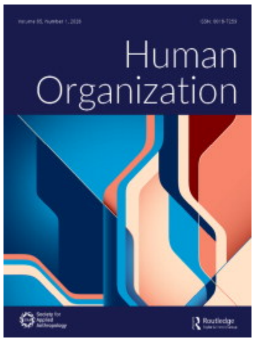

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Indigenous women and obstetric care in Hospital San Antonio de Mitú, Vaupés

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ABSTRACT

The Amazonian region of Vaupés holds some of the worst health indicators in Colombia. Despite being a primarily indigenous area, its decontextualized, biomedical public health system often neglects indigenous realities, contributing to poor access to services, culturally incongruent hospitals, and alarming maternal-child indicators. We study indigenous ideas and practices of obstetric health, and indigenous women's decision-making and experiences visiting *Hospital San Antonio de Mitú*. Drawing on participant observation, eight in-depth interviews, and three focus groups with community members, we identify key characteristics of Amazonian indigenous health models, their interactions with biomedicine, and barriers indigenous women face when accessing care. The data point to some shortcomings of the Colombian public health system and advocates for the potential of intercultural medicine.

ABSTRACT (SPANISH)

La región amazónica del Vaupés presenta algunos de los peores indicadores de salud en Colombia. Aunque es un área predominantemente indígena, su sistema biomédico de salud pública a menudo desatiende las realidades indígenas, contribuyendo al acceso precario a servicios, hospitales culturalmente descontextualizados e indicadores materno-infantiles alarmantes. Investigamos las ideas y prácticas indígenas de salud obstétrica, así como la toma de decisiones y las experiencias de las mujeres indígenas al visitar el Hospital San Antonio de Mitú. Basándonos en observación participante, ocho entrevistas a profundidad y tres grupos focales con miembros de la comunidad, identificamos características clave de los modelos Amazónicos de salud indígena, sus interacciones con la biomedicina y barreras que enfrentan mujeres indígenas al acceder a servicios. Los datos señalan algunas deficiencias del sistema de salud pública colombiano y abogan por el potencial de la medicina intercultural.

PLAIN LANGUAGE SUMMARY

Despite being a predominantly indigenous region, Vaupés has a public health system that follows a biomedical model and does not match many of the practices and ideas on which indigenous health models are based. Additionally, it overlooks local challenges indigenous people face to access institutional care, leading to alarming health indicators in the Colombian Amazon. We study indigenous obstetric health models and indigenous women's experience with hospital care, highlighting the shortcomings of the current system but also the possibilities that come with an intercultural public health model.

SOCIAL MEDIA STATEMENT

We explore indigenous obstetric health models and experiences with institutional care, highlighting the shortcomings of the public health system but also the potentials of intercultural medicine to address health inequities. Handles: @emiliacr10, @sinergiasong

KEYWORDS
maternal and child health; health services; intercultural medicine; indigenous health; structural determinants of health

PALABRAS CLAVE
salud materno-infantil; servicios de salud; medicina intercultural; salud indígena; determinantes estructurales de la salud

Located in the Colombian Amazon, Vaupés is the department with the highest ethnic and cultural diversity in Colombia, with 81.7% of its 46,777 inhabitants identifying as indigenous, dispersed across over 255 pluriethnic communities (MinSalud 2020; DANE 2023; Montaña et al. 2012). The rainforest ecosystem and high dispersion make Vaupés hard to access, something historically used as an argument for institutional neglect, absence of public health systems, and low public resource allocation (Sinergias 2013). Spanish colonization, churches, resource extractivism, NGOs, and settlers introduced multiple cultures (Jackson

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1991), marking the territory with a complex intercultural reality.

Exploitation and discrimination towards ethnic communities has led to alarming maternal child health indicators among indigenous people. Vaupés' under-five infant mortality and maternal mortality ratios are 2.3 and 4.3 times above the national average (MinSalud 2019). Some 56–66% of births in Vaupés occur in a hospital, compared to the national average of 98.28%, and 28–36% of births are estimated to have completed four antenatal checkups, compared to the 84.78% national average (MinSalud 2021).

According to Amazonian indigenous cosmology, humans are part of the territory and in social relationships with all other forms of life (Viveiros de Castro 2019). Health is a product of these relationships, indicating that environmental and human health are inextricably entangled. The interconnectedness of Amazonian life frames health as a complex, collectively practiced responsibility through which social order is kept (Sinergias 2021). Traditional healers, called *sabedores* or *payés,* are key figures maintaining the equilibrium of these social relationships. Healing work is based on their capacity to change perspectives and negotiate with other living beings (Viveiros de Castro 2019). Obstetric health work includes ceremonies and indigenous healing practices with chants, medicinal plants, and sacred objects for the family, newborn, and surroundings (Sinergias 2022).

