A qualitative exploration of indigenous women’s experiences seeking obstetric care and the possibilities of intercultural medicine in Hospital San Antonio de Mitú, Vaupés

Emilia Cardenas

A thesis
submitted in partial fulfillment of the
requirements for the degree of

Masters of Public Health

University of Washington
2023

Committee:
James Pfeiffer
Pablo Montoya

Program Authorized to Offer Degree:
Department of Global Health

University of Washington

Abstract

A qualitative exploration of indigenous women's experiences seeking obstetric care and the possibilities of intercultural medicine in Hospital San Antonio de Mitú, Vaupés

Emilia Cardenas

Chair of the Supervisory Committee:
James Pfeiffer
Department of Global Health

The department of Vaupes in the Amazon region of Colombia accounts for some of the worst health indicators in the country. The majority of its population is indigenous, but the public health system available in the region is based on a decontextualized biomedical model that has been in place in Colombia since the health reform of 1993. The current health system has proved insufficient to address indigenous health realities, leading to poor access to health services, culturally incongruent hospital practices, and, ultimately, worrisome maternal-child indicators. This research focuses on understanding indigenous women's ideas and practices of obstetric health, their decision-making processes regarding seeking hospital care, and the experiences they had when they did decide to visit the hospital (Hospital San Antonio de Mitú), focusing on the main barriers they face when attempting to access health care services. A qualitative study was conducted during June to September of 2022, which included participant observation in five communities and Hospital San Antonio de Mitú, in-depth interviews with five indigenous mothers, two indigenous healers, and the hospital manager, two focus groups with indigenous parents, and one focus group with hospital providers. Two sets of themes emerged from the data: the cultural clashes between indigenous health models and the biomedical model, and the logistical barriers that indigenous women face when trying to access the hospital.

1. Introduction

Located in the Colombian Amazon, Vaupés is the department with the highest ethnic and cultural diversity in Colombia, with 81.7% of its 46,777 inhabitants belonging to one of 27 indigenous groups. Around 63% of the region's population lives in rural areas, dispersed across over 255 pluriethnic indigenous communities (Ministerio de Salud y Protección Social, 2020; DANE, 2023; Montaña et al, 2012). The jungle ecosystem and high dispersion of indigenous communities make the region a hard-to-access area, something that has historically been used as an argument for institutional neglect, absence of public health systems, and low resource allocation by the government (Sinergias, 2013). Spanish colonization, religious missionaries, bonanzas of rubber, coca leaf, animal skin and NGO projects, and incoming settlers urbanizing Mitú introduced multiple cultures into the indigenous setting (Jackson, 1991). Recent corporations seeking carbon offsets and an increasing contact with Western culture due to globalization have intensified the negotiations between cultures, marking the territory with a complex intercultural reality (Bermudez, 2023).

The history of exploitation and discrimination towards ethnic communities has led to alarming health indicators among the indigenous communities, with pregnant women and children being especially affected. As can be seen in figures 1 and 2 below, recent reports from Colombia's Health Ministry indicate that Vaupés has a perinatal mortality, under 1 infant mortality, under 5 infant mortality, and maternal mortality ratio that is 2.1, 1.9, 2.3, and 4.3 times the national average, respectively (Ministerio de Salud & Secretaria de Salud Departamental del Vaupes, 2019). Figures 3 and 4 show that Vaupés has some of the lowest percentages of hospital births and of live births that received four or more antenatal check-ups in the country (DANE, 2019). Around 56 to 66% of births in Vaupés occur in a hospital, compared to the national average of 98.28%, and only 28 to 36% of births in Vaupés are estimated to have completed 4 antenatal check ups, compared to the 84,78% national average (Ministerio de Salud y Protección Social, 2021). *Hospital San Antonio de Mitú (HSAM)* (the only hospital present in Vaupés) identified perinatal mortality as one of the top ten causes of hospitalization among indigenous patients in 2021.

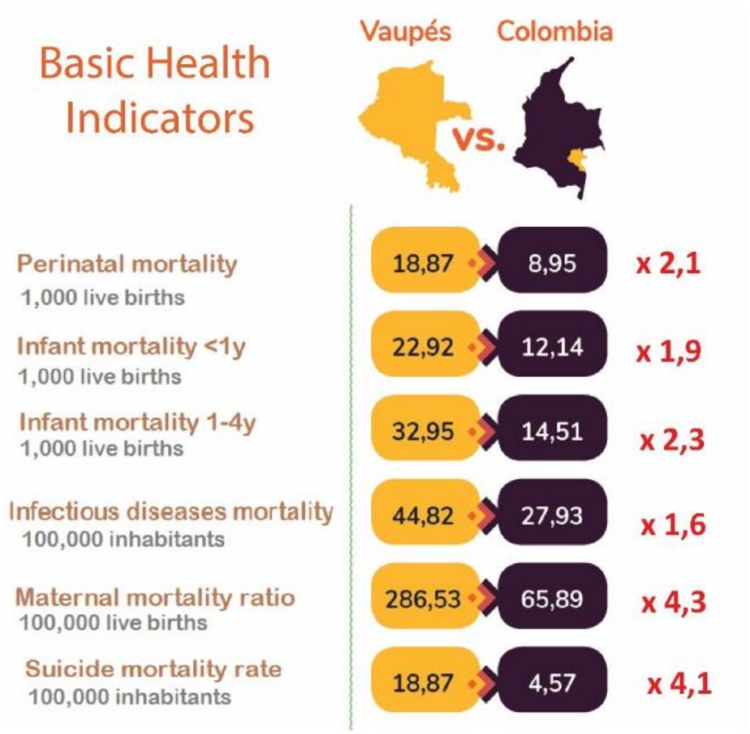

Figure 1. Basic health indicators for indigenous people in Vaupés, Colombia.
Source: Análisis de Situación de Salud (ASIS) 2019, Ministerio de Salud, Secretaria de Salud Departamental del Vaupés, and Sinergias

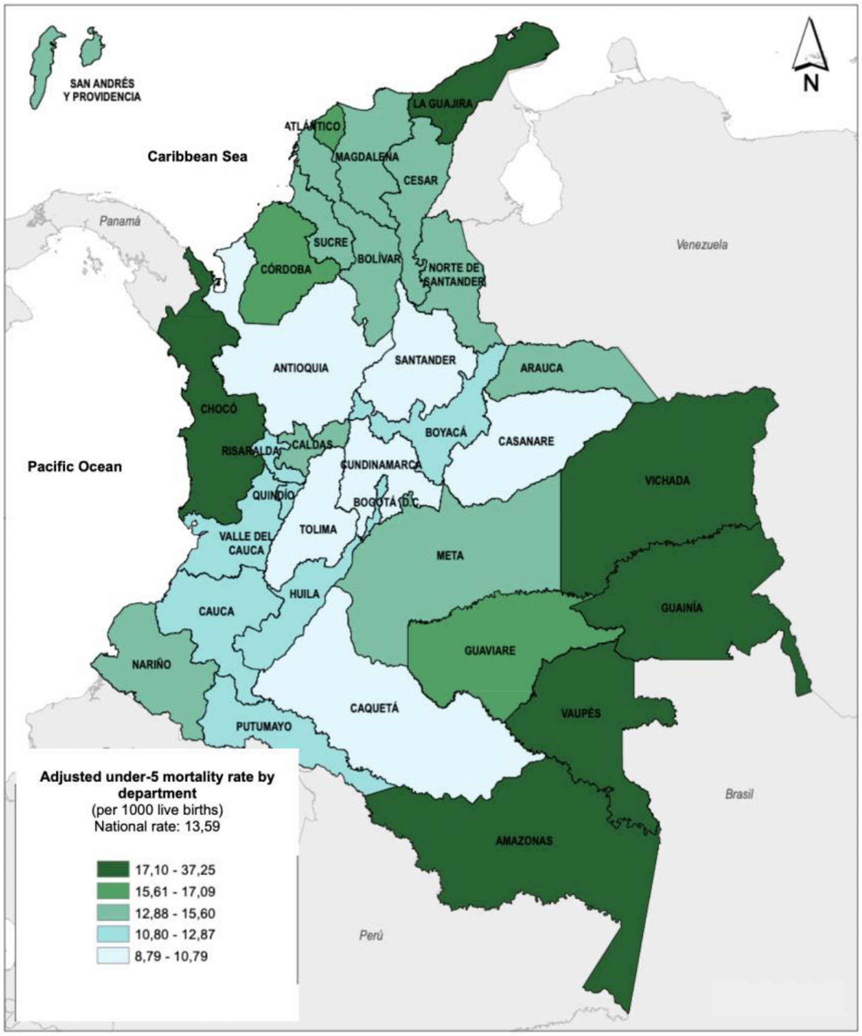

Figure 2. Under 5 mortality rate in Colombia, 2019.
Source: Indicadores básicos de salud en Colombia 2021. Ministerio de Salud.

