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Gonzalez, Paula

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Implementing Indigenous Health Policy in Colombia:

SISPI's Promises & Progress for the Wayuu in La Guajira

A Thesis submitted in partial satisfaction of the requirements

for the degree Master of Arts in Global Studies

by

Paula Gonzalez

Committee in charge:

Professor Kai M. Thaler, Co-Chair

Professor David Lopez-Carr, Co-Chair

Professor Lisa Sun-Hee Park

June 2026

The thesis of Paula Gonzalez is approved.

Lisa Sun-Hee Park

David Lopez-Carr, Co-Chair

Kai M. Thaler, Co-Chair

June 2026

Implementing Indigenous Health Policy in Colombia:

SISPI's Promises & Progress for the Wayuu in La Guajira

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Paula Gonzalez

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ABSTRACT

Implementing Indigenous Health Policy

in Colombia: SISPI's Promises & Progress for the Wayuu in La Guajira

by

Paula Gonzalez

In this thesis, I analyze Indigenous peoples' interactions with contemporary Colombian political and social spheres regarding their health, autonomy, practices, and systems, specifically in relation to the passing of SISPI, the Self-Determined and Intercultural Indigenous Health System. After years of efforts involving local stakeholders, Indigenous leaders, and health rights activists, Decree Law 0480 was passed in April 2025, meant to strengthen Indigenous peoples' own health systems and mechanisms for coordination with the national health system. Although widely celebrated across Indigenous communities in Colombia, SISPI was passed under a left-wing government more inclined toward protecting Indigenous autonomy and rights, raising urgent questions about funding, implementation, and continuity ahead of the May 2026 elections. This thesis asks: can national health systems genuinely support and coexist with Indigenous health systems and practices? And what do Wayuu women's own understandings and experiences of sexual and reproductive health reveal about the gap between what SISPI promises and what it delivers?

This research draws on qualitative methods conducted between August and November 2025 in Riohacha and surrounding communities of La Guajira, Colombia, including four focus groups with Wayuu Indigenous women, two physician interviews, site visits to Fundacion

Baylor's clinics, and observations at various locations and interactions. Fieldwork was conducted in partnership with Wayuu Woven Community, whose existing relationships with the women made this research possible. It is situated within a broader policy analysis of Colombia's national healthcare system and a Latin American comparative framework. Findings reveal that the coexistence of biomedical and ancestral healing systems in La Guajira is not a policy achievement but a survival strategy Wayuu women have built themselves such as choosing herbs and ancestral knowledge first and leaving biomedical care for serious conditions. For the Wayuu, near-universal insurance enrollment does not guarantee healthcare access. Transportation costs and rural locations render care economically impossible and highlight institutional indifference. Sexual and reproductive health emerged as the sharpest edge of these contradictions. Women understood SRH as encompassing the whole body, yet the system narrowed it to fertility management which reflects a system that has treated Wayuu women's reproductive capacity as something to be managed rather than respected.

SISPI represents a genuine, hard-won achievement. Yet the same institutional architecture that produced it also produces discriminatory hospital staff and non-consensual medical procedures. Organizations like Wayuu Woven Community, Un Nuevo Amanecer, and Fundacion Baylor are not filling gaps in the system and for many Wayuu women, they are the system. This thesis concludes that national health systems can support and coexist with Indigenous practices, but only if they are willing to be transformed by what they encounter rather than simply expanded to contain it. Whether SISPI can truly get there, structurally and not just on paper remains the central and still-open question this work hopes to provoke.

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ABBREVIATIONS

CHW	Community Health Worker
CRIC	Consejo Regional Indígena del Cauca [Cauca Regional Indigenous Council]
DANE	Departamento Administrativo Nacional de Estadística [National Administrative Department of Statistics]
EPS	Entidades Promotoras de Salud [Health Promoting Entities]
EPSI	Entidades Promotoras de Salud Indígena [Indigenous Health Promoting Entities]
ETPV	Estatuto Temporal de Protección para Migrantes Venezolanos [Temporary Protection Statute for Venezuelan Migrants]
GFMD	Global Forum on Migration and Development
ICBF	Instituto Colombiano de Bienestar Familiar [Colombian Institute of Family Welfare]
ICU	Intensive Care Unit
IDP	Internally Displaced Person/Population
ILO	International Labor Organization
IOM	Organización Nacional Indígena de Colombia [National Indigenous Organization of Colombia]
IPS	Instituciones de Prestación de Servicios [Health Providers Institutions]
IPRF	Indigenous Policy Research Framework
ONIC	Organización Nacional Indígena de Colombia [National Indigenous Organization of Colombia]
MPC	Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas [Permanent Concertation Table with Indigenous Peoples and Organizations]
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization
RDT	Raices de Talento

SDET	Social Determination of Health
SDOH	Social Determinants of Health
SGSSS	Sistema General de Seguridad Social en Salud [General System of Social Security in Health]
SISBEN	Sistema de Identificación de Beneficiarios [Beneficiary Identification System]
SISPI	Sistema Indígena de Salud Propia e Intercultural [Self-determined and Intercultural Indigenous Health System]
SNS	Sistema Nacional de Salud [The National Health System]
SSI-MPC	Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas [Indigenous Health Subcommittee of the Permanent Concertation Table with Indigenous Peoples and Organizations]
SRH	Sexual and Reproductive Health
T&CM	Traditional and Complimentary Medicine
TKP	The Kid's Playground
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WWC	Wayuu Woven Community
UN	United Nations
UNDRIP	UN Declaration on the Rights of Indigenous Peoples

I. Introduction

1.1 Research Puzzle & Argument

Originally, this research was focused on analyzing the maternal health variations between migrants and Indigenous¹ women in Colombia. I was interested in how identity, nationality and healthcare intersected and differentially impacted access to healthcare, specifically sexual and reproductive healthcare. I wanted to look at sexual and reproductive healthcare (SRH) because of my interest in homeopathic versus medicalized practices regarding things from sexually transmitted infections (STIs) to childbirth, things that people have long dealt with around the world, mainly women. Especially when considering how migration and Indigeneity have long existed before the creation of borders and nation-states, how does ‘modern’ medicine which has significantly elongated our life expectancy and thought of as improving quality of life interplay with migrant and Indigenous identities? As my research developed, I centered on Indigeneity due to both my own time frame and availability of participants since my fieldwork depended on many factors such as people’s interest, weather conditions, and most importantly time to build trust and relationships. Essentially, my interlocutors framed and shaped this research by showing me that these topics are much more complex and dynamic than what I had originally thought, and that policy held a central role in shaping healthcare access and promoting certain practices.

For Indigenous communities in Colombia, the passing of the Self-determined and Intercultural Indigenous Health System (SISPI)² policy was a step towards preserving and

¹ The international community of Indigenous Peoples has struggled academically to make a distinction that the term “Indigenous” with a capital “I” “articulates and identifies a group of political and historical communities, compared to the lower case ‘i,’ which can refer to anyone”. For this reason, I choose to capitalize Indigenous and use it in this context.

² Sistema Indígena de Salud Propia e Intercultural

promoting Indigenous ancestral forms of health within the national healthcare system.

Although many Indigenous peoples in Colombia consider this a huge win, and many were involved in advocating and drafting the policy, there is still uncertainty as to how SISPI will look in each community and potential implications for them. Putting this policy into context with my field work, I thought back to when I first began developing my research project.

This concept of ‘health governance’ and how national healthcare systems can work to bridge health disparities such as bringing resources to communities, was at the forefront of my work. Yet, at the very same time, I knew that these same national healthcare systems repeatedly fail to serve people, and in regards to Indigenous peoples whose concept of health extends well beyond occidental or western frameworks³ and understanding of health, how may national healthcare systems fail to serve them or worse? This line of questioning is what led me to establish my two main research questions that I consistently circle back to throughout my work:

- 1. Can national health systems *support* Indigenous health systems and practices?**
- 2. Can national health systems *coexist* with Indigenous health systems and practices?**

In the subsequent section I will further define what I mean when I say ‘national healthcare systems’ and ‘Indigenous based healthcare systems’. Healthcare at large encompasses a vast and broad spectrum of ‘things’, but essentially is a fundamental human good because it affects one’s opportunity to pursue life goals, reduces one’s pain and

³ For the purposes of this research I use ‘western’ and ‘occidental’ interchangeably

suffering, helps prevent premature loss of life, and provides information needed to plan for one's lives⁴. For this research, I chose to focus on women's health, which includes issues that affect people in general such as diabetes but also issues specific to women or people assigned female at birth such as endometriosis⁵. For the purposes of this research, I choose to focus specifically on sexual and reproductive health (SRH) because of the way governments can control populations through family planning programs, over medicalization of maternity and childbirth, and regulation of contraceptives. At the same time, the reach that governments have does not and cannot extend to all of its populations, especially in more rural areas where the infrastructure may not be in place. Ancestral practices such as midwifery are still highly used in Indigenous populations and becoming more popular in non-Indigenous spaces. These midwives, healers, or knowledge holders, can symbolize the collective importance of community relationality to support individual agency and informed SRH decision-making⁶. Therefore, when thinking about specifically about Indigenous women, their SRH, and biological, gender, cultural, environmental factors that affect their health outcomes⁷ these are the questions that guided my fieldwork:

- 3. What are Indigenous women's understanding, perceptions, or preferences about their SRH?**
- 4. How well do current national policies address SRH access?**

⁴ American Medical Association, "Defining Basic Health Care."

⁵ NICHD, "Women's Health."

⁶ Hickey et al., "Community-Based Sexual and Reproductive Health Promotion."

⁷ World Health Organization, "Women's Health."

These questions are not meant to have simple answers or ignore nuances that occur across Indigenous communities or as my fieldwork demonstrates, nuances within the same community. These questions are precisely what give meaning to my research, specifically about efforts involved in preserving, protecting and promoting Indigenous health knowledge and practices within national healthcare systems. Is this truly possible? And should it be an ‘ideal’ or standard approach? I chose to keep my questions broad, bearing in mind that there is no clear answer and wanting to understand how and if Indigenous knowledge and health practices can work within a nation-state health governance framework. My hope for this research is to demonstrate the importance of local, grounded policies that allow space for the vast and diverse Indigenous identities whose land, health and bodies are unwillingly and willingly integrated into nation-state systems of governance. Yet, I hope through the conversations with my interlocutors to also offer new insights and provoke new, revolutionary ideas of what health is and could look like.

1.2 Defining Terms and Theoretical Frameworks

First I have to define terms such as ‘Indigenous’, ‘healthcare system’ and ‘policy’. These terms are used in a variety of contexts, and are often much more nuanced. Especially when talking about Indigenous peoples, concepts such as ‘policy’ and institutions such as ‘health systems’ have historically been used to eliminate, harm and erase Indigenous identity and sovereignty. I will also be introducing the Indigenous concept of ‘Buen Vivir’ and Latin American Social Medicine/Collective Health concept of ‘social determination of health’.

Indigenous Peoples

The term Indigenous Peoples refers to someone who is descended from populations, who inhabited the country or geographical region at the time of conquest, colonization or establishment of present state boundaries and they retain some or all of their own social, economic, cultural and political institutions, irrespective of their legal status⁸. Although the term tribal is sometimes used when discussing Indigenous matters, it encompasses a specific group's social, cultural and economic conditions that distinguish them from other sections of the national community and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations⁹. The biggest difference is where historically people's ancestors come from. Te Ahukaramu Charles Royal's definition of Indigenous refers to those cultures whose world views place special significance on the idea of the unification of the humans with the natural world¹⁰. Royal presents the Indigenous world view which sees people as integral to the world, with humans having a seamless relationship with nature which includes seas, land, rivers, mountains, flora, and fauna. In similar fashion, Redvers et al., a group of Indigenous scholars representing different nations across the world, revised the World Health Organization's (WHO) definition of 'health' as "a state of dynamic balance within and between our physical, mental, social and spiritual well-being that is completely dependent on planetary health"¹¹. In these conceptions, being Indigenous and being healthy is tied intrinsically to Mother Nature. I believe combining these definitions provides the best interpretation of Indigenous peoples, constantly connecting to

⁸ International Labour Organization, "Who Are the Indigenous and Tribal Peoples?"

⁹ Ibid.

¹⁰ Royal, *Indigenous Worldviews*.

¹¹ Redvers et al., "Indigenous Rights, Health and Traditional Medicine Systems."

the natural world, being an essential part of it, and practicing this intention even if colonization severed personal ties or stripped knowledge from communities including ways of communication.

Buen Vivir

In Latin America, the concept of Buen Vivir has been widely studied over the past three decades, with interpretations varying depending on scholars' engagements with Indigenous communities. Broadly understood as a Spanish approximation, Buen Vivir refers to what many Indigenous groups describe in their own languages as a relational process of living a dignified and healthy life within specific territorial and cultural contexts. Its academic usage gained prominence in late 20th-century anthropological work, particularly following Philippe Descola's research with the Achuar in the Upper Amazon¹². Since then, Buen Vivir has informed scholarship across three main areas: 1) Indigenous onto-epistemologies¹³, 2) socio-economic and political movements, and 3) environmental justice, sometimes described as the "trinity" of Buen Vivir research¹⁴. However, many Indigenous scholars caution against reducing Buen Vivir to a fixed concept, instead emphasizing it as a living, relational process centered on life itself, grounded in the understanding that all beings, human and non-human, are interconnected and alive¹⁵. Through these practices,

¹² Descola, *La Selva Culta*.

¹³ Epistemology and ontology are inextricable: knowledge cannot be abstracted from the ways of life from which it emerges. Western Science's separation of knowing from being mirrors its treatment of the world as furnished by extractable objects, a logic that runs parallel to the exploitation of human and natural resources, and lies at the heart of coloniality; Gatt, "Decolonizing Scholarship?"

¹⁴ Hidalgo-Capitán and Cubillo-Guevara, "Deconstrucción y Genealogía del 'Buen Vivir' Latinoamericano."

¹⁵ Rodríguez Salazar, "Teoría y Práctica del Buen Vivir."

communities sustain collective well-being and ecological harmony. Importantly, some Indigenous terms are often left untranslated to avoid the loss of meaning that occurs through simplification or decontextualization¹⁶. Similar relational frameworks exist across the region, including *Vivir Sabroso* among Afro-Colombian communities¹⁷. As such, Buen Vivir is not only foundational to Indigenous understandings of health and well-being, but also informs broader efforts toward therapeutic pluralism and intercultural health governance in Latin America.

Social Determination of Health (SDET)

To bridge together these concepts of Indigeneity and health, I will use Jaime Breilh's Social Determination of Health (SDET)¹⁸. Although this concept was developed during the 1970s, the preferred and popular concept in international public health circles are social determinants of health (SDOH). SDOH was first coined in 1999 and established environmental factors (stress, work, food, etc) that impact health with the goal 'that policy at all levels – in government, public and private institutions, workplaces and the community – takes proper account of recent evidence suggesting a wider responsibility for creating healthy societies'¹⁹. Wilkinson and Marmot established that: 1) differences in health between population groups are due to characteristics in society, not differences in health care, 2) when people change social and cultural environments, their disease risks change, 3) the health gradient is not a function of poverty alone (meaning poor health for the poor and good health

¹⁶ Oviedo Freire, "El Posmoderno Buen Vivir."

¹⁷ Quiceno Toro, *Vivir Sabroso*.

¹⁸ Breilh, *Critical Epidemiology and the People's Health*.

¹⁹ Wilkinson and Marmot, *Social Determinants of Health*.

for the rest), rather it is a problem across the entire socioeconomic spectrum—as one moves down the social hierarchy, life expectancy gets shorter and mortality rates are higher”, 4) the health gradient can change (and change quickly) with interventions, and 5) the health gradient is not a matter of election, health does not determine social position, rather, social position determines health²⁰. SDET relies on a conflict-driven framework to map how daily power and labor asymmetries produce unequal conditions that fuel health disparities. By examining how historically conditioned political and economic structures dictate health-disease processes, it moves beyond the basic evaluation of care. SDET provides both a theoretical model to analyze these interwoven conditions and an ethical framework dedicated to continually challenging the structures that shape our society. For this research, I chose to follow the SDET framework since it acknowledges how capitalist rule continues to shape global structures and public health concern²¹ and provides a different understanding of health-disease processes that can better serve our Indigenous communities because it fundamentally requires searching for alternative social arrangements. Using Hasemann Lara et. al’s comparison of SDOH and SDET, they mention how SDOH proffers neoliberal solutions that obscure much of the violence and dispossession that influence contemporary migration and health-disease experiences and that the political project that informs the SDOH both represents a Eurocentric approach to health-disease processes and best explains/characterizes the health interventions, or lack thereof²². In developing this distinction, the authors build on existing critiques of SDOH while pushing the conversation

²⁰ Ibid.

²¹ Morales-Borrero et al., "¿Determinación Social o Determinantes Sociales?"

²² Hasemann Lara et al., "Towards a Social Determination of Health Framework."

further through a decolonial lens, positioning SDET as a framework that more explicitly interrogates power, colonial legacies, and structural inequality within global health. They question whether global health initiatives can truly align with decolonial objectives²³, while also engaging work that highlights how public health systems continue to be shaped by Eurocentric assumptions²⁴. Through this approach, SDET is not only presented as an analytical tool, but as a way to expose how global health systems may normalize and reproduce inequality, rather than address its root causes.

Health System

Standard definitions of health system range from the combination of resources, organization, financing and management that culminate in the delivery of health services to the population²⁵ to all the activities whose primary purpose is to promote, restore or maintain health²⁶. To think of ‘health system’, I am pulling from Park, Hoekstra, and Jimenez’s *The Third Net: The Hidden System of Migrant Health Care*, where they describe the concept of purposive disarray of care²⁷ in which the health system is intentionally designed to exclude certain groups out, and that it is not a failure, but instead is working exactly as intended. Although this was conceptualized in regards to undocumented migrant care in the United States (U.S.), this can and should be applied in other places to combat the narrative that the health system is ‘failing’ and must be ‘fixed’, rather than focus on the root cause, that it is the

²³ Benton, "What's the Matter Boss, We Sick?"

²⁴ Edu, "Anthropological Knowledge under Redaction."

²⁵ Roemer, *National Health Systems of the World*.

²⁶ World Health Organization, *The World Health Report 2000*.

²⁷ Park, Hoekstra, and Jimenez, *The Third Net*.

system itself that is at fault and functions accordingly. Just as the U.S. health system depends on migrant exclusion to function, does the Colombian health system depend on Indigenous exclusion to function? Even the idea of a ‘health system’ is much more nuanced and is often composed of multiple entities, operating at differing levels (international, national, local), and with different schemes or ‘models of care’, especially regarding financing. Support and health outside of this broader institutional system has always existed, especially when it comes to marginalized populations, such as the Black Panther Party’s²⁸ Peoples’ Free Medical Clinics which were started due to systemic discrimination against Black Americans in hospitals and private medical practices²⁹ (Figure 1). In the subsequent chapter I will expand upon Colombia’s ‘universal healthcare system’, but as we will see neither the system nor the insurance aspect can be considered ‘universal’; neither can Indigenous health systems due to the specificities and differences between different Indigenous groups and even individual members of the same community. Yet, I will continue to refer to these as ‘health systems’ or ‘healthcare systems’ in order to better explain between them and for the purposes of the SISPI policy.

²⁸ Political organization created to fight police oppression of Black Americans in the Oakland, California

²⁹ Pien, "Black Panther Party's Free Medical Clinics."



Figure 1: The Black Panther Free Health Clinic Fliers
(Left) *To the People of the Community* 8 1/2 x 14 in. printed flyer³⁰
(Right) *The Opening of the Bobby Seale People's Free Health Clinic* printed flyer³¹

In this case, what I refer to as Indigenous health systems is what is known as Traditional and Complementary Medicine (T&CM). T&CM systems are present in many countries and can be seen through policies, laws, and regulations. Yet, most national health systems are typically based on bio-medicine which is a clinical based medicine with roots in physiology and biochemistry. Since the 1970s, the World Health Assembly (WHA) has released resolutions calling for more research and inclusion of T&CM into national health systems. Although the WHO has a definition for T&CM policies as “guiding principles

³⁰ Black Panther Party, Harlem Branch, "To the People of the Community..."

