TECHNICAL NOTES

Webinar series

Innovative models of Primary Health Care in Colombia

4

Fourth webinar

Innovative Experiences in Primary Health Care in Colombia based on community participation

Tuesday, July 26, 2022

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Webinars Series

Innovative models of Primary Health Care in Colombia

Innovative Experiences in Primary Health Care in Colombia based on community participation

Tuesday, July 26, 2022

4:00 p.m.: Colombia, Ecuador, Peru
5:00 p.m.: Washington, Chile
3.00 p.m.: Costa Rica
6:00 p.m.: Argentina, Uruguay

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Community participation in strengthening of PHC in the department of Cauca
Andres Narvaez
Secretary of Health of Cauca

Experience of community participation in health in Guatemala
Lorena Ruano
Researcher University of Bergen- Norway

Interculturality Program in Maternal Care of the-ESE CXAYU'CE JXUT (State's Social Company)-Hospitals of Toribío and Jambaló in Cauca
Beatriz Bohorquez Salinas
Manager ESE CXAYU'CE JXUT
(Hospitals of Toribío and Jambaló Cauca)

Community participation in the EPSI Anas Wayúu in La Guajira
Beda Margarita Suarez Aguilar
Wayuu woman of Uriana caste,
EPSI Manager Anas Wayuu

Citizen participation: from theory to practice. The experience of the Rasa Foundation – Antioquia
Gustavo Campillo
President of the Rasa Foundation

Panel Discussion
Moderator: Luis Gabriel Bernal

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Content*

* This document was translated by Ethical Method Language Solutions

Introduction

The Primary Health Care Performance Initiative -PHCPI, has been working for several years with different countries around the world in measuring the performance of Primary Health Care -PHC. In the case of Colombia, PHCPI has been working with the Ministerio de Salud y Protección Social (Ministry of Health and Social Protection) on the profile of vital signs of the country in PHC.

In this context, PHCPI is also advancing in the generation of a national "Comunidad de Práctica"(Community of Practice) that allows knowing and documenting learning about the innovative models of Primary Health Care developed in Colombia.

The Innovative Models of Primary Health Care in Colombia webinar series promotes the discussion around this topic. This document reviews the fourth webinar in the series, called *Innovative Experiences in Primary Health Care in Colombia based on community participation*, held on July 26, 2022.

A special thanks to the speakers of this webinar, who with their experience and knowledge contributed in a valuable way to this dialogue which we hope will enrich the reflection and implementation of Primary Health Care in Colombia. Similarly, thanks to the team of leaders and organizers of the webinars and the community of practice: Luis Gabriel Bernal, Oscar Bernal, Janet Bonilla, Yulieth Rodríguez, and Juan Carlos Jiménez.

Manuela Villar Uribe

World Bank Health Specialist

Key messages
Innovative experiences in Primary Health Care in Colombia based on community participation

"With political empowerment, the indigenous communities of Guatemala have managed to improve the quality of health services and generate relationships of trust. The experience has allowed support for the construction of active citizenry in health care and funds have been obtained for human resources of health, medicines and ambulances". *Lorena Ruano*

"We realized that the indigenous population has felt that the State has never been there for them or has betrayed them many times, likewise, organized civil society comes and asks for things and then leaves. We started to develop a platform to report cases of abuse and discrimination based on text messages. We saw that the process of political empowerment began at the individual level, trying to increase knowledge of situations of exclusion. Then we moved on to the construction of collective consciousness to later arrive at the surveillance of public services with the goal of reaching the political power of the citizenry". *Lorena Ruano*

"In Cauca, the various currents of local thought determine how to care for health, how to face the challenges posed by the disease, and also how to manage health care. The care models are adjusted from a community and local logic. Social and community participation is a permanent force". *Jorge Sotelo*

