

A New Hope: Perspectives on Implementing the Pilot of a New Comprehensive Health Care
Model in Guainía, Colombia

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Abstract

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The 1993 health reform in Colombia structured a General System of Social Security in Health that fragmented the national health system creating the current health care crisis in this country, especially within indigenous communities living in disperse rural areas. The Ministry of Health, in collaboration with Colombian research institutions and other ministries, designed a Comprehensive Health Care Model with an approach based on the principles of ethnic and cultural diversity within primary health care. In 2016, the Ministry of Health selected the Province of Guainía to host the five-year pilot of this model to target disperse rural communities, due to its diverse population and adverse topographic, health, and economic conditions. This research explores the perspectives of key stakeholders, directly or indirectly involved in implementing this model for indigenous populations living in disperse areas in Guainía, Colombia. The two main goals of this thesis research are to describe how different stakeholders perceive the model's implementation in the local indigenous population of Guainía, and to identify to what extent this model is addressing the needs of indigenous populations living in disperse areas of this Province. In this descriptive qualitative research, 23 semi-structured interviews were conducted during July and September 2017. The term "*Interculturality*" was identified as the main overall theme. Specific sub-themes derived from *Interculturality* including

1) contextual disconnect, 2) *prior consent*, 3) “traditional” medicine, 4) transit homes, and 5)

SISPI vs MIAS. Narratives collected for this project suggested that the model is promising, but it could increase success by adjusting some of its community-based participation, methodological, and epistemological approaches.

INTRODUCTION

Implementing the Primary Health Care approach of guaranteeing universal health care access, as it states in the Alma Ata declaration of 1978, has proved to be challenging around the world (World Health Organization, 2003; Janovsky & WHO, 1988; Vaughan & Walt, 1984). In 1993, Colombia sought to implement the *Sistema General de Seguridad Social en Salud* (SGSSS, or General System of Social Security in Health) as a step forward to a universal health care system (Londoño de la Cuesta & Frenk Mora, 1997). This implementation experienced challenges that led to the current health care crisis in this country (Porras & Gorbanev, 2014), especially within indigenous communities living in disperse rural areas (Martínez-Silva et al., 2015). The diverse indigenous population in Colombia, which encompasses approximately 106 distinct groups according to the *Organización Nacional Indígena de Colombia* (ONIC, or National Indigenous Organization of Colombia), reported discrepancies delivering primary health care services to their communities. Some of these discrepancies include poor quality of health services, lack of cultural sensitivity by health practitioners, inadequate access to healthcare, long waits to schedule appointments with providers, and the absence of an institutional presence in these areas (Corte Constitucional de Colombia, 2017). Within this diverse indigenous population, there are groups on the verge of extinction as a result of the internal armed conflict in Colombia (OEA, 2018). Endangered indigenous populations also face disproportional exposure to diseases of poverty and preventable deaths which adds to the dangerous survival condition they are currently experiencing (Sinergias, 2013). These disproportional health outcomes intensify when inequity on accessing adequate health care services is part of their everyday struggle seeking health care. Another critical aspect of indigenous health in Colombia is Law 1438 which recognizes indigenous ancestral knowledge in health as an “integrated and multidisciplinary approach to

primary care” (Congreso de la Republica de Colombia, 2011). However, the indigenous perspectives and approaches are not reflected in the SGSSS and the system is not currently providing adequate primary health care access to indigenous populations (Martínez-Silva et al., 2015). In recent years, the Colombian government expedited a series of health policies to address this specific health crisis in disperse rural areas. As a result, the Ministry of Health (MOH), in collaboration with Colombian research institutions and other ministries, designed the *Modelo Integral de Atencion en Salud (MIAS*, or Comprehensive Health Care Model) with an approach based on the principles of ethnic and cultural diversity, within primary health care (Avellaneda & Banco Interamericano de Desarrollo, 2015).

In 2016, the MOH selected the Province of Guainía to host the five-year pilot to implement “*differential*”¹ MIAS, specifically for disperse rural communities, due to its diverse population and adverse topographic, health, and economic conditions. Guainía’s population reaches 41.500 inhabitants, where 82% of its population is indigenous (Avellaneda & Banco Interamericano de Desarrollo, 2015). This bio- and ethnic-diverse province is part of the Colombian Amazon Rainforest bordering north with the Province of Vichada, east with Venezuela, south with Brazil, and west with the Provinces of Vaupés and Guaviare (see figure 1), in which the main sources of transportation are fluvial and aerial (Gobernación de Guainía, 2018). The rough topographical conditions contribute to challenges delivering adequate primary health care services to all corners of Guainía. These limitations reflect the health care coverage in this province which showed only 17 percent of its population covered before implementing *differential* MIAS

¹ A set of sectoral and cross-sectoral policies and interventions that seek the recognition of social differences and, consequently, the application of measures in favor of those social groups in which those differences imply a disadvantage or situation of greater vulnerability, aimed at achieving equity in health guided by the fundamental rights of these groups (Ministerio de Salud y Protección Social de Colombia, 2018a).

according to MOH (2018b). These challenges are observed in the precarious health situation of the region by showing significant discrepancies on health indicators when compared to the general population (see table 1). Additionally, recent reports highlighted the high prevalence (see table 2) to certain neglected tropical infectious diseases (NTDs) in disperse indigenous populations that could impact growth and cognitive development (Sinergias, 2018). The MOH (2013) estimates about two thirds of the population in Guainía is at high risk to contract an NTD. This situation is also fueled by the economic disparity indigenous populations living in disperse areas are exposed to. According to the government of Guainía (2012), 75% of disperse populations live under the poverty line while 23% of those live under extreme poverty. These numbers may increase due to the current influx of displaced populations fleeing from the sociopolitical turmoil Venezuela is currently experiencing. These adversities capture the current challenge delivering primary health care to disperse areas in Guainía.