³¹ Robertson, "A Conversation with Prof. Alondra Nelson on the Black Panther Party's Fight for Health Care."

regarding policy, planning or future direction”³², it is broad and does not encompass the nuances in terms such as ‘traditional’ and ‘complementary’ and how they are used and understood differently with specificities in each region. For many millions of people, often living in rural areas, herbal medicines, traditional treatments and traditional practitioners are the main, sometimes the only, source of health care. Whilst for some people, traditional medicine meets an additional set of needs, who want natural products and want to have more control over their health and turn to complementary and alternative medicine to relieve common symptoms, improve their quality of life and protect against illness and diseases in a holistic way. Some find that success looks like traditional medicine being an option, a choice, offered by a well-functioning, people-centred and integrated health system that balances curative services with preventive care³³, yet what does this health system look like? Should it not be an Indigenous health system? Building on the concept of medical pluralism³⁴, I will be using Gallego-Pérez et al.’s concept of ‘therapeutic pluralism’³⁵ defined as “the strategic action field in which a variety of social actors perceiving life, health and healing according to diverging (or converging) cosmologies and cultures, mobilize for social space and the transformation of socially constructed systems and agency for inclusive action in health” to understand SISPI and the dynamics between the national health system and ancestral Indigenous health systems. Replacing the word medical for therapeutic connotes a meaning closer to the “art of healing”³⁶ whilst dropping the biomedicine subtext.

³² World Health Organization, *WHO Global Report on Traditional and Complementary Medicine 2019*.

³³ Zhang, "Traditional and Complementary Medicine in Primary Health Care."

³⁴ Leslie, "Medical Pluralism in World Perspective."

³⁵ Gallego-Pérez et al., "Characterizing Therapeutic Pluralism Policies in Latin America."

³⁶ *OED Online*, "Therapeutic, n."

Policy

Policy, as used throughout this analysis, operates on multiple levels. At the most visible level it refers to formal instruments such as laws, decrees, and health regulations such as SISPI, that codify rights and govern access to services. But policy also operates as an embedded governance practice, one in which, as Maria John argues in *Sovereign Bodies, Sovereign Spaces*, structural neglect becomes institutionalized over time, shaping Indigenous health governance in ways that outlast any single law. At a third level, policy functions as a site of power, determining who bears responsibility for Indigenous health care and under what framework. When health is positioned as a citizen's right rather than an inherent one, as John notes, policy becomes the mechanism through which access is conditioned on belonging to the nation-state³⁷. These tensions raise important questions about how policy operates in practice, particularly in Indigenous health contexts. Drawing on the concept of poverty governance, the idea that the state is less concerned with eradicating poverty than with managing the poor by processing them into docile and industrious subjects³⁸, does SISPI represent a genuine attempt to address health inequity, or a mechanism for containing it? And when the state offers 'self-governance' as a solution, does that represent genuine Indigenous autonomy or a quiet withdrawal of state responsibility?

This analysis also draws on Kanenberg et al.'s revised Intersectional Feminist Policy Analysis Framework³⁹, which expands McPhail's (2003) Feminist Policy Analysis

³⁷ John, *Sovereign Bodies, Sovereign Spaces*.

³⁸ Piven and Cloward, *Regulating the Poor*. ; Wacquant, *Punishing the Poor*. ; Soss, Fording, and Schram, *Disciplining the Poor*.

³⁹ Kanenberg, "Revising McPhail's Feminist Policy Analysis Framework."

Framework: Through a Gendered Lens⁴⁰. McPhail's original framework provides a systematic set of questions for evaluating any policy's gendered implications, examining whether it achieves equality or merely role equity, whether it is symbolic or material in its reforms, how it mediates state-market control over women, and whose experiences and identities it centers or renders invisible⁴¹. Kanenberg et al.'s revision incorporates an explicitly intersectional lens, foregrounding how gender cannot be separated from race, ethnicity, class, sexuality, documentation status, and ability, and how policies produce compounding, not simply additive, forms of discrimination⁴². Applied here, this framework moves the analysis of SISPI beyond whether it formally includes Indigenous women toward asking whose definition of health shapes the policy, who holds power in its implementation, and whether its reforms translate into material change in women's lives. These frameworks allow me, the researcher, to practice reflexivity, understand the complex dynamics that affect individuals, as well centering relationality, reciprocity, and accountability.

1.3 Global Recognition of Indigenous Rights

Indigenous peoples rights have long been violated in the Americas. Over 500 years of violence, assimilation policies, land removal and most importantly, resistance, Indigenous peoples across the Americas continue to fight for their sovereignty. Since the 1930s, Indigenous rights have been present in the International Labour Organization's (ILO) mission, which first began by addressing the discrimination and exploitation of Indigenous

⁴⁰ McPhail, "A Feminist Policy Analysis Framework: Through a Gendered Lens."

⁴¹ Ibid.

⁴² Kanenberg, "Revising McPhail's Feminist Policy Analysis Framework."

workers with the ILO Forced Labour Convention, 1930 (No. 29)⁴³. It was not until post World War II when human rights discourse was at an all time high, that it became clear that Indigenous rights violations were the consequences of deep rooted injustices and prejudices and intrinsically linked to broader issues of identity, language, culture, customs and land. With the passing of the World Health Organization (WHO) Constitution⁴⁴ and the Universal Declaration of Human Rights (UDHR)⁴⁵ in 1948, human rights were internationally established and recognized, holding all nation-states accountable for guaranteeing rights such as health while acknowledging that time and resources are required to fully achieve them⁴⁶. The 1957 ILO Indigenous and Tribal Populations Convention (No. 107) , in collaboration with the United Nations (UN) system, was the first international instrument adopted to protect Indigenous populations from oppression, discrimination and dealing with the rights of Indigenous peoples⁴⁷ with three quarters of member states ratifying this convention⁴⁸. Yet the architects of Convention No. 107 had an assimilationist approach, which in 1986 led to the convening of an expert committee of the ILO Governing Body which deemed the approach ‘obsolete’ and ‘detrimental’ in the modern world⁴⁹. After revising it, in 1989 the ILO adopted Convention No. 169 based on respect for the cultures and ways of life of indigenous peoples whilst recognizing their right to land and natural resources and to define their own priorities

⁴³ ILO, *Convention No. 169*, art. 6.

⁴⁴ WHO, “Constitution.”

⁴⁵ United Nations General Assembly, *Universal Declaration of Human Rights*

⁴⁶ WHO, “Human Rights and Health.”

⁴⁷ ILO, *Convention No. 107*

⁴⁸ United Nations General Assembly, *United Nations Treaty Collection*.

⁴⁹ ILO Library, “Indigenous Peoples.”

for development. One of the fundamental principles of this Convention was stressing the importance of consultation and participation of Indigenous peoples on a variety of issues such as employment and vocational training, education, health and social security, customary law, traditional institutions, languages, religious beliefs and cross-border cooperation⁵⁰.

A couple years later, the UN proclaimed 1993 to be the International Year for the World's Indigenous People calling upon the UN system and governments which have not yet done so to develop policies in support of the objectives and the theme of the International Year– “Indigenous People- a new partnership”– and to strengthen the institutional framework for their implementation⁵¹. This was then followed by the establishment of the UN Permanent Forum on Indigenous Issues in 2000, which gives Indigenous voices a direct avenue to international policymakers with issues related to economic and social development, culture, the environment, education, health and human rights⁵². Currently, out of the sixteen members of the Permanent Forum who are serving the 2026-2028 term, three are Latin American, one from Chile and two from Ecuador⁵³. Then in 2007, the landmark UN Declaration on the Rights of Indigenous Peoples (UNDRIP)⁵⁴ was adopted, the most comprehensive instrument detailing the rights of indigenous peoples in international law and policy, containing minimum standards for the recognition, protection and promotion of these rights while establishing a universal framework of minimum standards for the survival,

⁵⁰ ILO, *Understanding the Indigenous and Tribal Peoples Convention (No. 169)*

⁵¹ United Nations General Assembly, *Rights of Indigenous Peoples*, A/RES/61/295.

⁵² United Nations, “UNPFII.”

⁵³ United Nations, “Current UNPFII Members.”

⁵⁴ United Nations General Assembly, *Rights of Indigenous Peoples*, A/RES/61/295.

dignity, wellbeing and rights of the world's indigenous peoples⁵⁵. It also addressed both individual and collective rights, cultural rights and identity, and rights to education, health, employment, language, etc. while explicitly encouraging harmonious and cooperative relations between States and indigenous peoples⁵⁶. Out of all member states only four voted against ratification and eleven abstentions, including Colombia, yet in 2009 Colombia endorsed the UNDRIP⁵⁷. By 2010, all four countries who originally voted no reversed their positions⁵⁸.

The first UN World Conference on Indigenous Peoples held in 2014 served as an opportunity for Indigenous Peoples to share their perspectives and best practices on the realization of the rights of Indigenous Peoples and to pursue the objectives of the UNDRIP⁵⁹. Human rights are often intertwined, and as mentioned Indigenous Peoples' rights encompass a variety of other rights. Health itself is a very broad topic, and in preparation for the UN World Conference on Indigenous Peoples, the Inter-Agency Support Group (IASG) on Indigenous Issues released several thematic papers including not only 'Health of Indigenous Peoples'⁶⁰, but more specifically 'Sexual and Reproductive Health and Rights of Indigenous Peoples'⁶¹. Although there is an abundance of literature in regards to health rights, for the

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ UNHCR, "Colombia's Support for UN Declaration on Indigenous People Welcomed."

⁵⁸ United Nations General Assembly, *Rights of Indigenous Peoples*, A/RES/61/295.

⁵⁹ United Nations, "Press Release: General Assembly Adopts Resolution on Organization of the High-Level Plenary Meeting."

⁶⁰ Inter-Agency Support Group on Indigenous Peoples' Issues, *The Health of Indigenous Peoples*.

⁶¹ Inter-Agency Support Group on Indigenous Peoples' Issues, *Indigenous Peoples' Access to Health Services, Including Sexual and Reproductive Health*.

purposes of this research, I will be looking at health through an Indigenous rights lens, situating health within the context of Indigenous ideology and interpretations of health, which in and of itself is nuanced and specific to communities and individual experiences. Indigenous rights have also had significant advances regarding international environmental law in which Indigenous peoples successfully advocated for their inclusion in the 2015 Paris Agreement⁶² and the 2030 UN Agenda for Sustainable Development⁶³. Most recently, in May of 2025, the WHO's World Report on Social Determinants of Health Equity for the first time, formally recognized Indigeneity as a social determinant of health (SDOH)⁶⁴ which has been shaped by discrimination and historical injustice. Thinking through this international frame regarding Indigenous rights, healthcare systems worldwide have undergone significant changes impacting and reshaping Indigenous experiences with healthcare. For the better, these changes have also given opportunity for Indigenous communities to preserve and use their health practices and in the case of Colombia, policies prioritizing Indigenous ideology and sovereignty in numerous aspects primarily health.

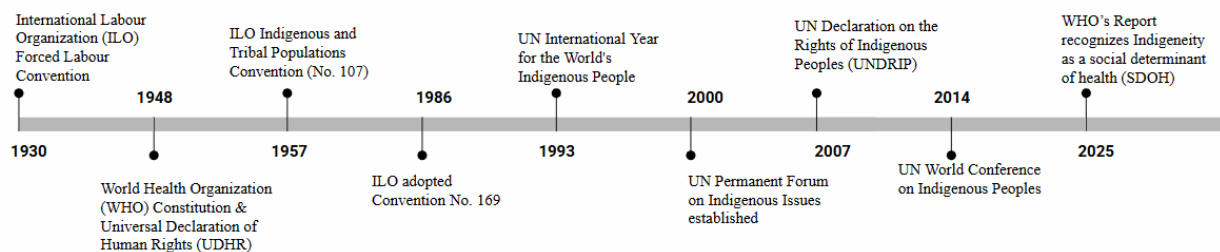


Figure 2: Timeline of International Events on Indigenous Rights

⁶² UNFCCC, Paris Agreement.

⁶³ United Nations, Transforming Our World: The 2030 Agenda for Sustainable Development.

⁶⁴ WHO, *World Report on Social Determinants of Health Equity*.

1.4 Why La Guajira, Colombia and the Wayuu?

According to Colombia's 2018 national census (DANE)⁶⁵, there are approximately 1,905,617 Indigenous peoples in the country, representing about 4.4% of the total population across 115 distinct groups⁶⁶. The largest of these groups are the Wayuu, who inhabit the northern Caribbean region of Colombia and extend into Venezuela across the La Guajira Peninsula and are descendants of the Arawak and Carib tribes that spread across the wider Caribbean world⁶⁷. For the purposes of this research, I refer to the Wayuu as a single Indigenous people, recognizing that Wayuu identity is fundamentally relational and often matrilineal, where belonging is transmitted through family lineages and clan organization. The Wayuu live within a matrilineal, clan-based social structure composed of numerous *eirukuu* (clans), including Ulewana, Epieyú, Uriana, Ipuana, Pushaina, and others. Their territory, the Guajira Peninsula, is an arid desert ecosystem that they understand not as peripheral land but as a sacred and living space. This territorial relationship is not bounded by nation-state borders; rather, Wayuu mobility and identity extend across Colombia and Venezuela, reflecting a form of binational Indigenous existence that predates the formation of both states. To name this reality on its own terms: the Wayuu, like all Indigenous peoples of the continent, inhabit *Abya Yala*⁶⁸, meaning 'mature land, living land or flowering land'⁶⁹, a name that asserts Indigenous peoples' relationship to this land as preceding and exceeding the colonial designations imposed upon it. Recognizing the continent as *Abya Yala* rather

⁶⁵ Departamento Administrativo Nacional de Estadística

⁶⁶ DANE, *Censo 2018: ¿Cuántos somos?*

⁶⁷ Vanderbilt University Libraries, *Culture (MZO Archive)*.

⁶⁸ Term used by the Kuna people who live on the borders of the nation-states of Colombia and Panama

⁶⁹ Carrera Maldonado and Ruiz Romero, *Abya Yala Wawgeykuna*.

than 'America' is not merely terminological; it is a political and epistemological refusal of the colonial framework that produced the very borders the Wayuu now navigate (Figure 3). However, this transnational Indigenous reality is not recognized within state governance structures and for the purposes of this research I will use Abya Yala going forward to refer to the Latin American continent as a whole in accordance with Indigenous interpretations and relations to land while using countries names such as Colombia to indicate policy demarcations and governance implications. As a result, Wayuu individuals who cross from Venezuela into Colombia are often classified as migrants, despite belonging to the same ancestral territory⁷⁰. This reflects a broader structural disjuncture in which Indigenous territoriality is rendered invisible within national legal and administrative systems, producing conditions in which the Wayuu are simultaneously Indigenous to the land and treated as outsiders within it. La Guajira is therefore not only geographically distinct but politically and socially complex. It is a region shaped by intersecting histories of colonial extraction, contemporary resource economies, and state marginalization⁷¹. Despite being rich in natural resources, including coal and wind energy potential, the region has been repeatedly characterized by severe infrastructural neglect, water scarcity, and high levels of poverty and food insecurity⁷². At the same time, La Guajira has become a central site for extractive industries and energy transition projects, which further complicate Indigenous territorial rights and governance.

⁷⁰ Dayanna Gladys Palmar Uriana and Paulo Ilich Bacca, “The Binationality of the Wayuu People.”

⁷¹ Gilbert, Gilbertson, and Jakobsen, “Incommensurability and Corporate Social Technologies,” ; René Kuppe, “El Cerrejón, the Wayuu Struggle and Coal for Germany.”

⁷² “From a Vibrant Past to a Desolate Future.”



Figure 3: Map of Abya Yala⁷³

The region is also shaped by multiple overlapping populations and mobilities, including Indigenous Wayuu communities, Afro-Colombian populations, internally displaced Colombians, and Venezuelan migrants. These intersecting identities contribute to a layered social landscape in which access to healthcare, citizenship rights, and basic services is unevenly distributed and structurally mediated. The Venezuelan migration crisis has further intensified these dynamics, particularly in border municipalities, where Indigenous and migrant populations often share precarious conditions while being differently classified by the state⁷⁴. This has produced a situation in which Indigenous communities are frequently positioned within humanitarian frameworks rather than recognized as rights-bearing political collectives with autonomous governance systems⁷⁵. La Guajira is also central to

⁷³ Jason Antrosio, “Before the Europeans.”

⁷⁴ Malteser International Americas, “Do Not Forget the Wayuu Nation.”

⁷⁵ Open Society Justice Initiative, “Need for Papers Threatens an Indigenous Way of Life.”

understanding the Colombian healthcare system's limits in Indigenous territories. Despite formal legal recognition of Indigenous health rights, access to services remains uneven, particularly in rural and desert areas where infrastructure is limited and where Indigenous health systems operate alongside or outside state provision. Taken together, La Guajira is not simply a field site but a critical analytical space where questions of Indigenous sovereignty, state governance, migration, and health intersect. It is a region where the tensions between Indigenous territorial continuity and nation-state borders become especially visible, and where policies such as SISPI must be understood not only as reforms but as contested forms of governance embedded in long histories of neglect, extraction, and resistance. Can there ever really be sustainable ways to integrate Indigenous practices into existing medical systems when processes of biomedical training and institutional indoctrination may produce internal ruptures within communities? This is particularly evident in conversations around younger Wayuu generations who have become doctors or now enter spaces that were once structurally and socially separated from Indigenous ways of knowing, reshaping how health, identity, and authority are negotiated within the community⁷⁶.

1.5 Methodology

Thinking through these tensions, my research consisted of qualitative methods ranging from literature review, policy analysis, interviews, focus groups and lived experience. More broadly, I will be using Binish Ahmed's Indigenous Policy Research Framework (IPRF)⁷⁷ which encompasses eleven principles: 1) Locating self-

⁷⁶ Malteser International Americas, "Creating Social Cohesion."

⁷⁷ Ahmed, "Decolonizing Policy Research as Restorative Research Justice: Applying an Indigenous Policy Research Framework (IPRF)."

outsider/insider; 2) Relationship building; 3) Identify why the work is being done and why you are doing this research? Does the community desire it? Who benefits? Does the community benefit? ; 4) Engage, read and cite Indigenous knowledge holders and scholars 5) Sovereign Indigenous research jurisdictional (SIRJ) rights 6) Long term relationships rather than parachuting 7) Building relations that honor Indigenous and Tribal protocols 8) Collaborative partnerships 9) Practicing proper knowledge attribution 10) Critical-self reflexivity; and 11) Research as a practice of counter-hegemony (disrupting the status quo).

I begin the first chapter by providing some examples of how T&CM has been integrated within different countries in Abya Yala. This is then followed by a brief overview of Colombia's history and emergence of the national healthcare system and the Indigenous activism that set the foundation for SISPI to emerge. Followed by a country comparison, situating Colombia's SISPI policy alongside other countries' in Abya Yala similar policies, highlighting differences, similarities and potential implications regarding policy implementation. Looking closer at La Guajira's position and certain actors, such as Anas Wayuu, and efforts that made SISPI possible in order to situate local action and policy decisions with the fieldwork I conducted from August to November of 2025. In the second chapter, I write through the conversations I had with Wayuu women in one test focus group (a.k.a focus group 0) and three official focus group interviews (Table 1), two interviews with physicians, and observations from other experiences places I visited. In this chapter, I also add in personal encounters, images, and provide more context as to the environmental, physical, and cultural aspects that impact health decisions and outcomes for Wayuu communities showcasing that SIPSI's national approach still leaves many local issues that need to be addressed and resolved.

All focus groups and interviews were conducted following the IRB guidelines and protocol submitted, participants were informed of research purposes, the format of the discussion and their presence was completely voluntary— see appendix for data collection questions. The names of all the participants, organizations I directly worked with and rancherías (communities) have been pseudonymized for their privacy and confidentiality. Focus Group 0 unexpectedly occurred during a community visit with the international organization that I worked with, Wayuu Woven Community (WWC), after the Wayuu women heard about my research and wanted to participate. Focus Group 1 and 2 were coordinated and scheduled with WWC, so participants were picked by the organization and those who could make it came to their office in Riohacha. Raíces de Talento (RDT), a local organization working with WWC, put me in contact with the Wayuu woman who helped me plan and schedule Focus Group 3. She went out into her local neighborhood, advertising the focus group conversation essentially employing snowball sampling. One of my physician interviews I met through snowball sampling after one of the co-founders of WWC mentioned working on a women's health project together a few years back in La Guajira. The other physician I met during an international forum on migration that was hosted in Riohacha during my fieldwork. There were several other Wayuu women interested in participating but due to time constraints I was unable to conduct additional focus groups sessions. Situating the national, political dimensions with the local, lived experiences aims to use La Guajira as a case study for how these pro-Indigenous health policies at large can impact Indigenous communities in Colombia and globally.