"Social and community participation in PHC, led jointly with the Ministerio de Salud and health actors, is proposed in the document of the *Provision of Health Services Comprehensive Network,* which will be the navigation map to strengthen the infrastructure of the first levels of care". *Andrés Narváez*

"In Cauca, the *Sistema Indígena de Salud, Propio e Intercultural* (Own Indigenous and Intercultural Health System) was created. In Cauca there is talk of respected childbirth. There is a syncretism of care processes in which the different voices of the territory speak, agree, define forms of communication,

from the indigenous, the Afro, the mestizo, the peasant, ways to adjust the processes of health care and health management public". *Jorge Sotelo*

"The Interculturalidad en el Cuidado Materno (Interculturality in Maternal Care) program of the ESE CXAYU'CE JXUT in Toribío and Jambaló in Cauca reduced maternal mortality in the community to zero and has remained so to this day". *Beatriz Bohórquez Salinas*

"In La Guajira, participation is aimed at developing a management and administration model centered on the individual and their community. Ruling T 302 of 2017 of the Constitutional Court establishes that La Guajira is an unconstitutional state of affairs because there is no guarantee of the right to health, water, or food security. Part of the challenges is to strengthen the intersectorality to make an effective intervention of the social determinants". *Beda Margarita Suárez*

"We have our *Sistema Indígena de Salud, Propio e Intercultural Intercultural* (Own Indigenous and Intercultural Health System - SISPI). Community participation is at the center of the system and is guaranteed from the General Assembly, our highest instance, made up of traditional authorities from the "Asociación de Cabildos" and the "Asociación Sumuwuja"". *Beda Margarita Suárez*

"In order to guarantee access and continuity of care, we have bilingual shelters, with sentinel teams that are vehicles adjusted to our territory that can reach both the desert and areas with other vegetation, which carry bilingual workers and auxiliary nurses, responsible for monitoring cases of public health pathologies, as well as the transfer of pregnant women so that they can complete their process in safe conditions at the institutional level". *Beda Margarita Suárez*

"We have a micro-cultural team, responsible for outlining the differential elements incorporated into our care model, and for determining psychological and psychosocial factors of our affiliates through a strategic tele-assistance ally. We have, he says, an induced demand team, with a group of bilingual educational agents, with mobile units that allow access and continuity of services within the communities, due to the dispersion of the territory". *Beda Margarita Suárez*

"It is required to go from the concept of Primary Health Care to something more holistic, more complementary that could be "Acciones Poblacionales hacia la Salud" (Population Actions towards Health). Towards health in terms of well-being. To detach the concept of PHC from health interventions". *Gustavo Campillo*

"A first step is to defend the rights so that people do not get sick. Guaranteeing the protection of the rights of people who are already affected and that we could have avoided is not an achievement, it is perhaps a failure". *Gustavo Campillo*.

In the indigenous communities of Cauca and La Guajira in Colombia, the Departmental and Municipal Development Plans are harmonized with life plans and health worldviews

"We have changed the chip. Before, it was western medicine first and then the community. The population had to be adopted into our health services. Now it is different.

In our territory, Toribío and Jambaló, we have the *Path of self and intercultural health within the framework of the Own Indigenous and Intercultural Health System SISPI*, from the life plan of the Nasa Project.

On this path are the family, the community and the ancestral experts who are very important to us. There are health animators who support PHC in the context of the family. Community health workers continue. Then, the SISPI team that is in the community health centers.

You have to unlearn a little and keep learning day by day. For example, the medical staff had the vision of not letting a midwife into the delivery room, not involving companions, not allowing the use of alternative non-pharmacological strategies for pain management. However, awareness was woven little by little, in order to open the mind on both sides.

In the Conversations with pregnant women, women of childbearing age, mothers and midwives, we talked about what a home birth is like, what baths with medicinal plants are like, in what position women prefer to give birth to feel more comfortable and live that experience in a freer, calmer, more respectful way. Childbirth ceased to be a traumatic experience, to become a beautiful and safe experience.