Biomedical care rarely aligns with this holistic vision of health. It often approaches the pregnant body as a biological pathology in need of pharmacological interventions (Shaw 2012) and a biological object separated from the mind (Davis-Floyd 2001). Pregnant women in this framework are seen as victims of a reproductive and hormonal system in need of male legal and medical regulation (Cahill 2001) and often experience medicalization, fragmentation and depersonalization of their bodies, alongside increasing unnecessary interventions (Torres, dos Santos, and Muniz da Costa Vargens 2008) and obstetric violence (Vallana Sala 2019).

The biomedical context of Vaupés also presents challenges. Vaupés has the lowest number of doctors per inhabitant in the country (MinSalud 2024). Health workers at the hospital include medical doctors, with a few specialists who are only available some months of the year, nurses, a social worker, a pharmacist, laboratory technicians, and administrative staff. Due to disparities in Colombia's education and labor system, most trained workers are not from Vaupés, are not indigenous, do not have experience in indigenous territories, do not stay in Vaupés for more than a couple of years, and have been trained in a decontextualized, biomedical, urban system. Midwifery is not recognized nor authorized by the Colombian medical system, so nonindigenous doctors lead hospital births. Many technical level nurses are indigenous, some try to provide culturally adequate care, and a *payé* has sometimes been hired.

The Colombian health system, *Sistema General de Seguridad Social en Salud*, established in 1993 (Congreso de la República de Colombia 1993), offers a westernized, biomedical, urban model that disregards the country's cultural diversity, including its needs and assets, and has not addressed indigenous realities. Although it intended to guarantee free universal healthcare, the system became disorganized and fragmented, incapable of keeping up with all patients and unable to offer widespread quality services. This triggered a healthcare crisis among indigenous communities living in dispersed rural areas (Martínez-Silva, Montoya-Chica, and Caicedo-Sandoval 2015), who experience scarce, poor quality, culturally inappropriate care (Puerto 2018) and hard-to-reach health services (Corte Constitucional de Colombia 2017).

A different model existed in Vaupés during the 1980s and 1990s: an intercultural primary healthcare system implemented by the *Servicio Seccional de Salud* (SSS) (Servicio Seccional de Salud del Vaupés, Convenio Colombo-Holandés 1985). The model focused on the region's particularities, acknowledged indigenous people as key actors, conducted participatory research to understand local realities, and collectively designed and implemented public health agendas with an intercultural team, supported by both government and indigenous authorities (Guevara 1989, 2003). Interculturality was a pillar of this model, representing mutual understanding and dialogue between cultures (Dietz 2017), indigenous voices guiding the creation and adaptation of health programs based on local values (Sinergias 2013), and a framework under which health aligned to indigenous realities was seen as a human right (Martínez-Silva, Montoya-Chica, and Caicedo-Sandoval 2015). Efforts like the SSS were dissolved in the early 2000s when Colombian public health systems became centralized and homogenized under the Ley 100. New, decontextualized actors like the Health Promotion Entities (EPS) took over the responsibilities of local Health Departments, and the latter were too weak to develop new differential healthcare models under the new regime. Despite exceeding their capacity, hospitals were forced to cover rural areas for which Health Departments were previously responsible, and programs became increasingly disarticulated and challenged when covering dispersed areas. Additionally, resources were lacking and poorly managed, there was a lack of knowledge about indigenous regions (Correa 2019), and indigenous efforts took too long to coordinate responses to these events. Global pushback against primary health care models due to resistance to socialist ideals, neoliberalism, and debt and structural adjustment programs (Farmer et al. 2013) also contributed to the system's downfall.

There is little interest in understanding indigenous experiences in the current health system, despite efforts like the *Sistema Indígena de Salud Propio e Intercultural - SISPI* (Indigenous and Intercultural Health System) (Decreto 1953 del 2014, Decreto 480 del 2025) and occasional research partnerships between health departments and NGOs. The lack of technical and financial capacities to conduct research in rural areas, the costs and logistical challenges of expanding a public health system to jungle areas, and continuous epistemic violence against indigenous groups, accentuate these disparities.

A history of tensions between the State and indigenous governments has also hindered prioritization of indigenous regions. The 1991 Constitution promised territorial autonomy and physical and cultural protection of indigenous people (Asamblea Nacional Constituyente 1991), yet the Colombian Congress ignored such agreements. Indigenous groups have demanded that the State fulfill its promises of guaranteeing access to culturally adequate health for all and have pushed for the SISPI (Congreso de la República de Colombia 2015, Ley 1751 de 2015, Art. 6; Presidencia de la República de Colombia 2025a, Decreto 480 de 2025). Recent legislation attempts to mend this include formalizing indigenous territories, indigenous political-administrative capacities, intercultural agreements (Presidencia de la República de Colombia 2014, Decreto 1953 del 2014; Presidencia de la República de Colombia 2025b, Decreto 488 del 2025), and ordering the creation of a health model based on interculturality (Corte Constitucional de Colombia 2017, Sentencia T-357/17). Gustavo Petro's government has been important in these efforts, recognizing the relevance of indigenous health systems to address health disparities, and creating plans to accelerate the reduction of maternal mortality (Presidencia de la República de Colombia 2025a; Decreto Ley 480, Art.3, Lit. e; Presidencia de la República de Colombia 2025b, Decreto 488).

