]
OPIAC	Organización de los Pueblos Indígenas de la Amazonía Colombiana [Organization of Indigenous Peoples of the Colombian Amazon]
PAR	Participatory Action Research
PCVC-PI	Plan del Cuidado para la Vida Colectiva de los Pueblos Indígenas [Care Plan for the Collective Life of Indigenous Peoples]
PHC	Primary Health Care
PIC	Plan de Intervenciones Colectivas [Collective Interventions Plan]
POS	Plan Obligatorio de Salud [Mandatory Health Plan]
PTS	Plan Territorial de Salud [Territorial Health Plan]
RIAS	Rutas Integrales de Atención en Salud [Comprehensive Health Care Routes]
ROM	Roma/Romani communities
SGSSS	Sistema General de Seguridad Social en Salud [General System of Social Security in Health]
SISPI	Sistema Indígena de Salud Propia e Intercultural [Self-determined and Intercutural Indigenous Health System]
SNS	Sistema Nacional de Salud [The National Health System]
SSI-MPC	Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations]
SSSV	Servicio Seccional de Salud de Vaupés [Regional Health Service of Vaupés]
UPAS	Unidades Primarias de Atención en Salud [Primary Health Care Units]
UW	University of Washington

Notes on Terminology and Style

Translation

The reviewed official documents and conversations in this dissertation were in Spanish. As a native Spanish speaker, and as a part of my commitment with the Indigenous leadership in Colombia, I wrote the initial document in Spanish and then translated to English. I performed all the translations the best I could. My focus was translating meaning.

Also, I maintain some labels in the Spanish language as there are similar translations but did not convey the full connotation. For example, the word "*Departamento*" could be like Province, but it would not be the same. For these types of labels, I provided the meaning and Italicized the work throughout the document.

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CHAPTER ONE: INTRODUCTION

> *"Aquí se encuentra el pensamiento del hijo de las selvas que lo vieron nacer, se crio y se educó debajo de ellas como se educan las aves para cantar, y se preparan los polluelos batiendo sus plumas para volar desafiando el infinito para mañana cruzarlo y con una extraordinaria inteligencia muestran entre si el semblante amoroso cariño para tornar el vuelo, el macho y la hembra, para hacer uso de la sabiduría que la misma Naturaleza nos ha enseñado, porque ahí en ese bosque solitario se encuentra el libro de los amores, el libro de la filosofía; porque ahí está la verdadera poesía, la verdadera filosofía, la verdadera literatura, porque ahí la Naturaleza tiene un coro de cantos y son interminables, un coro de filósofos que todos los días cambian de pensamientos…"* ~ (Manuel Quintín Lame Chandre 1939)

> *"Here is the thought of the jungle's son who saw him born; he was raised and educated under them [the jungle] as birds are educated to sing, and the chicks are prepared by flapping their feathers to fly defying the infinity to cross it tomorrow and with an extraordinary intelligence shows each other loving affection to take flight, the male and the female, to make use of the wisdom that Nature herself has taught us because in that lonely forest there is the book of love, the book of philosophy; because there is true poetry, true philosophy, true literature because Nature has a chorus of songs and they are endless, a chorus of philosophers who change their thoughts every day…"* ~ (Manuel Quintín Lame Chandre 1939)

Vivencias[1] of Jabokū and José in Bogotá – Part 1

Upon returning to Bogotá from my first visit to the Vaupés territory in 2018, I had a few days to share with my family in the farewell of my maternal grandfather to the spiritual world. My children and my partner were with me in the last days of my visit to Colombia. The morning after the ceremony celebrating my grandfather's life, we were getting ready to visit other family members. My children were playing with my mother while my partner and I were preparing breakfast. Suddenly a message came to me via WhatsApp, a voice and text message application widely used in Colombia and the world. It was José, one of Jabokū's sons in the Puerto Golondrina community

[1] The elders affirm that ***vivencias*** represent the embodiment of life through interdependent connections with other beings that constitute our environment. These connections can be between human beings and between humans and non-human beings. Experiences are not restricted solely to physical and mental aspects but also encompass spiritual, emotional, and energetic dimensions.

(Jabokū, in the Pamíe language, comes close to the hierarchical description known as a Captain or legal representative of the community). I was glad to see his message.

After exchanging greetings, José informed me that Jabokū had had a heart attack. They were waiting at Mitú airport to fly to Bogotá since he urgently had to see a cardiologist, a medical specialty not available in Vaupés. I was concerned about him as we (Jabokū and I) had built a good and respectful relationship. José shared the hospital's name with me, and I told him that I would be communicating with him during the day to see when Jabokū could receive visitors.

Hours later, on WhatsApp, I sent a text message to José,

Hi José, how was the trip?

The flight went well, Hugo; we arrived at the airport and went straight to the clinic, José answered.

Although text conversations are convenient for many reasons, face-to-face or voice communication in situations like these is preferable. So, I replied to José,

That's good. I hope everything goes well. Are you available to talk?

Upon responding positively, I called José, and he shared with me what was happening,

Hugo, they [the doctors] *already received my father, and they will do some exams. So, it looks like they're going to leave him here tonight.*

A feeling of relief crossed my body, and I responded,

At least he is in the hospital with the necessary care. And then, where are you going to stay?

Well, the New EPS [Health Promoting Entity] *was supposed to find me and my dad shelter, but they haven't told me anything. However, here at the hospital, they said that I had to stay in the waiting room and couldn't go anywhere. So, I'm going to wait, but it looks like my dad will need to stay here.* José responded.

I let José know that if he did not hear anything about the shelter, I would reach out to find him a place to stay for the night. Finally, at around five in the afternoon, I received a text from José,

Hugo, do you remember the person who worked at Sinergias, the anthropologist Daniela Rangel? She just called me, and she told me that I could stay at their house tonight.

Knowing that José had a place to stay alleviated many uncertainties that night. I told him that I would stop by the following morning to visit them. I said goodbye to him, trusting that the health system would accommodate them as part of their rights as Indigenous People and members of the subsidized health regime. I was very wrong.

Vivencias' Notes 8/5 – 8/22, 2018

Introduction and Research Goal

Historically, the health of the Indigenous[2] Peoples in "*Abya Yala"*[3] has been severely affected since the 15th century with Europeans' arrival to this continent (Sotomayor 1998a; Salaverry 2010). During that period, libraries of ancestral Indigenous health knowledge and practices were plundered and suppressed by colonization's brutal destruction. The loss of Indigenous human lives due to the spread of diseases foreign to the context, and violence against them (Salaverry 2010) that devastated these communities in the *Abya Yala*. European colonialism reached many corners of the planet and built strategic systems of oppression to deprive the Indigenous of their

[2] The term **"*Indígena*" [Indigenous]** does not capitalize its first letter in the Spanish language because it is not a proper noun in that colonizing language. However, the international community of Indigenous Peoples has struggled academically to make a distinction that the term "Indigenous" with a capital "*I*" "*articulates and identifies a group of political and historical communities, compared to the lower case 'i,' which can refer to anyone*" (Weeber 2020). For this reason, I join the struggle of Indigenous Peoples and use the word "Indigenous" from now on as a proper noun and capitalize its first letter.

[3] ***Abya Yala*** is a term used by the Kuna People (who currently live mostly on the borders of the nation-states of Colombia and Panama), and it means "mature land, living land or flowering land" (Carrera Maldonado and Ruiz Romero 2016). This term refers to the entire continent before the European invasion. Recognizing that the label of "America" was imposed by colonizers, Indigenous Peoples have preferred to call the continent *Abya Yala*, resisting the continuous colonial imposition on an identity that is not their own.

territories, eliminate the native as native, and exploit labor (Fanon 1967; Dussel 1994; Anibal Quijano 2000; Oviedo Freire 2012; Wolfe 2006; Speed 2017). These figures of domination and exploitation are still present today under a colonial logic which Aníbal Quijano describes as the coloniality of power (2000). The arrival of the Spanish to *Abya Yala* led to the introduction of a new conception of health and, with it, a structure of healthcare services that divided access to medical attention into two categories: one for the Spanish groups and another for the Indigenous groups. (Salaverry 2010). Within this division, Europeans characterized Indigenous Peoples as inferior in a system imposed by them (A. M. Sánchez 2004). These practices did not cease with the creation of the republics in *Abya Yala* during the 19th century, as the labor exploitation of Indigenous Peoples in mercantilist activities continued (Sotomayor 1998a). These various mercantilist activities brought more epidemics to the Indigenous Peoples, such as yellow fever and cholera during the mid and late 19th century (Sotomayor 1998a). The construction of the concept of citizenship in the new republics transformed ethnic differences into characteristics of an inclusive republic but designed under a majority rule, disregarding Indigenous Peoples' priorities and health rights within the new republics (Contreras 1989; Maldonado 2016). In the context of health, this silencing of Indigenous health priorities and rights takes another form of colonization through the imposition of "Western" medical[4] knowledge and its unquestionable truths (Córdoba 2010). These interactions trying to silence Indigenous knowledge are reflected in

[4] In this manuscript, I refer to "***Western" medicine*** as a medicine that focuses on how the human body works mechanically, distancing itself from the person's subjectivity.

the comments of compañero[5] José Martínez, from the Puerto Golondrina community, saying that "*they* [the "Western" world] *see us as animals that need to be tamed.*"

However, the Indigenous resistance in *Abya Yala* gained political strength in the past three decades, materializing achievements of great importance to continue their struggle for autonomy in every aspect. One of these achievements was Convention No. 169 of the International Labor Organization (ILO) about Indigenous and Tribal Peoples in 1989. This agreement recognizes the violation of Indigenous Peoples' human rights globally and seeks to address these issues through international policies and laws to protect them. In this way, prior consultation with Indigenous Peoples arises to encourage their participation in decisions that affect their lives (International Labor Organization 2003). In Colombia, these Indigenous People's efforts are key to a *"Buen Vivir"* (good living or living well in English). The *"Buen Vivir"* is deeply linked to health and healthcare for these communities and is grounded in ancestral knowledge. *"Buen Vivir"* is defined in official documents as the "*result of the harmonious balance of people's relationships with themselves, with their families, their communities, their territory and nature*" (SSI-MPC 2016, 3). However, *"Buen Vivir"* is a dense philosophy of life expressed and developed in different ways based on the context, and it is in constant construction, as I will discuss in chapter three of this dissertation. As a result, Indigenous Peoples demanded a national Indigenous health system, resisting a state system that continuously ignores Indigenous knowledge and priorities. As the Indigenous compañero, thinker, friend and leader Gaudencio Martínez explains in a simple metaphor, "*the big fish is eating the little fish.*" In summary, this resistance seeks to

[5] One of the concepts used frequently in different levels of collaborative work with communities in Colombia is ***compañero*** o ***compañera***. In the context of SISPI, this concept signifies a bond of trust between cooperative parties working for health and social justice to eliminate hierarchical labels within a group.

preserve, protect, and implement their ancestral knowledge of health as well as to build new intercultural knowledge that is relevant to each community.

This research aims to contribute to the global discourse on justice to live a dignified and healthy life, especially with and for Indigenous Peoples. This work is carried out in collaboration with the Colombian non-governmental organization (NGO) *Sinergias: Alianzas Estratégicas para la Salud y el Desarrollo Social* [Synergies: Strategic Alliances for Health and Social Development], who interact and actively work with Indigenous communities in Colombia. Sinergias played a crucial role in this research by establishing relationships and providing guidance. The foundations for this dissertation are the collective *vivencias* of different *compañeros(as)* (Indigenous and non-Indigenous), including myself, accompanying the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-Determined and Intercultural Indigenous Health System]. Its making has been a journey where different threads are interwoven, making the blanket of SISPI from a national level to a specific place in the *Departamento*[6] of Vaupés in the nation-state of Colombia. It is a collective work built on trust and empathy in the face of a desire for Indigenous health and healthcare justice through an Indigenous health system governed by local cosmovision[7] and culturally equipped to apply its own and intercultural approaches. As used in this context, *interculturality* represents a respectful dialogue and understanding of

[6] ***Departamento***. The 1991 Colombian constitution establishes this nation-state as a politically and an administratively decentralized unitary republic in 33 partitions: 32 *Departamentos*, governed by their respective capital cities, and a *Capital District* (Bogotá). *Departamentos* form geographic, cultural, and economic regions (República de Colombia 1991).

[7] ***Cosmovision*** is a commonly used Spanish term similar to worldview, how a person or culture understands the world around them. It includes beliefs, values, and perspectives that give meaning to reality, such as the universe's origin, human nature, morality, relationships with others, and the environment. Cosmovision is influenced by education, tradition, experience, and interaction with others. It is not static or universal and can vary among individuals, cultures, and historical periods. A person may have elements from different cosmovisions.

knowledge between different cultures (Dietz 2017; Maria Elena García 2014; Salaverry 2010; Sinergias 2013; Zárate Pérez 2014). One of the core values of the SISPI is relationality, which focuses on the importance of relationships between humans and other beings, developing deeply interconnected bonds (Wilson 2008).

For Indigenous Peoples, the SISPI is something they have been practicing for millennia. Therefore, Indigenous Peoples seek to systematize culturally appropriate healthcare access for their communities at the national level to preserve their knowledge and complement it with other health knowledges where relevant and necessary. Departing from this goal and guided by the principle of relationality, I attempt to address with other compañeros(as) the central question of priority for SISPI: how can SISPI support local communities to build or strengthen their health models? However, when incorporating the intercultural aspect into SISPI, it is also important to address if bridges can be constructed between Indigenous medicine and western medicine to provide a more comprehensive and culturally appropriate healthcare access to Indigenous communities. And if such a bridge possible, how could these bridges be built through SISPI? This research explores the feasibility of establishing connections between various medical systems, focusing on Indigenous health, to integrate Indigenous principles while fostering collaboration and dialogue to further inform the ongoing SISPI implementation process. Specifically, the intention is to provide vivencias accompanying the SISPI to inform strategies for improving health services for the Indigenous population in the *Departamento* of Vaupés. The dramatic inequalities and outcomes in Indigenous health in Colombia are the urgent foreground and motivation for my accompanying, assisting, documenting, and understanding the SISPI process.

Health Disparities

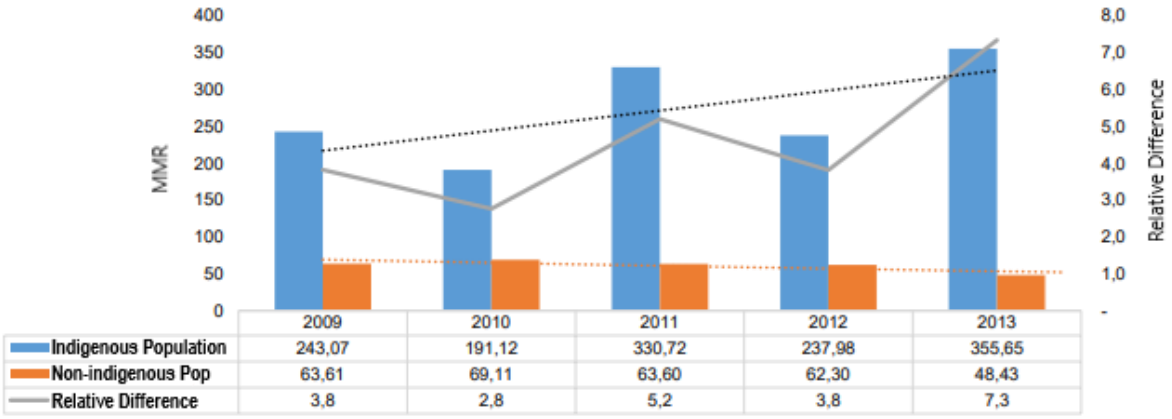
The Indigenous population in the nation-state of Colombia makes 4.4% of the total population - approximately 1.9 million people (DANE 2018). The sociopolitical, structural, and cultural diversity of Indigenous Peoples in Colombia represents a mosaic of traditions, worldviews, and organizational systems that reflect the patrimonial richness of this territory in *Abya Yala*. The interconnection and dependence of these three domains provide a comprehensive perspective on their significance in the Colombian sociocultural fabric.

The Indigenous Peoples of Colombia are heterogeneous. According to the *Organización Nacional Indígena de Colombia* (ONIC), Indigenous Peoples encompass more than 102 distinct groups, each with organizational particularities in social, political, and territorial spheres. These organizational structures have been carved out over the centuries, strongly influenced by their ancestral worldviews and their intrinsic relationship with the land (Rappaport 1990). The ONIC has aptly emphasized the importance of these structures in safeguarding and promoting Indigenous rights at both national and international levels (ONIC 2020).

From a structural standpoint, Colombian Indigenous communities have established systems based on a deep community connection. Within this framework, territory transcends the mere conception of property to be understood as a living entity intertwined with the community and its essence. The Colombian Constitution of 1991 legally recognizes Indigenous reservations, supporting the Indigenous worldview. These places symbolize the Indigenous relationship with the land and grant these peoples a degree of political and administrative autonomy (República de Colombia 1991 Art. 329).

Culturally, Colombia stands as the cradle of vast linguistic and cultural diversity. According to the Ministry of the Interior, the country hosts over 60 Indigenous languages, several of which face the threat of silence and oblivion. These languages, along with a repertoire of traditions, rituals, artistic expressions, and ways of life, consolidate the Indigenous cultural heritage as one of the most treasured and most "vulnerable" within the Colombian landscape (Ministerio del Interior 2019).

In terms of health, the most recently published national health profile of Indigenous Peoples by the Ministry of Health is from 2016 and compares indicators between the years 2009 and 2013. Figures 1 and 2 below show very high rates of maternal and infant mortality among Indigenous Peoples compared to the non-Indigenous population.



	2009	2010	2011	2012	2013
Indigenous Population	243,07	191,12	330,72	237,98	355,65
Non-indigenous Pop	63,61	69,11	63,60	62,30	48,43
Relative Difference	3,8	2,8	5,2	3,8	7,3

Figure 1. Maternal Mortality Rate (per 1,000 births) in Indigenous *and non-*Indigenous *populations, Colombia, 2009-2013. Source: Ministerio de Salud y Protección Social, Colombia, 2016*

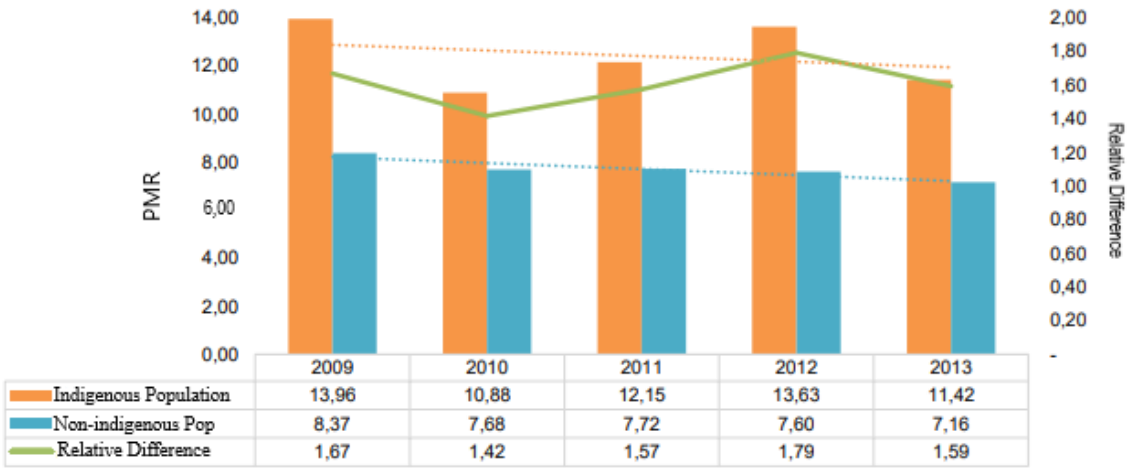


Figure 2. Perinatal Mortality Rate (per 1,000 births) in Indigenous *and non-*Indigenous *populations, Colombia, 2009-2013. Source: Ministerio de Salud y Protección Social, Colombia, 2016*

Critically reflecting upon these data, the question arises: Why are these numbers so disproportionate? What are the factors that affect the reproductive health of these populations? Indigenous populations frequently endure the lingering consequences of colonialism, contemporary state interventions, and various forces. These encompass socioeconomic disparities and multiple manifestations of physical, economic, structural, and epistemic violence[8]. Such conditions heighten their susceptibility to specific diseases and health issues, notably during prenatal and perinatal periods. These situations are called social determinants of health and can explain a significant part of the data presented in these figures. These social

[8] ***Epistemic violence*** refers to the practices and attitudes that promote the devaluation, exclusion, and invalidation of certain individuals' knowledge, perspectives, and experiences. In an era marked by the persistent effects of epistemic violence, communities have shown remarkable resilience in constructing their collective social realities. However, this resilience also underscores the profound implications of such suppression. Consider a young individual belonging to a marginalized group, burdened by internalized oppression and questioning their worth in society. As they navigate this environment, ancestral traditions and stories risk being overshadowed by dominant narratives. This cultural undermining further hampers economic prospects as potential innovations from these communities go unnoticed. The dominant society feels threatened when marginalized voices seek recognition and validation. The absence of these voices in academic circles results in limited diversity of thought, constraining academic progress. Therefore, despite the ability of communities to shape narratives in adversity, the extensive repercussions of epistemic violence permeate all aspects of society, emphasizing the need for recognition, education, and reparation.

determinants of health affect Indigenous communities globally, creating cultural and linguistic barriers, socioeconomic inequalities, discrimination, and marginalization. This gives rise to maternal and perinatal mortality patterns, for example, tracked in these figures.

It is important to note that the data presented in Figures 1 and 2 correspond to a specific period (2009-2013) and may not reflect the current situation. However, these data highlight the need to address health inequalities among Indigenous Peoples and improve access to culturally congruent healthcare services tailored to their cultural and linguistic needs. It is also crucial to address the underlying causes of these disparities, such as discrimination and marginalization, to improve the health and well-being of Indigenous Peoples globally.

For the Indigenous leaders working to structure an indigenous and intercultural health system, the SISPI is like a large blanket they are weaving with different threads so that, ideally, it meets the needs of their communities, providing access to culturally appropriate health services for them. Each thread represents the stories and relationships between humans and other beings that intertwine on this path. Many threads are missing, and this dissertation adds some threads to support the making of this blanket that warmly envelops everything it touches, both internally and externally.

The support I provided for this process took place in different spaces and periods. Between July 2017 and March 2020, I made four visits to Colombia, each for two to four months per visit. They focused on Bogotá and the *Departamento* del Vaupés, with a brief, but substantial, visit to the *Departamento* del Guainía (figure 3).

Figure 3. Mapa de Bogotá y la Región Amazónica Colombiana. Incluye los Departamentos de Vaupés y Guainía.

The *Departamento* of Vaupés is part of the Colombian Amazon. It has a population of 40,797 inhabitants (DANE 2018), 81.7% of whom identify themselves as from 27 different Indigenous groups, according to the latest references from the Vaupés Government. According to public health data, the basic morbidity and mortality profile of the Indigenous Peoples of Vaupés is concerning compared to the non-Indigenous population at the national level (figure 4). Similar to the data from Figures 1 and 2, the social determinants of health can largely explain the data presented about Vaupés in Figure 4. This association between the social determinants of health and the Indigenous health profile at the national and Vaupés levels suggests that health goes beyond just discussing illness.

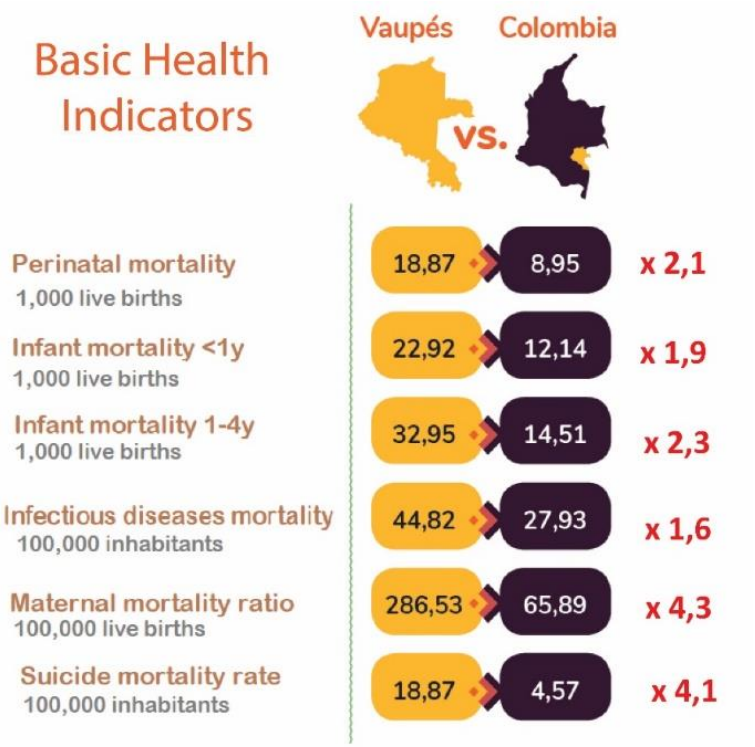


Figure 4. Basic Health Profile of Indigenous *Peoples in Vaupés. Source: Análisis de Situación de Salud (ASIS) 2019 de Minsalud, Secretaria de Salud Departamental del Vaupés, and Sinergias.*

Positionality

Before continuing, it is important to clarify that in writing this dissertation, I do not attempt to seek absolute conclusions, prioritize one perspective over another, or romanticize Indigenous Peoples. Rather, I seek to center and amplify experiences of resistance and hope and uplift the human desire to live a dignified and healthy life. The foundation of the narrative in this manuscript lies in respect for all human relationships and relationships with other beings. Therefore, I must position myself socially and respectfully to convey relational vivencias in my work. There is a consensus among Indigenous compañeros(as) whom I worked with that knowledge belongs to the universe and that we only contribute to its production in a situated manner. In this manuscript, I acknowledge and am in dialogue with the companions who deserve

credit for contributing to this work. Many of our Indigenous compañeros(as) have taught us that "*stories are sacred, and we must allow them to flow in the transmission of their message.*" In this way, I will begin by situating myself socially.

I am from the capital of Colombia, Bogotá, a nation-state founded under a territory violated by European invasions: a land that was and continues to be cared for and protected by Indigenous Peoples from this context. In 1999, at the age of 19, I emigrated to the United States, where I currently live. In the Colombian context, I am considered a cisgender man, not Indigenous, white, or *mestizo*[9] (depending on who you ask), of a medium-high economic status, and educated in an institution in the United States. These socially constructed labels carry many relative systemic advantages bestowed upon me by oppressive structures such as patriarchy, capitalism, and colonialism. Recognizing these advantages, I am responsible for unlearning these identities to fight for social, knowledge, and health justice for all to break the perpetuation of these oppressive structures. But it is also necessary to mention that, despite all these social labels, I am part of a system of deep relationships of which we are all part in one way or another (Potts and Brown 2015; Smith 2013). I am a father, partner, brother, son, friend, uncle, and a being from mother earth. Like any human, I seek to live a dignified and healthy life. Unfortunately, colonialism tries to deny that desire to our *global majority*[10]. Therefore, in resistance to

[9] ***Mestizo*** refers to individuals of mixed European, primarily Spanish, and Indigenous "American" descent. Originating during the colonial period in Abya Yala, the Spanish caste system used the term to categorize and stratify individuals based on their racial and ethnic backgrounds. Over time, the concept of ***mestizaje***, or the process of mixing, has come to symbolize the blending of cultures and has played a significant role in forming national identities in various Abya Yala countries (Wade 2010; Bonfil Batalla 1996).

[10] The term "***global majority***" refers to the collective populations of Africa, Asia, and Abya Yala, constituting the majority of the world's population. This term is often used in contrast to the term "minority," commonly used in "Western" contexts to describe people of non-European descent. By using "***global majority***," the emphasis is shifted to recognize the numerical dominance of these populations on a global scale, challenging Eurocentric perspectives and highlighting the importance of these regions in global affairs.

perpetuating colonialism, advocating initiatives that aim to provide culturally adequate healthcare access and services in Colombia and globally for the Global Majority drives this work.

Although my inclination is to move in ways that are *decolonial*[11] and *anti-racist*[12], my colonized mind still carries heavy baggage that I am gradually transforming towards more liberating thought patterns. I also recognize the word "Indigenous" is a colonial creation to refer to as an "other." Similarly, "traditional" carries colonial baggage that discredits knowledge as "unscientific." However, these words also carry a great social, political, and economic weight for Indigenous Peoples, and therefore I will use them respecting that important counterweight. Most conversations shared in this manuscript took place in a casual environment; thus, these conversations are paraphrased with the respective validation from participants. However, I kept quotation marks in each paraphrase to recognize each voice participating in this story.

As I learned and weaved relationships along this path, I have encountered countless mentors who influenced my perspectives on how I view the world and constructed this research project. The entire process of this project brought great challenges for me as it directly and constantly confronted me with my biases and internal identity struggles. These internal confrontations motivated me to take a genetic test to learn about my ancestry from a molecular lens. With a sense of curiosity, I went to the laboratory website where I would find the results of that test.

[11] In an academic context, ***decolonization*** refers to critically examining, challenging, and undoing the legacies of colonialism in education, research, and knowledge production. It involves recognizing and addressing how colonial histories and ideologies have shaped academic disciplines, methodologies, and curricula. Decolonization seeks to center Indigenous and marginalized voices, perspectives, and methodologies historically sidelined or suppressed by colonial powers (Smith 2013).

[12] ***Anti-racism*** is an active and conscious effort to challenge and counteract racism at individual and systemic levels. It involves recognizing and opposing racist beliefs, actions, policies, and structures and actively promoting policies and actions that produce racial equity. Anti-racism goes beyond simply not being racist; it requires taking active steps to dismantle structures of racial inequality and injustice (Kendi 2019).

Although I am aware of my genetic mixture, I always thought that my genetic lineage would be more on the European side than the Indigenous side. To my surprise, the results showed that 45% of my genetics come from my "*Amerindian*" ancestors of the Andes, as characterized in the results. Although the results also showed 46% of European ancestry, the difference is minimal. Seeing these results, I wondered why I believed my ancestry was significantly more European.

I am a mestizo, a mixture of different groups. Therefore, why did I associate or believe my ancestry is more European than Indigenous? This question led to many more. For example, what histories does my claiming mestizaje silence? What is the purpose of mestizaje? And why was it never a concern for me but rather a source of pride? The underlying purpose of mestizaje is invisible, goes beyond a mixture of different groups, and makes a big part of our history in *Abya Yala*. The narrative of mestizaje, in the social context, has been used to promote colonial logics that seek the elimination of the Indigenous to justify the control of lands and labor.

Considering this intricate lineage of historical relationships I navigate, I contemplated the purpose behind my efforts for this project. Why did I choose to participate in this particular work? My decision arose from a desire to contribute to my homeland. Through connections I established at the University of Washington, I had the privilege of collaborating with Sinergias. While giving back to my native country drove my initial involvement, the relationships I formed during this journey have profoundly impacted my professional growth and personal development.

I experienced unlearning and relearning through various encounters and interactions, gaining invaluable knowledge from my diverse companions. This transformative vivencia revealed a part of my ancestral heritage silenced by the oppressive forces of colonialism. As a result, I learned that Indigenous Peoples are relatives who constantly face challenges in accessing culturally

appropriate health services due to exclusionary structures that do not consider their priorities. However, spending time with these relatives taught me they possess invaluable skills and knowledge that resist oppressive structures to continue caring for their communities. Therefore, my commitment is to support these Indigenous relatives in addressing their health priorities by providing my skills where needed and utilizing the privileges that current structures have granted me as advocacy tools. These priorities are not only focused on health. For example, my commitments with these relatives materialized in various ways, such as facilitating the coordination of a visit to Vaupés by Indigenous national leaders to socialize the SISPI initiative in Vaupés. When I talk about socializing the SISPI, I mean informing and raising awareness among all the actors that are part of the system (territorial entities, health sector organizations, Indigenous traditional authorities, and the community in general) about SISPI's conceptual and methodological aspects. In these spaces, members of *the Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas* (SSI-MPC) [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations] present the SISPI, explain its purpose, identify the actors of the system, describe their roles, and visualize its implementation. Additionally, I supported the construction of a *Maloca*[13] in the community of Puerto Golondrina. In this same community, I taught English as something that the community requested that I could share. These commitments lasted until I had to leave Colombia due to the pandemic.

[13] A ***Maloca*** is a traditional longhouse prevalent among the Indigenous Peoples of the Amazon rainforest, notably in Colombia, Brazil, and Venezuela. This ancestral structure, symbolic of the universe, is integral to Amazonian communities. Architecturally, Malocas possess a distinctive large, oval, or rectangular form, featuring a central open area flanked by adjoining compartments. Constructed primarily from natural materials like wood and palm leaves, they are designed to house multiple families (Reichel-Dolmatoff 1971; Gaia Amazonas 2019).

Indigenous *Health within the Framework of the Nation-State of Colombia*

In Colombia, different efforts to organize a health system at a national level during the 20th century reflected a lack of contextual understanding regarding Indigenous health. *The National Health System* (SNS) in 1973. Its replacement, the current health system, did not address those critical issues for Indigenous Peoples (Maldonado 2016). During the SNS period, insurance reached only 23% of the population. The majority of the insured people were urban and suburban working people. As a consequence of geographical barriers, economic disparities, cultural differences, political neglect, internal conflicts, and a lack of trained medical personnel,, the low institutional presence and poor medical infrastructure in rural and dispersed populations were evident (Vélez 2016), where there is a large Indigenous population presence (DANE 2018). During the 1980s, social mobilization increased in Colombia due to political exclusion and the invisibility of issues affecting certain groups, especially Indigenous and Afro-descendant communities. These mobilizations helped draw the attention of the government at the time to the demands of Indigenous Peoples for culturally appropriate healthcare services. For example, in 1981, in response to these demands, the *Ministry of Health* (1981) issued Resolution[14] 10013, recognizing Indigenous communities' organizational, political, administrative, and socioeconomic structures, including their values, traditions, beliefs, attitudes, and cultural heritage. Furthermore, this resolution introduced the concept of free services for "vulnerable" or "poverty-stricken" populations. However, this legislative recognition by the government perpetuated the stigmatization of the Indigenous population as "poor" from a capitalist

[14] A ***Resolution*** is a "procedural act emanated by a court, through which a controversy originated between the parties is resolved, likewise it can authorize or order the fulfillment of specific measures." ("Definiciones | Normatividad AGN" 2018)

perspective. It also implied that Indigenous knowledge of health lacked Western science validity (Urrego Rodríguez 2020). Therefore, these characterizations allowed the health of Indigenous Peoples to continue to be directed by state health entities and the Western scientific perspective (Urrego Rodríguez 2020). Although these types of characterizations appear subtly in Colombian regulations, this did not stop Indigenous Peoples' struggle for healthcare justice.

Indigenous peoples' continuous struggle for their fundamental health rights led to significant public policy regulation of Indigenous health in Colombia. The constitutional reform of 1991 was one of the outstanding accomplishments. It opened a window for Indigenous Peoples to participate in public policy construction despite their small representation in the Republic's Congress. Since then, Indigenous health regulations have expanded, although tension between Indigenous Peoples and the Colombian government persists with the health privatization measures that are a fundamental part of Law 100 of 1993, which gave rise to the current national healthcare system (Maldonado 2016).

The constitutional reform of 1991 was of great importance because, for the first time, there was the participation of minorities in the Congress of the Republic. The political parties of the time, including the political party of the *M-19* group, collectively constructed this reform. The *M-19* group was one of the guerrillas that reached an agreement with the national government and handed over their weapons in 1990. This stage is important since Indigenous Peoples have been one of the groups most affected by decades of armed conflict between the government and armed groups in Colombia. These conflicts involve a war to control territories for different purposes, such as producing illicit crops. These fights have displaced and violated many communities, affecting their relationship with their territory and, therefore, their health. Although the *Movimiento 19 de Abril* (M-19) [April 19 Movement] group disarmed, other groups like the

Fuerzas Armadas Revolucionarias de Colombia (FARC) [Revolutionary Armed Forces of Colombia] and the *Ejército de Liberación Nacional* (ELN) [National Liberation Army] continued to combat the Colombian government. One of the most impactful events in Vaupés was the armed takeover of the capital, Mitú, by the FARC in 1998. This combat resulted in significant loss of human life and material destruction, affecting this area of the Colombian Amazon (Ardila Arrieta 2008). In 2016, the FARC signed a peace treaty with the Colombian government. However, some political groups have prevented the implementation of this peace agreement as they disagree with the pacts laid out in it. By 2023, the current government aims for a "total peace," which includes reactivating the peace agreements with the FARC and initiating peace talks with subversive groups such as the ELN.

The constitutional reform of 1991 gave rise to the adoption of Law 100 in 1993, initiating the current health system in this country, the *Sistema General de Seguridad Social en Salud* (SGSSS) [General System of Social Security in Health]. The principles that govern the SGSSS are universality, solidarity, efficiency, comprehensiveness, unity, and participation. Based on these principles, lawmakers believed that they could achieve them through privatization, decentralization, on-demand subsidies, and identification processes. Consequently, with articles 48 and 49 of the 1991 constitution, the health system is privatized based on insurance where the person who joins contributes. Two main regimes constitute the system, contributory and subsidized. The contributory regime focuses on the working population in which the employee and employer contribute through taxation for its sustainability. Most of these contributions come from salary percentages from employees (4%) and employers (8%). The subsidized regime uses contributions via the budget, or solidarity resources, or local powers to ensure populations that do not make enough money to contribute to the system can get health insurance. Law 100 also

created the *Entidades Promotoras de Salud* (EPSs) [Health Promoting Entities]. EPSs are insurers whose function is to link their affiliates to the *Instituciones de Prestación de Servicios* (IPSs) [Health Providers Institutions]. The goal was to establish a robust network of service providers encompassing all plan components at all levels of care. The idea was that this network would enable people to quickly access appropriate health services that are relevant and respectful to their cultural context. The EPSs receive monthly resources from the government for each affiliated user to guarantee the *Plan Obligatorio de Salud* (POS) [Mandatory Health Plan] benefits every month. Currently, the POS has been replaced by the *Plan de Beneficios en Salud* [Health Benefits Plan], which refers to a list of benefits guaranteed to all members of the SGSSS in Colombia. The IPSs, for their part, are the institutions that provide health services such as clinics and hospitals. Both EPSs and IPSs can be private or public (Congreso de la República de Colombia 1993, 100).

Indigenous Peoples were limited by including them in the subsidized regime as a vulnerable group and living in poverty (Maldonado 2016). The EPSs aim to affiliate the population with the healthcare system and promote prevention programs. Their theoretical purpose is to create health models based on prior characterization to improve demographic data collection and health indicators. Additionally, they seek to promote social and community participation, assess health risks, and contract health services through the IPSs for patients. Thus, it proposes health promotion and prevention actions, including social and community involvement. With only six Indigenous EPSs in the country, the majority lacks an intercultural and appropriate approach towards Indigenous communities, despite achieving a significant increase in Colombia's insurance affiliation to 96% (Puerto 2018). The decontextualization continued in the Indigenous territories by not offering cultural sensitivity and respect for their knowledge, which led to an

increase of distrust from Indigenous Peoples towards the national health system (Maldonado 2016). The Indigenous Peoples' demands in Colombia for better cultural and human treatment through different legal battles for the right to health, prompted the Colombian government to seek alternatives to improve Indigenous health with the *Modelo Integral de Atención en Salud* (MIAS) [Comprehensive Health Care Model] in 2016 (Puerto 2018) and currently with the *Modelo de Acción Integral Territorial* (MAITE) [Comprehensive Territorial Action Model]. Although MAITE is a recent proposal, and is in its initial phase of implementation, MIAS promoted the need to contextualize public health in every territory (Chacón, Cubides, and Escorcia 2018).

From its inception, the SGSSS did not fulfill the promises established by its principles. MIAS and MAITE seek a significant change in health, not only for Indigenous Peoples but for all Colombians, to correct these errors by focusing on *Atención Primaria Integral de Salud* (APIS) [Comprehensive Primary Health Care]. The APIS proposal is a platform influenced by *Primary Health Care* (PHC) promoted in the *Alma Ata* declaration, and that seeks to strengthen the Colombian health system by connecting different sectors of the government, the private sector, and the community (R. Vega et al. 2009). The APIS was launched in 2004 by the Ministry of Health. The focus of the APIS encompasses individual, family, and community healthcare, along with the collaboration of other sectors, to address the social and environmental determinants of health according to the population's needs (WHO 2008). The APIS served as the foundation for the development of the *Rutas Integrales de Atención en Salud* (RIAS) [Comprehensive Health Care Routes] and MIAS in Colombia (Ministerio de Salud y Protección Social de Colombia 2016). But what is PHC? Its title gives us a broad understanding of what it means. However, PHC was defined more precisely, together with its components, at the international PHC

conference in 1978 in Alma Ata, in the former Soviet Union. In this conference, the definition of health presented by the World Health Organization in 1946 resurfaced: "*a state of complete physical, mental, and social well-being, and not merely the absence of disease or illness*" (The International Conference on Primary Health Care 1978; WHO 2020). This new definition of health is a little closer to how Indigenous Peoples see it through *"Buen Vivir."* Participants of this conference also recognized that healthcare is:

> "*a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector*." (The International Conference on Primary Health Care 1978)

This definition of health in the 1978 *International Conference on Primary Health Care* has the following preamble to introduce PHC:

> "*...[an] essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process*." ~ (The International Conference on Primary Health Care 1978)

As a result, Alma Ata's declaration highlights PHC as a fundamental part of any health system. However, many Indigenous compañeros(as)' skepticism continues as the same problems with the SGSSS continue despite the good intentions of the new models presented by the Colombian government. The different initiatives on the APIS, for example, are often questioned by Indigenous Peoples when leaving private entities to manage health since private entities in the Colombian health system have focused on seeing health as a business to obtain profits (Puerto 2018).

Sistema Indígena de Salud Propia e Intercultural (Self-Determined and Intercultural Indigenous *Health System, or SISPI)*

The SISPI emerged in 2010 as an initiative by Indigenous Peoples to systematize Indigenous health, aiming to address deficiencies in healthcare for these communities. It recognizes and respects their traditional health systems while promoting their autonomy in making health-related decisions. One of the Indigenous organizations that greatly influenced this initiative is the *Consejo Regional Indígena del Cauca* (CRIC) [Cauca Regional Indigenous Council] (Urrego Rodríguez 2019). The CRIC represents 115 Cabildos, and 11 Associations of Cabildos divided into nine strategic zones within the *Departamento* of Cauca in the southwestern Andean region of the nation-state of Colombia (Consejo Regional Indígena del Cauca 2021).

Indigenous organizational structures have different layers and dynamics from the national to the community level. In the context of Vaupés, we find a relationship between ONIC (at the national level), *Organización de los Pueblos Indígenas de la Amazonía Colombiana* (OPIAC) [Organization of Indigenous Peoples of the Colombian Amazon] (at the regional and national level), zonal organizations (at the Departamento level), and the captaincy (at the community level). Although other Indigenous organizations are also part of an organizational dynamic in the Vaupés territory, the listed entities are the ones I found listed to work with SISPI.

In other territories, community organization is different. In the context of the CRIC, for example, the **Cabildo Indígena** is defined in Colombian legislation as "*a special public entity, whose members are members of an* Indigenous *community, elected and recognized by it, with a traditional socio-political organization, whose function is to legally represent the community,*

exercise authority and carry out the activities attributed to it by the laws, their uses, customs and the internal regulations of each community" (República de Colombia 1995a Artículo 2).

Since its formation in 1971, the CRIC has worked extensively for its self-determined governance making important advances in organizing a health system based on their knowledge with the opportunity to complement with other knowledges (Urrego Rodríguez 2019). Their health system has been in operation for many years and is highly effective in their territory. The presence of the CRIC in the construction of the national SISPI is significant since their SISPI is the template for constructing a SISPI at a national scale (figure 4). Since the national SISPI largely begins to weave from the expectations, experiences, and contexts of the CRIC, it finds a greater challenge to intertwine threads among a diversity of Indigenous Peoples in Colombia. The differences in sociocultural, demographic, historical, geographical, economic, territorial, linguistic, and hierarchical scales are among the themes of constant work to continue weaving a SISPI at the national level that allows, as the Zapatista movement says, "*A World Where Many Worlds Fit.*"

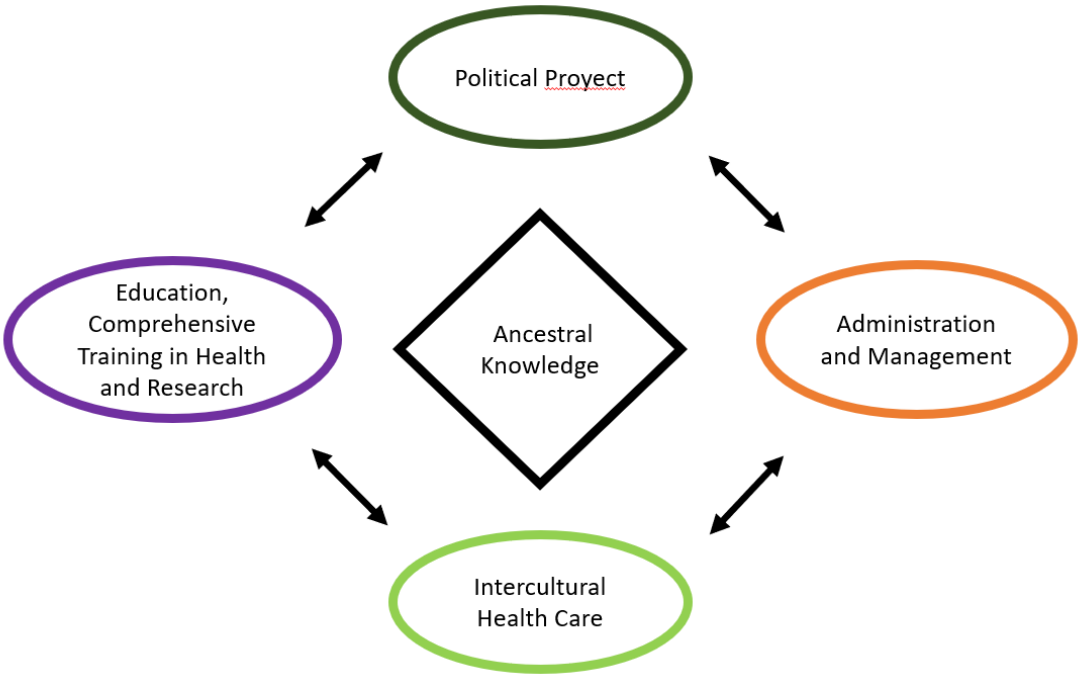


Figure 5. The five basic components of the CRIC's health system. Source: Urrego Rodríguez (2019)

In 2010, Indigenous national leaders met to address how to manage their healthcare situation nationwide due to the case mentioned above (ILSA 2011). The assembly took place in Villeta, Cundinamarca, and emphasized the necessity to build a self-determined Indigenous health system that addresses their health adequately to their contexts. The 1991 political constitution and Law 691 of 2001 were essential pieces to demand an Indigenous health system in Colombia. These legislature pieces assert Indigenous Peoples' right to their autonomy in decision-making based on their priorities and worldviews. Therefore, the Indigenous national assembly consolidated the proposal for the construction of a SISPI (SSI-MPC 2016).

During the following years, legislation emerged to strengthen the case for the need for a SISPI. One of these pieces of legislation focused on the effect of the country's historical armed conflict in Indigenous communities. The armed conflict in Colombia has devastated and

disproportionately impacted Indigenous Peoples. Their location in strategic areas for armed groups and abundant natural resources in their territories have made these communities recurrent targets of violence and forced displacement. The violation of their human rights, the dispossession of their ancestral lands, the loss of their cultural identity, the forced recruitment of their youth, and the murder of their leaders have been some of the most serious consequences.

Furthermore, the illegal exploitation of natural resources in Indigenous territories has deteriorated the environment, threatening Indigenous ways of life and their survival as people. This context of violence and impunity has limited their political participation and ability to exercise territorial autonomy, despite the existing legal protections. Therefore, the armed conflict has worsened the situation of Indigenous peoples in Colombia, exacerbating existing socioeconomic and ethnic inequalities. Due to these facts, the constitutional court has issued important judgments to protect the fundamental rights of women, children, and Indigenous peoples who are victims of the armed conflict. In 2011, the Ministry of the Interior issued Decree Law 4633 of 2011, which established measures to assist, address, and fully restore the territorial rights of Indigenous Peoples who are victims of the armed conflict. The decree also included implementing a comprehensive healthcare strategy for these communities. Subsequently, in the 2016 peace agreements between the government and the FARC, an ethnic chapter was included, recognizing historical conditions of injustice against Indigenous Peoples and acknowledging their important role in the construction of sustainable peace. As a result of these events, this legislative part becomes an important component to develop and implement the SISPI.

These measurements were part of the RIAS for these groups. As a result, it contributed as another argument to build an Indigenous health system of their own (SSI-MPC 2016). The Ministry of Health's Social Promotion Office supported the conversations between Indigenous

leaders and the government regarding the construction of SISPI. This support led to the creation of the SSI-MPC (figure 6) through decree 1973 of 2013 (SSI-MPC 2016). According to the decree 1973 (2013a), the SSI-MPC aims to guide and develop public health policies for and with Indigenous Peoples. In collaboration with the Indigenous communities and their authorities, this body seeks the comprehensive and respectful implementation of said policies within the framework of the SISPI, respecting their cultural and medicinal traditions to guarantee universal access to health for this population. The SSI-MPC's work led to the official adoption of the SISPI by the national government in decree 1953 of 2014 (SSI-MPC 2016).

Figure 6. Structure of the SSI-MPC with Indigenous *Peoples and Organizations (ONIC 2018)*

The decree 1953 (2014) says:

> *A special regime is created to operationalize the* Indigenous *Territories regarding the administration of the* Indigenous *Peoples' systems until Congress issues the law referred to in Article 329 of the Political Constitution.*
>
> *With regard to health, in its Title IV -* Indigenous *Intercultural Health System – SISPI, defines it as the set of policies, norms, principles, resources, institutions, and procedures that are based on a conception of collective life, where ancestral*

> *wisdom is fundamental to guide said system, in harmony with Mother Earth and according to the worldview of each people. The SISPI is articulated, coordinated, and complemented by the General Social Security System in Health, SGSSS, to maximize* Indigenous *Peoples' health achievements.*
>
> *Likewise, it establishes that the SISPI is comprehensive and developed within the framework of the fundamental right to health,* ***under the directorship of the Ministry of Health and Social Protection*** *or whoever assumes its responsibilities, through the instances and procedures determined by said Decree and other provisions that modify, replace, and regulate it.*

Subsequently, in 2015, the statutory law 1751 (2015) was enacted, in which the State supports and guarantees the essential right to holistic health, according to Indigenous perspectives and conceptions, implementing it through the SISPI. This law served to continue accumulating supportive legal tools to solidify the path for protocolizing and implementing the SISPI.