Beatriz Bohórquez Salinas

Presentation
Innovative Experiences in Primary Health Care in Colombia based on community participation

Departmental and Municipal Development Plans harmonized with the life plans and health worldviews of the indigenous communities of Cauca and La Guajira

The indigenous communities of Colombia and Guatemala were protagonists of the webinar "*Experiencias innovadoras de Atención Primaria en Salud en Colombia basadas en participación comunitaria*" ("Innovative experiences of Primary Health Care in Colombia based on community participation"). Beatriz Bohórquez, Manager of the ESE CXAYU'CE JXUT in the department of Cauca, presented the experience of interculturality in maternal care in Toribío and Jambaló, and showed how maternal mortality has been reduced to zero in that region. Beda Suárez, Manager of the health insurer Anas Wayúu Indigenous EPS (health promotion company), in the department of La Guajira,

explained the characteristics of community participation in this EPS, the role of indigenous authorities and assemblies and councils in decision-making. The Secretary of Health at the Cauca department (Departmental Health Authority of Cauca), Andrés Narváez, and Jorge Sotelo, public health adviser for the entity, presented the reorganization of services and intersectoral health actions in the area. In Toribío and Jambaló, two indigenous communities of the country, the Departmental and Municipal Development Plans are harmonized with the life plans and health worldviews of the indigenous communities. International researcher, Lorena Ruano from the University of Bergen, reviewed the experience of defenders of the right to health in Guatemala. Gustavo Campillo, president of the Rasa Foundation from the department of Antioquia, proposes going from the concept of Primary Health Care to a more holistic one such as Population Actions towards Health aimed at the well-being in the territories. To detach the concept of PHC from health interventions.

To finish, the panel mentioned the need to defend and advocate from Primary Health Care, for the rights of those who are healthy so that they can be preserved that way.

Further information Watch video in spanish

Context interventions
Community participation in strengthening of the PHC in the department of Cauca

Jorge Sotelo Daza

Consultant in public health management processes, models and health systems
Secretaría de Salud (Health Secretary) of the department of Cauca

PhD candidate in Anthropology, health line, Universidad del Cauca -Popayán.
Master of Public Health, Universidad del Valle Cali. Specialist in Quality Management and Audit in Health Universidad Cooperativa de Colombia.
Professional Nurse, Universidad del Cauca.

In Cauca, the various currents of local thought determine how I take care of my health, how I face the challenges posed by the disease, and how to manage health care.

Cauca is the most diverse department in Colombia, says Dr. Sotelo, and therefore full of opportunities from Primary Health Care. Our geography, the Puracé Volcano and the mountain chain that accompanies us, define the way to walk the territory from the health point of view.

The department of Cauca is located in the south west of the country. It has a very important geographical diversity and thermal floors. It is characterized by the presence of different indigenous ethnic groups, Afro-Colombians, mestizos and peasants who cultivate the land and provide food to the region and the country.

Cauca has about 1,490,000 people. 22% of the population is indigenous and is distributed in 16 indigenous reservations. 24% of Cauca's residents consider themselves Afro, 16% are peasants, and 32% are mestizo. This ethnic distribution means that there are different currents of local thought that determine how I take care of my health and how I face the challenges posed by the disease, explains Dr. Sotelo. These diverse ways of caring for health also socially and culturally determine the way to manage health care processes. This poses some challenges to reach the entire population in accordance with local way of thinking, but also opportunities to manage public health according to the particularities and essence of the territories. Of course, Sotelo says, there are also proposed ways to adjust as a health system to the dynamics of PHC. In Cauca, we take the structure proposed by PHC as a basis and apply it to the reorganization of services, community participation and sectoral action to achieve equality in health.