The research described in this article explores local health experiences in Vaupés, shedding light on structures shaping indigenous reproductive health. We use the term interculturality in response to Latin American discussions of indigenous health and public health systems that attempt to think through the context's medical pluralism and adjust public health systems accordingly (Pesantes, Bazán Maccera, and Ponce Lucero 2025). It also follows the language used in Colombian negotiations with indigenous communities.

Methodology

The following is a qualitative study of indigenous women's obstetric experiences in Vaupés, their ideas and practices of obstetric health, their decision-making regarding hospital care, and their experiences when visiting the public Hospital San Antonio de Mitú in Vaupés (HSAM). We understand obstetric experiences as health practices women in Vaupés experience during their pregnancy, birth, and postpartum. These include practices they do themselves, those conducted by indigenous healers, and health services received at the hospital in Mitú. The data derive from fieldwork conducted from June to September 2022 and previous public health work done with the Colombian NGO Sinergias, an organization that has collaborated with Vaupés' communities since 2012 helping strengthen indigenous health systems and adapt public health systems to local contexts. In the following, we highlight barriers to access health services and the clashes and possibilities for articulation between care models.

Data were collected in HSAM and five surrounding indigenous communities (Table 1). The research team accompanied health workshops held with indigenous women (organized by Sinergias and *Asociación de Autoridades Indígenas Aledañas a Mitú,* an indigenous association), and participated in public health meetings with HSAM, indigenous women, and Sinergias. Participant observation was conducted in the hospital's waiting rooms for several hours per day on different days of the week, and four women were accompanied by the researcher Emilia Cárdenas when traveling from their communities to appointments at the hospital (the researcher did not attend their appointments). Observations of interactions between women and providers were done in the hospital's public areas, with additional data gathered from interviews and focus group discussions (FGD). Individual in-depth interviews and FGD were conducted in Spanish by a Colombian, female, mestizo anthropologist and public health worker, and an indigenous, female researcher. Several informal conversations with indigenous mothers also took place in the hospital's waiting area.

Communities were chosen due to accessibility, previous collaborations with Sinergias, and ethnic, religious, and geographical differences representing diverse experiences. Participants were chosen through

Table 1. Characteristics of the study population.

	Age range	# of participants	Roles of participants	Ethnicities	Indigenous communities included
Interviews	18–33 years	9 interviews	6 indigenous mothers, 2 male indigenous healers, 1 female hospital manager	Cubeo, Piratapuyo, Tucano, Desano, Guanano, Tuyuca, Curripaco, and Bará	Ceima Cachivera, Mituseño Urania, Macaquiño, Tucunaré, Puerto Golondrina, Santa Marta, Pueblo Nuevo, Yapú, and Mitú
FGD-indigenous women	18–45 years.	9 women in first FGS, 8 in second FGD	Indigenous women who gave birth		
FGD-health providers	35–45 years	5 females	OBGYN, nurses, health administrators	Mestizo	Outside Vaupés

purposive sampling during community visits. All participating women were indigenous, over 18 (legal age in Colombia), with recent obstetric lived experience. Snowball sampling was used to recruit traditional healers and hospital actors with experience working with indigenous women in Vaupés.

Audio recordings were gathered with previous consent, field notes and visual data collected during community workshops and gatherings. Data were transcribed and inductively analyzed using Thematic Content Analysis to identify key themes (Vaismoradi, Turunen, and Bondas 2013). Transcripts were coded with Dedoose. Constant conversations with the Sinergias team (which includes indigenous members) were held to discuss, validate, and adjust emerging themes.

Results

Two themes describing indigenous women's obstetric experiences were identified: differences between indigenous health models and the biomedical model, and logistical barriers indigenous women face when trying to access the hospital. These illustrate the consequences of the current health system and the history of structural violence in Vaupés.