Another important regulatory piece that emerged in 2015 for SISPI was Resolution 518, which establishes responsibilities focused on the *Plan de Intervenciones Colectivas* (PIC) [Collective Interventions Plan]. This Resolution describes this plan as a design to improve health promotion interventions and risk management. These components align with the strategies outlined in the *Plan Territorial de Salud* (PTS) [Territorial Health Plan] and aim to positively influence the social determinants of health while achieving the desired outcomes specified in the PTS. Article 11 of the Resolution describes the department's key responsibilities regarding the public health PIC. These responsibilities include formulating, implementing, monitoring, and evaluating the plan. Social participation is essential, and the plan must adhere to relevant national, departmental, and community-specific frameworks and policies. Additionally, the plan must consider the *Life Plans* of Indigenous Peoples, the plans of Afro-Colombian and the ROM (Roma or Romani) communities, national policies, and provisions specified in Resolution 518. The Life Plans are the Indigenous Peoples' pathways to navigate life guided by their cosmovision (República de Colombia 1995b). This term is not Indigenous in origin but is proposed by the

State in Law 152 of 1994 (República de Colombia 1994) when recognizing that an approach to an Indigenous development plan is not adequate to their contexts. From this legal and historical framework, I proceeded to learn more from Indigenous colleagues who have been working directly with the SISPI.

I developed professional and friendly relationships with two Indigenous national leaders over these three years, compañeros Rafael Guayabo and Rosendo Ahue. Walking by their side, los compañeros shared their knowledge about SISPI with me. Rafael is a compañero *Curripaco* from the territory of Guainía, the land of the waters. When I met Rafael, he was the secretary, on the part of the Indigenous leadership, of the SSI-MPC. Compañero *Mayor*[15] Rosendo, from the *Ticuna People* of the Amazon, was the Senior Counselor for Indigenous Health of the ONIC, and a member of the SSI-MPC when I met him. They broadly taught me the regulations and the history that would allow the SISPI to emerge. In the 2010 assembly, Indigenous Peoples generated five components to achieve this systematization following their organizational process: 1) ancestral knowledge, 2) organizational politics, 3) training (for technical jobs), 4) generational training and use of self and intercultural health care, and 5) administration and management (figure 7). *The National Ten-Year Public Health Plan* reflects the government's commitment to protocolize SISPI, which establishes steps to continue adopting an Indigenous chapter to improve their health. However, in the current COVID-19 pandemic situation faced by Indigenous Peoples, the SGSSS continues to show its weaknesses in maintaining those commitments. The SISPI covers not only Indigenous knowledge but also intercultural issues. With this view, SISPI recognizes and respects the differences in each community and their

[15] Indigenous Mayor (man Elder) or Mayora (woman Elder) in Spanish refers to Elders who hold high respect in society.

respective continuous changes over time due to their different interactions with different human and non-human actors. For this reason, SISPI focuses on strengthening or creating its health models in each Indigenous community.

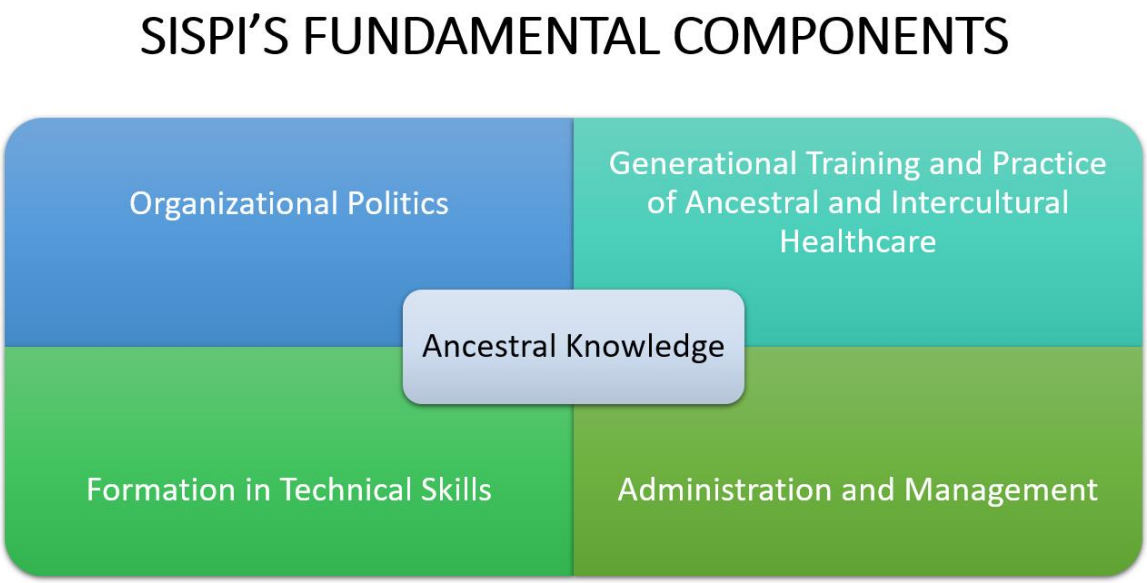


Figure 7. Basic components of the national SISPI (Ministerio de Salud y Protección Social de Colombia and Subcomisión de Salud de la Mesa Permanente de Concertación con los Pueblos y Organizaciones Indígenas de Colombia 2016)

Implementing the SISPI involves constant adaptation and learning that requires the will and commitment of all involved actors. Governmental institutions and Indigenous authorities at all levels (national, regional, departmental, and community) are the main actors in this implementation. According to the content of the *SISPI Methodological Guide* (2016) and the meetings I attended, the SISPI will be implemented in three phases: general context of the Indigenous People, content construction and action plan for the implementation of the SISPI, and consensus, coordination, and articulation for the implementation of the system.

During the initial phase of implementing the SISPI, a comprehensive study of Indigenous Peoples' sociocultural characteristics, including culture, territory, demography, and unique health

structures, is conducted. This study involves identifying relevant health institutions within these communities, understanding their constitution, and discerning the SISPI's interaction with other unique and institutional processes. Analysis of the health situation encompasses the Indigenous conception of health and *"Buen Vivir,"* identifying prevalent diseases and factors disrupting health balance and harmony. The state of Indigenous medicine and the conditions of traditional knowledge holders are assessed, as are the physical infrastructure and unique or institutional information systems. The health situation is examined through the SGSSS lens, covering institutional health analysis, community participation, and the service provider network. Barriers within the SGSSS framework are pinpointed, the health imbalance and disharmony among Indigenous Peoples are analyzed, health personnel needs are estimated, and the advancement and challenges in developing intercultural health processes are identified.

The second phase of the SISPI implementation process actively constructs content and formulates the action plan, addressing several key aspects to accomplish this goal. First, the SISPI and SGSSS actors actively coordinate and articulate actions across different government levels, establishing strategies to harmonize health care from a local and intercultural perspective. It also defines the internal and external actors involved in comprehensive health care, generates technical proposals for their implementation, and includes the corresponding costs.

Another important aspect is strengthening ancestral wisdom and formulating necessary proposals and agreements for its implementation. The process also tackles the political-organizational component, proposing actions to reinforce it and setting up coordination mechanisms between the SISPI and the SGSSS. Proposals are also put forward for the training and development of human talent in health, considering the general context, costs, and institutional co-financing.

The active management and administration of the SISPI include defining proposals, agreements, and processes for affiliating the Indigenous population with the SGSSS and assessing the needs for physical infrastructure and information systems. They identify the necessary human talent teams and generate proposals for their formation in harmony with the network of ancestral knowledge holders. Furthermore, the processes of unique and intercultural health care, both in hospital settings and outside them, are defined, designing evaluation and monitoring strategies for constructing and implementing the SISPI.

The third phase of the SISPI implementation process aims to secure the necessary consensus, coordination, and alignment for effective operation. This stage involves determining communication methods and synchronization strategies with stakeholders from the SGSSS. These stakeholders exist at various levels, including local, departmental, and national, and it is important to establish effective communication with all of them to guarantee successful implementation. It also includes establishing agreements with involved entities, generating financing agreements for the proposals put forth by each component of the SISPI, and setting up intersectoral agreements addressing the social determinants of health. These determinants encompass the protection of natural and cultural heritage, access to clean water and basic sanitation, and the creation of healthy environments. Finally, this phase designs an operational plan to implement the agreements established in the SSI-MPC. This phase concludes with the design of the SISPI components, emphasizing that its implementation works in articulation, coordination, and complementarity with the SGSSS, as Decree 1953 of 2014 mandates.

These are the actions that, in principle, will be carried out to implement SISPI, although the process had not yet reached that point during this research.

Anthropology and Indigenous *Peoples' Health in Vaupés*

It is neither new nor surprising to recognize that anthropology, in general, has its roots in and for colonization. The dark history of anthropology continues influencing our work as anthropologists, and it is our responsibility to question what we refer to as anthropology and its practices. In this reflective search, the Colombian anthropologist Eduardo Restrepo (2019, 12:33) invites us to think that "*anthropology is practices embodied in concrete institutions, in specific contexts, with very particular implications.*" He describes anthropology as what anthropologists have done "in the name of anthropology" in certain contexts. As a result, he affirms that anthropologists demark the conception of the discipline as such from those particular practices. Restrepo challenges a standardized definition of anthropology, pushing for a more situated definition based on its practices and power relations. This author proposes that we should focus on "*what has been done historically and situationally, ethnographically, in the name of anthropology in establishments and specific historical moments*" (2019, 13:03). Based on what this anthropologist shared, I will try to place historically and spatially, as approximate and relevant as possible, the role of anthropology concerning this research accompanying the SISPI in the *Departamento* of Vaupés. In addition, I recognize that in this part of the manuscript, I limit myself to presenting works that I found walking on this academic path and possibly leaving out many contributors that I did not get to read or know. The works that I mention in this dissertation constantly stood out when investigating the particular history of the anthropological influence in the Vaupés and its relationship with the SISPI.

In the Amazon region, Europeans produced the first ethnographies and historical documentation about this territory. They interpreted and disseminated that information based on their worldviews. Many historical accounts were created by missionaries and colonizers who sought

to convert the Indigenous Peoples to their religion and to pursue the mythical city of El Dorado, respectively, during the 16th, 17th, and 18th centuries (Zuluaga 2009). However, the rugged geography of the Amazon led the foreigners to declare this region as an inhospitable zone in the 18th century (Pineda Camacho 2005; Zuluaga 2009) and temporarily stop these expeditions. According to the so-called "explorers," the jungle had no history and led "man" to savagery (Serje 1999). At the end of the 19th century and the beginning of the 20th century, a series of Franciscan missionaries (Zuluaga 2009), naturalists, and environmentalists resumed these expeditions in the Amazon region (Pineda Camacho 2005).

One of the first ethnographic works carried out in Vaupés was in the 1930s by Irvin Goldman with the "Cubeo"[16] People. Goldman's visit to Vaupés was short, and much of his investigation occurred through correspondence with his contact. Copies of these letters are in the Mitú library, inviting questions about the interpretation of those words. Nevertheless, Goldman does recognize in his writings the importance of, and embraces, local participation in research as they are the masters of their reality.

During the same decade, I could not find any ethnographic work done by and for the Indigenous Peoples of the Vaupés within the written archives. However, I did come across an Indigenous intellectual from that time, but in another part of the nation-state. Manuel Quintín Lame, a thinker and defender of Indigenous Rights of the Nasa Nation in the Andean region, documented his experiences rigorously while theorizing about Indigenous resistance against the nation-state and colonial logic (Lame Chandre 1939; 1973). Published in the 1930s, his work as an Indigenous philosophical and ethnographic approach caught the attention of a few scholars in

[16] The word "***Cubeo***" has no meaning for the Indigenous Peoples of this region, as it was a categorization imposed by the "white" man. Within this foreign categorization, there are different groups where they have historically developed strong relationships that continue to this day.

institutions of the dominant paradigm during the late 20th century (Castillo-Cárdenas and Lame 1987; L. A. F. Sánchez 2000; Rappaport 2000). Even though Quintín Lame belongs to a context outside the Vaupés, his ideological contribution has been greatly important in the different political achievements for the Indigenous Peoples of Colombia. In particular, the legal and philosophical struggles led by Quintín Lame would contribute to systematically organizing many Indigenous Peoples in the Andean region, as happened with the CRIC, who would exponentially influence the construction of the national SISPI.

By the 1940s, people began to talk more about ethnological studies and interest in Indigenous Peoples in Colombia. The *Escuela Normal Superior* (ENS) [Superior Normal School], led by José Francisco Socarras, was one of the important institutions that widely promoted these studies. This interest led to the creation of the *Instituto Nacional Etnológico* (IEN) [National Ethnological Institute] within the ENS. The IEN recruited academics from the social sciences, primarily European (Restrepo 2014; Pineda Camacho 2005). Names like Justus Wolfram Schottelius from Germany, Paul Rivet from France, and Gerardo Reichel-Dolmatoff from Austria were part of the European group that would influence the institutionalization of anthropology in Colombia. Part of the contribution of these intellectuals was the emphasis of an ethnographic deepening with Indigenous communities. Thus, the ENS promoted the importance of fieldwork even though they relied heavily on European and North American social theories to analyze their ethnographic work (Pineda Camacho 2005).

In the 1960s, Gerardo Reichel-Dolmatoff significantly influenced anthropology in Colombia, especially in ethnographic works in the Colombian Amazon. One of his most emblematic works in this region focused on Vaupés with the Tucano People. Like Goldman, Reichel-Dolmatoff did most of her Vaupés work remotely, with interviews conducted in Bogotá, visiting the Vaupés for

only three months (Pineda Camacho 2005). Although this practice brought some criticism, Reichel-Dormatoff promoted social research in Vaupés by calling for the urgency of ethnographic studies in this territory (Pineda Camacho 2005). The focus of anthropological research at the time in Vaupés was to study the "native and his customs" (Jackson 2001), thus, bringing in more researchers both from the interior of the country and from abroad. It is worth mentioning that a study on the history of Gerardo Reichel-Dolmatoff (also known as Erasmus Gerhard Reichel), published in 2012 by anthropologist Augusto Oyuela-Caycedo (2012) from the University of Florida, revealed that Reichel-Dolmatoff was involved with the Nazi SS in his early history. Reichel-Dolmatoff deserted and published writings confessing his actions against humanity and how he was manipulated by the Hitler movement (Oyuela-Caycedo 2012), generating confusion about his work. Despite this fact, Reichel-Dolmatoff advocated for Indigenous Peoples for the remainder of his life. Reichel-Dolmatoff and his partner, Alicia Dussán (Paul Rivet's student at the ENS and an essential part of the anthropological and advocacy work with Indigenous Peoples) created the first Anthropology Department at the Universidad de Los Andes in the city from Bogota in 1964. Both Reichel-Dolmatoff and Dussán had very close ties with graduates of the ENS, which would significantly influence the creation of that first Anthropology Department (Pineda Camacho 2005). However, the program was initially criticized by students as they emphasized theory rather than practice.

In 1966, the Universidad Nacional de Colombia opened the anthropology specialization within the newly created Sociology Department (Restrepo 2014) led by sociologists Orlando Fals-Borda and Camilo Torres (Ochoa 2015). By 1966, the National University offers the Anthropology degree (Román Saavedra 1986). The Sociology Department and its specialization in anthropology focused on social inequality and applied anthropology (Pineda Camacho 2005).

Fals-Borda influenced the social sciences in *Abya Yala* with the application of *Participatory Action Research* (PAR) that focused on the community and its knowledge to promote social change (Ochoa 2015). Thus, recruiting a faculty of intellectuals with experience in anthropology and committed to a more equitable social change was a priority. One of the first teachers that Fals-Borda recruited was Virginia Gutiérrez de Pineda. She graduated in social sciences and ethnology at the Escuela Normal Superior in 1944 and in medical anthropology at the University of Berkley, California, in the United States in 1954 (Herrera and Low 1987). Gutiérrez de Pineda largely influenced a transformation of the practice of medicine and public health by offering a more culturally sensitive perspective (Pineda Camacho 2005).

During the 1970s, the influence of other Eurocentric theories continued, motivating many anthropologists to work with Indigenous Peoples, the symbolic system, and cognitive anthropology (Jackson 2001). These approaches maintained classical anthropology practice with a subject-object approach and a motivation for a "thick" description in ethnographies reflected in the time's academic works. In other words, it was about describing the life and practices of a group of human beings without providing a clear idea of how those communities would benefit from it. It was a collection of "data" to continue studying the "other," perpetuating misrepresentation by interpreting the information from the "objective" view of the researcher. However, anthropology would begin a transformation during that decade. Globally, anthropologists started to question ethical issues of representation and where anthropologists were speaking from, creating a representation crisis (Marcus and Fischer 1986). Once again, multiple disciplines in the area of social sciences begin to question the same. Argentine philosopher based in Mexico, Enrique Dussel, shared his criticism of the structures of imperialism, colonialism, globalization, sexism, and racism from a Marxist point of view in the

face of the exploitation and alienation of the so-called “global south.” Dussel called this critical analysis the philosophy of liberation. He invites us to build a self-determined approach to knowledge production and reproduction. Critical thinking about ethics in the social sciences was a common conversation for the first promotions of the Escuela Normal Superior in Colombia (Herrera and Low 1987; Pineda Camacho 2005). These critics would question the same European and North American theories used to understand contexts foreign to them. From here, a line of anthropologists with a more critical view of the discipline and its practice would begin to form in Colombia.

At the end of that decade, anthropology began to become much more politically involved globally. In public health, the 1978 Alma Ata agreement in the former Soviet Union on PHC provided an opportunity for anthropology to contribute to this cause. Anthropologists from different sectors came together to seek possibilities to build bridges for universal access to health care and appropriate to the context according to what the PHC (Coreil 1990) mentions. As I mentioned earlier, the Alma Ata declaration aligns with Indigenous communities' desires to address their health priorities. The Alma Ata declaration would significantly transform intercultural health in the *Departamento* of Vaupés through the Colombian-Dutch agreement to implement PHC in the 1980s (Convenio Colombo-Holandés en Salud 1981; Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés 1985). The interest of the Dutch nation in Colombia stems from the global interest in eradicating "poverty" through the rhetoric of "development" in the 1960s (Malcontent and Nekkers 2000, 18). During the period from 1961 to 1971, Dutch cooperation multiplied fivefold, expanding to countries that were not former colonies, selecting a small group of countries based on various criteria, including the needs of countries categorized as "poor," political and economic implications, as well as historical ties

(Malcontent and Nekkers 2000, 25). Colombia made it to that list. A series of development agreements emerged from this binational cooperation, including the health agreement signed in the late 1970s and implemented in the early 1980s (Zewuster 2010). This agreement allowed the anthropologist Juan Guevara Garzón to use an anthropological approach, influenced by the PAR of the Orlando Fals-Borda school, supported by the national and local governments and traditional authorities. Guevara toured the entire region listening to the communities and investigating a PHC model that complements the different Indigenous knowledge and "Western" medicine within the health system.

The 1990s began to see an explosion of Indigenous social movements in *Abya Yala* (Jackson and Warren 2005; Dávalos 2005; Walsh 2010b). These movements fought, and continue fighting, against the continued exploitation of their peoples and the deprivation of their autonomy. At this time, academics who began a critical education of their disciplines joined the different struggles for social justice in the nation-state, primarily supporting Indigenous groups. This shift in thinking helped some anthropologists work more towards the benefit of the community within their context. The early work led by Guevara in Vaupes (1984a; 2003) is an example of such collaborative efforts building a health model with and for the Indigenous People. This health model worked in synergy with Indigenous knowledge while it lasted until the beginning of the 21st century. Guevara opened new horizons with his work, which has been fundamental in shaping the way Vaupés approaches and continues to strive to address the health of its population. Many healthcare professionals have built upon Guevara's work to give it continuity, as discussed in Chapter 5. However, although the collaboration of many anthropologists like Guevara is supportive, the fight is constant for Indigenous Peoples for their rights internationally.

The development of more critical social sciences in universities embraced anthropologists to shift their focus from classical anthropology, which distances researchers from the Indigenous realities, to amplifying Indigenous Peoples' wishes and voices of resistance (Martínez Silva 2006; 2016; Salazar, Gutiérrez, and Franco 2006; Rodríguez, van der Hammen, and Gruezmacher 2007; Acosta Muñoz, García Rodríguez, and Dubois Migoya 2016; Franky and Mahecha Rubio 2018; Acosta García 2020; Guevara 1984a). Anthropological studies in Vaupés (Guevara 1984a; 2003; Martínez Silva 2006; 2016; Salazar, Gutiérrez, and Franco 2006; Von Hildebrand and Brackelaire 2012; Acosta García 2020) have been referent to non-governmental organizations and state agencies related to the issue of Indigenous health in the Vaupés. However, I did not come across anthropological works made from the Indigenous paradigm and by Indigenous compañerxs. The only Indigenous educational institution with significantly advanced research from the Indigenous paradigm is *Universidad Autónoma Indígena e Intercultural* (The Autonomous Indigenous and Intercultural University) in the Andean region. Still, I did not find any in the Vaupés. This experience does not mean that they do not exist. Within my short walk through the Vaupés, I did come across Western educational entities focused on *interculturality* (UNIMINUTO, SENA, and the National University of Colombia, Amazonas headquarters). The National University of Colombia, Amazonas campus, was one of the educational entities that actively promotes more Indigenous students' involvement and ancestral knowledge in their Amazonian studies. One of the proposals of the Universidad Nacional Amazonas campus is to build an intercultural health program where different medicinal knowledge is in constant conversation to bring culturally appropriate care to the communities of the region. This commitment is promising for SISPI as it continues its spread in this region.

A question frequently arose in my head while reading some of these manuscripts is about the Indigenous voice. And when I refer to the Indigenous voice, I am not referring to Indigenous quotes, interviews, or stories shared in different ethnographies. Their voice in the debate is not present because it is not the Indigenous Peoples who interpret what we call “data” about their vivencias. At least, this is the case in most of the dominant paradigms in academia. The emergence of Indigenous movements in the past four decades amplified their voices in some areas. Additionally, we must advocate and collaborate with Indigenous communities to develop appropriate structural pathways that effectively amplify Indigenous voices.

Most academic institutions in the dominant paradigm consider oral tradition as a non-valid tool to maintain records. However, I have come across narratives that I consider Indigenous ethnographies. These ethnographies come from Indigenous methodologies from their particular context. The production of these ethnographies comes from their vivencias and knowledge of the territory. The oral tradition is critical to transferring ancestral knowledge through storytelling that only a few individuals receive through rigorous training to preserve and protect this information. Oral tradition has preserved and continues to pass down much of the ancestral knowledge, despite some of it disappearing or getting mixed with other knowledges. It also facilitates the transmission of new knowledge to future generations. Supporting oral tradition continues to be a challenge as the colonial logic threatens the ancestral knowledge that still survives. This discrepancy does not mean that there is no Indigenous research, but rather that it is made invisible due to many factors of discriminatory aspect.

Compañero José asked me, "*why the madness of the 'white' man to know and own everything?*” His question is not surprising. Perhaps compañero José is proposing a concise statement about the coloniality of power and epistemic violence. As non-Indigenous academics, we lose

ourselves in our arrogance and obsession with producing knowledge since it has been commodified and individualized in such a way that it blinds us to an amalgam of other worldviews. This situation reminds me of the story that my compañerxs from Puerto Golondrina shared with me about the spirits that inhabit the jungle. The community knows that you have to be very careful and respectful when walking certain jungle areas. A few meters behind the community, if you walk without understanding and respecting the spirits that live there, they will play with the person's mind and make them lose their path. Similarly, I believe that many of us, non-Indigenous academics, get lost in a jungle that we do not know. With our arrogance, we continue to fail without consulting those who know and have developed a strong relationship with different beings in the environment where they live.

General Arc of the Dissertation

This dissertation contains eight chapters, which begin with this introductory part interwoven with different stories and vivencias accompanying the SISPI process, especially in the Vaupés *Departamento*. The individual vivencias of Indigenous compañeros(as) in Colombia unravel ontological dissonances that reflect the everyday life of these communities, protecting their ancestral knowledge and seeking intercultural convergences to balance their *"Buen Vivir."*

In the second chapter, I focus on the methodology built for this project and the appropriate inquiry strategies for having conversations that contribute to answering the research questions. The chapter consists of three fundamental parts: relationality, inquiry strategies, and the project's ethics. I invite my readers to walk with me while weaving with ideas, people, and territory in the relational part. I share the how and why of the chosen theme and people for this project. This narrative highlights the threads to weave the project's methodology, where I emphasize and justify the research strategy. This second part of the chapter presents the relevant tools. In this

way, ethnography, vivencias, talking circles, and storytelling represent the relational tools most appropriate to the context. The third and last part of the chapter focuses on the project's ethics, listing the commitments agreed between the compañerxs and I. These commitments seek to reduce, as much as possible, the imbalance of power constantly present in these spaces.

Chapter three explores the principle of "*Buen Vivir*'s" relationality as a life philosophy deeply rooted in Indigenous cosmologies and its potential challenges when incorporated into public policy, particularly within the context of the SISPI in Colombia. In addition, it highlights the complexities of defining "*Buen Vivir*" due to its diverse interpretations across different Indigenous communities. As a result, the SISPI faces the challenge of incorporating these deeply rooted visions into a framework that provides comprehensive well-being while fostering intercultural interactions. The chapter also touches upon the historical context of Indigenous health systematization in Colombia and the intertwined narratives of resistance against colonialism and the pursuit of self-determined health. The chapter underscores the importance of recognizing and integrating Indigenous knowledge and philosophies into public health policies, highlighting the challenges and complexities of such endeavors.

Chapter four focuses on the complicated and tense relationships in the protocolization of the SISPI between Indigenous Peoples and the dominant paradigm that governs the nation-state of Colombia. In this part of the dissertation, I share the experiences of three days of meetings negotiating the resolution of the *Plan de Atención a la Vida Colectiva de los Pueblos Indígenas* (PCVC-PI) [Care Plan for the Collective Life of Indigenous Peoples] as part of the SISPI. During these encounters, knots emerge as ontological dissonance weaving the blanket of the SISPI between Indigenous Peoples and the nation-state. This ontological dissonance becomes evident in both parties' different perceptions of health. Furthermore, this chapter analyzes the power

relations that unravel within the space of encounter and disagreement through interactions that expose the coloniality of power in these processes.

By centering myself more on accompanying SISPI in the *Departamento* of Vaupés, narratives of an intercultural model that worked well in the territory began to emerge. In this way, chapter five focuses on the intercultural model of PHC implemented in Vaupés during the 1980s and 1990s. This intercultural health model has been an important reference for Indigenous health in the territory, especially during the current COVID-19 pandemic. The chapter weaves the history of this model, amplifying the different voices that experienced first-hand an intercultural PHC that many still remember and miss. The voices I brought to this chapter came from conversations and written material documenting the model. Two central themes derived from these conversations: the influence of the anthropologist Juan Guevara Garzón and the Colombo-Dutch Health Agreement in Vaupés.

Chapter Six: Transition Story details the challenges and lessons learned in coordinating a visit to Vaupés, Colombia, by a committee from the SSI-MPC. The narrative highlights the need to understand the complexity of relationships among Indigenous organizations and the importance of careful and respectful dialogue in this context. The story underscores the importance of learning from mistakes and adapting to local cultural sensitivities and practices, which I illustrate through real-life situations like the coordination issues of the visit and the responses to the initial lack of effective communication with Indigenous organizations. This process emphasizes humility, responsibility, and effective communication as requirements to conduct respectful and practical work in Indigenous contexts.

In chapter seven, I focus on the shared vivencias about the development of COVID-19 in Vaupés and the rest of the Amazon region in Colombia. Although the situation in the Panamazon region

is of concern, ancestral knowledge has been critical for the management of this highly contagious virus. In this way, the SISPI stands out as an important system for Indigenous Peoples that already shows fundamental movements towards its implementation. Thus, the weaving of this chapter intertwines with interactions in situ and away. Three parts define this chapter: The start of COVID-19 in Vaupés, conversations about the pandemic in the distance, and an intercultural radio program fighting COVID-19 in the Amazon region of Colombia. These three parts highlight how *"Buen Vivir"* informs what is happening in the territory and promotes actions to face the pandemic with its own and intercultural knowledge.

The dissertation ends with chapter eight, presenting conclusions from my limited experiences and place of speech. These conclusions focus on the wealth of Indigenous Peoples and not on their scarcity since scarcity is the product that the destructive project of economic development and growth of the modern global world sold to us. In this chapter, I also join the sentiments of many colleagues to transmute from a classical colonial, or even modern Eurocentric, anthropology to one of liberation led by local people's desires and knowledge. I propose to unlearn and learn again about the politics of life centered on the community promoted by different global Buenos Vivires. *"Buen Vivir"* refers to the politics of life as what allows good health by balancing relationships among all beings that make life possible in general.

CHAPTER TWO – METHODOLOGY

> *"Las universidades hasta ahora han propuesto una educación desde el ser. Pero, ese ser que nos han formado es un ser individualista, mercantil, racional, que solamente mira en un solo punto que es el tiempo lineal. Entonces nosotros [los Pueblos Indígenas] empezamos a plantear que así no debe ser la educación porque esa educación lo que nos ha hecho es una ruptura con la madre tierra… para volver otra vez a acercarnos a la madre tierra nos posibilitaría saber el papel que tenemos los seres humanos ¿Cuál es ese papel? Proteger a ella. Entonces la educación ya no puede ser individual sino colectiva, desde el corazón, que permee de que somos parte de la naturaleza [y que] no estamos por encima de la naturaleza como nos han enseñado en las universidades."* ~ Dr. Abadio Green Stocel (Pedagogía de la Madre Tierra)
>
> *"Until now, universities have proposed an education based on the self. However, the self they have formed is an individualistic, commercial, rational being that only looks at one point, which is linear time. Therefore, we* [Indigenous Peoples] *began to propose that education should not be like that because that education has caused a [relational] rupture with Mother Earth... to return to Mother Earth would enable us to understand the role that human beings have [in life]. What is that role? To protect her. So, education cannot be individual anymore, but collective, from the heart, permeating the idea that we are part of nature [and] we are not above nature as we have been taught in universities."* ~ Dr. Abadio Green Stocel (Pedagogy of Mother Earth)

Introduction

Learning about all this history from a critical lens led me to reflect on how to develop my dissertation work in a decolonizing way. In this work, I advocate for a continuous process of critically reflecting on epistemic justice through decolonizing research practices. However, different perspectives may perceive decolonization differently. My approach to decolonizing research practices centers on the priorities of local autonomy in knowledge and territory, destabilizing the colonial logic of hierarchical hegemony of domination and exploitation.

In this chapter, I present a research methodology relevant to the context. Although my approach involves research tools from the dominant Western paradigm, I try to converse, listen, and be guided by Indigenous knowledge of *"Buen Vivir"* [Good Living]. As part of this Indigenous

knowledge guide, I am putting into practice the concept of relationality by describing, to the best of my ability, the relationships I have built and continue to build as part of this research project. Through the description of these relationships, I present the methodology of this project with its challenges and learnings. The structure of the chapter focuses on placing the different relevant aspects of the project relationally to understand the methodology that guides the research. This relational position is a practice of the teachings of academic Shawn Wilson (2008) in his book "*Research is Ceremony*," where he positions himself relationally in research with his Cree community in Canada. Although I try to maintain a chronological order of the stories throughout the manuscript, the interconnected relationships make it difficult to keep them linear. Instead, the stories connect as interrelated networks between time and space.

Relationality with the SISPI project

When I was admitted to the University of Washington (UW) in 2016 as a master's student in Global Health, it was not in my thoughts to work in Colombia, much less with Indigenous communities. At the beginning of my MPH, my master's advisor and future doctoral advisor, James Pfeiffer[17], sat down with me to evaluate the goals of my master's program and how he could support me in achieving those goals. My previous work had focused on the health of im/migrant farmworker communities in the United States, specifically in Florida. I intended to continue my studies in that line of research at UW. However, James asked me, confirming: "*Hugo, you're from Colombia, right?*" Upon responding affirmatively, he asked me the question that would change the course of the topic and the place of my professional career, "*Wouldn't you like to work there?*" His question drew a smile of excitement from me, as that was something I

[17] The power hierarchies within and outside of academia are power dynamics that perpetuate colonialist hegemonies by overlaying the superiority of one knowledge over another through these titles. Therefore, to align with and maintain the principles of this project, I will refer to colleagues in this manuscript without academic titles.

desired but did not see as possible. Responding positively once again, James told me about a Colombian colleague who worked with him at *Health Alliance International* (HAI) and now directed a *Non-Governmental Organization* (NGO) in Colombia called *Sinergias.* James encouraged me to contact him to see if there were possibilities for working on a thesis project and practicum in Colombia to fulfill the requirements of the MPH. Seeing this opportunity, I decided to set a phone meeting with Sinergias' director, Pablo Montoya[18], in December 2016, whose headquarters are in Bogotá, Colombia. Montoya is a physician from the *Universidad Nacional de Colombia* [National University of Colombia] with a master's degree in global public health from the UW, where he met James. They would later work together at HAI, an organization associated with the UW. Montoya's work with Indigenous health dates to the 1990s as a practicing physician in the Colombian Amazon.

The network of relationships I built during my vivencias in Colombia was thanks to Sinergias, who provided me with unconditional support at every level. I immediately clicked with Montoya and discussed the possibility of working with the organization. A list of projects I could participate in emerged. One project that particularly caught my attention was the educational workshops to prevent, diagnose, and treat neglected infectious (tropical) diseases in Indigenous communities in the *Departamento* of Guainía. Montoya told me that these workshops were interactive and that the Indigenous communities in the area had contributed to the construction of the materials, which I found very interesting and gave me a new perspective on research. My curiosity about this collaborative practice led me to propose an internship to evaluate Sinergias' educational materials used in the workshops with the Indigenous communities of Guainía, a

[18] From this point forward, I will refer to Pablo Montoya as Montoya to avoid confusion with another colleague who contributed to the path we have been following, also named Pablo.

proposal that Montoya received positively. Through further conversations, Montoya helped me develop a master's thesis project focused on following up the process of piloting the Ministry of Health's new *Modelo Integral de Atención en Salud* (MIAS) [Comprehensive Health Care Model] in Guainía.

The topic was timely since Guainía is a territory with a mostly Indigenous population and concerned health indicators. In the summer of 2017, while I was in Bogotá for my first meeting with Sinergias, Montoya informed me about the development of the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System], which was nearing standardization for national implementation. Due to the highly Indigenous demographics of Guainía and the topic of my master's thesis on MIAS, it seemed appropriate to include the SISPI in the research on how different actors in the system perceive these two health approaches. While constructing interview questions for MIAS research, I met Pablo Martínez[19], a physician, anthropologist, and economist working in Indigenous health and with Sinergias for many years, particularly in strengthening Indigenous knowledge and systems. In one of my many conversations with Martínez, he told me that Indigenous Peoples clearly understood what they wanted with the SISPI.

On the other hand, Martinez shared that the MIAS brought similar elements of the SISPI but did not consider Indigenous cosmovision. In this conversation, the name of anthropologist Juan Guevara emerged. Guevara worked with the *Servicio Seccional de Salud de Vaupés* (SSSV) [Regional Health Service of Vaupés], adapting PHC for Indigenous communities in the region. He used *Participatory Action Research* (PAR) for this work during the 1980s, 1990s, and early

[19] De este punto en adelante me referiré a Pablo Martínez como Martínez, para evitar confusión con Pablo Montoya.

2000s. Martínez told me that Guevara's work was used as a base of information for developing MIAS, but without real community participation. To learn more about the SISPI, Montoya and Martínez connected me with colleagues Rafael and Rosendo, who are experts on the subject and spoke with me directly.

Maria Camila Rodríguez, a doctor from the *Universidad Nacional de Colombia* [National University of Colombia] with a master's degree in global public health from the UW, accompanied me on my visit to Guainía. She taught me a lot about the region's Indigenous context and institutional framework. Due to her long work history in the area, Camila (preferred name) has extensive knowledge about the social structures and dynamics of relationships in the Amazon region. Camila's parents, both recognized researchers (anthropologists and biologists), have worked with many Indigenous communities in the Amazon region for several decades. She has gained much of her understanding of these communities from them.

During one of our conversations, Camila explained the differences between ethnic groups and the importance of understanding how they relate to each other, institutions, and "white" people. She told me that the dynamics of these relationships differed between the *Departamento* of Vaupés and Guainía because the ethnic and geographic contexts varied in many ways. In this conversation, the name of Juan Guevara came up again as how he entered the Vaupés jungle to build an APS model with Indigenous communities based on their cosmovision and open to being complemented with biomedical knowledge of the time. Although Guevara's work was in Vaupés, I wondered if something similar happened in Guainía with MIAS and SISPI. But the answer to this question would become evident thanks to conversations with national and local Indigenous leaders.

In conversations with Indigenous leaders at the national level (in Bogotá) and local level (in Guainía) about MIAS, the topic of SISPI came up. Indigenous leadership said the government did not consider SISPI when creating MIAS. At the national level, Indigenous leadership commented that government officials never mentioned the topic of MIAS during meetings about SISPI. Guainía is an example of this lack of communication. Some Indigenous leaders in the region even told me many communities confused MIAS with SISPI (Puerto 2018). Additionally, government officials and healthcare providers who participated in MIAS research interviews acknowledged a lack of knowledge about SISPI in institutions and Indigenous communities (Puerto 2018). These findings left a big question about the implementation status of SISPI and its role within the SGSSS. The SISPI, in response to the lack of culturally appropriate healthcare at all levels for Indigenous Peoples in Colombia, is promising but faces economic, political, colonial, and communication challenges. This visit to Guainía would give me the platform for a doctoral research project on the SISPI that would begin in the summer of 2018.

The first few days of my return to Colombia in mid-June 2018 were filled with emotions as it was a visit to continue developing relationships and finalize my doctoral thesis topic. I was determined to build a participatory research project since I learned more about the community-based participatory research used by Indigenous communities (Wallerstein et al. 2018). This visit aimed to talk to Indigenous leaders to see if they were interested in working with me as part of the doctoral research process. I had the support of colleagues from Sinergias, who suggested I speak with some communities in Vaupés to see if they were interested in working with me. It was a timely moment since the organization worked with 18 Indigenous communities in the area, and their relationship with these communities was healthy and positive. First, however, I needed to speak with compañeros Rosendo and Rafael (Indigenous delegates of the Indigenous Health

Subcommittee of the Permanent Concertation Table - SSI-MPC - with Indigenous Peoples and Organizations) to present the results of MIAS research and obtain their approval for the participatory research proposal on SISPI as Indigenous national leadership. Therefore, I scheduled my trip to Vaupés for mid-July. Still, I was worried because the approval and support of Indigenous national leadership were essential to working on a participatory research project with local Indigenous communities. Compañeros Rosendo and Rafael had a very tight schedule, but I met with them independently a week before the trip to Vaupés.

First, I met with compañero Rosendo to personally present the conclusions of my master's thesis on the MIAS. Then, we discussed the challenges the MIAS faces when viewing health from a Western perspective rather than the Indigenous cosmovision. Rosendo explained that these differing perspectives on health continue to create obstacles for Indigenous Peoples to access appropriate health services in their contexts. Thus, it was necessary to construct the SISPI, where its fundamental basis is the Indigenous cosmovision of *"Buen Vivir."* After listening to Rosendo, I expressed my interest in conducting participatory research for my doctoral thesis, accompanying the SISPI from the national to the local level. The idea was to use the research to support and strengthen the SISPI. At this point, I shared my tentative research question: Can bridges be built between Indigenous medicine and biomedicine? And if so, how could these bridges be built through the SISPI? Rosendo said these were fundamental questions, but there was a more pressing issue: How can the SISPI support the construction or strengthening of the health models of each Indigenous community in Colombia? In response to this question, Rosendo invited me to read the SISPI methodological guide to understand this health system and seek answers at the local level in Vaupés, if the Indigenous communities in this region are willing to work with me. Compañero Rosendo also explained that it was necessary for each

community to define who the actors are in their respective health model and to determine what resources they have available. Therefore, Rosendo highlighted the need to strengthen local communities' technical and political capacities to have a sustainable system. At the end of our conversation, Rosendo expressed his support for the research as long as communication was transparent and open throughout the process, which was our first professional commitment. This first meeting began to weave an important relational thread into the project. However, I still had to speak with compañero Rafael, who was the technical secretary of the SSI-MPC during the construction and protocolization process of the SISPI.

I arrived early at the *Organización Nacional Indígena de Colombia* (ONIC) [National Indigenous Organization of Colombia] office two days later for the scheduled 8 am meeting with compañero Rafael. He warmly greeted me and let me know he could only meet for a few minutes as he had a meeting with the SSI-MPC at the same ONIC office. I quickly explained the results of the investigation on the MIAS, and Rafael immediately thanked me because these results were something that Indigenous leadership had been hearing from the grassroots in Guainía. The information I shared with Rafael reiterated the MIAS's disconnection from the context despite its good intentions. I quickly informed him of my research proposal and meeting with compañero Rosendo. At that moment, he looked at me and asked, "*Do you have time today to join us in the SSI-MPC meeting? That meeting would help you learn more about SISPI.*" Accepting his invitation with great gratitude, I settled into the meeting room where the meeting would take place.

It was a small meeting of six members of the SSI-MPC from Indigenous leadership and a Ministry of Health advisor[20]. The group's interaction showed the camaraderie of a strong bond dating back to the early stages of the SISPI. As participants arrived at the meeting, I felt nervous, recognizing that my positionality could influence the conversation if I did not handle it well. However, the meeting participants welcomed me to the dialogue regardless of where I came from. I acknowledged that my knowledge of SISPI was new and that I only gave my opinion from my limited experiences on the subject. At some passages they encouraged me to participate in the discussion by sharing my perspective. The purpose of this encounter was to finalize the SISPI document before sending it to the Ministry of Health for approval. In this meeting, I learned more about the history of SISPI, its components, and the flexibility of this system for Indigenous communities to develop their health models and connect with SISPI at the national level. In this dialogue, colleagues discussed a challenging aspect of implementing SISPI, how or through which agencies and local health models could connect harmoniously with SISPI. This challenge is what compañero Rosendo told me in our previous conversation and what we would try to investigate with the doctoral thesis project.

One of the compañeros I met that day was Alcides Musse Mumucue, from the Nasa People, who significantly contributed to creating the SISPI at the national level and with whom I developed a great friendship. At the meeting, I learned that the CRIC had a well-structured health system and was a model for building the SISPI nationwide. The idea was to build a nationwide SISPI to benefit all Indigenous Peoples in Colombia. The meeting lasted approximately 10 hours, and

[20] I will refer to this advisor with the pseudonym Victoria since I couldn't obtain consent to use their name for this manuscript.

many of us were tired, but there was a strong desire to keep working. During autonomous meetings, the discussion of pending issues would continue for the next few days.

At the end of the meeting, I talked with colleagues Rafael and Victoria about my thesis proposal. I told them about my trip to Vaupés through Sinergias. They knew the work of Sinergias, especially through the work of the "Pablos" (Pablo Montoya and Pablo Martinez). Sinergias' strong relationships with Indigenous organizations, non-governmental organizations, and government institutions at the national and local levels were fundamental to my access to different colleagues, both Indigenous and non-Indigenous. With this access also came a great responsibility on my part toward them. Rafael and Victoria well-received the proposal on the condition that it strengthens the SISPI and does not fragment it. Throughout the process, the commitment to transparency was revisited in this conversation since there is no *Indigenous Institutional Review Board* (IIRB) in social research for researchers to be accountable for their work to Indigenous communities. For a few minutes, we discussed the possibility of building an Indigenous IIRB in Colombia and using this research project as the first case. Unfortunately, there was no personnel or resources to initiate an Indigenous IIRB, although Rafael said it was an essential issue for future discussions with Indigenous leadership. Despite being unable to formalize an Indigenous IIRB, I proposed the idea of an Indigenous co-investigator to maintain balance in the process. They thought it was a good idea but warned me they didn't know if someone was available since it was a temporary job. It didn't help that I couldn't provide a clear picture of the specifics of compensation because I first needed to obtain funds for the project. However, our conversation ended with their verbal approval and support for the research project. With the support of compañeros Rosendo, Rafael, and Victoria, I left the meeting feeling more at ease about the trip to Vaupés.

Relationality with Colonialism and Whiteness

I was born and raised in Colombia, an environment that celebrates mestizaje as a source of national pride. However, this celebration hides a silent process of "*whiteness.*" But what do I mean by *whiteness*? According to RacismoMx director José Antonio Aguilar (2020), *whiteness* is the attitude and mentality that considers white, modern, and Western culture superior to any other culture, race, or way of thinking. This hierarchy of *whiteness* encompasses several aspects of social identities, such as race, class, gender, sexuality, and ability (Lund 2022). As a result, the norms constructed in many territories influenced by *whiteness* tend to perceive *whiteness* as a social goal. By this, I mean the attempt to adopt languages, religions, lifestyles, and values, especially from white elites from the global north (especially from Europe and the United States). Therefore, *whiteness* is not necessarily linked just to skin color. Instead, it often involves ignoring racial and class consciousness and denying the perspective and knowledge of Indigenous and Afro-descendant Peoples, systematically making them invisible (Aguilar 2020).

This understanding of mestizaje (racial and cultural mixing) as a form of *whiteness* is much clearer as I reflect on my relative systemic advantages. For example, I never had to think about my skin color, sexuality, or faith when experiencing my environment as a cisgender, heterosexual, and Catholic man (no longer practicing it). In this environment, using words like "Indian" negatively to degrade an individual is an example of silent *whiteness*, rejecting or diminishing anything that does not align with this attitude or mentality. Peter Wade explains that, although mestizaje wants to pass as pride in inclusion and mixing of groups, it actually "marginalizes black and Indigenous Peoples while valuing *whiteness*" (2005).

After reflecting on my mestizaje, I could not help but feel a mix of emotions because colonialism took away from me, like many others, the opportunity to know my Andean ancestry. This

reflection does not intend to justify any right or appropriation of Indigenous knowledge. Instead, I share this experience because even though I did not grow up with the knowledge of my Andean ancestors, I refuse to perpetuate the colonial imaginary that seeks to disappear native representation through mestizaje silently. This research project is helping me rediscover my ancestry, which colonialism took away, and acknowledge our collective traumatic historical context in *Abya Yala* that still affects us all.

This ancestral denial process has been ongoing for centuries and is intimately related to power. According to the Oxford Dictionary (2022), power is "*the capacity or ability to direct or influence the behavior of others or the course of events.*" One of my great mentors and friends, the scholar and activist Rachel Chapman (2022), concisely describes power as a "*possession of controlling influence.*" Reflecting on these power dynamics over my mestizaje, I also reflected on colonialism's mechanisms and tools to eliminate the native as native through *whiteness*. Researchers have studied these approaches based on the premise of settler colonialism. Australian anthropologist Patrick Wolfe describes settler colonialism as a "*land-centered project*" with the premise of eliminating Indigenous Peoples to establish a permanent settlement (2006). Settler colonialism focuses on the mechanisms that settlers use to impose their institutions and values over those who previously lived in those territories to validate their presence and control at any cost. Therefore, settler colonialism follows the logic of elimination and possession. I identify these logics as colonial logics. Wolfe (2006) explains that this type of colonialism is not just an event but a process that continually seeks to dispossess Indigenous Peoples of their lands and eliminate them. The logic of elimination that Wolfe (2006) speaks of describes not only the physical elimination of the native but also the native in themself (i.e., knowledge, language, norms, gender, and sex, among other aspects), which is what I was

referring to in my reflection on mestizaje. Therefore, settler colonialism constructs structures of oppression, including structural racism, guided by a logic of elimination and possession, validating the possession of the land they invaded (Wolfe 2006) and subjugating, in some instances, the people of those lands for labor (Speed 2017).

In *Abya Yala*, one of the biggest exponents of colonial logics was the Peruvian sociologist Aníbal Quijano (2000; 2007) through a critical reflection on the power matrix (see figure 8). Quijano's reflection is very similar to Wolfe's. Through this matrix, Quijano (2000) explains a process of domination and exploitation in five fundamental areas of society: labor, collective authority, subjectivity, sex, and nature. This matrix explains how colonial logics are foundational on structures of oppression that still govern the dominant Western paradigm.

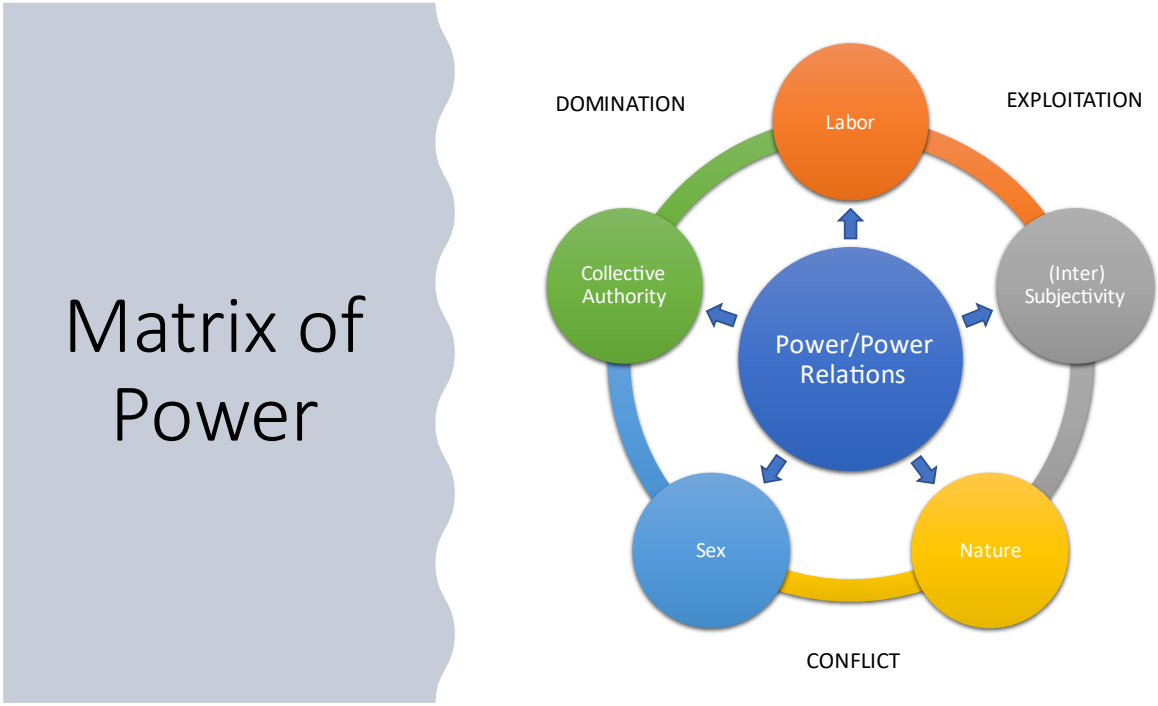


Figure 8. Visual representation of Quijano's Matrix of Power.