Figure 1. Province of Guainía (Source: Instituto Geográfico Agustín Codazzi de Colombia)

Description	Colombia 2011	Guainía 2011	Denominator
Infant mortality rate	12.25	32.7	1,000 life-births
Neonatal mortality rate	7.81	9.82	1,000 life-births
Malnutrition - children under 5 years of age - mortality rate	0.07	1.39	1,000 life-births
Tuberculosis mortality rate	1.85	2.57	100,000 people
Infectious diseases mortality	6.3	10.27	100,000 people

Table 1. Comparison of basic health statistics between population in Guainía and general population (ASIS Guainía 2012).

Neglected Infectious Disease	Prevalence (%)
Trachoma	23
Soil Transmitted Helminths	81-93
Pediculitis	15

Table 2. Prevalence of neglected infectious diseases in Guainía that require prompt attention (Sinergias 2018)

While this is only the second year of the model’s pilot implementation, some concerns have been raised by stakeholders regarding the level of engagement among indigenous communities living in disperse areas. This research explores the perspectives of key stakeholders whom are directly or indirectly involved in implementing *differential MIAS* for indigenous populations living in disperse areas in Guainía, Colombia. The two main goals of this thesis research are 1) to describe how different stakeholders perceive *differential MIAS*’ implementation in the local indigenous population of Guainía, and 2) to identify to what extent *differential MIAS* is addressing the needs of indigenous populations living in disperse areas in this province.

Background

The health reform of 1993 in Colombia created entities, *Entidades Promotoras de Salud* (EPS, or Health Promoting Entities), that mediate health care services between patients and *Instituciones Prestadoras de Servicios de Salud* (IPS, or Health Providing Institutions). Under this reform, the government finances the EPS by recognizing these entities for every person affiliated through them with a *Unidad de Pago por Capitación* (UPC, or Health Capitation Payment). A differential UPC, or differential health insurance premium, is paid to the EPS for people affiliated that live in disperse rural areas, which includes indigenous territories. The role of these EPS is focused on affiliating the population to the health care system, promoting prevention programs, improving demographic and health indicator data collection, assessing health risks, and contracting services for patients with IPS (Congreso de la Republica de Colombia, 1993). Since the health reform, SGSSS has been successful in increasing health care access from 23.5 percent in 1993 to 95.6 percent by the end of 2016 (Ministerio de Salud y Protección Social de Colombia, 2017). However, the increase of health care access did not translate into quality of service. Patient flow analysis by MOH (2016b) showed that most patients ends up, unnecessarily, in emergency rooms due to the lack of addressing primary health care services by EPS in a timely and quality manner. This situation escalated in rural areas, especially in disperse rural areas, where health providers find no other choice but to refer patients to major cities due to the limited services they provide. As a result, patients end up fighting against the system to obtain adequate primary health care services.

MIAS is framed as an operational system that enforces health policies to avoid patients to end up fighting against the system on seeking for adequate primary health care services (Ministerio de Salud y Protección Social de Colombia, 2016a, 2016b). As presented by MOH, MIAS seeks to

improve Colombia's current national health system by implementing 10 components (see figure 2) centered around patients. These components aim to address the following aspects:

- a. Access to comprehensive process of healthcare
- b. Better resolution addressing primary health care
- c. Guaranteeing networks for tertiary care services within local territories
- d. Authorize comprehensive health care within groups at risk or with disease
- e. Integrate collective and individual risks following patients' health improvement by EPS

This model is for the entire Colombian territory and it is divided into three areas (see figure 2): urban, rural and disperse rural areas (Ministerio de Salud y Protección Social de Colombia, 2016b). The pilot implementation in the disperse region of Guainía required a *differential* MIAS - especially designed for disperse populations - which I will refer to from now on. The *differential* MIAS is expected to reach full implementation by the end of 2021. In Guainía, considerable number of indigenous communities live in dispersed areas with challenging socio-economic conditions, and in many cases living in poverty (Gobernación de Guainía, 2012).

Part of the *Differential* MIAS in Guainia involve the construction and/or improvement of strategically positioned facilities - one hospital, four health centers, and 23 health posts - to provide adequate access to primary health care. For health centers and posts, workforce includes local community members due to their knowledge about these areas and their population. In addition, the model establishes four medical brigades a year to reach out disperse communities keep health profiles from these populations up to date. Furthermore, *differential* MIAS brings specialized health providers in different fields, such as, family medicine, obstetrics/gynecology, and pediatric services, which are absent in this region (Avellaneda & Banco Interamericano de Desarrollo, 2015). These are just a few items in the *differential* MIAS agenda that also aims to

reduce the number of unnecessary referrals to major cities. The MOH expects to implement MIAS's pilot in Guainía in five years, in which a *prior consent* with local indigenous peoples will take place for the purpose of improving the health outcomes of these communities. *Prior consent* was established by the International Labor Organization in their Agreement No.169 (1989) as a fundamental right of indigenous peoples and other ethnic groups to participate in the conversation to carry out any project or activity within their territories. Colombia ratified this agreement in the 1991 constitutional reform, later on put it into law (Corte Constitucional de Colombia, 1997), thus seeking to protect their socio-cultural and economic integrity by guaranteeing these populations the right to participate. Regarding indigenous health, *prior consent* must go through the Sub-Commission on Indigenous Health, an indigenous institution of consultative and technical authority between the national government and indigenous peoples in Colombia.