Theme 1: Differences between indigenous and biomedical health models

Health as a product of equilibrium

According to the indigenous healers interviewed, healthy inhabitants come from having a healthy territory, which is achieved via respectful relationships between living and spiritual beings. The *Ley de Origen* are foundational guidelines explaining the history and social norms indigenous groups in Vaupés must follow to sustain these relationships and keep the cosmos in equilibrium, so protecting and reproducing life. A significant part of indigenous health is directed by the indigenous calendar, which marks the seasons and ecological events, and indicates practices that must happen (like behavioral restrictions called *dietas*, ceremonies, healings, and medicinal plant use). Participants explained that medical abnormalities (lengthy labors, bleeding, breech positions, disabilities) are often associated with a disrupted equilibrium, usually caused by inadequate social interaction between beings. Health risks are tied to how closely a family follows the *Ley de origen*, which for obstetric care includes sexual abstinence during postpartum, dietary restrictions during pregnancy, avoiding prohibited actions in sacred places, receiving protective indigenous healings, and avoiding social conflict that could result in evil sorcery, among others:

> The elder gives recommendations and you have to follow. My child was sick all the time and I sent him to get a traditional healing and then after a month he was still sick, so the elder told me *"you must not eat this fresh yacaré (caiman), you are the one harming the child, stop breastfeeding and give him food"* and then he did a traditional healing and the child got better. (interview, indigenous mother)

Health as a collective practice

Indigenous thought also frames health as a collective practice involving many actors. Indigenous healers in interviews and focus group discussions reported that parents needed to follow the *Ley de origen* to ensure a healthy obstetric process, and that *sabedores*, mothers, or mothers-in-law (who guide them throughout pregnancy and know medicinal plants) should also participate. Non-human actors, as sources of risk or health, are also involved. Animals can attack a pregnant woman or newborn, can make the mother, her breastmilk, and the newborn sick if eaten when prohibited or before a healer has treated them, and non-human beings can cause breech positions. These are all ways in which non-human beings try to swap a person's body or soul at birth.

> Yes, c-section. The baby was sitting. But I don't know, it's strange because at the beginning I had her… how do you call that, she was in a good position and then she turned around, I don't know what happened.

> Well, the *payé* said that maybe somebody sent her harm, you know…it is always like that. (interview, indigenous mother)

Timeline and scope of obstetric processes are lengthy

The consequences of not following the *Ley de origen* can present immediately or later, so that indigenous obstetric health extends for a much longer period than biomedicine does. Behaviors during menstruation, for example, shape pregnancy and birth outcomes years later.

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

During interviews, indigenous healers stated that pregnancy and birth are powerful life events with higher potential to destabilize the equilibrium and thus trigger health complications. Caring for obstetric processes includes the use of medicinal plants, and protections and healing practices conducted by a *sabedor* for the family, family spaces, and the elements involved in birth and postpartum. This includes the birthing place, the river where the parents' and newborn's first bath will be, the mother's breast milk, the family's food, and equipment the father uses for hunting and fishing. The healers explained that through these healing practices, the *sabedor* introduces the newborn to the territory and mediates a ritual between the place and person, ensuring they recognize each other and that harm is prevented. *Sabedores* also examine and address disruptions that occur and make people sick, mediating with non-human beings, performing rituals, and having the family or mother change their behavior to restore balance and health.

Violations of indigenous norms during biomedical care

Elements within biomedical care were mentioned by women in the FGD as violating indigenous norms. People who are menstruating may cause harm to those receiving their care, men are not allowed to see women during birth, Mitú's hospital is in a sacred place for indigenous people and so giving birth there is prohibited, and the food provided by the hospital often includes foods proscribed for pregnant women and their partners according to their *Ley de origen*.

> Woman 1: But over there (in the hospital) menstruation is harmful… (because) they don't do preventions when their menstruation comes, in contrast to us as indigenous.
>
> Woman 2: One knows when the menstruation is coming … so I take out a glass of water when there is a cold going around, I have my father do the indigenous protections and healings, I send it to sweeten, as we say, the body, and so I give the water to my children, I drink it because I'm the one preparing their food, and so when the children are sick I don't fear (for them). (FDG, indigenous mothers)

The illnesses experiences of indigenous people are not entirely addressed when the broader system in which an illness or health condition is embedded is ignored. Biomedicine's siloed approach leaves patients feeling dissatisfied and misunderstood, particularly when indigenous care that could cover biomedicine's gaps is unavailable or rejected by medical providers.

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

During the FGD and interviews, indigenous women explained they usually give birth by themselves or with a female relative, in their homes or *chagra* (crops), using a vertical position assisted with massage (*sobos*), hammocks, plants and preparations (such as *agua rezada*, consecrated water) to accelerate birth, tobacco and *carayurú* for protection, and branches or knives to cut the umbilical cord. A *payé* is present before and after to perform protective rituals for the family, the newborn, and the welcoming community.

