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Intercultural Medicine among Indigenous communities in Cauca and Vaupés, Colombia

Colombia is composed of a mix of mestizos, Afrocolombian groups, raizal and rom communities, and over 115 indigenous groups spread across multiple regions. Each group has its own set of beliefs and practices, which include specific health models through which they understand and care for their wellbeing. Spanish colonization, religious missionaries, NGOs, settlers, and the national public health system have brought in different health models that interact with the health systems previously in place, adding to the diversity of Colombia's health panorama.

Intercultural medical practices have been an effective proposal through which Latinamerican rural communities have navigated their health needs over centuries (Menendez, 2016). The scarcity and barriers to access the public health system, the presence of communities' own healers and practices, and long-held fights for political sovereignty and cultural self-preservation have maintained the practice of indigenous and Afrocolombian communities' own health models. At the same time, calls for the protection of human rights via access to health services, government efforts toward protecting the most vulnerable, and the precarity of many communities' own health models have maintained people's interest in using the public health system in rural regions. Rural areas thus often implement an intercultural approach to their healthcare, making use of all systems available to fulfill their needs (Menendez, 2024).

Multiple efforts have been made to develop more organized intercultural health processes in Colombia, particularly in indigenous regions. Initiated in 2016, the SISPI (*Sistema Indígena de Salud Propio e Intercultural* – Indigenous and Intercultural Health System) became the first nation-wide attempt at creating a large-scale intercultural health system that meets indigenous health demands. The system has attempted to establish a network to support indigenous health models financially and logistically, work with public health systems in their adaptation to fit indigenous territories more adequately, and develop the necessary legal frameworks to protect indigenous rights and improve their health. Intercultural medicine efforts like the SISPI have faced multiple barriers due to neoliberal economic pressures that resist primary care health models, the high dispersion of rural communities, the challenges of organizing amid so much diversity, and resistance from a conservative medical sector, among others. Colombia's armed conflict and a history of discrimination towards ethnic communities have also hindered these efforts, silencing community leaders and disrupting both government and community efforts to improve rural health.

All of these factors shape the health ecosystem in indigenous territories like those of Vaupés and Cauca, which I explored over the summer with the CLACS award. I spent over a month traveling across both regions and meeting with health system users, community leaders, and health workers from NGOs, public health departments, hospitals, and indigenous organizations. I accompanied them in their daily activities, helped in community health programs and SISPI activities, attended meetings with public health and indigenous authorities, and had countless conversations about the challenges of developing the intercultural health system. I was able to learn from different ethnic groups, including the Cubeo and Guanano people of the Amazon rainforests of Vaupés, and the Nasa and Misak people of the mountains of Cauca. Throughout my fieldwork I accompanied the local NGO Sinergias, who have over 12 years of public health experience in these territories. With them I learned of the different intercultural health efforts that

have succeeded, failed, or been lost over the past decades. I learned of the complexities of sustaining efforts amidst changing local leadership and public health staff, the temporary nature of external aid, the government health reforms of the 1990s, and the drug trafficking that controls several areas of Colombia.

In Vaupés, I learned how a centralized public health system does not quite adapt to the high dispersion and geographical isolation of Amazonian communities in a jungle setting. On another note, I witnessed the immense effort of indigenous people traveling for hours and days to reach the hospital, a testament of their interest in accessing hospital services despite access barriers. I learned how biomedicine often rejects the interconnected and ecological approach of indigenous health, but I also saw the possibilities that indigenous ontologies open for collaboration, with indigenous healers explaining that biomedicine and indigenous medicine operate on different levels of a health issue, and that their own healing traditions have become precarious after violent evangelizations. I saw the struggles to advance SISPI negotiations in the Amazon due to the population's high dispersion, corruption, and the impossibility of fitting indigenous cosmology into Western government templates, among others. But I also followed the work of local organizations like Sinergias NGO who supports intercultural health projects at smaller scales via the strengthening of indigenous health governance, the adaptation of hospital protocols, and the constant training of incoming hospital staff to adapt their work to a jungle ecosystem.

My fieldwork then led me to the Nasa and Misak people in Cauca. This region experiences intensified violence due to drug trafficking and land disputes, and indigenous, Afrocolombians and farmer communities have been violently displaced, silenced, and repressed over past decades. On the other hand, such disputes have come hand in hand with highly organized indigenous movements that have led many successful negotiations with the government throughout the years. The SISPI is one of such efforts, spearheaded by some indigenous groups of Cauca. My time there allowed me to meet with health workers from the public health system and from indigenous clinics, members of an indigenous university that trains communities in the negotiation, administration, and implementation of the SISPI, and indigenous leaders that hold public administration positions in the region. I was introduced into the complex world of a SISPI that is operating much more than in Vaupés. The Cauca system is filled with hope and successful collaborations that have improved health outcomes, but also permeated by complex disputes over the potential bureaucratization of indigenous movements and the loss of sovereignty that can come with the articulation of indigenous and government models.

These realities point to deeper questions I hope to continue exploring about how governments grapple with the question of diversity and sovereignty, in this case through healthcare. The complex processes experienced in Vaupés and in Cauca show the multiple layers that come with building a system that effectively supports a particular community. At the same time, the vast differences in health processes between Vaupés and Cauca show a deep pluriethnicity of Colombia that, although recognized legally since the 1991 Constitution, has not yet been successfully accounted for in institutional negotiations that attempt to cover an entire nation. I will continue examining these processes throughout my PhD. I hope to help expand the literature on health systems, indigenous health ontologies, rural health, and intercultural health processes in Colombia, topics on which there still is scarce documentation. I also hope this helps bridge medical anthropologies of the Global North and Latin American perspectives, creating research that is in dialogue with both. I look forward to continuing this research and contributing to the understanding and improvement of Latinamerican health systems and health disparities in

Colombia. I would like to thank CLACS and the Tinker Foundation for making the first step of this process possible.

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