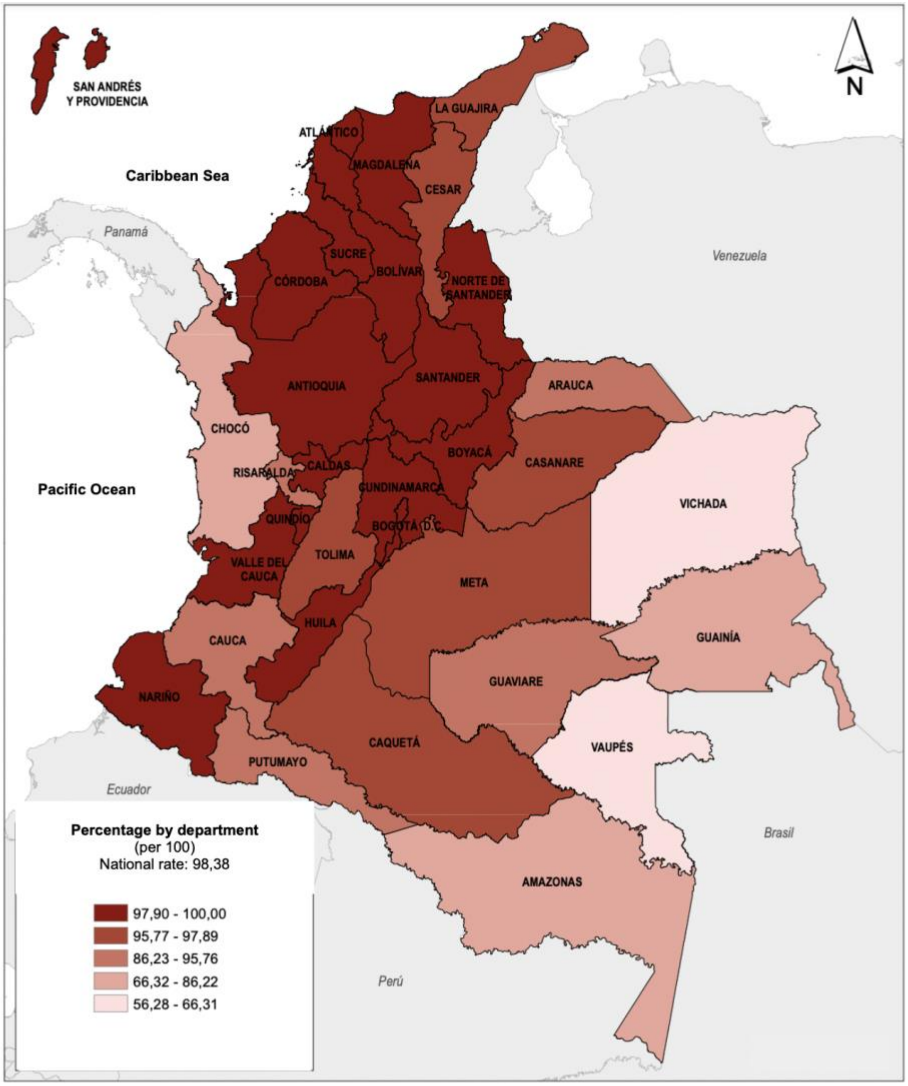

Figure 3. Percentages of hospital births in Colombia, 2019.
Source: Indicadores básicos de salud en Colombia 2021. Ministerio de Salud.

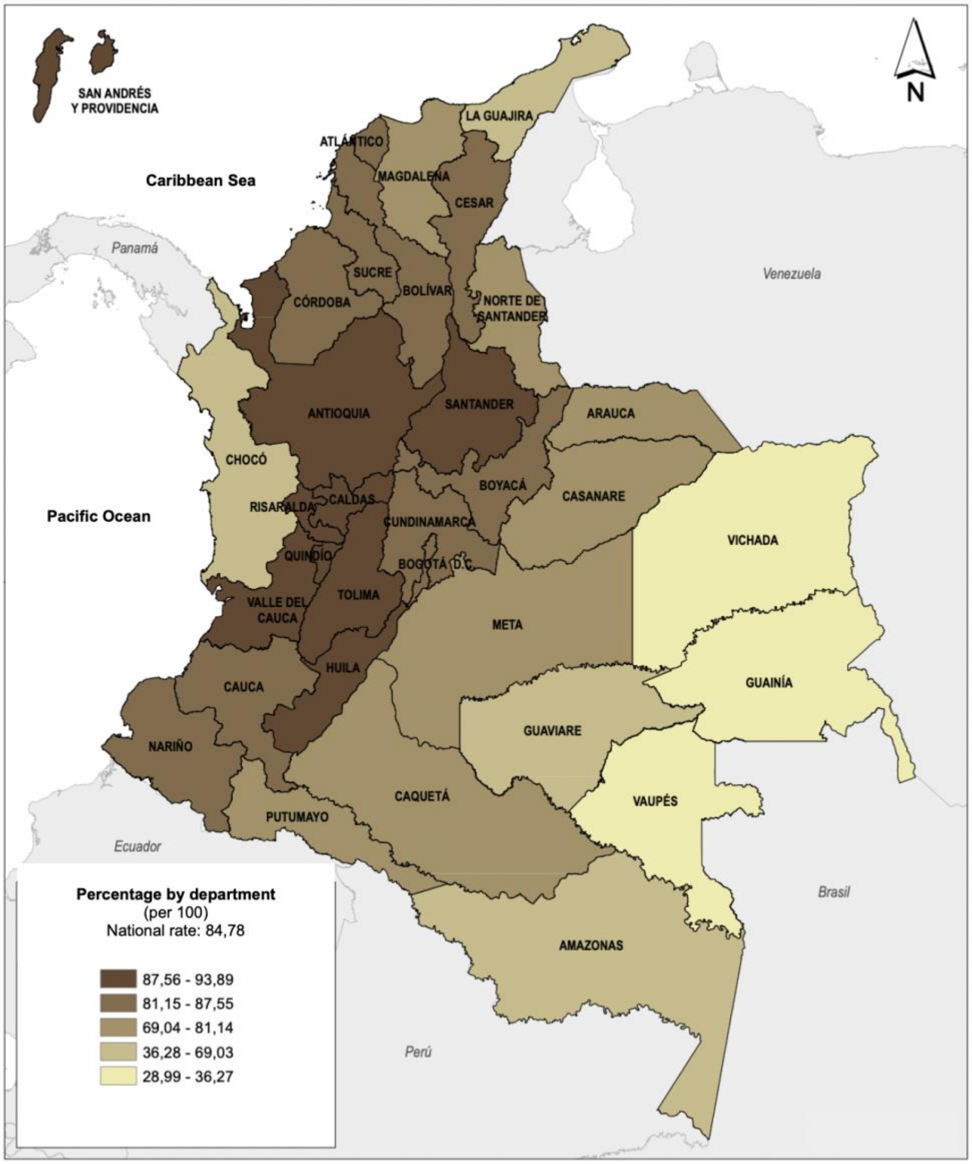

Figure 4. Percentages of live births with four or more completed antenatal check-ups in Colombia, 2019. Source: Indicadores básicos de salud en Colombia 2021. Ministerio de Salud.

In Amazonian indigenous cosmology, human and environmental health are inextricably interconnected, due to humans being part of the territory and in social relationships with all other forms of life (animals, plants, spirits, etc) (Viveiros de Castro, 2019). The interconnectedness of Amazonian life shapes indigenous experiences of health, framing health as a complex, collectively practiced responsibility through which the social order is kept (Sinergias, 2021).

Traditional healers, called *sabedores, payés*, *kumú,* among others, are some of the key figures in charge of maintaining the equilibrium of these social relationships. Most publicly recognized *sabedores* are men, but there are female *sabedoras* who do healing work in secret due to stigma and potential gender violence. *Sabedores* are selected and prepared during their youth to receive training in indigenous knowledge and healing, and their healing power (which is based on their capacity to change perspectives, interact and negotiate with other living beings, (Viveiros de Castro, 2019)) varies depending on the amount of training and years of experience. The work of *sabedores* is practiced in the form of ceremonies, indigenous prayers, and the use of medicinal plants, among others, through which they ensure the protection of individuals, families, communities, and entire territories, and health a range of health issues. For the case of obstetric health, *sabedores* conduct indigenous protective prayers and provide medicinal plant preparations (*agua rezada, carayurú,* tobacco, among others*)* to the mother, family, newborn, and surrounding elements and spaces, thus ensuring that the newborn will do no harm to others and will be welcomed safely into the territory. Each ethnic group has its own set of knowledges, laws, and healing traditions, so *sabedores*' knowledge and work is usually local and not fully translatable to all indigenous groups in Vaupés (Sinergias, 2022).