Indigenous women who deliver in hospital reported remaining in an operating room, having a horizontal birth, multiple foreign health workers being present (including men), and receiving pharmacological interventions. Although several elements of indigenous births could be implemented at the hospital, the participants reported that because of clinical protocols, most health workers did not allow them nor the company of a *payé*. A couple of hospital workers did allow *payés* in the room before and after birth, recognizing that they helped to discuss and facilitate emergency procedures. Nonetheless, there is no *payé* on the hospital team, and health workers said that they were unaware of *payés* in the region and that they were hard to find. Indigenous healers explained that the wide diversity of ethnic groups implied diversity in healing practices, so that *payés* from different ethnic traditions would be needed to cover the needs of all patients. Other accessibility issues identified by both women and hospital leaders included the increasing monetization of indigenous health, with *payés* now charging fees (rather than receiving food or gifts); the lower numbers of *payés* available due to loss of knowledge transmission, old age, and alcohol abuse; and the lack of resources needed for indigenous healing (such as medicinal plants) due to environmental change and loss of knowledge.

Social interactions at the hospital

Some health workers asked indigenous patients during obstetric clinical encounters about the indigenous health practices they observed. Some indigenous women recognized this as respect towards their culture and a way to give indigenous health practices space within a biomedical setting. Othertimes, the questionning was perceived as aggressive or discriminatory. For example, some providers infantilized indigenous patients, scolding them for adhering to traditional practices, and making derogatory comments:

> Well, there are some that are … very rude, I have seen. One time I was hospitalized, I saw a young woman from a far away community. 'Oh well, give her breast', said the hospital provider. Well, they are supposed to be the guides, they could have told her 'look *mamita*, breastfeed your newborn like this so the baby can feed', … I didn't like that service. (interview, indigenous mother)

Conversations and focus group discussions with hospital workers revealed that most staff were unfamiliar with indigenous experiences in Vaupés. When asked about indigenous patients' living conditions, health needs, health cosmologies, practices, and the demographic composition of Vaupés, the vast majority responded they didn't know much. According to interviews with hospital leaders, experienced hospital workers, and Sinergias, this lack of awareness reflected the high rotation of staff, associated with poor working conditions, staff not wanting to live far from home, and working in Vaupés only during their mandatory year of rural service. Health workers therefore had few opportunities to get to know the region. Most workers lacked intercultural training, and Sinergias (2021) identified the lack of cultural and structural competency education.

Indigenous women highlighted instances of racism, with white patients being treated more politely and quicker by providers, and many providers seeming to be negligent when caring for indigenous patients:

> Well, sometimes white people come in (to the hospital waiting rooms), they talk more than us, and well yes, they get called on by the staff faster … We sit there with our baby, crying and sometimes the baby even vomits there and the hospital workers don't pay attention to you. Only when the baby is seriously sick then they do let you in. (FDG, indigenous mothers)

Women stated the short time of clinical encounters with providers prevented the development of trusting relationships, and the lack of indigenous staff in the hospital and communication with indigenous leaders prevented patients from feeling represented and safe.

Theme 2: Logistical barriers to access hospital services

Traveling and staying in Mitú is challenging

The barrier most often mentioned by indigenous women, and confirmed through participant observation, was the burden of traveling to the hospital. Patients travel several hours or days through dangerous roads, rivers, jungle, or air while pregnant or with children. Conditions are often problematic, with travelers exposed to animals, armed groups, and poor weather conditions. Transport is usually scarce, expensive, and unsafe.

The cost of staying in Mitú is another barrier. Indigenous communities have limited access to cash, but patients and their companions need to pay for food, clothing, medicine, and housing in Mitú, since the long waiting times at the hospital usually require them to stay days, weeks, or months in town. *Albergues* are available – spaces for long-term patients and companions to stay – but these don't host larger families and they lead to additional costs.

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

Interviews and focus groups with indigenous women and Sinergias indicated that patient housing offered by the public health system is limited, low quality, has been implicated in cases of sexual and domestic abuse and kidnapping, is not widely accessible (due to distance and health insurance), does not always allow families, and is culturally incongruent (Western food, beds instead of hammocks, unavailability of indigenous healers). Conversations with Sinergias revealed that women therefore sought additional resources in town, including being involved in risky activities like sex work. Precarious living conditions, isolation, and racism in Mitú also contributes to patients' psychological deterioration. Finally, leaving the community for a long time also implies leaving children and partners, and leaving crops unattended. Families often fall apart during this time, and children left alone can experience abuse and malnutrition.

> Woman 1: There is another problem now with the food, during birth and with the companion, I see all that as being very complicated … when my nephew was born (by) c-section … her wound opened, it got a lot of pus, I had to go there, I spent a week without food… I (had to) find my ways…
>
> Woman 2: Nobody gifts you anything, not like "hey since you are sick come and I will give you."
>
> Woman 1: "You don't have family over there? Go, I don't know, go eat at your family's place" – that is what the hospital tells you. But in town that is very complicated, everything is bough. (FDG, indigenous mothers)

These barriers are associated with structural determinants of health (SDH), and hospital leaders claimed these issues were outside their scope and budget. Other institutions are held accountable, such as the Health Secretariat or the *EPS* (health insurance companies in charge of organizing and guaranteeing provision of health services to Colombians). But there is little response from most public health actors.