MIAS' Components

1. Health profile of population
2. Regulation of comprehensive health care routes
3. Implementation of collective and individual risk management in health
4. Territorial delimitation of the MIAS
5. Comprehensive networks of health services
6. Redefining the role of the insurer
7. Redefinition of the incentive scheme
8. Requirements and processes of the information system
9. Strengthening human resources in health
10. Strengthening research, innovation and appropriation of knowledge

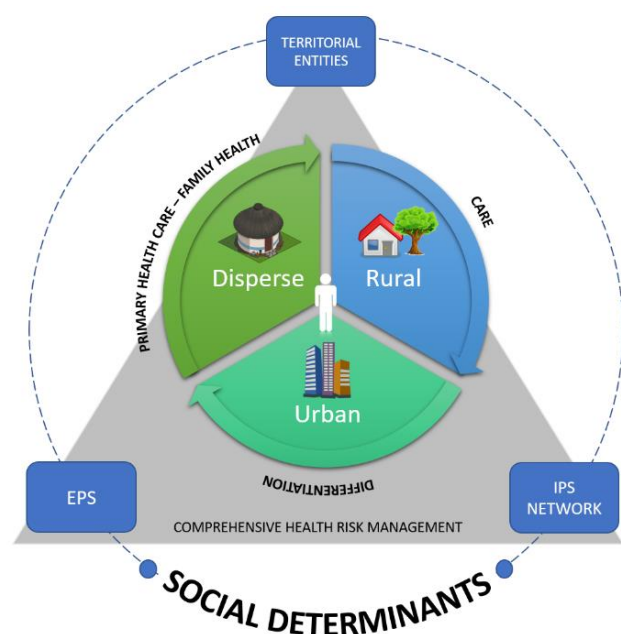


Figure 2. List of the 10 components of MIAS (Ministerio de Salud y Protección Social de Colombia, 2018)

Historically marginalized indigenous groups maintain long standing efforts to protect community-based ancestral health practices. Their constant work has highly influenced the development of health policies that paved the road to develop particular health care models. This is the case for the development of *Sistema Indígena de Salud Propia e Intercultural* (SISPI, or Indigenous Health Care System). The development of SISPI is important for indigenous populations because for the first time the state allows and protects the right to implement an indigenous health care system that aligns with their worldviews. However, lack of political will and lack of technical capacities from indigenous communities as well as institutions has not allowed their implementation (Martínez-Silva et al., 2015). Because SISPI is not a completely independent system, but a branch from SGSSS, lack of political will lays on the competition of resources and power (Martínez-Silva et al., 2015).

A major challenge on delivering health services is the limited local cultural knowledge approaching these communities by state representatives. “*Interculturality*,” a concept that represents a respectful dialogue and understanding among different cultures (Dietz, 2017; García, 2014; Salaverry, 2010; Sinergias, 2013; Zárate Pérez, 2014), is often used for reducing cultural breaches by creating spaces to inform and adapt health programs guided by indigenous populations’ cultural values (Sinergias, 2013). The Colombian government has used this term to address many aspects of their relationships with indigenous populations, however, with less clarity when discussing indigenous health (Presidencia de la República de Colombia, 2012). Under *Interculturality*, health is a fundamental right, which aligns to the reality of indigenous groups in Colombia (Martinez-Silva et al. 2015). Unfortunately, relationships between the state and indigenous people remain in tension due to the lack of cultural understanding impacting the

adequate delivery of primary health care to indigenous communities. Since 2008, after the constitutional court announced for the first time that health was a fundamental human right, constitutional action or *tutelas*² asking for access to health care increased, especially within indigenous populations (Corte Constitucional, 2017).

The MIAS initiative, led by the MOH, represents hope to people in Colombia to improve the current fragmented health system. Its implementation in Guainía shows important results in the first two years. The most recent MIAS' report (Ministerio de Salud y Protección Social de Colombia, 2018b) shows a series of health improvements in Guainia. Some of these improvements include an increase of access to health services from 17 to 79 percent, a decrease in *tutelas*, zero maternal deaths in 19 months, infrastructure strengthening, and one of the lowest rates for late perinatal and neonatal mortality in the country. Nonetheless, *differential* MIAS still have aspects that need additional attention. This project highlights some of these aspects and seek to inform the development of necessary strategies to guarantee the provision of culturally and linguistically responsive services in providing a more adequate healthcare access and services in different contexts. As a collaborative research with Sinergias Alianzas Estratégicas para la Salud y el Desarrollo Social, a Colombian NGO, we explore perspectives from key stakeholders that are currently involved with implementing *differential* MIAS in Guainía, directly or indirectly. Our aim is to see how different those perspectives are and to what extent *differential* MIAS is addressing the needs of indigenous populations living in disperse areas in this province.

² In the 1991 Colombian constitution, *tutela* is described as one of the legal mechanisms to actively protect fundamental rights.

METHODS

Study Setting

In this descriptive qualitative research, the principal investigator (PI) conducted 23 semi-structured interviews in Bogotá (Colombia's capital city), and Inirida (Guainía's capital city) (See table 1) during July and September 2017. Participants came from different sectors, such as national and local health authorities, national and local indigenous leadership, and non-governmental organizations. The PI interviewed participants after they provided informed and voluntary consent.

Sampling Strategy and Data Collection

This study used purposive sampling strategies to select research participants. Each interview ranged between 30 minutes – 2 hours long. Inclusion criteria included the position held by participants in each institution and their participation in implementing *differential* MIAS in Guainía. National health authorities from MOH who participated in the project were selected due to their direct involvement in the development of the model. Participants who represented local health authorities (local health departments, health providers, and EPS representatives) were chosen for their direct involvement applying the model in Guainía. National and local indigenous leadership representatives who participated were invited to participate on this research due to their involvement on the *prior consult* and their perspectives on how indigenous population are receiving the model. Finally, participants from non-governmental organizations (NGOs) were selected for their close work with indigenous health and their indirect involvement with *differential* MIAS in the region.