Table 1: Focus Group Details with Wayuu Women				
Focus Group	#0	#1	#2	#3
Participant Number	7	9	15	12
Location	Rancheria A	Riohacha (WWC Office)	Riohacha (WWC Office)	Camarones (Settlement K)
Length	unknown	1:03:00	00:59:25	00:43:06
Wayuu Communities	Rancheria A Rancheria B	Rancheria B Rancheria C Rancheria D Rancheria E Rancheria F Rancheria G	Rancheria A Rancheria B Rancheria C Rancheria D Rancheria E Rancheria G Rancheria H Rancheria I	Rancheria A Rancheria J Settlement K
Affiliation	WWC and Un Nuevo Amanecer	WWC	WWC	Raíces de Talento

* WWC: Wayuu Woven Community

1.6 Intersectional Health Justice & Positionality

This project is grounded in intersectional health justice by examining how the Colombian health system accounts for (or fails to account for) Indigenous identity, territory, gender, and historical marginalization. SISPI's emphasis on traditional and ancestral forms of care raises critical questions about whether state healthcare structures can truly support Indigenous ways of healing. By focusing on La Guajira, this research highlights how intersecting systems of colonialism, race, gender, and geography shape health access and outcomes. My parents are Colombian immigrants to the U.S., with no Indigenous identity,

and I was born and raised in the U.S.. Growing up, I would spend most holidays in Bogota, the capital of Colombia, visiting my family and to this day most of my extended family still lives there. This work has been shaped by the focus groups I conducted with these Wayuu women regarding their perceptions, understandings and barriers to health, more specifically sexual and reproductive healthcare. It is also shaped by the interactions, conversations, literature and experiences that I have encountered prior, during and after my field work as I continue to learn more and more about the intersections between health, policy and Indigeneity mostly shaped by the Wayuu community. This positionality informs my interest in how state policies intersect with Indigenous knowledge systems, while also requiring ongoing reflexivity about power, representation, and accountability in my research. Thinking critically through these policies at not just the national Colombian level, but focusing on the local and global simultaneously while also situating this work within my broader research interests which include personal, moral, ethical and spiritual aspects. Envisioning a world where Indigenous people's health practices and knowledge are respected, creating more collaborative efforts to take care of one another and moving away from capitalist, profit-driven models that do not ensure equitable access to healthcare.

II. Policy Chapter

2.1 Traditional and Complementary Medicine in Abya Yala

Across Abya Yala, the question of how to relate Indigenous and traditional health practices to national biomedical systems has generated a rich and contested policy landscape. The region is home to one of the largest concentrations of Indigenous peoples in the world, and their health needs, epistemologies, and healing traditions have increasingly demanded recognition within state health frameworks, not as cultural supplements to biomedicine, but as distinct and coherent systems of knowledge in their own right. In Abya Yala, there is a range of T&CM vocabulary to describe Indigenous health systems. In Brazil, 'health practices' is preferred over 'medicine' while in countries like Colombia, Chile, Ecuador, Guatemala, and Peru the term 'alternative' medicine or therapies is still commonly used. These terminological differences are not merely semantic. They reflect distinct political histories and different degrees of institutional willingness to recognize Indigenous health knowledge as legitimate rather than supplementary. Calling something 'complementary' or 'alternative' already positions it in relation to a biomedical center as subordinate, optional, or secondary. The preference for 'health practices' in Brazil, by contrast, sidesteps that hierarchy entirely.

A central concept threading through this region's efforts to integrate these systems is interculturality which is understood not simply as cultural sensitivity, but as a structural commitment to horizontal relationships between different healing traditions, rejecting dominance and hegemony in favor of genuine dialogue. Gallego-Perez et al. describe interculturality as a proposed decolonizing mechanism, one that seeks to develop symmetries

in power relations and to move beyond neoliberal and capitalist frameworks for health⁷⁸. In practice, however, the gap between interculturality as principle and interculturality as implemented policy has been persistent and wide. Meanwhile, the philosophy most deeply embedded in Indigenous understandings of health across the region is Buen Vivir, translated variously as 'good living' or 'living well', which understands health not as the absence of disease but as a relational process: the harmonious balance of a person's relationships with themselves, their family, their community, their territory, and nature⁷⁹. Countries such as Bolivia and Ecuador have incorporated versions of this philosophy, Vivir Bien and Sumak Kawsay respectively, into their constitutions, establishing it as a foundational principle of the state⁸⁰. Yet, some scholars have argued that based on how Buen Vivir was implemented in Bolivia and Ecuador, the concept has been colonized for neoliberal political purposes⁸¹. Colombia's SISPI, in its definition of health as Good Living, draws on this same tradition, though it does so within a national healthcare framework that has not undergone the same constitutional transformation.

The different T&CM landscape across Abya Yala reveals both what is possible and what remains structurally constrained. Brazil's framework for therapeutic pluralism is among the strongest in the region, enabling not only domestic integration of traditional medicine but international health diplomacy⁸². Bolivia's intercultural health initiatives in Tinguipaya,

⁷⁸ Gallego-Pérez et al., "Characterizing Therapeutic Pluralism Policies in Latin America."

⁷⁹ SSI-MPC, Guía metodológica para la implementación del SISPI.

⁸⁰ Rapid Transition Alliance, "Buen Vivir: The Rights of Nature in Bolivia and Ecuador."

⁸¹ Acosta, "El buen vivir, una oportunidad por construir."

⁸² WHO, "Integrating Traditional Medicine into Health Systems."

Potosí, demonstrate that networks between traditional healers, biomedical staff, and communities can improve both access and acceptability of care, while also revealing the persistent challenges of differences in epistemologies and decision-making authority⁸³. Mexico's initiatives to hire Indigenous nurses and train Indigenous community health workers offer another model, though implementation varies widely by region⁸⁴.

What these examples share, and what the Colombian case will illustrate in depth, is that legal recognition and participatory frameworks are necessary but not sufficient. Recognition on paper does not automatically produce equitable care. Sustainable improvements in Indigenous health require systems that are bottom-up, culturally grounded, and locally managed, which is precisely the model that SISPI aspires to be, and that the following sections examine with both recognition of its achievements and honest scrutiny of its limits. In order to understand how SISPI is meant to operate, an understanding of how Colombia's national healthcare system has developed and how it currently operates is necessary.

2.2 Brief Overview of Colombia's National Healthcare 'System'

In 1991, the constitutional right to healthcare was established in Colombia⁸⁵. Two years later, in 1993, Colombia passed Law 100 introducing the Sistema de Seguridad Social Integral otherwise known as its universal healthcare plan with the purpose of ensuring the right to healthcare for all of its citizens⁸⁶. Prior to this law being passed, Colombia's

⁸³ Torri and Hollenberg, "Indigenous Traditional Medicine and Intercultural Healthcare in Bolivia."

⁸⁴ Gabriela Soto Laveaga, "Doña Hermila Diego."

⁸⁵ Constitución Política de la República de Colombia.

⁸⁶ Congreso de la República de Colombia, *Ley 100 de 1993*.

healthcare services were provided by three different systems: the public system, the insurance system and the private system. The National Health System (SNS)⁸⁷, which was created in 1975 aimed at integrating all hospitals (private, public, or social security) to extend services to the population and increase efficiency, struggled to meet population needs. High-income individuals comprised most of the private system, individuals with formal employment comprised most of the social security system, whilst the rest of the population fell into the public system⁸⁸. Although the public system was a government-financed operation, aimed at low-income and unemployed citizens it was not protected by any type of health insurance. The trend towards universal healthcare was happening in many middle-income countries, but Colombia's model was both new and 'radical'⁸⁹. Pressing issues led to Law 100 being passed and subsequently the General Social Security Health System (SGSSS)⁹⁰ which is essentially the entire national healthcare system meanwhile the SNS became the regulatory body that supervises and controls the entities within.

During the SNS period, insurance reached only 23% of the population, with coverage concentrated among urban and suburban working people and the consequences for Indigenous communities were severe. Factors such as geographical barriers, economic disparities, cultural differences, political neglect, internal conflicts, and a lack of trained medical personnel produced low institutional presence and poor medical infrastructure in precisely the rural and dispersed areas where Indigenous populations were concentrated. The

⁸⁷ Sistema Nacional de Salud

⁸⁸ Glassman et al., From Few to Many.

⁸⁹ Ibid.

⁹⁰ Sistema General de Seguridad Social en Salud

1981 Ministry of Health Resolution 10013 attempted to address this by recognizing Indigenous communities' organizational and cultural structures and introducing the concept of free services for 'vulnerable' populations, but this framing perpetuated the stigmatization of Indigenous peoples as 'poor' from a capitalist perspective, and implicitly treated Indigenous health knowledge as lacking Western scientific validity⁹¹. The health of Indigenous peoples continued to be directed by state entities and Western scientific frameworks rather than by Indigenous communities themselves, and it wasn't until the 1991 constitutional reform that universal health insurance became available.

One of the most impactful changes of this universal health insurance, known as Health Promoting Enterprises (EPS)⁹², is that it is defined by two regimes: the contributory regime, mainly formally employed and independent workers with a predetermined minimum income level, and the subsidized regime, people who are identified as poor and indigent through the Beneficiary Identification System (SISBEN)⁹³ created in 1994⁹⁴. This classification placed Indigenous peoples within the subsidized regime as a 'vulnerable group,' a designation that, as Puerto (2023) argues, continued the colonial logic of rendering Indigenous peoples as subjects of state welfare rather than rights-bearing political collectives with their own governance systems and health priorities⁹⁵. Since its inception, many efforts have been made to ensure insurance coverage or enrollment in these EPS from the most

⁹¹ Hugo Puerto, *Weaving Life*.

⁹² Empresas Promotoras de Salud

⁹³ Sistema de Identificación de Beneficiarios

⁹⁴ Zuluaga and Tejerina, "30 Years of Social Targeting in Colombia."

⁹⁵ Hugo Puerto, *Weaving Life*.

urban to rural of places so that people can access the Health Providers Institutions (IPS)⁹⁶. Today, Colombia boasts that upwards of 90% of its population is covered by health insurance, yet it has been repeatedly found that long wait times and access to health services continue to pose a problem for the majority of the population. Additionally, the Colombian healthcare system has undergone many challenges requiring changes in financial models⁹⁷, addressing barriers regarding the growing internally displaced population's (IDP) needs, to most recently accommodating services amidst the Venezuelan migrant crisis which began around 2014⁹⁸. Serving a diverse population with complex identities ranging from Indigenous, Afro-Colombian, internally displaced, Venezuelan migrants, Mestizos and more. Although each of these groups interact and experience the healthcare system differently, lack of infrastructure, complicated geographies, socioeconomic status, and cultural differences all affect health outcomes. Yet, with these challenges have come many triumphs for many groups, especially Indigenous peoples.

The creation of Indigenous EPSs (EPSI) spurred the creation of Indigenous IPSs which are located mostly in rural areas, where many Indigenous Peoples reside; also holds contracts with non Indigenous IPSs in order to maximize coverage and access. Colombia has six EPSIs operating nationally, each created by Indigenous organizations rooted in specific territories: Anas Wayuu (Maicao, La Guajira), Asociación Indígena del Cauca (Popayán, Cauca), Dusakawi (Valledupar, César), Mallamas (Ipiales, Nariño), Manexka (San Andrés de Sotavento, Córdoba), and Pijaos Salud (Ibagué, Tolima) that collectively provide coverage to

⁹⁶ Instituciones de Prestación de Servicios

⁹⁷ Rodríguez-Monguió and Infante Campos, "Universal Health Care for Colombians."

⁹⁸ UNHCR, "Venezuela Crisis Explained."

approximately 1,180,000 people⁹⁹. Unlike standard EPSs, EPSIs operate within Indigenous governance structures and go beyond insurance administration by supporting traditional health practices, nutritional sovereignty, the recovery of traditional crops, intercultural health programs, and bilingual services. Indigenous IPSs affiliated with these EPSIs concentrate in rural areas, where 78% of Colombia's Indigenous population lives, organizing health brigades that reach isolated communities¹⁰⁰. Despite operating within the same legal and financial constraints as standard EPSs, and facing additional pressures from armed conflict, geographic dispersion, and political interests, EPSIs have demonstrated that Indigenous-led health governance can produce measurably better outcomes in access, cultural appropriateness, and user satisfaction than the broader system.

After fifteen years of efforts, involving local stakeholders, Indigenous leaders, and both Indigenous and health rights activists, Colombia's Ministry of Health passed Decree Law 0480 in April of 2025 which establishes and implements SISPI as a state policy. This law is meant to regulate the administration, financing, and operation of health services in Indigenous territories, respecting their autonomy and integrating them with the general health system¹⁰¹. Yet, due to an extensive history of violence and conflict, stemming from colonial and imperial powers to modern day state sanctioned, corporate extractive activities and armed group tensions, Indigenous livelihood and sovereignty are consistently put at risk with health being at the center of this. It is also worth noting that the SGSSS framework does not fully account for the Wayuu, whose territory spans the Colombian-Venezuelan border, yet

⁹⁹ Mignone, Nállim, and Gómez Vargas, "Indigenous Control over Health Care."

¹⁰⁰ Mignone and Gómez Vargas, "Health Care Organization in Colombia."

¹⁰¹ Ministerio de Salud y Protección Social, *Decreto Ley 0480*.

are a people for whom the nation-state's categories of citizenship and territorial jurisdiction have always been an imposition rather than a reflection of their reality. Venezuelan Wayuu who cross into Colombia are classified as migrants despite belonging to the same ancestral territory, and the SGSSS, including its Indigenous provisions, offers them no clear path to the rights it formally guarantees. This structural disjuncture, which SISPI has not yet resolved, is one of many issues that must still be resolved. Understanding the evolution of the Colombian national healthcare system and the subsequent development of SISPI requires a close examination of past and ongoing Indigenous activism and advocacy.

2.3 Indigenous Activism in Colombia: SISPI's Creation, Promises and Progress

Between the 1970s-1980s, Indigenous mobilization was at an all time high in Colombia. In 1971 the Cauca Regional Indigenous Council (CRIC)¹⁰² emerged demanding for land and rights within the department¹⁰³ of Cauca¹⁰⁴ and in 1982 the National Indigenous Organization of Colombia (ONIC)¹⁰⁵ emerged to defend autonomy, culture, and traditional medicine. Apart from the reforms to the health system, in 1996, Decree 1397 created the National Commission on Indigenous Territories¹⁰⁶ and the Permanent Concertation Table with Indigenous Peoples and Organizations (MPC)¹⁰⁷. During the 1990s-2000s, the peak of the armed conflict, Indigenous communities faced violence, displacement and human rights

¹⁰² Consejo Regional Indígena del Cauca

¹⁰³ The term "department" in Colombia refers to a legally demarcated region like a state or a province.

¹⁰⁴ Urrego Rodríguez, Configuración de las políticas públicas de salud.

¹⁰⁵ Organización Nacional Indígena de Colombia

¹⁰⁶ Comisión Nacional de Territorios Indígenas

¹⁰⁷ Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas

violations, and amidst this the Law 691 of 2001 was passed which regulated the right of access to and participation of Indigenous Peoples in the SGSSS to guarantee that Indigenous communities could receive health care services in a manner consistent with their cultural background, while also strengthening their autonomy in managing these services. Additionally, as previously mentioned, Colombia supported the UNDRIP in 2009 which established minimum standards for the survival, dignity, and well-being of Indigenous peoples worldwide¹⁰⁸.

The emergence of SISPI is said to begin in 2010. The assembly held in Villeta, Cundinamarca specifically called for the creation of a special health system for Indigenous Peoples and the establishment of the National Coordinating Roundtable on Health for Indigenous Peoples¹⁰⁹; this was where the formulation of the foundational document for SISPI began and was done in accordance with the 2010–2014 Colombian National Development Plan. In 2011, Law 4633 was established with specific measures to assist, address, and fully restore the territorial rights of Indigenous Peoples who are victims of the armed conflict, including implementing a comprehensive healthcare strategy. Following that, Decree 1973 established in 2013 led to the creation of Indigenous Health Subcommittee of the MPC (SSI-MPC)¹¹⁰, which led to the official adoption of SISPI by the national government in Decree 1953 of 2014. Subsequently in 2015 Law 1751 regulated the fundamental right to health, recognizing the health rights of Indigenous Peoples based on their systems of knowledge, worldview, cosmology, and beliefs while including a definition

¹⁰⁸ UNHCR, “Colombia’s Support for UN Declaration on Indigenous People Welcomed.”

¹⁰⁹ Mesa Coordinadora Nacional de Salud para Pueblos Indígenas

¹¹⁰ Subcomisión de Salud Indígena de la Mesa Permanente de Concertación con Los Pueblos y Organizaciones Indígenas

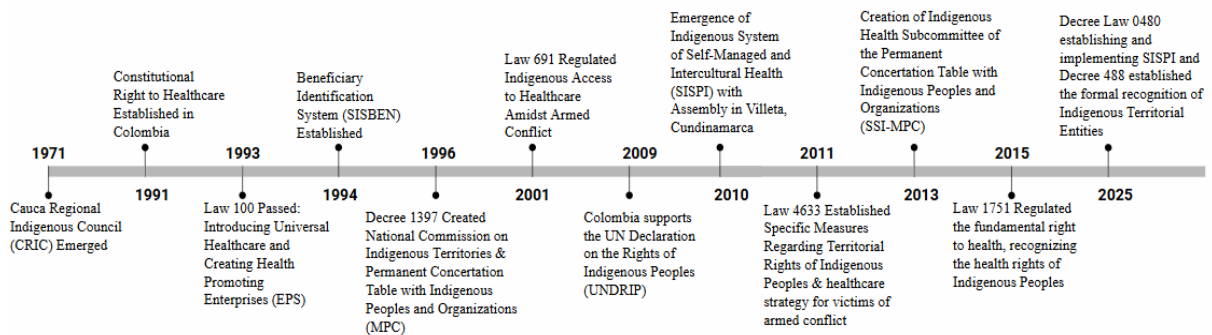
of the social determinants of health. In the next ten years, regional and national discussions were taking place regarding Indigenous autonomy and health with international support from the UN Special Rapporteur on the rights of Indigenous Peoples in 2024¹¹¹. These laws and decrees ultimately resulted in the April 2025 Decree Law 0480 establishing and implementing SISPI as a state policy on health for the Indigenous Peoples of Colombia is issued, and defined as a set of policies, norms, principles, resources, institutions, and procedures based on collective life and ancestral wisdom. Within those ten years, COVID-19 had a huge impact on Indigenous communities, the Colombian healthcare system and government, delaying the progression of SISPI, yet through multiple roundtable discussions across the country they were able to get it into national policy.

This effort also led to the passing of Decree 488 in May 2025 which established a legal framework for the formal recognition of Indigenous Territorial Entities¹¹² with political, administrative and fiscal autonomy. This form of legal pluralism advances a model of governance in which Indigenous law is not merely tolerated or informally exercised, but officially recognised within the legal architecture of the Colombian State. Integrating Indigenous self-governance and health services within state frameworks directly addresses critical questions of accountability and decision-making power. Although there are clear reasons as to the importance and recognition of Indigenous ideology within state governance, how can these institutions support Indigenous practices if their very creation was often set up against Indigenous identity?

¹¹¹ UN, “UN Expert Urges Colombia to Prioritise Indigenous Peoples’ Rights.”

¹¹² Entidades Territoriales Indígenas

SISPI was no easy feat, and questions regarding feasibility and implementation are still pressing amongst Indigenous communities facing ongoing health challenges. Although each individual Indigenous community is able to ‘choose’ its participation, acceptance and formulation of SISPI, this broad national policy even applied locally can still miss the nuances between individuals and even subgroups within one Indigenous community. How do all Indigenous peoples get grouped together, erasing identity and the complex ways that make each person and community different? How does power come into play within Indigenous communities where certain stakeholders or actors are in charge of shaping, framing, and delegating the implementation of SISPI? What does it mean for ancestral practices and ideas of health stemming from Indigenous roots when it is a part of a broader neoliberal health system?



**Figure 4: Timeline of Colombian National Events and Policies
Regarding Indigenous Health Rights**

2.4 Policy Comparison and Implications for Colombia

Rather than simply mapping the differences between Indigenous and national health systems, this section uses Gallego-Perez et. al's (2023) concept of 'therapeutic pluralism' to analyze how these systems relate to, contest, and negotiate with one another. Placing

Colombia within a broader cross-national comparison, the aim is to examine not only what SISPI promises but how it measures up against regional models and what those comparisons reveal about the possibilities and limits of integration. At the time, Gallego-Perez et al. (2023) categorized Colombia with a ‘participatory’ approach to therapeutic pluralism policy, characterized as relying on ample participation of social actors in policy development, with a ‘bottom-up’ approach, and health ministries usually facilitating policy development. The other two countries classified in this way were Brazil and Chile. These differences in terminology and policy approach illustrate the diversity of therapeutic pluralism across the region and set the stage for examining country-specific frameworks in Brazil and Chile.