Long waiting times and schedules

Long waiting times discourage people seeking care:

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

The health system's lack of flexibility is another barrier. There are few appointments available for obstetric care, and the hospital's schedules and requirements are rigid. Women miss appointments due to difficulties travelling, losing their paperwork, or not knowing how to read information previously given about dates and requirements. Although the hospital's rigidity is partly due to lack of resources and staff, and efforts to meet safety and legal criteria, this is worsened by the non-recognition of social determinants, lack of proper communication from hospital providers to patients, and insufficient efforts among many hospital workers to adapt what is possible:

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

Lack of information and outreach efforts

Most patients believe they must go to the hospital to request an appointment, and this discourages them from trying. The other scheduling options are unavailable in communities due to the lack of phone and internet connectivity, and lack of information. Many women highlighted the usefulness of the health brigades the previous *SSS* offered. Although brigades still occur, they no longer articulate with indigenous health nor develop relationships with communities.

> I took her to pediatrics, because of that thing she got sick with diarrhea, it was then that I took her to pediatrics, when the brigade came. I never missed one of those, I really liked to take her so they could check how my daughter is doing, her growth process. And they give her vitamins there. (FDG, indigenous mothers)

Accessing information needed to care for pregnancy and address complications was another barrier. Although indigenous women have their own resources, they also recognized some of this knowledge has been lost or is inaccessible to those in Mitú. They also pointed out that although they were interested in hospital care because it was useful, they had scarce knowledge of biomedicine, information regarding prevention, identification and management of obstetric risks, and were confused about how to navigate the hospital system. Sinergias indicated this is partly due to lack of research, communication and healthcare strategies for intercultural settings (for example, accounting for the orality of indigenous knowledge and indigenous languages), and limited dissemination and use of existing intercultural educational materials:

> The last time some people came from the hospital to explain … lack of communication, when we do communicate (to the hospital) who comes to pick us up (to take patients to the hospital)? The route to access services? They left us a cellphone…but with what money are we going to call? … Every now and then there is some cellphone service, it is not good now, sometimes there is some. (interview, indigenous mother)

Accompanying indigenous mothers while they sought hospital care also showed inconsistencies in the educational efforts to guide patients during therapeutic processes, including explaining procedures to women (such as c-sections), and what is expected from the patient after a procedure or appointment (where to get medications, how medications work, how to take them). The information offered is difficult to understand for indigenous patients, is not in indigenous languages, is not contextualized to indigenous values and norms, and there is little space to discuss with patients *why* a health practice is important. Some health professionals make great efforts to guide indigenous patients, but this is not widespread.

> The thing is that it's too much and that's why people don't understand … that's something that is always missing: the education by the hospital or the health secretariat or from some other place, they should come to these places and explain that. (FGD, indigenous mothers)

> I remember they told me that word and I said *"okay"*, like I am saying it now, well when you are seeing that and with all that suffering, well you don't have thoughts, what is it they are doing, and so you say *"yes, okay."* (interview, indigenous mother)

The hospital does have a "user office" with staff available to communicate with patients, and although some indigenous women found it useful, many are frightened of being mistreated and thus avoid going there. Others felt the staff did not address their concerns, especially when they spoke limited Spanish. Only recently did the hospital incorporate social workers, and they currently only have two. Social workers and other community agents could be responsible for inquiring about patients' social circumstances, their psychosocial needs, and could identify support networks, guide patients through the paperwork, and connect them to corresponding services (like hospital housing and meal plans in Mitú). These are key actions that could contextualize medical care, understanding patients within their culture and targeting barriers preventing good health.

> Many women believe it is very hard to get to the hospital because they are scared or because they (at the hospital) are white … so it is also about how to disseminate, talk more between us and support each other, yes. That is what we have been doing for a long time but I have left it because I am (currently) not there (in the community). (interview, indigenous mother)