The matrix of power that Quijano (2000) proposes is the basis of a permanent colonization process, which he calls the coloniality of power. He explains that the beginning of the coloniality of power in *Abya Yala* was due to the European invasion (also known as the "conquest"). This coloniality of power seeks to establish a system that reinforces the urban European social hegemony, with its values and customs, to impose forced assimilation on the invaded territories to put natives at the service of European elites. From this event, Quijano derives two axes, one of a system of domination and the other of a colonial axis. From this event, Quijano derives two axes, one of a domination system and the other colonial. The first axis leads to a social classification to justify access to land and resources and impose its system of knowledge. While the second focuses on production control (see figure 9) (Quijano 2000).

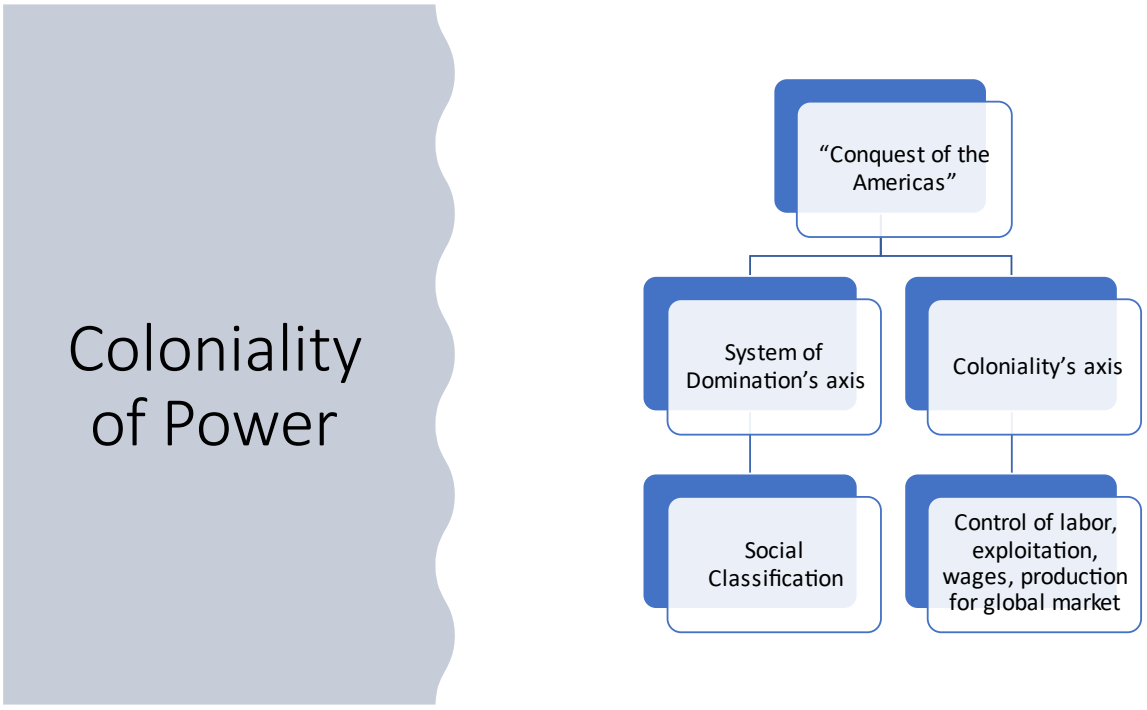


Figure 9. Visual representation of Quijano's Coloniality of Power.

Within this framework, historiographic and ethnographic work allows academics to situate Indigenous struggles in the present day, revealing their ongoing resistance and resilience against

this oppressive structure. It also provides potential alternatives for Indigenous Peoples to continue resisting colonial logic (Kauanui 2018; Dennison 2017; Morgensen 2012; Stark and Stark 2018; Arvin, Tuck, and Morrill 2013; Hunt and Holmes 2015; Tuck and Yang 2018; Simpson 2007; Todd 2016; Dhamoon 2015; S. Wilson 2008; Smith 2013; Slater 2017). This critical reflection challenges the foundations of the dominant Western paradigm, revealing an oppressive structure that most of us reinforce.

On the other hand, there is another way of colonization in *Abya Yala*, the colonization of the occupant. This focuses more on settlers who come to occupy a territory to exploit its "natural resources," but without any indication of staying permanently (Rivera Cusicanqui 1984). However, it follows colonial logics with the objective of accessing territories and labor (Rivera Cusicanqui 1984). The colonization of *Abya Yala* took both forms of colonialism (settler and occupant), which continues to affect the lives of Indigenous Peoples through the coloniality of power. For the Indigenous health in Colombia, for example, the impacts of the coloniality of power materialize in the lack of equity in the national health system for Indigenous Peoples. The recent COVID-19 pandemic revealed that fragmented and unequal health structure for Indigenous Peoples in this country, especially overlooking one of the territories most affected by the pandemic, the Amazon.

In this regard, anthropologist Shawn Wilson's work is a powerful approach to addressing topics about relationality and power with communities participating in anthropological work. Wilson (2008) suggests that the participating community's ontology, epistemology, methodology, and axiology (see table 1) should guide a research project. In his book, "*Research Is Ceremony*," Wilson argues that Indigenous Peoples and research must "*break free from the hegemony of the dominant system*" by establishing self-determination in conducting research (S. Wilson 2008,

17). He states that the foundations of Indigenous research paradigms are constructing and maintaining relationships, providing a concise justification for his research framework with his Cree community.

Table 1. Definitions of ontology, epistemology, and methodology provided by academic Shawn Wilson (2008, 33–34)

Ontology	Ontology is the theory about the nature of existence or reality. Ontology asks the question, "What is real?"
Epistemology	Epistemology is the study of the nature of thought or knowledge. Epistemology asks, "How do we know what is real?"
Methodology	The methodology refers to the theory of how knowledge is acquired, or in other words, the science of discovering things. Methodology asks, "How do we find out more about this reality?"

One key aspect highlighted by many academics, particularly Indigenous scholars, is the importance of relationality in research and in many aspects of life (S. Wilson 2008; Smith 2013; Tuck and Yang 2018; Simpson 2007; Dennison 2017; TallBear 2014; Hunt and Holmes 2015; Dhamoon 2015; Slater 2017; Todd 2016; Mbembe 2016; Fals Borda 1996; Escobar 2018). I understand relationality as the interconnectedness of all beings (both human and non-human) that walk on this path we call life. This definition is not foreign to Indigenous colleagues with whom I shared experiences during this research project. Relationality is fundamental to *"Buen Vivir,"* which I perceive as the fundamental principle that guides the SISPI. Departing from this Indigenous paradigm of relationality, I reflected that the principles of the dominant anthropocentric paradigm could not be guiding this research project. I also reflected that my limited understanding of the density of Indigenous knowledge would not allow me to construct a

research project fully from the paradigm of *"Buen Vivir."* So, one of the project's biggest challenges emerged with the question of how to design this research from the Indigenous paradigm in Colombia. There is great diversity among Indigenous groups in Colombia. Would it be necessary to bring multiple paradigms? When consulting with compañero Alcides about these challenges and his suggestions for working with Indigenous Peoples from their priorities, he replied…

> *To work with* Indigenous *Peoples, you have to unlearn in order to relearn. If you come with your own way of thinking to try to work with us* [Indigenous Peoples], *it won't work. You have to allow yourself to be taught.* (Vivencias notes 2018).

His words gave me direction to walk on this path, weaving relationships. Therefore, I focused on facilitating dialogue among ways of knowledge through the guidance of different companions. This guidance allowed me to begin the unlearning and relearning process and recognize my limitations. Compañero Alcides also said that, although there is a wide diversity of Indigenous Peoples in Colombia, they share the principle of relationality. This principle is fundamental for the *"Buen Vivir"* and therefore critical for the SISPI.

Relationality with Density

I came to this project with intellectual influences from many academic sources and biases resulting from the dominant global Western paradigm in which I grew up. Designing this research project, I learned from the ideas proposed primarily by Indigenous scholars from the United States, Canada, Australia, and New Zealand. When relating to the context of Indigenous health in Colombia, academic works in *Abya Yala* have guided me to better understand the Indigenous issues in this part of the world. My relationship with the ideas that led me down this path continues to be forged as I constantly unlearn and relearn from other knowledge sources. One of these ideas, intimately related to this project and very present in this document, is density.

To understand what density is and its relationship with research, I will share a fragment of a debate on indigeneity/indigenism. This academic review will allow me to turn to density as the most appropriate approach to guide a significant part of this project, which consciously keeps me reflecting internally from my roles as a researcher and human being.

In the diverse literature produced by scholars focused on *Abya Yala*, the terms "indigeneity" and "indigenism" frequently appear (sometimes interchangeably) as keywords used in anthropological work with Indigenous Peoples in this geopolitical region. Within ethnographic and historiographic research in *Abya Yala*, these terms describe a complex and constant construction of "self-identification and identification by others" about who is Indigenous (De La Cadena and Starn 2007). These controversial terms are social constructions that arise from "difference and equality" (De La Cadena and Starn 2007). The term "Indigenous" originated as a label constructed by European colonizers who used it to create categories of primitive/civilized to impose their hegemony over native groups and justify their invasions from the position of legitimate and "civilized" masters of the land (Gerharz, Uddin, and Chakkarath 2017; De La Cadena and Starn 2007; Kaltmeier and Rufer 2017).

The practice of creating labels of "otherness," characterizing Indigenous Peoples as "inferior," "uncivilized," "infantile," and "vulnerable," among other stereotypes, remains part of the discourse of the colonizers, the state, the church, and academia (Kaltmeier and Rufer 2017). European and missionary ethnographic work in the Amazon region, for example, evidences a static representation of Indigenous Peoples (Silva 2016; Becerra 2015) and creates their historical narratives from the colonial perspective that silences the voices of these communities (Pineda Camacho 2005). Indigeneity/indigenism is a colonial representation that would not exist without the binaries of colonizers/natives.

While most ethnographic and historiographic work in *Abya Yala* uses indigeneity and indigenism interchangeably, there are some anthropological works in which the conceptual meaning of these terms fluctuates. For example, scholar Peter Wade (2013) asserts that indigenism is a concept that focuses on the Indigenous past, while indigeneity refers to current Indigenous identities. Here, he refers to indigenism as an "*assimilationist and paternalistic ideology*" used by European invaders during colonization (Wade 2013). In the same line as Wade, anthropologist Alcida Rita Ramos (1998) analyzes how the conceptualization of indigeneity/indigenism by the Brazilian government and urban areas is used to characterize Indigenous Peoples as less than human but also as a key population in the formation of the nation-state's identity. However, she clarifies that when the construction of indigeneity/indigenism involves the participation of Indigenous Peoples, it becomes a collection of ideas about Indigenous recognition and self-determination within the nation-state (Ramos 1998). Finally, building on the above meanings, De la Cadena and Starn (2007) assert that indigenism/Indigenousness is not a fixed form of existence but is "*a process; a series of encounters; a power structure; a set of relations; a matter of becoming.*"

However, Indigenous Peoples have a different perspective on these terms that carry negative connotations due to colonial ideas of eradication and exploitation. The rise of Indigenous voices worldwide in the 1980s, both politically and academically, gave the term "indigeneity" a meaning of power in resisting the gaze of the dominant Western paradigm (Ch'aska Eugenia and i Oller 2015; Canessa 2012; Grey Postero and Zamosc 2005; Kaltmeier and Rufer 2017). This rise led many anthropologists to focus their ethnographic studies on Indigenous political activism against neoliberalism (María Elena García 2005; Ramos 1998; Gerharz, Uddin, and Chakkarath 2017; Briones 2007; De La Cadena and Starn 2007; Blaser and de la Cadena 2017; Da Silva

2012; Grey Postero and Zamosc 2005; Kaltmeier and Rufer 2017; Hale 2004; Canessa 2012) and to situate the meaning of indigeneity/indigenism in different contexts.

These academic works focus on the political relations between Indigenous Peoples, the state, and global powers (María Elena García 2005; Ramos 1998; Gerharz, Uddin, and Chakkarath 2017; Briones 2007; De La Cadena and Starn 2007; Blaser and de la Cadena 2017; Da Silva 2012; Grey Postero and Zamosc 2005; Kaltmeier and Rufer 2017; Hale 2004; Canessa 2012). Some of these studies show the malleable conceptualization of indigeneity/indigenism within the political arena in this geopolitical area. The ethnographic work of anthropologist Andrew Canessa (2012) with the Aymara community of Wila Kjarken, for example, analyzes how Indigenous Peoples define indigeneity in Bolivia with the emergence of Indigenous social movements. Similarly, anthropologist Alcida Rita Ramos (1998) explores indigenism/indigeneity as "a political phenomenon" that reveals the domination logic of the Brazilian nation-state. These reflections are not unfamiliar with the problems facing Indigenous Peoples in Colombia.

The debate on identifying who is Indigenous in both the dominant Western and Indigenous paradigms continues in academia and outside of it. However, one of the constants I perceived is the focus on the difference between Indigenous and non-Indigenous, even among Indigenous Peoples. This focus is particularly noticeable from the dominant Western paradigm, but I also perceived it to some extent in conversations with Indigenous colleagues. From my reflections, these difference-focused approaches, mostly political, limit intercultural dialogue since an "other" is created and seen as different rather than a collective that offers other profound ways of seeing life. For example, in Colombia, the language used in the normative as an intercultural approach with communities - "enfoque diferencial" [differential approach] - focuses on the difference of those groups not part of the dominant Western paradigm. Based on my current

learning, that "differential approach" generates negative consequences, mostly unintended, propitiated by colonial logics.

When discussing these ideas and sharing them with José (Jabokū's son from the Puerto Golondrina community), he shared,

> *To understand the Indigenous Peoples, you must have an open mind and share with their community; live with them; feel with them. It is very difficult to try to understand Indigenous Peoples without building genuine relationships of mutual learning. Our ancestral knowledge is complex and deep and is not even transferred to another* Indigenous *person if they are unprepared to receive it. But we also cannot allow our knowledge to disappear. If it is not shared with the community, their priorities or needs will not be understood.* (Vivencias notes 2018).

José's words reminded me of a similar reflection I read about "*density*" in one of my classes. This concept, used by academic Chris Andersen (2009), is inspired by African American scholar Robin Kelley, who uses this concept to refer to the multifaceted and intricate nature of the Black Being, especially concerning the struggles and gestures beneath the surface (Kelley 2005). As Kelley conceives it, density represents the sources of creativity and desire often overlooked by the Western gaze. It signifies a complex, vivid experience that cannot be easily described or confined within simplistic academic frameworks. Building on this approach, Andersen (2009) draws parallels between the density of blackness and the complexity of indigeneity, emphasizing the dangers of reducing these experiences to general sets of structural imperatives. Representations from the white mainstream and binary oppositions undermine the authenticity and legitimacy of blackness and indigeneity by reductively fixing them in time and space. In this way, Andersen invites us to focus on density rather than the differences in working with Indigenous Peoples.

The density of Indigenous Peoples in Colombia is very rich and complex. Part of that complexity is the intimate interconnection of historical relationships (both beneficial and traumatic) that continue to shape the territory's future. For this reason, density is appropriate to guide reflections on the shared vivencias in this research.

Relationality with Research

Many reasons led me to study anthropology. One of them was my interest in learning about other customs and traditions. At the beginning of my career as an anthropologist, I knew little about the critical history of anthropology. Anthropology presented itself as a discipline of studying the "other" without my realizing it. It was not until I started my master's degree in anthropology in 2012 that I encountered critical historical reflections about the discipline I had never considered or read about in my undergraduate studies. It was a big shock to discover that anthropology emerged from colonialism to perpetuate that coloniality of power.

The discipline of anthropology emerged from colonialism in the 19th and early 20th centuries, often reflecting and perpetuating the power dynamics of colonial control. During this period, European powers were expanding into Africa, Asia, and the Americas, and anthropologists studied these "exotic" cultures, often through a Eurocentric lens (Said 1977). As a part of colonial administration, anthropologists helped to classify and categorize native societies, contributing to the understanding and often justification of their "otherness," which led to their subjugation (Asad 1973). This classification sometimes provided the intellectual justification for colonial rule, reinforcing stereotypes and racial hierarchies (Fabian 2014).

Even today, anthropological practices show the lingering influences of colonialism. Research methods that treat studied cultures as objects to be examined and dissected rather than engaging

with them on equal terms can perpetuate the unequal power relationships that were a hallmark of colonial rule (Smith 2013). Western institutions continue to dominate in defining the research agenda, even when the study subjects are in formerly colonized regions. This dominance echoes the extractive practices of the colonial period, where the colonizers took knowledge from these regions and used it primarily for their benefit. (Escobar 2011).

The influence of the colonial gaze in anthropology was replicated in my first approach to working with Indigenous communities in the nation-state of Colombia, starting from a superficial understanding of their struggles. My Western perception and privilege pushed me to see Indigenous Peoples from a romantic and exotic perspective of an "other." My respect and admiration for them at that time for their knowledge were more due to a desire to believe in magical and pure Indigenous wisdom in opposition to a dark and toxic capitalist society. Along the same line, I felt inclined to label Indigenous Peoples as a group of "vulnerable" individuals facing a predatory capitalist system. Although the label of Indigenous Peoples as "vulnerable" is used globally and locally by government and health institutions, it is not how many Indigenous Peoples see themselves. Through developing relationships in this project, I realized that we create a perception of the Indigenous person from our way of seeing the world, Western, even if we have good intentions.

In one of my first conversations with my colleague Rafael in 2017, I learned much about how colonized my mind is. Rafael pushed me to see the label of the Indigenous person as "vulnerable" more critically...

> *Until now, the court has just told us that Indigenous Peoples are no longer "savages." Until now, this year* [2017]*, they have just told us... that we cannot call Indigenous Peoples "savages," which is disrespectful...* [And] *I don't understand why the courts sometimes think we are vulnerable People, poor People... I don't*

> *understand that* [mentality]. *A characterization already very much ingrained in the country.* ~ Rafael Guayabo

With these words, Rafael explained that labeling Indigenous Peoples as "vulnerable" characterizes them as incapable of fighting and having autonomy in the nation-state. He told me that, on the contrary, Indigenous Peoples had fought hard for their survival.

The historical ties between anthropology and colonialism, and hearing these words from Rafael, make me think again about how to use anthropological tools in a decolonizing way in this research project. Can we dismantle the master's house with the master's tools, as the black feminist Audre Lorde (1984) discussed in her manuscript "*The Master's Tools Will Never Dismantle the Master's House*"? This question is difficult to answer with a simple yes or no. However, when I consulted this issue with one of the Elders in the Colombian Amazon while working on my public health master's degree in 2017, he responded with a series of reflective questions…

The Elder: *Why are tools created for?*

Hugo: *As support to build or destroy something.*

Elder: *Very well, and who uses them?*

Hugo: *Well, the person who builds or destroys something, right?*

Elder: *Okay, so do the tools build or destroy? Or is it the user depending on their purpose?*

Hugo: *The user.*

Elder: *Exactly. Tools are just that, tools. We are the ones who decide how to use them, to build, destroy, or even renovate. So, who is responsible for deciding how to use the tools?*

Hugo: *Us.*

Elder: *That's right! Sometimes some tools don't work for certain jobs, so we look for the appropriate ones.*

After this conversation, I concluded that we could use tools once employed to build systems of oppression to resist and/or change those oppressive systems. A non-oppressive perspective could use them even to build a new system. This reflection prompted me to investigate further what research tools could be used when working with Indigenous Peoples from a local, non-colonial perspective. Here, I came across many Indigenous scholars who offered their knowledge through their writings to guide me on this path.

For example, anthropologist Eve Tuck (2009; 2010) proposes research from a desire-based approach, rather than a damage-based approach, for Indigenous Peoples (or any other community affected by the dominant hegemonic paradigm). She argues that social sciences often use the suffering and pain of communities as the centerpiece to hold those in power accountable (Tuck 2009; Tuck and Yang 2018). These characterizations reinforce the colonial representation of these people as desperate and broken (Tuck 2009). As Tuck describes, "*Desire-based frameworks concern themselves with understanding the complexity, contradiction, and self-determination of lived lives*" (2009, 416). The documents I read about Indigenous Peoples in Colombia focused mainly on these communities' suffering. Eve Tuck provided me with an important research tool to detach myself from continuing that line of research based on suffering. Victimizing Indigenous Peoples makes their struggles, achievements, advances, and desires invisible. I do not suggest that we should not recognize the suffering embodied by Indigenous communities, but I suggest refocusing research on the desires and priorities of Indigenous

Peoples instead. Therefore, How could I develop research based on the desires of these specific communities, specifically in the Colombian context?

I came across PAR in this line of inquiry. One of its proponents, Orlando Fals-Borda (1996), used it as an emancipatory tool to break the subject/object binary by working hand in hand with participants throughout the research process, including decision-making. One of his significant suggestions for researchers is to become aware of their positionality and the power inequalities it entails (Fals Borda 1996). Fals-Borda (1996) emphasizes active reflection and critique of power by encouraging researchers to be skeptical of information that responds to dominant interests.

The PAR principles emphasize a collaborative and inclusive approach to knowledge and research (Fals-Borda 1996). Rather than monopolizing or imposing one's techniques, PAR encourages integrating professional skills with the wisdom of grassroots communities, treating them as full partners and co-researchers to bridge the gap between subject and object. In addition, it challenges dominant historical and scientific narratives, advocating for receptiveness to counternarratives that can be harnessed for education to further social struggles for justice. Moreover, the PAR also calls for a culturally inclusive interpretation of facts, recognizing and utilizing local values, traits, practices, beliefs, and arts in collaboration with researched organizations to enhance their dignity and power, aligning with the researcher's commitment to social justice. Finally, it emphasizes clear and engaging communication of results, rejecting the imposition of complex scientific jargon and promoting knowledge sharing in an understandable and literary manner, reflecting the belief that science should not be a mysterious domain exclusive to experts but accessible and pleasant for all.

In the early stages of my thesis project, I found it difficult to use the regular methodologies learned from the dominant Western research paradigm. When I refer to the dominant Western

paradigm now, I am describing a globalized paradigm where its ontology and epistemology are based on the logic of individuality, competition, possession, the human being as the center (especially in men), and the objectification of nature (cf Wilson 2008). Continuing my story, I struggled to use the dominant Western research methodologies because they rely on an ontological view that considers knowledge belonging to the individual, as stated by Wilson in his book (2008). However, knowledge belongs to the cosmos for the Indigenous colleagues I spoke with. Therefore, it was necessary to use more inclusive, flexible, and open methodologies to build a research strategy that allows different knowledge from each cosmovision to complement our efforts to make and respond to appropriate research questions.

On my return to Colombia in the summer of 2018, one of my great friends and colleagues, Ana Judith Blanco, provided me with even more information about the PAR. Ana Judith has an extensive background working with Indigenous health in Colombia. Through her, I learned much about the Colombian sociologist Orlando Fals-Borda's school and his work with PAR for social transformation. I heard about something similar here at the University of Washington called *Community-Based Participatory Research* (CBPR). I found that CBPR is just another way of doing PAR, but most importantly, I learned that these types of practices are more than just methodologies; they are a philosophy of life. As Fals-Borda stated, this practice allows us to be *"Sentipensantes"* [feel-thinkers] who "*think with the heart but also with the head*" (Ochoa 2015). Fals-Borda borrowed the concept of *feel-thinker* from a fisherman on the Colombian Atlantic Coast to describe a way of thinking and feeling that seeks to integrate intellect and emotion (Ochoa 2015).

Based on this information, the PAR sounded appropriate for the thesis research because it promotes empathy, highlights the importance of taking a stance on the priorities of the people we

are working with, and supporting them in addressing these priorities with the skills and resources we can provide; it is based on desire. Therefore, PAR has no standardized practice because it varies from context to context. So, I followed the best I could, and within my capacity, the principles of the PAR described earlier. With these principles of the PAR in mind, this research used a strategy of inquiry that was built with Indigenous and non-Indigenous peers to create a respectful and committed collaborative experience between the SSI-MPC, the Puerto Golondrina community, Sinergias and myself (Wallerstein et al. 2018; Fals Borda 1996).

Strategy of Inquiry

The information shared in this dissertation came from four trips to Colombia, spanning from July 2017 to March 2020, each visit lasting two to four months. These visits primarily centered around Bogotá and the *Departamento* of Vaupés while encompassing a short visit to the *Departamento* of Guainía. The information came from different sources and methods. One of the sources was me, documenting my vivencias extensively. In a sense, it had the component of auto-ethnography where I used how I embodied different situations to contribute to the collective learning process. In addition to sharing some of my vivencias, the compañeros(as) who walked with me in different parts of this journey also entrusted me with transmitting their vivencias. Many people shared their vivencias in various ways, including casual conversations, interviews, voice messages, and talking circles. All these vivencias came from interactions with reviewing government policy documents, sharing quality time with the community of Puerto Golondrina, attending national and local leadership meetings related to the SISPI, and talking to the Sinergias team. Even though there was a previous selection to work with the community of Puerto Golondrina with the respective permission, the compañeros(as) who participated in this collective learning process came into the project organically. Through supporting the

socialization of SISPI in Vaupés, compañeros(as) from different backgrounds and professions wanted to share their vivencias.

The first step in attempting to apply PAR was to carefully listen to the questions that Indigenous leaders were interested to address. As a result, and based on the importance of this network of relationships that sustains "*"Buen Vivir,"* Indigenous leaders at a national level were interested in answering the question of how SISPI can support the construction or strengthening of local Indigenous health models. And at the local level, the issue of highest priority is how to preserve and practice local Indigenous knowledge about health. In addition, there is interest in knowing how Indigenous communities can obtain culturally appropriate health services (in health facilities and from healthcare professionals who visit communities). Making these questions a priority for this dissertation, we developed a set of commitments and accountability with Indigenous leaders to strengthen the SISPI in Colombia. These commitments included transparency in our communications and constant reporting of the process. Additionally, I committed to sharing information about the SISPI with the communities I speak with, reviewing writings with Indigenous colleagues before making them public, supporting the SISPI in general, granting appropriate credit and compensation to Indigenous collaborators, and respecting cultural traditions.

After discussing with Indigenous and non-Indigenous colleagues at the national and local levels, we decided to use the tools of documenting and learning from vivencias and oral tradition as an appropriate research strategy. These tools are similar to the ones implemented in ethnographic research but go further within the Indigenous context even though they both seek to tell stories. However, ethnographic research focuses mainly, if not completely, on human interactions. An

important aspect of storytelling I learned from our Indigenous colleagues is that people are not the only ones who tell stories.

Accompanying the SISPI, the concept of vivencias emerges as a pivotal strategy of inquiry that transcends conventional methods. This approach is deeply rooted in the Indigenous philosophy. It offers a comprehensive understanding of experiences that are not merely confined to the physical and mental realms but extend to the instinctual and spiritual dimension.

The elders of the Indigenous communities I work with elucidate that vivencias is centered on embodying experiences through a complex web of interconnected relationships with other beings that form part of the environment. These multifaceted relationships encompass interactions between humans or between humans and non-humans. Such a perspective challenges the conventional dichotomies and offers a more nuanced understanding of the Indigenous cosmovision, where experiences are integral to a larger ecosystem.

Fals-Borda (1996) further enriches this argument by defining vivencias as a lived experience that is both purposeful and committed for the practitioner of PAR. Unlike theoretical knowledge from academic study, vivencias incorporates common people's wisdom and practical know-how. This practice is not a passive acquisition of information but an active engagement with the lived realities of the community. The principles of PAR likely serve as a framework to achieve this synthesis, allowing the practitioner to develop a more holistic and grounded understanding. This alignment with PAR principles underscores the relevance of *vivencias* as a methodological approach that is both culturally sensitive and epistemologically robust.

Using vivencias as a strategy of inquiry in the study of the SISPI is not merely a methodological choice but a philosophical stance that recognizes and honors the complexity and richness of

Indigenous knowledge systems. It bridges the gap between the academic and the experiential, fostering a dialogue that is both inclusive and transformative. The integration of vivencias thus is a testament to a research paradigm committed to social justice, cultural integrity, and intellectual rigor.

The second method, the oral tradition, focuses on the power of the word as a space for relational and sacred conversations, where I worked to build relationships and discuss the SISPI and its complexities. The oral tradition is of great importance to the Indigenous colleagues I shared and learned with because it is an ancient practice that produces and reproduces Indigenous knowledge. It is the action of embodying memories of our ancestors. These memories consist of the different relationships (human and non-human) that will develop during the inquiry process. Based on the principles of the relationality of the *"Buen Vivir,"* the Indigenous research strategy promotes these relational tools, which are foundational to the SISPI. Therefore, these relational aspects are the most useful, appropriate, and respectful ways of being aware of the empirical reality of Indigenous Peoples' resistance to a colonial state while navigating and confronting the complicated scenarios of building, protocolizing, and implementing the SISPI. In this project, I aim to apply an anti-oppressive research approach to the best of my abilities by following the relationality principles of the *"Buen Vivir."* Considering relationality and ethical responsibility is essential for conducting research that enables this practice. Donald (2009, 6) defines ethical responsibility as having a "*deeper understanding of how our different histories and experiences place us in relation to others.*"

While working in the Vaupés region, another area of the Colombian Amazon on the border with Brazil and Venezuela, I had the opportunity to experience collaborative work with Indigenous communities and Sinergias. The project focused on developing a food orientation manual for the

area. This collaborative work was key to learning firsthand how to include anti-oppressive tools in research. Additionally, I had the opportunity to develop good relationships with different communities and begin to support the SISPI locally by providing information and establishing communication from national to local Indigenous leadership (and vice versa), as it was part of my commitment to Indigenous leaders.

During my training on CBPR, one of the critical aspects taught in this training was creating a stakeholder advisory board (Wallerstein et al. 2018). Unfortunately, a formal advisory board could not materialize in a Western way. That rigid form of meeting and forming an advisory board was ineffective due to the lack of resources, space, and time. Although there were Indigenous leaders and community members interested in participating in the process, they had more urgent responsibilities. However, there were constant conversations with two leaders from the SSI-MPC (Rafael and Rosendo), a leader from the Puerto Golondrina community (José), my advisor at UW (James Pfeiffer), and the Sinergias team. I reported on the project's status and sought their advice orally and in writing independently, as it was difficult to get everyone simultaneously. Within this project, accountability forms a relationship of respect and reciprocity with Indigenous Peoples in Colombia, represented by the commitments assumed between the SSI-MPC, the Puerto Golondrina community, Sinergias, and myself. Four main themes represent these commitments: fair compensation, ownership of knowledge, participation of Indigenous colleagues, and being driven by Indigenous knowledge.

Regarding compensation, the compañeros(as) who contributed to this project received it according to their wishes. Compensation was not solely monetary. The information produced in this project belongs to the Indigenous relatives that participated in the project. I shared the information the Indigenous relatives allowed me to share. Additional information not referenced

in the manuscript belongs to the groups that participated in the project. The participation of Indigenous colleagues was constantly present during the process, both in Bogotá and Vaupés. Finally, as mentioned earlier, this research aims to be guided through the relational knowledge of "*‘‘Buen Vivir’’*," recognizing that it is an Indigenous paradigm knowledge and necessary in this research.

The SISPI presents a complex and multifaceted subject that requires a nuanced and culturally informed approach to analysis. In this context, integrating Dian Million's Felt Theory with Fals-Borda's description of the concept of *feel-thinker* offers a methodological perspective for understanding and analyzing the realities Indigenous communities face.

The Felt Theory, proposed by Dian Million (2009), explores the impact of Canadian First Nations and Métis women's narratives on mainstream scholarship, focusing on the colonial history of Canada and the United States. It emphasizes the political acts of these narratives, challenging the so-called "objective" accounts of colonial histories and shedding light on the poverty, discrimination, and genocidal child abuse faced by First Nations women. The theory also highlights the transformation of shame into a powerful experience, revealing colonialism's "domestic" secrets, and builds on the implications of affective discourses, stories, and narratives. It emphasizes the importance of felt experience as community knowledge and critiques academia's tendency to suppress Indigenous voices.

In parallel, *feel-thinking* emphasizes empathy, emotion, and intuition as equally valuable to logic and reason in the research process (Fals-Borda, Reason, and Bradbury 2006), fostering a direct link to the vivencias of the Indigenous community. By integrating Felt Theory into the framework of *feel-thinking*, the argument for utilizing it as an analytical tool in Indigenous health research becomes compelling and robust. The Felt Theory's emphasis on affective discourses and

the transformation of personal narratives resonate strongly with *feel-thinking*'s focus on feelings as integral to understanding (Million 2013). It also critiques the suppression of Indigenous voices in academia, aligning with Fals-Borda's commitment to community-based knowledge production.

Together, *feel-thinking* and the Felt Theory bridge the gap between emotion and logic, allowing for a more holistic understanding of the complex realities Indigenous communities face in Colombia. This integration not only supports a culturally informed way of analyzing Indigenous health issues but also advocates for the rights and recognition of Indigenous communities, challenging colonial histories and promoting self-determination.

In essence, the utilization of *feel-thinking* in this research is not merely an addition but a necessity, ensuring that exploring experiences is both an intellectual exercise and a profound journey that engages the whole being. This approach provides depth and authenticity, resonating with the complex realities of people and the environment, rooting this methodology in an intended ethical approach.

Limitations

I was guided in my research by Indigenous research paradigms, and that is fundamental for Indigenous Peoples to "*regain control of research*" about their lives (Smith 2013). In other words, the focus is more from an "*anti-oppressive*" lens where the methods are not what should be distinctive but the epistemology (Potts and Brown 2015) and methodology (Harding 1987). Despite my best efforts to use different lenses in the process of unlearning and relearning, I do not doubt that colonial threads still intertwine in this project. For example, the lack of broad participation is present in the dissertation project. Therefore, instead of treating this document as

an absolute about the SISPI, we should consider it one more thread in weaving the ongoing SISPI.

In my effort to build a participatory research project based on the principles of PAR (*Participatory Action Research*) and CBPR (*Community-Based Participatory Research*), I faced multifaceted challenges that hindered my goal of achieving truly inclusive participation. Resource limitations played a significant role, but the complexities were even deeper. For instance, the voices of children and some women from the community were missing. I did not have the ethical tools to work with children, such as obtaining parental consent, proper Institutional Review Board approval, a collaborative plan with the community, and ensuring their well-being through culturally appropriate research tools. Furthermore, there were no discussion spaces to amplify women's voices, especially in specific cultural contexts. Even though I established deep conversations with some Indigenous women leaders, it is understandable that some women in the communities distrust the "white" man from the "West" since there is a problematic history of abuse and discrimination by the "white" man towards Indigenous communities. This limitation highlights the unequal power dynamics that Indigenous women, and women in general, constantly face. These voices are critical to complement vivencias experiencing health and healthcare access in the region, which are unfortunately lacking in this project.

For the Indigenous Peoples I worked with, the principle of relationality includes both humans and non-humans. However, I could not include the voices of non-human entities, such as animals, plants, hills, and water, due to my strong "Western" epistemic influence and little understanding of this type of communication that remains beyond my reach. Herein lies the important role of knowledgeable Elders who are deeply intertwined with their environment and

serve as mediators to amplify these non-human voices. What some elders shared with me was intellectually enriching, but I did not practice it, and not embodying it limits me to talking about it.

Additionally, language barriers added even more to this complexity. Although I could communicate in Spanish with many of my Indigenous peers, the depth of their languages is guided by their worldviews. My understanding of topics that required fluency in the local language and a deeper relationship with the territory was limited. The dominant "Western" paradigm, which often overshadows and even questions the rich tapestry of Indigenous knowledge reproduced through their languages, influences my bias and reveals this limitation.

Before proceeding with the chapter, it is essential to mention that it was not possible to fully follow up on the SISPI in Vaupés with this research as I had to leave the territory due to the rapid spread of the COVID-19 virus in the Colombian nation-state and the world. However, we should not discard what we built up to that point.

The Relationality of Vaupés

I woke up very early on Tuesday, July 17, 2018, to finish packing for my trip. I checked twice to ensure I had everything I needed for my flight to Mitú, the capital of Vaupés, scheduled to leave Bogotá at 12:30 pm that day. Due to its dense jungle topography, the only way to enter Mitú from Bogotá is by plane. Only three flights leave per week on planes with a capacity of no more than 50 people. The flight was relatively smooth and short, only an hour and fifteen minutes. As we approached the landing, I could not help feeling excited as I saw, through the plane window, a huge green carpet of trees and rivers that looked like snakes caressing everything in their path. It was as if the jungle knew we were coming and welcomed the people arriving on that steel bird.

When I got off the plane, I felt the humid heat of a territory that warmly embraced me. It was a feeling I would never forget.

A colleague from Sinergias picked me up at the airport and took me to the hotel where I would stay. On the way, I noticed the strong presence of military forces and asked my colleague about it. He told me that the military presence increased due to the guerrilla takeover of Mitú in 1998, the only capital city taken by the FARC in its 60 years of existence. It lasted approximately 72 hours, leaving a lot of destruction and death. However, after the army expelled the FARC from Mitú, military presence increased to prevent a future attack. This event is one of the many impacts generated by the "white" man (as the area's Indigenous Peoples consider the colonizer) throughout history.

The history of Vaupés is complex from different perspectives. The accounts of the territory's history mark a division between pre- and post-contact with the "white" man. Indigenous knowledge holders maintained their pre-contact records in their mental and cultural libraries. Many of these libraries have disappeared, although the remaining ones share this knowledge with their communities through oral tradition. From my limited access to some of these knowledge holders, the functioning of our Indigenous relatives in this area is much more complicated than non-Indigenous anthropologists claim. It is an interconnection of visible and invisible relationships showing great knowledge of their relationships with their environment. Undoubtedly, my description here is superficial since these relatives' cosmovisions were not part of my education, but I share how I embodied these vivencias. Post-contact brought many changes for Indigenous communities and other actors in the area.

At the end of the 19th and beginning of the 20th century, religious missions in the Amazon region, first Catholic with the Capuchin monks and later with the evangelicals, significantly

impacted the lives of Indigenous Peoples. The religious doctrine led many people to abandon their ancestral practices or be ashamed. However, some communities have adopted the practices they want to maintain from external religions and their ancestral knowledge. Historical events added further complicated relationships in this territory. During this period, the Amazon was also heavily invaded by rubber exploitation (Mongua Calderón 2018). This rubber boom in Vaupés affected many communities as they suffered enslavement (Salazar, Gutiérrez, and Franco 2006) and diseases from outside (Sotomayor 1998b). At the end of the 20th century, another boom occurred in Vaupés, coca production. There are few written records about this boom. Still, in one of my conversations with an Indigenous colleague, he describes this brief event of great monetary abundance accompanied by increased alcohol consumption (Vivencias notes 2019). The presence of state-nation institutions and NGOs also impacted relations in Vaupés, marking another power dynamic within this territory. Public policies and cultural assimilation infrastructure, such as boarding schools, reflect the dominant Western paradigm's imposition on this region's Indigenous Peoples. With this brief historical framework of relations in the territory, I only seek to contextualize the complex dynamics of relationships in Vaupés broadly. With this in mind, I continue to share the interweaving of relationships through the dissertation project.

Relationality in Community

During my visit in 2018, it took me three days to speak with the community leaders to share and discuss the research project. I accompanied the Sinergias team to some communities they worked with during that time. In one of them, whose name I will omit, I witnessed a challenging conversation about mental health. Due to my ethical views, I will not give details of the situation, but I will say that the nation-state of Colombia did not consider mental health a problem in this area through their health data. On the contrary, despite different calls to address these issues, it

was perceived as almost non-existent in the area. The work of Sinergias emphasized this problem. They provided, working with the communities, data for a better overview of the mental and emotional well-being of the context. This work highlighted the issue with great caution as this situation provides two perspectives that need more dialogue. I mention this experience because the SISPI addresses what is known as mental health in the West comprehensively and relationally to Indigenous cosmovision.

The next day after this visit, I contacted the Captain[21] (Jabokū in the Pamíe language) of the community of Puerto Golondrina, Domingo Martínez. I met with Jabokū in the central park of Mitú next to the Ancestral Canoe monument (image 1) that represents the origins of the so-called "Cubeo" People (I will refer to them as the Pamiwa People from now on, as this is how these communities better identify themselves). Sitting on one of the park benches, Jabokū listened to me carefully as I explained the purpose of my visit. Jabokū received my words with respect and supported me in speaking with the community because they were the ones who ultimately had to decide if they wanted to work with me. Our conversation ended up scheduling my stay in the community for four days, arriving on Saturday, July 21. On the way to the Sinergias office, I met with the Jabokū from the other community I would ask to work with. He showed interest in the project, and we arranged for him to visit them after my visit to Puerto Golondrina.

[21] ***Captain*** is a community authority figure created under pressure from the nation-state to Indigenous communities, in order to establish a sociopolitical organization that can directly communicate with the institutions of the Colombian government to coordinate actions and receive resources for those communities. This imposed structure includes the creation of a community advisory council, composed of a vice-captain, secretary, health coordinator, work coordinator, sports coordinator, women's coordinator, education coordinator, and youth coordinator. This sociopolitical structure is not part of how Indigenous Peoples in these territories organized themselves prior to contact with "white" men.

Image 1. The Ancestral Canoe. Photo taken by Hugo Puerto during the 2018 visit.

On the morning of July 21st, Jabokū Domingo picked me up from one of the small ports, el Puerto del Burro, where canoes from different communities arrive and depart. Depending on the season, Puerto Golondrina is relatively close to Mitú, on the Cuduyarí River. The Vaupés rivers are abundant during the rainy season, generally from late March to early November. The river rises so high that it provides easier access to some communities near the Cuduyarí River, including Puerto Golondrina. It takes 20 - 25 minutes to get to Puerto Golondrina from Mitu during the rainy season. My first visit to Puerto Golondrina was during the rainy season.

During the dry season, some rapids formed, known as "cachiveras," (see Images 2 and 3) making navigation difficult. Additionally, the waters recede so much that it is no longer possible to cross the riverbanks of the Cuduyarí River that almost reach the community of Puerto Golondrina. For

this reason, canoes from Puerto Golondrina stop at the community of Santa Marta (approximately 15 – 20 minutes by canoe) and continue on foot for about 25 minutes to arrive at the community.

Image 2. Cuduyari River during the dry season at the Santa Marta community. Photo taken by Hugo Puerto, December 2019.

Image 3. "Cachivera" in Caño Sangre [Blood Canal] approximately 3 miles from Mitú. Photo taken by Hugo Puerto, December 2019.

Upon my arrival, Jabokū and one of the community elders, Hector, set me up in a house that was available for visitors. Elder Hector spoke with me and explained a bit about the community. He also taught me some words in Pamié, the community language. Elder Hector and his family supported me in preparing the food I had brought to share, although the food in the context was tastier.

In the afternoon, I met José Martínez (son of Jabokū, a community leader and great thinker), with whom I developed a professional and friendly relationship that we still maintain. Many of our conversations will come through this manuscript to share our critical reflections on different vivencias in this process. That night, Jabokū gathered the community to share my research

proposal. The meeting took place where all community events are held, including evangelical worship, which is part of the community. José offered his support as a translator during this meeting. After Jabokū introduced me and gave me the floor, I introduced myself by name and the entity I represented. There was a large community presence, so I continued to describe that I was accompanying the implementation of SISPI as a doctoral dissertation. With their permission, I also explained that I wanted to listen to the community on strengthening or building their own health models to begin supporting SISPI's work.

After José translated what I said, there was a conversation in Pamíe that I did not understand. I did not know what was going on until José asked me fundamental questions,

> *Hugo, first of all, thank you very much for thinking of us, but the community wants to know who you are (as a human being). How did you hear about us? Why did you choose us and not another community?*

They were excellent questions to which I responded with transparency and respect. I shared my entire history with Sinergias, and they recommended that I speak with the community of Puerto Golondrina since there was a previously established relationship. I also acknowledged that many of us, "whites," had abused Indigenous knowledge and lives, as well as their territories. Therefore, I explained that my interest was working with them on a community health priority. I also talked about how the data produced by the community would be theirs and that I would only use what they allowed me to. Therefore, I asked for permission from the community to stay with them for a few days to get to know each other on a basic human level. Upon receiving a positive response about my stay, we decided to discuss it in those days, and at the end of my visit, they would decide if they would like to work with me.

During my days in Puerto Golondrina, every family I spoke to welcomed me with a lot of warmth. I was able to talk with almost all of the families. We shared food, jokes, stories, and

thoughts. I learned a lot about their specialization in clay handicrafts, which is recognized nationally. It is a community full of life and excellent football players, both men and women. I also learned that the community's knowledge about health is highly valued, and they want to preserve and continue practicing it. Additionally, I understood that there was no knowledge about the SISPI, but I was interested in learning more about it.

The community met with me again on my last night at Puerto Golondrina. Jabokū started the conversation with a prayer. Subsequently, the same community members who initially participated proceeded to dialogue among themselves to decide if they were interested in working with me. José translated the decision that I received with great responsibility and respect. José said:

> *Hugo, we have decided that we want to work with you. Honestly, you have been one of the few people, if not the only one, who has asked us what we want. And that told us a lot about you.*

I felt very honored to receive that comment, although sad to know that we still live in an oppressive society that continues with predatory colonialist behavior against Indigenous Peoples. Nevertheless, they were clear in their desire to preserve their health knowledge. Some ways to safeguard that knowledge would be through audio and video to document experiences as part of the community's knowledge library. The community members who participated that night also expressed their interest in working with entities willing to support this proposal in how I presented it. The community's approval meant another big step in starting the research dissertation on SISPI.

My visit to the second community was different. The community received me with great respect even though the Jabokū of that community forgot to inform them of my visit. Without going into unnecessary details, I decided not to work there to avoid family conflicts. The Jabokū of that

community welcomed me and also shared many interesting things about their lives. However, the meeting with the community had powerful and respectable positions against the project. Part of the community showed distrust since many "white" men had come in to steal their knowledge. Although Jabokū was in favor of working with me, I decided that it was not the right time to develop this process there.

These vivencias brought the spotlight onto a word that carries a connotation of distrust: “research”. According to the Jabokū of this community, the families that reacted this way have been victims of "white researchers" since they arrived to steal their knowledge. For example, they shared with me that some "white" people arrived a few years ago to research a plant. The researchers conducted the research, and upon its completion, they left and never returned, despite the community members' participation. Later, someone told them that the researchers they worked with were producing medicine from the knowledge of that community's plants. However, these researchers never recognized them with any credit or compensation for that shared knowledge.

Learnings and Conclusion

The relationality of the *“Buen Vivir”* [Good Living] guides the methodology of this project. I have presented a series of relationships developed before and after the project to situate myself from where I speak. I am responsible for bringing my influences of thought to the table and being accountable for what I share in this document. Hence the importance of discussing the words "mestizaje" and "whiteness" and how I use them. Since mestizaje is a topic that is discussed little in depth in the Colombian context but consciously and unconsciously practiced as a process of whiteness, it is necessary to recognize it and also better understand certain power relations, including my own. In this manuscript, my colleagues often use "*white*" man to describe

the no-Indigenous person. However, it is necessary to clarify that what they refer to when they say "*white*" is precisely the hierarchical system that whiteness promotes.

Conversations with the mentioned compañeros(as) prompt me to consider how my social location and privileges contribute to the contextual systems of domination, which may be linked to other forms of oppression. The works of Anibal Quijano, Eve Tuck, Orlando Fals-Borda, Patrick Wolfe, and Shawn Wilson (among the most prominent) have been fantastic references that have reshaped my research approach. Rooting my doctoral project in relationality gives it the necessary flexibility to adapt to the desires of the community I am working with. It provides a critical reflection on how to use the anthropological tools we have at hand. It allows me to reflect on my relationships with Indigenous communities and their environment, committing to relational responsibility and solidarity. Finally, it leaves room for me to recognize the complexity of power relations and the different systems of domination that operate at different levels by implementing SISPI.

The PAR is a concept that has many limitations. Although the research project maintained its principles, it could not fully achieve many participatory actions. Pretending that a community will fully participate in any project or program offers a false idea. The complexity of our relationships as human beings makes participatory action dependent on many aspects which do not necessarily have to do with a lack of interest. It also depends on what is happening around us, as with COVID-19.

It is essential to mention that I prefer to address academics and non-academics involved in knowledge production (which belongs to everyone and everything) as compañeros(as). We must detach ourselves from the dominant Eurocentric and anthropocentric paradigms. Knowledge is not exclusive to people. Some things surpass our understanding (Blaser and de la Cadena 2017),

which is okay. This project goes beyond the parameters of the dominant Western paradigm, including anthropology. The voices expressed here are *feel-thinkers* and not just rational. The project not only aims to be an anti-oppressive way of researching with our Indigenous relatives but also a source of learning to complement knowledge that focuses on life, weaving life.

CHAPTER THREE: THE RELATIONAL PROCESS THAT GUIDES THE SISPI IN BUILDING PUBLIC HEALTH POLICY

> *"Sí vamos a hablar de salud, el territorio también debe de estar saludable. Si el territorio está enfermo pues lógicamente esa energía, ese humo, como somos sus hijos, viene hacia nosotros y nos vamos a enfermar y viceversa."* ~ Alcides Musse Mumucue (Pueblo Nasa)
>
> *["If we talk about health, the territory must also be healthy. If the territory is sick, then logically that energy, that smoke, as we are its children, comes towards us, and we will get sick and vice versa."* ~ Alcides Musse Mumucue (Nasa People)]

Introduction

In one of the conversations with compañero Alcides, he told me that the *"Buen Vivir"* is "*being tranquil, being well*." He said that it did not have much science but that "*moving away from our human condition and relationship with mother earth moves us away from the 'Buen Vivir.'"* Alcides added that the "*Buen Vivir*" is very important in the *Consejo Regional Indígena del Cauca*'s (CRIC) [Cauca Regional Indigenous Council] health system, and that it was used as the framework for the construction of the SISPI at the national level.