Semi-structured interviews were conducted face-to-face in Spanish by the PI. All formal interviews were recorded in digital form (mp3) and then transcribed word-for-word by the

researcher and a qualified local transcriber trained in research ethics. Transcriptions and notes taken in the field were saved in a Microsoft Word document. The data was managed and coded using the Atlas.ti software, version 8 (Corbin & Strauss, 2015). A deductive code list was created based on relevant literature. Additional codes emerged during the inductive analysis. The intercoder agreement took place with another bilingual researcher from Colombia that has worked on indigenous health for over five years. The analysis process focused on theme identification in the coding process (Bernard & Ryan, 2010). To protect participants' identity, the data was stored on a password-protected laptop, identifiers were coded, and their names were omitted in this document.

Ethical Considerations

This thesis research was approved by the Institutional Review Board of the University of Washington in Seattle, Washington. After presenting the project's process and goals to participants, the PI answered their questions and asked each participant to sign a document to provide their informed consent. Participants were asked for permission to record our conversations prior to interviews. Participating institutions and individuals expect that the findings of this project will help overcome barriers to providing adequate healthcare access for diverse population of Colombia. The interview protocol and guides were structured in Spanish by the bilingual PI. The various interactions with participants sought to explore the perspectives of different stakeholders about the implementation of MIAS as well as the role of *Interculturality* during this process.

RESULTS

A total of 23 participants took part in the interviews. These participants work for different sectors from local to national levels of leadership (See table 3). In addition, they represent individual perspectives and, therefore, do not represent any official standpoint from any institution involved in this investigation. All participants agreed that the information collected will be used as a guide to continue work towards improving of access to health services to diverse populations in Colombia.

Method	Type of Stakeholder	Description	# of Interlocutors
Semi-structured in-depth interviews	Local Indigenous Leadership (LIL)	Representatives from the local indigenous organization	3
Semi-structured in-depth interviews	National Indigenous Leadership (NIL)	Representatives from national indigenous organizations and political leaders	3
Semi-structured in-depth interviews	Non-governmental organizations (NGOs)	Representatives from NGOs and non-profit organizations	3
Semi-structured in-depth interviews	Local Health Authorities (LHA)	Representatives from the local hospital, health department, and EPS.	8
Semi-structured in-depth interviews	National Health Authorities (NHA)	Representatives from the Ministry of Health	6
Total			23

Differential MIAS offers a more inclusive and effective health system for populations living in disperse areas as described previously. During the second year of *differential* MIAS' pilot implementation in Guainía, a variety of stakeholders expressed excitement for the model's accomplishments as well as concerns on specific topics. Most of these concerns point toward *Interculturality* as a missing component implementing the model within indigenous territories.

The following sections expose narratives reflecting challenges addressing the needs of indigenous groups while implementing *differential* MIAS.

Interculturality Implementing MIAS

Contextual Disconnect

MIAS brought change to health care practices in Guainía. Some of the aspects that participants agree upon what is working with MIAS during the first two years of its implementation are: increase of specialized doctors, allocation of one EPS to the Department, synchronize EPS with IPS, and increase health care networks. However, the high expectations for MIAS to bring adequate healthcare services to disperse populations reflected some differences in how participants described the model and what it offers. Health authorities expressed their hopes in the model by asserting that the model would adapt to any context and bring adequate health services to communities living in disperse areas. One emotive quote from a health authority stated: “*MIAS is to tell people effectively... we will finally listen, and we will ensure that health is a right for all Colombian people.*” Participants from national and local indigenous leadership were optimistic but cautious as it is represented in the opinion of one participant: “*On paper, MIAS shed light to a more adequate and inclusive health system in Colombia.*” It is important to highlight that within the cultural context, when people say “on paper,” it is implying the contrast between what *differential* MIAS ideally purports to do and what is actually happening.

The phrase, “*on paper,*” arose significantly in interviews with these participants as to describing that *differential* MIAS still faces challenges in its application. All participants, in different ways, shared their concerns about sustainability and intercultural relationships implementing the model. Health authorities are conscious of the limited resources, increasing efforts to engage

different levels of government to finance the model. In the case of national and local indigenous leadership, the problem of resources goes hand-in-hand with the disconnect between the national government and the local context. According to an indigenous representative, one of the disappointing aspects of MIAS is the removal of the differential UPC:

“In Colombia, there are IPS, EPS, and indigenous EPS; we were told here [in Guainía by the government] by the EPS national call that the EPS that wins will have privileges of receiving [differential] UPC. After Coosalud [the only EPS in Guainía] won, the government saw this [EPS] was not an indigenous EPS. Therefore, they [the government] said they could not give [Coosalud] all the money [differential UPC]; the government explained to us that if they [Coosalud] were providing a diversity approach of UPC, then with that money they [Coosalud] would be contracting traditional doctors. With the current budget, it is not possible!” (LIL_1)

The differential UPC is a topic of discussion, especially at the local government level as to find resources to finance the implementation of *differential* MIAS in Guainía where the majority of the population is indigenous. A health care professional, expert in delivering primary health care to indigenous populations in Colombia, explains:

“The national government says to the local governments, ‘here are the resources for it [differential MIAS]. It comes from the health system, and there are no additional resources.’ Then, they [local governments] take all these tasks that have not been fully consulted with them, without seen their experiences and contexts, and then is when we will start seeing difficulties.” (NGO_2)