Cauca has some areas that have been distributed for the provision of services given the enormous distance from some municipalities to Popayán, the capital of the department. To the south, 350 kilometers away, is Piamonte. To the west, 600 kilometers from Popayán, is Guapi. There is no highway, you have to arrive by plane, explains Sotelo. To the north, there is a municipality 112 kilometers away; to the east, there are municipalities 120 kilometers away; towards the center there is a municipality 207 kilometers away. By this I mean, Sotelo says, that the geographical distance from Popayán to certain municipalities poses great management challenges.

If we identify the epidemiological profile in the different territories, it also becomes different. In the north of Cauca, cardiovascular events are much more common and in the southern area it is infant mortality due to acute respiratory infection. This difference must be taken into account.

The document of the Provision of Health Services Comprehensive Network

Social and community participation in PHC, led jointly with the Ministerio de Salud and health actors, is proposed in the document of the *Provision of Health Services Comprehensive Network*, which will be the navigation map to strengthen the infrastructure of the first levels of care. That is, from the first contact of individuals, families, and communities with the Network.

The document, which has a political and economic instance, has been built with the people, according to the health management itineraries that occur in each municipality. It is in accordance with the stages of the life course and according to the needs of the municipalities. Information is generated to manage the risk in the municipalities according to the particularities and of course, explains Dr. Sotelo, the financing of this Provision of Health Services

Comprehensive Network is considered, which includes the individual actions of the health benefits plan and collective actions of public health plans. The Cauca Provision of Health Services Comprehensive Network has strong community participation. It presents us with its needs and limitations in terms of opportunity, access, quality and continuity of care.

On the other hand, in the administrative process of the department's Secretary of health, different elements of public policy converge. Collective actions are managed taking into account the Plan Decenal de Salud Pública (Ten-Year National Public Health Plan), we link the National Comprehensive Health Care Routes that affect the PHC structure. We have an ongoing PHC-based technical assistance process that calls for community participation. With them, we do this exercise, the advisor Sotelo Daza says, we strengthen capacities, at all levels, with the actors of the health system and with the people in the territory. We link it with public health surveillance, and we exercise the inspection and surveillance of the actors.

Adjustment of care models from community and local logic

All these elements are framed in a management model, explains the advisor Sotelo, who plans to reach all the territories of the department. We have adjusted the care models from a community and local logic, not only from what is established by the norm.

We have a quality management process, says Dr. Sotelo, we carry out a continuous evaluation of level 1 hospitals. In the department's Secretary of Health, we have an insurance area that is complemented by public health management. Each Empresa Social del Estado (State's Social Company), each public hospital, render their accounts. We are continually in a process of capacity development with health personnel at all levels and with those who manage this matter, explains Dr. Sotelo.

The power of community participation

Management is combined with the strength of social and community participation in the department of Cauca. We make agreements between health institutions and the community to see how we reach the territories, says Dr. Sotelo Daza. There is an exercise in continuous conversation to reach agreements, to see how attention is raised. This is mobilized through the collective intervention plans and the consultation tables in the municipalities. In the departmental development plan, along with other portfolios, limitations on access, opportunity, and quality are managed, and there is a process for responding to complaints and claims that also allows for continuous conversation with community participation.

With these elements of social and community participation, intersectoral action and PHC actions, we have continuous conversations with education, with the person in charge of managing water and basic sanitation, with the Corporación Regional del Cauca, which does environmental management, with Indeportes (Sports management entity of the department), with agriculture, with all gender dynamics, with infrastructure. We have recognized the social determinants that define these territories. From the analysis of the health situation, all are permeable to social and community participation.

These strategic elements of PHC that are linked to health policy are related to the particularities of the territories, the people and the ways of building alternatives in health care and recovery from illness.

In Cauca, the *Sistema Indígena de Salud, Propio e Intercultural* (SISPI) was created, explains Dr. Sotelo. In Cauca there is talk of respected childbirth. There is a syncretism of care processes in which the different voices of the territory speak, agree, define forms of communication, from the indigenous, the Afro, the mestizo, the peasant, ways to adjust the processes of health care and public health management.