I was unfamiliar with the Indigenous "*Buen Vivir,*" so I wondered how this life philosophy reflected in the laws for its practice. Similarly, I questioned whether the laws of the dominant "*Western*" paradigm allow for the applicability of "*Buen Vivir.*" Although in the meetings I attended, the narratives from the Indigenous delegation described a SISPI of complete Indigenous autonomy, the laws describe something different. For example, the Decree 1953 of 2014 specified that the SISPI is "*…under the direction of the Ministry of Health and Social Protection or its equivalent, through the instances and procedures determined by said Decree and other provisions that modify, replace, and regulate it.*" In other words, the SISPI is under state supervision. The level of Indigenous autonomy in the SISPI is unclear within this legal narrative.

Upon encountering these conflicting narratives, it brought me back memories of the *Modelo Integral de Atención en Salud* (MIAS) [Comprehensive Health Care Model] research interviews from 2017. In those interviews, national and local Indigenous leaders addressed the SISPI as an autonomous health system governed by Indigenous cosmology (Puerto 2018). On the other hand, most government officials, among those who knew something about the SISPI, saw it as a special branch of the *Sistema General de Seguridad Social en Salud* (SGSSS) [General System of Social Security in Health] (Puerto 2018). It seems that both sides perceive the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] from different lenses. And if the SISPI is perceived differently, what implications would this have for practicing the "*Buen Vivir*"?

Establishing the "*Buen Vivir*" in public policy is challenging, especially when the parties involved understand it differently. The process can bring tremendous advantages but also disadvantages. A good referent to this attempt to implement the "*Buen Vivir*" in public policy is the countries of Ecuador and Bolivia. Based on how the "*Buen Vivir*" was implemented in these countries, critics argue that "*Buen Vivir*" has been colonized for neoliberal political purposes and disguised under the guise of a green or ecological economy (Acosta 2009). Some Indigenous communities have also criticized the contextual disconnect between the Spanish term " *Buen Vivir* " and the concepts as they are referred to in their native languages (Escobar 2010).

The complex and dynamic sociocultural, political, economic, and geographical interrelationship of "*Buen Vivir*" within the SISPI underscores the need for multifaceted attention. In this chapter, I explore the complexity of "*Buen Vivir*" in its definition through various conversations in Colombia and literature about the topic. In addition, I critically reflect on its application to public policy, looking broadly at the cases of Ecuador and Bolivia. The purpose is to highlight potential

benefits and challenges in establishing "*Buen Vivir*" as a public health policy for the Indigenous Peoples of Colombia through SISPI. It also seeks to provide some context on issues in constant contention in the frequent interactions between the Indigenous Peoples and the SGSSS in Colombia, illustrated in the following chapters' stories. Finally, the goal is to learn from these conversations, documents, and historical events to better inform SISPI in its quest to provide culturally appropriate healthcare to all the country's Indigenous Peoples.

What is Known About "Buen Vivir?

In Latin America, much has been studied and written about *"Buen Vivir"* over the past three decades. Each author gives an interpretation according to their encounter with this theme. To begin with, *"Buen Vivir"* is a Spanish translation that broadly approximates what Indigenous communities refer to, in their languages, as a relational process to live a dignified and healthy life within their contexts. In academia, *"Buen Vivir"* began to be used more frequently in anthropological work with Andean-Amazonian communities at the end of the 20th century, especially after Philippe Descola's work with the Achuar community in the Upper Amazon (Descola 1987). Since then, *"Buen Vivir"* has been a source of research on Indigenous onto-epistemologies (Bautista 2010; Macas 2010; Lajo 2011; Estermann 2012; Oviedo Freire 2012; Viteri Gualinga 2012; Pacari 2013; Yampara Huarachi 2016), economic sociopolitical movements (Coraggio 2007; Féliz 2011; Escandell Sosa 2011; Ramírez Gallegos 2012; van Norren 2020) and environmental justice (León-Trujillo 2008; Acosta and Martínez 2011; Aguinaga et al. 2011; Gudynas 2011; E. Vega 2011). Known as the *Trinity of "Buen Vivir*," these three intellectual sources highlighted most research on the *"Buen Vivir"* (Hidalgo-Capitán and Cubillo-Guevara 2017). For their part, some Indigenous intellectual currents have drawn

attention to seeing the *"Buen Vivir"* as a process centered on life (Rodríguez Salazar 2016) and not as a concept.

Taking it as a concept, *"Buen Vivir"* moves away from the density of Indigenous knowledge to economically, epistemologically, socially, and politically please the so-called "Western" society. Precisely, seeing *"Buen Vivir"* as a process centered on life is what the Indigenous compañeres in Colombia shared with me. For example, these compañeres explain that the relational process of the *"Buen Vivir"* comes from the perception that we inhabit a world where everything is alive. Consequently, through the *"Buen Vivir,"* some ethical and aesthetic principles are practiced to develop further relationships of respect and care with the beings that inhabit the territory. This process allows a relational balance between the different beings living in these territories for the survival of all. In some parts of *Abya Yala,* these relational processes are not translated into Spanish to avoid decontextualization and content alteration, as is the case of *Sumak Kawsay* in the *Kichua* language (Oviedo Freire 2012) and *Suma Qamaña* in the *Aymara* language (Bautista 2017; Yampara Huarachi 2016). Similarly, there are other ways of looking at this relational process of life, such as "*Vivir Sabroso*" for the Afro-Colombian communities (Quiceno Toro 2016; Lozano and Copete 2019). When speaking with various compañeros(as) in the Department of Vaupés (see Annex A), "*Buen Vivir*" is a topic of discussion but not of controversy since, in those territories, it is not called such. For instance, the conversations go around the "*Vivir Bien* [Living Well]" or "*Vivir Una Vida Plena* [Living a Full Life]." In discussions among regional Indigenous organizations, it was decided that, for their territories, within the context of the SISPI, it would be called "*Vivir Bien*." Compañero Gaudencio described in his words that "*'Buen Vivir' or 'Vivir Bien' is like in mathematics; the order of the factors does not alter the product,*"

stating that the vision is very similar among Indigenous Peoples and that the differences are fundamentally formal.

These labels interchange through conversations depending on the context accompanying the SISPI and must fit the context appropriately. This multiplicity or diversity of the "*Buenos Vivires*" makes it difficult to give it a general or standardized definition since it is experienced and constructed differently in each context. The only constant that stands out when reading and hearing about different "*Buenos Vivires*" is the importance of relationality. Compañero Pablo Martínez, within his experiences supporting processes with different Indigenous Peoples in Colombia, shares:

> *"Buen Vivir" is something that is perceived in the territory. One cannot arrive and say, "here is a "Buen Vivir"." "Buen Vivir" is embodied. You have to be in a certain territory, at a party or a ceremony, and at that moment, your body perceives something that makes you say, "I'm living well!" That is the "Buen Vivir". It is like reaching a utopian but contingent and achievable moment, not permanent, that is experienced step by step in accordance with the actions that are carried out collectively.*

Pablo Martínez reveals with his words the richness and power of the *"Buen Vivir"* as it cannot be defined with a series of specific variables but rather as the construction of relationships from a "*corporeidad compartida* (shared corporeality)," as he calls it. These relational dynamics give each *"Buen Vivir"* a density that makes it difficult to explain in simple words, especially without being embodied. As compañero Rosendo explains:

> *The "Buen Vivir" for* Indigenous *Peoples, in the case of Colombia, where I have been able to hear the argument from the* Indigenous *Peoples' perspectives through the conversations, the talking circles with the elders… and they [the elders] manifest the following: That the "Buen Vivir" is to see the person or the community (in their contexts) having the possibility of being able to access to the basic human rights in the first place.*

These voices that describe their understanding of "*Buen Vivir*" are only a small illustration of the diversity of understanding of "*Buen Vivir*" among the Indigenous communities in Colombia.

They enrich and highlight the density of this life philosophy, avoiding simplistic reductions. Given this, the SISPI, as a public policy tool, faces the challenge of incorporating these multiple and deeply rooted visions into a framework that ensures the comprehensive well-being of the communities. Adding a layer of complexity, the SISPI also aims to supplement intercultural interactions to complement knowledge and provide greater benefits to the health care of Indigenous communities. However, SISPI proposes coordinating these processes and dialogues between knowledge with the different actors of the system through the "*intercultural pathways.*"

Intercultural pathways for Indigenous health are strategies for integrating Indigenous medicine with other medical practices, such as allopathic medicine, based on dialogue and mutual respect between different forms of knowing. These pathways aim to intervene at both the collective and individual levels, working with the *Direcciones Territoriales de Salud* [Territorial Health Directorates] and the *Empresas Administradoras de Planes de Beneficios* (EAPB) [Companies Managing Benefit Plans] to address the health imbalances identified by traditional doctors in each Indigenous community. The main objective is to promote comprehensive health and *"Buen Vivir"* for Indigenous Peoples, with one of the outcomes being the *Plan de Atención a la Vida Colectiva de los Pueblos Indígenas* (PCVC-PI) [Care Plan for the Collective Life of Indigenous Peoples], which focuses on promoting collective health and preventing imbalances. All of this is done within a framework of respect and therapeutic complementarity (Ministerio de Salud y Protección Social 2018)

To better understand why "*Buen Vivir*" is brought into public policy, it is necessary to briefly discuss the historical context of the SISPI and the atmosphere in *Abya Yala* in resisting neoliberal and neocolonial policies.

Systematization of the Indigenous *Health in Colombia and "Buen Vivir" as a Political Movement of Life*

The history of the systematization of Indigenous health in Colombia and the *"Buen Vivir"* movement in *Abya Yala* intertwine in many aspects. Therefore, this section shares these two stories in parallel. In Colombia, the resistance of the Indigenous Peoples to colonialism and coloniality marked important changes in the systematization of their self-determined and intercultural health, especially in the southwestern zone of Colombia (Urrego Rodríguez 2019; 2020). Since the early 20th century, Indigenous Peoples in the Colombian Andean Southwest, led by Manual Quintín Lame of the Nasa People, have fought physically and legally to protect their territories from settlers and the state (Lame Chandre 1939; 1973). In addition, the Indigenous Peoples in these territories have been in the middle of an armed conflict that has lasted for almost eight decades, affecting their lives and territories significantly. Reflecting on this story, I return to the words of compañero Alcides at the beginning of this chapter, emphasizing that for the Indigenous Peoples, the territory is essential for their health. Although the historical struggles described in this part do not mention health or "*Buen Vivir,*" for Indigenous Peoples, their bodies are an extension of their territory. Therefore, and as I explained earlier, the relationship with the territory for them is critical. It is that intimate relationship with the territory that allows its survival and, therefore, constitutes the cornerstone of their fight for health and life.

The struggles led by Quintín Lame generated a change in Colombian laws that allowed them to recover part of the territory of many Indigenous Peoples of the Andean area without paying *terraje* (Lame Chandre 1939). Terraje is a feudal practice that allows a person to work on land considered "private property" to produce, and from that production, the person who works the

land has to pay the landowner for using "his/her land." By 1971, the Indigenous struggles led by Quintin Lame resumed with the creation of the CRIC by organizing themselves systematically (Urrego Rodríguez 2020). During this decade, through the CRIC, they recovered territory. Furthermore, the CRIC started to structure their health and education based on their ancestral knowledge, complementing it with intercultural knowledge. These actions took place in response to the lack of nation-state attention to the Indigenous communities' priorities (Gros and Morales 2009). Little by little, the CRIC built political power and established its first intercultural health program in 1982 (CRIC 2022). Six months after the start of the CRIC Health Program, the nation-state issued resolution 10013 through the Ministry of Health in response to continuous requests for an inclusive health policy (recognition of "otherness with rights") by the native populace. Although the resolution considers the adequacy of primary health care services to Indigenous contexts, especially through the important figure of health promoters, it maintains a colonial logic of keeping the Indigenous subordinate to a hegemonic system of state health (Urrego Rodríguez 2020).

Some of these logics consider Indigenous knowledge mythical and inferior to "Western" knowledge of health, which should be subordinate to state authority. This resolution also highlights the "free nature" of these services, which portray Indigenous Peoples in the capitalist economic perspective of the market and money as "poor." This approach by the nation-state dismissed the foundation of the Indigenous Peoples' political economy rooted in "*reciprocity, redistribution, and complementarity*" (Urrego Rodríguez 2020). In the face of these political power tensions, Indigenous Peoples across the nation-state came together to create the *Organización Nacional Indígena de Colombia* (ONIC) [National Indigenous Organization of Colombia] as an organization to promote an Indigenous political platform (ONIC 2022).

During the eighties, Indigenous Peoples achieved significant victories, but they were still subtly stigmatized by Colombian regulations. For example, in resolution 10013, Indigenous knowledge was recognized, but it was categorized as mystical and without scientific validation from the "Western" perspective. (Urrego Rodríguez 2020). Additionally, the structural violence against these groups intensified through the measures adopted by the Colombian government during that time with structural adjustments, which worsened the situation of these populations. However, the effectiveness of social mobilization meant that the 1990s heralded winds of significant change for the Indigenous Peoples of Colombia and *Abya Yala* in general.

At the beginning of the nineties, the Colombian nation-state recognized the self-governance of the Indigenous Peoples in every respect, by committing to the implementation of Agreement 169 of the *International Labor Organization* (ILO), which emphasizes this attribute globally. This recognition impacted all of *Abya Yala*, where Indigenous movements were strengthened in response to the neoliberal policies that were negatively affecting their life processes or *"Buenos Vivires."* Given the substantial external debt in which the nation-states of central and southern *Abya Yala* found themselves at the end of the eighties, these nation-states decided to adopt a series of policies supported by international financial institutions. This list of economic policies is known as the "Washington Consensus," which proposed political reforms as financial strategies to address the external debt crisis faced by several of those nation-states (Guillen 2004). The economic strategies presented by the Washington Consensus advocate for trade openness and the promotion of exports, reducing government spending and fiscal deficits, privatizing public industries, controlling inflation, effectively managing monetary policy, and promoting deregulation and liberalization in the financial sector (Rodríguez Salazar 2016, 69).

The Law 100 is one of the outcomes of those policies in Colombia, which established private health intermediaries. Like all private businesses, these entities must generate revenue to turn a profit. Consequently, the health of a significant portion of rural and scattered rural populations was affected. Among these are many Indigenous communities, as health services are negotiated to cut costs, thereby contracting low-budget services that are not suitable for serving the less affluent population. The different policies, known as neoliberal, were disguised as the path to economic development, which resulted in the increase of inequality, unemployment, the displacement of communities, banking crises, the plundering of territories, the exploitation of labor, the lack of adequate access to health, among others, in the center and south of *Abya Yala* (Bonner 2014). As a result, social tensions increased in opposition to these policies, considered as policies of death, or "*necropolitics*," as termed by scholars Achille Mbembe and Libby Meintjes (2003).

During the nineties, the *"Buen Vivir"* also began to be publicly discussed in international Indigenous meetings as various ways of living that differ from the narrative proposed by the neoliberal development (Ruiz Hernández and Burguete Cal y Mayor 2003). For example, in 1992, at the Rio Summit, or Earth Summit, the Indigenous Peoples from *Abya Yala* in attendance drew up the Kari-oca Declaration pronouncing themselves on the possibility of other ways of living (Pueblos Indígenas en la Cumbre de Rio 1992). To this is added the rise of social movements in the center and south of *Abya Yala*, especially the re-visualization of the Indigenous Peoples, as a response to neoliberal policies that put the relations with their territories and their existence at risk (see image 4).

Image 4. Public expression about the entry of neoliberal policies in Abya Yala. Courtesy of Otro12Octubre.wordpress.com. Translated edition by Hugo Puerto

The resistance of the working class and the Indigenous Peoples in *Abya Yala* has been a constant since the European invasion. Still, during the nineties, these movements came together and spoke out with more force, achieving some important changes. Image 4 shows an example of this resistance with a widely spread message against neoliberalism.

In Colombia, the Indigenous movements managed to obtain representation spaces in the nation-state's congress and constructed a new political constitution in 1991. The new constitution recognizes the Indigenous Peoples as the cultural heritage of the nation-state. It also includes their right to self-determined governance in all aspects (República de Colombia 1991). However, in 1993, inspired by the Washington Consensus and without the participation of Indigenous Peoples, Law 100 reformed the Colombian health system, focusing on free competition (Urrego Rodríguez 2019; 2020). This reform continued to characterize Indigenous Peoples as a "poor" population without the ability to pay. They went from having free care services to receiving an individual and partial health subsidy from the nation-state.

This reform caused significant dissatisfaction among the Indigenous Peoples, as the provisions of Law 100 did not show any change regarding the guarantee of access and appropriate differential

treatment by health services towards these communities. The CRIC was one of the Indigenous organizations that openly rejected Law 100 since its approval in Congress. However, the new private EPSs mediating the health system between the nation-state, the IPSs, and the citizenry permeated the Indigenous communities with deceit (Urrego Rodríguez 2020). These tensions would lead to a collective Indigenous rejection of Law 100 and the EPSs, who, under the leadership of the CRIC, demanded the EPSs withdrawal from Indigenous territories nationwide. Indigenous demands continued, and continue to be, the lack of differential attention or understanding of the territory's health priorities and the lack of compliance with land, education, and human rights treaties in Colombia and throughout *Abya Yala* (Bonilla 2004; Del Popolo 2018).

By the 21st century, the struggles of the different Indigenous movements in *Abya Yala* bore fruit to speak about the *"Buen Vivir"* as a public policy. In the case of Ecuador and Bolivia, the process was rigorous and had the active participation of the Indigenous Peoples. However, by establishing a dialogue with the government, the *"Buen Vivir"* public policy began to take another form aligning with expansionist economic development agendas. In these events, conflicts emerge between and within Indigenous organizations as they see that the relationality principles of the "*Buen Vivir*," initially described by Indigenous Peoples, were significantly simplified. The Uruguayan economist, Eduardo Gudynas (2016), explains this situation from a conceptual approach through three different types of development disputes. The ones of type one are discussions within the same ideological or partisan political family. Type two discussions are those that occur among ideological families that defend different varieties of development. However, what the Indigenous Peoples are aiming for, in terms of Gudynas, is a type three discussion outside the framework of development thinking. He explains that "*this posture implies*

a discussion resulting from efforts to deal with alternatives that are beyond the modern realm of all varieties of development" (Gudynas 2016: 727). In the case of Ecuador and Bolivia, at the time, these disputes generated a citizen mobilization of great importance, forcing these nation-states, in turn, to include the *"Buen Vivir"* within their public policies to appease that criticism.

The "Buen Vivir" as Public Policy in Ecuador and Bolivia

Integrating the "*Buen Vivir*" into public policies in Ecuador and Bolivia garnered global attention. Its historical relevance could offer some lessons for the SISPI about what worked and what did not when building public policies around it.

One of the main benefits that "*Buen Vivir*" brought to public policy was the constitutional acknowledgment and empowerment of Indigenous Peoples. In Ecuador, the 2008 Constitution included "*Buen Vivir*," recognizing the rights of nature (Becker 2013). This act signaled a cultural shift toward Indigenous knowledge, and many saw it as a bold attempt to redefine the expansionist development paradigm promoted by the "West." Similarly, Bolivia's 2009 constitution empowered Indigenous justice systems with their social control initiative (Farthing and Kohl 2012), actively involving Indigenous communities in policy formulation and governance.

Initially, these regulations embraced environmental sustainability and resource management in certain areas. For example, the Yasuní-ITT Initiative of Ecuador, which refrained from drilling for oil in the Ishpingo-Tambococha-Tiputini (ITT) oil fields located within the Yasuní National Park, demonstrated its commitment to the "*Buen Vivir*" principles in protecting biodiversity and innovative resource management (Rival 2010). However, that commitment by the state to the communities not to drill oil was broken in 2013 (Mena Erazo 2013). The Law of the Rights of

Mother Earth in Bolivia granted legal rights to nature, emphasizing the interconnection of ecological health and human well-being (Vidal 2011).

Incorporating "*Buen Vivir*" also impacted social and economic advancements. In Ecuador, "*Buen Vivir*" guided investments in healthcare, education, and social welfare, resulting in measurable progress in poverty reduction (SENPLADES 2013). Adopting similar principles, Bolivia reduced poverty and improved governance through increased participation (Postero 2017). However, the "*Buen Vivir*" public policy also left some dissatisfaction among the Indigenous population.

One of the shortcomings of "*Buen Vivir*" as public policy was the lack of genuine implementation. In Ecuador, conflicts arose due to inconsistencies between "*Buen Vivir*" and traditional economic policies, especially in extractive industries (Radcliffe 2012). In Bolivia, challenges included the displacement of Indigenous communities without adequate compensation (Postero 2017). This lack of genuine implementation and economic interests led to conflicts with environmental degradation, contradicting "*Buen Vivir*" and eroding trust among Indigenous communities (Becker 2013; Fabricant and Gustafson 2011).

Furthermore, cultural misinterpretation created significant tensions between Indigenous communities and the government. In both countries, misinterpretation by state authorities led to policies that prioritized economic growth over community well-being (Escobar 2010; Walsh 2010a). This misrepresentation resulted in a lack of participation and representation, undermining the unique needs of Indigenous communities (Fischer 2007).

Manipulation of "Buen Vivir" to Serve the Expansionist Development Project

As a movement, *"Buen Vivir"* questions the expansive economic development project that is based on a power relationship of domination and exploitation of both labor and territory

(Gudynas 2011; 2020; Viteri Gualinga 2012; Monni and Pallottino 2015; Rodríguez Salazar 2016; Bautista 2017; Oviedo Freire 2012). Neoliberal policies brought exploitation to territories in a violent way for their inhabitants (human and non-human). These actions have been denounced as "terricide" by one of the leaders of the Mapuche People in Chile, Moira Millan (2011). Numerous Indigenous Peoples from *Abya Yala* have united her in condemning the necropolitics that endangers life in general. Additionally, as a movement, *"Buen Vivir"* proposes an alterity way of life focused on the politics of relationships and life. This means it seeks to reconstruct a way of life focused on the community (common unity) from a vision of ancient cultures. According to the *Coordinadora Andina de Organizaciones Indígenas* (CAOI) [Andean Coordinator of Indigenous Organizations],

> *This heritage of the first nations considers the community as a structure and unit of life, that is, constituted by all forms of existence and not just as a social structure made up solely of humans. This does not imply a disappearance of individuality, but rather that it is widely expressed in its natural capacity in a process of complementation with other beings within the community.*

This passage informs us that this way of life advocates living a dignified and healthy life with all beings (human and non-human) that are part of the living earth. According to what was shared by the Indigenous relatives, they see relationality as a comprehensive way of life which translates to "*Buen Vivir*" and is therefore healthy.

> *But, for the "Buen Vivir" to be a reality, they say* [the elders]*: That a human being, a family, a community can have the minimal possibility of having access to, first of all, a territory. Territoriality, because they say* [the elders] *that without territory, a human being, a community, or an* Indigenous *community would be in an empty place because the subject of territory is very important for the* Indigenous *Peoples. That is why we call it mother earth and mother nature because the territory is what guarantees everything in it. From her* [mother earth] *comes the sustenance for the survival of those families, people, and their community.* ~ Rosendo Ahue

These words from compañero Rosendo describe another layer of complexity about the *"Buen Vivir,"* or "*Buenos Vivires*," as a rhizome of relationships between sensitive bodies (both human and non-human) found in their life journeys. These different bodies build their habitat in continuous negotiation and renegotiation to live a collective life in harmony in particular contexts. As mentioned earlier, everything is alive within the "Buenos Vivires" expressed by different Indigenous Peoples. Therefore, developing relationships is essential to achieve and maintain harmony, thus leading to "Vivir Bien." Yet, Indigenous compañeros(as) shared that it is necessary to distance ourselves from assuming that the harmony that the *"Buen Vivir"* seeks is homologous to the biblical utopia of paradise or a cultural romanticism since that is not what the Indigenous Peoples refer to. Instead, as compañero Rafael Guayabo shares: "*harmony is when the different forces of life complement each other and flow so that life endures.*" The Andean philosopher, Atawallpa Oviedo Freire, describes more explicitly what harmony means within the framework of the *"Buen Vivir"*:

> *Harmony, as the dictionary says, means keeping a balance between different forces and not the idea that there are no problems or disputes, as some seem to understand.* [For example] *The animal world is in harmony because they eat other animals in the amount necessary or sufficient to maintain life in balance. And the same thing has happened with a series of physical phenomena, in which Mother Earth has sometimes lost her harmony but has always managed to recover it. It has reached extremes as in the ice ages, producing important changes, but it has been re-harmonized.*

The clarification of Oviedo Freire is a response to imaginary prejudices built by the "west," characterizing the *"Buen Vivir"* as romantic or essentialist and, in some contexts, as radical leftist ideologies. Certainly, these clarifications are necessary because these imaginary prejudices perpetuate an ongoing coloniality of power and settler colonialism that jeopardizes Indigenous lives in the face of capitalist expansionist development. One example of these risks is the continuous intimidation of Indigenous communities, where leaders expose their lives by resisting

the invasion of their territories. In addition, there is an imaginary prejudice from part of the non-Indigenous population towards them founded on the hegemonic colonial logic regarding domination and exploitation. These imaginaries surfaced through social networks during the Mingas[22] between 2019 and 2021 in Colombia due to major blockages by Indigenous communities, raising discontent among a small group of people whose privileges temporarily tumbled.

In addition to the forced shape of modern expansionist development, there has been another more subtle surge in using "*Buen Vivir*" as an adaptation to the language of that development. We can see this example in the Colombian Amazon Region with the so-called "carbon credits." On the environmental front, the discourse of carbon credits and the green economy has emerged as a sustainable proposal to address the climate crisis. However, in regions like the Colombian Amazon, this rhetoric might be hiding a new form of extractive, masked under the guise of sustainability. Martínez-Alier et al. (2016) found that while people promote carbon credits to incentivize forest conservation and reduce CO2 emissions, these financial mechanisms often facilitate the expansion of extractive projects like mining and agribusiness in areas of high ecological value. For instance, some companies purchase carbon credits to "offset" their emissions but continue to engage in unsustainable activities elsewhere, thereby perpetuating environmental degradation (Lohmann 2006). Moreover, by focusing on the monetary

[22] ***The Minga***, an ancestral practice of collaboration by Andean Indigenous communities in Colombia, Ecuador and Perú, has as its main objective the community's well-being. Historically, the minga has been used for various tasks such as planting, opening roads, clearing land, or constructing health and educational facilities. However, nowadays, the minga has acquired a political character of resistance, allowing Indigenous Peoples to make themselves heard and present their demands and claims in the public sphere. ***The Minga*** does not arise spontaneously but rather has the support of ethnic organizations such as Indigenous, peasant, and Afro-descendant movements. Despite how it is often portrayed in the media, the minga is a response to the lack of spaces for democratic dialogue and participation, systematic non-compliance with agreements, and the assassinations of social leaders (Alvarado 2019).

quantification of carbon, these schemes often disregard the rights and knowledge of local communities, who have been stewards of these ecosystems for centuries (Sullivan 2009). Therefore, although carbon credits may seem attractive, they risk perpetuating an extractivist development narrative in contexts like the Colombian Amazon, presented under a new "green" facade.

Despite battling against all these powerful modern expansionist developmental forces, Indigenous Peoples in Colombia have made significant progress in public policy by achieving recognition of the land as a subject of rights. This legal action is an important step for the Indigenous Peoples because it puts life and its relationship between different beings at the center, which is the basis of different Indigenous cosmovision. For example, in Colombia, the Amazonas and Atrato rivers were legally recognized in 2017 as rights-bearing entities through arguments similar to those presented by Indigenous counterparts in Ecuador and Bolivia in their defense of Mother Earth. Although only these two legal victories have been achieved, it is a gigantic and decolonial step towards starting to see the territory as a subject that is part of the production and maintenance of life. Likewise, the Indigenous Peoples in *Abya Yala* also began to advocate for the inclusion of their "Buenos Vivires" as part of their *Life Plans*. These sentences strengthen the *"Buen Vivir"* within public policies and more directly in the SISPI.

Learnings and Conclusion

The content shared above opens the door of complexity and challenge to the research questions of this dissertation. For instance, the *"Buen Vivir"* described in the SISPI documents comes mainly from Indigenous Peoples of the Andean region, especially from the CRIC. The influence of CRIC on the national SISPI is not a surprise as they have been a major force in Indigenous Peoples' rights struggles before Colombia's nation-state. As a result, the CRIC has been

instrumental in making SISPI a reality today by bringing together other Indigenous forces at the national level. When speaking about *"Buen Vivir"* to build public policy at the national level, it reflects a high complexity when encountering a diversity of understandings of this relational process from contexts with different spaces, organizational politics, worldviews, economies, etc. In other words, "*Buen Vivir*" is not uniform, as it originates from various Indigenous languages forged by their worldviews, each with its interpretations and priorities. While "*Buen Vivir*" might be linked to a harmonious relationship with nature for some communities, others may focus on the social fabric or specific spiritual practices (Escobar 2010). In capitalist economies, people often measure development by gross domestic product growth. However, from the perspective of "*Buen Vivir*," development might be considered in terms of equity, sustainability, and respect for nature (Acosta 2009).

Borrowing the words of sociologist, Adriana Rodríguez, the *"Buen Vivir"* is also peoples' resistance to colonization (2016). This resistance led the Indigenous Peoples of Bolivia and Ecuador to establish the *"Buen Vivir"* as a public policy. Nevertheless, the density of Indigenous knowledge of the *"Buen Vivir"* began to dilute when it started incorporating development policies from a more nation-state vision. For many, this situation seems to be the nation-states' colonization or co-optation of *"Buen Vivir".* This situation opens the question of whether it is even possible to decolonize nation-states, to which there is no easy answer.

Adopting "*Buen Vivir*" in public policies implies rethinking traditional organizational structures. For instance, in Ecuador and Bolivia, "*Buen Vivir*" has been incorporated into their constitutions, leading to fundamental changes in how issues like the rights of nature and collective well-being are addressed (Walsh 2010a). In Colombia, efforts to rethink public policies around the

principles of the relationality of “*Buen Vivir*” have already been seen with the legal processes to recognize the land as a subject of rights and to develop the SISPI.

In addition to this, each territory has its realities and challenges. Implementing "*Buen Vivir*" as public policy in urban, rural, or dispersed areas might differ from place to place due to their sociocultural and political intersectionality. For example, an Indigenous woman living in the rural area of the Andean Mountains may face a different reality than an Indigenous woman in a city. Added to this are other contextual variables present in the territories of the Indigenous Peoples. Furthermore, there is an intersection of Indigenous and non-Indigenous institutions that interact with each other to implement public policies for Indigenous Peoples. Therefore, aligning these different institutional actors to implement adequate policies around "*Buen Vivir*" requires a substantial effort.

Incorporating "*Buen Vivir*" into public policies requires a deep and nuanced understanding of local communities' values, priorities, and challenges. The diversity of interpretations makes this task complex, but it also offers a unique opportunity to redefine development more inclusively and sustainably.

Integrating "*Buen Vivir*" into public policies presents a mixed picture. There have been substantial advancements in constitutional empowerment, environmental sustainability, and social progress. Yet, significant challenges persist, highlighting the complexities of translating Indigenous philosophies into practice, especially in intercultural relations. The learnings from the historical events of Ecuador and Bolivia provide insights on how the SISPI could better address this situation, where a more participative and comprehensive approach, deeply rooted in Indigenous principles, is crucial to realize the full potential of "*Buen Vivir*."

The influence of the social movement of the *"Buen Vivir"* has a clear commitment to advocating for policies defending life in all their forms, offering another way of relating to life for collective survival. Although this is an inspiring and urgent approach, some challenges require critical reflection when proposing an eventual implementation of the *"Buen Vivir"* as a public health policy, through SISPI, for Indigenous Peoples. Although the nation-state of Colombia has not declared the *"Buen Vivir"* as a national public policy, the experiences of the nation-states of Ecuador and Bolivia are cases to learn from in this type of paradigm shift.

An example of how the narrative of "*Buen Vivir*" begins to emerge in the discourse of expansionist modern development is in the explosion of the green economy in the Colombian Amazon with the so-called "carbon credits." This rhetoric reaches places like Vaupés offering monetary compensation to protect the territories' diversity. At first glance, it sounds good, but many questions arise that require a more profound approach; why this sudden interest in protecting the Amazon? How do these companies receive the income to pay compensation and generate profits since they are private companies? What are the clauses that the Indigenous Peoples have to comply with? Although these initiatives may come with good intentions, all parties involved (including Indigenous Peoples) must address similar questions mentioned above based on the situated "*Buenos Vivires*" of the Amazonian Peoples.

This chapter actively presents the concept of Indigenous "*density*," offering valuable insights that can shape the development and implementation of public health policies for Indigenous Peoples. A significant manifestation of this density is Indigenous Peoples' deep connection with their territory. Rosendo Ahue highlights the profound relationship between Indigenous Peoples and the territory, relating it to "mother earth." This analogy emphasizes the territory's vital role in sustaining life, emphasizing the depth and complexity of this relationship.

The dynamic and complex nature of relational experiences through "*Buen Vivir*" is portrayed not as a simple idea but as a vibrant network of relationships that include human and non-human entities on their life journey. This network continually seeks balance. Pablo Martínez captures the complexity of "*Buen Vivir*," noting its deep richness, which is challenging to express without direct experience.

I also delve into the tumultuous history of Indigenous communities, highlighting their resistance against colonial oppressors. Their persistent efforts have led to significant changes in Colombian legal systems, enabling them to reclaim territories and establish their distinct health and education models. Vivencias, challenges, and victories from this rich history shape the present scenario. A primary challenge in improving the health care system for Indigenous Peoples in Colombia is addressing the consequences of neoliberal policies, such as the Washington Consensus. By prioritizing profit over holistic well-being, these policies amplify the Indigenous narrative's complexities, further emphasizing their challenges.

The theme of *density* runs throughout this chapter, evident in the intricate relationships, historical accounts, and diverse interpretations of "*Buen Vivir*." These examples highlight the depth and complexity of the Indigenous narrative, urging us to avoid simplistic academic perspectives.

In this chapter, I explored the complexity of the "*Buen Vivir*" as the relational principle that guides the SISPI. I delved into different stories and historical documents through the lens of the concept of density to provide a perspective from a collective *feel-thinking* on how all this could potentially inform the SISPI (and why not, the SGSSS as well) systematizing the "*Buen Vivir*."

The profound connection between territory and health is undeniable. This understanding is clear in the SISPI, which prioritizes the territory's health based on local needs and relationships. The

SISPI clearly outlines this connection on how to achieve it broadly, allowing for flexibility in adapting to context. While this approach makes sense, unfortunately, it opens a window for multiple interpretations by non-Indigenous institutional representatives who are used to strictly following regulations. For this reason, since state regulations tie SISPI, these regulations must provide detailed guidance to territorial entities that need to enforce these rules as much as possible. Additionally, the accompaniment of a commission from the SSI-MPC is needed to ensure that the regulations are properly complied with.

"*Buen Vivir*" represents an individual goal and a collective and relational journey. Therefore, policies should promote community participation and adequate follow-up supporting local well-being and harmony with nature. Effective communication between Indigenous communities, organizations (Indigenous and non-governmental), and government bodies is crucial for mutual understanding, ensuring that the "*Buen Vivir*" principle of relationality is part of policy decisions. In a way, this is what is intended with the Indigenous Peoples' proposal on *intercultural pathways* in the SISPI. Given the varied interpretations of "*Buen Vivir*" among different Indigenous groups, engaging with these communities is essential to grasp their unique perspectives and needs. For instance, conversations with peers from Vaupés (see Appendix A) display the complexity and dynamics of "*Buen Vivir*" or "*Vivir Bien*." Even though some passages do not mention "*Vivir Bien*" or even health directly, the peers describe the importance of these life processes for health in Indigenous communities of that context. "*Vivir Bien*" in Vaupés is diverse and dynamic. It is a territory with great biodiversity and ethnic diversity where historical interactions of various types have transformed life processes just as the territory itself. The constantly changing relationality makes "*Vivir Bien*" a complex process to understand

without experiencing it in context. For this reason, this principle of relationality goes beyond SISPI itself and should be the foundation for developing government plans in these territories.

Finally, in the context of "*Buen Vivir*," it is critical to evaluate neoliberal policies prioritizing economic benefits over holistic well-being. A thorough revision and adjustment of these policies are necessary if there is a serious commitment to the philosophy of life of "*Buen Vivir*" that highly resonates with Indigenous communities and environmental harmony principles. Even though the SISPI commits to this on paper, it is necessary to learn from the experiences in Ecuador and Bolivia, where the relational principles of "*Buen Vivir*" were compromised by modern expansionist development. The experiences of our neighboring countries could raise awareness among those responsible for formulating modern policies committed to Indigenous health to promote a reevaluation of the legislative language concerning SISPI's Indigenous autonomy. Could SISPI continue under the regulations of the SGSSS but with full Indigenous autonomy? It is a complex question to tackle, but necessary to ask.

When reflecting on all these vivencias accompanying the SISPI, the voice of compañero Alcides haunted my head, who told me, *"... to work with the Indigenous Peoples, you have to unlearn to learn again.*" It is not a simple process in which I am still unlearning and learning. However, within this process, I could experience how another way of seeing health exists and resonates when we put it in a holistic perspective. The diversity of the "*Buen Vivir*," with its densities, equips the SISPI with the tools to support Indigenous health and life in general. Nonetheless, the work of SISPI to ensure that this is reflected in the realities of each Indigenous community in Colombia comes with many regulatory and implementation challenges.

CHAPTER FOUR – DECOLONIZING SPACES TO HEAL: FIGHTING FOR THE RIGHT TO INDIGENOUS HEALTH IN THE NATION-STATE OF COLOMBIA

> *"¡Guardia, guardia! ¡Fuerza, fuerza! ¡Por mi raza, por mi tierra! Indios que, con valentía y fuerza en sus corazones, por justicia y pervivencia, hoy empuñan los bastones… Son amigos de la paz, van de frente con valor. Y levantan los bastones, con orgullo y sin temor… Pa' delante compañeros, dispuestos a resistir: Defender nuestros derechos, así nos toque morir… Compañeros han caído, pero no nos vencerán. Porque por cada indio muerto, otros miles nacerán… ¡Y Que Viva la Guardia Indígena!"* ~ Himno de la Guardia Indígena
>
> *["Guard, guard! Strength, strength! For my race, for my land! Indians who, with courage and strength in their hearts, for justice and survival, today wield the baton... They are friends of peace; they go forward with courage. And they raise their batons, with pride and without fear... Go ahead, compañeros, ready to resist: Defend our rights, even if we die... Compañeros have fallen, but they will not defeat us. Because for every dead Indian, thousands more will be born… And Long Live the* Indigenous *Guard!"* ~ Hymn of the Indigenous Guard]

Introduction

In December 2019, marches were taking place throughout Colombia in protest of the murders of social leaders (including Indigenous leaders) and the decisions made by President Iván Duque's administration regarding the peace treaty with the *Fuerzas Armadas Revolucionarias de Colombia* (FARC) [Revolutionary Armed Forces of Colombia]. Additionally, the protests represented the dissatisfaction of many citizens with the social, environmental, and economic policies implemented by that government. Indigenous Peoples were not immune to these structural problems, so they joined the marches. Hundreds of people could be seen on the streets singing, playing music, engaging in street theater, and participating in other activities as part of an artistic resistance, demanding accountability from the state. The first marches occurred in late November and early December, with some encounters leading to riots that partially paralyzed certain cities in the nation-state. There was fear that the unrest would escalate, but the December marches became more artistic and saw an active presence of the Indigenous Guard. This

presence of the Indigenous Guard resulted in more organized marches without public order issues. The Indigenous Guard protected both the protesters and establishments to prevent physical and material damage, adhering to their principles of care and respect.

Amidst protests in December, the *Subcomisión de Salud Indígena de la Mesa Permanente de Concertación* (SSI-MPC) *con Los Pueblos y Organizaciones Indígenas* [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations] held three-day meetings at the Tequendama Hotel in downtown Bogotá to finalize the document on the resolution of the *Plan del Cuidado para la Vida Colectiva de los Pueblos Indígenas* (PCVC-PI) [Care Plan for the Collective Life of Indigenous Peoples]. The PCVC-PI is a fundamental part of the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] and a cornerstone of *"Buen Vivir."* The purpose of the document, according to the Indigenous leadership of the SSI-MPC, is to provide a written plan on how Indigenous collective health works and how it can be complemented, when relevant, with the Western healthcare system. It was not known if the meetings were going to take place given the situation that the nation-state was going through; finally, they were held at the Tequendama Hotel in downtown Bogotá, where many of the marches were taking place. Although the meetings took place, the delegates of the Indigenous Peoples of the SSI-MPC were resolute in expressing their support for the marches, announcing that if those who were participating required their presence, they would interrupt the conversations and join the marches. That's how these spaces began.

The first day was designated as an autonomous space, in which members of the Indigenous Delegation of the SSI-MPC discussed and updated the draft document to debate it with government delegates during the following two days. The purpose of these meetings was to

finalize the resolution of the PCVC-PI and send it to the Minister of Health for approval and signature. Compañero Rosendo invited me to attend these meetings to gain a better understanding of the development of the SISPI, especially regarding the dynamics of dialogue with the nation-state.

This chapter shares the intricate relationships that compose an Indigenous and intercultural health system in the nation-state of Colombia and how they are expressed in navigating the general health system. To elucidate the complexity of these interactions, I share two intertwined stories on how Indigenous Peoples strive for a dignified and healthy life as they also provide different ways of resistance and healing. The first story is a continuation of the vivencias of Jabokū and José (from the Puerto Golondrina community) navigating the healthcare system in Bogotá; it provides the context for the importance of the SISPI. The second story is based on the experiences during the meetings I attended of the SSI-MPC between Indigenous delegates and representatives of the nation-state to finalize the resolution document of the PCVC-PI with the aim of formalizing the SISPI. Throughout the text, the two narratives intertwine and complement each other.

Departing from the priorities of SISPI, focused on supporting local health models and the possible bridging between "Western" and Indigenous medicine, these stories provide teachings of potential interest for these purposes. The pursuit of Indigenous autonomy while navigating a social and political system governed by the dominant paradigm of the nation-state of Colombia is complex. The stories shared in this manuscript reflect resistance to the colonial gaze and the effort to construct a proposal for collective healing by Indigenous Peoples. This chapter offers a reflection on the tense and profound relationships between two systems of thought that, while aiming to improve Indigenous health, propose two different paths to get there.

Vivencias of Jabokū and José in Bogotá – Part 2

Around 7:30 am on Monday, August 6, 2018, I took an Uber to a place that was not easy to find. I was headed to the hospital where Jabokū was being treated. It took some time to find the place since it was not a hospital that was easily identifiable. We drove past the hospital a few times, thinking it was just a big house with no visible signs that it was a hospital. José, Jabokū's son, stepped outside to meet me and show me where it was. He greeted me with a smile. When I asked him how his family was, he responded emphatically, "*We're fine, Hugo. Thank God.*"

Based on my hospital experiences in Colombia, it seemed the hospital lacked proper infrastructure when we stepped inside. However, the staff was very attentive and guided us towards where we needed to go. We walked through a few narrow corridors and up a few stairs that were being remodeled. We finally arrived at a small waiting room with chairs lined up around the walls and a small window at the top of the far wall.

In those firm chairs, José shared with me what had happened with Jabokū while we waited for more information about Jabokū's health…

My father began to feel bad, and we took him to the Mitú hospital, where they told us it was a pre-heart attack and that they had to refer him to Bogotá immediately.
And has the cardiologist here told you something, I asked.

Well, the doctor said it seems to be for surgery, but he replied they want to do more tests." José responded.

And what does Jabokū say about this? I continued with my inquiry, to which José replied.

My dad said that he knows how to treat what the doctors found in him with his own medicine. So, he is waiting for the other results to come out so he can return to the community and start his treatment with our medicine.

Intrigued by the response they received from the doctor, I asked what he had said.

With the spontaneous laughter that José usually expresses his joy with, he replied...

I think he didn't like too much what my dad said. He said [the doctor] that if the tests came out as he was thinking, my dad needed the surgery if he wanted to live more than a month.

Although I recognize the importance of Indigenous medicine, my colonized mind led me to question whether "Western" medicine would not be better for Jabokū's case then. So, with that line of thought, I added.

So, the situation is quite serious, isn't it?

José took a moment to respond and said…

Hugo, my dad knows a lot about plants. If he says he knows how to deal with it, it's because he knows. As a son, I respect and support his decision.

With his answer, I understood it was not my place or position to suggest such a thing. Jabokū's knowledge and relationship with plants and their territory are much more dense than what I know superficially. José continued explaining to me…

What my dad needs is to know what he has. And, well, the medicine of the "white man" has the tools to find out. Knowing that, my dad can see if he can treat that problem. It is not to distrust [the knowledge of] medicine from here ["Western medicine"] but to complement it with ours. By itself, we value the medicine of the "white man", but we also have one that works.

Good point, Jose. I answered.

Given what José had said, I added that *if this society were more open to seeing other knowledge to build a better place, it would not be necessary to refer so many patients to the big cities.*

Upon hearing my comment, José shared with me his reflection...

That is another big problem. Just look at our case. We are not from around here and are still waiting for them [the insurance] to find us shelter. As a reflection, for me to stay there [in the hospital] … so, the doctor told me, "You have to stay here. Don't go anywhere." He was telling me what I had to do, and it was a real thing. But in my mind, it hit me really hard. Staying

there… Imagine… I felt lost. I started thinking about sitting there for twelve hours waiting for the sunrise. I mean, it had never happened to me. Well, at that moment, I compared; it is as if a white man were left in the middle of the jungle; there are no people, there is nothing. So, what will he [the white man] feel? That is how I felt, literally. The situation made me want to cry. The feeling was much greater. That was very hard. Imagine that I lost all knowledge of where I was for a moment. I was scared.

The feeling was that I had never stayed... well, not to sleep because I had to be awake for twelve hours there [in the waiting room]. That [situation] had never happened to me. Well, that was very hard for me. And having people like you, like Daniela too… Even at that moment [when Daniela contacted José], my breath returned; it made me feel relieved to hear that I would not spend the night there [in the hospital] but in a place safe, in a house. In other words, I felt great happiness.

Imagine an Indigenous *person who doesn't know anyone [in the city]. At least we know people here. This place [the city] is a jungle we do not know. Many* Indigenous *People don't even speak Spanish. So, imagine the disorientation and fear of many of these people. And to add another layer, these hospitals are not adequately prepared to care for* Indigenous *patients. Just look at the doctor who treated my father. It is difficult for him to accept my father's knowledge and decision. That is a problem for many of us.*

His reflection was very concrete and clear, which expanded beyond his vivencias to think about the vivencias of other Indigenous Peoples. His words reminded me of the shelter for him and Jabokū, so I asked…

And speaking of the shelter, have they not contacted you yet?

Nothing. I spoke with a person from the hospital. They told me that this was already in process. However, they did not know why it was taking so long. José answered.

After a few minutes, we were able to see Jabokū. His bed was at the end of the intensive care corridor on the left. There were no rooms, only curtains separating the beds of each patient. When Jabokū saw us, he smiled, albeit weakly. He could not speak much, but softly, almost like a whisper, he said, "*Thank you for coming.*" They [the nurses] did not allow us to stay for a long time, but it was very nice to see him. After seeing Jabokū, I let José know my concern about the shelter. So, I decided to send a message to compañero Rafael Guayabo from the SSI-MPC to see if he could guide us on what we should do. Rafael asked me for the details of José and Jabokū to

find out. I had to go, so I said goodbye to José; we would continue communicating to organize where José could stay in case Jabokū continued being hospitalized.

Hours later, José confirmed the shelter had contacted him and would provide transportation from the hospital to the shelter and vice versa. Compañero Rafael's immediate action took effect quickly. After this news, I felt more at ease, although a question from José resonated in my thoughts: What happens with the Indigenous patients who don't speak Spanish and don't know anyone in these cities?

Jabokū spent three days in the hospital. Upon discharge, José and Jabokū continued to stay at the shelter that the New EPS [the insurance] had assigned them until they got their return air tickets. On the discharge day, we were able to talk.

Aru[23] *José! How is Jabokū doing?* I greeted.

Aru Hugo! My dad is feeling better now.

And what did the doctor finally say after seeing all the tests? I asked.

Well, he said almost the same thing I told you a few days ago. He told my dad to think about it carefully because he [the doctor] had already confirmed my dad's condition through the tests and that he needed surgery immediately if he wanted to live more than a month. My dad thanked him for his concern and attention, explaining to the doctor that he [Jabokū] already knew how to treat his sickness with our medicine. However, the doctor was not very happy with my dad's decision.

Although Jabokū was going to start treatment with his own medicine upon arriving in the community, I asked him if he had been given medicine at the hospital for the time being, to which José replied affirmatively, and added:

[23] "Aru" is a greeting in the Pamíe language.

My dad said he would take the medicine the doctor gave him while we got to the community. When we get to the community, he will stop taking the "white man" medicine and prepare to start taking our medicine.

Well, at least the doctor understood Jabokū, I replied when I heard his words.

José paused briefly and answered…

Well… I don't know if that's the case because before letting us go, [the doctor] made my father sign a document saying that if something happened to him, neither the hospital nor the doctor would be responsible. So, my dad signed, and from then on, we never saw the doctor again.

After this conversation, I continued communicating with José to follow up on his return home.

The days passed, and José and Jabokū continued staying in the shelter. Five days after Jabokū's discharge, José and Jabokū had no clear answer about the return tickets to Mitú. By that time, I had already returned to the United States. Finally, José told me on a phone call...

Well, imagine Hugo that they still are not giving us information about the tickets to return to Mitú. Instead, they told me they must wait for the New EPS to authorize it.

Upon hearing this, I asked José if they had not reported that Jabokū had already left the hospital, to which he responded...

We were supposed to inform the shelter so that they would let the EPS [the insurance] know to approve purchasing the return tickets to Mitú. We let the shelter know the day my father left the hospital. It seems they want to keep us here more time than necessary to charge more to the EPS. Here I have met Indigenous *People from different parts of the country who have been in the shelter for up to six months. Even a person who works at the shelter asked why I did not take advantage of the shelter giving me free food and lodging to go out and explore the city. He even suggested looking for work to stay a few more months. That doesn't seem right to me. In addition, the* Indigenous *people who have been in the shelter for quite some time want to return to their territories with their families. You have to see something else, Hugo; in the shelter, they don't even provide food from our territories; they give us the food of the "white man." So, this is very sad around here.*

Given what José was telling me, I replied…

I had no idea that this happened in shelters, José. That's problematic.