The situation about this contextual disconnect mentioned in the previous passages takes another dynamic while discussing intercultural interactions and how *differential* MIAS was presented. Participants asserted that the model came across as the implementation of SISPI in some of the local indigenous communities. Health authorities corroborated this information pointing out that indigenous people's concerns about MIAS replacing SISPI created tension implementing the model in the area. Furthermore, it seemed the limited explanation about MIAS happened at all levels as a local health provider described:

“A weakness of the model is that many people do not know the depths of [differential] MIAS. I think there was lack of more publicity, know who the actors in [differential] MIAS are. You ask people, and many people know that there is a model, but does not really know what it is [differential] MIAS; I even say that this is also the situation within operational health institutions [IPS and EPS]. I think there was a weakness not including that stage of advertising induction, [to spread] knowledge [about differential MIAS] to many people.” (LHA_2)

The concept of *Interculturality* emerged in all interviews as a key element for *differential* MIAS to adapt into different cultural contexts. Even though the concept itself is about mutual cultural respect (Dietz, 2017; García, 2014; Salaverry, 2010; Sinergias, 2013; Zárate Pérez, 2014), participants showed different perspectives on how *Interculturality* is currently applied within the model in two major aspects: during *prior consent* and integrating “traditional”³ medicine.

Prior Consent

³ According to some indigenous leaders, the categorical term of “traditional” medicine is a colonial categorization and not how most indigenous people see their ancestral healing practices

The process of *prior consent* is mandated by law (Corte Constitucional de Colombia, 1997) and did take place with indigenous leadership before the pilot of *differential MIAS* went live in Guainía according to participants. A national health authority explained that “*it [differential MIAS] was constructed with indigenous peoples’ prior consent, telling them what the model was and how they [indigenous people] were going to see it structurally.*” Even though national indigenous leadership agreed that there was a *prior consent*, they expressed concerns about a communication breakdown creating and implementing *differential MIAS*. Asking about these concerns, a participant from the national indigenous leadership responded:

“When they [the government] organized the model, knowing that there are indigenous people in this country, we were never informed! We were never informed that the Ministry [of Health] was formulating public health policy. When we were discussing with them [the government] about our public policy, SISPI, they didn’t even mention anything [about differential MIAS] to the Sub-Commission on Indigenous Health.” (NIL_1)

This narrative is further reflected in a perceived disconnect between national health authorities and the local indigenous populations of Guainía by local indigenous leadership. According to a participant from a local indigenous leadership, one of the factors in which this disconnection is visible is in how both agendas - government and indigenous people - enter into conflict when there is not a transparent communication and mutual understanding:

“They [MOH] meet there [Bogotá] with their technicians and get their figures, their statistics and no more. They [MOH] don’t explain what happened; that is the fear that the entities that manage health in this province have. There are

clashes [between the government and local indigenous groups].... because they will be right, well, we are also right.” (LIL_1)

What this participant expressed resonates with other professionals in the medical field that have worked with indigenous health. For instance, participant NGO_2 explains: *“When one sees MIAS competencies, the participation appears diffuse, [it] doesn’t demonstrate how the population participates in the generation of alternatives.”* A national health authority agrees that not having broader participation is one of the weaknesses of *differential* MIAS but that it is something MOH is addressing through local governments:

“Any public policy has the risk of presenting guidelines without the sufficient level of participation that would be wanted. Because in the times in which a policy is formulated and fulfilled the whole cycle of design, implementation, adjustment, monitoring, and evaluation, not always all the participation that one would like from a government instance is given. Although, there was the participation of organizations, of associations, professionals, academics, territorial entities, lenders, and EPSs. Surely the participation of direct citizenship that has no level of representation in organizations, or associations, did not have all the breadth that one would like. Perhaps the [absence of population’s] discussion, appropriation, is a level of primary weakness that has been settling with territorial appropriation in the implementation where the model has a general national structure but adapts to the needs of the territory.”

(NHA_6)

Similarly, a local health professional points out that there are more actors to involve in the process to apply *Interculturality* accordingly:

“The Indigenous leaders also look at [differential] MIAS from its Interculturality. As a result, I think this process needs more work that requires to sit down at the table. There was a prior consent with only a few indigenous representatives participating. However, it turns out that you go outside and find other actors that are the cabildos⁴, the governors and they have another perspective of this. We do not know what the knowledge about [differential] MIAS for indigenous institutions that live in disperse areas is. What is the correct understanding, is it the Western perspective? or the indigenous that sees [differential] MIAS different? Who has the most accurate perspective?” (LHA_3)

Traditional Medicine

Discussing *Interculturality* from a local health authority’s perspective is challenging because of their limited understanding and flexibility to integrate “traditional” medicine into *differential* MIAS. National and local leadership asserts that they know that “*MIAS is for all citizens and not only for indigenous people.*” However, indigenous leadership explain that if “*MIAS is going to work with their communities, then it must be culturally driven.*” Following-up with the previous statement, one participant from this indigenous leadership expressed that they “*are not looking to incorporate ancestral health practices for all population in Colombia but just to be included, respected and accepted, when working with indigenous people.*” Even though this is work in progress, as health authorities assert, there are challenging aspects of integrating “traditional” medicine into the SGSSS. After asked for what are those challenges, a health authority replied:

⁴ *Cabildo Indigena* is a special public entity, whose members are from indigenous populations, elected and recognized by them, with a traditional sociopolitical organization. Their function is to legally represent indigenous communities, and to enforce their local laws to carry out activities, customs and the internal regulations of each community (Gobierno de Colombia – Ministerio del Interior, 2013).