Biomedical care does not align with this holistic vision of health. Instead, it approaches the pregnant body as a biological pathology in need of pharmacological interventions (Shaw, 2012), a reproductive machine controlled by medical specialists (Davis-Floyd 1990; Rothman 1993; Oakley 1980) and as a biological object separated from the mind (Davis-Floyd, 2011), among others. Pregnant women in this framework often experience the medicalization, fragmentation, depersonalization, and pathologization of their bodies, alongside an abusive use of unnecessary interventions (Torres et al. (2008), and increasing obstetric violence (Vallana, 2019).

The current health system of Colombia, established with the health reform of 1993, has not proven successful at addressing the indigenous reality. The *Sistema General de Seguridad Social en Salud* attempted to guarantee free universal healthcare for the country by having most health service provision privatized, the government subsidizing the enrollment of all citizens in a basic health insurance program, and those who can afford it enrolling in higher quality health insurance. However, this ended up as a messy, fragmented health system that could not keep up with all patients (especially in peripheral regions that already lacked stable health systems), could not ensure quality services for everybody, was based on a westernized biomedical, urban model, and disregarded the periphery's cultural diversity, including its needs and assets. The reform triggered a health care crisis that continues today in indigenous communities living in dispersed rural areas (Martínez-Silva et al., 2015), who experienced scarce, poor quality, culturally inappropriate (Puerto, 2018), and hard-to-reach health services with long waiting times (Corte Constitucional de Colombia, 2017).

A different model did exist in the 1980s. The *Servicio Seccional de Salud* (SSS), a Colombian primary health care system that was present at the time, operated a regional intercultural model in Vaupés that was designed as part of an agreement between the Colombian and Dutch governments (Convenio Colombo-Holandés). The model was led by the anthropologist Juan Guevara and inspired by the principles of Alma Ata and the Participatory Action Research methodology of sociologist Orlando Fals Borda (Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés, 1985). The model focused on the particularities of the region, acknowledged indigenous people as key actors, conducted extensive participatory research to understand the cultural and medical realities of the communities, and collectively designed and implemented public health agendas with an intercultural team, incorporating both indigenous and biomedical assistance into health brigades and hospital work (Guevara 1984; 2003). The model was supported by national, departmental, and indigenous authorities, and most of the interviewed indigenous people and health workers that experienced the model said it was a successful approach to the region's health issues. The concept of interculturality was a pillar of this health model, representing mutual and respectful understanding and dialogue between cultures (Dietz, 2017), indigenous voices that guided the creation and adaptation of health programs based on local cultural values (Sinergias, 2013), and a framework under which a notion of health aligned to indigenous realities was seen as a human right (Martinez-Silva et al., 2015).

Primary health care worldwide faced multiple challenges due to the lack of political and resource commitment from governments, global resistance to socialist ideals, increasing push for neoliberal policies, and debt and structural adjustment programs that limited its funding (Farmer et al, 2013). François Correa suggests that the SSS efforts in Colombia were restricted by poor infrastructure, lack of resources, difficulty of training staff, challenges of covering geographically distant and dispersed areas, and lack of sufficient knowledge about sociocultural manifestations of indigenous communities (Correa, 1987). The SSS were dissolved in the early 2000s, after a government-level decision to re-assign the SSS's tasks to hospitals and Health Secretariats, which is the current health system.

The interest in documenting indigenous cultural understandings and experiences of health has been limited with the new health model, although there have been some efforts from the Health Secretariat in recent years, as well as by multisectorial actors involved in the current development of the SISPI (Indigenous Intercultural Health System) (SSMPC & Ministerio de Salud y Protección Social, 2016). Continuous lack of documentation of indigenous realities has hindered possibilities of returning to intercultural health actions that are more relevant and respectful of the indigenous context. This research thus builds on the SSS's efforts and focuses on exploring indigenous women's obstetric experiences, and their relationship with HSAM in Vaupés, and their perceptions of biomedical care and access to that care. Understanding these experiences can shed light on the structures that are shaping indigenous reproductive health challenges and access to services, which can help guide development of more culturally congruent health services and systems.

The following is a qualitative study of indigenous women's obstetric experiences and their relationship with Hospital San Antonio de Mitú in Vaupés. The research focused on understanding the women's ideas and practices of obstetric health, their decision-making processes regarding seeking hospital care, and the experiences they had when they did decide to visit the hospital, focusing on the main barriers they face when attempting to access health care services.

Although this research is informed by previous public health work with indigenous communities in Vaupés conducted by the NGO Sinergias, the vast majority of data presented here comes from fieldwork conducted from June to September of 2022.

2. Methodology

This research is part of a collaborative, intercultural, interdisciplinary effort to improve obstetric health and hospital services for indigenous people in Vaupés. Besides the Sinergias team, two key contributors of this research are Rosa Gonzalez, an indigenous leader and mother who has collaborated with the hospital and Sinergias for several years and is an avid advocate of intercultural health and indigenous rights in Vaupés, and Felix Moreno, an indigenous nurse trained in the biomedical system, son of a traditional healer, who has experience both with the NGO and with the hospital. They both helped conduct interviews and focus groups, offered ample descriptions of indigenous understandings and practices of obstetric processes, and participated in reviewing, editing, and validating the themes that emerged during the data analysis.

The data collection included the following methods:

Part*icipant observation: The author and team engaged in participant-observation* in five indigenous communities surrounding Mitú. She accompanied three workshops on women's health organized by Sinergias with indigenous women from each community, and a workshop on women's health and rights organized independently by an indigenous association in their community. She accompanied and assisted indigenous mothers throughout their journey from their community to the hospital, and participated in the daily work of the Sinergias team in the community.

Individual In-depth interviews: The author conducted IDIs in Spanish with five indigenous mothers in their community to learn about their individual experiences with birth and with accessing hospital obstetric care. She interviewed two traditional healers to learn about their views and approaches to indigenous health and epistemologies, and their view toward the biomedical system. One interview with the hospital manager was conducted to assess their perspective on serving indigenous patients.

Focus Group Discussions: Two focus groups in two communities (one with three mothers, one with around twelve male and female parents) were also conducted to learn about community perspectives on hospital services. Several less formal conversations with indigenous mothers about their experience accessing hospital care also took place while they waited at the hospital for antenatal or postpartum appointments. Finally, one focus group with two hospital providers of obstetric care who have worked in the hospital for over a decade were conducted in the hospital to learn about hospital workers' experiences working with indigenous patients. The interviews and focus groups were mainly led by the bilingual PI and an indigenous co-researcher.

Sampling

Communities: The communities in which participant observation was conducted were chosen due to their road and river accessibility and due to their previous familiarity with the research team, with whom they have collaborated on previous public health projects and have a trusting relationship with. They also have different ethnic and religious compositions, and they have different routes and distances to the hospital in Mitú, representing a wider diversity of experiences.

FGDs and IDIs: The individual interview and focus group participants were chosen based on purposive recruitment when the research team visited the communities. These visits were done while Sinergias was undertaking previously arranged women's health workshops with the women from three communities, and while an indigenous association undertook a different workshop in a different community with its female members. Two women were recruited for interviews from 3 different communities to ensure community coverage. Snowball sampling was used to recruit traditional healers to ensure trust and rapport for the interviews. During one of these visits, women interviewees referenced the research team to a traditional healer for an interview, the other traditional healer interviewed was the father of an indigenous member of the research team, chosen due to his knowledge of the topics at hand and his availability, considering that there were few healers accessible. The conversations with indigenous mothers at the hospital took place while they waited for antenatal or postpartum appointments, since this allowed us to talk to women from diverse communities, and guaranteed that our sample was indeed experiencing hospital care. All participating women were indigenous, over 18 (legal age in Colombia), pregnant or with children under 5, meaning that they had obstetric experience. The hospital actors that participated were chosen based on snowball sampling to ensure trust and frank responses. They all have over 10 years of experience working in Vaupés with indigenous women in obstetric health.