Well, answered José, *I don't know if it is like that in all the shelters, but at least in the one we got, it seems that way. I got to speak strongly to the shelter today. I told them that if they didn't have the tickets in a couple of days, I would leave the shelter to return to Mitú. I don't know how, but we would return to our territory. I also told them I would complain to the EPS [the insurance] about this situation, which was unacceptable.*

With a spontaneous laugh, José continued...

It makes me laugh that the person who works at the shelter told me to calm down, that they would fix the problem, and that I didn't need to complain to anyone. I wasn't angry by any means, but I was telling them specifically what was happening and what we would do. How could it be that an Indigenous *man from Vaupés who had been in the shelter for a few weeks approached me and asked if he could go with us? I told him yes. Hugo, I'm proud of who I am and where I come from, and I won't allow them to treat us that way. We are human beings too. I do not remain silent, but it makes me think about the other Indigenous People who do not speak Spanish or are intimidated by speaking with the "white man," who knows how long they will leave them there [in the shelter].*

I spoke with José again a few days later to find out that they had already obtained the tickets back to Mitú for him, Jabokū, and the other Indigenous companion. José, knowing and defending his rights in this situation, managed to get them to take them seriously and resolve their return home quickly. Almost five years have passed since this experience, and Jabokū continues to be healthy, leading his community.

Respecting Relationality

It was a little over a year since Jabokū's hospitalization when I attended the SSI-MPC meeting in December 2019. That Wednesday morning, December 11, 2019, I met compañero Rosendo at the reception of the Tequendama hotel to attend the first three-day meeting about the PCVC-PI. We talked for a few minutes and took the elevator to the meeting room where the autonomous meeting would occur. Upon entering the room, a group of about 20 people were already there emanating an atmosphere of friendship; I noted a strong relationship among the attendants. While looking for familiar faces, I did not recognize anyone from my previous visits to the *Organización Nacional Indígena de Colombia* (ONIC) [National Indigenous Organization of

Colombia]. In the room, there were two tables, one large table in a U-shape for the Indigenous delegates and a small table for the facilitators of the meeting. Compañero Rosendo invited me to sit at the big table while he sat at the facilitators' table. A few minutes later, another group of people arrived, including colleagues whom I already knew. In this group, I found compañero Rafael, who warmly greeted me.

As the minutes passed, the participants took their seats around the boardroom table. Between the table and the board where the meeting agenda was being projected, there was a spacious area where some elders were placing offerings on a series of blankets of different colors, as if for a ceremony. The blanket that stood out the most to me, due to its size and diversity of textiles and colors, was the Indigenous flag, known as the *Wiphala*[24]. The symbolism of this flag represents aspects of their cosmovision and Indigenous resistance to colonialism. Before starting the meeting, compañero Rosendo spoke about the harmonization ceremony that would take place prior to each encounter to ensure that conversations flowed harmoniously. However, it was made known that the hotel protocols did not allow certain practices, such as using tobacco smoke or lighting a candle. This announcement created commotion among the Indigenous delegates since this ceremony is of the utmost importance for the Indigenous Peoples and deserves the respect of doing them in the space and with the necessary offerings. One of the women elders, known as Mayoras, explained that the offerings possess a unique energy and are an essential aspect of the community's relationship with their ancestors and the universe. This highlights the interconnectedness of various relationships within their cosmovision. Hence, the use of those

[24] ***The Wiphala*** represents more than just a flag or emblem for the Andean nation and the Aymara People. It symbolizes Andean philosophy and the principles of Pachakama (the beginning, Universal order) and Pachamama (mother, cosmos), encompassing space, time, energy, and the planet. Its significance is all-encompassing and is currently being used to symbolize the revitalization of the culture that originated from the Four States of Tiwantinsuyo ("La Whipala" 2020).

offerings was important. That situation reminded me of the experience of Jabokū and José, in which the doctor did not consider Jabokū's relationship with plants as part of an integral relationship seen from another perspective. The Mayora even emphasized that "*not only do they* [the colonizers] *displace us from our territories, but also from our ceremonies,*" sharing her disappointment with the limitations to practice the ceremony. Nevertheless, the ceremony was carried out with the permitted offerings.

I approached the elders organizing the ceremony and asked them if they would permit me to take a photo of these offerings. There was a momentary silence. Then, the elders looked at each other, making surprised facial expressions. Finally, they agreed to let me take the photo. After taking it (image 6), the elders thanked me for having asked for permission. There was no further conversation about my request, although their reaction sparked my curiosity. I was not sure why it was surprising to ask for permission to take photos of these offerings; perhaps it is not a common practice. Grateful, I returned to my seat. A few minutes later, everyone was invited to participate in this ceremony where we expressed our gratitude to the various beings that give us life, asking them for wisdom so that our conversations would flow in harmony.

Image 5. Ceremonial blankets with offerings for the harmonization ceremony. Hugo Puerto took the photo with the permission of the Indigenous *Mayores who organized the harmonization ceremony - Autonomous* Indigenous *Meeting of the SSI-MPC (11/12/2019).*

In the limited space of the conference room, we formed a semicircle around the ceremonial blanket. The ceremony was conducted in Spanish and in the language of the Indigenous elder who was leading the ceremony. Although I was an outsider to this practice, it was a profound experience of camaraderie and respect for me. Respect not only towards the knowledge being shared, but also towards a universe to which we are intimately interconnected. The ceremony ended with a series of hugs among the participants. It was an energizing beginning and a clear desire to continue fighting for the fundamental right to health for Indigenous Peoples.

We practiced this ceremony for three days before starting each day. On the second day, the meeting was between the Indigenous and nation-state delegations. I arrived early to this one. The conference room was larger. From the entrance, located in the right corner of the hall, you could see a layout of several tables organized in a U shape with a screen at the back for projecting

slides. On the right-hand side, there were two rows of chairs for guests. This setup indicated a fairly large meeting.

People started to arrive, and I saw the elders who had performed the harmonization the previous day, preparing for this day. The U-shaped tables formed a space in the center where the *Wiphala* flag was displayed. I noticed there was a cameraman who seemed to be recording the meeting. I briefly talked to him, and he told me the recording was for the Ministry of Health's records. As I took my seat, I saw the cameraman taking photos of the offerings for the ceremony. One of the elders approached him and asked, "*Did you ask permission to take photos?*" The cameraman seemed embarrassed and apologized while requesting permission to photograph and record the ceremony. The elder then told him it was not a problem but that he should always ask first. A smile filled my face, and I proceeded to take my seat.

After the Indigenous elders organized the space for the ceremony, they invited all present people, Indigenous and non-Indigenous, to participate. Compañero Rosendo spoke to the Ministry of Health delegates about the limited ceremonial situation from the previous day. However, there was no change in the offerings used for the ritual on the second day. As the ceremony began, I observed a connection in that space that broke down all labels and brought us closer as human beings. Despite its novelty to many of us, there was a respectful and determined atmosphere towards the ceremony. The offerings were from different Indigenous groups and portrayed various Indigenous densities generally overlooked through a Western lens. These offerings were not used randomly and had a specific spiritual, physical, and mental purpose. Through this vivencia, I embodied a deep connection with everyone in the room. It made me think about the density of these ways of knowing, focusing on constant relationship-building.

Despite having a larger space this time, the number of people was greater, and we found ourselves crowded again during the ceremony. Some of those participating for the first time in this ritual, both Indigenous and non-Indigenous, had physical reactions to certain offerings. One of them was powdered tobacco that was inhaled through a device made of bone. The person leading the ceremony went person by person, asking for permission to offer that offering. Subsequently, upon accepting it, a prayer followed, asking for clarity in our minds to have productive conversations.

On the third day, there was a significant change in the ceremony. The delegation from the Ministry of Health took action and moved the ceremony to an open space within the hotel premises, adjacent to the meeting room for that last day. It was a refreshing ceremony with the appropriate space for the participating people. Although we were still in a colonized space, offerings that had not been able to be used previously could now be employed. Those individuals who reacted physically to the ground tobacco decided to abstain this time, although they took part in the rest of the ceremony.

To defend these practices is to defend the fundamental right to Indigenous health in the nation-state of Colombia and an act of resistance against the colonial lens that seeks to silence the production and practice of Indigenous knowledge. Although Colombian regulations recognize and protect the ancestral practices of Indigenous Peoples (República de Colombia 2001; 2013b; 2013a; 2014; 2015), Indigenous comrades still have to struggle to make this a reality. Indigenous delegates of the SSI-MPC claimed and re-indigenized the hotel as a space for their ceremonies, demonstrating resistance despite colonial limitations.

Narratives Between Knowledges

During the three-day meetings in December 2019, the nation-state had a strong sense of socio-political and economic tension. "*Guardia, Guardia! Fuerza Fuerza!* [Guard, Guard! Strength, strength!]" followed by a "*¡Viva el paro nacional!... ¡Que viva!* [Long live the national strike!... Long live!]" was loudly declared by Indigenous leadership in unison at various points during the meetings. Although they were ready to march if needed, the meetings continued.

On the first day of the autonomous meeting, I learned (and unlearned) a lot about Indigenous Peoples and their struggles. In part, there was a discussion about the need to use Indigenous language when dealing with the state. While discussing this topic, my colleague Rafael turned to me and, invitingly, asked me, "*Doctor, what do you think about what has been discussed so far?*" The question surprised me, as I did not think it was a space for my comments or opinions. However, it was an invitation to share my perspective, which I accepted with great respect.

Before sharing my comment, I acknowledged to the delegates that my knowledge about the SISPI was limited and that I had more questions than opinions. I also expressed that it was not necessary to call me "Doctor," as I was not yet a doctor and because those labels reinforce hierarchies imposed by colonialism, perpetuating power imbalances in certain spaces. My intervention was well received, although they patiently awaited my response to Rafael's question. I shared that if they were trying to use their own words, why were they still using the word "traditional"? I explained that although the word itself was not disrespectful, it carried a strong colonial weight. My point was that in public health, the term "traditional" is generally used to refer to something that is not considered valid or validated by "Western" medicine and therefore lacks "scientific" value in the eyes of the West.

When I finished speaking, there was a silence of about ten seconds that seemed longer from my perception. Then, suddenly, simultaneous conversations broke out around the table animatedly. I could not hear what they were discussing and thought I had said something wrong. Finally, Rafael asked for the floor and said that Indigenous Peoples knew there were many problematic words, starting with the word, "Indigenous," and that they needed to have a deep conversation about that. However, one of the delegates stated that "tradition" was heavily used in the Colombian legislature and had important political weight for Indigenous Peoples dealing with the nation-state. The interventions of Rafael and the other delegate were a learning opportunity to see the complexity of the power carried by certain words. These interventions allowed me to understand better the dense and tense power relationship that Indigenous Peoples must navigate with the colonial language of the nation-state.

These tensions became more visible during the presentation of the report on a deep study of the PCVC-PI document carried out by a group of Indigenous colleagues of the SSI-MPC. One of the Mayores, Mayor Tiksi Kamak Maca Jimenez of the Yanakuna People, presented the report and began by acknowledging and thanking the trust placed in this group by the SSI-MPC to review the document and feel it spiritually to see if it fulfilled the elements that represent Indigenous Peoples. Subsequently, Mayor Kamak shared two conflicting points observed in the document's review. The first one was that the document refers to guidelines for working on differential health in Indigenous contexts and not a plan for collective life health. However, it was clarified that the document provides a differential approach to certain lines of responsibility of the government that must be carried out through the territorial entities. This action implies attention to health following Indigenous healthcare structures and routes so communities can implement and protect their health knowledge and be attended to with resources from the SGSSS through

the SISPI. Part of this point of conflict was the editing of the technical annex[25] by the ministry delegates, where the intercultural pathways were left out. These pathways delineate how the plan for collective life complements the general healthcare system.

The second point of conflict was the way in which the PCVC-PI is understood by the government as part of the *Plan de Intervenciones Colectivas* (PIC) [Collective Interventions Plan] and not as an independent plan that seeks to complement the PIC. Mayor Kamak explained that the problem arises from how both parties perceive and address health. According to Mayor Kamak, for the state (the world of laws), "*principles belong to individuals, and when one speaks of the collective individuality[26] principles, thoughts begin to get truncated.*" Specifically, in the agreement signed with Indigenous Peoples, the Mayor referred to how the Ministry of Health holds only one branch (the Promotion and Prevention Directorate) responsible rather than an integral team between branches. As a result, the department responsible for dealing with Indigenous Peoples only authorizes what falls within its scope. In this way, if Indigenous Peoples need support from other areas according to the comprehensive vision they manage, they would not be able to receive assistance because it would require the involvement of new agencies. One of the examples shared was the topic of *chagras*[27], which is important in the comprehensive

[25] The ***technical annex*** is an accompanying document that explains in detail how to implement the resolution with specific actions. In the case of the PCVC-PI resolution, the Indigenous leadership constructed the ***technical annex*** on how PCVC-PI is developed within their communities, but with the review of the Ministry of Health delegates.

[26] Regarding the ***collective individuality***, the CAOI states: "*This heritage of the first nations considers the community as a structure and unit of life, in other words, constituted by all forms of existence and not just as a social structure made up solely of humans. This does not imply a disappearance of individuality, but rather that it is widely expressed in its natural capacity in a process of complementation with other beings within the community.*"

[27] Indigenous communities in Colombia view the ***chagra*** not only as a place to grow crops, but also as a means of fostering relationships. The practices and behaviors associated with food production extend beyond the purely technical, involving interactions with a range of natural elements, including plants, animals, minerals, and spiritual entities. Through their use of the chagra, Indigenous Peoples demonstrate a holistic approach to the environment, in which food production is integrated with the cultivation of relationships with both human and non-human entities.

health vision of Indigenous Peoples. However, since *chagras* do not fall within the jurisdiction of the responsible department, that part remains blocked. Similarly, those narratives expressed in the laws that force a fragmentation of the integrity of Indigenous Peoples are reflected in the absence of an inter-ministerial team that handles issues of their interest from that perspective, added the Major Kamak.

The group that reviewed the document also suggested correcting a section that conflates illness with disharmony, providing an inaccurate understanding of Indigenous Peoples' perspective. Indigenous and government representatives write the document as a collaborative effort to develop health policies. However, the document reviewed by the Indigenous leadership team was the last version edited by government representatives. Mayor Kamak's mentions of this surprised me because, based on my understanding, I also attributed illness to disharmony. Upon reflecting on my reaction, it was no longer surprising to see that the association between illness and disharmony as synonyms came from a limited understanding of Indigenous knowledge density by the nation-state representatives who edited the document. The Mayor clarified that the PIC only focuses on health from a physical and human perspective, while Indigenous Peoples discuss the territory, cosmos, culture, and other aspects. Therefore, the Mayor concluded, illness can hardly be equated to disharmony. The dimension of disharmony is broader, as Mayor Kamal explained in more detail and visually.

On the first day of the joint meeting, the Indigenous delegation requested a space to address Indigenous density. Different leaders suggested this exercise to clarify perspectives on Indigenous collective health to state representatives and thus align the understandings of an appropriate intercultural framework. Compañero Mayor Rosendo facilitated the conversation and invited Mayor Kamak to share this knowledge.

Mayor Kamak projected a diagram on a whiteboard illustrating how the PIC and PCVC-PI work (see image 7). The diagram projected the map of Colombia on the lower left part, displaying the areas where Indigenous Peoples inhabit. Above the map was an illustration of a mountain with different beings coexisting and the cosmos on the upper left. The right part of the diagram presented a general list of the differences in how collective health is perceived and managed from two perspectives (the PIC and the PCVC-PI).

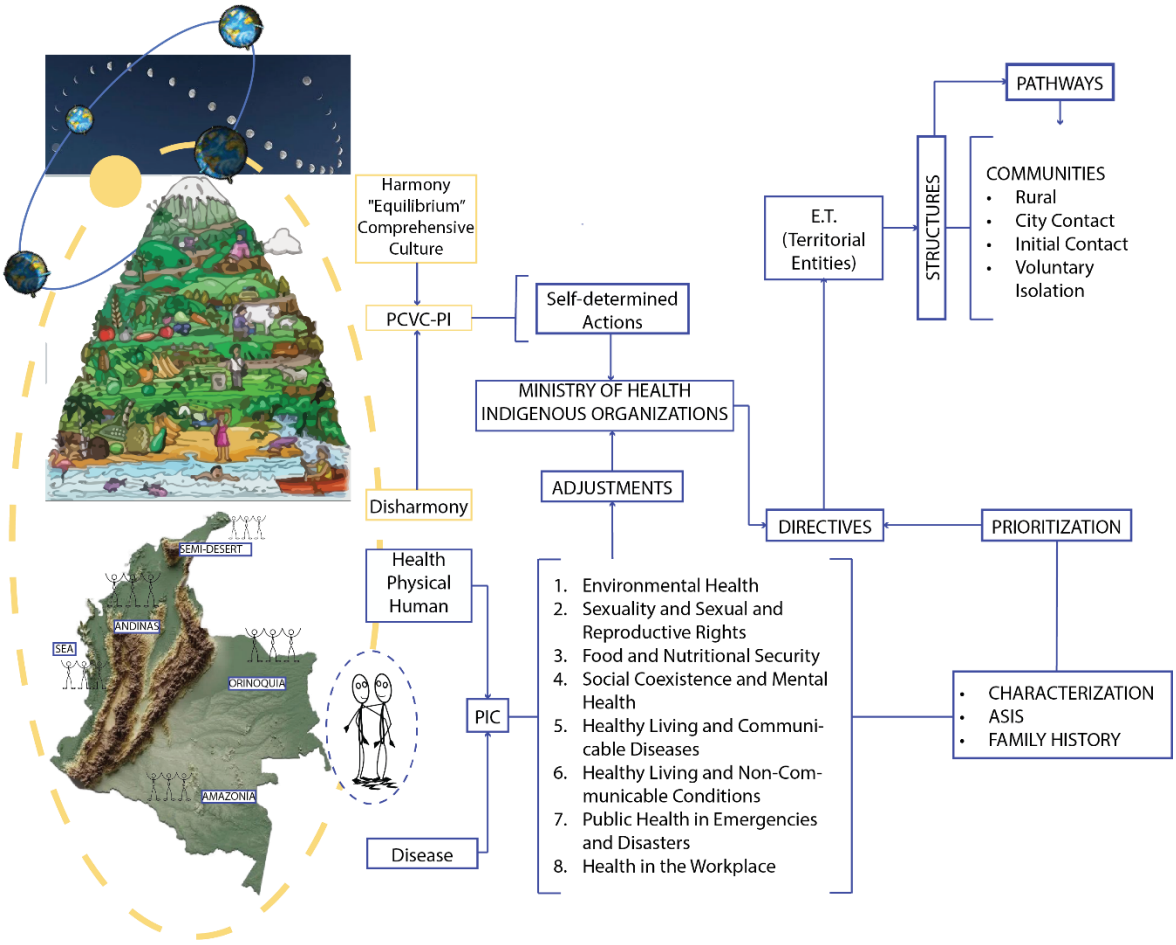


Image 6. Illustration created and presented by Major Kamak at the joint meeting. Digital reconstruction made by Hugo Puerto.

He began by explaining that, despite many Indigenous Peoples inhabiting different environments, they live connected to Mother Earth. This connection implies a series of spiritual,

physical, and mental responsibilities over those places and their communities. "*In very general terms, we could say that among us* [Indigenous Peoples]*, we have similarities according to our territories and how we live in community,*" shared Mayor Kamak. One of the points highlighted in his presentation was the importance of the different calendars used by Indigenous Peoples. The daily calendar defines "*the daily responsibility that we* [Indigenous Peoples] *have with this connection that exists.*" But other calendars also guide these responsibilities, such as the lunar calendar, which establishes the responsibilities of the month; the solar calendar, with the solstices and equinoxes; the cosmic calendar, and other calendars that he deemed unnecessary to mention. In itself, the Mayor made it clear that what he was sharing in that meeting was what the ancestors had allowed him to share; no more, no less. The explanation was necessary to understand what Indigenous Peoples mean by "harmony," "balance," or "culture" and how all of this is a critical part of the PCVC-PI and different from the PIC. The Mayor shared that all of this...

> *...has to do with how we* [Indigenous Peoples]*, through our cultural practices, try to always achieve those points of encounter when there is disharmony; to redirect energies when they become misaligned... So all these types of practices lead to a great responsibility, so to speak. And that is what we have tried to capture with the knowledge that the commissioners have had and all the effort they have made to systematize knowledge into the actions that are included in the Collective Plan of Life of* Indigenous *Peoples* [PCVC-PI]*, which we have been in charge of finishing... These are actions that are specific to contributing once again to this harmony, confronting the disharmonies a little, and from what we see, that is what we are understanding.*

The government representatives appeared attentive, listening to the words of Mayor Kamak. He continued his presentation, distinguishing how the government and Indigenous Peoples approach health prioritization. He emphasized that Indigenous Peoples adhere to certain prioritization methods called "*self-determined pathways.*" These pathways are ancestral methods employed by

each community to implement their actions. One example presented was suicide indicators in Indigenous communities. From the government's perspective, the question in response to this situation is, "*What is happening with the youth?*" The Mayor went on to elaborate,

> *You* [the government]*, from a psychoanalytic point of view, from your studies, can arrive at a logical reason for why people are committing suicide from a mental standpoint. When we* [Indigenous Peoples] do all this analysis [integral analysis of the calendars]*, and we achieve communication from the day, from the moon, from the sun, from everything cosmic, we communicate... or we can also say that we ask the sacred laws, "What is happening?" And they* [the sacred laws] *also say, "Let's review the territory; what's going on?" So, this is not only done with strategies aimed solely at humans. For us, it must be done with strategies proposed from an integral perspective, and that is why we are here defining the guidelines because we have had difficulty* [understanding between knowledges].

After explaining this, Major Kamak concluded that the Resolution would recognize these processes specific to the PCVC-PI, acting in conjunction with the PIC for common achievements. Additionally, from the institutional framework, the Resolution would be the legal document that territorial entities must enforce and act under what is stipulated. In other words, this document asserts that the PCVC-PI and the PIC are interconnected and not overlapping.

The government delegates showed an understanding of Major Kamak's explanation. However, one of the government delegates expressed the challenge of clearly incorporating what Major Kamak shared into the document. As this government delegate explains:

> *How can we diagram the PIC? Because that's when we will translate it into words that create a norm so that our territorial directors comply with it as it should be. They receive it [the norm] and comply with it, so in that respect, we have to be, or at least our responsibility is to be, very careful in ensuring that we can understand each other in the same way. It would be a mistake to make decisions that will not be understood in the same way by all the actors involved in the process. And in the intercultural paths, I wanted to delve into that because although we understand that the SISPI is not something new, here we have to consider them because, as we explained, it is collective for us [the government]. How do we understand those paths within the collective? Because, as you were*

> *saying, it's worth revisiting the text, making it absolutely clear within the collective. In that regard, I believe we have an understanding.*

After this intervention, one of the Indigenous leaders asked the government delegates if the government then agreed with what the Indigenous delegation was proposing. In response to that question, a government delegate replied:

> *Well, yes. As you said, we understand it, and it's the way we can all fit in the territory. That's why we told you initially we believe there are more agreements than disagreements. The thing is, it would be very irresponsible if we understand one thing and you understand another. It's very easy to paint a picture here; I understand that. But it's in the document where it has to be completely clear, and no doubts should arise. The territorial directors need to have a clear understanding. Because even though we have socialization processes, it's important that in the operational details... we have transparency [in the document] for both parties to align our understanding.*

This conversation ended upon reaching an agreement between the Indigenous sub-commissioners and the government delegates that the PCVC-PI would not remain as an annex but as a Resolution, where the PCVC-PI engages in equal dialogue with the PIC, harmonized.

This series of interactions revealed that both Western and Indigenous health knowledge carries a density that marks serious political and economic tensions. These tensions became visible in the joint meetings but yielded fruit by allowing an open space for respectful discussion between ways of knowing. At least in the topic of the PCVC-PI as an independent body from the PIC.

Learnings and Conclusion

Two aspects intimately intertwine the stories shared in this chapter. The first one is the constant clashes of knowledge that Indigenous Peoples face when seeking culturally appropriate healthcare. Colombian legislation has made significant progress in recognizing the rights of Indigenous Peoples. In various legal documents (República de Colombia 2001; 2013b; 2013a; 2014; 2015), the right to intercultural healthcare and the autonomy of these communities to

develop their healthcare system are guaranteed. However, there is a considerable gap between the affirmation of these rights in the legislation and the reality of their implementation and enforcement. One of the most significant challenges lies in the lack of clarity on enforcing these rights in an intercultural context, where genuine dialogue between Indigenous knowledge and Western knowledge can occur.

The government must establish a sincere and respectful dialogue with Indigenous Peoples to ensure effective convergence between healthcare systems. If this is not carried out, it will be challenging to translate these efforts into tangible results. As discussed in the joint meeting, the legal framework derived from national directives must be explicit in the regulations that territorial directives must comply with. This chain of command raises certain issues regarding the capacity of territorial directives to implement what the norm stipulates and the understanding to establish intercultural paths without a clear comprehension of how they unfold in practical reality.

In the history of Jabokū, one can see the lack of clarity from Western healthcare providers regarding how to support Indigenous patients. Although Indigenous patients represent a minority in city hospitals, it is important to recognize that some hospitals receive referred Indigenous patients more frequently. These healthcare centers, in particular, should have a greater understanding and acceptance of Indigenous patients' belief systems and practices. In the case of Jabokū, despite the doctor showing concern for his health, he had difficulties understanding and accepting Jabokū's decision to use plants, based on his own ancestral knowledge and practices, to treat the problem identified in the hospital.

This situation highlights the urgent need for a more systematic intercultural approach in healthcare. While it is challenging to accomplish such an approach in areas where Indigenous

Peoples are the majority, it is even more challenging to expect its implementation in large cities. However, if political, economic, and epistemological willingness exists to expand educational horizons, genuinely intercultural training could open new pathways for understanding and addressing health. It is a challenge that involves accepting other belief systems and recognizing their value in a broader medical context.

This lack of articulation and intercultural understanding in practice generates stress in people who are removed from their territories and communities to be treated in cities, as José described in his experience. Both in the so-called "*shelters*" for Indigenous patients and in Western clinics, there seems to be a limited, prejudiced, and paternalistic perception of Indigenous knowledge and practices that disrupt relationships affecting their *"Buen Vivir"*. José's critical reflection on his experience with Jabokū in Bogotá highlights how Indigenous patients are exposed to cities without any cultural or social support to navigate the urban context, interrupting a critical relational balance for the health of Indigenous Peoples. José's experience visualizes the negative impact of these relational imbalances when he describes, "*I felt lost... I even felt like crying... It was very tough. Imagine that I lost all knowledge of where I was for a moment. I practically got scared.*" Being in a city that lacks a cultural and social support structure for Indigenous patients, José takes his critical reflection even further, recognizing that this traumatic process is magnified in other cases, especially when they don't speak Spanish or know anyone to support them during the experience.

Precisely, the presentation by Mayor Kamak at the joint meeting brought that point into the conversation. The lack of knowledge about the density and history of Indigenous Peoples by the dominant Western culture constantly creates spaces that can be considered aggressive, and resurrect historical traumas created by the coloniality of power. A clear example of this event is

reflected in the limitations on using offerings in the harmonization ceremony at the SSMPC meetings. The meetings taking place within physical and social systems rooted in colonialism serve as a stark reminder of the ongoing efforts to marginalize and dismiss Indigenous Peoples. These aggressive interactions, in some cases unintentional, allowed me to perceive the profound consequences these interactions have on Indigenous leaders when they said: "*they* [the colonizers] *not only displace us from our territories but also from our ceremonies."* The harmonization ritual was limited by structures of the dominant paradigm governed by colonial logic that directly and indirectly excluded many Indigenous practices. The tensions caused by these restrictions reflect the dense and constant ontological and epistemic disagreement between Indigenous Peoples and the dominant paradigm, which includes each one's conception of health.

Through the shared vivencias with compañeros(as) from the Indigenous Delegation of SSI-MPC and the discussions surrounding their worldview, I understood that they believe everything is alive and interconnected and that human beings are part of Mother Earth. Hence the importance of the relationships built with all beings collectively and in complementarity to achieve the *"Buen Vivir"*. The ceremony experience reminded me of the words of Cree Indigenous scholar Alex Wilson (2016) from the nation-state of Canada, who said,

> *white people are starting to be the gatekeepers of our bodies; white people telling us where to seat what to wear in a ceremony even. That is not cool. Because if anything we have the right to our ceremonies. We have the right to that land knowledge.*

Despite Wilson speaking from a different context, the similarities in relationships between Indigenous Peoples and "white" people are very similar globally. The struggles for Indigenous autonomy over their practices and knowledge in colonized spaces are constant. For instance, many Indigenous Peoples in Colombia are striving to halt the colonization of their land and their lives. In the dominant paradigm, there is a disconnection between humans and other beings,

establishing an anthropocentric paradigm governed by individualism and possession. Under this notion, the claim of Indigenous compañeros (as) about the limitations to practicing the harmonization ceremony is clear. The dominant paradigm puts those relationships at risk by not taking Indigenous ceremonies as practices of building and strengthening relationships with all beings. The Mayor eloquently stated during the joint meeting that including the PCVC-PI in the PIC would cause a fragmentation of the relational integrity of health as understood by Indigenous knowledge. Indigenous Peoples have not and will not permit this fragmentation.

The limitations of the ceremony's practice reminded me of the shelter's failure to provide José and Jabokū with traditional foods from their territory. Not taking into account the importance of traditional food for Indigenous visitors, the shelter puts at risk the integrity of the *"Buen Vivir"* of Indigenous Peoples. As a result, the shelter ignored any relational importance between the territory and body. As described by the *"Buen Vivir"*, for Indigenous Peoples, their body is an extension of their territory. The territory, therefore, has a deep relationship with its bodies as it provides what is necessary for their survival. This lack of recognition of the relationship between the territory and the body promotes relational disruptions that affect their survival.

In addition, there are complex relationships with allies of Indigenous Peoples who often propose solutions from the outside, disregarding the path that Indigenous comrades have had to walk. In academia, for example, many of us have debated and condemned colonization theoretically, calling for its dismantling. This call has suggested replacing words that carry significant colonial weight and perpetuate that legacy. However, using those words as political tools complicates matters, making it not that simple. For instance, when I mentioned the word "tradition," I encountered this complexity. The intimate intertwining of the word "tradition" with nation-state legislation suggests that its suppression could result in a loss of political weight in constructing

public policies related to Indigenous Peoples. In this clash of knowledge, the proper use of words is of utmost importance in protecting Indigenous rights.

At the joint meetings, I experienced interactions that exposed this complexity of negotiating relationships with the dominant paradigm for Indigenous autonomy and respect for their practices. However, these interactions also revealed another aspect, the construction of relationships decolonizing spaces to find commonality and healing. Not only dialogue but also both Indigenous and intercultural practices constantly negotiate these relationships.

Despite the constant clashes of ways of knowing in the joint meetings, how they unfolded showed significant points of convergence. For example, Indigenous delegates made a call to explain their cosmovision's density in the discussions on public health. This gathering became a living testament to Indigenous strength, offering a space where their voices were heard respectfully and fostering open dialogue among all present actors.

Indigenous leader, Mayor Kamak, described the sacred relationship that his people maintain with Mother Earth. This connection, which goes beyond the purely physical and delves into the spiritual and cognitive realms, presented a valuable point of convergence and provided a new perspective for reflecting critically on Indigenous public health. Furthermore, the inherent complexities of Indigenous knowledge were highlighted, particularly concerning their calendars that delineate their obligations and responsibilities. Mayor Kamak emphasized the importance of understanding and respecting these differences to address public health issues from their perspective effectively.

Another highlighted aspect of this dialogue was the recognition of differences in prioritizing health between government entities and Indigenous communities. This recognition allowed for a

deeper and more reflective dialogue on synchronizing these divergent perspectives to foster more productive collaboration. The meeting concluded with an important agreement: the PCVC-PI would be a Resolution, not an annex. This step would ensure an equal footing dialogue with the PIC, laying the legal foundations for effective cooperation. These points of convergence, of vital importance, pave the way for an open and respectful dialogue, thus facilitating greater mutual understanding and effective collaboration in Indigenous collective health.

From an academic standpoint, my experiences have imparted significant lessons. While I am not well-versed in the intricacies of Indigenous knowledge, I have been fortunate to collaborate with Indigenous peers who have guided me in re-evaluating and relearning life from an alternative viewpoint. A notable lesson I gleaned was the concept of decolonizing the written word. In our collaborative sessions, Mayor Kamak emphasized the significance of oral traditions for Indigenous communities. He also insightfully discussed the symbiotic relationship between reading and writing. I perceived Mayor Kamak's reference to "*spiritually feeling the document*" as an intimate method of engaging with the content during our collective review. This engagement transcended mere reading; it encompassed a visceral and spiritual connection, acknowledging and honoring ancestral ties. Through these insights, I came to perceive both reading and writing, in tandem with oral traditions, as rituals fostering interconnectedness and healing. This sentiment resonated with anthropologist Claudia Serrato's (one of the colleagues I admire and respect) reflection when I shared this experience with her: "*If writing is a ritual, then we are writing to heal.*"

The *feel-thinking* in which Mayor Kamak expressed himself in the joint meeting impacted how government representatives received his presentation. The Mayor's focus was more on Indigenous density and less on differences. His detailed explanation of the densities of PIC and

PCVC-PI allowed for a better understanding of how these two ways of viewing health can generate points of convergence. The joint meeting undoubtedly fostered a sense of receptiveness among the participants, which enabled them to reach agreements by the end of the session.

Within my limited understanding of Indigenous knowledge density and even of the dynamics of the government itself, these collective vivencias have taught me many lessons. From my perspective, one of them is that the dominant paradigm continues to be governed by colonial logic that, intentionally or not, impacts the *"Buen Vivir"* of Indigenous Peoples and their structures. This top-down approach conceals the colonial vision that resides strategically, safeguarding knowledge validated solely by the "observer" from above. Jabokū's story reveals the colonial perspective, as the doctor who attended to him did not validate Jabokū's knowledge as part of health treatment. However, both Jabokū and his son, José, recognize a need to complement ways of knowing because none have absolute answers. In other words, this lesson is about understanding that humans do not know everything and that putting into dialogue different ways of knowing without hierarchies' benefits humanity and the planet.

Furthermore, I learned that depending on how one relates to the world, the methodology for learning more about that world changes significantly. For example, reviewing a document not only intellectually but also feeling it physically, emotionally, and spiritually changes how research is conducted from a relational standpoint. Instead of distancing ourselves from what is being studied, we become part of it and engage with it. This lesson leads me to be more aware and humbler about the depth of each being and the importance of Indigenous ceremonial practices. For instance, the limited ceremonies during the first two days of the meetings provided a perspective that empowers offerings. Not respecting that empowerment put the ancestral relationship of the attending Indigenous compañeros(as) at risk. The hotel where these meetings

took place restricted any practice that did not align with the dominant paradigm or a certain socio-economic status, despite the meeting coordinators' support for the ceremony to take place. However, by raising this concern to the government representatives, Indigenous leadership could carry out the ceremony in an appropriate space. When we truly desire to listen to each other, we can achieve mutual respect, or at least that is what I learned from these interactions.

In conclusion, with all this relational complexity experienced in these stories, it is clear that these genuine intercultural dialogues between Indigenous and Western knowledge occur only in small spaces. Educational curricula and the broader national discourse do not actively share these dialogues of knowledge, structurally speaking. The colonial gaze toward Indigenous Peoples will continue to perpetuate if no social structure actively complements different forms of knowledge. Indigenous compañeros(as) bear the burden of explaining this density again every time there is a change in government or government representatives, making it a part of the problem. Some of these new people are receptive to the Indigenous message, while others are not.

CHAPTER FIVE - INTERCULTURAL BRIDGES: THE NOSTALGIA OF THE INTERCULTURAL PRIMARY HEALTHCARE FOR THE INDIGENOUS HEALTH OF VAUPÉS

> *"Se ha buscado por diferentes medios extender los planteamientos de la cultura mayoritaria a la población Indígena [en Colombia] y hacer efectivos programas que responden a problemáticas percibidas en contextos socioculturales ajenos a su realidad. Esto, por supuesto, ha creado conflictos en la comunicación con los Indígenas. Resulta un contrasentido hablar de respeto y, al mismo tiempo, forzarlos a tomar decisiones en un esquema extraño a su propia cultura" ~* Juan Guevara Guzmán 1998
>
> *"Efforts have been made through different means to extend the ideas of the majority culture to the* Indigenous *population* [in Colombia] *and implement programs that address perceived issues in sociocultural contexts foreign to their reality. This, of course, has created conflicts in communication with the* Indigenous *Peoples. It is contradictory to speak of respect and, at the same time, force them to make decisions within a framework foreign to their own culture." ~* Juan Guevara Guzmán, 1998

Introduction

In the late seventies and early eighties, the *Servicio Seccional de Salud de Vaupés* (SSSV) [Regional Health Service of Vaupés] embarked on a journey to build and implement an intercultural *Primary Health Care* (PHC) model for its entire population. This model brought many challenges but left many important elements still used in addressing public health in the department. However, the different policy changes over the years eventually led to the dismantling of the model. This event reopened intercultural gaps, limiting access to culturally appropriate health services for Indigenous communities in Vaupés.

This PHC model arises from an agreement between the Colombian and the Netherlands governments in the late 1970s. With the support of a PHC management group, the SSSV officially began implementing the model in 1983, focusing on community participation (Guevara 1984b).

The model went through three important phases before its dismantling. The first phase occurred between 1979 and 1984, during which planning, execution, control, and evaluation occurred, accompanied by the APS management group created by the agreement. Anthropologist Juan Guevara Garzón played an important role in documenting and understanding the Indigenous density of the territory to develop the model in Vaupés. The second phase, although poorly documented, involved adopting and maintaining the model by the SSSV between 1984 and 1997. During this process, Guevara continued to support the model by training healthcare workers from the communities and Western public health professionals. The third and final phase, considered the transition phase towards its dismantling, occurred between 1997 and 2007. In 1997, the Functional Group for the Coordination of Health Service Delivery in the Rural Area of the department was created in response to the demand for a separation of competencies between health service providers and the institutions responsible for the governance of the health system, as required by Law 100 of 1993. The creation of this group within the SSSV aimed to systematize, operationalize, and develop some components of the model that had not been originally conceived, marking an interesting moment where the political demands of the time were being addressed without abandoning key components of the outgoing model. In 2007, the model faced an unsustainable situation regarding implementing the fundamental elements established in Law 100, which led the Ministry of Health and control agencies to demand that the department eliminate the provision of health services by the SSSV. In response to this demand, the San Antonio Hospital in Mitú partially took over this task, although it argued the insufficiency of available resources to assume it fully. As a result, the model was dismantled.

This chapter focuses on revitalizing what has been learned from the intercultural PHC model in Vaupés through its different stages. This revitalization highlights the contribution of different

people who worked on this culturally significant model in Vaupés. Some are no longer with us, but their legacy remains to be resumed and put into service for the population's health in Vaupés. This is the case with the participatory anthropological work of Guevara, which significantly contributed to the construction of the model's foundations. This revitalization is possible through the vivencias of those who personified that model and continue working for Indigenous health in Vaupés. The chapter begins with a story that illustrates the impact on health without considering the depth of Indigenous knowledge. Subsequently, the intercultural PHC model is presented along with its different phases and whether this model can inform the SISPI. Finally, the chapter concludes with the learnings and conclusions drawn from these experiences.

"Not Anyone can Come to Perform a Prayer…"

In October 2019, I arrived in Mitú for the second time to carry out the fieldwork for my doctoral thesis with the Puerto Golondrina community and the Sinergias organization. I arrived with many expectations and good intentions to contribute to the decolonization of knowledge and the socialization of SISPI. In addition to my academic task, my commitment to the *Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas* (SSI-MPC) [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations] was to coordinate a visit from a committee of delegates from the SSI-MPC to socialize the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] in the territory. However, upon meeting dentist Adelia Prada, I quickly realized my Western academic bubble and the complexity of relationships in this context. Adelia has been working with Indigenous health in Colombia for many years and is the coordinator of the Sinergias organization in this territory. She would become one of my great mentors in Vaupés through our extensive conversations. In

one of the deep initial conversations in which I outlined my decolonial proposal criticizing academic and public health works based on colonial logic to work with Indigenous communities, she said:

> *Look, Hugo, it's great that students can come and work with* Indigenous *communities and join the struggle for better health for* Indigenous *Peoples. However, assuming that serious intercultural work hasn't been done here because it's not found in academic writings from foreign institutions shows a lack of understanding of the Vaupés context.* (notes of vivencias, October 2019)

This conversation was a learning opportunity for me in how our unconscious biases operate and the importance of reflecting on them constantly. However, Adelia agreed that there were problematic works. She told me that these problematic works were usually led or implemented by outsiders to the territory who were not interested in understanding the context's historical relational complexity through practice. In other words, they lacked interest in the density of Indigenous knowledge and relationships. To elaborate more on meaningful intercultural work done in Vaupes, Adelia provided a clear example of the intercultural PHC model built and implemented in the 1980s and 1990s. From this conversation, the name of anthropologist Juan Guevara resurfaced alongside the Colombo-Dutch agreement that promoted the implementation of this intercultural PHC in Vaupés.

> *... I believe it is important to understand that... in the territory, there are impressive developments regarding primary health care with community participation…* [it] *would be very important... to be able to have... a documentation bank... because we see that* [from] *the progress that was worked on with the communities in the company of Juan Guevara, working in the regional health service... there are people who are still part, and we were part, of all these developments... these developments are* [a] *support for* Indigenous *Peoples to be aware that they have the power... we sometimes talk about losing knowledge, losing tradition, and sometimes I see it as despair. But I believe that we also have to recognize that there are people, there are institutions, there are entities, there are communities, there are, in any case, different spaces where we have to work on it and that it is possible and that it is not something that is lost, but rather we need to gather more strength and continue empowering people,* Indigenous *Peoples, leaders, new leadership, so that they become empowered and see that*

> *this is really necessary... not only for the current generations but for future generations to feel they have* [an] *identity, that they have valuable knowledge, and well, if we don't work on this, future generations will be the most affected. ~ Adelia* (notes of vivencias, October 2019)

I have actively reflected on the relationships that weave and continue weaving the "*Vivir Bien*" [Living Well] in Vaupés. My encounter with Adelia was transformative throughout this journey. Another vivencia that expanded my understanding of these relationships took place in a situation supporting one of the families in Puerto Golondrina to urgently attend to one of their youths at the hospital.

This vivencia happened in mid-February 2020 when I encountered Mayor Héctor from the Puerto Golondrina community on my way to the Sinergias office in Mitú. I stopped to greet him and chat for a while. Mayor Héctor seemed a bit worried and with good reason. He told me that his grandson, Johnny, had been injured in a football match a few days ago. For two and a half days, Johnny was in a lot of pain, to the point that he had to be taken to the emergency room because he could not take it anymore. Mayor Héctor informed me that at the hospital, they took X-rays, but the doctor told the family that Johnny did not have any fractures. The doctor sent Johnny back home with a prescription for ibuprofen, minimal movement of his right foot (the affected foot), and the recommendation to keep it elevated. Mayor Héctor told me that he and his partner, Mayora Margarita, were worried about their grandson's health. Fortunately, one of their family members had a house near Mitú in the "Bosques de Morillo" area, where they stayed with Johnny. I promised to stop by that afternoon to see how Johnny was doing. However, I was not sure of the location of the house. When I asked for the address, Mayor Héctor told me it was a house with a door that had a piece of red-painted wood, and it was located right in front of a store. I left wondering, how am I going to find that house? I was unfamiliar with the spatial

orientation of Mayor Hector and his context. Those are different parameters than the ones I learned to relate spatially, but his references were crucial to finding the house they stayed at.

Upon arriving at Sinergias I ran into my colleague Martha Bibiana, a head nurse who has been working for many years in Vaupés in Indigenous health. I told her what had happened to Johnny and asked her if she knew where to find the house where he was staying. Without thinking twice Bibiana (preferred name) told me she would go with me. It took us some time, but we found the house where Johnny stayed. Johnny's aunt, Nury, was taking care of him. When we entered the room where Johnny was, we saw him lying down with his right leg raised. Clearly, Johnny was showing signs of great pain. His right foot was swollen, warm, sensitive to touch, and red. Bibiana immediately recommended taking him to the hospital because it seemed like a case of cellulitis (an infection). She shared with me that she had witnessed some cases in which patients with the same symptoms ended up losing one of their lower limbs due to a lack of timely care. Bibiana explained to Nury and Johnny the importance of addressing this health issue immediately. Johnny looked at me, and although he was not saying anything verbally, his eyes were pleading with us to keep him at home. He did not want to go to the hospital at all. Johnny complained about the long hours it took to see them. I heard this sentiment repeatedly from many Indigenous compañeros(as) from this area. To respect his wishes, we decided to advise him on how to keep the leg elevated, and we brought him ice bags so he could apply cold to the affected foot to reduce swelling. However, the heat of the Amazon didn't allow the ice to last long, which worried us. We told them that we would come back in the morning to see the progress.

The next morning, we returned to "Bosques de Morillo." This time Mayora Margarita and another man were at the house. Johnny's foot appeared warmer and redder. His pain worsened. We decided to call a motorcycle taxi and take him and Mayora Margarita to the emergency room

at San Antonio Hospital in Mitú. We arrived at around 9 in the morning to the hospital and went straight to the emergency area. While entering, I noticed that outside, at the back of the hospital, there was a structure that resembled a Maloca. When I asked Bibiana about that structure, she told me it was a Maloca. According to her, traditional healers used the Maloca to care for community members in conjunction with the healthcare services the SSSV provided during the intercultural PHC model developed in the 80s, which persisted until 2007. However, Bibiana explained that since dismantling the model, the Maloca has become a space for events and meetings. I wondered what that model was like and what happened to it. Did it work for all the communities in the region? With these questions surrounding my head, we waited 30 minutes in the waiting room until the nurse called Johnny in.

Bibiana and I approached to and informed her about the situation using our medical language. The nurse agreed with us that an infection in the foot was possible; however, she could not prescribe any antibiotics because it was the doctor's responsibility to diagnose the infection and prescribe the treatment. The nurse went to consult with the doctor, and the doctor responded to the nurse that she was busy and that if we wanted to wait, she would see us, but it might be a few hours; otherwise, we could make a priority appointment at the outpatient services. So we decided to wait, although Bibiana made an appointment at the outpatient services just in case. Bibiana and I had scheduled a meeting at 10 am, so we decided to split up. She attended the meeting, and I stayed with Johnny and Mayora Margarita. Johnny was in a lot of pain. I did not know what to do, so I asked for a glass of water and a towel. Johnny drank a glass of water, and I used the bathroom sink to wet the towel to place it on his foot. I rinsed the towel several times to have something relatively cold on his foot. Johnny was almost crying at that moment.

We finally saw the doctor at 11 am. I used my privilege to introduce myself as a public health professional from the University of Washington working with Sinergias and as a mediator for Johnny and Mayora Margarita. The doctor asked if Johnny followed the recommendations she gave them the last time the doctor saw Johnny. They told the doctor that they followed all her recommendations. However, despite this confirmation, the doctor's first words after hearing what happened were, "*No, I don't think you followed the directions. Because you* [Indigenous Peoples] *don't follow our recommendations… it's very difficult for you to get better.*" The doctor revealed her prejudice with her words, blaming Johnny and his family for not following the instructions to improve his condition. Mayora Margarita looked at me with watery eyes and said, "*We did everything they told us* [to do]." Immediately, I understood more than ever why the community prefers not to go to the hospital, as there is prejudice from the start. Although Mayora Margarita verbally and physically opposed the prejudice of the doctor with her reaction, I felt that Mayora Margarita needed my support because she was looking at and responding to me, not to the doctor. As a result, I told the doctor that that was not the case and that both Bibiana and I had followed up with them for a couple of days, and indeed they followed everything recommended by the doctor. However, his foot was getting warmer and redder, which made us suspect a possible cellulitis or another infection. The doctor stopped blaming them and considered the possibility that it was an infection. After my intervention, I could see Mayora Margarita at more ease.

Giving in to our insistence, the doctor decided to hospitalize Johnny and order a blood test to see if it was cellulitis. She told us, "*We're going to keep him overnight for monitoring and perform the* [cellulitis] *test to give you more peace of mind.*" La Mayora Margarita stayed to accompany Johnny, as only one person was allowed to be with him until a certain hour. I offered to bring

them anything they needed, but Mayora Margarita only asked me to bring a blanket for Johnny from the house where they were staying. Johnny was also about to start school to become a teacher, so he asked me to request Nury to inform the academic program coordinator of his situation. When I left, Johnny was still in a lot of pain.

The next day, I went to the hospital to visit Johnny. I arrived around 8 am. Visiting hours did not start until 9:30 am. Johnny and Mayora Margarita authorized Bibiana and me to ask the medical staff about the results and procedures. The Mayora Margarita told me, "*We trust you, and besides, you communicate* [in the medical language] *better with the doctors here* [at the hospital] *than us.*" Unable to wait until 9:30 am, I asked the nursing assistant about his laboratory results. The doctor was there, and when she heard me, she came out excited and updated me on Johnny's condition. She stated he was stable and that they were trying to control his pain with medication; she also said, "*The lab results came back, and he has cellulitis. We've already started treatment, and he will remain here* [hospitalized] *for seven days.*" I replied that it was what we suspected he had. She did not say anything else, just that we had to keep an eye on him constantly.

I returned in the afternoon with Bibiana to visit Johnny. He was asleep. It seemed he was getting better from the pain even though his foot was still swollen. Mayora Margarita told me she saw a great improvement in his condition and that he had been able to sleep. It was a relief to see him a little better. I left that afternoon to avoid interrupting Johnny in his healing process.

The next day, I returned to visit him in the afternoon, and he was better. He was smiling and in less pain. His foot was still swollen, not as much as the day before, but the redness had decreased. In the room were Johnny, Mayora Margarita, Mayor Hector, and another patient with whom Johnny shared the room. The patient was an elder from another community. Upon hearing us converse, the elder said he had performed a "*prayer*" for Johnny because he was screaming in

pain. I thanked him and told everyone that "*prayers*" are also important for healing and that having someone who could offer them was great. They thanked me for staying involved. I'm glad we could do something to save his foot. I told them I would go to the community and announce that he was recovering and that the "*veterans*" [the middle-aged adults' soccer team in the community] should prepare to lose in soccer against the young people because Johnny was coming back full of energy. Johnny and his relatives laughed. I left with the good feeling that he was recovering.