We see PHC as a proposal that generates opportunities to reach the population. In what sense? In being able to connect and align with the Ten-Year National Public Health Plan 2022-2031 in the sense that one of the axes is PHC.

From social and community participation in health, there are different elements that we need to converge to mobilize the aspects that this marvelous strategy raises for us and thus guarantee the right to health, access and everything that the values and principles of PHC propose to us, says Sotelo.

See presentation Watch video in Spanish

Intersectorality, multidisciplinary health teams, and a greater focus on prevention in Cauca

Andrés Narváez

Secretary of Health of Cauca

Dentist. Master in Health Business Administration. Specialist in Hospital Administration and Comprehensive Management Control and Audit of Health Services. He was Secretary of Health of the Municipality of Caloto and director of the La Niña María Hospital in the same municipality. He was manager of the Hospital Universitario San José de Popayán, and Manager of Asmet Salud EPS at the departmental level

In the Secretaría Departamental de Salud del Cauca (Cauca Departmental Health Secretariat), says Dr. Andrés Narváez, we have fulfilled and advanced on the long road of improving the performance of the different actors in the health system. We have led many actions knowing that Primary Health Care is not an end, but a means to achieve the improvement of the living conditions of our department that have particularities and all imply a different performance of the actors.

When we worked on the change of the document of the *Provision of Health Services Comprehensive Network, that is approved by the Ministry of Health and Social Protection of Coombia*, it was to seek that the services come closer to the community through strategies in accordance with the reality of the department. For example, the document of the Network that we had before, considered the liquidation of two hospitals, that of Guapi and that of one Empresa Social del Estado (State's Social Company) that has three municipalities. Always thinking about the consumer, explains Dr. Narváez, we told the Ministerio de Salud (MoH), liquidation is not the way. These institutions must be strengthened. If we succeed, we will have a better provision of services in the department.

We have acted, says Dr. Narváez, in the structure of the network and we have ensured that our public managers adopt and interpret the needs of their municipalities through care models that are consistent with the epidemiological profile and the needs of each region.

We work in intersectorality, explains the Departmental Secretary of Health of Cauca, linking all the actors, being aware and more focused on prevention. We are acting with the intentions of the new government regarding the formation of multidisciplinary health teams in different regions. We chose twenty municipalities of the department. Toribío, here present, was one of those selected. Multidisciplinary teams are formed to get much closer to the community.

We know that there are challenges due to geographical dispersion, due to the high costs of people's travelling. However, with the resources we have, we can finance and reach out to multidisciplinary teams and bring care to these distant sites and seek a characterization of the population. We have pushed meetings forward with insurers that are responsible for individual care so that together we can make a much stronger characterization that allows us to focus our efforts on risk groups, there, in the place where people live.

In the department of Cauca, we work very hard. We have a path that we have begun to walk and with everyone's support we are going to improve the living conditions of our population. We have new care models. One of them, the care model that we are pleased to show you today, says the Department's health secretary, is the one developed by ESE CXAYU'CE JXUT, located in the indigenous territory of Toribío and Jambaló.

Watch video in spanish

Central interventions
Experience of community participation in health in Guatemala

Lorena Ruano

Researcher and teacher at the Center for International Health at the University of Bergen, Norway. Coordinator of the research, education, and learning area of the Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud CEGSS (Center of Studies for Equity and Governance in Health Systems).

Sociologist with a PhD in Public Health from Umeå University, Sweden.

At CEGSS, she leads the Strengthening the Agency and Learning in the Health Systems of the Americas project (SALHSA) focused on the development of capacities among

academics, civil society, and decision and policy makers of relevant public health organizations in Latin America.