Due to the large number of Indigenous peoples in Abya Yala, many countries have what are considered therapeutic pluralism policies, horizontal relationships between traditional medicine and biomedicine, encompassing ideas of interculturality and positioned as a decolonial mechanism moving beyond neoliberal and capitalist methods¹¹³. Therapeutic pluralism refers to systems where multiple healing traditions coexist, including biomedicine and Indigenous practices, ideally in a collaborative and culturally sensitive manner. Comparative studies of Indigenous health policies across Abya Yala and beyond offer valuable insights for Colombia’s SISPI initiative. While these lessons are drawn from diverse global contexts including Australia and New Zealand they resonate with experiences in Abya Yala and provide a framework for understanding how participatory approaches can be operationalized in Colombia. Research examining Australia, Brazil, Chile, and New Zealand highlights how governmental recognition of Indigenous health needs and meaningful engagement with Indigenous communities varies widely, with Brazil and New Zealand

¹¹³ Gallego-Pérez et al., “Characterizing Therapeutic Pluralism Policies in Latin America.”

demonstrating stronger policy frameworks, while Australia and Chile show limited structural support for Indigenous participation in health governance¹¹⁴. Even where policies exist, implementation gaps persist, demonstrating that recognition on paper does not automatically translate into effective, equitable health care. Taken together, these cross-country comparisons underscore that while legal recognition and participatory frameworks are necessary, they must be paired with robust accountability, adequate resources, and culturally grounded implementation strategies to reduce health inequities effectively.

Brazil's leadership in traditional medicine extends beyond national policy. Brazil's strong national framework for therapeutic pluralism enables it to engage internationally, demonstrating how domestic policies can inform global health diplomacy and Indigenous knowledge protection. In June 2024, during the G20 health working group meetings in Brazil, the country helped organize a high-level event on traditional medicine alongside India, South Africa, China, Indonesia, and the United States, with participation from WHO, PAHO, and World Intellectual Property Organization (WIPO)¹¹⁵. The discussions highlighted advances in integrating traditional medicines into national health systems, capacity-building initiatives, and international frameworks for protecting Indigenous knowledge. A milestone was the signing of the WIPO Treaty on Intellectual Property, Genetic Resources, and Associated Traditional Knowledge, which ensures Indigenous Peoples are recognized as custodians of biodiversity and traditional knowledge, and that benefits arising from their use are equitably shared. This international engagement reinforces Brazil's domestic policies, situating Indigenous and traditional health practices not only

¹¹⁴ Davy et al., "Indigenous Engagement in Health."

¹¹⁵ WHO, "Integrating Traditional Medicine into Health Systems."

within national healthcare systems but also on the global stage, providing lessons for Colombia in legitimizing Indigenous knowledge while protecting cultural heritage. Chile, by contrast, demonstrates the limits of participatory frameworks, despite policy language supporting Indigenous health, structural support for Indigenous participation in health governance remains weak in practice. Colombia's SISPI occupies a middle position more institutionally ambitious than Chile's approach and more community-driven in its origins than Brazil's top-down integration, but facing implementation challenges that neither country's model fully resolves.

Within Colombia, translating SISPI from national policy into community practice has proven neither linear nor uniform. According to the SISPI Methodological Guide (2016), implementation unfolds across three phases: 1) a comprehensive study of each Indigenous community's sociocultural characteristics and relationship to the SGSSS 2) the active construction of a community-specific action plan coordinating Indigenous and institutional actors across local, departmental, and national levels and 3) a final phase of consensus-building, financing agreements, and operational planning anchored in each territory's specific conditions¹¹⁶. What this framework makes clear is that SISPI is not a standardized program applied uniformly across Colombia's 115 Indigenous groups, but it is a process that must be built differently in each community, shaped by that community's language, governance structures, and territorial realities. The will and commitment of all involved actors, from national government institutions to local traditional authorities, is not incidental to implementation, it is constitutive of it.

¹¹⁶ Ministerio de Salud y Protección Social, *Guía metodológica del SISPI*.

The arrival of the Petro government in 2022 opened a more favorable political moment for Indigenous health autonomy, with SISPI financing and implementation explicitly incorporated into the 2022-2026 National Development Plan. A critical milestone was Decreto 968 of 2024, which formally recognized and regulated the SISPI experience developed by the CRIC in Cauca, a system built autonomously by eleven Indigenous peoples and 138 traditional authorities, which served as a territorial pilot for the eventual national Decreto Ley 480 of 2025. This trajectory reveals both the possibility and the fragility of SISPI's progress: it required decades of Indigenous organizing and a specific political alignment to reach national policy status, and its future implementation depends on sustaining that alignment across changing administrations. The structural challenge identified by Indigenous organizations themselves is not primarily financial or administrative, it is epistemological. The risk is that SISPI becomes absorbed into the same bureaucratic logics of the SGSSS that have historically fragmented care and subordinated Indigenous autonomy, reducing interculturality to symbolic adaptation rather than genuine transformation. La Guajira sits at the center of this tension: home to one of the most institutionally developed Indigenous health entities in the country in Anas Wayuu, and yet facing some of the most acute structural conditions that make meaningful implementation genuinely difficult. These structural conditions are further complicated by the region's dependence on international humanitarian aid, which has historically filled gaps the state has failed to address but without the permanence or community grounding that sustainable health governance requires.

International aid plays a huge role, providing emergency assistance to people when the state's resources alone are insufficient or unable to reach people. Colombia is no different, receiving numerous NGOs and international organizations who came to address

Venezuelan migrant health needs that at first could not access the Colombian national health system apart from emergency services. In areas of the country with a high presence of armed groups and/or rural areas with complicated geographies— dense jungles, swamps, mountainous, desert, etc— and little to no infrastructure such as the department of La Guajira, NGOs come and address health gaps, but as is the norm for humanitarian aid and emergency response, these organizations don't stay for long and their effectiveness can often be short lived. How can reinforcing bottom-up, community based systems of health address health disparities in the long run? La Guajira's rich Indigenous presence and cultural significance in both national and international aspects can serve as an indicator for SISPI's policy progress and Indigenous led health initiatives. Taken together, these examples highlight that while top-down policies are important, sustainable improvements in Indigenous health require bottom-up, culturally grounded, and locally managed systems.

2.5 Anas Wayuu and SISPI's Implications in La Guajira

In 2001, the IEPSI Anas Wayuu was created by two Indigenous associations representing 120 Indigenous communities: the Association of Cabildos and/or Traditional Authorities of La Guajira, and the Sumuywajat Association¹¹⁷. Anas Wayuu's governance structure reflects its origins as a community-based organization rather than a standard insurer¹¹⁸; governance authority is formally vested in these two founding associations, and by extension in traditional Indigenous authorities rather than external shareholders or state appointees. This distinguishes Anas Wayuu structurally from both private and public EPSs.

¹¹⁷ Mignone and Gómez Vargas, "Health Care Organization in Colombia."

¹¹⁸ Anas Wayuu EPSI, *Organigrama Anas Wayuu ITA 2024*.

As one of the six EPSIs operating nationally, Anas Wayuu plays a critical role in translating the principles of SISPI into practice within La Guajira. Unlike standard health insurers, EPSIs are designed to operate within Indigenous governance structures, mediating between state health systems and community-based models of care. The majority of Anas Wayuu's staff are Wayuu community members who speak both Wayuunaiki and Spanish, and the organization maintains active relationships with community health workers, traditional midwives, and local Indigenous authorities in the communities it serves. This embeddedness in Wayuu governance structures is what allows Anas Wayuu to function as more than an insurer and instead operates as an institutional expression of the same Indigenous health autonomy that SISPI formally recognizes at the national level. Operating in La Guajira, Anas Wayuu provides coverage to more than half of the Wayuu population (also covers non-Indigenous people), offers services in Spanish and Wayuunaiki, and provides coverage for primary, secondary, and tertiary health care services, as well as health promotion programs. In 2012, Colombia's Ministry of Health ranked Anas Wayuu the top performing EPSI in the subsidized regime, demonstrating the immense potential of Indigenous-led governance. Grounded in traditional practices, these organizations served as vital instruments in shaping SISPI's national policy designed to be broad enough to accommodate each community's unique decision-making mechanisms.

In 2017, Anas Wayuu hosted the other five EPSI for the 5th roundtable of SISPI presented the strategies they have developed regarding the health management models promoted within their respective communities¹¹⁹. The objective of this gathering was to produce a document detailing the implementation of the agreements already established for

¹¹⁹ *El Informador*, "Implementación del SISPI busca mejorar la calidad en la salud de los pueblos indígenas."

the execution of the SISPI which was subsequently presented to the National Government for implementation within the national health program. During those years, these EPSI were working to define the specific actions that will enable the establishment of operational policies within Indigenous communities. These gatherings allowed the EPSIs to share and discuss the models implemented while respecting their traditions and ancestral medicines in order to reach a final agreement to present. This agreement was formalized in a document outlining the specific manner in which Indigenous authorities wished to receive healthcare services, situated within their own distinct social and cultural contexts. The steps to activate SISPI can be found on the MPC website (Figure 5) and outlines the following: 1) Official Authorization: The Indigenous Governing Council must issue an official resolution (act) authorizing the request to the Ministry of Health. 2) Population Census: You must provide official census lists certified by indigenous authorities, detailing the number of residents in the territory. 3) Legal Representative: Submit the documentation officially designating and recognizing the legal representative authorized to manage the process. 4) Territorial Boundaries: Provide an official act or resolution defining the territorial scope, adhering to current laws, jurisprudence, and international standards. 5) Health Care Model: Submit your community's intercultural health care model. If completed, include a cost breakdown; if it is still a draft, submit a baseline document with the minimum required elements. 6) Model Finalization: If only a baseline was submitted in step 5, the finalized model will be automatically integrated into the SISPI administrative process for budget allocation once completed. This process empowers Indigenous communities by giving them formal authority, legal structure, and financial resources to manage their own culturally tailored healthcare systems.

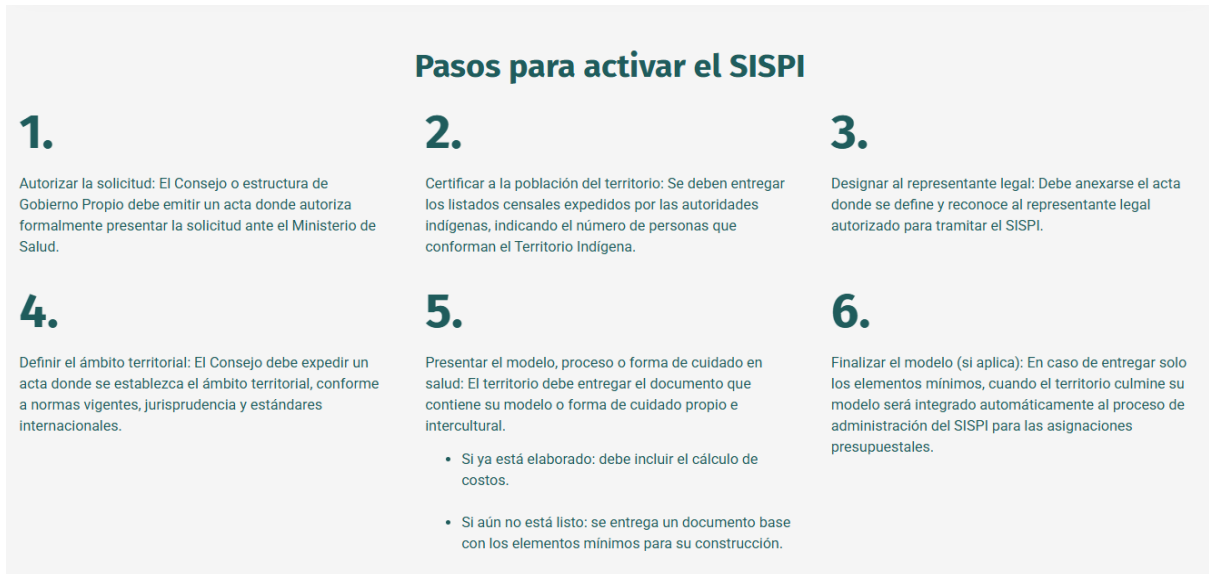


Figure 5: Mesa Permanente de Concertación (MPC) Website
Outlining ‘Steps to activate SISPI’

In September 2022, Wayuu representatives engaged directly with national health officials through the SSI-MPC, marking an important moment in which leaders from La Guajira helped shape broader national health discussions while foregrounding the specific needs of their territory¹²⁰. This positioning was further solidified in September 2023, when La Guajira was selected as the site of the Subcommittee on Indigenous Health, intentionally relocating policy deliberation from central government spaces into Indigenous territory¹²¹. The gathering brought together representatives from 116 Indigenous peoples, reinforcing La Guajira not only as a region in crisis given ongoing challenges such as those highlighted in Constitutional Court ruling T-302 but also as a critical site of political leadership and agenda-setting. The presence of the Pan American Health Organization (PAHO) as an observer in

¹²⁰ Causa Guajira, “Pueblo Wayuu Participó de un Encuentro de Salud.”

¹²¹ Consultor Salud, “La Guajira sede de la Subcomisión de Salud Wayuu.”

these discussions further elevated the visibility of La Guajira within international health policy spaces, signaling its importance in shaping broader frameworks around Indigenous health¹²². Anas Wayuu has functioned as a key site of coordination, where Indigenous actors collectively define how healthcare should be delivered on their own terms.

By 2024 and 2025, this territorial centrality translated into more concrete forms of governance and implementation within La Guajira itself¹²³. Wayuu communities played a key role in advancing locally grounded health system processes through prior consultation, emphasizing that health interventions must address not only clinical care but also structural conditions such as food insecurity, water scarcity, and poverty that disproportionately affect the region specifically through Anas Wayuu Subcomisión de salud en la Guajira¹²⁴ (Health Subcommittee in La Guajira). The formal recognition of Indigenous health policy through Decree Law 480 in 2025, shaped in part by Wayuu leadership, including Manuel Pulido Redondo¹²⁵, further underscored the influence of actors from La Guajira at the national level. At the same time, implementation efforts remained deeply territorial: local organizations, Indigenous authorities, and regional health institutions in Riohacha convened to analyze and operationalize the decree, demonstrating how policy is actively interpreted and reshaped within the region¹²⁶. Together, these developments position La Guajira not merely as a site of policy application, but as a central arena in which Indigenous health governance is

¹²² PAHO, “Colombia: Indigenous Peoples’ Health.”

¹²³ Consultor Salud, “Indígenas Wayúu de La Guajira Constituyen SISPI.”

¹²⁴ EPSI Anas Wayuu, “La Subcomisión de Salud en La Guajira.”

¹²⁵ Diario La Guajira, “Decreto Ley Reconoce el SISPI.”

¹²⁶ Ministerio de Salud y Protección Social, “Sesión No. 82 de la Subcomisión,” Facebook video.

negotiated, contested, and enacted, revealing both the possibilities and ongoing challenges of grounding national reforms in historically marginalized territories. These moments reflect a shift from consultation to co-governance, with Indigenous actors increasingly shaping national health policy.

Empirical studies of Indigenous health organizations in Colombia suggest that entities such as Anas Wayuu have improved both access to and perceived quality of care among Indigenous populations, particularly by aligning services with linguistic, cultural, and territorial realities¹²⁷. Drawing on Park, Hoekstra, and Jimenez's concept of 'the third net' in which the health system is intentionally designed to exclude certain groups out, and that it is not a failure, but instead is working exactly as intended¹²⁸, Anas Wayuu can be understood as operating beyond the binary of state versus informal care systems. Rather than existing outside the system, it represents a hybrid space where Indigenous and biomedical practices intersect, negotiate, and at times conflict. However, the scale and diversity of the Wayuu population complicates any singular notion of "Indigenous health." Internal differences in geography, language, and social organization shape how care is accessed and understood, raising questions about who benefits most from institutionalized systems like SISPI and who may remain marginalized. These tensions are particularly significant in La Guajira, where the Wayuu people have long been simultaneously hyper-visible in national discourse and structurally neglected in practice. This dynamic reflects what Elana Resnick describes as a 'waste-race nexus,'¹²⁹ in which marginalized populations are rendered both symbolically

¹²⁷ García and Macintyre, "The Wayuu People in Colombia."

¹²⁸ Park, Hoekstra, and Jimenez, *The Third Net*

¹²⁹ Resnick, *Refusing Sustainability*

central and materially disposable. In this context, SISPI and institutions like Anas Wayuu carry the burden of not only improving health outcomes, but challenging deeper patterns of exclusion.

Ultimately, Anas Wayuu illustrates both the promise and the limits of SISPI's implementation. On one hand, it demonstrates the potential of Indigenous-led health organizations to improve access, foster culturally grounded care, and reshape governance structures from the ground up¹³⁰. On the other, it highlights the ongoing challenges of scaling such models within a national system still shaped by biomedical dominance, resource constraints, and regional inequalities. As SISPI continues to unfold, the experience of Anas Wayuu in La Guajira will remain a critical indicator of whether Colombia can move beyond symbolic recognition toward genuine Indigenous health sovereignty. This long trajectory demonstrates that SISPI did not emerge in a vacuum, but builds upon decades of Indigenous-led organizing around health governance.

Contemporary health systems remain deeply shaped by the structural legacies of colonialism, which continue to fragment relationships between individuals, communities, and the environments they inhabit. In contrast, Indigenous knowledge systems offer alternative frameworks that re-center health as inherently relational, grounded in connections to land, community, and collective well-being¹³¹. As seen in La Guajira, Wayuu approaches to health emphasize not only care practices, but the broader social and ecological conditions necessary for sustaining life. These perspectives point toward the possibility of reimagining health systems in ways that move beyond purely biomedical models and toward more holistic,

¹³⁰ De la Cruz et al., "Indigenous Health Systems and Intercultural Health Policies."

¹³¹ Redvers et al., "Indigenous Rights, Health and Traditional Medicine Systems."

interconnected forms of care. However, such a transformation cannot occur without confronting the historical and ongoing harms experienced by Indigenous communities; meaningful change requires not only inclusion, but accountability which many scholars describe as the necessity of truth before reconciliation. At the same time, the implementation of these models remains deeply contested. Recent critiques of SISPI, warn that without robust oversight, transparency, and accountability mechanisms, the expansion of Indigenous-led health governance could risk reproducing existing inequalities within new institutional frameworks¹³². Concerns raised in public discourse particularly in relation to La Guajira highlight fears of insufficient state supervision, potential mismanagement of resources, and uneven distribution of care, underscoring the tension between autonomy and regulation. While some view these risks as evidence of structural vulnerabilities, others interpret them as reflections of long-standing systemic neglect and the challenges of implementing transformative policy in historically marginalized regions. In this context, the experiences of the Wayuu underscore both the promise and complexity of reshaping health governance.

Centering Indigenous voices in the design, implementation, and evaluation of health policies remains essential, particularly through the principle of free, prior, and informed consent. Yet, as this chapter has shown, achieving equitable and effective health systems will require more than integration; it demands sustained engagement with questions of power, accountability, and historical responsibility. Ultimately, the future of health in places like La Guajira will depend not only on recognizing Indigenous systems of care, but on ensuring that autonomy is accompanied by the resources, transparency, and structural support necessary to translate policy into meaningful improvements in everyday life. While this chapter examined

¹³² Colmenares Rodríguez, “SISPI: Un peligroso experimento con la salud indígena.”

the structures and policies shaping Indigenous health in La Guajira, the following chapter shifts to the community level, incorporating focus groups, interviews, and everyday observations to center the voices, experiences, and practices of Wayuuwomen themselves. Focusing on their SRH in order to analyze how gender inequities, systemic injustices and health disparities could or could not be addressed with the SISPI policy.

III. Fieldwork Chapter



Figure 6: Plane view of the Caribbean Coast of Colombia
Photograph taken by Paula Gonzalez

My first impression of Riohacha, La Guajira, Colombia was from a plane, seeing the beautiful coastal city with bright blue water and soon after stepping out of the plane to a very hot climate (Figure 6). This was August 10, 2025 and I was traveling with Natalia, one of the employees at Wayuu Woven Community (WWC), an organization that works with Wayuu 'tejedoras' (weavers) women focused on entrepreneurship, empowerment, and cultural preservation specifically through woven items. One of the most recognizable and symbolic Wayuu and nowadays Colombian items is the 'mochila' which is an intricate woven bag using two sets of threads which is a sturdy and staple part of Wayuu culture. I originally met Natalia and WWC at Santa Barbara's Earth Day festival and although I was running late to a volunteer shift, upon seeing the mochillas I had to stop and investigate. Growing up, I remember seeing my mom and her Colombian friends display the most beautiful mochilas, intricate designs and bright colors, so seeing them in Santa Barbara piqued my curiosity. After asking Natalia all about their organization, goals and history, I mentioned my research interests and coincidentally their organization was wanting to bring in some health conversations and focus. After spending years working alongside these women, developing relationships, and getting to know them personally, WWC noticed that many of the women would mention different health issues and problems which many times would go unresolved or would take so long to address that would then result in worse health outcomes, including death. After our conversation, I met with Jennifer, one of WWC's cofounders and Natalia, to discuss the technicalities and when I could go to Riohacha to begin my fieldwork. Upon our arrival, Natalia and I had a busy week filled with workshops which WWC hosts every month and community visits where Natalia was checking the progress of community projects that

are funded through the mochila sales. This was my first introduction to the Wayuu women that WWC works with and the beginning of my fieldwork.