When I returned to the Puerto Golondrina community, two days after visiting Johnny, I enthusiastically brought the good news to everyone about his recovery. They were happy to hear that he was out of danger. I mentioned the kindness of an elder from another community offering a "prayer" to help Johnny. To my surprise, this information worried them. José's explanation made me realize the need for a cautious approach, which I did not understand previously. Prayers, while they can be for healing, can also be for illness. It depends on the relationships that exist between communities and individuals. I became concerned because I had not considered that practice as something harmless, and I reflected on my great ignorance regarding the density of the Indigenous ways of knowing in the area. José educated me to some extent, within the limits allowed. He taught me that, for him, Indigenous ancestral knowledge has a very profound energy relationship. This density of knowledge varies among communities. For example, José was telling me that each community focuses on a specific knowledge (i.e., prayers, plants, connection with other beings, among others), and that depending on this knowledge, communities exchange healing methods or cures. However, José reiterated to me,

> *Not anyone can come to perform a prayer or give a plant for healing. That person must be recognized by the community and go through a very complicated process of several years to become a Payé or another ancestral medicine person. So, it is*

> *dangerous to receive these practices from someone we do not know. For example, we know about plants, and there is a plant that can help with the flu. But if that plant is collected when it is not ready to heal the person, it can make it worse. And that knowledge takes time and practice to learn.*

In addition to what José shared with me, Jabokū complemented by saying that,

> *it is very important for the sick person to be treated with one medicine at a time and not mix them. The thing is, if a person is treated with two medicines at the same time, the reaction can cancel out the effect of the treatment or even worsen the person. That is why if the person is being treated with Western medicine, they should not be treated with plant medicine until they stop the Western treatment, or vice versa.*

These conversations with José and Jabokū were a learning lesson for me. I realized it was not my place to validate what is applicable using traditional knowledge. In a sense, I romanticized Indigenous knowledge, going to the opposite side of the doctor who attended Jhonny. I did apologize to Jabokū and José, who received these apologies with much understanding. With this in mind, the story of Johnny and the Mayora Margarita highlights the challenges of complementing different knowledges seeking a "*Vivir Bien*" [Living Well]. As a result, these experiences underscore the importance of constantly checking our prejudices and privileges. This continuous exercise of critical reflection is necessary to support the communities with whom we share and develop these collaborative relationships, responding to their priorities and desires. So, how can we create intercultural bridges considering our relationship with everything? In conversations with colleagues from the Vaupés context, I constantly highlight what Adelia previously shared about the initiative of a culturally appropriate PHC model for the Vaupés context that existed in the 1980s, 1990s and part of the 2000s.

This chapter focuses on revitalizing what was learned from the intercultural PHC model in Vaupés and the work of Juan Guevara to provide further insight into the SISPI process in this context. This revitalization is possible through the vivencias of those who embodied that model

and continue to work for Indigenous health in Vaupés. Part of these stories also shares the desire to preserve and understand the importance of the density of Indigenous health knowledge by the community of Puerto Golondrina.

The PHC in Vaupés – First Phase (1979 – 1984)

Once in Vaupés, I had a specific task assigned by the SSI-MPC. It was to organize a commission visit from the SSI-MPC, led by the current technical secretary, compañero Mayor Rosendo. The idea was to talk directly with the communities about the SISPI. As a result, in February 2020, we facilitated an assembly with representatives from almost all the zonal organizations in Vaupés. In this assembly, the zonal leaders agreed to invite this SSI-MPC commission at the end of April of that year.

One of my commitments at the assembly was to ensure that an Indigenous compañero(a) would lead the process. In this way, we could establish a direct and sustainable connection between local and national Indigenous leadership. Only one of the leaders of these zonal organizations was familiar with the SISPI topic during the assembly. The leader who knew about SISPI was from the *Asociación de Autoridades Tradicionales Indígenas* (AATIAM) [Association of Traditional Indigenous Authorities], who had been working with Synergies to develop their own health model within the framework of SISPI.

Realizing this imbalance of information and practices related to the SISPI, within my limited knowledge and with the permission of compañero Rosendo, I shared a basic explanation of the SISPI with these leaders. The AATIAM leader accompanied this information and shared part of their processes with other leaders. Upon receiving this explanation, the leaders reacted positively to the information. They suggested I continue coordinating the event with the *Asociación de*

Autoridades Tradicionales Indígenas (AATIs) [Association of Indigenous Traditional Authorities] health delegate of Vaupés.

Following the suggestions of my colleagues, I met with the leader of the AATIs, and in that meeting, I met the health delegate of this association, Mayor Jaime Pereira. Our first encounter was full of learning. Mayor Jaime is originally from the Tatuyo community and has been a public health worker in Vaupés for many decades. He told me that the health system had changed a lot in the *Departamento*. With nostalgia, Mayor Jaime shared his vivencias about learning and integrating himself into the intercultural PHC model built and implemented in Vaupés in the 1980s,

> *At that time, I was a teacher in Yapú. I noticed that there was a group that received training in healthcare right here. The person in charge was a sociologist before the Colombo-Dutch Agreement… a sociologist and a nurse. I saw that they came to practice and all that. They sent a group of* Indigenous *assistants to study in Florencia, Caquetá. That's where it all began, as an interest* [for him]. *I think the Colombo-Dutch Agreement... was... education research.*
>
> *I observed all of that. I was with the Colombo-Dutch* [Agreement], *the educational part. When it ended, they transferred me to when the Colombo-Dutch* [Agreement] *was already in place. They* [the coordinators of the agreement] *saw... as... an effort... that there was interest here* [in Vaupés] *in health, the way of working in primary health care.*

These vivencias of Mayor Jaime describe the intercultural model of PHC that began to be developed in Vaupés in the late 1970s, promoted by an agreement between the government of Colombia and the Netherlands. The Colombian-Dutch Health Agreement was a cooperation project between these two governments aimed at implementing PHC strategies in marginalized rural areas to expand the coverage of health services (Convenio Colombo-Holandés en Salud 1983). Part of the implementation of this agreement was influenced by the International Conference on Primary Health Care held in Alma Ata, in the former Soviet Union, in 1978. This

conference produced a declaration to protect and promote the health of all world peoples (The International Conference on Primary Health Care 1978).

The first process of this model began in 1979 with an identification phase that selected the regions of Chocó, Urabá, Vaupés, and Guaviare for development. From 1980 to 1981, the project progressed to a construction phase, followed by an ongoing service deepening phase (1982-1983). Three levels describe the organizational structure of the project:

1. A steering committee represents the leadership level. This level is responsible for establishing policies and approving programs and budgets.
2. A coordination office represents the policy coordination and implementation level. This level is responsible for coordinating and implementing the policies established by the steering committee.
3. Regional coordination represents the action coordination and implementation levels. This level coordinates and executes the necessary actions to fulfill the policies established by the steering committee and the coordination office.

In the context of Vaupés, using the primary care strategy, the agreement aimed to expand and improve healthcare services for Indigenous communities. The PHC approach also provided a local perspective on the health problems of Indigenous Peoples, who were the majority in Vaupés and were and continue experiencing inequality and marginalization at that time. The implementation process between 1980 and 1981 focused on four strategic areas: Training, Infrastructure, Supplies, and Sanitation. In terms of training, there were Indigenous health promoters, nursing assistants, and sanitation promoters. In terms of infrastructure, the proposal included the construction of seven health posts in strategically accessible locations for

communities to provide basic healthcare services. In terms of supplies, the agreement provided for the healthcare posts. Sanitation measures were also implemented to prevent diseases.

By the end of the 1980-81 biennium, they had implemented a significant portion of the proposed training and infrastructure (Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés 1985). After that, however, the program shifted towards participatory work based on close collaboration with Indigenous communities and their leaders. In 1982 - 1983, the advice of a social sciences professional was linked to these participatory works. For this two-year period, community participation, technical advice, a multidisciplinary support team, and continuous education were incorporated as additions to the strategic areas of Primary Health Care approach. The technical advisory was the responsibility of a Dutch professional, while the multidisciplinary team consisted of a coordinating nurse, training nurse, sociologist, sanitary engineer, and doctor. According to the agreement, between 1982 and 1983, the objective was to "*develop an Operational Plan for Primary Care, taking into account the socio-cultural and geographical situation of the region*" (Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés 1985, 11). This expansion of strategies strengthened the community participation component and extended the work to more remote areas (Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés 1985).

In 1984, the strategic areas expanded with the inclusion of health education. In the 1980-81 budget, health education was a subcomponent of infrastructure, and in the 1982-83 budget, it was considered a subcomponent of training and community participation. For the 1984-85 phase, health education included educational materials and advisory services (Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés 1985). In infrastructure, health centers began

to be built in addition to health posts to provide the auxiliaries and promoters with everything they needed to provide services to the communities (Guevara 1984).

The anthropologist Juan Guevara Garzón was part of the team in this first process and significantly contributed to constructing the foundations of the Intercultural PHC model, using *Participatory Action Research* (PAR) for this purpose. Guevara graduated from the *Universidad Nacional de Colombia* [National University of Colombia] and worked for the SSSV for many years, building intercultural bridges to implement context appropriate PHC. Although he had a supporting team with whom he constantly worked to achieve these objectives, his academic training and humanity were of great importance in working hand in hand with Indigenous communities in the region.

Guevara documented (1984) this initial process of the model in Vaupés as a manual for different healthcare workers in the *Departamento*. This manual emphasizes the importance of dialogue, education, and constant participation among all actors in the system. One of the challenges that emerged in the model's construction process was the different understandings of PHC among public health workers and communities. Reflecting on the question of "*What is the first thing to do in healthcare?*" was a complex issue requiring collective learning. For some, the first thing to do was to provide medication, especially for diseases brought by the "white" people. However, other participants acknowledged that "white" people's medicine should not treat all diseases. Other perspectives highlighted that, although treating the disease was important, the main focus should be prevention. This preventive approach refers to Indigenous knowledge of health in the territory, which focuses on balancing relationships to stay healthy and "*Vivir Bien*". As a result of these initial conversations, participants decided that the first step to take was to promote health improvement by inviting Indigenous communities to "*reflect on effective ways of preventing and*

curing diseases as they did before the arrival of non-Indigenous Peoples in Vaupés" (Guevara 1984:20).

After this health promotion, the next step to follow was "*the participatory search for the concept of Primary Care*" (Guevara 1984:20). This step consisted of organized education. The education referred to by Guevara is not conventional education from the dominant paradigm that imposes their perspectives but rather a reconnection with the communities' knowledge for self-care. He called this approach "*Educación Continuada*" [Ongoing Education]. This *Ongoing Education* went hand in hand with training, where the goal was to complement knowledge where there is convergence to provide culturally appropriate services to Indigenous communities. However, community participation in investigative processes (also known as PACO) and supervision were necessary to develop this educational organization. These participatory aspects were crucial for the development of the model.

The PHC model's structure adapted to the Vaupés context emerged from these steps. The manual states that the PHC focuses on two levels: attention to individuals and attention to the environment. Attention to individuals focused on the services that the SSSV provided to the individual. On the other hand, attention to the environment addresses the care of our surroundings to prevent diseases. The educational and supervisory aspects are intertwined in these two levels of focus, providing a participatory and intercultural structure for the PHC model (figure 10).

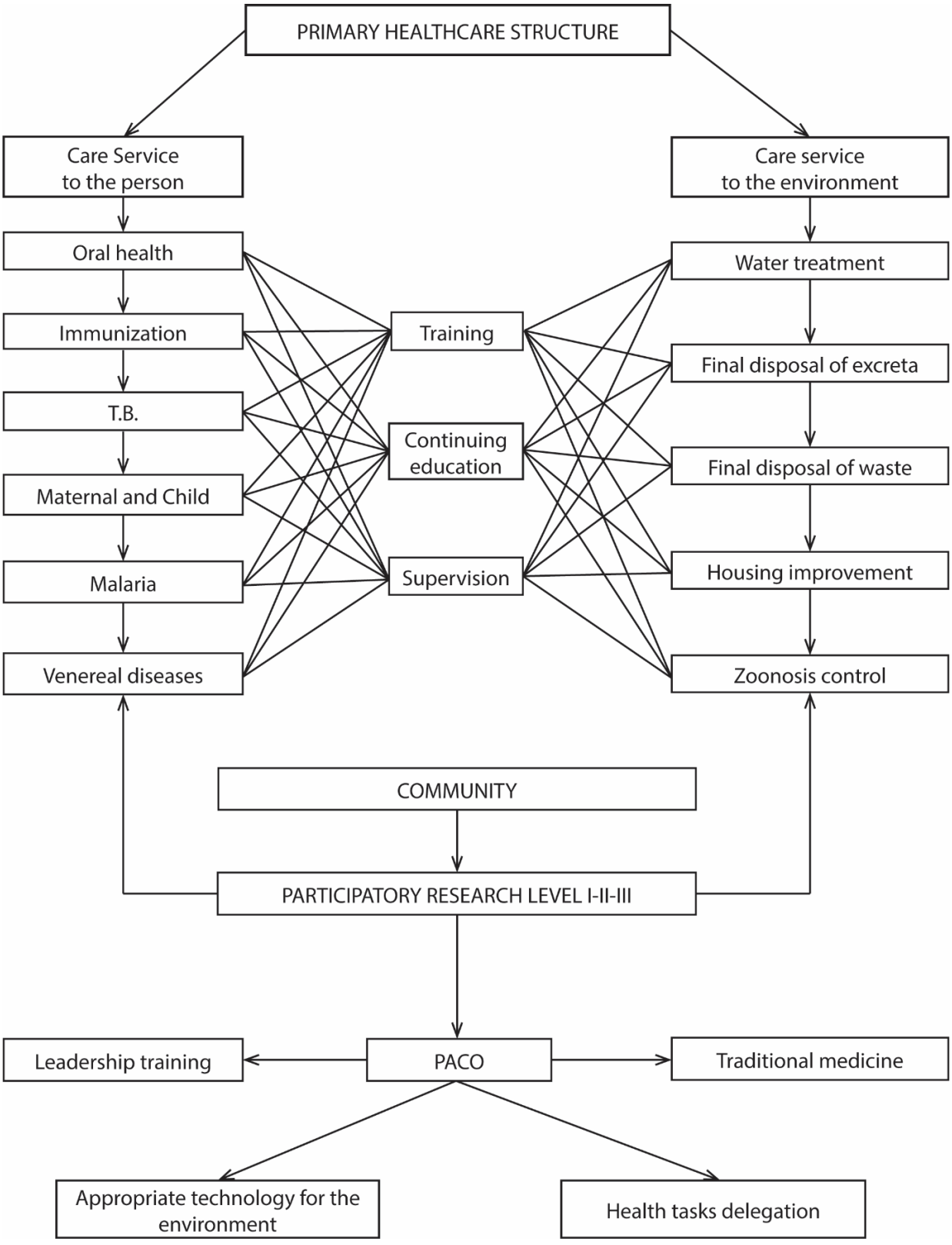


Figure 10. Structure of the intercultural model of Primary Health Care in Vaupés in 1984 (Guevara 1984:22).

A methodology that encompassed community participation was necessary to implement the structure of the model. This methodology was cyclical. It began with a dialogue between the health program and the communities. After a collective analysis of these conversations, participants proposed alternative solutions. They evaluated the proposals to provide feedback for the dialogues that they carried out again after implementing the actions (figure 11).

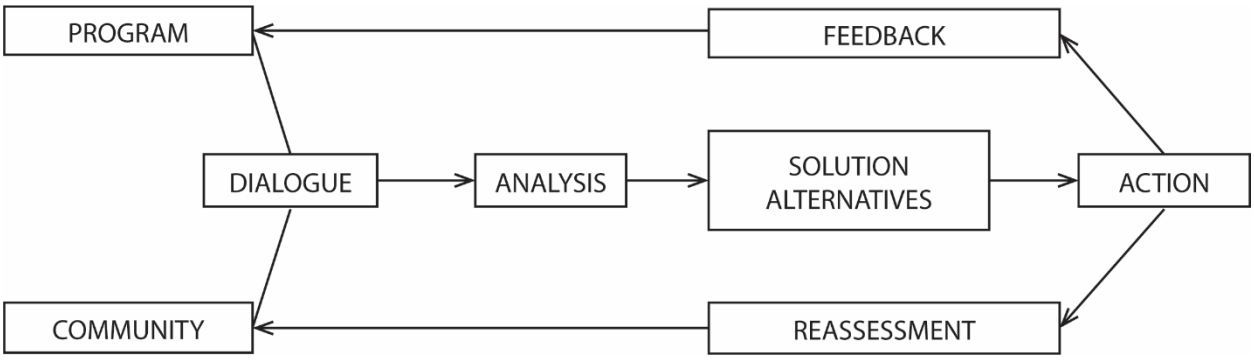


Figure 11. The methodology that embraces community participation used in the model in 1984 (Guevara 1984:30).

To have a more organized orientation of community participation in the intercultural model of PHC, 17 *Unidades Primarias de Atención en Salud* (UPAS) [Primary Health Care Units] were established, to which Coverage Units were assigned (48 units in total distributed among the 17 UPAS) under the administration and coordination of the SSSV. The hospital served as a reference point for interaction with this structure. The model used this infrastructure to establish more direct and participatory contact with the communities. In addition, the model created the roles of auxiliaries, promoters, and health vígias, which were fundamental for its operation. Assistants were responsible for supervising the activities of the assigned promoter every two months. They also provided technical support to the promoters regarding the model. Promoters were the link between the communities and the primary level of the health system. Compañera Adelia provides a more in-depth description of her experience with these health figures,

> *The promoter was a key figure in the development of this work because, ultimately, the promoters and assistants* [auxiliaries] *were community members. Being from the community, they spoke the same language and communicated more closely. When someone from outside the community arrives, they don't know how to speak the language... There are many barriers there in terms of interpretation and communication.*
>
> *...the promoter as a fundamental figure at the core of primary healthcare achieved that bridge in communication in order to build these agreements and work appropriately in the face of these risk factors and their possible solutions, as well as educational and ethno-educational strategies... because, in addition to the work I mentioned earlier, educational materials were also created. So, how was this ethno-educational material developed? Well... the community would identify their issues, what was affecting them the most in terms of health, and based on that, they would create booklets in which they would tell... it was about understanding the disease from an ethnic perspective, how they also treat it, what their protections are. And from the Western perspective, there were also recommendations. So, this ethno-educational material was developed with the community, where they would draw, act as translators, and mentioned the key messages; the purpose of all this was for the material to serve as support to strengthen education within families and the community. Therefore, this model of community-based primary care was indeed a model that, at least for me, changed many aspects of how to intervene and provide support to the community because one is educated in a structured manner, even though at least in my university, there is a community component, this* [their vivencias in Vaupés] *allowed us professionals to open our minds to other forms of work, other ways of relating and building intercultural agreements. I believe it made a significant difference in our work, and for those of us who had the opportunity to experience this approach to healthcare, I think it changed our lives.*

Lastly, we see the emergence of health vigías. This role focuses on high school students or members of communities to provide social assistance to the community near the school, training them in wellness-related matters so they could guide community members in this area.

There was an increase in members of the communities taking on these newly created roles, where they received training in basic Western healthcare and continuous education to strengthen their traditional knowledge. These roles aimed to address prevention based on self-awareness and approach illnesses from an intercultural perspective.

The SSSV developed the pertinent PHC at the regional level based on local decisions. These local decisions were made in zonal-level spaces called "Community Zonal Seminars." For these seminars, two to three UPAS are grouped together with their respective Coverage Units, and Indigenous authorities from different communities in the area participate in discussing their communities' health problems and possible solutions. These seminars also offer *Ongoing Education* workshops for promoters and monitors. The duration of these seminars was 11 days. The facilitators of these seminars were the auxiliaries with the support of the SSSV health team.

In addition to this regional, zonal, and local framework, the model discusses two additional levels of health attention: the intra and extramural levels. The intramural level focuses on providing specific services in urban areas. The extramural level refers to a service aimed at reaching the most remote communities but based on prior consensus with the communities based on their priorities. However, what Guevara proposes in the manual does not clearly explain the operation or systematization of this level.

Mayor Jaime recalls his vivencias with this model, providing context for what he embodied in the field,

> *...during that time... when Alma-Ata was functioning. They said, "Well, these* [people from Vaupés] *are interested." The coordinators of the agreement began to implement and train the* Indigenous *communities and organizations.*
>
> *First, they organized through the zonal organizations as leaders; they were monitored. Then, according to their zonal criteria, they began to train themselves with the Colombo-Dutch agreement... After that, there was a health sentinel; it was a long process. That's when they started training Health Promoters. Later on, they progressed to Health Auxiliaries. Yes, it's a very long and slow process, but steady. They* [the promoters and auxiliaries trained under the agreement] *are here now, very prepared. They are excellent and elegant auxiliaries and leaders! They are not just health delegates... they are leaders within communities. As the* Indigenous *communities say, "We are about collective construction. We can never forget that aspect; we are not just individuals." Whatever we acquire to eat with our families, it is for everyone. That is interesting. They do not detach themselves.*

> *We, the* Indigenous *Peoples, said, "Well, how would this be? Is this complementary? What is the strength? Both will serve. There was access to Western medicine. Yes, but with a sense of interculturality.*
>
> *Each community and ethnicity should integrate their own medicine... with interaction, as the late Juan Guevara called it; interaction, but respecting the Vaupés territory's internal cultures, to strengthen, not separate. That is interesting.*
>
> *That was the strength and dynamic; seeing the efforts made with the communities. The Ministry of Health approved all of that with primary health care... The implementation was already progressing with the nurses. There was a Training Center... within the hospital, within the Health Secretary's office.*
>
> *A group of nurses and doctors trained the Promoters and Nursing Auxiliaries and worked with the communities,* [there was] *community participation. They reached out to the people there without breaking the cultural aspect.*
>
> *Also, integrating with the elders, the knowledgeable individuals, and women... we don't separate… women were also trained... women... attended to girls, boys, ladies, and young women. There is always a very strong cultural intimacy... within the communities.*

Guevara (1984) also presented the challenges that the model faced that need attention, despite bringing notable changes to the healthcare structure of Vaupés. These challenges, especially regarding supervision and delegation of functions, were due to limited transportation and communication technology throughout the territory. Guevara also states that the educational process cannot be disconnected from the context and that public health workers from the West must act with more humility and receptiveness towards Indigenous cosmovisions. As he stated in his work:

> *An institutional promotion of Community Participation and Development, well executed in its different components, ultimately leads to a* ***social effect*** *(where the community becomes the subject of its development, transforming its reality) and a* ***medical effect*** *(health for all by the year 2000).*

Unfortunately, Vaupés did not achieve the goal for the year 2000.

The PHC in Vaupés – Second Process (1985 - 1997)

In this period, there was not much written about the model. However, with Guevara's assistance, the SSSV continued implementing it as stated in the manual. The limited information about this second process of the model came from the vivencias of compañeros who worked at that time in the SSSV with Guevara.

The nursing auxiliary, compañero Luis Hernando Rodríguez Cordero, from the Tatuyo People in the Pirá Paraná river area, remembers working with Guevara during that time,

> *I had the opportunity to work with Juan Guevara... He would conduct his investigations, studying how people lived, what they needed, or what people thought about improving the delivery of health services. He also explored how traditional healers worked, how Western and* Indigenous *medicine could complement each other, or how they had to collaborate if it was feasible to combine traditional and Western approaches.*
>
> *He started working with people by zones. He traveled throughout the Departamento. Since we have several ethnic groups here in Vaupés, he would go there and work with one ethnic group, then another day, he would go to another area and work with another ethnic group. He also compared the thoughts of one ethnic group and another to see what they understood, how things were, and how they communicated with each other.*
>
> *He would start working and propose all the needs that people expressed in the workshops and training he conducted at the hospital. That's where things started to come together. I remember he would also provide training and technical assistance to the promoters and even to the assistants throughout the Departamento.*

Additionally to what Luis shared, Mayor Jaime adds the fundamental component of community oversight on which the model's work depended,

> *His* [Guevara's] *strength was that he started to shape the perspective of the non-*Indigenous *world; how to look at health interculturally. We both started to consider, "We need oversight," yes... He said, "Well, yes, we can say we're functioning," but the people had their own organizations, including health.*
>
> *Yes, strong health monitors, the community board, or the women's organization. They would check if things were truly working. There were also health promoters, health assistants, doctors, and extramural commissions because it was truly*

> *functioning. During the periodic evaluation meetings held here to assess how the programs were going, they would provide reports to determine whether things were truly going well or not.*
>
> *In other words, at that time, we all had a shared understanding of Public Health, the Primary Care Program. We all wore the same shirt; everyone did. From the janitor to... Everyone spokes the same language. So, it was very interesting.*

The Colombian-Dutch agreement brought a significant shift to intercultural healthcare attention in Vaupés, although we have limited knowledge about this second phase of the model. The vivencias of compañero Luis and Mayor Jaime make it clear that the model continued. This continuation would not have been possible without the political will and action of the SSSV.

In Puerto Golondrina, I shared what I learned about the model in one of our conversation spaces after dinner. In that conversation, Jabokū, Mayora Leti (Jabokū's wife and mother of José and Gaudencio), José, Gaudencio, and Victoria (Gaudencio's wife) confirmed Mayor Jaime's story. In addition, they shared their embodied memories of that process and how they came to receive training as *Health Vigías* and *Promoters*. The PHC model, as Jabokū shared, "*was very good because it included us* [the Indigenous communities]."

One of the achievements of this project was the creation of a "*Primary Care Unit*" within the Ministry of Health in 1988 (Zewuster 2010). However, with the implementation of Law 100 in Vaupés, the contextual disconnection was experienced once again, as the new model did not respond to the needs of the context and relegated the intercultural PHC.

The PHC in Vaupés – Third Process (1997 - Beginning of the 21st Century)

As I listened to vivencias with the health model, many focused on work in the late 1990s and early 2000s. I thought that the model had remained the same since its creation. However, while talking to Pablo Montoya, I learned about another process the model underwent that developed after 1997 when the transition began in Vaupés to implement Law 100. Part of that transition

was to separate health services from the SSSV and assign them to the hospital. For this process, a Functional Group was created to take care of the rural part, while the hospital took care of the urban and suburban areas of Mitú. During this process, Pablo coordinated this group for several years, where some components of the intercultural APS model were systematized and implemented. The purpose of this task was to give continuity to the model as much as possible within the framework of the new policies. Regarding the influence of the model on the work of the Functional Group, Pablo explains,

> *The work of the model was important; it was visionary. The agreement documents and Guevara's book guided us in the work done on the ground. The conceptualization of traditional medicine and ecological medicine was significant. I thought it was good that the Ministry of Health recognized the importance of the model and decided to continue it as a de facto policy. De facto policy because there is no written policy, but everyone assumed that that was how health should be approached in the territory. The people in charge of the different technical areas in the SSSV had that clarity and provided guidance. The work of the Functional Group needed to establish the model within the framework of the current health policies and understand the role played by* Indigenous *organizations. For example, we looked at how to support the* Indigenous *communities in establishing their* Indigenous *Territorial Entities. We were thinking about how to support their life plans and capacity-building processes for organizations. Organizing the extramural groups' activities better and coordinating with promoters and auxiliaries, making it more systematic. While there were key elements in everything proposed in the model, there was no integration among the different components, and many things were not operationalized. Those were some of the main contributions we could make at that time with the Functional Group and with the tools we had.*

The Functional Group accomplished a series of objectives to further promote the intercultural PHC model at the beginning of the new millennium. One of these objectives was the formation of interdisciplinary health teams (known as *Extramurales* [Extramurals]) that align with the health plan needs of the communities. These groups periodically visited Indigenous communities house by house in coordination with the traditional authorities. Although the country's legislature mentions the *Entidades Territoriales Indígenas* (ETIs) [Indigenous Territorial Entities], in

Vaupés, there was no ETI framework but rather local traditional authorities. As a result, the Functional Group systematized the process of coordination and consultation with these authorities before each extramural group visit to their communities. Intending to promote local knowledge to identify protective and risk factors, the extramural groups focused on four key components: health promotion, disease prevention, public health surveillance, and healthcare assistance.

Another objective was to support strengthening traditional health capacities and practices and implement appropriate health policies through a PAR strategy, which benefited both Indigenous and non-Indigenous communities in Vaupés. Additionally, the Functional Group tried to equip Indigenous communities and traditional authorities with the tools to manage their health and guide them in developing diagnoses and health plans. Lastly, they also contributed to a reliable community health surveillance system, involving everyone in analyzing their health situation.

Adelia and Bibiana invited me to walk through the structural interweaving and practices they embodied promoting the intercultural model of PHC. During this walk, Adelia shared her vivencia in the extramural groups,

> *...we used to form the groups for the rural area or the extramural groups, as they were called. At that time, we were about six or seven groups, approximately, composed of doctors, dentists, nurses, and bacteriologists... sometimes we were accompanied on certain occasions by traditional doctors, and I also had the opportunity to work with anthropologists. So, upon arrival, we would receive an induction process into the territory because it had already been worked on for some years... The Departamento* [of Vaupés] *had been working on a model of primary health care based on community participation, and this allowed us as healthcare professionals to arrive and receive an induction into the territory, where we were given readings on primary care topics on how work was carried out in the territory with* Indigenous *communities... we read... we had readings that introduced us to anthropology topics regarding the recognition of ethnic groups and* Indigenous *populations in terms of their ethnic distribution.*

Well, we received a very appropriate induction process into the territory, which also allowed us as professionals to have a mental openness to how we would carry out our functions within the community. Within this work, obviously, there were not only these readings, but they also explained to us how it was developed, who were part of this work system, and we understood that there were health centers, basic units of primary care, health posts, and there was also the hospital. It was like the entire organism in terms of structure. And in the same way, there were health promoters, nursing assistants, extramural teams, and a foundational team that was part of... that coordinated all this framework of primary health care based on community participation.

… they [the Regional Health Service of Vaupés] *even gave us a training about the food as well, which seemed very interesting to me... because they showed us what it was called, like quiñapira, muñica, knowing that it was a smoked fish, fariña, casaba* (all these dishes are traditional Indigenous cuisine of Vaupés)… *Well, it was that, a very comprehensive introduction in order to understand that we are arriving in a territory where the majority of the population is* Indigenous.

As an extramural team, the first step was to coordinate with the Indigenous *Territorial Entities, previously known as ETIs, where we would plan the travel and stay durations in the communities. Initially, the Regional Health Service coordinated this through the community participation office. Afterward, we would arrive in the territory. In my case, I worked as a dentist in the Acaricuara zone, and as part of our duties, we would engage in direct coordination processes within the communities. We would arrive, speak with the highest authority, the captain, and then plan a community meeting to introduce ourselves as team members. During these meetings, we could organize the actions that would be carried out. These actions were not solely focused on providing healthcare but also involved organizing home visits. Our main objective was identifying and coordinating with the community, including determining the number of people and families living there. Once we identified the families, we would schedule visits accordingly. We would visit each family, bring our equipment, conduct a census, and assess risks. Identifying the risks helped us determine the necessary care for each family, such as growth and development monitoring for children, dental care, maternal and perinatal consultations, or general medical consultations. Considering their specific risks, the goal was to provide comprehensive care to 100% of the families.*

In addition to these activities, we also worked on environmental health because there were clear risks and factors within and around households, such as proper waste and water management. At that time, we also focused on identifying tuberculosis, leishmaniasis, and malaria risk factors. The idea was to work closely with the communities and families to identify these risk factors and collaborate to prevent diseases using their resources. We conducted meetings and community workshops, providing support and training to the healthcare assistant [auxiliary] *and the promoter. This* [practice] *helped strengthen their capacities and abilities in the field, enabling them to conduct follow-ups and directly support families regarding the identified risk factors. We spent significant time in the*

> *communities because the duration depended on the number of families in each community. Typically, we spent 4 to 5 months in a particular area, covering multiple communities. The duration and work schedule were determined based on the population and the healthcare needs of the families and the community.*

Adelia's words deeply touched me as I listened to her powerful vivencia. She projected so much passion and commitment to providing culturally appropriate and fair access to healthcare. However, Adelia was not the only one projecting this passion for this work. All the compañeros(as) I spoke to about this model of PHC expressed a common feeling of nostalgia. Compañera Bibiana added a clear example to this conversation about how she personified the experience promoting the intercultural model of PHC with the Functional Group, strengthening relationships that would have a positive impact on Indigenous health in the region:

> *Developing these processes and putting everything into practice with experience was very interesting. I remember once in Tiquié when a woman arrived with a nine-month-old girl suffering from diarrhea for a month. We took advantage of the situation; all the health promoters were attending to her, applying everything we should, and implementing the educational methodology.*
>
> *Because what they told me was, "Every time a child with diarrhea arrives, you have to teach them to wash their hands, you have to teach them many things," and what we did, unconsciously, was to repeat* [what was learned in medical training] *regardless of what the other person* [the patient] *thinks. Not because we were not interested in the other but because the methodology did not allow for more.*
>
> *We went through that whole process. First, we assessed everything… It was very interesting to know that the girl was not dehydrated after a month... with diarrhea. That showed us that despite the girl experiencing diarrhea for a month, the mother had developed optimal care processes, but the girl continued to have diarrhea.*
>
> *The million-dollar question, "Mommy, why do you think your daughter has diarrhea?" The mother answered, but in her language, because an assistant translated. I didn't understand the language. She told the assistant, "The thing is, I was careless, and the girl ate a lot of yapurá."* [Yapurá] *It's a white, greasy food… I didn't know what yapurá was, but she* [the mother] *explained it to me.*
>
> *What happens with yapurá? She* [the mother] *said, "Yapurá should not be given before the age of one." The girl was eight months old and ate a large amount. That's when we started to work with her* [the mother] *to develop a care plan and discuss everything related to Western practices because she was still going*

> *through that process. That's how we began to see the benefits of truly applying the technical and scientific aspects and the process of building with families.*

Through the example shared by Bibiana, the practicality of those processes with their benefits becomes easier to visualize. However, she also shared emergent challenges managed thanks to the structure of open dialogue provided by the model:

> *I forgot to mention that within the training* [for health promoters and auxiliaries], *there were also very important elements for them to learn how to take vital signs accurately, make referrals, and also understand how to give treatments according to each case, how to administer and use medications properly.*
>
> *The clinical reports started to arrive. We designed some formats that allowed the assistants to review all the care-related topics and roughly identify a probable diagnosis. It was quite interesting because sometimes they would write down the name of a medication, for example, for a common cold, and at that time, trimethoprim-sulfamethoxazole was commonly used, even though an antibiotic was not required for a common cold. So we would write to them, and whenever there was an opportunity, we would send them a note with all the observations... we started to provide that kind of reinforcement.*
>
> *... I started receiving a list of diseases. Because we* [health practitioners] *talked about health diagnosis, the community prioritized "the flu, diarrhea, lice." A list of diseases. We began addressing… the health concepts that the community constructed, but it wasn't in line* [with the Western understanding of health].... *they told us that for them,* [health] *meant not being sick, and that was it.*
>
> *We started to investigate why there was no coherence between the* Indigenous *concept of health and the health diagnosis. We went through the same process asking the million-dollar question, "Why do you do it?", and the other person will always have a fundamental reason for doing it. I believe is a dynamic that one must apply at work and interpersonal relationships.*
>
> *I asked that question to several assistants, and they said, "Martha, the thing is, with diagnosis, people… even I thought you wanted a list of diseases." Because when we had the Colombo-Dutch Agreement, they became familiar with microscopes, and it was said that through the microscope, one could identify what kind of organism or microorganism was present.*
>
> *… they* [promoters and auxiliaries] *often associated diagnosis with pathology or diseases. So, we had to start changing the technical orientations as well. We no longer said, "Let's conduct a health diagnosis," but rather, "Let's assess the health situation of the community." We started to see that the community began to identify real problems coherent with the concept of health.*

> *It was truly a wonderful time of contact with the assistants in their work and the integration of traditional medicine. Because we always said that in any illness process, they had to consult with the family and check if the traditional healer could treat that pathology, and if not, the referral process* [to the Western health services] *would be initiated.*

What the compañeros(as) describes in these vivencias reflects a methodology rooted in active listening, relationality, and community participation. By listening to their voices, one can sense that they momentarily achieved the political and human will necessary to implement a culturally appropriate PHC. However, I wonder how much of the intercultural PHC model remains in Vaupés. And how could the intercultural PHC model inform the SISPI?

Speaking about SISPI in Vaupés

Continuing conversations with compañeros(as) about what happened with that model brought back personalized memories of my previous work in Guainía when participants shared that "*healthcare in Colombia has become a business.*" Recalling the memory from earlier chapters, the healthcare system in Colombia underwent a major transformation with Law 100 of 1993. With the addition of *Entidades Promotoras de Salud* (EPSs) [Health Promoting Entities], mostly private, as intermediaries between the government, healthcare services, and the citizens, a market-oriented scheme was created, but in healthcare. In light of this, compañera Adelia critically reflects on how the 1993 healthcare reform affected the intercultural PHC model in Vaupés.

> *When Law 100 was introduced within the healthcare system, there were already developments in primary healthcare... and within this Law 100, EPSs emerged as administrators of the subsidized regime... certain entities began to emerge that ultimately provided healthcare services to communities. Within this context, the Plan Obligatorio de Salud* (POS) [Mandatory Health Plan] *also requires adaptations, as stated by its regulations, to tailor it to the territories... We sometimes demonize Law 100 because people always say that since Law 100 was implemented, the healthcare system worsened... but if one looks at it from a regulatory perspective, there are actually things that... if implemented and carried*

> *out as intended, could lead to intercultural developments... that are not invasive... that truly have a more inclusive approach towards customs and traditions. However, I believe that the system became distorted and ultimately misinterpreted somewhere along the line, functioning differently from what the regulations state. This* [distortion] *resulted in decentralization... the transformation of the Vaupés Departamento's Health Service. The Departamento's Health Service used to provide care to the entire Departamento through health centers, outposts, and the only Departamento's hospital involving promoters, assistants, and extramural groups.*
>
> *When all these transformations exist, and the EPSs begin to function in the Departamento, this creates a clear transformation of the model that had been worked on because the figure of the promoter no longer exists, the health promoter as such, and only auxiliaries and [extramural] groups remain. Then, the attention starts to reduce a little, and in some way, as the health care providers become social enterprises of the State, adopting the figure of a business, health becomes a business. Therefore, this business makes it necessary to bill for all services... This dynamic changes and is reflected in the territory. The extramural groups, everything we developed regarding community involvement, building agreements, and conducting these visits, operationally and economically, I believe that's where it starts... in economic terms, it transforms because it does not bring resources to the State's social enterprise. This is ultimately reflected in the actions carried out in the territory. Currently, primary health care is divided. I understand that some extramural groups travel throughout the Departamento but are insufficient for all communities and the territory. In addition, there are field [nurse/health] assistants who are not employed all year round, unlike before when we had assistants employed throughout the year, and there was also the figure of the promoters who are no longer present in the communities at this time. So, the assistants are also limited.*

José Esteban's firsthand vivencias in the communities that are part of the Pira Parana zone reflect the changes described by Adelia in the territory.

> *...another EPS arrived. That's when all the implementations that had been agreed upon with Salud Total fell apart. What did they say? Those with Salud Total had to automatically switch to Caprecom* [the new EPS that arrived in the area] *without any consultation any agreement with the community. They didn't discuss coffins, shelter support* [for Indigenous patients referred to places outside their communities]*, or medications. Nothing was done.*
>
> *They forgot about the agreement and started removing pregnant women* [from the community]. *There was no prenatal care in the communities. They* [Caprecom] *started removing people [from their communities] as they pleased because it was the obligation of the State to take care of children and pregnant women. They started removing everyone. The traditional medicine we had agreed upon [to be*

> *included in the health care process] was not considered; they disregarded it. "We are responsible for caring for people's health"* [said Caprecom] *representatives. Then... Caprecom left. They* [the State] *issued another* [order]*... automatically switched to the New EPS without any agreement.*
>
> *They* [the New EPS] *continue doing what Capricorn did, removing patients as they please. They hire nursing assistants as they please, for however many months they want. They hire them for two or three months and then let them go.* [The communities were left] *without medication. That was not the agreement we initially made with Salud Total. We said, "Provide as much as you can because we know there are specific diseases here, and we need to send the appropriate medication, not just any medication." No, that [intercultural PHC model] didn't continue; it died.*
>
> *Now there is no medication. They* [the New EPS] *send a promoter, a nursing assistant, without anything.* [communities are left with] *useless first aid. That is crucial for the Departamento. There was poor attention and no extramural group because we used to have an extramural group circulating in the area and other zones. They would arrive with all their supplies and their doctor. Full-time with their medication, and that [intercultural PHC model] died.*

This embodiment of memories of compañero José Esteban describes the same feeling expressed by Indigenous leaders at the national level in previous chapters of this manuscript. When I brought all these conversations to Mayor Jaime and asked him if SISPI could revive what was done through that intercultural APS model with Juan Guevara's work in Vaupés, Mayor Pereira answered,

> *When you look at SISPI, it's better. Each intercultural health system... that's where the real talk is happening! In other words, there's evidence... that it already fits correctly. The organizational structure is* [there]*... yes, it is, it's all there, the infrastructure, everything. I think what needs to be done now is to look at how it can be reactivated the infrastructure, human resources,* [and] *materials.*

Mayor Jaime provides an interesting interpretation of the situation as he proposes building upon what has already been built instead of starting from scratch. Similarly, Jabokū, Gaudencio Martínez, and José Martínez from the Puerto Golondrina community share that sentiment. The community desires to rescue as much of their knowledge as possible and preserve it. Gaudencio shared that "*teaching and preserving our language was necessary.*" Much of the community's

knowledge has been passed down through oral tradition and in their language. Part of the revitalization of their knowledge in Puerto Golondrina includes the construction of a Maloca in the community as a space for education, specifically in the Pamíe language.

One specific area of knowledge they expressed needing support is strengthening their plant knowledge. José and Jabokū shared that some Cuban doctors and the *Corporacion Universitaria Minuto de Dios University Corporation* (Uniminuto) [Minuto de Dios University Corporation] actively performed significant work on this topic with communities of the area. According to them, these doctors brought microscopes and worked with the communities to strengthen their knowledge of plants. José and Jabokū shared that it was a very respectful and interesting collaboration. However, once the Cuban doctors left, the work stopped. These interactions sounded similar to those mentioned by the community I did not work with and why they were upset with the researchers. I cannot say for certain, but it is worth exploring this association to prevent these situations from happening again in these communities.

Listening attentively to the insights shared by these leaders, I immediately thought of SISPI as systemic support for this self-revitalization. So, I brought up the topic of SISPI once again. Gaudencio and José requested more information since they had not heard about SISPI in detail, only through me. José added that even the information about institutional programs hardly reaches the communities. I knew some leaders had received this information, but it did not reach many communities. As I mentioned earlier in this chapter, even during the assembly with the zonal leaders, there was a discussion about the lack of knowledge about SISPI. They did not even understand what the acronym SISPI stood for. Apart from that assembly, compañero Alfonso, who has been working on Indigenous healthcare in the region for many years, shared,

> *That acronym, SISPI, I believe that most people don't understand what it means... I only recently came to understand what it is. Of course, when you're working in a hospital, you don't know what it is, but I think I've completely learned about SISPI through Sinergias.*
>
> *Look, Hugo, I believe that understanding it very well is the service one can provide in order for the service to be appropriate in helping* Indigenous *communities. But, first, it requires trained individuals who understand the context well and can assist in every way. Because what do we gain, brother, by having people who care but don't know which path to take? Because one must first learn what that means in order to help them better.*
>
> *What do I mean by that? SISPI is a beautiful word when you analyze it deeply. It brings many benefits to* Indigenous *communities, but preparation is necessary. That's all I'm saying. We must delve deeper, gain more knowledge about it, and be prepared because that's where the resources come from to help the communities.*
>
> *Perhaps if the communities come to understand what it is. I know that some organizations are very advanced* [in implementing the SISPI]... *They have explained very well what it entails, what goals those organizations propose, and if it is achieved, it would be much better. With that, one could help people much better in terms of health.*

Compañero Alfonso eloquently describes the need to dialogue about the density of the SISPI. Precisely, the visit of the SSI-MPC committee led by compañero Rosendo was to establish that dialogue. Additionally, compañero Alfonso describes the relational importance between Indigenous communities to develop the SISPI in different regions. There were already advances in working on the SISPI in Vaupés, institutionally speaking, with the Indigenous zonal organization AATIAM. Although it did not have a direct follow-up from the SSI-MPC, AATIAM decided to reconstruct its local health model following the principles of the SISPI, with very close accompaniment from the organization Sinergias. During my stay in Vaupés, there was talk of AATIAM's SISPI. Still, it confused me when talking to compañero Rosendo because he reminded me that the SISPI is a system at a national level and that this system ensures that the local health models can be sustainable. If it is a system or a health model, the important aspect is that it came from the AATIAM communities. With that being clear,

compañera Bibiana shared with me her vivencia of accompanying AATIAM in that work building their health model,

> *The Sistema Indígena de Salud Propia e Intercultural, SISPI* [Self-determined and Intercultural Indigenous Health System]*, we practically came back into contact* [with the SISPI] *while working here at Sinergias. Through Pablo Montoya and Pablo Martínez, they began to establish contacts with the AATIAM organization, which represents four communities. There, we began to exhaust all the stages in the SISPI construction process.*
>
> *There were four moments in two days. It was quite interesting because it's practically starting to recognize and apply their knowledge. So many traditional healers are already alive and have all that ancestral knowledge, but they are being left behind due to many other practices.*
>
> *It's about rethinking our identity, what we have from our roots, and how we can practically give it life in the sense that each ethnic group and culture within its own has ecological and traditional calendars. According to those periods, they used to carry out all the preventive processes because the* Indigenous *system itself has a strong preventive component.*
>
> *It's not only curative but also preventive according to the seasons. There is the worm [the invertebrate being] season, the rainy season, all those things. According to the seasons, they develop all the processes of prevention and healing because, for each season, there were also new events of pathologies or diseases that needed to be addressed and all the traditional healing for that system.*
>
> *What we have seen is that many traditional healers have disappeared. In many communities, the Maloca is no longer there, and practically the traditional healer was the community's leader. The captain now takes that leadership role, so the traditional healer is left to perform healing while participating and applying the entire ecological calendar of preparation and prevention. So, they practically started to take a back seat.*
>
> *For the* Indigenous *communities, for example, where the process was carried out... it was very interesting for them because even though they had a traditional healer in the community, they didn't talk to him about those healing and preventive processes. Through the SISPI, they had to sit down with them [traditional healers] and listen to them. Many of the [unhealthy] events happening in communities are practically due to abandoning the application of the traditional calendar. So, it was quite motivating for them. They began to carry out consolidation and community organization processes because we also learned that ancestral knowledge is there.*

This re-establishment of relations with ancestral knowledge through traditional healers describes an important process of building local health models focused on prevention. For this reason, while reminding me of Juan Guevara's work with the intercultural PHC, Mayor Jaime suggested using Juan Guevara's work as significant support in developing the SISPI in Vaupés and possibly in other regions, at least in the intercultural aspect.

Learnings and Conclusions

In my preliminary search of health systems in Vaupés in academic publications, Juan Guevara's work did not emerge. The search gave me some general assessments of the Colombian-Dutch agreement and the PHC in the region, but Juan Guevara did not appear. When I heard about the books written by Juan Guevara, it was not easy for me to find them in conventional bookstores or libraries. However, I could access these documents thanks to colleagues from Sinergias who had kept copies for many years. Upon reading these books, I was surprised because the shared information in those writings seemed to be a practical guide to PAR that medical anthropology had not done, or at least not within what I learned at university. As I read his work, Guevara's proposal seeks to complement ways of knowing in pursuing health through constructing and nurturing relationships. But then, why was Guevara's work not widely recognized in academic circles? Some institutions and organizations in Vaupés discuss his work and continue to apply his practices. The work of the Functional Group is an example of how the intercultural model of Primary Health Care proposed by the Colombian-Dutch agreement continued to be built upon through the documentation and work of Guevara and the SSSV.

Although I could not delve into Juan Guevara's life in detail because I had to leave Colombia prematurely due to the COVID-19 pandemic, I learned so much through his writings and the vivencias shared by other compañeros(as) that met him. I believe Guevara was one of the first

medical anthropologists to bring intercultural bridges between ways of knowing into practice in a systematic manner. Given his significant contribution to implementing PAR in Vaupés, Guevara's work should be considered a fundamental piece for genuine intercultural work focused on density rather than difference. It should also be acknowledged the work of the SSSV for maintaining that model as their modus operandi until it was dismantled by Law 100 and the emergence of the EPS figure in the region.

The different vivencias shared in this chapter provide embodied memories that, when revived in our conversations, reflected the nostalgia for an intercultural health model that worked harmoniously in this region. In this chapter, I encountered each person who left important learnings that could be useful in answering the questions of how SISPI can support the construction or strengthening of local Indigenous health models, whether there are intercultural bridges, and, if so, how they forge them for Indigenous health. The first learning that can support SISPI is about the importance of work that invites community participation and organizational support. Juan Guevara's work through the Colombo-Dutch agreement and later the work of the Functional Group, for example, developed and maintained an intercultural model of PHC in Vaupés, as long as it lasted, which integrated the basic components outlined in SISPI.

One of the methodological tools that Guevara's participatory work left to continue using and shaping is what he defines as *Ongoing Education*. From my understanding of this methodological tool, it involves building upon the existing foundations. In other words, this practice validates and respects all ways of knowing, making them available to anyone and mutually expanding these knowledge systems based on their needs and relevance. It is not about imposition but about exchange. Guevara documented the process of developing *Ongoing*

Education and the network of individuals, infrastructure, human values, and thoughts and feelings needed for its implementation.

This documentation enabled the Functional Group to systematize and operationalize some components of the model that were not fully integrated into institutional actions. This work facilitated an additional platform for advocacy and support, including implementing and optimizing processes for political-organizational development, the development of life plans, capacity strengthening, and integrating health into these plans. The group adapted aspects of the model and introduced elements to coordinate extramural groups, promoters, assistants, and traditional authorities. This participatory work with Indigenous communities created a certain relational harmony, reflected in the experiences shared by colleagues, which could inform SISPI about the work dynamics in Vaupés.

A second learning that can support SISPI is a critical reflection on how dialogues unfold in academia and in real-life experiences in context. Based on my experiences, I am learning that there is an internal struggle within academia to critically reflect on structures of power and oppression, both within and outside academia, but partially disconnected from the reality of each context. This disconnection potentially leads us to perpetuate characterizations (such as victimizing, romanticizing, vilifying, etc.) that can limit the development of fruitful intra- and intercultural relationships. The dynamics of the matrix of relationships between different Indigenous and non-Indigenous groups are complex and, in parts, disconnected. As a result, and in addition to gaining a better understanding of the density of knowledge, there is also a need to understand the density of relationships better. From my perspective, this is what Guevara refers to as working with humility and humanity with Indigenous Peoples.