The project was approved by the Institutional Review Board of the University of Washington in Seattle, the Hospital San Antonio de Mitú, indigenous authorities, and indigenous women of the communities that participated, these last three being the ones who sought assistance to study the obstetric experiences of indigenous women trying to access hospital care.

Audio recordings were gathered with previous consent, as well as extensive field notes and visual data in the form of drawings and posters done during community workshops and gatherings. This data was then transcribed and then inductively analyzed using Thematic Content Analysis approaches to identify key themes (Vaismoradi, et al. 2013). The transcripts were coded by the PI with Dedoose, Microsoft Word and Google Drive, depending on what was available at different times with the low connectivity of Vaupés. Constant conversation with the Sinergias team (which includes indigenous members) were held during this process to discuss, validate and adjust the themes that emerged in the coding.

The outcomes of this research include the current paper, the collaborative development of an intercultural annex for HSAM's maternal-child clinical guidelines, and advocacy and educational products in multiple formats for the hospital, Sinergias, and the indigenous communities to use, among others.

3. Results

Two sets of themes describing indigenous women's obstetric experiences were identified in this research: the cultural clashes between indigenous health models and the biomedical model, and the logistical barriers indigenous women face when trying to access the hospital. Each theme has a set of subpoints. The themes presented offer a picture of some of the consequences of the current inefficient health system and history of structural violence in Vaupés.

Clashes between indigenous health models and the biomedical model

Health as a product of equilibrium

According to the indigenous healers interviewed, healthy inhabitants come from having a healthy territory, which is achieved via sustainable and respectful relationships with all living beings. The *Ley de Origen* is the set of foundational guidelines that explains the history and social norms that each indigenous ethnic group in Vaupés needs to follow in order to sustain these relationships, keep the cosmos's equilibrium, and thus protect and reproduce life. Wellbeing, including obstetric health, is largely dependent on how much the *Ley de origen* is followed. A significant part of indigenous health experiences is also directed by the indigenous ecological calendar, which marks the passing of seasons and the corresponding events that will take place (such as droughts, foods in season, animals in mating season, and diseases). The calendar also indicates the practices that indigenous people should do accordingly in order to preserve the equilibrium during each season (such as behavioral restrictions called *dietas*, ceremonies, prayers conducted by a *sabedor*, or taking preventative medicinal plants). The indigenous women and healers interviewed explained that abnormal health issues (such as a lengthy labor, extensive bleeding, a breech position, or a newborn with a disability) are often associated with a disrupted equilibrium of the cosmos, usually caused by an inadequate social interaction between beings. Health risks are tied to how closely a family follows the *Ley de origen* rules, which for the case of obstetric care include sexual abstinence the first months postpartum, dietary restrictions during pregnancy, avoiding prohibited actions in spaces that are considered sacred according to the *Ley de origen*, receiving the protective indigenous prayers, and avoiding social conflict that could conclude with someone sending evil sorcery to a pregnant woman, among others.

> *The elder gives recommendations and you have to follow. My child was sick all the time and I sent him to get an indigenous prayer and then after a month he was still sick, so the elder told me 'you must not eat this fresh yacaré (an animal), you are the one harming the child, stop breastfeeding and give him food' and then he did a prayer and the child got better (indigenous mother during interview)*
>
> *When she doesn't manage to receive the prayer she (the newborn) gets diarrhea if she eats fish, gets diarrhea if she eats wings, gets diarrhea because she eats big fish (indigenous mother during interview)*

Health as a collective practice

Indigenous thought also frames health as a collective practice that involves many actors. The indigenous healers interviewed and the focus groups and interviews with indigenous parents reported that for the case of pregnancy and birth, both the mother and father need to follow the *Ley de origen* guidelines to ensure a healthy obstetric process, accompanied by key health figures such as the *sabedor* or *payé* (who provides protective prayers and conducts healing) or the woman's mother or mother in-law (who can guide the woman throughout her pregnancy and has knowledge about medicinal plants for reproductive and family health). Indigenous women and healers interviewed also explained that non-human actors are also involved, often times being the main sources of obstetric risk (ranging from animals that could attack a pregnant woman or newborn in the *chagra* (crops), animals that could make the newborn sick if eaten when prohibited, to non-human beings that can cause a breech position or swap a newborn's body or soul at birth), but also being sources of health (such as the key role of food for indigenous health). Depending on the community, Western religious beliefs introduced through missionary presence also shape an indigenous women's understanding of risk and health.

> *Yes, c-section. The baby was sitting. But I don't know, it's strange because at the beginning I had her..how do you call that, she was in a good position and then she turned around, I don't know what happened. Well the payé said that maybe somebody sent her harm, you know that…it is always like that (indigenous women during interview commenting on the causes of her obstetric complications)*

Timeline and scope of obstetric processes are lengthy

On another note, the consequences of not following the *Ley de origen* can be immediate or can take place many years later, meaning that obstetric health from an indigenous perspective encompasses a much longer stage of life than it does in the biomedical perspective. Menstruation, for example, is a key moment in which several rules must be followed, and behavior during this time shapes the pregnancy and birth outcomes of the woman years later.

> *-Did you do the preventions with your first menstruation?*
> *-Yes, well..It is always demanding, you must be very careful, do a lot of diets, they did leave me 5 days in punishment haha, to be honest I was afraid. There was no light in the community at that time. In a separate room. Since your mom is caring for you during your menstruation sometimes she leaves you alone to go to the chagra and you have to wait until she comes back. Well, they tell you 'if you step on this this will happen, if you step on that that will happen. Maybe those preventions we had, those diets, well thank God I..I have always been a healthy woman (indigenous woman during focus group talking about the extensive care practices during her first menstruation).*

During the interviews, indigenous healers stated that pregnancy and birth are powerful life events with higher potential to destabilize this equilibrium and thus higher risk of triggering health complications. Caring for obstetric processes includes medicinal plants and prayers to the family, the spaces, and the elements involved in birth and postpartum, such as the place where the birth will occur, the river where the newborn's first bath will be, the mother's breast milk, and any food the newborn is fed. The healers explained that through these prayers, the *sabedor* introduces the newborn to the territory and mediates a mutual acknowledgment ritual between the place and person, ensuring that neither will harm the other.

Health responses in indigenous contexts thus involve more than treating the immediate symptoms in the body, participant observation showed that obstetric care included following several preventative practices throughout the person's life cycle (including following the *Ley de origen* rules, and having the *payé* perform the corresponding individual, family, and community protective rituals in each stage of life), and when there are issues, examining and addressing where the disruption happened (via a traditional healer mediating with non-human beings and having the patient change their behavior).

Biomedical violations of indigenous norms

There are specific elements within biomedical care that women in the focus groups mentioned are direct violations of indigenous norms. People who are menstruating are understood to cause harm to those that receive their care or food, men are not allowed to see indigenous women during birth, the hospital happens to be in a sacred place for indigenous people and so giving birth (or any healing act) is actually a prohibited action for indigenous people, and the food provided by the hospital often includes foods that pregnant women and their partners should not be consuming according to their *Ley de origen*. The interviewed women also stated that the short time of clinical encounters prevents trusting relationships to be formed between patients and providers (in contrast to the close relationship that indigenous people have with their *payés*), and the lack of indigenous staff in the hospital and communication with indigenous leaders prevents patients from feeling represented and safe in the hospital.

> *Woman 1: but over there (in the hospital) that, menstruation, anything, that is harmful. For example they don't do preventions when their menstruation comes, in contrast us as indigenous…*
> *Woman 2: For example I, before, one knows when the menstruation is coming (...) so I take out a glass of water when there is a cold going around, I have my father do the prayers, I send to sweeten, as we say, the body, and so I give (medicinal plant beverage prayed upon by the payé) it to my children, I drink because I am the one that prepares their food, and so when the children are sick I don't fear, I prepare that and I send them to get prayed and I leave it there. (conversation between two indigenous mothers during focus group)*

The illnesses experiences of indigenous people are not being addressed in their entirety at the hospital, because the rest of the system in which an illness is embedded is being neglected in biomedical care. The reductionist and siloed approach of biomedicine leaves many patients feeling dissatisfied and uncomprehended by the public health system, particularly when other indigenous approaches to health that could complete the gaps are unavailable or rejected by the medical providers.

Characteristics of an indigenous birth can't take place in a hospital

During the focus groups and interviews, indigenous women explained they usually give birth either by themselves or with a female relative (men are not allowed to be present at birth), in their own homes or in the *chagra*, via vertical births assisted by massages (*sobos*), a hanging hammock, medicinal plants and preparations (such as the prayed water -*agua rezada*- to accelerate and protect birth, tobacco, and *carayurú* for protection), and with branches or knives to cut the umbilical cord. A *payé* is present before and after to perform protective rituals for the family, the newborn, and the community that the newborn is now entering.