Discussion

The difference between values and practices of indigenous health models and biomedical models is the first layer that stands out in indigenous women's health experience. A call is made for more recognition of local knowledges and experiences of health to guarantee each model has space in Vaupés' public health system. Notwithstanding the risk of essentializing culture, homogenizing patients' backgrounds, stereotyping cultural representations, and blaming health realities on culture (Kleinman and Benson 2006), we must still introduce culture as a variable, in its diverse expressions, in biomedicine. Colombian legal frameworks exist (Congreso de la República de Colombia 2011; Congreso de la República de Colombia 2015), but they have not translated into meaningful action. Indigenous health models are still not truly understood and worked with, nor are indigenous people represented in Colombian public health. This leads to hospital practices that transgress indigenous social and moral codes, and therapeutic processes that do not address multilayered indigenous experiences of health. Hopital San Antonio de Mitú has conducted efforts to address these issues, such as building indigenous infrastructure (*malokas*) for patients to rest, hiring *payés,* and adapting space for vertical deliveries. However, the Ley 100 reforms that homogenized health systems and continuous financial limitations have prevented these efforts from lasting. Actors like Sinergias are helping create intercultural orientation programs for hospital staff and adapted clinical guidelines, among others, but the high rotation of staff hinder these efforts.

More community participation and decentering biomedicine in Vaupés' public health is needed. Through indigenous-led research (Todd 2016), Fals Borda's Participatory Action Research (Ochoa 2015) and Community Based Participatory Research proposals, among others, indigenous voices could guide health systems. Local efforts such as *Planes Integrales de Vida Indigena* (PIVI) (Indigenous holistic life plans) through which indigenous communities establish and communicate their health priorities based on their own conceptualizations are key, yet undervalued and often ignored. Proposals like the *SISPI* can be further supported as indigenous-led spaces of intercultural dialogue and health planning. Some challenges in this process include heterogeneity within indigenous groups, the transformation and loss of indigenous health models due to cultural changes and violent colonization processes, and tensions within indigenous groups when administering funds brought by external initiatives. Special attention must also be paid to power inequities within indigenous groups. Historically marginalized subgroups such as women and children must be given space and public health leadership.

> Many projects have arrived here and the men always say no, but us women, yes, we will take advantage of it. Even if there is no money, no resources, we plant some things and they grow, we are caregivers. (FGD, indigenous mothers)

A common question is the compatibility of indigenous and biomedical models. Menéndez (2016) suggests Latin American social groups practiced interculturality before anthropologists thought of studying health in these terms. The issues of interculturality that scholars now discuss have long been solved by these groups, and we should thus learn from them. In Vaupés, most indigenous women indicate that there *is* space for biomedical and indigenous practices to collaborate. The health models are not incompatible: they operate at different levels of care, and indigenous people recognize how biomedicine can complement their model's strengths and shortcomings. Additionally, indigenous worldviews do understand the obstetric life cycle more holistically, but this still parallels the stages of biomedical obstetric health, and both prioritize obstetric health.

At the same time. the indigenous context of Vaupés requires an intercultural health response. The lack of articulation between models is not necessarily a product of incompatibility, but rather of a colonizing and homogenizing framework, founded on epistemic violence and structural racism, undergirding the biomedical industrial complex. This framework imposes biomedicine's practices and unquestionable truths on others (Córdoba 2010), disregards how social forces shape biology and health experiences (Lock 1995; Lewontin 2000), delegitimizes communities' resources and decision-making processes, reinforces obstetric violence (Vallana Sala 2019), and reduces medicine to individual, biological processes. If these core values shift, biomedical and indigenous skills could collaborate and more effective health systems could emerge.

The second layer of indigenous women's experience responds to politics of inequality, materialized in barriers to access care. Structural forces, not just cultural differences, shape patients' capacities to reach healthcare and comply with therapeutic processes. Public Health has attempted to address this through using the concept of social determinants to show that health is conditioned by social, economic, and political factors. Physician-social scientists have called for "structural competency," where assessments of "structural vulnerability" are incorporated into medical practice (Bourgois et al. 2017; Metzl and Hansen 2014). Government and health institutions in Vaupés have neglected to respond to the social and structural circumstances of indigenous patients. The intercultural clinical protocols and trainings Sinergias is developing alongside Mitú's hospital, and the revitalization and strengthening of indigenous health practices, attempt to counter this.

A stronger primary healthcare system could have considerable potential in regions like Vaupés. Rather than focusing on medical practice, a stronger preventive health model based on community-level care and articulation with community actors, as Alma Ata promised almost 50 years ago (Coreil and Mull 1990), could yield better long-term results. The success of the *Servicio Seccional de Salud* and the results of Sinergias' intercultural work (Montoya et al. 2017) are proof of this potential. Neoliberal policies guiding the current health system and lack of efficient implementation of laws promoting adaptation of health services for ethnic minorities remain barriers.