I am refreshing our memories by discussing how the intricate depth of knowledge production occurs when I refer to the density of knowledge. The Puerto Golondrina community ties plant knowledge to a rigorous learning system outside "Western" understanding. I am not suggesting that the dominant "Western" paradigm should know everything about local knowledge because it is not within its purview and lacks the onto-epistemic tools and humility to do so. What I mean by understanding the density of knowledge is to listen, accept, and value other knowledge to seek points of convergence, as shared by our compañeros(as) in their voices.

Dismantling this model in Vaupés also provides lessons about the negative effects of these changes in public policies and a historical perspective on the impact on Indigenous health. Although the provision of services was separated from the SSSV to be transferred to the hospital, the Functional Group maintained a significant part of the model. However, the entry of the EPSs in Vaupés significantly fragmented the model, leading to its complete dismantling. By placing healthcare in the hands of EPS, the figure of health promoters was eliminated, once again disconnecting communities from the healthcare system. Although efforts have been made to incorporate components of the model into the current healthcare system, the structure imposed by Law 100 makes it difficult to do so. As our colleagues have pointed out, as long as health is seen as a means to obtain monetary gains, little will be achieved in terms of social justice and health. In the face of the regulatory framework that the SISPI has to navigate, concerns arise: Will SISPI become a victim of state bureaucracy? Will it manage to free itself from the monetization of health? Now that Colombia is going through another healthcare reform process in 2023, it is time to reflect on how public policies that prioritize profits over human lives have never worked in favor of the global majority, and they never will.

In the context of Vaupés, not all relationships are in harmony and require constant nurturing to continue collectively building knowledge. For example, in this journey through shared experiences with colleagues, I learned that there is an intersectionality of organizational relationships that seems to impact the information reaching the communities. The lack of knowledge about SISPI in Puerto Golondrina and some local leaders also provides a lesson about a partial disconnection between different organizational layers in the territory. This disconnection was reflected during the coordination of the visit of an SSI-MPC commission to socialize the SISPI with Indigenous communities and organizations in the region. I experienced and learned that there are necessary relational processes to understand between different organizational levels.

CHAPTER SIX: TRANSITIONAL STORY

This story happened before the COVID-19 pandemic hit Colombia and illustrates the contradictions and difficulties of overlooking the relational density among Indigenous organizations. There are underlying layers of interactions that are sensitive and overlooked when viewed through a Western lens. This experience highlighted the importance of recognizing and learning from mistakes and listening attentively to those who guide us on the path.

Mayor Jaime and I were very excited about the visit from a team of the *Subcomité de Salud Indígena de la Mesa de Consulta Permanente* (SSI-MPC) [Indigenous Health Subcommittee of the Permanent Consultation Table] led by its technical secretary, Mayor Rosendo, to socialize the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] more actively in Vaupés. One of the next steps was to connect Mayores Jaime and Rosendo, a milestone we achieved after the former took over coordinating this visit. In that conversation, these Mayores established a direct relationship. Mayor Rosendo informed us that the Indigenous leadership of the SSI-MPC was going to have an assembly in a few days to discuss priority matters regarding the SISPI and to select a new technical secretary. As part of Indigenous organizational policies, the rotation of leaders is essential to balance powers and nurture new leaders, and it was time for such renewal. At that time, we asked Mayor Rosendo if this change would impact the planned visit; he explained that part of the assembly's agenda was to discuss the visit to Vaupés and would let us know the next steps.

While we waited for Mayor Rosendo to inform us about the assembly's discussions, Mayor Jaime and I started working on the logistics exercise to make progress. The visit also included socializing the SISPI with the local institutional bodies. Mayor Jaime already had a proposal, and I supported him with whatever he needed. Part of the plan was to coordinate with different local

state institutions for a day of conversation about SISPI and the role of these institutions in its implementation with the SSI-MPC. Sinergias played a very important role in supporting Mayor Jaime in coordinating with the institutions and Indigenous organizations in the Vaupés region. In addition to providing the venue for the initial assembly with the regional leaders, the Sinergias team offered to schedule meetings with local state institutions to discuss the coordination of the visit. However, we had to wait for Mayor Rosendo's response to continue coordinating the visit.

When we spoke again with Mayor Rosendo, he informed us that the SSI-MPC had already appointed a new Indigenous technical secretary and discussed the visit to Vaupés. In addition, he explained that, although the conversation about the visit was positive, the president of the *Organización de los Pueblos Indígenas de la Amazonía Colombiana* (OPIAC) [Organization of Indigenous Peoples of the Colombian Amazon] suggested better communication among the organizations involved in coordinating this event. As I listened to Mayor Rosendo, I realized that I had not considered the relational density between Indigenous organizations and that this lack of awareness could jeopardize other organizational relationships. When compañero Mayor Rosendo approved this dissertation project, I assumed we only needed to coordinate with the local Indigenous authorities in Vaupés and their communities. I also thought that with the approval of the SSI-MPC secretary, all Indigenous organizations would be ok with it. I was wrong. The reaction of OPIAC's president is understandable, so we needed to address that situation to avoid a bigger issue disrupting relationships between organizations. Mayor Rosendo continued to be part of the SSI-MCP as a sub-commissioner representing the *Organización Nacional Indígena de Colombia* (ONIC) [National Indigenous Organization of Colombia] as Chief Health Advisor. He encouraged us to speak with the representatives of OPIAC to open communication channels and continue organizing this much-needed visit.

Upon receiving this news, I remembered the teachings of José in Puerto Golondrina when I shared my concern about unconscious colonial bias. We discussed that researchers could negatively impact a community even when they come with good intentions. His response was firm and instructive,

> *Look, Hugo, no one is born knowing everything. As human beings, we learn through vivencias. I am still learning from everyone, even from you. You don't have to worry too much about it as long as you have the humility to listen to the community when they tell you you're doing things wrong. Trust me; we will let you know if you're doing something wrong. And if you think you're doing something wrong, just ask. We know what kind of person you are at heart. The problem arises when someone is doing something that is not beneficial for the community, and they are told, but they don't listen. That's when measures need to be taken.*

José's words left a mark on my thoughts and served as a guide to navigating the situation while supporting the coordination of the SSI-MPC visit. So, I immediately contacted one of the representatives of OPIAC in the SSI-MPC whom I had met in Bogotá. Upon reaching out to him, we could discuss what happened and offer our apologies. I took responsibility and asked for his guidance to make this visit a reality since the communities were excited about it. The OPIAC compañero thanked me for contacting him and clarifying the situation This compañero provided great support and recommended extending a formal invitation to the new Indigenous Technical Secretary of the SSI-MPC, the Ministry of Interior, and the Indigenous organizations representing these territories in the SSI-MPC, such as OPIAC. The invitation had to come from the *Asociación de Autoridades Tradicionales Indígenas* (AATI) [Association of Indigenous Traditional Authorities] of Vaupés. We followed the steps proposed by the compañero from OPIAC. Finally, we took the suggestion to the president of the AATI. He listened to and supported us. In mid-February 2020, the AATI sent out the invitation. Mayor Rosendo confirmed

his participation in the visit and continued coordinating in Bogotá so that other members of the SSI-MPC, including the new technical secretary, would come to Vaupés.

Upon hearing this, we proceeded, with the support of Sinergias, to meet with the newly elected governor of Vaupés. Pablo Montoya and Adelia facilitated the conversation with him, who offered us his support with the visit from the SSI-MCP. With the governor's approval, we began meeting with the Departmental Health Secretariat, Municipal Health Secretariat, and the Hospital. We had scheduled meetings with other institutions and were waiting to schedule a meeting with representatives of the OPIAC in Vaupés. Unfortunately, COVID-19 reached Colombia by mid-March 2020, and everything took a different turn.

These vivencias accompanying SISPI in Vaupés have taught us valuable humility, responsibility, and relationship-building lessons. In addition to the academic component, a critical aspect of this dissertation project was the commitment to support the development of the SISPI within the capabilities and privileges I possess. However, understanding the density of knowledge and relationality within the contexts must accompany good intentions. This understanding is a process and does not mean one must know everything about the communities.

My vivencia collaborating in the coordination of a visit to Vaupés by a committee from the SSI-MPC brought with it opportunities to educate myself about the importance of recognizing and learning from mistakes. A key aspect of this process was listening attentively to the people who guided me. For instance, my compañero Mayor Rosendo advised me on how to handle the situation with OPIAC and allowed me to rectify the impasse with relationality and responsibility. Another important guide was compañero José from Puerto Golondrina. His teachings emphasize accepting our condition as human beings and understanding that we don't know everything and will make mistakes along the way. With this in mind, José highlighted that these mistakes are

meant for learning, not to paralyze work with communities. He stressed that the most important thing was to communicate with the communities when there was any doubt. If the community called attention to something, it was so that I would listen and learn so that I would not repeat it. These two mentors provided me with tools to take responsibility for the situation and seek dialogue with one of the representatives from OPIAC in SSI-MPC. In this way, we rebalanced the relationships and continued the process.

CHAPTER SEVEN: RELATIONALITY IN TIMES OF PANDEMIC: CHALLENGES AND MANAGEMENT OF COVID-19 IN VAUPÉS

> *Hemos determinado que el COVID es una enfermedad netamente occidental. Sin embargo, se ha venido diciendo por parte de los abuelos, de los sabedores nuestros, que se ha venido dando por el tema del desequilibrio en la naturaleza; por el mal manejo que la parte occidental le ha venido dando a los diferentes espacios de explotación de los recursos naturales; de la deforestación y todo ese contexto.* ~ Johny Zumaeta de la etnia Andoquia en El Canto del Tucán
>
> *We have determined that COVID is a purely Western disease. However, our elders and knowledgeable individuals have been saying that it has occurred due to the imbalance in nature caused by the mismanagement of Western society in various areas of natural resource exploitation, deforestation, and all those related issues.* ~ Johny Zumaeta from the Andoquia ethnic group in El Canto del Tucán.

Introduction

In the heart of the Amazon rainforest lies Vaupés, a region that, like many others, was not spared from the clutches of the COVID-19 pandemic. Yet, to understand the challenges and management of this global health crisis in Vaupés, one must delve deeper than the mere statistics and headlines. The Indigenous communities of Vaupés offer a unique lens through which the pandemic can be viewed, not just as a health crisis but as a reflection of deeper societal and environmental imbalances. As Johny Zumaeta from the Andoquia ethnic group poignantly notes, the pandemic is perceived as a manifestation of the West's mismanagement of nature and its resources. This perspective challenges the dominant narrative and suggests that modern society's relationship with nature might be the root of such global crises. Would this perspective limit any collaborative effort with "Western" organizations and institutions to address the pandemic in this region?

This chapter seeks to illuminate the intricate web of relationships, knowledge, and experiences that shaped the Indigenous communities' response to the pandemic in Vaupés. Drawing from firsthand accounts, it underscores the resilience and wisdom of these communities, who

navigated the pandemic despite facing systemic health disparities with a blend of ancestral knowledge and contemporary strategies. In doing so, it challenges prevailing notions of vulnerability and highlights the importance of intercultural dialogue in forging effective and meaningful health interventions.

The Vaupés' COVID-19 Outbreak

On Friday, March 6, 2020, I was in the office at Sinergias, reviewing my notes and emails. One of the emails I received that day came from the University of Washington, informing me about the global outbreak of COVID-19. The email confirmed that the studies conducted by students from the university abroad were continuing as planned. However, they outlined steps to follow if students wanted to return to the United States as a precautionary measure. Until then, I was not concerned as I did not know of any reported cases in Colombia.

On Tuesday, March 10, 2020, while having breakfast at one of the places I frequented in Mitú, the news on television reported three confirmed cases of COVID-19 in Colombia. They expected to confirm more cases later that day. I became a bit worried upon seeing this news, although I believed the situation was manageable. The next morning, the number of cases started to increase. I still did not grasp the magnitude of the situation. Over the following days, Mayor Jaime and I continued coordinating the visit with significant progress. With the support of Sinergias, Mayor Jaime and I managed to secure spaces to present the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] to public health institutions and Indigenous community leaders in Vaupés.

On Thursday, March 12, the Ministry of Health declared a sanitary emergency in the country, suspending any event with more than 500 people. This announcement made me and Mayor Jaime ponder, as we did not know if what was happening would affect the *Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas* (SSI-MPC) [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations] visit. We went to see the president of the *Asociación de Autoridades Tradicionales Indígenas* (AATI) [Association of Indigenous Traditional Authorities] seeking his assessment of the situation, but he also had the same information we did. The president of the AATI advised us to continue coordinating while monitoring the developments of the COVID-19 situation in the country. The president of the AATI reassured us with his words that the SSI-MPC visit would not exceed 500 people in one place to prevent its cancellation. After speaking with the president of the AATI, we continued the coordination without much concern.

The next day, Friday, March 13th, Mayor Jaime and I met with the municipal health secretary in the morning. We had a good meeting where the secretary expressed their support for our participation in the SISPI socialization event with the institutions in Vaupés. During that meeting, the secretary invited us to be part of another emergency meeting in the afternoon to discuss the COVID-19 situation with different non-governmental organizations and local government institutions involved in public health. The meeting was scheduled for 4 pm. We arrived early, and while waiting, I took the opportunity to check my emails. Among the emails I received that day, the university sent an important one. The email was a general notice canceling all international studies for

students. The message stated that they based the decision on preventive measures due to the rapid spread of the global COVID-19 pandemic. Therefore, students who chose to stay where they were did so at their own risk. When I received the message, I became worried. At that moment, I was dealing with two decisions that occupied my mind: when to leave the country and how to transfer my job to another person so that they could maintain continuity. I thought I had at least a month to transition my work to someone else since the situation with COVID-19 was not too severe yet in Colombia. I shared the message's contents with Mayor Jaime, and we started thinking about possible solutions. Unfortunately, they called us to enter the meeting before we could find a suitable solution.

Upon entering the meeting, the place was completely crowded. People started talking, and you could feel the concern among the participants. The *Ministry of Health* announced the cancellation of events with more than 500 people. One participant suggested canceling events with more than 100 people since the healthcare system in Vaupés was not prepared for a pandemic. Upon hearing this, the compañeros(as) who shared how the healthcare system had changed in Vaupés supported this participant's assessment. At that moment, another person informed me that a significant evangelical event was coming up in Vaupés over the weekend. That event had the potential to have more than 500 people. Not only Indigenous communities would participate in that event, but also non-Indigenous evangelicals were coming from outside Vaupés. At that moment, everyone collectively expressed concern and delegated the *Departamento Health Secretariat* to contact the event coordinators and cancel it as a preventive health measure. The participants, both Indigenous and non-Indigenous, who were part of the meeting

discussed the steps to prevent the virus from reaching Vaupés. One of the suggestions was to implement a surveillance and monitoring process for COVID-19 at the airport for anyone arriving in Vaupés. Upon hearing this, I could stay for another month to support the surveillance and monitoring efforts while finding someone who could continue supporting Mayor Jaime with the event and everything related to SISPI in Vaupés.

After leaving the meeting, I tried to contact my academic advisors to hear their advice on what I should do, whether to stay or leave the country. It was a night of uncertainty as I couldn't reach any of them due to my limited connectivity at night. I thought about my children and how they needed me by their side as much as I needed them by mine. Seeing the news at night that COVID-19 cases were increasing in Colombia, something told me I had to leave as soon as possible. However, I reconsidered staying another month to fulfill the commitments agreed upon with the Indigenous compañeros(as). On Saturday morning, different public health workers in Mitú started spreading rumors that the local government was considering indefinitely closing the airport. Upon hearing that, I contacted the airport directly, and they told me they had not received any closure order. Minutes later, I spoke with Pablo Montoya, director of Sinergias and academic advisor. He suggested that if I had decided to leave the country, it would be better to do it as soon as possible because things were getting worse. After that conversation, I immediately went out to buy plane tickets to Bogotá without hesitating. The only available option was for Tuesday. When I checked return flights to the United States, I found one for Wednesday. So, I bought it.

Everything was happening so fast. During the weekend, I could not contact anyone from the community. Finally, however, I talked to compañero Bayron Orrego, a Colombian

anthropologist working and living in Vaupés for many years. He offered me his full support to continue the work with Mayor Jaime and the community of Puerto Golondrina. Bayron was well-known by many communities and organizations in the region due to his community-building work with various organizations, including Sinergias. By Monday, March 16th, I could contact José and Jabokū to explain what was happening and put them in touch with Bayron. They understood me and wished me the best on my journey back. It was an emotional farewell as my departure was sudden, and I could not continue with what we had planned to do. Nevertheless, I met with Mayor Jaime to put him in touch with Bayron so that the work could continue to the extent possible. However, as we expected, the pandemic caused the cancellation of the SSI-MPC visit.

Upon returning to the United States, I communicated via WhatsApp with some people from Vaupés, including the Sinergias team and the community of Puerto Golondrina. Although I did not directly experience the pandemic in Vaupés, the voices of the people I communicated with and the information I received through various media outlets are part of this ongoing story.

COVID-19 in Vaupés

The impact of COVID-19 in the Pan-Amazon region was significant. Some of the first urban areas in this region heavily affected by the virus were Leticia (Colombia), Iquitos (Peru), and Manaus (Brazil), which are part of the triple border between Colombia, Peru, and Brazil. In these places, highly populated by Indigenous communities, the healthcare system collapsed due to a lack of capacity to handle the rapid spread of cases (Connectas.org 2020). The scarcity of *intensive care units* (ICUs) could not cope with the number of positive and severe cases (Federación Médica Colombiana 2020). Part of the collapse of public health in Manaus was due to the lack of action by Brazil's President Jair Bolsonaro in rejecting isolation measures

(FRANCE24.Español 2020), which contributed significantly to the virus's spread across the triple border. The World Health Organization stated in a communication that South America had become the new epicenter of the global pandemic, especially in the Pan-Amazon region (BBC News Mundo 2020). According to the newspaper Ciudad Nueva from Argentina (2020),

> *one of the major concerns, not only of the Pan American Health Organization, is the* Indigenous *populations, as they are the most fragile and vulnerable communities in the region. And, in particular, the* Indigenous *populations living in the Amazon basin, which encompasses more than 2,400 territories scattered across nine countries: Brazil, Colombia, Peru, Bolivia, Ecuador, Venezuela, Suriname, Guyana, and French Guiana.*

I also turned to the social media of Indigenous organizations and compañeros(as) to listen to or read about their vivencias. Indeed, the gravity of what was happening in the triple border area was concerning, and it was only a matter of time before Vaupés had its first encounters with COVID-19. The state of public health in Vaupés faced similar challenges in terms of the capacity of the health system as the urban areas of the triple border affected by the virus. One of my concerns was that the virus would reach the community of Puerto Golondrina, as some families have relatives in the urban area of San Gabriel, on the border of Brazil and Colombia.

Between March and early May 2020, Vaupés did not report any COVID-19 cases according to the media and the people with whom I kept in touch through WhatsApp. Although there was global uncertainty about how to stop the pandemic, Vaupés remained case-free until early May. COVID-19 arrived in the context of Vaupés, where health indicators among Indigenous populations are concerning: there is a high rate of perinatal, infant, and maternal mortality, along with deaths from infectious diseases and suicide, compared to the rest of the country. Additionally, Vaupés faces significant challenges due to a lack of infrastructure and personnel capacity. Vaupés only has one ICU at San Antonio Hospital in Mitú for the entire *Departamento*,

and an outbreak of this highly contagious virus could overwhelm the current healthcare system of the territory, as happened in the Amazonian urban areas of Leticia, Iquitos, and Manaus. Furthermore, the hospital has only 24 beds, while the health centers in the municipality of Taraira and Carurú each have only two beds. Adding to this is a lack of culturally prepared personnel to handle a pandemic in the Amazon rainforest.

Due to the lack of knowledge about the virus, the alarming news that came through various media outlets described an apocalypse for Indigenous communities in the Pan-Amazon region, as I mentioned earlier. In one of my conversations with José, I shared the information I saw on social media and expressed my concern for the community. José replied with his usual cheerfulness, "*No, Hugo, don't worry. We are fine.*" I asked him if they were practicing isolation and following the recommendations of public health professionals. In response to that question, José said,

> *Hugo, isolation is not new to us. We have experience in managing pandemics. It's already normal for us. Ever since the white man arrived, their diseases also arrived, and with our ancestral knowledge, we have fought against those diseases. You see, public health professionals from the Western world come and tell us what to do as if we don't know. Instead, they should come to consult with us about what we know in handling these cases and complement their knowledge for a better collective response. For example, as I mentioned earlier, if total isolation is needed, we retreat into the jungle until the illness passes. At the moment, in our community, we have a very strict surveillance system. We are currently not receiving visitors, and if someone shows symptoms of illness, we isolate them in one of the houses, and only one person is responsible for bringing them food and providing whatever they need. That person is also being treated with traditional medicine. So far, we haven't had anyone sick with COVID.*

José helped me understand that external narratives about his community reinforce paternalistic characterizations towards Indigenous Peoples. But more importantly, it reflects an effective response to the pandemic by the community, practicing their ancestral knowledge. Building on

what José shared, in a conversation with Gaudencio about isolation, he talked about this practice from his own experiences,

> *Regarding isolation, for us, it wasn't something new because we have been practicing isolation since our ancestors. Even talking about my family, when my mother heard that measles, which is also highly contagious, was coming, she would take us to the chagra, or the plot of land where we grow our food, specifically the tubers. We would stay there for a few days until the illness passed. It's something temporary for us, so from that perspective, she would take us into the middle of the jungle until the illness passed. But in this case, isolation or curfew wasn't something new for many of us.*
>
> *It has been an ancestral practice for many people, including us. Knowing that nobody could reach the place we were going to, a messenger was designated to inform us about what was happening in the affected area or if the virus had arrived. Therefore, we have been practically practicing isolation or curfew, which has been implemented worldwide, in that way. But for us, it is something normal; therefore, it is something we also have to see from our worldview, adapt, prevent, and heal.*

José and Gaudencio helped me unlearn and relearn with these conversations. Indigenous Peoples are not unfamiliar with this type of health crisis and know how to handle such situations. While not diminishing the severity of what was happening in the Pan-Amazon, we also cannot diminish the Indigenous Peoples' capacity to react and their knowledge in dealing with these public health situations. As I reflect on how the Argentine newspaper characterized Indigenous Peoples as "vulnerable," I realize that, albeit unintentionally, the newspaper continues to minimize the Indigenous capacity for action and knowledge in responding to a crisis of this magnitude. This reflection reminded me of my conversations with compañero Rafael Guayabo about these characterizations. He shared that categorizing Indigenous Peoples as "vulnerable" implies that Indigenous individuals lack agency and autonomy. The assumption that Indigenous Peoples lack agency characterizes them as needing and depending on someone else as if they were children. Rafael concluded by sharing that Indigenous Peoples desire to complement ways of knowing and practices for a *"Buen Vivir"* [Good Living], but equitably.

Considering this reflection, it is important to listen to and learn more about the specific knowledge held by each community to support initiatives that are appropriate to the context. For example, on the first anniversary of the pandemic, compañero Gaudencio shared more about the knowledge of the Puerto Golondrina community and how they use it to manage pandemics,

> *We have known about that disease since last year, or it already existed. Still, it was heartbreaking when it arrived in Colombia and when we saw it through different media channels, social media, television, and radio, how it affected the health in different sectors. But it also brought a lot of fear or terror because no person wants to leave this earth. We want to live for a long time. That's what it's about. So since the new disease arrived, it has been present in our midst for some time, and within our environment, we started seeing it through different media channels, as we have done with different diseases.*
>
> *We know that our ancestors have existed for millennia. Even before colonization, we had our way of healing, preventing, and persisting for many years. But we have been adapting over time since we coexist* [with non-Indigenous]. *Now that we speak of interculturalization, we might as well discuss health and prevention interculturally. Now we even share diseases.*
>
> *When the pandemic arrived, many of us, including our elders and medicine people within our territory, as there have different practices, performed protection prayers. But these prayers have a strong connection with nature. The prayers are related to the names of things that actually exist in nature. So, for example, they mention an animal or a plant so that those energies can protect the person. And that is in relation to the prayers.*
>
> *In our case, we do not practice prayers but believe in what nature provides, especially the flora and fauna. Due to that, many of us were very scared by the discussions in different media about prevention and isolation, which was something new for everyone. I know that it has had a negative impact on the world in general and created terror. But when we see how the handling and treatment, how to cure or prevent, is done, for example, in the Western world, they began to search and investigate the virus. In our community, we search for plants that nature provides us, make warm water baths, and consume those plants in tea form. So far, this has prevented us [from getting COVID], and we continue with this prevention.*
>
> *Until now, none of us have received the vaccine in our community. We have only been using the treatment of drinking teas made from the plants provided by nature. As for bathing, if someone had COVID, the traditional healer recommended taking warm baths because, according to our practice, anything cold affects or strengthens any virus. Therefore, all food must be hot so the virus cannot gain strength and harm anyone.*

> *The diet must be special. We also follow a specific diet to heal as soon as possible. Care is the most important aspect during treatment. There are certain parameters that the traditional healer provides to a patient. And at this moment, we thank God that we continue to survive through nature and the ancestral practices we have been following to this day.*

As described by my colleague Gaudencio, the community has its processes for managing these viral diseases based on ancestral knowledge. When discussing the resistance to vaccines, both Gaudencio and José shared with me that, unfortunately, Indigenous communities have had problematic experiences with Western medicine regarding vaccines, which created distrust among people. José mentioned that this does not mean no Indigenous person believes in vaccines. He continued to share that "*there are those who do want to take the vaccines, and their wishes should be respected. However, there is still a lot of distrust.*" In addition, social media and media outlets presented a scenario of terror by capitalizing on people's fear. When I talk about capitalizing on people's fear, I mean using fear as a vehicle to generate an audience that subsequently translates into monetization. Fear is something that Gaudencio mentioned in his previous statement. That fear impacted how certain situations unfolded, which did not contribute to building the necessary trust to support the communities during the pandemic. One example of this tension occurred at the beginning of the curfew between the police and the communities. José shared that, unfortunately, fear was leading people to do dehumanizing things during the curfew. When asked a little more about what he meant, José elaborated,

> *Well, look Hugo, after they decreed the curfew, a group of women from another community had come to sell juice. Some police officers arrived and told them they had to leave because the town was under curfew. I don't know why the women didn't leave, but they stayed there, and instead of helping them find transportation or something else, the police officers overturned their bucket of juice, spilling its contents on the ground, and that's just not right. Those police officers treated them without respect or dignity. We understand that a pandemic is a serious matter, but we also have to understand that some communities need to make a living. If no one will support us in what we need, at least treat us well. I understand that police officers also have very important and difficult tasks to do,*

> *especially in cases like these. But I think there was no need to do what they did to these women. That's just mistreatment.*

José reminds us that, despite going through moments of crisis, we must always keep our humanity in mind. However, that fear also led to the spread of a chain of misinformation that would affect efforts to contain the pandemic not only in Vaupés but globally. In Vaupés, misinformation spread in some communities, leading to questioning the existence of the virus. As compañera Camila communicated, this misinformation chain was one of the greatest challenges in managing the pandemic in Vaupés. In her experience supporting the COVID-19 management process in Vaupés, Camila adds that there may have been hidden morbidity and mortality in those early months because people were afraid to seek medical help.

Institutional Response to COVID-19

All territories nationwide, including Vaupés, actively participated in mitigating the COVID-19 virus. Vaupés, aware of its geographical and demographic particularities, carried out proactive actions such as active community searching. The first 11 cases identified in mid-May 2020 were asymptomatic and did not require hospitalization (Instituto Nacional de Salud 2020). Although the initial theory suggested that the virus arrived through the border with Brazil, this could not be proven. Fortunately, the spread did not start in Indigenous communities, which allowed the implementation of preventive measures. The actions of the Departmental Health Secretariat, such as active case searching, border closure, and the preparation of response teams, were effective in initially controlling the infection (Instituto Nacional de Salud 2020).

The public health personnel initially worked on tracing these cases to contain the spread of the virus in the urban area. After achieving that goal, they began reaching out to the more remote communities, starting with those on the border with Brazil. Compañera Camila, who was in

Vaupés at the time, explained to me that it was challenging to reach all corners of the *Departamento* immediately due to the limited personnel capacity. When the pandemic reached Vaupés, the *Departamento* had only 11 physicians, 37 nurses, two therapists, and 57 nursing auxiliaries (Ministerio de Salud y Protección Social 2020). Additionally, there was a logistical problem regarding the COVID-19 testing. These tests had to be kept refrigerated, and reaching certain communities would take so much time that it would compromise the tests. The public health authorities also sent messages to the communities recommending isolation in their chagras while stabilizing the situation.

The cases began to increase in Vaupés as time went on, although with a low mortality rate, at least according to official records. Institutional actions developed a manageable control strategy in the urban and suburban areas despite this increase in cases. As a result, this institutional coordination allowed for the mobilization of nurse auxiliaries to reach the most remote Indigenous communities. For this task, the Department of Health and the hospital began to prepare these workers to approach the communities culturally appropriately. For this training, the local government sought the support of some of the compañeros(as) that experienced the intercultural model of *Primary Health Care* (PHC) to conduct the training. However, the training required Juan Guevara's documentation of the model. Indeed, compañera Adelia reached out to me and asked if I had a digital copy of Juan Guevara's books, as they needed them for training the assistants. Adelia and Bibiana, in conjunction with the Departmental Health Secretariat and the hospital, were collaborating to conduct these trainings. Juan Guevara's books were not available in digital format, and if they were, it would expedite the training process. Fortunately, I had digitized those documents before leaving Colombia and shared them for the training.

As part of this pandemic management process in the territory of Vaupés, compañera Camila explained that there was an attempt to reintroduce components of the intercultural model of PHC by reinstating the figure of community health promoters, even if only for a limited time. The response to this revival of the model by local institutions was positive. However, this effort proved to be complex due to structural barriers. As Camila, a fellow member, shared in 2021 when she spoke about her experiences on the anniversary of COVID-19 in Vaupés,

> *In 2020, I worked with the pandemic management team in the Departamento of Vaupés, and we wanted to incorporate community health promoters into the teams. However, these promoters had to be from the local* Indigenous *communities who could help us with the surveillance of COVID cases in those communities. We carried out a selection process to identify these individuals. Some nursing assistants went to the communities and asked if people were willing to be hired as community health promoters and who could help us monitor what was happening with COVID in those communities. It had to be someone from the community who lived there and could share information with the local health authority. What happened? Because the hiring process was through the government and the local health Departamento, the applicants had to go through a hiring process requiring a lot of documentation that* Indigenous *communities don't have. Let's think about a social security number, those kinds of things that they* [Indigenous Peoples] *don't have in the communities. They also don't have access to the internet; they can't get any of those documents on time in their communities and then send them to the health Departamento in the main city of the Departamento. So, after months of trying to hire them* [community health promoters], *it was almost impossible because the government's human resources structure also has many laws to prevent hiring people in those positions in the local government; hiring people without formal education is difficult. Although there was a willingness to incorporate local people into the entire COVID-19 monitoring and surveillance system, hiring local people took over five months, and it was only possible in the main city but not in the more remote communities. Therefore, changing those structures where local people can be incorporated without so much bureaucracy is also very important because, even with the willingness, there are many administrative barriers for this to be possible.*

Upon hearing from compañera Camila, I pondered the response to the pandemic if Vaupés had upheld the intercultural PHS model. Although we will not know for sure, what has been shared by the voices in these vivencias with COVID-19 highlights that an intercultural system based on the community would strengthen the response to a future pandemic in the region.

Without having people from the communities accompanying the process, negative encounters with the government and the spread of misinformation increased mistrust. Recognizing this lack of access to reliable information about COVID-19 in the communities, Sinergias, in collaboration with Indigenous organizations and academic institutions, organized a radio program throughout the Colombian Amazon to inform the communities. The radio program, called "*El Canto del Tucán*" [The Singing of the Toucan], provides a space for dialogue between knowledge systems. Trusted community traditional healers, public health workers, and academics complement each other in these dialogues to support Indigenous communities in the Amazon in receiving trustworthy information to respond to COVID-19.

El Canto del Tucán: Intercultural Voices Responding to the Pandemic

Image 7. The drawings in this section are courtesy of the Sinergias team (2020).

The precarious public health situation unleashed in the Colombian Amazon due to the COVID-19 pandemic led various actors to take swift action to prevent the further spread of the virus. Pablo Montoya remembers that at the beginning of the pandemic, the Sinergias team evaluated the global situation and realized that it was only a matter of time before COVID-19 reached

Colombia and Indigenous communities. This meant that the approach to working with these communities had to be changed since they could no longer be accompanied the same way. Anticipating the coming radical change, Sinergias asked people about their needs and their anticipated needs of the developing situation. This inquiry exercise was conducted in Vaupés and Leticia with the communities they had been working with. From these conversations, four priorities were identified: the need for context-appropriate information, personal protective equipment, strengthening of capacities for health institutions (provisions and adaptation of protocols issued by the ministry), and informing about what was happening in the communities.

Based on these conversations, the idea of a collaborative radio program emerged to address the needs expressed by the communities. The radio program was called "*El Canto del Tucán*" [The Singing of the Toucan] and involved academic institutions, NGOs, and Indigenous authorities from the territories where the program was broadcasted. Initially, *El Canto del Tucán* was part of an extension [distance learning] course conducted by Sinergias and the Universidad Nacional de Colombia, Amazonas campus, intending to strengthen the capacities of healthcare auxiliaries and promoters in remote communities. This course included intercultural educational modules focused on refreshing knowledge and providing relevant information about the coronavirus. Additionally, the program combined traditional perspectives by giving voice to the communities. It served as a platform where experiences were shared, from institutional and community perspectives, regarding what was happening in the territories, fostering collective learning. This collective learning also provided tools to communities not yet in that situation.

Booklets accompanied the radio program as tools to address the pandemic and any health issues in the area. Although available to the general public, these tools specifically target healthcare entities, traditional authorities, and local Indigenous communities. In one of the radio program

modules, one participant described the ancestral meaning of the name *El Canto del Tucán*, relating it to the program's purpose. (Module 1, Season 2, Vaupés).

> *Every night, the toucan goes out to sing, announcing what the next day will bring to the rest of the jungle animals. The toucan prepares the jungle so that it can face the new day. The toucan travels through different territories to learn about and disseminate the vivencias of the communities. El Canto del Tucán gathers the challenges and lessons learned from the Amazonian corners and shares them, highlighting stories of wisdom, resilience, and solidarity that give us all the strength to face a new day.*

From my point of view, this meaning gives a deep purpose to the radio program and projects an understanding of the density of Indigenous knowledge of the territory. Just as the toucan flies to "*disseminate the vivencias of the communities,*" the radio program spread across a large part of the Colombian Amazon region to share vivencias and complement ways of knowing to understand better and respond to the pandemic. The program broadcasted in the *Departamentos* of Vaupés, Amazonas, Caquetá, and Putumayo. While listening to the program and learning more about it, I had the opportunity to meet and talk to one of the people who were part of the program's development process, Emilia Cárdenas. Emilia is an anthropologist and part of the Sinergias team. She has been working with different communities in Colombia and internationally, supporting approaches to health based on local knowledge. When discussing the beginnings of the program *El Canto del Tucán,* she shared:

> *Several of us from Sinergias were in the field, and others were in Bogotá when the pandemic started. We realized the information emerging about the pandemic wasn't reaching Vaupés. There was a lot of fear, a lot of misinformation. The media wasn't effectively reaching the Vaupés territory due to the lack of technology and communication infrastructure, but also because it was in Spanish and technical language. We know that these are historically abandoned territories, and there was a high chance that vaccines would arrive very late. We also know that the available hospital system was very precarious. Part of the fear was thinking about how COVID cases would be managed. Neither the hospital nor the communities know how to handle them, nor is the infrastructure to manage severe cases. All of this led us to consider with the communities what*

> *their needs were and how we could strengthen the territorial response to what was happening. So, we created a strategy with multiple actions that included providing material support to communities during the quarantine and isolation, especially those living near Mitú, who may have depended more on exchanges in Mitú. For example, we sent fishing hooks, soap, and goods usually obtained in Mitú.*
>
> *On the other hand, we started to work a lot on the issue of communication. Part of the key was trying to translate the public health information to inform and adapt it to the context of Vaupés so that people in Vaupés could also access that information, which was supposed to be a public good. But it wasn't truly a public good because it remained inaccessible to those not educated in Western culture. As a result, we thought about the types of information channels and communication formats used in the territory. We discussed with community leaders and members about the oral format and how one of the few things that reach the communities is the radio. This is something that, in general, in all of Colombia, and I would say in many other countries, the periphery has radio connectivity. So, we started proposing from there; let's send information from there. Sitting down with the communities and with the entire* Indigenous *team of Sinergias, we thought about how a radio program could communicate these things, and we came up with the idea of creating a podcast with episodes on key topics that we felt were important to communicate, but also building on what already existed in the territory. That's why we decided to make a podcast to inform people about an intercultural interpretation of what was happening and an intercultural response to what was happening. We started working with leaders, traditional healers, women, and other Indigenous Peoples to gather their stories, interpretations, and explanations from Indigenous thinking about the pandemic, as well as their recommendations alongside Western public health recommendations on isolation, cleanliness, hygiene, etc., on how infectious diseases are transmitted, etc. So, we combined* Indigenous *voices with Western biomedical voices and created that podcast. We started broadcasting it and realized that it was working, and that people resonated with it, so we continued to expand it and eventually expanded it to other topics. For example, in the next season, we talked about the projects we were working on with women regarding the empowerment of women's leadership, and it became a much larger project, very beautiful, very community-led, and very intercultural in terms of participation.*

Compañera Emilia emphasized the importance of community participation for local health benefits in this passage. These vivencias shared by Emilia brought back memories of my conversation with compañero Alcides from the Nasa People, who told me that to work with Indigenous Peoples, one needed to unlearn to relearn. Even though the communities received the Canto del Tucán program well, non-Indigenous people were required to engage in the unlearning

and relearning process in this work to make the program a reality. Part of that unlearning was to stop approaching Indigenous Peoples from a perspective of scarcity and instead support them based on what they have at hand, from their abundance and strength. Emilia further elaborated by explaining how she faced and overcame challenges in navigating the process of building the program in Vaupés:

> *These were complex experiences that involved a lot of learning and doing—making mistakes and trying alternative approaches. The suggested ideas have been, let's say, applied in other contexts where there is usually more communication infrastructure, technology, and a more connected community and society, not as dispersed. However, when one thinks about other territories like Vaupés, like the jungle, it's necessary to rethink how all the things we have learned can be adapted to make sense in non-Western contexts. I believe that was part of what needed to be learned. It's like, well, we don't have computers, we don't have the internet, we don't have renowned editing software, we don't have professional recording equipment. So, what do we have? We relied on cell phones, the [editing] programs we had, going to a person with a cellphone, recording a voice note, and sending it via WhatsApp because that's the only thing that works in the jungle. On WhatsApp, well, in Mitú, because you can't upload anything to Google Drive or anything like that, it had to be done through WhatsApp. And based on all of this, we had to rethink our communication methods.*
>
> *On the other hand, the fundamental aspects of audio communication, like podcasts, were already present in the territory. So, another learning experience was to rethink the technological layer around communication, but orality was already the foundation of communication in the territory. The fundamentals were already there; what we were learning was about that.*
>
> *That was the second lesson, to honor what was already present in the territory, which turned out to be the most important thing: orality, knowledge in an oral format, like the tools for transmitting knowledge through orality. And that truly became what guided the strategies, and I think it's the greatest lesson—starting from what exists and creating systems around what exists, taking elements that can be useful from other cultures, systems of thought, technologies, but starting from what is there and building upon it.*
>
> *Regarding working with the people, it was also difficult because of the logistics of reaching them due to the difficulties of the territory, the scattered nature of the populations, and how challenging it is to reach the communities. Moreover, during the pandemic, all that mobilization was even more difficult. Another challenge is always ethnic and linguistic diversity. For example, one of the questions we had was in which languages to disseminate the information because*

> *we wanted to do it in Spanish as a common medium. Still, the populations we wanted to reach often didn't speak Spanish. So, we tried to incorporate messages in local languages, but then it was like, "But in which language?" There are about 67 languages* [in this region]. *That was another challenge and a limitation that will always remain. These were some of the concessions that had to be made.*
>
> *It was also really cool to incorporate other elements from the context into the oral aspect, like other elements of reality through sound. In addition to words, there were songs, music, and sounds of the jungle. That's another learning experience about how the experience of another territory, even if I only perceive it through one sense, is multidimensional because it's the sound of animals, the words of people, the songs, and the prayers. This is part of the interconnected web of life the* Indigenous *world represents. Part of that learning process and why we incorporated all of this was a way to honor that holistic thinking about how interconnected life is. I think it was great to use the audio format because a written format perhaps flattens that interspecies character, the many dimensions of life that create the fabric of Indigenous life.*

Compañera Emilia unpacks a series of important relationships for Indigenous communities that are, in a way, almost excluded when we focus on the transmission of knowledge in written form. Oral tradition incorporates human speech and the words of other beings with whom we constantly interact and are part of the knowledge transmission. In addition to oral tradition, symbolism, and ancestral stories play an important role in transmitting knowledge. The use of these components was crucial for creating the booklet that accompanied *El Canto del Tucán*. Compañera Ana Judith explains that the communities shared ancestral stories with symbolic and relevant content to disseminate information about the pandemic in an appropriate context. For example, when addressing the topic of isolation, the booklet presents stories that resonate more with the communities:

The people of the Miritíi River imitate the "ñamã" or deer [left image], *fleeing as soon as they know that a man or another animal that can harm them is nearby.*

The "picure" [right image] *ventures into the jungle before any threat.*

The behavior of these animals represents what should be done when there is a threat to life, in this case, the pandemic. This symbolism helps us better understand the importance of isolation.

Regarding monitoring the disease, there is also a symbolism of ancestral knowledge that helped reach points of convergence in this aspect:

The COVID-19 contact tracer acts like the anteater. They are community members who know the signs of the disease spreading and can quickly identify other people who might have it.

Ana Judith adds that ancestral stories about mutual care were part of a revival of bartering or exchange in some contexts. One of those stories was the story of the Danta [Tapir] hunt:

In the past, if a family hunted a Danta, they would share it with all the families and exchange part of the meat for salt, casabe, or other things they might need. This way, all the families benefited. Or if a family were good at gathering seeds, they would exchange them for fish with another family. In this way, both families had different food types, ensuring a more complete diet.

One can build upon what has been built by encouraging community participation to develop alternatives to what communities already have. As Emilia explains, regarding human communication, WhatsApp is quite popular in the area, although it requires being close to urban areas like Mitú to send messages. However, radio signals are one of the forms of communication that reach some remote communities, and upon receiving this information, they can share it with other communities. For this reason, local radio networks also were part of the collective support to broadcast *El Canto del Tucán*. This program provided an important space to disseminate information validated by the community through its knowledgeable individuals and leaders, complementing Western knowledge in a dialogue of knowledges.

Learnings and Conclusions

When COVID-19 reached Vaupés, it tested the capacity for response and relationships in this context. Despite the pandemic's impact on the Departamento, from my perspective, it also provided lessons for different healthcare systems, including the SISPI. One fundamental lesson is

the need to reinstate community participation as the operative core of any healthcare system so that it operates effectively and harmoniously.

In this sense, it is worth noting that the dismantling of the intercultural PHC model driven by the Colombian-Dutch agreement and the *Servicio Seccional de Salud de Vaupés* (SSSV) [Regional Health Service of Vaupés] through Juan Guevara, and subsequently the Functional Group, left a current healthcare system disconnected from the Indigenous communities in the rural area in the local response to the virus. The *Departamento Health Secretariat* and the hospital acknowledged this disconnection. They tried to revive intercultural components of the model to recruit and train personnel to reach these remote communities in this pandemic context. However, in the current landscape, there are still obstacles in the healthcare system's structure that hinder the implementation of an intercultural PHC focused on community participation. Camila's vivencia illustrates these barriers, facing difficulties when hiring Indigenous community health promoters.

These learnings highlight the indispensable promotion of an intercultural model of PHC that privileges community participation and overcomes the structural and bureaucratic barriers that hinder the incorporation of local health promoters. Likewise, it is necessary to value and use culturally relevant communication methods. Programs like *El Canto del Tucán* have proven to be efficient means to overcome communication barriers, providing reliable and appropriate information about COVID-19 and preventive measures and serving as platforms to share experiences and collective knowledge.

Emilia and Pablo's work in *El Canto del Tucán*, for example, elucidated the complex mechanisms of Indigenous communication. They highlighted the significance of orality, an essential aspect of some Indigenous communities' interaction with the external environment, and the challenges associated with specific communicative tools. In the dense tropical forest,

WhatsApp and mobile phones have limited connectivity for sharing information, depending on their proximity to urban centers. However, Emilia and other collaborators used this technology to bring messages to the radio program team and thus be broadcasted through radio waves, which are more prevalent in this communicative framework to share information with the most remote communities. The ability to utilize these tools exemplifies the intricate process of identifying effective communication strategies to convey pertinent and trustworthy information to bolster Indigenous communities in the area. *El Canto del Tucán* was not merely a communicative platform; it incorporated ancestral melodies, ambient sounds of the forest, and traditional narratives. Animal vocalizations, arboreal murmurs, human songs, and spiritual invocations collectively form a synergistic existence network. This network encapsulates the density of Indigenous life, transcending the limitations of conventional academic categorizations.

El Canto del Tucán served as a confluence of diverse stakeholders: academic researchers, non-governmental organizations, and Indigenous chieftains, fostering a milieu of intercultural discourse. This spirit of collaboration, underscored by mutual respect and comprehension, illuminates the density of Indigenous community engagement. Once again, it contests prevailing stereotypes and simplistic representations, emphasizing the diverse Indigenous identity.

Confronted by the pandemic's impending threat, the Vaupés community sought guidance from ancestral knowledge. They found comfort in nature's embrace, the therapeutic properties of flora, the rejuvenating effects of water immersion, and the sustenance derived from these natural resources. Such practices, anchored in traditional wisdom, epitomize the density of Indigenous medicinal knowledge, underscoring a symbiotic relationship with the environment that extends beyond mere sustenance.

In essence, these vivencias facing COVID-19 in Vaupés are a compelling manifestation of the complexity of Indigenous realities. Their innovative communication practices, holistic perspectives, an amalgamation of traditional and contemporary knowledge, a communal ethos, and distinctive health paradigms challenge the often-myopic perspectives of the "Western" paradigm. Andersen's (2009) emphasis on recognizing *density* over mere distinctions echoes in the intricate and dynamic mosaic of Indigenous culture, relationality, and knowledge that this chapter highlights.

COVID-19 has highlighted the resilience and adaptability of Indigenous Peoples in the Pan-Amazon region. Despite adversity, they have managed to confront the health crisis using their knowledge and complementing it with Western knowledge. Therefore, these learnings provide pieces that can be useful for the SISPI. The intercultural model of PHC, for example, emerges again as a tool that may be useful in complementing the intercultural pathways mentioned in the SISPI. Furthermore, *El Canto del Tucán* focuses on Indigenous and Western public health density, providing concrete actions that may contribute to operationalizing those pathways. This focus becomes evident in how the program's dynamics are grounded in the SISPI and public health components to effectively respond to health crises and strengthen Indigenous communities and their organizational structures. The pandemic has taught us a valuable lesson: integrating different knowledge systems and actively involving communities are key to overcoming adversities and building more equitable and sustainable health systems.

CHAPTER EIGHT: CONCLUSIONS

> *Conecta tu mente, incorpora tu cuerpo, respira la mañana. Programa tu día, que tu energía este bien proyectada. Nada que te detenga, nada que a ti te frene. Decides a que conectarte, como enlazarte o por qué te detienes. Sabes que vienen quienes quieren hacer mal, también atarte. Si es el arte lo que día a día trata de liberarte. ¿De que haces parte? Conecta mi mano, dirige bien el volante, a donde el presente es un regalo, el futuro un pasado distante. Mundo flotante (flora, fauna) filtran mi flow, de frente al flete. Decides a que encadenarte, a que amarrarte. ¿Qué te somete? Rompe cadenas, libérate en tu mente, suelta los grilletes, viviendo en prisiones mentales solo por el hecho de querer billete. Empata y peque, suciedad maldita que nos dañó desde peques. El tirano tiene el poder, el pobre no tiene ni pa*[ra] *un trueque, aunque entregue horas de vida, gotas de sangre, sudor y llanto, porque no puede alzar la voz ¡Por esa persona yo canto! Dime ¿Qué tanto cuesta tener una digna calidad de vida? El de abajo le importa un comino al que tiene el poder, y está arriba (muy nociva). La vida que es parte de esta sociedad que grita: Pero somos libres, este sistema no nos limita.* ~ Conecta (canción del grupo Pueblo Nasa)

> *Connect your mind, embody your body, breathe in the morning. Program your day, let your energy be well projected. Nothing to stop you, nothing to hold you back. You decide what to connect to, how to link yourself, or why you pause. You know those who want to do harm are coming, also to tie you down. It's the art that tries to free you every day. What do you belong to? Connect my hand, steer the wheel well, where the present is a gift, the future a distant past.* [A] *floating world (flora, fauna) filters my flow, facing the freight. You decide what to chain yourself to, what to tie yourself to. What subdues you? Break chains, free yourself in your mind, release the shackles* [of] *living in mental prisons just for the sake of wanting money. Tie and sin,* [a] *cursed dirt that damaged us since we were little. The tyrant has power; the poor don't even have enough for a trade, even if they give hours of life, drops of blood, sweat, and tears, because they cannot raise their voice. I sing for that person! Tell me, how much does it cost to have a dignified quality of life? The one below doesn't matter to the one in power, who is above (very harmful). Life is part of this society that shouts: But we are free; this system does not limit us.* ~ Conecta (song by the group Pueblo Nasa)

Why the "white man" [referring to the Western world] is always running around.