“They [indigenous people] start, ‘ha no! But they [the government] also have to pay every midwife who attends a birth and how they are going to do with the traditional doctor?’ Well, that's not our medicine. One of them [indigenous representative] says that the fact that the midwife and the traditional physician begin to collect [money for their practices], would change their culture because they would no longer have the same purpose or intentionality.” (NHA_1)

Within indigenous leadership, the discourse about monetary compensation for “traditional” doctors is a topic of great concern at different levels. This permanent conflict roots in the vague perception by SGSSS of what “traditional” doctors do and ask in return for their services. Even though there is a traditional way of paying “traditional” doctors, it is not equivalent to getting these practitioners to payroll. The complexity of this topic is illustrated by the following indigenous leadership:

“Paying for ancestral healing knowledge almost goes in contradiction to our traditions. However, that requires a special treatment within MIAS, you have to look at how it is connected because as it was projected, a traditional doctor per river basin creates a conflict of interest. Every community, every river, has its ancestral knowledge and dedicating a single person to attend a whole basin creates jealousy among other ancestral healing practitioners. The one in Morichal, for example, may say, ‘no, send the patient to be treated by the assigned ancestral healing practitioner because they are getting paid and I’m not.’ That's pretty complex [topic] in the MIAS’ implementation.” (LIL_3)

“A traditional doctor asks ‘they [patients] bring money or what they bring?’ either with Mañoco⁵, or with fish or chili, whatever. For example, at home, my dad kept Casabe⁶, or chili, because it was not compensation in money [to ancestral healing practitioners]. However, here, in the urban area it is with money [that pays for health services]. for example, a normal consultation has a short charge of \$20,000 pesos, 70 or 80 they [other “traditional” doctors] charge, then this model [differential MIAS] of health was supposed to be focused to get the EPS, or the IPS, to hire traditional doctors, the best... If the doctor doesn’t earn his salary then if I get a headache, I have no money! How do I go to the doctor? I mean, it’s more expensive to go to a traditional doctor, so that’s the fight we’re having with the ministry, but they say there’s no rule.” (LIL_1)

Charging for ancestral healing practices is perceived differently not only between health authorities and indigenous leadership but among indigenous populations. For health authorities, this practice reflects the “*influence of colonization.*” From indigenous leadership’s perspective, compensation differs depending on the context. Reciprocity is a characteristic of socialization within indigenous communities. The previous passage exemplify that the means of reciprocity varies based on the environment one lives in, asserting that money is not the only source of compensation.

Transit Homes

⁵ Mañoco is granulated yucca and it is part of some indigenous communities’ diet in Colombia.

⁶ Casabe is a flat bread made out of grounded Yucca and it is part of some indigenous communities’ diet in Colombia.

Participants keep bringing back their concerns of the lack of contextual knowledge delivering primary health care services to indigenous populations living in disperse areas. Beyond understanding the compensation aspect of “traditional” practices, participants expressed concerns about transit homes⁷ in major cities and its lack of cultural sensitivity in their facilities. A local indigenous representative explained:

“In the transit homes... well the health model, within the protocol signed by the minister, the governor [of Guainía] and us, there is a part there that acknowledging that the change of how we live in our communities to go live in Bogotá, or Villavicencio, it totally changes everything for us; our food; our environment; the weather; [changes] everything. So, it is written within the model that indigenous people will administer the transit homes, right? And that the infrastructure would be built by the Ministry of Health and the departmental administration. But that has not been fulfilled.”

This lack of culturally adequate transit homes adds another brick in a wall of challenges for differential MIAS to incorporating *Interculturality*. These challenges reflected by indigenous leadership roots on the different accounts of distress experienced by indigenous patients that stay in these places. As a participant expressed: *“we get worse when we go there because we are not feeling comfortable. That is not our environment and they don’t make any efforts to makes us feel somewhat home.”* National and local health authorities claimed to be aware of the situation and to be working on improving these transit homes. However, it is important to note that the core

⁷ Transit homes are facilities that hosts indigenous patients that are referred to major cities for medical treatments that are not offered locally.

problem emerges from the overflow in the referral system sending numerous patients to major cities, which *differential MIAS* seeks to reduce.

SISPI vs MIAS

All these challenges applying *Interculturality* in *differential MIAS* raises concerns about autonomy implementing ancestral healing practices among national and local indigenous leadership. As a result, this leadership seeks to expedite the development of SISPI. A key element of SISPI is *salud propia* (or own health) which is explained by a national indigenous representative as:

“the knowledge, the knowing, the thinking, and the feeling of each person from his own worldview. If I believe in the sun, the earth, the moon, my cycles of lives, nature, those are my beliefs and culture. That is where salud propia comes from.”

(NIL_X)

SISPI has put ancestral healing knowledge in the forefront of indigenous discourse about health care in Colombia. Health authorities recognize that there are similarities in both SISPI and MIAS, especially regarding “*collective practices, integral services and context driven.*” Many participants expressed that SISPI should play a significant role implementing *differential MIAS* on indigenous communities. However, the model seems to not consider SISPI as part of the process according to several participants. This situation creates tensions and confusion as one participant asserted:

“What happens with indigenous groups is that by their trajectory they have a clearer notion of what they want. Then, this topic of what they are working in [SISPI] is so clear that when they start to touch the theme of MIAS, they do not

see themselves in that picture. They [indigenous people] say ‘so what about our work [with SISPI]? [This] is because you [non-indigenous people] are not in our picture?’, and this generates conflict. It happens because indeed MIAS does not contemplate how to incorporate those aspects in; [for example], how community initiatives can be implemented? [how] the population can contribute to improving their health service? So, this generates a bigger problem, which is distrust towards the [health] system.” (NGO_2)

SISPI fulfill one area of significance for indigenous populations which is their ancestral knowledge of health care. Dismissing the local efforts developing SISPI creates conflict implementing *differential* MIAS as many participants described above. *Differential* MIAS and SISPI seem to overlap in many aspects, especially on considering local context and community participation. The major challenges lay on the application of what is nicely presented “on paper.”