Through the interviews and focus groups, indigenous women that had given birth in the hospital reported that they remained in an operating room, had a horizontal birth, had multiple health workers present, were assisted by people that they do not know, and received pharmacological interventions. Although several of the elements of indigenous birth could be implemented at the hospital, indigenous women and health workers interviewed reported that most health workers don’t allow their use nor the presence of a *payé* because they are not part of the clinical protocol. Some hospital workers do allow a *payé* to enter the room before and after birth, and some workers have recognized that the *payé* has been a key figure to help discuss and facilitate certain emergency procedures such as c-sections, that might be life-saving but that the indigenous patient might be fearful about. Nonetheless, there is not a *payé* among the hospital team, the health workers interviewed recognized that they are not aware of the *payés* that live in the region, and they explained that it is not always easy to find an available *payé* in Mitú to accompany a patient. The indigenous healers interviewed pointed out that the wide diversity of ethnic groups also means that there is considerable diversity in indigenous healing practices (especially for key stages of life such as birth), so several *payés* who come from different ethnic traditions and are versed in different prayers and knowledges would be needed to cover the needs of all patients’ ethnic backgrounds. Other accessibility issues pointed out by women and hospital leadership include the increasing monetization of indigenous health practices leading to *payés* now charging fees for their service, the lower numbers of available *payés* due to less knowledge transmission, old age, and alcohol abuse, and the lower availability of key resources needed for indigenous healing (such as medicinal plants) due to environmental and knowledge loss.

Ignorance and poor treatment of hospital workers

Some health workers ask indigenous patients during obstetric clinical encounters which indigenous health practices they are doing. Depending on how these questions are phrased and how the health worker reacts to the patient’s answers, indigenous women recognized this interaction as a symbol of respect towards their cultural practices and a way to give indigenous health cosmologies a space in biomedical care, while others experienced it as an aggression or discrimination. For example, some providers infantilize the indigenous patient, scold them for doing their traditional practices, or make derogatory comments to others about indigenous patients’ motherhood practices.

> *Well there are some that are like..how would I tell you…like very rude, I have seen. (...)Well the time that I was hospitalized a young woman from over there, from (far away community). “Oh well*

> *give her breast" (said the hospital provider). Well they are supposed to be the guides, they could have told her "look her mother, breastfeed your newborn like this so the baby can feed", but she was all rude with the girl and I didn't like that..that service (indigenous mother during interview talking about stories she has seen in the hospital)*

Conversations and focus groups with hospital workers revealed that most of the staff is not well informed about the realities of the indigenous groups of the region. When asked about indigenous patients' living conditions, health needs, health cosmologies, practices, and the overall demographic composition of Vaupés, the vast majority responded that they did not know much. According to interviews with hospital leadership, hospital workers who have been working there for longer, and the Sinergias team, this lack of awareness is due to the high rotation of staff (associated with poor working conditions), which prevents workers from truly getting to know the region. Most of the younger hospital workers pointed out a lack of intercultural training (such as insufficient cultural and structural competency education), among others.

Indigenous women also highlighted instances of racism, pointing out that white patients are often given priority treatment (are treated more politely and are called on first by the provider), and that many providers seem to do negligent work when caring for indigenous patients unless the patient has contacts in the hospital.

> *Well sometimes white people come in (to the hospital waiting rooms), they talk more than us, and well yes, they get called on by the staff faster..not to be the one saying it but it is true. We sit there with our baby, crying and sometimes the baby even vomits there and the hospital workers don't pay attention to you. Only when the baby is seriously sick then they do let you in (indigenous mother during focus group)*

Logistical barriers to access hospital services

Traveling and staying in Mitú is challenging

The barrier that was most mentioned among indigenous women, and confirmed through participant observation, was the burden of traveling to the hospital from a community. Patients often travel several hours or days through dangerous roads, rivers, jungle paths, or air travel. These paths often have bad conditions, are exposed to animals, armed groups, and dangerous weather, and the means of transportation are usually scarce, expensive, and do not meet safety criteria, all of which is especially risky for pregnant women or mothers with young children.

The cost of staying in Mitú in order to receive hospital care is another barrier mentioned by the women and seen through participant observation. Indigenous communities don't rely on monetary economies and so do not usually have much money available, but patients and their companions do need it to pay for food, clothing, co-pay of medicine, and a place to stay in Mitú, since the long waiting times at the hospital usually require them to stay for days, weeks, or months in the town.

> *Yeah well they (other indigenous mothers) say 'no we don't have money to take the baby to the hospital'...'no, well the thing is that you must be patient' I tell them, 'so they call on you, give you medicine' (indigenous mother during interview explaining why other mothers don't go to the hospital)*

Interviews and focus groups with indigenous women and Sinergias indicated that patient housing offered by the public health services is limited, provides low quality living conditions, has presented cases of sexual and domestic abuse or kidnapping, is not accessible to everybody (depending on your health insurance affiliation you can access some of the housing but not all), does not always have space or accepts patients' families, and is mostly based on Western culture (Western food, beds instead of hammocks, unavailability of indigenous healers or relatives present to accompany the patients). Conversations with Sinergias pointed out that this leads to women seeking additional resources in the town, exposing themselves to risky activities such as sex work, and the precarious living conditions, isolation, and racism indigenous women face while in Mitú also contributes to psychological deterioration. Finally, leaving the community for long periods of time in order to receive hospital care also implies leaving children at home, leaving partners, and leaving crops unattended. Families often fall apart during this time, and children left alone often experience challenging situations (including abuse and lack of consistent food).

> *Woman 1: Well there is another problem now with the food, during birth and with the companion, I see all that as being very complicated because…when my nephew was born (sister of interviewed mother) got a c-section, I don't know how they did the c-section, her wound opened, it got a lot of pus, I had to go there, I spent a week without food. They didn't give me food, as I have said, so I…I find my ways, sometimes I get up and find food, so that is how I maintained myself, they (hospital) didn't let me in..*
> *Woman 2: and nobody gifts you anything, not like 'hey since you are sick come and I will give you.."*

> *Woman 1: "you don't have family over there? Go, I don't know, go eat at your family's place", that is what they (hospital) tell you. But in the town that is very complicated, everything is bought (conversation between two indigenous mothers during focus group)*

The mentioned barriers are associated with social determinants of health, and the hospital leadership interviewed claims that most of these issues are not medical care and thus are not within their scope. Other institutions are held accountable, such as the *Entidades Promotoras de Salud (EPS)*, in charge of organizing and guaranteeing the provision of health services to Colombians, or the Health Secretariats, but there is little response from most public health actors about this.

Long waiting times and schedules

The long waiting times were also pointed out as a barrier that limits patients' abilities to complete biomedical therapeutic processes, as well as a significant burden that discouraged many from seeking hospital care.

> *Well ever since I had my kids, when I have an appointment I do go to the hospital, but when they are sick no. Why? Because when you take a sick kid, you have to be sitting there in the waiting room. Wait and wait while the baby is coughing, with a fever, you go and ask in the window, you register him. Well you have to wait three hours..you get tired, and coming from the community all the way to the hospital you suffer a lot.. (indigenous mother during interview)*

Another barrier identified is the lack of flexibility of the health system. There are very few appointment slots available for pregnant women or mothers with newborns to receive obstetric care (antenatal care or other check-ups) and a lot of rigidity in hospital's schedules and requirements. Many women miss their appointment time due to how difficult the journey to the hospital is, due to losing their paperwork, or not knowing how to read the written information they were given in previous appointments about the dates and requirements for the next appointment. Although the hospital's rigidity is partly due to lacking resources and staff and attempts to meet safety and legal criteria, there is also a lack of recognition of the challenges patients face when attempting to reach the hospital, and a lack of willingness to adapt what can be adapted in order to make hospital care more realistic for patients' contexts.

> *Recommendations for the hospital…well to make their services more effective because sometimes they make you come back more than two, three times, you go to your appointment as normal, they see you, but it doesn't end up in one appointment, they don't discard it all, they schedule you more than two new appointments, and you live in the community so you have to go and come back..and the time… (indigenous mother during focus group)*

Lack of information and outreach efforts

On another note, most patients believe that they have to physically go to the hospital in order to request an appointment (which discourages them from trying or makes it extremely difficult for those who do try). The other options that exist for scheduling appointments (such as by phone) are not available in the communities due to lack of phone and internet connectivity and lack of information. Many women highlighted the usefulness of the health brigades that the previous *Servicio Seccional de Salud* model offered, and highlighted that although hospital brigades still occur, they no longer articulate with indigenous health actors nor develop relationships with the communities in the ways that they used to, among other changes.