It was around one o'clock in the afternoon in the community of Puerto Golondrina. We had just finished lunch, and the heat was intense. I was in José and Keyla's kitchen (Jose's partner). I was

planning to go back to where I was staying in the community to write for a while, but the zinc roof of that structure intensified the heat inside at that hour. So, I decided to stay in the kitchen with José, who invited me to lie in one of the two hammocks they had. The kitchen provided a sense of freshness amid the day's intense heat. The roof made of Karaná leaves (a type of palm tree found in the Amazon rainforest) protected us from the heat without trapping it inside. The open spaces in the kitchen allowed the wind to flow and cool us down. As we lay there, José asked me:

Hugo, I wonder why the "white man" [referring to the Western world] *is always running around.*

That's a very good question, José, I replied. *I think that in the Western world, we are always focused on producing and accumulating things.*

But I don't understand why so much stress and rushing, José reflected while swaying in the hammock. *They run so much and stress themselves out to the point where they don't really live life or only experience it in fleeting moments. They even end up getting sick, and that's even worse. For us, that's not "Vivir Bien"* [Living Well].

His words made me reflect on what we in the West consider "Vivir Bien" or *"Buen Vivir".* Is it this relentless desire to accumulate material possessions? And once we obtain them, what comes next? Accumulating more? What's the purpose of that if we don't take any of those material things with us when we die?

I shared some of these reflections with José, and he replied:

> *Well, Hugo, work is part of our responsibilities in life. For example, working in the chagra (agricultural fields), cleaning the community, preparing food, building our homes —those are all necessary tasks. But it is also our responsibility to appreciate and share life. You see us here, we work what is necessary, and then we share with the community and family. For instance, at this moment, we are calmly talking and lying in the hammock without any rush. And after we rest for a while, we'll go fishing with the youth, not out of necessity, but to share. Life needs to be appreciated, respected and seized because it's short. For example, when my dad had a heart attack, I was really worried, like any son would be. However, my dad and I have shared so much in this*

> *life, and we have expressed our love for each other that if God forbid, he had passed away, I would be at peace because I know I let him know in life the respect and affection I have for him. When a person dies, there's no point in regretting what you didn't do with the deceased person. What we need to do is act while they're still alive.*
>
> ***Vivencias' Notes 2/9/2020***

Although I received training in the "Western" school of research, it was necessary to structure the research in the best possible way from an epistemology that made sense within the context to support the *Sistema Indígena de Salud Propia e Intercultural* (SISPI) [Self-determined and Intercutural Indigenous Health System] and attempt to address the research questions. I had to unlearn that, as a researcher, I cannot separate myself from this story and pretend to look at it from an "objective" perspective since I bring biases that influence how I interpret what I observe. Although it may sound redundant, I had to relearn that I am part of this collective history and that, as *feel-thinker* beings, we share knowledge, emotions, laughter, food, music, dances, prayers, respect, and difficulties; in short, we share densities and learned collectively.

As external participants, our responsibility is to put ourselves at the service of the community first. If there is a desire to investigate something specific, then we need to develop these projects collectively, guided by the priorities of these communities. For example, my commitment to Indigenous national leadership was to serve by collaborating in the coordination of a visit from the *Comisión del Subcomité de Salud Indígena de la Mesa Permanente de Concertación* (SSI-MPC) [Indigenous Health Subcommittee of the Permanent Concertation Table] to Vaupés. Locally, my commitment was to document and support the construction of the Maloca in the Puerto Golondrina community and teach English in the community. These relationships inspired this manuscript, which I respectfully present for further development.

Throughout this document, the concept of density used by Andersen (2010) was helpful in better understanding the complexity and diversity of the Indigenous reality. Likewise, this concept was essential for analyzing the information through a *feel-thinking* lens and answering the research questions meaningfully. In this final chapter, I present how density manifests in these stories. I conclude by answering the research questions with suggestions of potential interest for the SISPI, the SGSSS, and Indigenous communities. These questions are: how can SISPI support local communities in building or strengthening their health models? Can bridges be built between Indigenous medicine and Western medicine? And if this is possible, how could these bridges be built through SISPI?

Density and SISPI

The concept of *density,* as portrayed in the shared stories, underscores the depth and complexity of the vivencias, knowledge, and relationships of Indigenous Peoples. This notion, intrinsically tied to Indigenous vivencias and wisdom, manifests in various ways in this manuscript. Additionally, it showcases the intricacy of my vivencias and learnings along this path.

The initial idea highlights that *density* is not just an abstract concept but reflects individual and collective vivencias. *Density* is evident in how individuals share knowledge, emotions, traditions, and experiences. It is an amalgamation of feelings, thoughts, and actions woven into a collective story. Furthermore, these stories emphasize the importance of focusing on the *density* of the context when addressing health issues in Indigenous communities. This contextual *density* encompasses knowledge and relationality, crucial elements to understand and properly support the needs of these communities.

The focus on Indigenous *density*, especially in dialogues with governmental entities, underscores the need to understand and respect the richness and depth of Indigenous experiences. This emphasis has led to a greater understanding of the importance of maintaining specific plans for Indigenous Peoples, recognizing their uniqueness. Indigenous Peoples have developed specific routes called *intercultural paths* to establish a dialogue between different forms of knowledge and provide culturally appropriate access to healthcare services for their communities.

In Chapter 4, we discussed how the *Plan del Cuidado para la Vida Colectiva de los Pueblos Indígenas'* (PCVC-PI) [Care Plan for the Collective Life of Indigenous Peoples] explanation of Indigenous *density* revealed the need for autonomy between the PCVC-PI and the *Plan de Intervenciones Colectivas* (PIC) [Collective Interventions Plan]. However, the *intercultural pathways* play a critical role in providing convergent routes for the mutual complementarity between "Western" and Indigenous knowledge. The limitation of performing the opening ceremony before each meeting exemplified the need to find these convergences, especially when Indigenous community members must traverse colonized spaces. Fortunately, when explaining this situation to government delegates, they spoke with hotel staff to provide the space the Indigenous delegates needed to hold the ceremony. This vivencia showed how these colonized spaces can be re-indigenized to maintain relational harmony with the support of non-Indigenous allies. The reaction of the government officials illustrates how our positionality as non-Indigenous allies is instrumental in advocating for culturally adequate spaces for Indigenous practices regardless of the location. Re-indigenizing these spaces allows for the full expression of Indigenous culture, promoting their resilience and affirming their existence and rights. Moreover, it facilitates dialogue and collaboration between Indigenous and non-Indigenous cultures and promotes the creation of inclusive and equitable spaces. This approach implies more than merely

making physical adjustments or allowing certain practices; it is an ongoing process of recognition and respect.

These interactions suggest that as long as there is not a genuine and respectful dialogue with communities to ensure processes of knowledge complementation in health, it will be very difficult to materialize an intercultural approach that guarantees the integration of knowledge. As discussed in that meeting, the legal framework from the national direction must be clear in the regulations so that territorial actors comply with them appropriately. This situation outlines some problems regarding the ability of these territorial actors to implement what is dictated by the standard and the understanding to operationalize *intercultural pathways* without clarity on how they develop in practice. Although these dialogues are necessary, the density that became visible in these relationships is the emotional, mental, and physical burden placed on Indigenous peers to constantly explain their worldview over and over again whenever the national and local government changes personnel.

Interactions with the *Sistema General de Seguridad Social en Salud* (SGSSS) [General System of Social Security in Health] health providers further increase the burdens on Indigenous Peoples to explain their worldviews in negotiating a culturally adequate healthcare service. The stories of Jabokū and José in Bogotá and Mayora Margarita and Johnny in Mitú reveal that these providers still exhibit paternalistic and discriminatory attitudes towards Indigenous Peoples. These interactions do not mean the health providers are not interested in serving Indigenous communities but bring to light the biases we are all structurally exposed to stand out. This reaction from providers emulates what some regulations describe Indigenous knowledge and behavior, as in resolution 10013 of 1981. These regulations result from a colonial history of minimizing Indigenous aspects in every way to maintain justified power over land and labor.

However, from my experience, I believe that these biases can be countered by institutionalizing intercultural education in the general education system, where the realities of communities, in general, guide that education. At least by learning directly about Indigenous realities, I was able to confront many of the biases imposed by the dominant system, even though there is still much more work to do internally.

I should clarify that the 1991 constitution brought about gigantic changes in the regulations' recognition and protection of Indigenous rights. Since then, lawmakers have created a wide range of rules to benefit Indigenous Peoples, which even led to the creation of the SISPI. Despite this great progress, subtle language still relegates Indigenous autonomy in some parts, as reflected in Decree 1953 on the SISPI. Now, with the concerning neoliberal structure of the SGSSS with private entities as intermediaries between the state and health services, it is starting to be questioned how could the SGSSS, based on neoliberal policies, support the SISPI without compromising the principles of the relationality of "*Buen Vivir*"? As public policy in Colombia, is "*Buen Vivir*" at risk of falling into state bureaucracy like it happened in Ecuador and Bolivia?

The shared and personal vivencias accompanying the SISPI also highlighted that the application of the norms does not match what the paper describes. For example, culturally appropriate care respecting Indigenous practices and customs by the so-called "shelters" and health providers shows significant gaps in this compliance. In this regard, there seems to be no follow-up to enforce these rules for Indigenous healthcare. Added to this are the limitations that laws impose on hiring community members to the health system. The COVID-19 pandemic exposed this in Vaupés when trying to reach most communities for disease monitoring and control. Hiring community health promoters was influential as they were key players in developing the intercultural *Primary Health Care* (PHC) in Vaupés from the eighties to 2007.

The "Buen Vivir" addresses the diversity of densities in another area. This diversity reflects the multiple interpretations and meanings of this life philosophy in different communities and territories. The "*Buen Vivir"* label is one of the closest representations in Spanish to what Indigenous Peoples refer to as their way of living in their language. As a result, the *"Buen Vivir"* cannot be standardized with a single meaning due to the diversity of densities found in different territories in Colombia. However, in delving into this diversity of densities, I learned that different interpretations of *"Buen Vivir"* are rooted in the principle of relationality. This broad relationality includes individuals, families, communities, organizations, state institutions, and non-humans like the land. In the particular case of Vaupés, *"Buen Vivir"* is known as "*Vivir Bien*" in Spanish, although the label still falls short of carrying the same density of meaning as it does in the local language.

Within this journey of shared vivencias, I also learned that sharing with communities and their participation in any project related to their context is crucial. From an academic perspective, I experienced how theory and practice must go hand in hand, known as praxis in academia. However, the communities we work with must accompany this process, which is collective, malleable, and transforms as relationships are built and developed. The shared experiences of the intercultural PHC model in Vaupés and the "*Canto del Tucán*" radio program in response to the COVID-19 pandemic in the Colombian Amazon illustrate how community participation is indispensable if we consider that we are mediating a system that is interconnected by critical relationships to strengthen not only Indigenous health models but the Health System as a whole. A key aspect of these projects where density clearly emerged was to depart from the strengths and abundance of the communities (or what they have on hand and in their cultural heritage) rather than from scarcity. This abundance illustrated intercultural communicative work that

included symbolism and oral tradition as components that communities master in their day-to-day communications. Therefore, community participation, rooted in relationality, was crucial to support Indigenous communities in Vaupés through these intercultural efforts. A critical aspect of these intercultural interactions was the coordination between state and Indigenous sectors. Coordinating these sectors was essential for both intercultural PHC and the response to the pandemic in Vaupés to flow in a balanced way. Unfortunately, this type of coordination is not consistent. Although the current general health system deviates from this relationality and community participation as the axis of the health system, different entities continue their effort to systematize and operationalize the intercultural approach in this territory based on the strengths of the communities, even though they encounter systemic barriers along the way. This is exemplified, once again, in the structural barriers when hiring community health promoters to respond to the COVID-19 pandemic.

We are all constantly learning, and the complementation of each individual's knowledge, dropping hierarchies, opens the doors to achieving collective goals for the benefit of all. Of course, we all have biases based on our vivencias, but critically reflecting on them helps us recognize our limitations. The compañeros(as) taught me a great lesson: When we support the communities we work with, we must not paralyze ourselves while critically reflecting on our biases. We must also not act without being aware of our role in the power dynamics wherever we are.

Finding a balance between critical reflections on our relative systemic advantages and using research as an advocacy tool is part of the work ethic that should underpin our actions in any community. For example, compañeros José and Mayor Rosendo encouraged me not to be afraid of dialogue and to take responsibility for my actions. Understanding relational density in

territories and constantly nurturing the balance of these relationships is crucial to supporting Indigenous processes of any kind. As José suggested, it can be as simple as asking the community if they have any doubts and listening if they have concerns about our actions as guests.

In summary, these stories suggest that shifting the focus towards *density* rather than differences achieves greater integration between theory, practice, research, and community participation. As Andersen (2010) presented, *density* emphasizes the richness and complexity of Indigenous vivencias. It is an invitation not to simplify or reduce these experiences but to approach them with the depth and respect they deserve, especially in academic and public policy contexts.

The vivencias on this journey suggest that the SISPI indeed holds a strong political and organizational position to support building or strengthening local health models and forge intercultural bridges between "Western" and Indigenous medicine. However, it requires support both institutionally and from allied organizations to develop this in their territories. After speaking with some Elders, one of their desires was to hear my ideas for putting this into practice and structure from my position supporting the SISPI. As they explained, hearing my suggestions does not mean this is how things should be done, but it could offer another perspective to this collective learning process. With the permission of these Elders and my respect for them, I proceed to share these suggestions.

Suggestions

Following up with Communities and Coordination Among Sectors

To help local communities develop or enhance their health models, the SISPI must offer regular and suitable guidance. From my limited perspective on the situation and based on what I have

learned from experiences in this project, there's a need to establish transparent communication pathways with a constant flow. To accomplish this goal, the SISPI could establish support committees at the national level through the SSI-MPC and at the local level with government and Indigenous territorial health authorities. It would be beneficial to include NGOs in these committees for support, depending on their relevance and necessity in each context. The local committees would be responsible for relationally accompanying the communities to develop or fortify their health models as necessary, fostering community participation. The national committees would focus on technical and relational support for local committees, enhancing their abilities to support local communities in constructing or strengthening their health models. This follow-up must occur frequently until those models run sustainably and adequately connected to the SISPI. After that, there should be only check-in visits once a year.

For this to develop, there's a need for support and coordination among national government ministries, departments within the ministries, local governments, and the various Indigenous organizations in the country. The SSI-MPC would be the most appropriate entity to lead this intersectoral coordination, clearly defining each participant's role and goals. These communication channels could facilitate continuous dialogue between health authorities, Indigenous leadership, and the communities, ensuring that policies are adapted and relevant.

Communication

In the vast and complex landscape of public health, communication emerges as an essential tool for transmitting and understanding vital concepts. However, in its rich diversity, language can be both a bridge and a barrier. Scholars David Flood and Peter Rohloff (2018) emphasize the centrality of language in interaction with communities, noting that terminology can make substantial differences in interpreting and applying health concepts.

When approaching different cultures, it is essential to research their traditions, language, and customs before engaging with them. It is not just about translating terms but understanding and respecting the inherent worldviews that these terms represent. Although learning from and developing relationships with Indigenous communities is a lengthy process, reintroducing the figure of community health promoters benefits the community, SISPI, and SGSSS. Since these promoters are part of the community, they are the cultural mediators within the communities. Strengthening capacities for these individuals with *Ongoing Education* creates an essential bridge between health systems and the community. These mediators translate words, contexts, beliefs, and values.

Additionally, a synchronized effort between the SISPI and SGSSS to organize awareness workshops for health professionals can equip these personnel with at least a basic culturally sensitive contextual approach. These practices can instill the importance of linguistic and cultural adaptation in medical and public health practice. Furthermore, the collaborative creation of a community glossary, which contemplates key terms and concepts, becomes an invaluable tool to ensure effective communication. However, it is important to recognize that linguistic adaptation is not limited to creating glossaries. Therefore, the promoters would be key players in that first level of contact with the SISPI and SGSSS. To achieve this, the SISPI, through the SSI-MPC, can lead advocacy work, re-evaluating and contextualizing normative procedures to support the hiring of community personnel for these jobs.

Developing educational material that reflects the terminology and culture of the community is another pillar in this process. These resources, whether brochures, videos, or other media, must be designed with and for the community, ensuring their relevance and effectiveness. For this, it is crucial to avoid the imposition of external terms. Communities should be seen and treated as

active partners in their medical care, not just as passive recipients of information. Promoting Indigenous autonomy and allowing communities to make informed decisions based on their terminology and understanding is an act of respect and empowerment.

Finally, the documentation and publication of experiences and lessons learned in the linguistic adaptation process serve as a valuable record and contribute to the academic and practical body, allowing other professionals and communities to benefit from this knowledge.

Curriculum

The integration of knowledge in the health field, which amalgamates tradition with contemporaneity, is imperative to forge medical care that is both comprehensive and culturally relevant. In this context, the confluence of "Western" medicine and the ancestral knowledge of Indigenous Peoples presents an opportunity and becomes necessary. Based on the vivencias shared on this path and my limited perspective, I broadly suggest possible strategies to materialize this integration, emphasizing the cardinal role of SISPI in Colombia.

First, it is essential to undertake a thorough situational diagnosis. Before any attempt at a curricular design for universities, it is crucial to understand the needs, aspirations, and challenges Indigenous communities face in the health field. Only in this way can a genuinely relevant curriculum be outlined.

Curricular design cannot be a unilateral exercise. It must result from a collaborative and participatory process that actively involves Indigenous health professionals, community leaders, and, of course, SISPI. This entity, in particular, has the potential to play an oversight role, ensuring that the curricular content faithfully reflects the desires of the communities. Additionally, SISPI can link communities and academic institutions, facilitating the

identification of Indigenous experts willing to provide *Ongoing Education* in the intercultural educational field. For this, it is imperative to underline the importance of equitable compensation. Indigenous professionals contributing to the educational process must receive remuneration that adequately recognizes their invaluable contribution.

The SISPI and SGSSS should not see training as a finite act. Guevara's work (1984) recommended that, beyond the basic curriculum, we establish *Ongoing Education* mechanisms. These mechanisms allow medical professionals to reinforce and expand their knowledge of Indigenous health in a relational, appropriate, and respectful manner. This curriculum targets students from different disciplines who are going to or are interested in working with Indigenous Populations.

Rigorous evaluation and feedback mechanisms must accompany the implementation of the curriculum. In this sense, SISPI can be instrumental in gathering direct opinions from communities to ensure the relevance and effectiveness of the curriculum over time. The promotion of *interculturality* must be the guiding principle of this curriculum. More than just a set of knowledge, *interculturality* should be instilled as a philosophy of relationality that celebrates and respects diversity.

Lastly, the selection of students for this specialized curriculum must be meticulous. The Indigenous delegation of the SSI-MPC could co-manage this process, ensuring that candidates have a genuine commitment to the well-being of Indigenous communities.

Implementation of Intercultural Health Models in Primary Health Care (PHC): A Proposal Focused on Community Participation

Intercultural health in PHC poses both a challenge and an opportunity to fortify the bond between health systems and Indigenous communities. As suggested earlier, to implement this model, a meticulous and participatory approach is necessary to acknowledge and appreciate the cultural richness and traditional knowledge of these communities. Fortunately, this approach has already been applied in Vaupés, yielding positive results. The SISPI and SGSSS can use the Vaupés case as a reference to create intercultural PHC models for each context.

Initially, it is imperative to carry out a participatory diagnosis. More than just data collection, this process should be an opportunity to establish a genuine dialogue with communities, identifying their needs, expectations, and resources. The SISPI can be instrumental in coordinating the development of these participatory diagnoses with local communities as a cornerstone for further collaboration in building any subsequent health intervention.

Health professionals must undergo intercultural training. They need the knowledge and sensitivity to understand and respect the particularities, beliefs, and practices of the communities they interact with. This training should not be an isolated event but an ongoing process, adapted and contextualized according to the specific characteristics of each community. Additionally, this training should be extended and systematized for government actors, thus relieving Indigenous colleagues from repeatedly explaining their worldviews. The SISPI would facilitate developing these continuous intercultural trainings for health personnel and government delegates working with Indigenous communities.

It is essential to establish continuous dialogue spaces. These spaces will allow communities, organizations, and health professionals to co-construct the intercultural PHC model, ensuring its relevance and responsiveness to local realities. In this scenario, the SISPI emerges as a critical entity. Its role is not limited to that of an observer; the health authorities of the SISPI must be active players, taking on oversight and collaboration roles alongside the health authorities of the SGSSS. Similar to the suggestion regarding curricula, the SISPI, as an overseer, will ensure that interventions are culturally appropriate and respect the rights and worldviews of communities. As a collaborator, its experience and knowledge in intercultural health will enrich the training of health professionals and ensure the relevance of interventions. These actions would reinforce what is implemented in the curricula, thus creating an *Ongoing Education* system that starts in universities and continues in the territory.

Recognizing and integrating traditional knowledge into health interventions is symbolic and essential for the model's effectiveness and sustainability. Flexibility and adaptability are inherent characteristics of any successful intercultural model. The SISPI, in coordination with the SGSSS, must build mechanisms for constant review and adjustment of health interventions, responding to feedback and the community's changing needs.

Both the SISPI and SGSSS must guarantee structures that always promote community autonomy. Communities are not just beneficiaries but central actors in deciding, designing, implementing, and evaluating interventions. Continuous, participatory, and contextualized evaluation will ensure that the intercultural PHC model is implemented, evolves, and strengthens over time.

As a final remark, the SGSSS must guarantee basic infrastructure and medical supplies to ensure everyone has adequate access to the first level of healthcare in Indigenous territories. Connecting

communities through health posts and centers for promotion and prevention is important, depending on the context. Although there is a significant network system in Colombia with the *Rutas Integrales de Atención en Salud* (RIAS) [Comprehensive Health Care Routes], the infrastructure for primary health care is weak. Health posts, in particular, would facilitate the provision and spaces necessary for the activities of promoters. These spaces include equipment and radial communication systems.

Closure

As researchers, we must put our situated knowledge at the service of the communities with which we work and under their guidance. This work cannot be solely professional; it must be relational and human to share, listen, unlearn, and learn.

Theory must go hand in hand with practice and community participation. As the focus shifts towards density rather than the differences between the communities we work with, praxis and community participation come together and transform. A focus rooted in theory helps us intellectually understand certain situations. Still, it does not allow us to embody the reality of other contexts, making it difficult to empathize with our peers. This approach is crucial because what I call practice is about developing relationships, unlearning to relearn, understanding that we all contribute to better understanding this path called life, understanding the history of the context (both in documents and oral tradition and symbolism), recognizing that we are part of a large ecosystem, and complementing our situated knowledge to live a life of common-unity, worthy and healthy. I hope this document continues its development through relationships and documenting vivencias. Let the lessons learned guide our ongoing fight for universally accessible, culturally appropriate medical care for everyone.

This manuscript is not for intellectual entertainment but to invite all those committed to social and health justice to actively walk this path alongside the communities in which they work within their contexts. In other words, community participation is essential to support local health management processes within the priorities identified by these communities. Even though the suggestions provided require more specificity, they can be a departing point to develop a more detailed plan.

In conclusion, embodied experiences, shared stories, and reviewed documents helped to answer the research questions broadly. However, as I mentioned earlier, it is necessary to continue incorporating stories, both from the communities and from the updating of institutional processes, to establish *Ongoing Education* where we constantly continue learning from the realities of each community to be able to support them appropriately by informing processes and public policies. This *feel-thinking* analysis suggests that the SISPI plays an important role in building or strengthening Indigenous health models and intercultural bridges. To pursue a "Buen Vivir," one must understand that it extends far beyond the SISPI, and aligning sectoral and intersectoral strategies is necessary. With this in mind, the principle of relationality must be the basis for developing government plans in these territories.

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APPENDIX A. Conversations About "*Buen Vivir*" in Vaupés

Rosita	
Soy de la etnia Desana, en el Departamento del Vaupés. En mi posición como mujer e Indígena, desde mi sentir propio, el "Buen Vivir" no se trata de la ausencia de la enfermedad y otras cosas. Para nosotros es el sentir propio. El "Buen Vivir" para mi es sentirme bien conmigo misma, no desde lo físico sino desde lo espiritual; que todas las energías puedan fluir conmigo misma, con los demás, con la misma naturaleza y con los demás seres que habitan en el entorno. El "Vivir Bien" es el tener una buena relación con la naturaleza, con los otros seres que viven en el cosmos. Para nosotros todo es una persona, un ser; sea un árbol, un animal, una piedra, el rio, los sitios sagrados son importantes. Estos seres necesitan tener respeto.	*[I am from the Desana ethnic group in the Departamento of Vaupés. In my position as a woman and* Indigenous*, from my self-determined feeling, the "Buen Vivir" is not about the absence of disease and other things. For us, it is our self-determined feeling. The "Buen Vivir" for me is to feel good about myself, not from the physical but [also] from the spiritual; that all energies can flow with me, with others, with nature itself, and with the other beings that inhabit the environment. "Vivir Bien" is having a good relationship with nature and the other beings living in the cosmos. For us, everything is a person, a being; be it a tree, an animal, a stone, or a river, the sacred sites are important. These beings need to have respect.*
"Vivir Bien" es también que todas las personas a mi alrededor puedan estar bien; que se sientan tranquilos. Desde el momento que nacemos, nosotros tenemos nuestras propias prevenciones, nuestras propias curaciones, y nuestra propia tradición. Esto hace que en algún momento seamos muy seguros de nosotros mismos. Este es el caso de los rezos que hacemos para el crecimiento y desarrollo de las personas; el rezo de la prevención contra las enfermedades, para que nos fluyan las energías para tener contacto con otros seres de la naturaleza y otras personas. El "Buen Vivir" se hace, se aprende, se escucha, se genera… La naturaleza y sus seres… tienen la misma organización, la misma estructura social que tiene este mundo. [nosotros] Hablamos como de las personas… de todo lo que físicamente se puede ver. En el otro mundo… pues hablamos como del otro mundo porque hablamos de la gente árbol, de la gente agua, de la gente piedra, de la gente animal, de la	*"Vivir Bien" is also that all the people around me can be well and feel calm. From the moment we are born, we have our [knowledge about] preventions, our [knowledge about] cures, and our [knowledge about] tradition. This means that at some point, we are very sure of ourselves. This is the case of the prayers we make for the growth and development of people, the prayer of prevention against diseases so that the energies flow in us to have contact with other beings of nature and other people. In the "'Buen Vivir'," you make, learn, listen to, generate it... Nature and its beings... have the same organization, the same social structure that this world has. We talk about people… everything that can be physically seen. In the other world… well, we talk about the other world because we talk about the tree people, the water people, the stone people, the animal people, the earth people; For us, these beings are alive; they share with us. They share their knowledge; we get the knowledge from them.*

gente tierra; para nosotros, estos seres están vivos, nos comparten. Ellos comparten sus conocimientos, nosotros sacamos los conocimientos de ellos. Pero, nadie va a saber que eso esta pasando porque la sabiduría ancestral es de la misma tierra, es de la misma naturaleza, es de la misma vida que ha estado enseñando parte de los conocimientos que nuestros ancestros o nuestros abuelos o nuestros payes tiene en este tiempo también. El lenguaje… la comunicación es importante porque también nos comunicamos a través de ella.	*But, no one knows this is happening because the ancestral wisdom is from the same land, it is from the same nature, it is from the same life that has been teaching part of the knowledge to our ancestors, grandparents, or our Payes in these times too. Language… communication is important because we also communicate through it.]*
José Esteban *Yo vengo del Pirá [Paraná]. He visto cantidades de cosas. En este deber de estar uno allá, yo he vivido el sistema de salud propio y dirigir, vivir en diferentes épocas muy pendiente del calendario ecológico. Y todo ese trabajo tradicional, se hace para el bienestar de la comunidad, de su familia y el territorio.* *Agarrando un poco la realidad donde uno vive, encuentro una diferencia muy grande porque el sistema general de salud lo quiere llevar [al sistema propio] a su manera desde la ley; funcionar un sistema diferente, pero que ellos manejan allá. Eso no le aterriza bien [al gobierno] porque no hay un dialogo donde las dos medicinas, o dos propuestas, pueden ser; recoger lo que sirve, teniendo en cuenta el sistema propio de uno y las prestaciones que vienen de parte del estado. Entonces ha habido cosas que uno nunca piensa. Por ejemplo, lo que yo contaba cuando hace unos 50 años el sistema propio estaba funcionando bien. Porque no había tanta interferencia; no hubo iglesia católica, no broto tanto, no hubo minería. Y el sistema pues se mantenía sin que estuvieran otros diciendo "vamos a vivir así, que tienen que vivir así de esta manera." No, porque los creadores nos dijeron como vivir, de qué*	*[I come from Pira [Paraná]. I've seen lots of things. In this duty of being there, I have experienced my self-determined health system and directed it, living in different times and being very aware of the ecological calendar. And all that traditional work is done for the well-being of the community, their family, and the territory.* *Grasping a little the reality where one lives, I find a very big difference because the general health system wants to take it [absorb other systems] in its way using the law; operate a different system, but with them managing it there. That does not land [the government] well because there is no dialogue where the two medicines, or two proposals, can be; collect what works, taking into account one's self-determined system and the benefits from the state. So there have been things that one never thinks about. For example, what I told you when about 50 years ago, the [*Indigenous*] self-determined system was working well. Because there was not so much interference; there was no catholic church (not much sprouting), there was no mining. And the system was maintained without others saying "we are going to live like this, they have to live like that." No, because the creators told us how to live, in what way; it*

manera; ya estaba organizado. Cada grupo étnico tenía su territorio y sus componentes. Entre eso [lo que los creadores proveyeron] estaban los saberes del manejo territorial. Ambientalista. *Y había una coordinación de saberes también de territorio a territorio. No había choques porque un grupo empezó a curar, [y así] lo puede hacer el otro y el otro. Todos estaban haciendo la misma cosa para evitar accidentes físicos, prevenir enfermedades de la época, para que no pase algo raro; todo controlado desde sus saberes. Esos mismos que tenían que ver con la curación de recién nacidos, también era una tarea muy grande y completa. Desde la última menstruación tenía un proceso que controla el embarazo hasta el nacimiento y crecimiento… desarrollo [del infante].*	*was already organized. Each ethnic group had its territory and its components. Among that [what the creators provided] was the knowledge of territorial management. Environmentalist.* *And there was a coordination of knowledge also from territory to territory. There were no clashes because one group began to heal, [and so] the other and the other can do it. They were all doing the same thing to avoid physical accidents, to prevent diseases of the time so that something strange would not happen, all controlled by their knowledge. Those same ones that had to do with the healing of newborns were also a very large and complete task. Since the last menstruation, she had a process that controls pregnancy until birth and growth… development [of the infant].]*
José Martínez *Eso es así. Cada comunidad tiene su conocimiento propio para manejar enfermedades. Por ejemplo, hay comunidades que su conocimiento se enfoca en el rezo y otras que su conocimiento es de plantas, como es el caso de nuestra comunidad de Puerto Golondrina. Lo que pasa Hugo es que cada comunidad en la selva tiene un conocimiento especifico y que se complementa entre comunidades desde que no haya conflictos entre ellas. Esta parte es importante porque, así como ese conocimiento se usa para el bien de una persona también se puede usar para mal.*	*[That's how it is. Each community has its knowledge of managing diseases. For example, there are communities whose knowledge focuses on prayer and others whose knowledge is about plants, as is the case in our community in Puerto Golondrina. So, Hugo, what happens is that each community in the jungle has a specific knowledge, and they exchange knowledge as long as there are no conflicts between them. This part is important because this knowledge can be used for the good of a person, but it can also be used for evil.]*
Hugo Puerto *Hablando con algunas personas del hospital, me comentaban que estaban pensando contratar a un sabedor o sabedora ancestral para tratar a los pacientes Indígenas ¿Como ellos saben si el sabedor o sabedora ancestral*	*[Speaking with some people from the hospital, they told me they were thinking of hiring an ancestral medicine person to treat* Indigenous *patients. But, how do they know if the ancestral medicine person is not in*

no tiene conflicto con alguna comunidad? ¿No estarían poniendo en riesgo al paciente?	*conflict with any community? Wouldn't they be putting the patient at risk?]*
José Martínez *Precisamente. Por ejemplo, si en el hospital hubiera un sabedor o sabedora ancestral que yo sepa que no tiene buenas relaciones con mi comunidad, pues yo no voy.*	*[Precisely. For example, if there were an ancestral medicine person in the hospital who I know does not have good relations with my community, well, I would not go.]*
Elder (inland community) *Las relaciones son muy importantes en nuestras comunidades, especialmente con nuestros ancestros. Lamentablemente, hemos perdido mucho conocimiento propio de nuestras practicas ancestrales y al querer volver a ellas, se pueden cometer errores que pueden costar la tranquilidad de una comunidad. El otro día, en una de las comunidades hicieron unas ceremonias ancestrales, pero a como ellos creían que era, y eso no es así. Lo que pasa es que, si no se hace apropiadamente, los espíritus pueden afectarnos. Y ¿qué fue lo que paso? Pues que un joven se quitó la vida y ahora otros jóvenes disque necesitan salud mental, o eso es lo que dicen los médicos occidentales. Pero, eso es una enfermedad del espíritu. Para resolver eso, se necesita una ceremonia ancestral bien hecha con un sabedor que conozca como hacer esas cosas, o si no el problema persistirá.*	*[Relationships are very important in our communities, especially with our ancestors. But unfortunately, we have lost a lot of our knowledge of our ancestral practices, and by wanting to return to them, mistakes can be made that can cost the tranquility of a community. The other day, in one of the communities, they did some ancestral ceremonies, but they did it how they thought it was supposed to be, which is not how it works. What happens is that, if not done properly, the spirits can affect us. And what happened? Well, a young man took his own life, and now other young people need mental health, or that's what Western doctors say. But, that is a disease of the spirit. To solve that, a well-done ancestral ceremony with an elder who knows the ancestral ways to do those things is needed, or the problem will persist.]*
Hugo Puerto *¿Qué otros aspectos pueden afectar o complicar la salud de una persona mirándolo desde el conocimiento propio del Pira, por ejemplo?*	*[What other aspects can affect or complicate the health of a person looking at it from the Pira's knowledge, for example?]*
José Esteban *Cualquier complicación era porque… las reglas de tener frío; complican, ¿no? [es importante guiarse] Con una persona que*	*[Any complications were because… the rules of being cold; complicate things, right? [it is important to be guided] With a person who*

vive en un territorio y viven sus saberes para cuando venga todo eso. Con respecto a los lugares eso era lo que pasaba. Cada quien tenía su curador, y se sanaban. Otra persona que es especial para eso, lo hacía. Y así vivió mucho tiempo los grupos étnicos con su saber, con su territorio y gobernanza, porque así gobernaban.	*lives in a territory and lives their knowledge for when all that comes. With respect to the places, that was what happened. Everyone had their healer, and they healed. Another person who is special for that did it. And so, the ethnic groups lived with their knowledge, territory, and governance for a long time because that is how they governed.*
Pero cuando llegó la interferencia de las diferentes bonanzas, ahí fue que en Pirá empezamos también ha pasar esa situación por los caucheros en ese tiempo. Empezaron a llevar armas, las trajeron. Y mucha gente que estaban direccionados a una corrupción. Recuerdo. Entonces se hizo un rezo porque allá pusieron empleados… Así empezó a bajar un poco el personal que tenía que mantenerse en el territorio y seguir trabajando [extrayendo caucho]. Después llegaron a imponer cosas también cuando llego la iglesia católica y los protestantes; nos inventaban por ahí, que para un dolor de cabeza tenemos una pasta, que crema entonces para dolores del cuerpo. Así fue que empezó de no reconocer al [sabedor] tradicional. Como eso [las pastas] es solo tomar y ya, pues calma.	*But when the interference of the different bonanzas arrived… that's when in Pira we also began to go through this situation for the rubber tappers at that time. They began to carry weapons; they brought them. And many people were directed to corruption. I remember. So a prayer was performed because they put employees there... That's how the people who had to stay in the territory and continue working [extracting rubber] began to drop a little. Later they came to impose things when the Catholic Church and the Protestants arrived; They invented [narratives to] us out there, that for a headache we have a pill, then that cream for body aches. So they [*Indigenous *communities] began not to recognize the traditional [healer]. Since that [the pasta] is just a drink and that's it, calm down.*
Y luegó vivir en Malocas otra persona ajena a la región decir que "organicen sus comunidades. Si se organizan, el estado les da la escuela, les va a dar puesto de salud." Entonces también fue un poco difícil para la gente que vive un poco dispersa evitando que las enfermedades… que no resultaran contagiados de una vez a todos los grupos, a todas las familias, porque ellos vivían así.	*And then, living in Malocas, another person from outside the region said [to* Indigenous *Peoples] that "organize your communities. If you organize, the state will give you schools; they will give you a health post." So it was also a bit difficult for the people who lived dispersed, preventing the diseases from being infected all at once, to all the groups, to all the families, because they lived like that.*
La iglesia católica está contenta de [la función de] la familia y todo eso, pero sin saber para qué es la comunidad, para ser un sacristán. Luego, llegaron disque con promotor. Nos fueron alejando un poco de lo propio, y empezamos a distribuir la parte ajena ya que tenían tanta crema. Pero	*The Catholic Church is happy with [the function of] the family and all that, but without knowing what the community is for, to be a sacristan. Later, they arrived with [health] promoters. They kept us away a bit from our own [knowledge], and we began to distribute the other's part since they had so*

tampoco solucionaba todas las necesidades porque no había una concertación con el sistema de salud propio. *Viendo todo esto, hicimos un trabajo, con el apoyo de fundación Gaia, a organizar un poco porque, así como llevamos, estamos desconociendo y alejando un poco los saberes propios y asumir lo que no es de uno. Entonces dijimos, bueno, ahora nos toca sentarnos a que todo eso funcione. De afuera hay cosas que sirven. Y nosotros también tenemos nuestro sistema de salud. Y se hizo un acuerdo con el hospital, con la IPS. Analizando bien a fondo, el manejo de salud propio que hacíamos tradicional desde el calendario ecológico (ver imagen 5), que enfermedades hay en cada una de las épocas; en que épocas hay más enfermedades fuertes. Para ver donde tenía que… con su medicamento, la persona no necesitaba ir al hospital. Porque hay enfermedades que no se pueden controlar [con la medicina propia] tampoco, entonces con el apoyo del sistema de salud ajeno eso se podía manejar. Pero que respetaran [el sistema ajeno] los trabajos de [médicos] tradicionales. Que siempre [para los Pueblos Indígenas] se acudiera inicialmente, que ese sistema [ajeno] apoyara también a ese sistema de salud propio [Indígena].*	*much cream. But it did not solve all the needs either because there was no agreement with the health system itself.* *Seeing all this, we did some work, with the support of the Gaia Foundation, to organize a little because, as we have been, we are ignoring and distancing our knowledge a little and assuming what is not ours. So we said, well, we have to sit down and make it all work. Outside there are things that serve. And we also have our health system. And an agreement was made with the hospital with IPS. Analyzing thoroughly the [*Indigenous*] self-determined health management that we did traditionally through the ecological calendar (see image 5), what diseases are there in each of the times; in which times there are more strong diseases. To see where he had to… with their medication, the person did not need to go to the hospital. Because there are diseases that cannot be controlled [with one's own medicine] either, they could be managed with the support of the third-party health system. But they [the third party health system] must respect the work of traditional [doctors]. They [*Indigenous *Peoples] should always go initially [to the traditional doctor], and this [foreign] system should support that [*Indigenous*] self-determined health system.]*

Image 8. Ecological Calendar of the Timbo community. Courtesy of Sinergias: Strategic Alliances for Health and Social Development 2019.

Bayron *Inicialmente es importante no perder de vista que, pues el SISPI en este caso, hace parte de una agenda de reconocimiento de la diferencia cultural. Desde un tiempo para acá, hace unas décadas, el país, y otros países, porque también es como un fenómeno regional y mundial que va más allá en la historia; hay un reconocimiento de la diversidad cultural; que "somos un país multicultural, pluriétnico, la cultura como el fundamento de la nacionalidad colombiana." Y se le otorgan a esa diferencia cultural, a partir de esos reconocimientos, la posibilidad de desarrollar sus propios saberes, y obviamente ya el estado con todo su*	*[Initially, it is important not to lose sight of the fact that, in this case, the SISPI is part of an agenda to recognize the cultural difference. For some time now, a few decades ago, the country, and other countries, because it is also like a regional and global phenomenon that goes beyond history, there is a recognition of cultural diversity; that "we are a multicultural, multiethnic country; culture as the foundation of Colombian nationality." And they give that cultural difference, based on these recognitions, the possibility of developing their self-determined knowledge, and obviously, the state with all*

aparataje y con todo su pensamiento filosófico entonces llega, vamos a decir que con sus mejores intenciones ¿cierto? Porque hay un reconocimiento. [el estado dice] "Ojalá que ustedes [los Pueblos Indígenas] desarrollen su sistema educativo, de salud, de justicia, de gobierno." Todo ese pensamiento viene mediado por quienes están ahí [en el gobierno]. Las instituciones no funcionan solas, son las personas las que hacen que funcionen esas instituciones y esas personas están imbuidas en diferentes ideologías. Bueno y hay esas corrientes grandes que llamamos occidentales y que una de sus características es que es de pensamiento dicotómico; naturaleza/cultura, alma/cuerpo, como cosas separadas y demás. Otra de las características de este pensamiento es que divide; que fragmenta todo; el análisis. De ahí viene la palabra análisis, que es fragmentar. Pues algo que es un fenómeno complejo, yo lo fragmento; voy a cortar acá este pedazo. De ahí surge también la especialización del conocimiento. Entonces en un momento se especializa el conocimiento. Y ahí conecto con lo que decía José Estaban al inicio.	*its apparatus and all its philosophical thought then arrives, let's say, with its best intentions. Right? Because there is an acknowledgment. [the state says] "I hope that you [*Indigenous *Peoples] develop your education, health, justice, and government systems." All that thinking is mediated by those who are there [in the government]. Institutions do not work alone, it is the people who make those institutions and do the work, and those people are imbued with different ideologies. Well, there are those great currents that we call "western," and one of its characteristics is that it is of dichotomous thought; nature/culture, soul/body, as separate things, and so on. Another characteristic of this thought is that it divides and fragments everything; the analysis. That's where the word analysis comes from, which is to fragment. Well, something that is a complex phenomenon, I fragment it; I'm going to cut this piece here. Hence also arises the specialization of knowledge. Then in a moment, knowledge is specialized. And there, I connect with what José Estaban said at the beginning.*
Todos sabemos que, desde la tradición de los Pueblos Indígenas y otras tradiciones de pueblos en el mundo entero, es decir la totalidad, el conocimiento es uno solo. Incluso desde el conocimiento de occidente antes que se hablaba de la filosofía, cubría todo. Entonces en un momento determinado, surgió el que nos vamos a especializar y surgen las disciplinas; la antropología, la sociología, la psicología, la ciencia política, la economía, etc., para estudiar nichos específicos de la vida. Entonces cuando decía José [Esteban], "es que nosotros siempre aquí desde la tradición de los Pueblos [Indígenas], la salud funcionaba; antes de que aparecieran las misiones católicas, antes de que aparecieran los investigadores científicos, los grandes exploradores, antes	*We all know that, from the tradition of the* Indigenous *Peoples and other traditions of peoples throughout the world, that is to say, the totality, knowledge is only one. Even the "western" knowledge before, when in philosophical debates, it covered everything. So at a certain moment emerged the idea of specialization, and the disciplines emerged; anthropology, sociology, psychology, political science, economics, etc., to study specific niches in life. So when José [Esteban] said, "it is that we have always been here from the tradition of the [*Indigenous*] Peoples, health worked; before the Catholic missions appeared, before the scientific investigators appeared, the great explorers, before the rubber industry appeared and all that, well, it worked well." And it worked not because they compartmentalized it, but [because they see*

que apareciera la cauchería y todo eso, pues funcionaba bien." Y funcionaba no porque lo compartimentaban, sino como el todo; funcionaba también por eso porque era como un todo, porque no se podía hablar de que usted es de educación, usted de salud y usted de justicia, no. Hay un pensamiento global que engloba todo eso. Los tradicionales al mando de ese pensamiento.	*it] as a whole. It also worked for that reason because it was as a whole, because you couldn't talk about education, health, and justice [in fragments], no. There is a global thought that encompasses all that. The traditional ones are in command of that thought.]*
Ana Judith *Me preguntan que es el "Buen Vivir" para mí y aquí quisiera comenzar aclarando que la postura y los argumentos que voy a traer a colación, son planteados desde mi experiencia de compartir durante varios años con los Pueblos Indígenas, algunos pocos Andinos, pero en especial de Indígenas Amazónicos. Las reflexiones sobre el "Buen Vivir" que aquí expongo se derivan también de revisiones documentales realizadas con la ONG, Sinergias, con la que trabajo hace más de 10 años, y también las realizadas desde mi postgrado en estudios amazónicos con la Universidad Nacional de Colombia. Nada de esto es de mi propia autoría sino derivado de esos compartires, de esas revisiones, sobre todo de las experiencias de trabajo colaborativo con grupos étnicos de la amazonia colombiana. Entiendo el "Buen Vivir" como una filosofía de vida; como un ideal de vida de diversos Pueblos Andino-Amazónicos… es una filosofía tan fuerte y enraizada, que más de cinco siglos de colonización y aculturación forzada no han sido suficientes para minar este concepto que aún pervive en estos pueblos, incluso en aquellas comunidades que se encuentran en contextos de transición urbana y que cada vez presentan un estilo de vida más permeado por la cultura occidental y han perdido buena parte de sus costumbres y tradiciones milenarias. He visto que la noción del "Buen Vivir" no es un concepto fijo, sino que se transforma; cambia en la medida en que se asume las particularidades de cada Pueblo -*	*[They ask me what the "Buen Vivir" is for me, and here I would like to start by clarifying that the position and the arguments that I am going to bring up are raised from my experience of sharing, for several years, with the* Indigenous *Peoples, some few Andean, but especially with Amazonian* Indigenous. *The reflections on the "Buen Vivir" that I expose here are also derived from literature reviews carried out with the NGO, Sinergias, with which I have worked for more than ten years, and also those carried out since my postgraduate degree in Amazonian studies with the National University of Colombia. . None of this is of my authorship but is derived from those sharings, from those reviews, especially from the experiences of collaborative work with ethnic groups of the Colombian Amazon. I understand the "Buen Vivir" as a philosophy of life; as an ideal of life for various Andean-Amazonian peoples… it is a philosophy so strong and rooted that more than five centuries of colonization and forced acculturation have not been enough to undermine this concept that still survives in these peoples; even in those communities that they are in contexts of urban transition and that increasingly present a lifestyle more permeated by Western culture and have lost a good part of their ancient customs and traditions. I have seen that the notion of the "Buen Vivir" is not a fixed concept but rather one that transforms itself; it changes to the extent that the particularities of each People*

según el conjunto de mitos y creencias de la cosmovisión de cada Pueblo - y también según las necesidades que moldean las decisiones que se toman durante los procesos de planeación y de gestión territorial de las autoridades tradicionales durante el ejercicio de gobierno propio… Por ejemplo, en la elaboración de sus planes de vida, sus planes de manejo ambiental. Pero, que también uno nota que es un concepto que modifica de acuerdo con las necesidades e interacciones con las instituciones del estado. Cada comunidad, cada Pueblo le imprime sus particularidades a este término. Es por esto que no es un concepto estático ni fijo en el tiempo, sino que se construye; se pone en práctica y emerge nuevamente planteándose esencialmente como un modelo para la convivencia armónica y justa, por así decirlo. Pero, no solo modelo para la buena convivencia con los parientes y las personas mas allegadas, sino con la naturaleza misma, con los seres que en ella habitan – bien sean seres humanos, no-humanos, o seres espirituales con los que se relacionan, intercambien y negocian constantemente para mantener el equilibrio del territorio y el bienestar colectivo. Tengo entendido que ese concepto del "Buen Vivir" ha existido en esos Pueblos desde tiempos inmemoriales, pero emerge como asunto político para hacer contrapeso a los conceptos de desarrollo… y a las políticas de desarrollo importadas de occidente y que no resuenan con las formas de vida e ideales de vida de estos Pueblos Andinos y Amazónicos. Con relación a la importancia del territorio para un "Buen Vivir" creo que tiene todo que ver. Lo uno no tiene sentido sin lo otro. El "Buen Vivir" esta muy ligado no solo al concepto del territorio sino al del buen manejo territorial y ambiental… aquí quiero hacer una aclaración, no me refiero a la visión hegemónica sobre el territorio como un espacio geográfico delimitado o un espacio cartográfico, sino a aquella noción de	*are assumed - according to the set of myths and beliefs of the cosmovision of each People - and also according to the needs that shape the decisions that are made during the planning and managing of territorial processes in each context. During the exercise of self-government, the traditional authorities, for example, elaborate on their life and environmental management plans. But, one also notices that it ["Buen Vivir"] is a concept that changes according to the needs and interactions with state institutions. Each community, each Town prints its particularities to this term. This is why it is not a static or fixed concept in time, but it is built; it is put into practice and emerges again, essentially posing itself as a model for harmonious and fair coexistence, so to speak. But, not only a model for good coexistence with relatives and closest people, but also with nature itself, with the beings that inhabit it – whether they are human beings, non-humans, or spiritual beings with whom they relate, exchange, and constantly negotiate to maintain the balance of the territory and the collective well-being. I understand that this concept of the "Buen Vivir" has existed with [*Indigenous*] peoples since immemorial time. Still, it emerges as a political issue to counterbalance the concepts of development... and the development policies imported from the West that do not resonate with the ways of life and ideals of life of these Andean and Amazonian Peoples. In relation to the importance of the territory for a ""Buen Vivir"," I think it has everything to do with it. One is meaningless without the other. The "Buen Vivir" is closely linked not only to the concept of the territory but also to that of good territorial and environmental management. Here I want to clarify that I am not referring to the hegemonic vision of the territory as a delimited geographic space or a cartographic space but to that notion of territory in which social relations prevail; where traditions, myths, and ceremonies are*

territorio en la que prima las relaciones sociales, donde se reproducen en el día a día las tradiciones, los mitos, y las ceremonias… donde se vivencian los límites territoriales al caminarlos, al relacionarse con la gente que vive en este territorio, al cultivar, a intercambiar comida y artefactos con otros parientes o grupos. Ahí se van tejiendo relaciones y se va tejiendo territorio. Todos estos ejercicios de reciprocidad, de solidaridad e intercambio, son los elementos constitutivos también del "Buen Vivir" para nuestros colegas e interlocutores Indígenas de la Amazonia Colombiana.	*reproduced on a day-to-day basis... where territorial limits are experienced by walking them, by interacting with the people who live in this territory, by farming, by trading food and artifacts with other relatives or groups. Here, relationships are woven, and territory is woven. All these exercises of reciprocity, solidarity, and exchange are constitutive elements of the "Buen Vivir" for our* Indigenous *colleagues and interlocutors of the Colombian Amazon.]*