This chapter presents findings from fieldwork conducted between August and November 2025 in Riohacha and surrounding communities of La Guajira, Colombia. Insights were elicited through four focus groups with Wayuu women across different communities, two physician interviews, site visits to Fundacion Baylor's clinics, and observations at the 15th Global Forum on Migration and Development. Rather than presenting them in chronological order, the findings are organized around my four research questions, drawing comparatively across all fieldwork to illuminate patterns and tensions in how Wayuu women experience, understand, and access health care.

3.1 National Health Systems & Indigenous Health Ideas

Across my interactions, a consistent picture emerged, that formal national health infrastructure in La Guajira is present in policy and coverage numbers, but structurally ill-equipped to support the specific health ideas and practices of the Wayuu. The following draws on women's experiences with the national health care system, observations at Fundacion Baylor, and interviews with health practitioners to examine where the system falls short and where promising models have emerged to address the research question: can national health systems support Indigenous health ideas and practices?

3.1a Fundacion Baylor

During the first week of September 2025, the city of Riohacha hosted the 15th Summit of the Global Forum on Migration and Development (GFMD). As stated on the International Organization for Migration (IOM) Website:

The GFMD is a voluntary, informal, non-binding and government-led process open to all States Members and Observers of the United Nations and selected observer organizations. It was created upon the proposal of the UN Secretary-General at the September 2006 General Assembly High Level Dialogue on International Migration and Development. Its main purpose is to address, in a transparent manner, the multidimensional aspects, opportunities and challenges related to international migration and its inter-linkages with development, to bring together government expertise from all regions, to enhance dialogue and cooperation and partnership and to foster practical and action-oriented outcomes at the national, regional and global levels.

Since initially a large part of my research related to Venezuelan migrants' experience with sexual and reproductive health, I showed up to the forum, which was less than a five minute walk from where I was staying. After explaining my research and interests, and offering to volunteer in exchange for entry to the event, I was given entry for the second half of the three day event. This was a chance to hear some of the global conversations regarding migration and organizations working with migrants and given that it was occurring in Riohacha, the Wayuu were at the front and center of many conversations. It was at the forum that I was finally able to meet the director of Fundacion Baylor, Ana Maria, and who after a short conversation invited me to their office that week. Riohacha's urban area is less than 10 square miles, so two days after the forum finished, I took a quick five minute taxi drive and arrived at Fundacion Baylor's doors. Fundacion Baylor, one of fifteen Baylor College of Medicine International programs, takes a holistic approach focusing on the health needs of vulnerable populations targeting maternal and infant mortality and morbidity rates in the municipalities of Manaure and Riohacha. In 2018, they were authorized by the Health

Secretariat of La Guajira to provide health services, becoming Fundación Baylor Colombia IPS, which are Health Service Providing Institutions (i.e. clinics and healthcare centers)¹³³. They work from four different angles: 1) healthcare and treatment 2) education 3) research and development 4) complementary activities- such as the Alimercambio program which is a bank of recyclable materials that are exchanged for food and health services.

After hearing a bit more about their work, we scheduled two days where I could go visit both clinics. The first clinic located in a rancheria in the Manaure municipality has a team that works three days intramurally in clinic and two days extramurally in the community. Every morning the team gets together around 7 a.m. at the Riohacha office, loads up supplies and personnel and in about three 4x4 cars heads on out to the clinic which is about an hour ride away. Only the drivers know how to get in and out of the rancherias, and during those rainy season days, sometimes it was not feasible for the cars to make it to the clinic to attend to people. Upon arriving, local Wayuu, Fundación Baylor midwives (all women) and community health workers (CHW; a mix of men and women) were already waiting for us; they don't come in every week but this time there was a guest workshop occurring. Walking around the clinic we saw the check in counter, with the patient rooms to the left, and the pharmacy to the right. The pharmacy had different types of medication and food supplements, all donations and free to the patients whilst supplies lasted. The patient rooms were set up for different, yet rotating specialties since although they list nine services- nursing, general medicine, nutrition and dietician, psychology, general dentistry, laboratory sample collection, gynecology and obstetrics, pediatrics, and as mentioned above a pharmacy- not all are available weekly. Things that are not mentioned are on occasion

¹³³ Instituciones Prestadoras de Servicios de Salud

available to patients through pro bono and volunteer opportunities, but an agreement with La Javeriana's medical school in Bogota provides two to three final year medical students to help with clinical rounds. Many of the posters and visual images were translated into Wayuunaiki and reflected cultural practices, including strengthening and investing into midwives and CHWs who were the majority of the time in the communities checking up on people's health and referring them to the clinic when needed. Compared to the Malteser project, which after four years left the territory, these midwives and CHWs receive consistent training and support as a part of Fundacion Baylor. As part of their holistic approach, they are working on an aquaponics project with the Wayuu community, a sustainable, soil-free, closed-loop farming method combining aquaculture (raising fish) and hydroponics (cultivating plants in water). Although when I visited they had recently run into complications and are a long ways of creating sustainable and subsistence food production, this was, as Ana Maria said, an example of addressing the SDOH.

The following day, we met up again at the Riohacha office in order to head out to Uribia's clinic. This was not a normal, every day trip, but due to this guest workshop, Fundacion Baylor provided transportation for the guest speaker, two of the Riohacha based employees and I which took about an hour and a half to get there. Upon arriving in Uribia, it was a completely different scene. Known as the 'Indigenous capital of Colombia', Uribia is a bustling city deeply rooted in the traditions of the Wayuu and yet the first thing I noticed was ditches filled with plastic and trash. Aside from the environmental implications and despite having a trash collection service¹³⁴, this unmanageable pollution poses great risks and has unfathomable health effects on the local community which in the end impacts perceptions of

¹³⁴ Alcaldía de Uribia, *Informe PGIRS Uribia Vigencia 2020*.

the community's worthiness¹³⁵. We arrive at the clinic that has a similar format to the other location and head on over to an enramada where the workshop will be taking place. When I first met Ana Maria, she mentioned that although the two clinics work similarly, their geographic placement influences which populations they serve, with Manaure's being completely for the Wayuu and Uribia's serving a mix of Venezuelan migrants and Wayuu peoples. At this workshop, most of the CHWs are Venezuelan migrants with a few Wayuu community members. Although the workshop was focused more on political influence, during their conversations there were moments when each 'side' would shift the blame onto the other in regards to topics from corruption to pollution- implying not being educated enough- on the other as well as what they considered were their rights and what was considered a favor whether from the government or different organizations. The guest speaker, Lina Guisao Crespo, a political science professor at the Universidad de Antioquia in Medellin, could not have said it better, 'the constitution is nice, but it's useless if we don't put it into practice' and in regards to health rights, Venezuelan migrants and Wayuu people face many similar issues.

3.1b Women's Experiences with National Health Infrastructure

Since the women who work with WWC did not know me, we decided it would be better to hold the first one with Natalia present in order to establish trust and explain that the goal of the focus group was beyond my research and focused on creating community-based health workshops where the women could talk about and learn different things regarding their health. Since the women are used to coming into the office for the workshops and

¹³⁵ Resnick, *Refusing Sustainability*

monthly product drop offs, we hosted it in Riohacha and both Jennifer (co-founder) and Natalia reached out to the artisan leaders explaining the purpose of the focus group and explaining that I would cover transportation costs, provide crackers and coffee, and lunch would be served. This was on par to how WWC usually receives these women, covering transportation since many women traveled over thirty minutes to reach the office and providing lunch since this focus group, like the workshops, were a day long event with the women arriving around 9 am and leaving around 4 pm. The decision to first invite the leaders was that due to their roles and history with WWC that they would be more open and wanting to engage in these topics; it also helped that they were in constant communication with WWC regarding the logistics of workshops and product delivery and the leaders were the ones who relayed information to their team.



Figure 7: Water Well in Rancheria B
Photograph taken by Paula Gonzalez

During this conversation, there was constant mention of 'El Pilotaje', a pilot program established by the Colombian Institute of Family Welfare (ICBF)¹³⁶ focused on reinforcing cultural customs and practices of Indigenous peoples in the department of La Guajira while integrating clinics and hospitals as sites of care and help¹³⁷. The manual to implement El Pilotaje in La Guajira was established as of March 15, 2025¹³⁸, yet in a neighboring state, Magdalena, the pilot program had started in 2022 with different, local Indigenous peoples. The Colombian government's effort to support and integrate Indigenous peoples' knowledge and culture through the Pilotaje is the same effort that resulted in the passing of SISPI. A couple days after the focus group, Marcela spoke a bit about this program in her community over a coffee as we sat at the edge of her community's chosen project, a water well (Figure 7). Out of the three community projects that Natalia and I were supposed to check and visit, we were only able to get to visit two due to last-minute plan changes when some of the women told WWC 'la cosa esta caliente' (the thing is hot) referring to the presence of armed groups, whether it be guerilla or paramilitary, that would make it unsafe for arijunas¹³⁹ to move in and out of the territory/community. As we moved from the pilotaje to Marcela's school capstone-esque project she was working on since deciding to go back to school, the clouds started turning gray and both Marcela and Natalia began packing up our things to

¹³⁶ Instituto Colombiano de Bienestar Familiar

¹³⁷ Guajira News, "Socialización del pilotaje de atención integral con comunidades Wayuu."

¹³⁸ Instituto Colombiano de Bienestar Familiar ; ICBF, *Guía Operativa para la Atención Integral al Pueblo Wayuu*.

¹³⁹ The Wayuunaiki word for non-Wayuu, to separate Indigenous and non-Indigenous people

head on out. Although La Guajira is known for its desert landscape, they have a rainy season from September to December that can bring heavy downpours, rendering the dirt roads that lead into and out of the rancherias into a muddy and difficult journey. In Riohacha, the paved roads turn into rivers where essentially the whole city stops and waits until the rain passes, and in places hours away from any paved road, like La Alta Guajira, ditches can become traps where cars get stuck in the mud, which is exactly what happened when I took a weekend tour through there (Figure 8). We left the well which at the time still had much work left, but that as of today is up and running, delivering water to people in Rancheria B.



Figure 8: 4x4 Car Stuck in Mud
Photograph taken by Paula Gonzalez

For my second focus group, WWC developed a list of women who they thought may be interested in participating, sent out invitations, and fifteen women showed up. Similar to the first focus group, I covered transportation costs, provided crackers and coffee, and provided lunch. As they gathered around in a big circle around the room, fans at high speed and windows open to try and combat some of the heat and humidity, we began similarly to my other conversations. UTIs, asthma, high blood pressure, diabetes, dengue (viral infection transmitted by mosquitos), headaches, body aches, gastritis and kidney stones were the health problems most impacting women in their community. On par with the previous women, they mentioned first attempting to treat their symptoms with medicinal plants and if they don't get better then they go to the hospital to address it. I asked again who knew of this herbal knowledge or who did they ask, to which they responded mostly their grandmothers or some elder women within the family- to which I assume meant extended family as well. We then proceeded to talk about what being healthy means to them and they responded with being able to protect themselves from diseases, being well-fed, do their checkups and controls (especially for pregnant women), and ultimately not have to depend on any medication. When I asked whether they and their children were all enrolled into the national health insurance, they all responded yes and chipped in that, depending on the IPS (clinics and healthcare centers), treatment and wait time varied. They explained that these IPS would come out to the rancheria around every three months- this also varied- and would provide very general care, such as the type one receives with a primary care physician, and referrals for followups or more specialized kinds of testing. To which they added that this then becomes difficult since it isn't economically viable for most to be traveling back and forth between the rancheria and the clinic, especially when in some cases they have to go in for

labs one day and then wait to speak with a provider. They stressed that it isn't that people don't want to go, it is that it becomes physically and financially impossible to continuously access the type of care they may need, especially for chronic conditions such as diabetes. Which in some cases carries potential repercussions such as being removed off their insurance plan due to 'inactivity' which then entails having to reinscribe oneself and fill out an application. These experiences were not isolated to women connected to WWC, they surfaced consistently across different communities and contexts, including among women who had no prior relationship with any organization.

Working for WWC, I met Petra. Raised in Bogota, Petra has been working in La Guajira for over ten years and has her own organization called Raíces de Talento (RDT) that supports a number of projects including a house dedicated for afterschool children's activity, growth and creative endeavors, called The Kid's Playground (TKP). TKP is situated in a settlement right at the entrance of Camarones called Settlement K. Most often referred to as 'invasiones' (invasions), these informal, squatter settlements are built on unauthorized land, often by families displaced by violence or in this case migration. In Settlement K the community is composed of Afro-Colombians, Wayuu peoples, and Venezuelan migrants. After volunteering for some of the children's activities, I spoke to Petra about potentially hosting a focus group with the Wayuu women in the area. Unlike the women working with WWC, none of these women were used to attending workshops and so Petra referred me to Elsa, the Wayuu woman who lived and looked after The Kid's Playground, to identify some potential women and organize the focus group. After a couple back and forth conversations, we were finally able to host a focus group and around twelve women showed up at varying times because coincidentally the focus group was held on the one day a month the Pilotaje

delivered packages of food to Wayuu community members, focusing especially on families with children under five. Some were from the surrounding Rancheria A, while others lived in Settlement K near the entrance of Camarones. For these women, this was their first time engaging in this kind of discussion since school and none were involved with WWC, yet the picture of health access they described was strikingly consistent with what I had heard across the other focus groups.

All the women said they and their children were registered with an EPS, and although they mentioned understanding the health system, transportation remained the barrier they named most consistently, even though they were located only about fifteen minutes from Riohacha with direct access to the main road. Going to the doctor was the choice when it was an urgent matter, to deal with chronic diseases, and for prenatal checkups. Yet the conversation quickly revealed deeper structural frustrations: one woman described having to visit two different clinics in order to receive a cesarean section that had already been approved by her EPS. Another recounted knowing people who had voluntarily withdrawn from the EPS entirely due to frustrations with wait times, complications, and overall dissatisfaction with service quality, including news stories of people dying in waiting rooms due to prolonged wait times¹⁴⁰. When they did go to the doctor, quality of service depended entirely on which IPS their EPS assigned them to, with some women stating that they often had to claim an 'emergency' so that they would be attended to quickly. This was not a workaround they could choose to bypass, they could only access the specific IPS linked to their insurance plan. Across communities as different as WWC's network of artisan leaders and Settlement K, the same structural gap persisted: insurance enrollment did not translate

¹⁴⁰ EL TIEMPO, "Man Dies in Kennedy Hospital Waiting Room."

into health access, and the distance between a woman's EPS card and the care she could actually receive was measured not just in kilometers but in economic impossibility, institutional indifference, and time.

After arranging transportation and making it to the doctor, I wanted to know how they felt interacting with medical providers and hospital staff, essentially what their experience entailed. Many answered that they are discriminated against, saying 'cuando nos ven la cara y después nos ven la mántica, así nos tratan' (when they see our face and then they see our mantica¹⁴¹ that's how they treat us), essentially saying that they are treated badly based on their identity. One of the women recounted a time she brought her husband to the hospital for an injury and told us how she had to essentially appeal to the nurse's humanity who aggressively grabbed him to pull him into a room. She reasoned with the nurse telling her, 'we are humans too, we have feelings and emotions' and then went on to say to us, 'because they are arijuna, they think we are less than them'. This then opened the floor to multiple conversations and stories of different experiences, emotions and acts of violence that the women had received, all from varying communities, health issues, and clinics or hospitals. This was especially the case in regards to their children, where hospital staff or medical professionals would threaten to call the police or social services on the mothers to report them for wanting to take their children out of the hospital. The justification for this was that once the child was admitted, the hospital had responsibility over the child.

Similarly, many of the women feared and resisted admitting children or family members into the intensive care unit (ICU) or being transferred to Barranquilla, around five hours by car from Riohacha, for specialized services or equipment. Although their Health

¹⁴¹ Diminutive of manta, traditional tunic worn by women

Promoting Entities (EPS, i.e. health insurance)¹⁴² covered everything, including transportation for the person in need of medical attention, many stated that there was a preference and urge to die alongside their family members and that when community members die elsewhere it can be an economic toll and hassle to bring them back. The Wayuu have very intimate 'velorios'¹⁴³, funeral rituals, consisting of the initial burial followed by an exhumation of the remains years later, the body is sacred to the Wayuu and these proceedings are not only a way to commemorate the memory but ensure that their spirit is at rest¹⁴⁴. Many of the women mentioned this tug-a-war feeling between medical professionals who would urge them to keep their loved one in the hospital and their elders who would urge them to take them out. Making these decisions or understanding what is best for a loved one is not an intrinsic decision, but knowing and understanding one's rights can better ensure making the most informed decision.

Nearly 100 years after the first hospital opening in Riohacha, the second one opened its doors in 2024, and although these serve as vital places that serve the community, often they cannot provide complete medical services as told by these Wayuu women and even arijuna Guajiros¹⁴⁵ who I encountered throughout my time there¹⁴⁶. To these women, sexual and reproductive health encompassed their whole body pertaining to pregnancy and much more, including passing down this education to their children to supplement what they

¹⁴² Entidades Promotoras de Salud

¹⁴³ Cuento Aparte, "Ayulaa."

¹⁴⁴ "IAM Venezuela, 'El guajiro muere dos veces.'"

¹⁴⁵ People from the department of La Guajira

¹⁴⁶ Alcaldía de Riohacha, "Después de Casi 90 Años, Riohacha Tendrá un Segundo Hospital."

already learn at school. Especially since, as mentioned before, many of the mothers feel that their children have more liberties than they did at their age which can expose them to earlier and unplanned pregnancies amongst other risks. In relation to this, during a conversation with Professor David Robles, he mentioned that University of La Guajira (UNIGuajira)¹⁴⁷ Riohacha's campus had just been approved to provide a medical program¹⁴⁸. Unlike the U.S. where one must first complete an undergraduate degree and then attend medical school, in Colombia if you want to be a medical professional you start straight out of high school. Before this, if a student in the department of La Guajira wanted to pursue medical school, the closest city that offered these programs was Barranquilla; many of the women brought up that although nowadays there exists 'university-trained' Wayuu doctors¹⁴⁹, since they would leave for about seven years, upon returning they felt that they no longer possessed the same understanding and compassion, resembling the ariajuna doctors, and at times worse. This news meant that as of this year, 2026, the first cohort of students began their studies at UNIGuajira to become future doctors. As education goes, the classes involve the basic and necessary science and medical courses and include a more cultural centered focus on the populations and needs of the community including taking Wayuunaiki language classes and indigenous legal and policy classes to name a few. This program serves as an example and ground zero for how SISPI's policy could potentially play out, incorporating Indigenous knowledge and practices whilst contributing towards the national medical system and highlighting the complexity in people's perception and experiences with health. While these

¹⁴⁷ Universidad de La Guajira

¹⁴⁸ UNIGuajira, "Programa de Medicina."

¹⁴⁹ Conversation with Professor Marissa Nichols at UCSB

structural barriers defined how Wayuu women interacted with the formal health system, they did not define how the women understood or practiced health itself. Across all focus groups and communities, a parallel and deeply rooted system of healing knowledge continued to operate alongside and often in place of biomedical care.

3.2 Coexistence of Western & Indigenous Healing Systems

A central tension running through all fieldwork sites is the relationship between government-based biomedical care and Wayuu ancestral healing practices. Rather than a simple opposition, women across all focus groups described a layered, pragmatic approach, one that reserves Western medicine for serious or unresolvable conditions while relying on plant-based and ancestral knowledge as a first response. The following brings together evidence from the focus groups, the Museo Wayuuwaa A'in, and the Alta Guajira to explore how this coexistence operates in practice, where it is strained, and where it may be strengthened to address the research question: can national health systems coexist with Indigenous health systems and ways of healing?

3.2a Medicinal Plant Knowledge and Its Transmission

Nine leaders showed up to the first focus group and I began by opening up the floor to discuss the most common health problems women in their community faced. They responded saying headaches, high cholesterol, cancer, heart disease and diabetes to name a few, and then followed that by mentioning that they normally go to the doctor first to find out what's wrong and will then primarily use herbs as the treatment method. Given that this was the second time I had heard something along these lines, I was curious as to what tools they

would like to have to address these situations preemptively. The women responded saying information on how to recognize symptoms to be able to identify methods of treatment earlier, restating that they prefer to use medicinal herbs and unless absolutely necessary will use medication, but again choosing to do a combination of both herbs and medication; this choice is also highly influenced by the type of disease or issue they face, with chronic or noncommunicable diseases versus deadly or communicable diseases. Since medicinal herbs are essential to Wayuu as well as many Indigenous communities, I wanted to know who holds this knowledge, how it's passed, and whether it was accessible to everyone. The women mentioned that they thought it was important to revive the medicinal herbal wisdom in the communities and make it more accessible to younger generations; what I think they meant was that normally younger Wayuu people have to seek elders who understand herbal medicine and because of the drastic changes that have occurred due to urbanization, technology, and resources, there may be a loss of this knowledge if it is not adaptable.