> *I took her to pediatrics, because of that thing she got sick with diarrhea, it was then that I took her to pediatrics, when the brigade came. I never missed one of those, I really like to take her so they check how my daughter is doing, her growth process. And they give her vitamins there.. (indigenous mother during focus group talking about the hospital health brigades to the communities)*

Accessing information needed to guarantee healthy obstetric processes was another barrier expressed by interviewed women. Although they pointed out they have their own local resources through which to have a healthy pregnancy and identify and respond to obstetric complications, they also recognized that some of this knowledge has been lost or is inaccessible to those living in closer contact to Mitú (Western culture). They also pointed out that although they were interested in seeking hospital care because they did find some of their services useful, they had scarce knowledge of biomedical practices, information regarding prevention, identification and management of obstetric risks, and understanding of how to navigate the hospital system. The Sinergias team indicated that this is due in part to the lack of information channels, the lack of research and application of better communication and healthcare strategies in intercultural settings (strategies based on the orality of indigenous knowledge transmission and on indigenous languages, for example), and the little dissemination and use of the intercultural educational materials that *have* been produced so far by other health actors.

> *Well the last time some people came from the hospital to explain, just as you are saying, well with us that happened, lack of communication, when we do communicate (to the hospital) who comes to pick us up (to take patients to the hospital)? The route to access services? How will we be able to..? They left us a cellphone, so we…but with what money are we going to call? If we have the cellphone but we don't have a data plan, that is complicated. Every now and then there is some*

> *cellphone service, it is not good now, sometimes there is some.. (indigenous mother during interview)*

The participant observation in which indigenous mothers attempting to seek hospital care were accompanied and the focus groups with mothers also point out that insufficient educational efforts are being made to guide patients regarding therapeutic processes themselves, including how procedures work (such as c-sections), and what is expected from the patient after a procedure or appointment (where to get medications, how medications work and how to take them, etc). The information offered is not easy to understand for indigenous patients, is not in indigenous languages, is not contextualized to indigenous values and norms, and there is no space to discuss with patients *why* a health practice is important rather than just *how* should be done.

> T*he thing is that it is too much and that is why the people don't understand, they won't understand because one thing is another thing (...) that is something that is always missing, the education topics by the hospital o by the health secretariat or from some other place, they should come to these places and explain that (indigenous mother during focus group)*
>
> *I remember that they told me that word and I said "okay", like I am saying it now, well when you are seeing that and with all that suffering well you don't have thought, what is it that they are doing, and so you say "yes, okay" (indigenous mother during interview speaking of medical procedures she accepted without fully understanding them)*

The hospital does have a "user office" with staff available to communicate with patients, and although some indigenous women find it useful, many are frightened of being mistreated and thus prefer not to go, and others do not consider their staff to have helped clarify their confusion, needs, and concerns (especially when the indigenous patients speak little to no Spanish). Only until 2020 did the hospital incorporate social workers into their team, and they currently only have two. Social workers and other community agents could be the ones in charge of inquiring about the social determinants of health of the patient, their psychosocial needs, identifying their support networks, guiding patients through the paperwork, and connecting the patient to corresponding services (like hospital housing and meal plans while they are in Mitú). These are key actions that could contextualize and understand the patient within their culture and target the barriers they are experiencing to guarantee their health.

> *That is something that between women we don't speak, we don't know…many women believe that it is very hard to get to the hospital because they are scared or because they (at the hospital) are white or because..so it is also about how to disseminate, talk more between us and support each*

> *other, yes, that is what we have been doing for a long time but I have left it because I am (currently) not there (in the community) (indigenous mother during interview)*

4. Discussion

The first important layer of indigenous women's health experience that stands out is the differences between the values and practices of indigenous models of care and biomedical models. A call for more recognition of local knowledges and experiences of health is made in order to find ways for each model to have space in the public health system of Vaupés. Although one must be wary of essentializing and tokenizing culture, homogenizing patients' backgrounds, reducing patients to stereotypical cultural representations, and blaming health realities on culture (Kleinman and Benson, 2006), we do have to find a way to introduce the culture variable (with the broad diversity through which it expresses in Vaupés) into the biomedical system. The Colombian legal frameworks for this exist (Congreso de la República, 2011; Ministerio de Salud y Protección Social, 2015), but most of these laws have not translated into meaningful action. Indigenous models of health are still not truly recognized nor have representation in Colombian public health, and most workers at Hospital San Antonio de Mitú, along with most public health sectors in the area, are poorly educated on the cultural specificities and resources of the indigenous region. This is leading to a hospital practice that often transgresses indigenous social and moral codes and proposes therapeutic processes that do not address the complex, multilayered indigenous experience of obstetric processes. It is worth noting that the hospital has recognized these issues and is currently showing a will to address them. Actors like Sinergias are assisting this process by supporting the creation of an intercultural experiential orientation program for hospital staff, and the adaptation of clinical guidelines, among others. The high rotation of hospital directors, on which the institution's will to address these issues depends, is a barrier in this process.

More community participation and decentering biomedicine in Vaupés' public health is needed. As Bishop (1998) states, we must "participate in the process that facilitates the development in people of a sense of themselves as agentic and of having an authoritative voice" (p.207). Through indigenous-led research (Todd, 2016), Fals Borda's Participatory Action Research (Ochoa, 2015) and Community Based

Participatory Research proposals, among others, indigenous voices could guide health systems and help them identify community needs, resources, and relevant actions in fruitful ways. Local efforts such as the *Planes Integrales de Vida Indigena* (PIVI) (Indigenous holistic life plans) through which indigenous communities establish and communicate their health priorities based on their own conceptualizations of health must also be given true recognition as public health tools, and proposals like the SISPI (Indigenous Intercultural Health System) can be further supported as indigenous-led spaces of intercultural dialogue and health planning. Part of the challenges that must be navigated here is the transformation and loss of indigenous health models due to the changing nature of culture but also due to violent colonization processes, including the religious boarding schools that removed entire generations of youth from their cultural contexts. Special attention must also be paid to the power structures and corresponding inequity within indigenous groups themselves. We must make sure that subgroups historically marginalized, such as women and children, are given more space and leadership, and that their knowledges, ways of thinking, and assets guide obstetric public health discussions in their territory.

> *I think it is interesting to receive that conversation only women, because many projects have arrived here and the men always say no, but us women yes, we will take advantage of it, we..even if there is no money, no resource, we plant some things and we plant and they grow, we are caregivers, instead they say no only because there is no money, no…we are not like that. We like to do entrepreneur work a lot. (indigenous woman during focus group speaking about projects that come into the communities with NGOs or other public health actors)*

A common question is that of the compatibility of indigenous and biomedical health models. Eduardo Menendez (2016) suggests that Latin American social groups practiced interculturality in their processes of health, illness and health care before anthropologists and other scholars thought of studying these health processes in terms of interculturality. The issues of interculturality that scholars are now putting forth have long been solved by these social groups in their practice, and our task should be focused on learning from them. In the case of Vaupés, it seems that most indigenous women indicate that there *is* space for biomedical practices to collaborate with indigenous ones. The indigenous health model in Vaupés is not necessarily incompatible with biomedicine's tools: each health models often operates at a different level of care, and indigenous people recognize their medical model's limitations (especially around physiological symptoms and obstetric emergencies), which biomedicine could help with. Additionally, despite indigenous understandings of the obstetric life cycle of women being more holistic, there are many parallels with the stages of obstetric health that biomedicine points out and there is a common understanding of obstetric processes as a health care priority. On the other hand, the indigenous context of Vaupés has been an intercultural reality for a long time, and thus an intercultural health response is needed and called for. The lack of articulation between models is not so much a product of incompatible skills, but rather of the colonizing and homogenizing framework founded on epistemic violence and structural racism on which the biomedical industrial complex stands. This framework imposes biomedicine's practices and unquestionable truths on others (Córdoba, 2010), disregards the way that social forces shape biology and health experiences (Lock, 1995; Lewontin, 2000), delegitimizes communities' resources and decision-making processes, reinforces obstetric violence (Vallana, 2019), and reduces medicine to individual, biological processes. If these core values shift, biomedical and indigenous skills will be able to work together and much more effective health systems may emerge.