CONCLUSIONS AND RECOMMENDATIONS

The Colombian government, through the Ministry of Health, is actively addressing challenges that have fragmented the current health system to guarantee adequate health care for all its citizens. The creation of MIAS is an example of the national government’s efforts to strengthen the current healthcare system. MIAS delineates a list of components that are necessary to comply with in order to reach the desired goal of providing adequate healthcare. However, the pilot implementation of *differential* MIAS in Guainía reflected a challenging situation around a main overall theme, *Interculturality*. Specific sub-themes derived from *Interculturality* which include 1) contextual disconnect, 2) *prior consent*, 3) “traditional” medicine, 4) transit homes, and 5)

SISPI vs MIAS. After listening to participants' accounts, questions about the communication strategies used for *differential* MIAS delivery and the incorporation of *Interculturality*, surfaced.

Narratives collected for this project suggest that MIAS is a promising model that could increase success by adjusting some of its community-based participation, methodological, and epistemological approaches. It is a challenging task to design, implement, and evaluate, national health policies, especially for a diverse population. Even though *differential* MIAS includes local communities to the conversation when it reaches local territories, community-based participation in all stages of the model will potentially benefit all actors.

A community standpoint will provide not only insight but ownership of the model from a specific community. This is critical practicing *prior consent*, for example, due to governments and institutions feel they are making great concessions while indigenous leaders and communities often feel they are not getting what they expect. This community-based participation approach could potentially improve relationships between government and local communities, especially with ethnic groups, and regain trust between all actors. As national and local indigenous leadership indicated in previous accounts, the gap in knowledge of what is happening nationally and locally need to be narrowed down. They suggest starting by integrating members of the population to the MIAS conversation at all levels.

The MOH made significant advances with MIAS by creating awareness about the diverse population that currently lives in Colombia and the importance of respectful intercultural relationships. From a methodological standpoint, however, the model struggles to identify how *Interculturality* should be applied within itself and by whom. Different accounts point out this issue, especially in the lack of clarity on how local populations participate in all phases of the model.

Epistemologically, the acceptance of local knowledge is discussed in *differential* MIAS, but it does not address with specificity how different epistemologies can coexist in a pluralistic health care system. The complexity of this situation extends when MIAS does not show a proper mechanism to integrate “traditional” medicine into the project implementation. The absence of a pluralistic medical structure creates unintended consequences compromising relationships between local communities and the state. National and local indigenous leadership vocalized this issue as a major concern for them, and they expressed urgency to expedite the implementation of SISPI. This urgency represents in different accounts their concerns on integrating “traditional” practices into the model, for instance, the limited cultural understanding of transit homes in major cities, and their autonomy over their ancestral healing practices by not taken SISPI into consideration when developing the model.

Developing health policy is not an easy task, especially if it is designed to serve diverse populations. Even though MOH latest report showed improvement in health indicators in Guainía by increasing healthcare access from 17 to 79 percent and registering zero maternal deaths in the past 19 months, these numbers do not describe quality of service and must be taken with caution due to the model was not able to deliver the four medical brigades to reach out all disperse areas as it anticipated for the second year, completing only one. *Differential* MIAS’ pilot project still has three more years. We hope that the narratives expressed in this study provide the necessary background to create collective strategies, strengthen the intercultural component of the model and guarantee adequate primary healthcare access and services in Colombia.

Recommendations

Participatory Methods

Constant consultation with local communities during the design, planning, implementation, monitoring, and evaluation, of future projects could be a perfect opportunity to see the applicability of a community-based adjustment for *differential* MIAS. As foreigners of indigenous worldviews, we should “participate in the process that facilitates the development in people of a sense of themselves as agentic [people as producers and products of their own social systems] and of having an authoritative voice” (Bishop, 1998, p. 207). Additionally, these approaches are essential to emphasize the struggle for autonomy over indigenous people’s cultural and health well-being (Smith, 2013). The system can reach a better understanding of local contexts by strengthen local knowledge and community-based research providing the necessary resources to build local capacity and sustainable practices.

Applying Interculturality

By using a community-based participatory approach, MIAS could illustrate how local communities envision a model that translates into their necessities and address issues of lack of *Interculturality*. In practice, the health system can see the benefit of investing in culturally adequate health services. This can be achieved by creating spaces to discuss *Interculturality*, historically unbalanced power dynamic, and different perceptions of health care, between the state and local populations in order to construct bridges that permit both medical approaches to coexist.

Limitations

It is important to acknowledge that this study has its limitations. There was no representation of each indigenous community from Guainía. Their presence could have offered a different perspective about MIAS, especially in disperse areas. Furthermore, MIAS is a dynamic model that constantly evolves. The narrative analysis comes from a researcher that has limited exposure to the SGSSS, MIAS, and SISPI. It is also important to note that as an instrument of this research, the PI's presence, within this context, may have influenced questions, answers, and relationships, among participants. The PI is originally from Colombia and considered in the local context as a "white" male with an education from the U.S. The PI was aware of his positionality and reflected on his role within the local power dynamic throughout the entire project. His lack of understanding of indigenous struggles represents his disconnection from local colonial history. However, he connects with these groups by humanity. The analysis of these narratives did not intend to generalize but to provide different perspectives on a situation that affects all parties involved.

Future Research

Other aspects of this study are worth mentioning and could be expanded in future academic work include: the dynamics of evangelization of indigenous communities and its impact of their health, the lack of intercultural information on systematic data collection in the Colombian Amazon Region, and the political economy of health when creating pluralistic medical systems in Colombia.