3.2b Midwives, Western Medicine, and Navigating Both

During my focus group 0 (test focus group) this dynamic between biomedical, western medicine and ancestral, indigenous forms of medicine and healing that the Wayuu practice became apparent. I asked about the methods or 'courses of action' that these women and their families took when they had health issues and many mentioned using plants and herbal medicine first for things such as postpartum recovery and plants that acted as contraceptives to prevent having children. Yet, when health issues got very bad they would then go to the clinic to see a doctor. If it can be dealt with medicinal plants such as cramps that is the preferred method, but if it is something more serious such as high cholesterol then

they will use a combination of medication and plants like cardon (cactus). This knowledge is not known to everyone and most times, these women will seek out their mothers or other elders who know which plants to use according to the type of pain or treatment. I followed this by asking how the practice and presence of midwives has changed over time and their own perceptions, as women and mothers. The women mentioned that they preferred to give birth at a hospital because it makes them feel safe that if any complication were to occur, that they trust that it can be solved by the medical professionals. To them, giving birth in the rancheria only happens when the labor progresses very quickly and there is no time to get to a hospital. One of the women, Marcela, shared that she had an unpleasant experience with a Wayuu midwife during her first pregnancy, and so for her second and third pregnancy she had her check ups with an OB and gave birth at the hospital. Marcela explained that normally the Wayuu midwives do their check ups with the pregnant women every two to three months where they measure the belly and feel the baby. If needed, they will massage and rub the belly to help the baby rotate to the proper position and will help and guide during the birthing process. Yet, if there is anything out of the normal or an unexpected emergency, Marcela said that at least the midwives that are around her (in her community) area don't have the knowledge or tools to attend an emergency at a home birth. This may not be every Wayuu woman's experience and I wanted to note that Marcela is married to an arijuna and when I spoke to her she was living with her husband in Riohacha and not on the rancheria that she is a part of. Although she was very actively involved as part of the Un Nuevo Amanecer group and focusing her university equivalent capstone project on the Wayuu culture and how to maintain it and educate the newer generations. Out of all the Wayuu women I met and interacted with I believe there were less than three married to an arijuna, something that has

become more common as Wayuu people become more involved with 'occidental society' in order to find jobs or educational opportunities, especially to contribute back Wayuu communities and their persistence.

At the end of every calendar year, WWC hosts a 'graduation' for all the women who successfully attend and complete year-long monthly workshops on topics from leadership to design innovation. After our conversation in Rancheria A, Natalia and I walked to a nearby hotel with Jorge leading the way. Jorge, Natalia joked as we passed the Jagüey (Figure 9), was the only Wayuu man that was a part of the WWC group. Being from Tocormana, and a family member of some of the women involved with WWC, Jorge has helped with numerous things, one of the biggest being building an enramada in Tocormana that was part of a community project that WWC was supporting. As we walked alongside the Santuario de Fauna y Flora los Flamencos, a natural park founded in 1977 for the protection of flora and fauna¹⁵⁰, Jorge told us of the conservation work he was doing with the government, planting native plants, and ensuring that the park was maintained. Jorge seemed super chipper and enthusiastic to talk about the importance of taking care of the land and tied that into the important role Wayuu men play as fishermen. Although Jorge never specifically told me, I was aware that in the past year he had been admitted to the hospital for mental health reasons which caused a bit of a rupture between some of the community members and WWC due to preferences in mental health management¹⁵¹. Although mental health illnesses are prevalent amongst the Wayuu¹⁵², as mentioned previously there is an interesting balance between using

¹⁵⁰ ProColombia, “Los Flamencos Fauna and Flora Sanctuary.”

¹⁵¹ WWC supported Jorge’s admittance to the mental health hospital whilst some community members, mainly his family, did not agree and believed these were Western practices that did not address the actual root of Jorge’s issues

¹⁵² Agudelo-Hernández, Coral-Vela, and Pabuena-Yepes, “Mental Health Risk Communication.”

'Western medicine' vs 'Ancestral medicine', with many Indigenous communities viewing mental health issues as stemming from different places and interpret it differently¹⁵³.



Figure 9: Video snapshots taken by Natalia of Rancheria A's Jagüey

3.2c Museo Wayuuwaa A'in and the Documentation of Ancestral Knowledge

As part of an excursion with the UNIGuajira Riohacha campus, I along with some exchange students visited the Museo Wayuuwaa A'in. This museum, located in the city of Maicao, which is about a thirty minute drive away from the nearest Venezuelan city, encompasses the Wayuu history and culture. As mentioned previously the Wayuu territory extends beyond borders creating this bi-nationality, state based framework placed upon a historically nomadic Wayuu community. From traditional weaving using natural materials to

¹⁵³ Ibid.

modern day synthetic fibers, to traditional face markings and orange, clay based 'sunscreen', to the very medicinal herbs found in the area and their purposes, this museum provided a profound and lengthy historical to present day storytelling of the Wayuu. A wall dedicated to the plants with a placard reading 'through dreams, the secrets of sacred plants are revealed to the Wayuu women' (Figure 10). This medicinal knowledge mentioned across all focus groups is not known to all, yet has a very place in this museum with open access and workshops dedicated to preserving and teaching the cultural knowledge and practices. Yet what took us about an hour and fifteen minutes from Riohacha to Maicao on a university provided bus, would take the women I spoke to much more time and is not economically viable to most.



Figure 10: Traditional Medicine Herbs in Museo Wayuuwaa A'in
Photograph taken by Paula Gonzalez

Table 2: Traditional Medicine Herbs in Museo Wayuuwaa A'in (left to right, top to bottom)	
Plant Name (Wayuunaiki; Spanish)	Purpose or Intended Use
Walaret; Mejorana	control blood pressure, anticoagulant
Walashii; Musgos de cabello	respiratory diseases
Erüliia; Frailejon del desierto	antibiotic, antidiuretic
Olia; Mirto	antibacterial, anti-inflammatory
Süüsü; Palo de anestesia	sedative
Malüwaa; Mirra	anti-inflammatory
Püsesü; Marrubio	stimulates the immune system
Stta; Siete cueros	antioxidant, anti-inflammatory
Maünaa; Margaritas del mar	prevents ovarian cysts
Kutena; Indio desnudo	cures respiratory diseases
Ichii; Dividivi	cures respiratory and skin infections
Aloüka; Palomatia	reduces anxiety and stress
Kousluapii; Atrayente de bala	extracts bullets*
Maravilla; Maravilla	controls blood sugar
Kaüliiapii; Bebida de suplemento	supplement drink, collagen
Süüalita; Semilla de totumo	anti-inflammatory; antimicrobial
Unücheta; Musgo talofito	antiviral
Pomplum; Nuez amarga	expel cysts, alleviate menstrual pain
Uliishii; Bija roja	iron concentrate
Palisa; Bija roja	skin treatments
Hiereta; Higuera	protects cellular damage*
Asiirupii; Cura herida	cures wound
Jawapi; Concentrado de hierro	regulates feminine hormones

* *translated accurately, not entirely super of its meaning*

This museum is active on social media (Facebook, Instagram) and Whatsapp (messaging application) where the women I spoke to could get access to resources and information, yet not necessarily describing each plant and how to prepare the concoction (Table 2). They often travel to different parts of Colombia showcasing their work and Wayuu culture and use the museum space to sell items from mochilas to traditional mantas. Inviting visitors to participate in a seated and interactive activity, smelling and learning about different herbs, their purposes and drinking chirrinchi, used for a multitude of things from drinking, velorios, spirit cleansing, and medicinal purposes being ingested in different forms or superficially applied. Apart from having a Wayuu population, Maicao has a diverse history of migrants from Lebanon, Palestine and Syria who have shaped and changed the essence of the town, from offering middle eastern cuisine to building the third largest mosque in Abya Yala¹⁵⁴. La Guajira's diversity stems from a history of colonization and migration which has interacted with and become a part of many Wayuu's daily life, ultimately impacting this large group of people in distinct ways with varying degrees of interaction.

3.2d La Alta Guajira: Embodied Knowledge in a Remote Landscape

Upon telling family members and friends that my research would be taking place in La Guajira, I was told that I had to go and visit La Alta Guajira. Apart from it being essential to my research, La Alta Guajira is known for its beautiful landscapes and being one of the most remote areas in Colombia, with little to no cellular connection. Although I have referred to La Guajira as a state, perhaps subtly implying a homogenous territory, to the Wayuu and Guajiros, La Guajira is divided into three subsections (Figure 11). Although most of my work

¹⁵⁴ Mosqpedia, "Omar Ibn Al-Khattab Mosque."

was in La Media Guajira, as mentioned previously I went to Fundacion Baylor's clinic based in Uribia and with a tour company, made my way up to La Alta Guajira where as the days passed we got deeper and deeper into the desert.

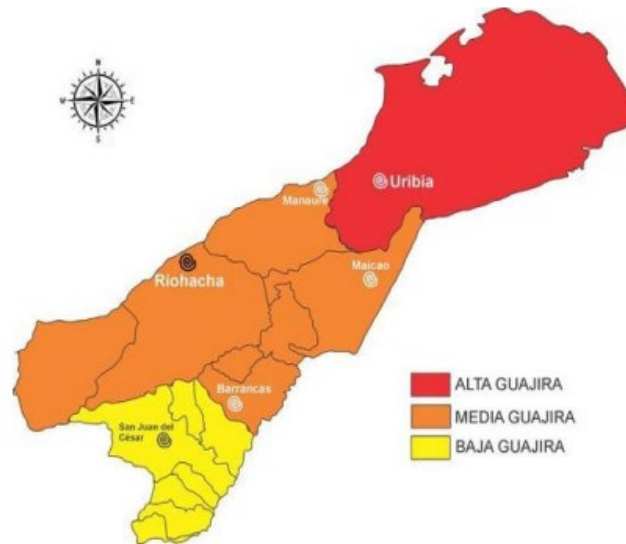


Figure 11: Map of La Guajira Showcasing Three Subsections¹⁵⁵

Upon being picked up in Riohacha, we made our way up to Manaure to visit the infamous salt mines where the majority of salt is produced in Colombia. What was once an artisanal practice was heavily industrialized in the 1900s¹⁵⁶ until the late 1990s to early 2000s when Wayuu communities asserted their rights to the territory and eventually struck an agreement with the government creating this public-private partnership. In Manaure, we visited the artisanal salt water ponds where we were told the history of 'white gold' (salt) when it was initially used to trade for essential foods and goods and how it became an integral part of Colombian commerce. There were intricate, detailed signs describing the

¹⁵⁵ Peters, "What Is Inclusion?"

¹⁵⁶ Aguilera Díaz, *Aspectos Históricos y Socioeconómicos de las Salinas de Manaure*.

methods of extracting the salt as well as the Wayuu people's significance in the process, including a community-based store called Emprendimiento Ichiipa where tourists could buy salt products from scrubs, to cooking salts (Figure 12).



Figure 12: Informational Posters at Manaure's Salt Lakes
Photograph taken by Paula Gonzalez

On this day alone, there were over five 4x4's parked next to industrial salt lakes, with about 30 people moving amongst the artisanal salt water ponds, taking pictures with the pyramid shaped salt mounds, and interacting with the locals. The tourist economy in La Guajira was far beyond what I expected, with a synchrony between the tour companies, drivers/tour guides, locals and accommodation options. After that we made our way up to Uribia, with the last chance to buy water or snacks that we may want to bring additional to the food we would be provided. On this stop, our tour guide told us that we should buy a

ready-made food package as part of the 'agreement' or expectations the Wayuu communities in La Alta Guajira have for tourists passing by. Using a rope or chain across the path, often held by children, roadblocks are created and most of the time are easily overcome by providing snacks or water- the snacks are mostly highly processed, high sugar unperishable items such as panela (unrefined whole-cane sugar) and popular Colombian candies. Yet this roadblock is relative since this is open territory where one can easily bypass them, or run over the chain or rope since they have to be manually held up; whenever our tour guide didn't want to give food he would just continue driving to which the children or adults would start yelling. This power dynamic is straightforward, many of these Wayuu communities do not have a choice as to whether tour cars pass through, and even though some may benefit and depend on the tour economy by selling artisanal products and receiving this food as a commodity, it seems that it is less done in the interest of the people and their needs and more on profit models and exploitative methods.

Passing by these communities, we also saw some cows, donkeys and numerous herds of goats, which can be widely seen all throughout La Guajira since goats are central to Wayuu culture, acting as a vital source of food, currency, and social status- many times goats are included as part of a woman's dowry. La Alta Guajira is also rich with seafood due to its proximity to the sea with lobster and a variety of fish, yet not all communities live right on the sea and so procuring these items may not be a daily event. With the rise of tourism, overfishing may pose a challenge and the all not too obvious effects of climate change¹⁵⁷. Aside from the nutritional aspects, the remoteness of the region and scarcity of resources mean that any health issue risks escalating into a serious one. On our last day, we explored

¹⁵⁷ Universidad de La Guajira, "Retos Frente a la Variabilidad Climática en La Guajira."

Las Dunas del Taroa, these huge sand dunes that lead right up to the Atlantic Ocean when I got some sand in my eye and all of the sudden it swelled up. There was nothing to do but to wait until it got better or we got back to the nearest city, Uribia, over three hours away.

Before we made our way back, we stopped to have lunch at this restaurant located in one of the rancherias. When we arrived, my eye was still swollen and red. A Wayuu man came over to ask what had happened and as I told him, he gently grabbed my face and with a napkin started blotting my eye attempting to get the sand out. He was calm and acted as though he had done this a million times before on himself or for others, and although it didn't make it better, it certainly did not make it worse like when one of our fellow travelers, a nurse, then tried to get the sand out by blasting water in my eye, ultimately causing it to swell even more and shut. This is not to say that the nurse didn't know what she was doing, but in regards to health, especially in places like La Guajira where many cannot depend on the medical system, who have traditional practices stemming from daily life, and who understand the body in different ways, there is knowledge and truth to what they do and how they do it. This is a clear example of how SISPI's policy can be applied, understanding that 'modern medicine' is not always the answer and that there is always something to learn from the very people themselves who constantly deal with injuries and health issues stemming from their environment- as simple as removing buried cactus spines to dealing venomous snake bites. Although not all health issues can be addressed with traditional methods especially with chronic and deadly illnesses, there is a beauty and need to incorporate both systems for the betterment of the Wayuu and all Guajiros health, whilst understanding the nuances that occur between each individual.

3.3 Wayuu Women's Sexual Reproductive Health Understandings & Preferences

Sexual and reproductive health (SRH) emerged as a rich and complex theme across all four focus groups, with women's framings shaped by generation, geography, education, and cultural practice. This section draws comparatively across the focus groups and the initial community visit in Rancheria A to examine how Wayuu women understand and experience SRH from definitions and taboos to practices around the encierro, contraception, and childbirth to address the research question: what are Indigenous women's understanding, perceptions, or preferences about their SRH?

3.3a Rancheria A: First Conversations on SRH

During one of the initial community visits, Natalia and I visited Rancheria A, a community right outside of the town of Camarones which is around a 15-20 minute drive southwest from Riohacha. Rancheria A is a unique rancheria (indigenous 'reservation'/community) that sits right next to the ocean and Camarones meaning it is relatively easy to get to compared to most rancherias that reside much farther from urban cities and essentially impossible to find for those not familiar with the area. We arrived at Camarones and then hopped on some motorcycles to complete our journey since no rancheria that I went to or know of has paved roads leading to the houses. In order to get to a certain house or enramada (Figure 13), a traditional, open-walled, thatched-roof structure that acts as the central living room, social hub, and workspace, one must travel by 4x4 or motorcycle. With our water jugs, coffee, sugar and crackers, we arrived at the enramada and met some of the women who worked with WWC as well as women who work with the group Un Nuevo Amanecer (A New Sunrise), a group created in 2002 by 8 Wayuu women from different

rancherías with the goal of creating safe environments for children and preventing child sexual abuse. Although I had no focus group planned for that day, while speaking to the women we very quickly began engaging in topics related to their health and interest in WWC's goal to create these health workshops. When I asked them what were the health problems that most affected the people in their communities they mentioned access to clean water.



Figure 13: Enramada in Rancheria B
Photograph taken by Paula Gonzalez

The methods that Wayuu people living in rancherías use to access clean drinking water can vary¹⁵⁸. Most communities have what is called a Jagüey, traditional Wayuu-made reservoirs that act as a system of water capture, storage and conservation where both people

¹⁵⁸ González, Pérez, and Rodríguez, “Water Security Challenges in La Guajira.”

and animals can drink from. Since these Jagüeyes are open air, still water and used by people and animals alike, the water is often contaminated and not always reliable since the hot desert climate can often dry them up. Communities also access clean water using water filters, often provided by varying NGOs, that add temporary solutions since these filters break over time, and other communities have wells, windmills, and during the rainy season, rainwater. Although some communities are situated near rivers, they have either been diverted or contaminated by the 'cerrejon', the largest open pit coal mine in Abya Yala. Drinking water can also be brought by carrotanques (tanker truck) provided by the Colombian state's National Unit for Disaster Risk Management (UNGRD)¹⁵⁹ or individually in the form of 5 gallon water jugs or bottled water, although this can get complicated due to travel distance. Given Rancheria A's proximity to Camarones and Riohacha, accessing water is not as difficult compared to other communities, yet still not easily accessible.

When I specifically asked what health problems they faced, answers ranged from ovarian cancer, breast cancer, and gastritis. Asking more specifically about sexual and reproductive health issues resulted in them mentioning the 'encierro' (confinement) period that occurs after a girl's first menstrual period. During the encierro, the girls are only allowed contact with their mother and grandmother, cut their hair, eat certain things, and use this time to connect with themselves, their culture, and prepare themselves for 'maturity' or adulthood. This practice varies depending on the family and recently has seen a decline since girls often have to spend weeks to months at home which interferes with their education. From my outside understanding, I assumed this was a time when these girls would learn about themselves and their bodies, but the women quickly explained to me that it is still pretty

¹⁵⁹ Unidad Nacional para la Gestión del Riesgo de Desastres de Colombia

taboo to talk about sex and how to protect oneself, and even if they wanted to, most don't know where to begin. Instead, most adolescents learn through school sexual education (sex ed.) courses, peers, or once they themselves become pregnant. Even when certain organizations have come to talk about sex ed., the manner in which they are introduced distracts from the actual information creating a disconnection and mistrust between organizations and community members. The women recounted a time Profamilia, a national, private, non-profit organization specializing in sexual and reproductive health services, rights, and education, came to their community to talk about contraceptives. The women laughed as they explained how Profamilia began pulling out contraceptives and handing them out while stating that it was okay to have sex with whomever they wanted, but to make sure they were protected. One of the women specifically said that she interpreted this as 'go be a slut' and further stated that this was an example of how not to begin having these conversations. I found it interesting that even just between three generations, so much had changed regarding the Wayuu, their health and culture. These women, most in their 30-40s, and older generations did not speak about their sexual and reproductive health issues, which as mentioned earlier, has led to preventable health problems worsening or becoming detrimental. Yet, it is within the younger generations that these topics are more openly discussed, and the women know that it is important to know about their health not just for pregnancy, but also to be able to identify certain illnesses and diseases. This idea of sex as taboo is not unique to the Wayuu and can be seen across the world¹⁶⁰, yet there are many barriers that the Wayuu have to face regarding their health apart especially the cultural aspects.

¹⁶⁰ San Sebastián and Hurtig, "Health in the Colombian Wayuu Population."

3.3b WWC Leaders: SRH Definitions, Contraception, and Bodily Autonomy

After the conversation quieted down a bit during my first focus group, I directed the conversation to think about what sexual and reproductive health means to them, to which they immediately responded with preventing pregnancy. Having done some background work, this made me think of Renacer's Family Planning Program and others similar to this where the problem of child malnutrition and responsibility is placed on individual Wayuu women and their families with a state based agenda of controlling bodies and reproduction. Rather than addressing the state's shortcomings and outright violence against the Wayuu and their ability to access food, water and health services. This answer also shows how the focus of many sexual and reproductive health conversations are centered on reproduction only, ignoring the numerous other health issues that impact women such as cancer, urinary tract infections (UTIs), and hormones. I followed up by asking what are some things they would like to improve regarding their sexual and reproductive health care to which they responded by preventing teenage pregnancies, stating they are more concerned and shameful about pregnancy than for example sexually transmitted infections or diseases. When asked whether they were taught sexual education in school, the answers varied by generation and by what grade level they completed in school. This led into talking about the practice of the encierro (confinement period), and that it was no longer a common practice because the women did not want their daughters to miss school knowing the importance it held for their 'superacion' or self-improvement and the value of education. Many of them stressed this, saying that although it used to be its own unique time of cultural and spiritual education and retreat from social life where the mother and grandmother would teach their daughters what it meant to be women, the care needed when menstruating and the practice of weaving, school was

important and in its own way their daughters were receiving some sort of sexual health education. The methods of sexual health education and communication may look differently at home than it does at school, with some of them implying that younger generations are in a way more likely to have unexpected pregnancies because this aspect of being protected by the family is lost in a sense. Whereas before they may have been young, but at least 'aware', prepared and in most cases married. This dynamic between awareness and unawareness ties back into the purpose of health education, which is to provide people with as much information as possible so they can make informed decisions regarding their health, acknowledging that information is only one of many factors which impacts health decisions. But for people who already consider some of these conversations to be taboo, how is there a need to provide new spaces or ways of going about this that stick? Especially when teenage pregnancy impacts the exact reason as to why the ritual of the encierro isn't practiced as much, which is attending school.