The second layer of indigenous women's experience responds to politics of inequality, materialized in the logistical barriers patients experience to access care. Structural forces, and not just cultural differences, shape patients' capacities to reach health care and comply with therapeutic processes. Public Health has attempted to bring these structural factors into health care with the concept of Social Determinants of Health, showing that health is conditioned by different social, economic, and political conditions in which an individual is immersed, and that we must develop interventions at these levels. Physician-social scientists have made the call for "structural competency" in medicine (Metzl and Hansen, 2014), suggesting medical practice include an assessment of the "structural factors" or "structural vulnerability" of patients. Bourgois et al. (2017) proposed a clinical assessment tool through which clinical encounters include screening for structural forces affecting a patient, which allows the clinician to be more aware of the community context, create a more accurate treatment plan, and connect the patient with corresponding services that will help them surpass the barriers they face (Bourgois, 2017). The government and public health institutions in Vaupés have again failed the indigenous people of the region by neglecting to identify and respond to the social determinants of health in indigenous patients, which is evident in the continuously unaddressed transportation, information, and economic barriers, among others, that patients face. Perhaps tools like these can be some immediate steps for a better health system in the short-term. The intercultural clinical protocols that Sinergias NGO is helping develop alongside the hospital in Mitú, the intercultural training to hospital staff, and the revitalization and strengthening of indigenous practices of health are other examples of these efforts. The government must also participate much more actively in these efforts. Although public health institutions might be the first ones capable of identifying health issues and addressing them in a down-stream manner, governments are ultimately shaping the capacity of public health institutions to respond, and are largely accountable for the negligent structural conditions of ethnic populations in the country.

It is worth thinking about the positive impacts that a stronger primary health care system, which requires much more proactive government action, would have in regions like this. Rather than expanding the overburdened clinician's scope to include structural assessments in their 20 minute clinical encounters, a stronger preventive health model based on community-level care and articulation with community actors, as Alma Ata once promised (Coreil and Mull 1990), would yield better, long-term results. The success of the health model implemented by the *Servicio Seccional de Salud in Vaupés* and the successful results of the intercultural public health approach proposed by Sinergias (Montoya et al, 2017), are proof of this potential. The neoliberalism policies guiding the current EPS model, and the lack of efficient implementation of the already established laws that promote the adaptation of services for Colombian ethnic minorities remain a barrier for a stronger primary health care system, but the current left-wing government of Gustavo Petro and Francia Marquez, the health reforms that are being proposed, offer an important window of opportunity for change.

There is also an additional layer that remains unaddressed in all of these short-term proposals: structural violence. Farmer defined it as the "social arrangements that put individuals and populations in harm's way" (Farmer, 2004, p. e499), and Galtung proposed it as the normalized economic, political, legal, religious, and cultural forces preventing societies from reaching their full potential by reinforcing disparate access to resources, political power, education, legal standing and health care, among others (Galtung, 1969; Farmer et al, 2006). This paper argues that the health indicators of Vaupés, the lack of recognition and space for indigenous models of health within the public health system of Colombia, and the barriers to access care

are products of structural violence. Mullings proposals also shed light on the link between indigeneity and inequity, suggesting that the concepts of race, class, and gender are “historically created relationships of differential distribution of resources, privilege, and power, of advantage and disadvantage” (Mullings, 2008, p.79).

The history of religious and political colonization, resource exploitation, institutional neglect, biomedicalization and political marginalization of indigenous people in Vaupés are structural forces that will continue creating the issues documented in this research until they are dismantled. Although developing an intercultural health model for Vaupés that is *aware* of cultural and structural factors and helps patients navigate them is a start, it is not enough. Helping patients survive an unfair system, or adjusting the clinical encounters in health institutions that were built within these systems (such as *Hospital San Antonio de Mitú*), must be accompanied with a fight to change the systems themselves. Failing to do so makes public health an accomplice to the status quo that perpetuates inequality. Organizations like Partners in Health and Sinergias (Montoya et al, 2017) propose paths to achieve this, such as sending state-of-the-art medication and services to areas that have been structurally vulnerable to epidemics, while also lobbying to change global policies that have concentrated poverty by displacing populations.

5. Conclusion

This paper attempts to discuss some of the obstetric experiences of indigenous women in Vaupés. It attempts to recognize some ontological and epistemological particularities of Amazonian life and how these might clash or articulate with biomedical approaches, but it also seeks to bring into the discussion the racialization of health in the form of discrimination and rejection towards indigenous ideas of health, on one hand, and barriers indigenous patients face to access care and guarantee a healthy obstetric process, on another hand. Both of these are products of the systems of inequality under which indigenous communities in Colombia (and many other ethnic minorities) continue to be marginalized and subjected as second-class citizens.

Latin american scholar's conceptual proposals to speak of the unit *salud-enfermedad-atención* (health-illness-health care), which fights back against biomedicine's fragmentation and compartmentalization of health and proposes to see and work on health processes in a more holistic way. Authors like Menendez (2003) use this framework to give space within health care for the many sociopolitical factors involved in creating wellbeing but erased in biomedical discourses. These factors include the knowledges, beliefs, and practices that are specific to indigenous experience of health and different from the biomedical paradigm (encompassed here in the proposal to return to an intercultural health system), but it also includes paying attention to the structural forces that condition a community's possibilities to guarantee wellbeing, as we have seen here. A more holistic and comprehensive health approach, as proposed above, might be a road.

The health panorama discussed here does more than just provide a demographic image of Vaupés. As Fassin explains, "life expectancies and mortality rates are not only quantitative indicators giving us a demographic image of countries, they are also qualitative data offering political insights as to how societies produce and reproduce themselves" (Fassin, 2012). The data discussed here sheds light on the ways in which maternal-child health is being conceptualized and enacted in Vaupés, and how through this, we are building a particular world, an unequal world, in the Colombian Amazon. The health realities explored here reveal the politics of life through which we assign more and less value to particular lives in Vaupés, choose who is excluded and included in our moral communities (Fassin, 2012), and ultimately, who is deemed worthy enough to be considered human. Indigenous people, especially indigenous women and children, have been carrying the weight of this for far too long.

6. Limitations

Trying to translate indigenous worldviews and their embodied ways of living into a Western academic text will always be a flawed exercise, and all scholars must be aware of decontextualizing and flattening indigenous wisdom when doing this type of work (Todd, 2016).

Vaupés is a highly diverse setting, and what is expressed in this paper might not be representative of all the region. This work intends to serve more as a discussion about interculturality and the limitations of the current Colombian biomedical system in indigenous contexts.

The research was conducted in Spanish, which is not the first language of most indigenous people, although part of the research team spoke some indigenous languages.

There are significant taboos around sexual and reproductive health in Vaupés. Due in part to this, and to the fact that most research has been led by men, there is a lack of research on sexual and reproductive illnesses, and a lack of adequate support to women in their obstetric processes. As a woman and an indigenous co-researcher, the PI may have had more access to this domain. Nonetheless, the mentioned barriers, and the research interests the indigenous participants had, shifted the research focus from the private domains of obstetrics to indigenous women's interactions with the hospital.

There is a historical lack of health data in the Amazon from which to start any research, and a lack of institutional disposition, alongside poor capacity, to do research in indigenous, rural contexts, much less community-based research.

7. Acknowledgments

I would like to express my deep gratitude to all the indigenous communities of the suburban area of Mitu, Vaupés, especially to the indigenous women with whom this research was conducted. Their wisdom, resilience, and drive is what keeps public health's hope and relevance. I would also like to thank Sinergias NGO team, especially Pablo Montoya, Maria Camila Rodriguez, Rosita Gonzalez, Adelia Prada, and Felix Moreno, who made this research possible and have dedicated their lives to helping the people of Vaupes. Finally, I want to thank James Pfeiffer, whose mentorship throughout this process has been invaluable.

References:

Bermudez, A. (2023, May 17). *Colombia: Corte Constitucional examinará por primera vez un conflicto por bonos de carbono*. Mongabay. https://es.mongabay.com/2023/05/colombia-corte-constitucional-examinara-por-primera-vez-un-conflicto-por-bonos-de-carbono/

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.

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. *Academic Medicine : Journal of the Association of American Medical Colleges*, *92*(3), 299–307. https://doi.org/10.1097/ACM.0000000000001294

Congreso de la República de Colombia. Ley 100 (1993).

Congreso de la República de Colombia. Ley 1438 (2011).

Convenio Colombo-Holandés en Salud. (1981). Experiencias En Atención Primaria.