Structural violence is an additional layer that must be discussed. Farmer defined it as "social arrangements that put individuals and populations in harm's way" (Farmer 2004, 499), and Galtung proposed this as normalized economic, political, legal, religious, and cultural forces preventing societies from reaching their full potential by reinforcing disparate access to resources, political power, education, legal standing and health care, among others (Farmer et al. 2006; Galtung 1969). We argue that the health indicators of Vaupés, the lack of space for indigenous health models in Colombia's public health system, the lack of recognition of indigenous governments despite the Constitution, and the barriers to access care, are all products of structural violence. Mullings' proposals also shed light on the link between indigeneity and inequity, suggesting the concepts of race, class, and gender are "historically created relationships of differential distribution of resources, privilege, and power, of advantage and disadvantage" (2005, 79).

The history of colonization, institutional neglect, and biomedicalization in Vaupés are structural forces that, unless dismantled, will continue creating challenges in health care. Although an intercultural health model for Vaupés may help patients navigate cultural and structural factors, this isn't enough. Helping patients survive an unfair system or adjusting to clinical encounters must be accompanied by strengthening their own health systems and changing institutional structures. Otherwise, public health is an accomplice to a status quo perpetuating inequality.[1]

Conclusion

In discussing some obstetric experiences of indigenous women in Vaupés, we have introduced ontological and epistemological particularities of Amazonian life and interactions with biomedicine. We have connected this with discussions of racialization of health in the form of discrimination towards indigenous epistemologies and barriers to access care. Both are products of systems of inequality through which Colombian indigenous communities become second-class citizens.

Although we have focused on obstetric experiences, our findings extend to other aspects of medicine because they point to systemic issues. The similarity of experiences reported by indigenous women across demographics or medical situations, and the manifestations of neglect we identified, show that, rather than being tied to particularities, this violence is associated with the larger category of indigeneity and is a product of a system that is not yet capable of addressing indigenous realities. It's worth noting that indigenous Amazonian understandings of health do not separate or prioritize obstetric health demands over a broader struggle for wellbeing and sovereignty. It is also important to note, however, that patriarchy and gender-based violence within indigenous spaces might also be silencing demands specific to women's health.

Latin American proposals speak of the unit *salud-enfermedad-atención* (health-illness-healthcare), which resists biomedicine's fragmentation of health and proposes to work more holistically. Authors like Menéndez (2003) use this framework to give sociopolitical factors space in healthcare, despite their erasure in biomedical discourses. These factors include knowledges, beliefs, and practices specific to indigenous experience of health, but it also includes paying attention to structural forces that condition a community's possibilities to guarantee wellbeing. A crucial element that lies within this is the need for public institutions to accept the constitutionally protected exercise of indigenous sovereignty, for example by having public health efforts respect, work with, and emerge from indigenous health proposals like the SISPI and PIVI.

The data we present sheds light on how maternal-child health is conceptualized and enacted in Vaupés, and how through this, we build a particular, unequal world in the Colombian Amazon. The health realities explored here reveal a politics of life through which we assign more and less value to lives in Vaupés and define who is deemed worthy enough to be considered human. Indigenous people, especially indigenous women and children, have carried the weight of these politics for far too long.

The case study we have presented is symptomatic of a broader problem of lacking State accountability towards commitments made to Vaupés and other indigenous territories in the country since the 1991 Constitution. Hence the continuation of multiple other poor health indicators in indigenous regions beyond obstetric health. Nonetheless, these issues disproportionately impact indigenous women. Interculturality efforts in Colombia offer paths to change these patterns of neglect. Nonetheless, as Pesantes, Bazán Maccera, and Ponce Lucero (2025) suggest, such discourses should not introduce culturally appropriate care as a mere variable in health services, but as a fundamental human right on which health systems are based. We hope to contribute to these efforts by producing multiple outcomes with this research, including this article, the collaborative development of an intercultural annex for the hospital's clinical guidelines, and advocacy and educational products for the hospital, Sinergias, and indigenous communities to use.

Limitations

Translating indigenous worldviews and embodied ways of living into a Western academic text will always be an imperfect exercise, and scholars must be aware of decontextualizing and flattening indigenous wisdom when doing this work (Todd 2016). Lack of health data in the Amazon, and lacking institutional support and capacity to do community-based research in indigenous, rural contexts, make research in Vaupés challenging. Vaupés is a highly diverse setting, and what we describe might not represent all the region. Our intent is to generate a discussion about interculturality and limitations of the current health system in indigenous contexts.

The research was conducted in Spanish, which is not the first language of most indigenous people, although members of the research team spoke indigenous languages. There are significant taboos around sexual and reproductive health in Vaupés and because most research has been led by men, there is little research on sexual and reproductive illnesses, and inadequate support for women in obstetric processes. As a woman working with indigenous co-researchers, the main researcher, Emilia Cárdenas, may have had more access to this domain.

Note

1. Organizations like Partners in Health and Sinergias (Montoya et al., 2017) propose alternatives, such as sending state-of-the-art medication and services to areas that are structurally vulnerable to epidemics, while lobbying to change global policies that concentrate poverty and wealth.

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