In regards to preventing pregnancy, I asked the methods they used and whether they had access to contraceptives. They answered that through their EPS they have access yet that especially the hormonal contraceptives caused many of them discomfort and fatigue with side effects known to contraceptives such as irregular periods, constant bleeding, headaches¹⁶¹. When some of them have decided to remove their contraceptive implant, they mentioned having difficulty achieving removal due to some doctors' refusal and ignorance of their reasoning and ultimately ending up forced to keep it. Removing contraceptives is not an uncommon ask and women reach this conclusion from reasons to wanting to have children to

¹⁶¹ Cleveland Clinic, "Birth Control Options."

not liking the side effects of being on hormones¹⁶² like I have done, given the trouble that these women have to go through to access medical care, from booking the appointment to finding transportation to get there, puts them in a precarious situation where they have no option but to succumb to what the doctors decide. Trying to look at this from another perspective or preventative measure, I asked whether they have conversations with their husbands regarding family planning, which allows people to attain their desired number of children and determine the spacing of pregnancies¹⁶³, and most of them said that their husbands don't like to use condoms. This essentially leads to the women ending up pregnant and at that point they contemplate whether to 'desconectarse' (disconnect oneself) or not, which is how they colloquially refer to tubal ligation, an invasive, surgical sterilization procedure that involves sealing or cutting the fallopian tubes, commonly known as getting your 'tubes tied'.

This was the first time I had heard of it spoken this casually, and so I asked whether the decision to 'desconectarse' was their own or if they felt it came more from external factors. They shared that when Wayuu women have three children by cesarean section— the delivery of a baby through surgical incisions made in the belly and uterus¹⁶⁴— the doctors sometimes tie their tubes to prevent them having more children, taking medical decisions into their own hands rather than respect their patients desires¹⁶⁵. This results in some women lying about the number of children they have so this will not occur while they're under anesthesia for the cesarean; this can be risky to the Wayuu women since doctors normally

¹⁶² Mukanga et al., “Perspectives on the Side Effects of Hormonal Contraceptives.”

¹⁶³ WHO, “Family Planning/Contraception Methods.”

¹⁶⁴ Mayo Clinic, “C-Section (Cesarean Delivery).”

¹⁶⁵ Becker, *Get it Out: On the Politics of Hysterectomy*

make decisions based on the 'complete' health history, understanding the risks. What does it mean when lying to medical professionals becomes standard? Is it already standard and how does this tie into medical mistrust in Indigenous communities? Following this, I asked if it was common for the women to go through childbirth in the communities and they responded that it depended, sometimes in the hospital and sometimes in the communities. Depending on the situation and if they can get to a hospital or not, the general consensus amongst these leaders was that they prefer to have it at the hospital because with traditional midwives there is the risk of not being equipped for emergency situations for both the mother and baby. I asked if getting information about pregnancy and childbirth may help to which they responded it would since there is a general lack of knowledge and even though they occasionally ask neighbors, they also don't know much. One of the women, Yolanda, shared that she lost a baby due to complications that could have been prevented if she had sought care earlier and added that if she had known what symptoms to watch out for that would have encouraged her to go to the hospital for a check-up. After confirming that without identification they would not be able to register for EPS, the national health insurance, I asked how they, as leaders, thought they could support having these conversations with women who are hesitant to speak or who don't understand Spanish to which they responded that fortunately, there are people at the EPS or the hospital who speak Wayuunaiki (Wayuu people's language). They also emphasized how this 'sex ed' talk needs to involve men so that the responsibility does not only fall on women and so that the men can see these conversations as important for their partner and family's health, and not perceived as

disrespectful or bothersome¹⁶⁶. Otherwise, there is an endless cycle where the women either end up pregnant, suffering through uncomfortable birth control, and at some point 'deconectandose' (disconnecting themselves, i.e. tying tubes).

3.3c Settlement K: Generational Perspectives on SRH

The third focus group took place in Settlement K, an informal settlement at the entrance of Camarones composed of Afro-Colombian, Wayuu, and Venezuelan migrant families. While the children were running around playing, we sat between two wooden benches, a couple of desks, and chairs. As part of Wayuu culture, coffee and food were served, especially since I was asking them to come and meet me for the first time and to have this conversation. For these women, this was their first time engaging in this kind of discussion since school and none of the women were involved with WWC. Similar to the first two focus groups, fevers, coughs, digestive issues, headaches, body aches and heat rashes affected their community members as well as UTIs for women. In one of my previous conversations with Petra, I asked how they managed to get water or if there were sanitation facilities, to which she responded that there was the 'monte' (mountain) where the people in the community would go to use the restroom¹⁶⁷. Taking care of themselves meant protection from disease, not urinating just anywhere to avoid infections, eating well, happy without any pain and the strength to work and fight — a joke that let out tons of laughter. They also

¹⁶⁶ Hardee, Croce-Galis, and Gay, “Are Men Well Served by Family Planning Programs?” ; Patil et al., “Markets, Incentives, and Health Promotion.” ; Biderman et al., “Pathways for Sexual Health Promotion among Indigenous Boys and Men.”

¹⁶⁷ Walker, “Water for the Wayúu.”

mentioned treating illnesses by going to the doctor, but the first step was herbal remedies that the elders would give them, although not all plants could be found, most were accessible.

When I asked the women about their health goals during my third focus group, one of them started saying that her goal for her girls is for them to finish their education, get married to whomever they choose, and when it's time to have children, that they decide what is best for them. She added that back in the day people could have and sustain eight to ten children, but nowadays everything is too expensive. Yet, later in the conversation we had a woman speak that she wants to have as many children as possible and was pretty happy with the idea of not having a plan. Another woman stepped in saying nowadays the girls don't think and can have boyfriends and children as young as eleven years old. Adding to that another woman said, the problems have changed over time since a lot of customs have been lost. She explained that she had her children at sixteen years old and although some mothers still practice the encierro giving their daughters advice and encouraging them not to marry young, not everyone receives that. When I asked how they received knowledge on sexual and reproductive health, they explained that the younger generations learned in school and from their mothers, while older generations were mainly from their mothers and grandparents, and some people learned once they were married. This conversation was much more different from my other two focus groups, although some seemed engaged and curious, others were talking amongst themselves, but nonetheless all of them showed up and this was the first step towards creating more women centered spaces that Petra hopes to empower within Settlement K.

This brought me back to Natalia and I's first community visit in Rancheria A. After arriving at the hotel, we befriended some ladies from Medellin who had booked a 'Wayuu

tour' right next to the hotel. They invited us to join and since Rancheria A's community project was to offer their own tour activity with their brand new enramada, we agreed to potentially gather some ideas and inspiration from them. After a quick drive, we passed by a large sign that read 'Rancheria Epiapush Etnoturistica' with their instagram handle displayed. Commonly referred to nowadays as community based ecotourism, this sustainable, locally managed tourism model where communities own and operate tourism activities to conserve natural resources and culture has become more and more popular within Wayuu communities and other Indigenous communities worldwide¹⁶⁸. As we entered the enramada with the two ladies and their personal tour guide, the tour began. We were given an overview of Wayuu culture, from explaining the different clans, and giving us chirrinchi, their traditional homemade liquor to try. Throughout this conversation, our guide stressed the significance of the matriarchy and that traditionally it was normal for men to have multiple wives since it was the mother and her family that made the important decision regarding the children, yet in recent generations this was not seen as much. This is when the ladies' personal guide began making inappropriate comments romanticizing the idea of multiple wives and essentially contributing to the sexualization of Indigenous bodies. Romanticizing this idea of 'non-Western' practices that allow men to do whatever they want while completely disregarding the rates of domestic violence and abuse that many of these women face¹⁶⁹. Yet as these thoughts came to my mind, our guide smoothly went over them and continued the tour, showing almost an ease and familiarity with this kind of interaction. This interaction was a small but telling reminder of how Wayuu women's bodies, relationships, and cultural

¹⁶⁸ Colmenares, "Community-Based Ecotourism in Colombia."

¹⁶⁹ Klingspohn, "The Importance of Culture in Addressing Domestic Violence."

practices are interpreted and consumed by outsiders in ways that rarely reflect their lived realities. Understanding how national policy measures up against those realities meant turning to the practitioners working most closely with these communities.

3.4 National Policy & Sexual Reproductive Health Access in Practice

The physician interviews with Fabio and Joaquin offer a practitioner-level assessment of how national policies perform in practice for Wayuu women and Venezuelan migrants in La Guajira. Where the focus groups revealed what the gap between coverage and access looks like from the inside, these conversations illuminate how those working closest to the system understand its failures and its possibilities. Together they address the research question: how well do current national policies address access to SRH healthcare?

3.4a Fabio

I met Fabio through WWC's other co-founder, Matilda, when they worked together in the department of La Guajira with Malteser Colombia in 2016. At that time, Fabio was working as a field doctor with Malteser Colombia, which then became Malteser International where he then proceeded to work as the project coordinator working with Wayuu communities and people affected by conflict. This program had a four year time frame, due to financing, in which it worked between the EPS and Indigenous community leaders to allow for the flow of information between both to be more efficient. From 2020-2023, Malteser International, moved also on ensuring access to the health care system for Venezuelan migrants with an 'irregular status' meaning they had no way of accessing the medical system. These efforts involved constructing health clinics, aiding registration to the

Colombian medical system, and focusing on Wayuu midwives work and how to incorporate them within the medical system. He said that since Malteser Colombia's mission was accomplished and the objectives were met, it allowed for a transition to focus on Venezuelan migrants due to the emergent medical needs and strain on the medical system¹⁷⁰. When I spoke to Fabio in August 2025, he said that the program would shut down at the end of that month due to the global reduction in humanitarian funding that was occurring¹⁷¹.

Malteser International had different components to their approach, one of the main ones being prenatal care especially for pregnant Venezuelan migrants where they would provide intramural care through a clinic and extramural visits to neighborhoods that they knew had high populations of Venezuelan migrants. Since the Colombian government had already made mandatory the assistance and care during childbirth for Venezuelan migrants¹⁷², they focused more on prenatal care which was still not available. Including nutritional focuses using supplemental kits to improve their weight and prevent gestational issues. They also had an extramural team looking for children who had malnutrition, involving both Venezuelan and Colombian children to prevent xenophobic indexes which can occur with migrant communities receiving more resources and attention compared to local populations¹⁷³. Fabio then described a third initiative focusing on patients with poorly managed chronic conditions who presented with severely imbalanced levels due to a lack of access to medication. He spoke about these sensitized educational initiatives to explain to Colombians that although the ideal is that everyone is covered by the state, the organization

¹⁷⁰ MSF, “Venezuelans in Colombia Struggle to Find Health Care.”

¹⁷¹ Mirbach-Harff, *LinkedIn Post on Colombia and Syria*. ; Malteser International, “Colombia.”

¹⁷² Alcaldía Mayor de Bogotá, “Decreto 135 de 2021.” ; Colombia, *Decreto 866 de 2017*.

¹⁷³ UN Network on Migration, “Xenophobia toward Refugees and Other Forced Migrants.”

was influenced and directed by its investors and that due to their being Venezuelan migrants in their neighborhoods, they too could benefit from these services that otherwise would not be available. He mentioned a CHW initiative composed of both Colombians and Venezuelan migrants who were assigned certain houses to promote and share health education. Lastly, Fabio mentioned the social workers who focused on guaranteeing migrants knew their rights, helping them register to the Colombian health insurance, as well as evaluating whether they could make a case to regularize their status to Temporary Protection Statute (ETPV)¹⁷⁴ when it was passed in 2021¹⁷⁵. Fabio mentioned that there was a pendular portion of the population that would come to Colombia in order to receive their health services and would then return to Venezuela. He mentioned that there were Wayuu Venezuelans –being clear that to Indigenous peoples such as the Wayuu the concept of borders is not limiting– that crossed freely and many Colombian rancherías would receive Wayuu Venezuelan migrants. For him, his work with Malteser was not limited to people who were migrating versus people who were looking to stay in Colombia longterm, but rather a general approach focused on addressing people's health needs who were not registered with the Colombian healthcare system.

I asked him whether he thought the Colombia government had done a good job in carrying out its policies regarding health for migrants and Indigenous peoples. He started off by saying that the healthcare system was on the brink of collapse so in his opinion they have done an excellent job incorporating migrants into the system and preventing them from exhausting emergency services. At that time, primary healthcare was not available to

¹⁷⁴ Estatuto Temporal de Protección para Migrantes Venezolanos

¹⁷⁵ Migración Colombia, *ETPV*, Decreto 216 de 2021, Resolución 971 de 2021.

Venezuelans and their only option was to seek care from emergency services which was seen as unsustainable due to funding mechanisms¹⁷⁶. When speaking of the Wayuu he mentioned factors such as culture, geographic (spatial) aspect, low literacy rates, and low education rates as affecting access and health outcomes. There was an idea at some point of using drones for telehealth-esque exams and delivering medications, but many armed forces such as guerillas and paramilitaries will use drones to target communities and so they refrained from trying to implement this aside from the economic limits. When I asked about the failures he began by listing one huge accomplishment which is high insurance coverage rates, but quickly added that coverage by no means ensures access and suggested that perhaps there needs to be more of a focus on access whether its from this telehealth approach or by using technological tools especially for historically marginalized communities that cannot access basic needs. The quality of this care also depended on the context, again reemphasizing the cultural and geographic factors that the Wayuu face versus the administrative and economic barriers Venezuelan migrants face. I would assume economic factors also apply for the Wayuu but Fabio did not mention that and he said the initial entrance or opportunity to receive medical care was worse. Elaborating he mentioned that the Wayuu have these midwives that will conduct prenatal and postnatal care and have the trust of the Wayuu women whereas many times the Wayuu have a mistrust of the state-based healthcare system. Meanwhile for Venezuelans it was more a case of documentation, experiencing xenophobia and not understanding the proceedings of the Colombian healthcare system and social services. Fabio discussed how the laws in place were not able to do as much as they promised due to the economic restraints. He mentioned some of the most impactful laws regarding Indigenous

¹⁷⁶ Doocy et al., “Venezuelan Migration and the Border Health Crisis.”

peoples and migrants. Law 1438 (2011)¹⁷⁷ aimed at improving healthcare quality and expanding access. Ruta Integral de Atención en Salud (RIAS; Comprehensive Health Care Pathway), stemming from the policy shift initiated in 2011 and further defined by Resolution 3202 (2016) act as mandatory tools to guide the user through a continuous, integrated, and organized pathway of care. TPS Designation for Venezuelan Migrants (2021) granting legal protections and access to the healthcare system for undocumented Venezuelan migrants. We wrapped up the discussion by getting into the perception of Wayuu people and Venezuelan migrants to the Colombian public and how that impacts their experiences and everyday lives. Fabio mentioned that, in his opinion, the Wayuu have been on the margin compared to southern and southwest Indigenous groups who have become more politically active. Colombia, he said, is a polarized country when it comes to Indigenous peoples with stereotypes ranging from resistance to 'western practices' and not agreeing with border practices, often seen as uncivilized and underdeveloped. For Venezuelan migrants, it is a mixed bag with some Colombians expressing solidarity while others express hatred, seeing them as a threat that infiltrates social services and takes away labor opportunities. Both groups face discrimination, cultural differences, bureaucratic, socioeconomic, and language barriers and mentioned that many Colombian rancherías gladly accept Venezuelan Wayuu migrants since they normally come in families and have a shared culture. Since then Fabio has also worked in La Salud Fundación para el Trópico working as a health coordinator and for La Universidad del Norte en Barranquilla teaching research courses looking at the influence of projects funded by the National Institute of Health (NIH). Currently he works with the Colombian Red Cross in a different region of Colombia. Where Fabio's perspective

¹⁷⁷ Franco-Giraldo, “La última reforma del sistema general de seguridad social en salud colombiano.”

was shaped by years of direct field work in La Guajira, Joaquin brought a different vantage point, that of a Venezuelan migrant physician who had navigated the Colombian health system from both sides of its bureaucratic divide.

3.4b Joaquin

After meeting Joaquin at the GFMD a couple months back, we hopped on zoom where he began recounting his move to Colombia after migrating from Venezuela where he worked as a doctor seventeen years ago. Previously he has worked with organizations in Venezuela like Ven Mundo and Un Mundo sin Bordanza and international organizations like Coalicion por Venezuela, Refugees Seeking Equal Access at the Table, Alianza Global por los Derechos Humanos, Right to Food and in its moment Proyecto Integra financed by USAID Colombia. He currently has his own organization based in Barranquilla promoting the protection of the Venezuelan population in Colombia, socioeconomic integration, and family reunification by working with numerous national entities such as Colombian Immigration Authority¹⁷⁸, Ombudsman's Office of Colombia¹⁷⁹, Colombian National Training Service¹⁸⁰, ICBF, and with local mayoral offices. Similar to Malteser's goal, they promote registration into the Colombian health system and have a network of Venezuelan migrant leaders who are working with the mayoral offices on a number of issues. His organization offers a community kitchen for children, adolescents and pregnant women and frequently partners with other organizations to provide health services or directs people to

¹⁷⁸ Migracion Colombia

¹⁷⁹ La Defensoria del Pueblo

¹⁸⁰ Servicio Nacional de Aprendizaje (SENA)

Profamilia or the Centro Integrate, service centers designed to provide free assistance to Venezuelan migrants, Colombian returnees, and host communities¹⁸¹. Similar to Fabio's pros and cons, he stated that Venezuelan migrants normally face administrative and economic barriers whereas the Wayuu normally face cultural and geographic barriers. Since the Wayuu extends between both the Colombian and Venezuelan territories, I asked whether treatment was different to which he stated, when he was in Venezuela there wasn't this differential focus based on identity. It didn't matter if you were Indigenous, Black, mestizo or white, you simply got the same healthcare as everyone else. When I asked him what policies stood out he mentioned National Council for Economic and Social Policy 3950 (Conpes)¹⁸² which laid out a strategy for addressing migration from Venezuela in 2018¹⁸³. As well as Resolution 8470 passed in 2019 establishing that children born to Venezuelan parents were granted Colombian citizenship who are at risk of statelessness¹⁸⁴. Although Joaquin works primarily with Venezuelan migrants in Barranquilla, through his work he has encountered issues that extend far beyond migrants and affect Indigenous peoples such as the Wayuu who, unlike migrants, are citizens and should inherently be granted state and social services. Together, Fabio and Joaquin offered a practitioner-level confirmation of what the women's focus groups had made clear from the ground up: that the formal health system's reach into La Guajira's Indigenous and migrant communities is wide on paper and shallow in practice, and that the people working to close that gap are doing so largely in spite of the system rather than because of it.

¹⁸¹ Ministerio de Igualdad y Equidad, *Centros Integrate*.

¹⁸² Consejo Nacional de Política Económica y Social

¹⁸³ CONPES, *Estrategia de Atención a la Migración Venezolana*.

¹⁸⁴ Colombia, ICBF, *Resolución 8470 de 2019*.

Taken together, these conversations, observations, and encounters reveal a region where health is experienced far beyond the walls of clinics and hospitals. From rancherías and informal settlements to museums, community organizations, and the landscapes of La Alta Guajira, understandings of health were inseparable from territory, culture, family, and everyday survival. The women, physicians, and community members who shared their experiences demonstrated that navigating health often requires moving between multiple systems of knowledge, care, and support. These experiences did not always fit neatly into the categories through which governments and institutions understand healthcare. Instead, they revealed health as something lived, negotiated, and continually reshaped through relationships between people, place, and systems of care. Rather than providing definitive answers, this fieldwork illuminated the complexities, tensions, and possibilities that shape health in La Guajira. It is from these lived experiences that the following discussion and conclusions emerge.