Convenio Colombo-Holandés y Servicio Seccional de Salud del Vaupés. (1985). Evaluación Interna Del Servicio Seccional de Salud Del Vaupés.

Correa, F (1987). Medicina tradicional Cubea. *Boletin de Antropología,* Universidad de Antioquia, Vol. 6, No. 21,1987. Med.,Col.

Córdoba, E. (2010). Historia de La Salud y (Re) Descubrimiento de Nuestra America. *Canadian Journal of Latin American and Caribbean Studies* 35 (69): 155–70.

Coreil, J, and Mull, D. (1990). *Anthropology and Primary Health Care*. Boulder, CO: Westview Press.

Corte Constitucional de Colombia. (1997) Sentencia SU-039/97: Derechos Fundamentales de Comunidad Indigena

Corte Constitucional de Colombia. (2017) Sentencia T357/17: Acción de Tutela Para la Protección de Derechos Colectivos Cuando Existe Vulneración de Derechos Fundamentales

DANE Departamento Administrativo Nacional de Estadística (2019). Estadísticas vitales. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/GCFI/indicadores-basicos-salud-2021.pdf

DANE Departamento Administrativo Nacional de Estadística. (2023). Proyecciones de población a nivel departamental periodo 2020-2050. Available from: https://www.dane.gov.co/index.php/estadisticas-por-tema/demografia-y-poblacion/proyecciones-de-poblacion

Davis-Floyd, R. E. (1990). The role of obstetrical rituals in the resolution of cultural anomaly. *Social Science & Medicine*, *31*(2), 175–189. https://doi.org/10.1016/0277-9536(90)90060-6

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics*, *75 Suppl 1*, S5–S23.

Dietz, G. (2017). Interculturalidad: una aproximación antropológica. *Perfiles Educativos*, *39*(156), 192–207.

Guevara, Juan V. (1984). *Etnodesarrollo y Medicina Indígena Ecológica*. Mitú, Vaupés: Ministerio de Salud, Servicio Seccional de Salud del Vaupés.

Guevara, J. (2003). *En Busca de Un Modelo de Salud Para Los Pueblos Indígenas*. Mitú, Vaupés: Ministerio de Salud, Servicio Seccional de Salud del Vaupés.

Farmer P. (2004) An anthropology of structural violence. Curr Anthropol 45: 305–326.

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLoS Medicine*, *3*(10), e449. https://doi.org/10.1371/journal.pmed.0030449

Farmer, P., Kleinman, A., Kim, J., & Basilico, M. (Eds.). (2013). *Reimagining global health : An introduction*. University of California Press.

Fassin, D. (2012). That Obscure Object of Global Health. In M. C. Inhorn & E. A. Wentzell (Eds.), *Medical Anthropology at the Intersections* (pp. 95–115). Duke University Press. https://doi.org/10.1215/9780822395478-007

Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, *6*(3), 167–191. http://www.jstor.org/stable/422690

Jackson, J. (1991). Being and Becoming Indian in the Vaupes. In *Nation-States and Indians in Latin America*. Greg Urban and Joel Sherzer, Eds. pp. 131-155. Austin: University of Texas Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLOS Medicine*, *3*(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Lewontin R. (2000). *Triple Helix: Gene, Organism and Environment. Cambridge*, MA: Harvard Univ. Press

Lock M. (1995). *Encounters with Aging: Mythologies of Menopause in Japan and North America*. Berkeley, CA: Univ. Calif. Press

Martin E. (1984). Pregnancy, labor and body image in the United States. *Social science & medicine (1982)*, *19*(11), 1201–1206. https://doi.org/10.1016/0277-9536(84)90371-x

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).

Menéndez, E. L. (2003). Modelos de atención de los padecimientos: De exclusiones teóricas y articulaciones prácticas. *Ciência & Saúde Coletiva*, *8*, 185–207. https://doi.org/10.1590/S1413-81232003000100014

Menendez, E. (2016). Cuestiones metodologicas sobre antropologia e interculturalidad. In *Antropología médica e interculturalidad* (pp. 1–13). McGraw-Hill.
Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Ministerio de Salud y Protección Social, Secretaría de Salud Departamental del Vaupés, and Sinergias (2019). Perfil de Salud básico de los Pueblos Indígenas en el Vaupés. Source: Análisis de Situación de Salud (ASIS). Available in: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/PSP/ASIS%20VAUPES%20RIPSA.pdf

Ministerio de Salud y Protección Social. (2019). LINEAMIENTO PARA EL CUIDADO DE LAS ARMONÍAS ESPIRITUALES Y DE PENSAMIENTO DE LOS PUEBLOS Y COMUNIDADES INDÍGENAS. Available in: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/ENT/lineamiento-cuidado-armonias-espirituales-pensamiento-pi.pdf

Ministerio de Salud y Protección Social. (2020). Boletines Poblacionales: Población Indígena [Internet]. Available in: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/PS/boletines-poblacionales-poblacion-indigena.pdf

Ministerio de Salud y Protección Social. (2021). Indicadores básicos de salud 2021, situación de salud en Colombia. Available in: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/GCFI/indicadores-basicos-salud-2021.pdf

Montaña, J, et al. (2012). ANALISIS DE LA SITUACION DE SALUD DEPARTAMENTO DEL Vaupés (ASIS). Gobernación del Vaupés, Secretaria de Salud Departamental, Área de salud Publica. Available in: http://www.minsalud.gov.co/plandecenal/mapa/Analisis-de-Situacion-Salud- Vaupés-2010.pdf

Montoya, P., & et al. (2017, October). *Experiencia de atención primaria en salud con enfoque intercultural en el Vaupés*. Décimo Congreso Internacional de Salud Pública: Salud, Paz y Equidad Social, Medellín, Colombia.

Moreno, F. (2015). *Prácticas culturales de la mujer de la etnia cubea en el periodo de gestación, parto y posparto en el municipio de Mitú.* Thesis for nursing degree. Universidad Nacional de Colombia.

Mullings, L. (2005). Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem. *Transforming Anthropology*, *13*(2), 79–91. https://doi.org/10.1525/tran.2005.13.2.79

Oakley, A. (1980). *Women confined: Towards a sociology of childbirth*. Robertson.

Ochoa, Nelson. 2015. *Orlando Fals-Borda: Investigación Acción Participativa*. Universidad Pedagógica Nacional.

Puerto, H. (2018). A New Hope: Perspectives on Implementing the Pilot of a New Comprehensive Health Care Model in Guainía, Colombia. Masters Thesis. University of Washington.

Rothman, B. K. (1993). *The tentative pregnancy: How amniocentesis changes the experience of motherhood* (1993 ed). Norton.

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. (2021). Fortalecimiento de capacidades para la gobernanza territorial en salud. Available in: https://www.sinergiasong.org/_files/ugd/842017_e908667c3c8546ee88f7c0c1580787e6.pdf

Sinergias. (2022). Endulzando el corazón: material de educación alimentaria y nutricional para gestantes y menores de 2 años. Available in: https://www.sinergiasong.org/_files/ugd/842017_360ee51b4ede40d29d8f50fa015da84e.pdf

Shaw, J. (2012). *The Birth of the Clinic* and the Advent of Reproduction: Pregnancy, Pathology and the Medical Gaze in Modernity. *Body & Society*, *18*(2), 110–138. https://doi.org/10.1177/1357034X10394666

Smith, L. T. (2013). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books Ltd.

SSMPC Subcomisión de Salud de la Mesa Permanente de Concertación con los Pueblos y Organizaciones indígenas de Colombia y Ministerio de Salud y Protección Social. (2016). Guía metodológica para la construcción de contenidos de los componentes e implementación del SISPI. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/PSP/guia-metodologica-sispri.pdf

Todd, Z. (2016). An Indigenous Feminist's Take On The Ontological Turn: 'Ontology' Is Just Another Word For Colonialism: An Indigenous Feminist's Take on the Ontological Turn. *Journal of Historical Sociology*, *29*(1), 4–22. https://doi.org/10.1111/johs.12124

Torres, J., et al. (2008). Constructing a care technology conception in obstetric nursing: a sociopoetic study. *Texto Contexto Enferm. 17(4)*. Pp 656–664.

Vaismoradi, M., Turunen, H. and Bondas, T., (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & health sciences, 15(3), pp.398-405.

Vallana,V. (2019). "Es rico hacerlos, pero no tenerlos": Análisis de la violencia obstétrica durante la atención del parto en Colombia. *Revista Ciencias de La Salud*, *17*(Especial), 128–144. https://doi.org/10.12804/revistas.urosario.edu.co/revsalud/a.8125