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REFERENCES

- Avellaneda, E. S., & Banco Interamericano de Desarrollo. (2015). Modelo Integral de Atención en Salud (MIAS). Vice-Ministerio de Salud y Protección Social del Ministerio de Salud y Protección Social de Colombia.
- Bernard, R. H., & Ryan, G. W. (2010). Analyzing qualitative data: Systematic approaches. *Analysis*, 8, 451.
- Bishop, R. (1998). Freeing ourselves from neo-colonial domination in research: A Maori approach to creating knowledge. *International Journal of Qualitative Studies in Education*, 11(2), 199–219.
- Congreso de la Republica de Colombia. Ley 100 (1993).
- Congreso de la Republica de Colombia. Ley 1438 (2011).
- Corbin, J., & Strauss, A. (2015). Basics of qualitative research: Techniques and procedures for developing grounded theory.

- Corte Constitucional de Colombia. Sentencia SU-039/97: Derechos Fundamentales de Comunidad Indígena (1997).
- Corte Constitucional de Colombia. Sentencia T357/17: Acción de Tutela Para la Protección de Derechos Colectivos Cuando Existe Vulneración de Derechos Fundamentales (2017).
- Dietz, G. (2017). Interculturalidad: una aproximación antropológica. *Perfiles Educativos*, 39(156), 192–207.
- García, M. E. (2014). Encounters with Interculturalidad:(Un) Learning Indigeneity and Decolonizing Knowledge in the Andes. *Indian Subjects: New Directions in the History of Indigenous Education*. Santa Fe: School for Advanced Research Press.[Links].
- Gobernación de Guainía. (2012). *Análisis de la Situación de Salud de Fronteras (Asis) Guainía (Inírida, San Felipe, La Guadalupe, Puerto Colombia y Cacahual) Guía Andina*.
- Gobernación de Guainía. (2018). Departamento. <http://www.guainia.gov.co/tema/departamento>
- Janovsky, K., & WHO, W. H. O. D. of S. of H. (1988). The challenge of implementation : district health systems for primary health care.
- Londoño de la Cuesta, J. L., & Frenk Mora, J. (1997). Pluralismo estructurado: Hacia un modelo innovador para la reforma de los sistemas de salud en América Latina, 15, 6–28.
- Martínez-Silva, P. A., Montoya-Chica, P. J., & Caicedo-Sandoval, E. B. (2015). Salud en los planes integrales de vida: aproximación a cuatro organizaciones indígenas del departamento del Vaupés. *Revista Facultad Nacional de Salud Pública*, 33(3).
- Ministerio de Salud y Protección Social de Colombia. Política de Atención Integral en Salud (2016).

Ministerio de Salud y Protección Social de Colombia. (2016b). *Presentación: Modelo Integral de Atención en Salud MIAS*. Retrieved from

<https://www.youtube.com/watch?v=G8bNa1iZ234>

Ministerio de Salud y Protección Social de Colombia. (2017). *Boletín Del Aseguramiento En Salud - Boletín No. 01 - Primer Trimestre 2017*.

Ministerio de Salud y Protección Social de Colombia. (2018a). *Glosario de términos - Enfoque Diferencial*. Retrieved from

<https://www.minsalud.gov.co/Lists/Glosario/DispForm.aspx?ID=21>

Ministerio de Salud y Protección Social de Colombia. (2018b). *Los exitosos resultados del MIAS*. Retrieved from <https://www.minsalud.gov.co/Paginas/Los-exitosos-resultados-del-MIAS.aspx>

Ministerio de Salud y Protección Social de Colombia, D. de P. y P. S. de E. T. (2013). *Plan Nacional Integral e Interprogramático Para la Prevención, el Control y la Eliminación de las Enfermedades Infecciosas Desatendidas*.

OEA. *Situación de derechos humanos de los pueblos indígenas en el contexto de los Acuerdos de Paz en Colombia*OEA - Organización de los Estados Americanos: Comisión Interamericana de Derechos Humanos (2018). Santo Domingo, Dominican Republic: OEA - Organización de los Estados Americanos: Comisión Interamericana de Derechos Humanos.

Organización Internacional del Trabajo. *Convenio No 169* (1989).

Porrás, C. A. M., & Gorbanev, L. (2014). *Literature on the Colombian Health System: An Evidence-Based View*, *15*(1), 1–12.

- Presidencia de la República de Colombia. (2012). Tejiendo el canasto de la vida. Propuesta metodológica para la construcción colectiva de los planes integrales de vida de los Pueblos Indígenas de Colombia.
- Salaverry, O. (2010). Interculturalidad en Salud, 27(1), 80–93.
- Sinergias. (2013). Propuesta para la Mejora de la Salud y Mayor Protección Contra Enfermedades Prioritarias para Mujeres, Niñas, Niños, Adolescentes y Poblaciones Excluidas en Situaciones de Vulnerabilidad en el Departamento de Vaupés. Ministerio de Salud y Protección Social y la Organización Panamericana de la Salud.
- Sinergias. (2018). *Newsletter: Neglected Tropical Infectious Diseases - Guainía Department*. Sinergias Alianzas Estratégicas para la Salud y el Desarrollo Social.
- Smith, L. T. (2013). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books Ltd.
- Vaughan, J. P., & Walt, G. (1984). Implementing primary health care: some problems of creating national programmes. *Tropical Doctor*, 14(3), 108–113.
<https://doi.org/10.1177/004947558401400304>
- WHO. (2003). *A Global Review of Primary Health Care: Emerging Messages*. Geneva: WHO: World Health Organization.
- Zárate Pérez, A. (2014). Interculturality and Decoloniality. *Tabula Rasa*, (20), 91–107.