IV. Conclusion

After spending the day with friends from the local university, UNIGuajira, we sat down at the beach and began to have conversations about policy, implementation, corruption and perceptions of La Guajira. Our group was a mix of exchange students (both international and national) and local residents, and although we all had different interests and disciplines, we wanted to understand a bit of how a state like La Guajira, which produces so many royalties from its enormous open-pit coal mine industry to marine salt extraction to the renewable energy initiatives, continues to be one of the departments with the highest poverty and infant mortality rates¹⁸⁵? At one point in our conversation, a kid walked by selling a local cactus fruit called iguaraya (Figure 14) to which my local friends told us is not commercially available and can only be obtained by collecting it oneself or through street vendors. I later came to find out that this fruit has significant meaning in Wayuu culture and is featured in many stories such as the belief that if a pregnant woman or a child eats the fruit, they might acquire the traits of the animal that has eaten it, so they are not allowed to eat the fruit¹⁸⁶. From something as small as the iguaraya, there is connection and significance to the Wayuu and women's health. These conversations reflected the central tension explored throughout this thesis: how a region so rich in resources continues to experience profound health inequities, particularly among Wayuu communities, despite progressive constitutional and health reforms.

¹⁸⁵ World Bank Group, Colombia: Regional Disparities and the Road to Integration

¹⁸⁶ Slow Food Foundation for Biodiversity, "Iguaraya (Dagger Cactus Fruit)."



Figure 14: Iguaraya Fruit in Riohacha, Colombia

Photograph taken by Paula Gonzalez

4.1 What the Women Said

Hosting these focus groups created space for collective storytelling, shared reflection, and conversation between women whose understandings of health are shaped by different experiences, cultural associations, economic, and geographical factors. During these conversations it became apparent that although SRH is generationally shifting, there are structural barriers still in effect leaving younger generations without cultural traditions (such as the encierro), but also without the safeguards promised through the national health system and policies such as SISPI. Although there were still many reservations about the national health system, it was clear that for these women the coexistence of these systems is not a policy achievement, but a survival strategy the women have built themselves. I found the women's responses were very telling of how nuanced and specific health is to each person and how health was often predetermined by the limitation of choices to a subpar range of possibilities. Although this idea of 'health choosing' is relative to each individual's identity,

privileges, preferences, and spatial and temporal aspects, for the Wayuu, health is everything. From being able to access drinking water and food, to living in a safe place, to physically and mentally being able to work, study, fight and laugh about it. Health is not just a service they are accessing but a condition of life, resistance and cultural preservation. Can we really incorporate and support Indigenous knowledge in a neoliberal health system, made in a profit model? Although I sought to focus primarily on women's sexual and reproductive health needs, SISPI incorporates all aspects of one's health and the gap between what these women understand health to be and what the system offers them is not a communication problem, it is a structural one. A structure built on a fundamentally different understanding of health than Buen Vivir, which holds that "for Indigenous Peoples, health is GOOD LIVING, as a result of the harmonious balance of the relationships of the person with [themselves], [their] family, the community, the territory and nature"¹⁸⁷.

4.2 Between Policy and Practice

Across the focus groups, physician interviews, site visits, and everyday conversations that shaped this research, four questions guided my inquiry. Returning to them now is a way of honoring what the women, practitioners, and communities shared with me, and of being honest about what this work was able to find and where it fell short.

The first two questions, whether national health systems can support Indigenous health ideas and practices, and whether they can coexist with them, are in many ways inseparable. What I found is that coexistence is already happening, but it is happening largely because Wayuu women have made it so. Herbs before hospitals, elders before doctors, this

¹⁸⁷ PAHO, *Indigenous Own and Intercultural Health System (SISPI) in Colombia*.

pragmatic, layered navigation of two systems is not the result of thoughtful policy design but a survival strategy built by women who cannot afford to wait for the system to catch up to them. SISPI, in its most ambitious form, is an attempt to institutionalize and honor what these women already know. Whether it can do so without flattening the very nuances that make Indigenous health knowledge meaningful is the central and still-open question. What is clear is that national health systems can support and coexist with Indigenous practices but only if they are willing to be transformed by what they encounter, not simply expanded to contain it. The same institutional architecture that produced SISPI also produces doctors who tie women's tubes without consent and hospital staff who treat Wayuu patients as less than human. Addressing one without addressing the other is not reform, it is a contradiction.

It is also worth naming what SISPI cannot yet address. The Wayuu are a people whose territory precedes and exceeds the Colombian nation-state, extending into Venezuela and shaped by a history of movement that state borders cannot fully account for. Venezuelan Wayuu crossing freely into Colombian rancherías are not an anomaly but are a reminder that a policy built on citizenship and territorial jurisdiction will always be partial when applied to a people for whom those categories were never designed. The question of how SISPI addresses, or inadvertently reinforces, these border-based exclusions remains an important one, particularly as political shifts in both Colombia and Venezuela continue to reshape the conditions under which the Wayuu live and move.

The third question, what are Wayuu women's understandings, perceptions, and preferences regarding their sexual and reproductive health, yielded some of the most layered and honest answers of this entire research process. These women understand SRH as encompassing the whole body, not just reproduction. They speak about UTIs, cancer,

hormones, and chronic disease alongside pregnancy and childbirth. Yet the system consistently narrows the conversation to fertility management, placing the burden of family planning on women's bodies while leaving their partners outside the conversation entirely. The generational shift is happening as younger women speak more openly about their bodies than their mothers or grandmothers did. But structural barriers remain with the encierro declining without being replaced by anything that offers the same cultural grounding and bodily knowledge, teenage pregnancies increasing even as women become more educated, and access to contraceptives that cause harm, cannot be removed when requested, or are made permanent without consent. The word 'desconectarse' captures something important, a surgical, permanent decision has been so normalized, so frequently made under coercion or without full information, that it has become conversational. That normalization is not cultural. It is the result of a system that has consistently treated Wayuu women's reproductive capacity as something to be managed rather than respected.

The fourth question, how well current national policies address SRH access, produced perhaps the most consistent answer across every person I spoke with, that coverage is not access. Colombia's high insurance enrollment figures are real, but they obscure the distance between a woman's EPS card and the care she can actually receive. Transportation costs, three-month gaps between IPS visits to rancherías, chronic conditions that cannot be managed on a referral system that requires multiple trips to a clinic hours away, insurance plans that drop patients for inactivity, and hospitals in Barranquilla that require families to leave their dying relatives far from home are not administrative inconveniences. They are the structural conditions that determine whether a woman lives or dies, whether a pregnancy is safe or dangerous, whether a chronic disease is managed or allowed to progress. The policy

gap is not a failure of language or intention. It is a reflection of how communities like the Wayuu are rendered symbolically central to national identity while remaining materially expendable in practice.

Taken together, these findings point toward something larger than any single policy can resolve. The decline of humanitarian aid, the fragility of a decree passed just a year before an election cycle, the ongoing challenges of implementation in a region shaped by armed conflict, corporate extraction, and decades of structural neglect, all of this means that SISPI's future is genuinely uncertain. The May 2026 first round of Colombia's presidential election brought that uncertainty into sharp relief. The June 21st runoff pits Senator Iván Cepeda, an ally of outgoing President Gustavo Petro who has emphasized Indigenous rights, environmental conservation, and continuity of intercultural health policy, against far-right lawyer Abelardo De la Espriella, who has campaigned on expanding extractive industries including fracking, escalating military action against armed groups, and slashing social spending. De la Espriella, endorsed by U.S. President Donald Trump, has close ties to paramilitarism and a political tradition that has historically treated Indigenous territories as security threats or resource frontiers rather than as spaces of autonomous governance¹⁸⁸. As one analyst noted, the election represents a choice between prioritizing environmental and community protection versus productive exploitation of Colombia's natural resources¹⁸⁹. This distinction is not abstract for La Guajira, a territory already shaped by the Cerrejón coal mine, wind energy extraction, and the chronic underdevelopment that follows when resource wealth flows out while structural neglect stays in. A De la Espriella government would likely

¹⁸⁸ Grattan, "Colombia's Presidential Runoff."

¹⁸⁹ Nick, "Who Is De la Espriella?"

deprioritize SISPI's financing and implementation, weaken the concertation mechanisms Indigenous organizations have built over decades, and potentially reverse the institutional gains of the 2022-2026 period. For the Wayuu, whose health, territory, and cultural survival are inseparable, the outcome of this election is not a distant political question, it is a direct determinant of whether SISPI can move from decree to practice, and whether the health sovereignty Indigenous peoples have fought for across generations can be sustained. What is not uncertain is the knowledge, resilience, and political clarity of the communities it is meant to serve. Organizations like WWC, Un Nuevo Amanecer, and Fundacion Baylor are not filling gaps in the system. For many Wayuu women, they are the system. And any honest accounting of what health justice looks like in La Guajira must begin there, with the nets that communities have already built, and with the question of how the state can finally learn to support rather than supplant them. One such example is an organization called Colectivo Mujeres del Desierto, which was founded and is run by a group of Wayuu women. The collective promotes and conducts training initiatives regarding sexual and reproductive health rights, gender-based violence, and human rights in Uribia through a gender-, ethnic-, and climate-focused approach. Although its work is concentrated primarily in Uribia, the collective also uses social media, digital storytelling, educational campaigns, and community workshops to share information about Indigenous sovereignty, women's rights, territorial defense, and Wayuu culture with broader audiences (Figure 15). Colectivo Mujeres del Desierto focuses on advocacy, consciousness-raising, and collective empowerment led by Wayuu women themselves, emphasizing community leadership, rights-based education, and the strengthening of local capacities to address the structural conditions that shape health and well-being.

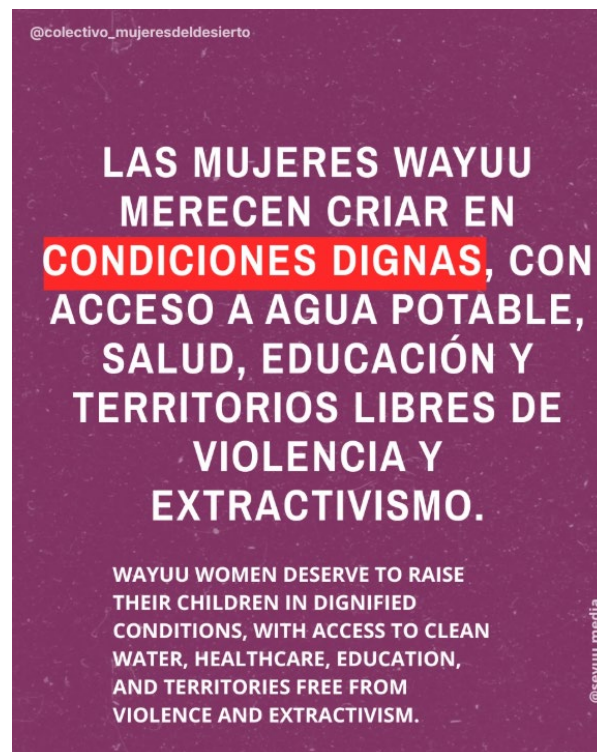


Figure 15: Colectivo Mujeres del Desierto Instagram Post on May 10, 2026

4.3 Limitations and Relationships

Originally, I was a bit unsure about hosting focus groups with Wayuu women because I was aware of the extrativist, one-sided and temporary interactions that research is known to be. Yet, starting off by getting to know the women through my work with WWC, I saw just how involved and intimate these relationships were extending beyond simply empowerment and entrepreneurship and focused on solidarity, community, safe space, and sisterhood. Although Jennifer and Matilda (the WWC co-founders) do not live in Colombia and visit the women about once a year, the ongoing, daily communication that it takes between them and Petra to coordinate the monthly workshops, delivery of materials, payments, and overall guidance is a constant presence in all of these women lives. Holding these first three focus groups went beyond my research interests and directly serves as a base for the health workshops that WWC wants to develop, recognizing that health is critical to any sustainable and community focused effort. The fourth focus group was a bit different since Petra's goal was to begin fostering women focused spaces extending beyond their children's needs and activities. The focus groups went well, but not at all how I had expected them to be. It was important for me to present myself as more than just a student or a researcher in order to create an inviting energy and be open to the pace, comfortability and responses of the women. Due to their structure and casualty, my recordings caught much of the conversations but there were moments when the women would speak amongst themselves in Wayuunaiki, or respond with specific terminology that I didn't understand making language barriers one of my biggest limitations. The limited time I was able to spend with the women was also a limitation since I would only see most of them about one to two times per month due to the timing of the workshops. Yet, even if I only had the chance to meet some of these women

once, or was able to build a stronger relationship with some, many of them came up to me excited about what would come from these conversations and just happy that these conversations were occurring. Even the women I didn't get to meet or interact with due to safety concerns were brought into my focus group conversations highlighting the community relations and solidarity to express not only their individual health needs and wishes but those of their family, friends and people.

As I mentioned previously, initially I wanted to work with both Wayuu women and Venezuelan migrants, but due to the nature of the research and who I was able to meet ultimately led my research in a different direction. The physicians I interviewed were part of this process, and getting to hear about the projects they had worked on and populations they worked with revealed the intricate dynamics and relationships that I didn't see in the literature. Being in Riohacha for those specific months allowed me to meet a plethora of people working on issues either directly or indirectly related to my work which allowed me to see how health was connected to far more than just the local clinics and SISPI policy. This work is a result of my time in Riohacha and the people who invited me into their space and allowed me to build a connection with them. Although there were many people I didn't have the opportunity to meet or simply ran out of time at the end, I know that this work is just the beginning of a much longer conversation and journey I would like to continue pursuing.

4.4 Reflections and Reimagining Health Justice

One of the main reasons as to why I decided to pursue a graduate degree was to gain the tools and knowledge that I felt I was lacking. My passion for helping others and fighting for injustices has grown more and more, yet I could not find the correct words, understand the extensive and complicated histories, or begin to come up with the methods and

approaches necessary for this work. I became very interested in the healthcare field because it is at the very center of all of our conversations, livelihoods, and impacts us on levels we cannot even begin to comprehend. As I began to understand how healthcare is used against communities, the histories and presence of racism and oppression, and the outright denial of systematic issues fueled me to understand that just like any other field, healthcare must be looked at as an interdisciplinary field. Every person's intersectional identity¹⁹⁰ defines the type of access and service they receive, and when healthcare, like most of our institutions, is based on ideas of colonialism, imperialism, racism, and subjugation of the 'other', it is hard to reimagine how healthcare can serve people. Especially thinking about communities whose definition, understandings and histories of healthcare are rooted in very different ideologies, connections to environments and space, and ultimately removed from simply physical and empirical methods.

The institutions and manipulations that were and have been used to oppress Indigenous peoples can be seen throughout the world. In order to understand what healthcare equity means and how to get closer to achieving this for everyone, it is important for me to understand the histories and avenues that are taken to continuously disempower and control communities. Not only do I want to understand my own identity and biases to recognize why I am motivated to do this work, but I need to understand the ways in which these systems are constructed and perpetuated to deconstruct and change the ways in which we approach things, starting from the very research I am conducting. Healthcare equity and justice are at the center of my work and these tools have not only allowed me to understand just how flexible yet rigid these systems are but that in order to work for the people, my work and

¹⁹⁰ Crenshaw, "Mapping the Margins."

ideas must stem from the very communities themselves. As I continue to do this work, Park, Hoekstra, and Jimenez's lessons from migrants in 'the third net' resonate at the foundation of this work: that the healthcare system is not broken but intentionally built this way; that the meanings of cost and care extend far beyond economics and medicine; and that any alternative vision must go beyond universal coverage toward a deeper reckoning with who is consistently left out and why¹⁹¹.

Although migrant and Indigenous health needs are not to be meshed together, Indigenous peoples have in a way created their own forms of nets in order to resist, survive and thrive amongst the attempted (sometimes accomplished) genocide. As can be seen in this work, there are cases such as the Wayuu, who may have overlapping identities that affect their health outcomes. Health issues gravely affect Indigenous communities in Colombia, with the Wayuu in La Guajira suffering from chronic diseases to infections and illnesses from unsafe drinking water. These issues go beyond simply health and point to problems in infrastructure, food scarcity, corporate pollution, armed violence, and more. Indigenous peoples' health in Colombia must go beyond universal health care, and SISPI may be a step in that direction, but is it heading where it was intended? And if so, can it get there when it is so inextricably tied to colonial institutions and systemic oppression? My hope for this work and my future endeavors is the reminder that health justice cannot be accomplished without addressing all the injustices, grounding it in community efforts and constantly reimagining and reflecting what health justice can and should look like.

¹⁹¹ Park, Hoekstra, and Jimenez, *The Third Net*



Figure 16: Yolanda's Mother Making the Chinchorro

Photograph taken by Yolanda

The first Wayuu woman I met in La Guajira was Yolanda, one of the leaders at WWC. She is resilient, funny, and has this warm energy that makes anyone feel welcome. Yolanda is also one of the few women that live in the city of Riohacha and due to her proximity and commitment to WWC she helps out at the monthly workshops. These extra responsibilities are in exchange for school, which WWC pays for, since Yolanda did not get past a middle school education when she was younger. At the workshops, Yolanda and I would talk and get to know each other better. I met her daughter and even found out that her mother knew how to make a chinchorro, a woven hammock, (Figure 15) that I was wanting to get and so we set a plan to go and buy the threads needed for the job. Yolanda and her

daughter met me at the Mercado Nuevo in Riohacha, which was a market where locals would go to buy threads for weaving amongst other products. We bought the threads and headed over to a nearby shop to buy some ice cream where we sat and talked for about an hour. Yolanda told me that she was saving up to buy a motorcycle to be able to take her daughter to school and move around the city easier and her daughter began telling me about her friends at school and that it was going to be her birthday soon. Throughout the whole conversation Yolanda made it clear that she has made it a priority to teach her daughter to be grateful for each day as it is. If they only have rice to cook and eat that day to enjoy it and if today they were having ice cream, to savor it and enjoy it as well. Yolanda, like all the women I had conversations with, is a person navigating a system that was not built for her, and yet building a life anyway. At the end of the day, that is what SISPI must ultimately serve. And whether it can get there, truly, structurally, not just on paper, is the question this work hopes to address.

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APPENDIX

Wayuu Indigenous Communities

1. What are the most common health issues that women in your community face? List off some health concerns that women in your community face. Which ones seem most important or prevalent?
2. How does your community currently address or manage these health concerns? For example, are there any remedies or special treatments?
3. Is there any type of support that would be helpful? Are there other forms of support that would be helpful? Would you like that support?
4. When you feel unwell, what do you do? Who do you ask for help?
5. Is there something you would like to better understand about your body to improve your health?
6. What does being healthy mean to you?
7. Are you registered with the national health insurance system (EPS)? How many kids do you have? Are all of them registered?
8. Do you understand how EPS works? Do you use it? Are there things that prevent you from using it?
9. Are all the women in your family registered? What about your neighbors? For people who don't register, why do you think they don't?
10. When do you go to the hospital? What are your community's perceptions of hospitals?
11. Are there aspects of medical care that you believe are helpful or harmful?
12. Does anyone know what reproductive health means? For example, what do you think it includes?
13. What are your reproductive health goals?

14. Have issues around sexual and reproductive health changed over time? Have they improved or worsened?
15. Have traditional practices or beliefs around sexual and reproductive health changed in your community?
16. How common is it for women in your community to give birth at home versus in a hospital?
17. Are there any tools or knowledge you think would be useful to have for home births?

Experts Interview Prompt

1. What organizations have you worked with?
2. What is the most recent organization you are currently working with or have worked with?
3. Have you worked on programs related to the health needs of Wayuu communities?
 - If so, can you describe specific programs, including their goals and how they were implemented?
4. Have you worked specifically on sexual and reproductive health programs with Wayuu communities?
 - When did these programs begin? Are they still ongoing?
 - If they ended, what were the reasons? (e.g., completion of goals, loss of funding, changes in direction)
5. Have you worked on programs addressing the health needs of Venezuelan migrants?
 - Can you describe specific programs, including their goals and how they were implemented?
6. Have you worked specifically on sexual and reproductive health programs for Venezuelan refugees?
 - When did these programs begin? Are they still ongoing?
 - If they ended, what were the reasons? (e.g., completion of goals, loss of funding, changes in direction)
7. In your opinion, has the Colombian state done a good job addressing the health needs of Wayuu communities? What about their sexual and reproductive health needs?
 - Can you give a couple of examples to support your view?
 - In what ways has the state fallen short? What changes do you think are needed?
8. In your opinion, has the Colombian state adequately addressed the health needs of Venezuelan refugees? What about their sexual and reproductive health needs?
 - Can you give a couple of examples to support your view?
 - In what ways has the state fallen short? What changes do you think are needed?
9. Do you think Wayuu women and Venezuelan migrant women receive the same quality of maternal care? Why or why not?

10. What do you think are the main differences in how Indigenous and migrant women are treated when accessing maternal healthcare?
11. Colombia is often described as having progressive laws to protect Indigenous peoples and refugees. Do you believe these laws have been effective in practice?
 - Can you give examples—for instance, a specific law and how it has (or hasn't) influenced your organization's programs or goals?
12. How do you think Wayuu communities and Venezuelan refugees are perceived by the general public?
 - What similarities or differences do you notice in how these two groups are viewed?