Associate researcher at the Petrie-Flom Center for Health at Harvard Law School. Editor-in-chief of the International Journal for Equity in Health (IJEqH) since 2008

In Guatemala, with political empowerment, indigenous communities have managed to improve the quality of health services and build trustworthy relationships

In her intervention, pre-recorded for the webinar, the researcher Lorena Ruano seeks to explain how her institution has supported citizen-led accountability, how they have used learning cycles to do this more effectively, and how they support the construction of an active citizenry through these learning cycles.

Guatemalan Context

We obtained independence in 1821, like the rest of the countries of the Central American isthmus, says the researcher. From there, we had a history of totalitarian and right-wing rule, with a brief period of about ten years, from the October Revolution between 1944 and 1956. During this time the country enjoyed high levels of social investment in schools, roads, and many things that helped raise the quality of life of Guatemalans. However, this revolution ended with a coup led by the USA's CIA, explains Dr. Lorena. As a result, she says, we began an internal armed conflict that ended in 1996. During these years, an estimated 150,000 people were direct victims and generations of leaders from the 1950s to the 1990s were routinely tortured and killed. Furthermore, the internal armed conflict, or our war, was characterized by very high levels of repression and left us with very weak state and social institutions. In 1996 we signed the firm and lasting peace that came with the mandate of equitable economic and social development for all Guatemalans. This mandate indicates that the health budget should be increased until reaching 1.44 of GDP by the year 2000. Today, 22 years later, it is around 2.6% of GDP, one of the lowest in Latin America.

We have had a legal framework since 2002. These four or five laws allow us to work directly on the development of the country and focus on the local levels where all power is decentralized. However, we have very low taxes and very little ability to collect them from large companies and businesses.

General indicators of pre-pandemic inequality in Guatemala

- 59% of the population lives below the poverty line
- 46% of children under the age of five are chronically malnourished
- One of the highest rates of maternal mortality: 144 per 100.000 live births according to the government. 290, adjusted data, according to UNICEF.
- Life expectancy: around 72 years
- 91% of non-indigenous men can read and write.

Indicators compared by ethnicity

In her speech, Dr. Ruano makes a comparison of indicators between the indigenous and non-indigenous population.

- 79% of the indigenous population lives below the poverty line. Only 35% of non-indigenous live below that line.

- 66% of indigenous children under the age of five are chronically malnourished, compared to 30% of non-indigenous children.
- Maternal mortality of the indigenous population: around 163. 78 from the non-indigenous population. (Unadjusted data from UNICEF)
- Life expectancy of the indigenous population: 59 years
- Only 35% of indigenous women can read and write in their language, not in Spanish.

Starting points in the CEGSS

When we wanted to start working with the citizens of Guatemala at the Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud CEGSS, explains Dr. Ruano, we started from the following aspects:

- Guatemalans do not trust their State as a result of the armed conflict and social exclusion.
- We use the legal framework to promote participation, generate dialogue, accountability and contribute to the democratic governance of the health system.
- We see the need to link academic work and support for the agency of historically excluded populations in order to enable them to do political advocacy.
- Today we work in 35 municipalities that have high rates of indigenous population.

What is our working model?

We focus on participatory research and action, says Dr. Ruano, to:

- Systematize local experience to facilitate collective analysis together with the indigenous populations we support
- Tie the analysis and reflection of these inequities with action to understand experiences, perceptions and facts
- Turn excluded communities into researchers and agents of change.

Accountability

Dr. Ruano explains that accountability is the collective effort made by public officials so that they can give explanations about the quality of the services they provide and how they use the money. It includes the right and the need to participate in the development of public policies, and emphasizes the links that exist between the different types of citizen action.

Accountability institutionalizes population control over public policy, explains speaker Lorena Ruano, and is rooted on the use of political costs or reputation to compel responses from the authorities based on:

- Predefined standards, for example, what the law says or what is defined by the government
- Information on public actions that have been implemented
- The justification for carrying out those actions
- The imposition of sanctions and rewards as appropriate.

What do we look for with accountability?

Dr. Ruano says, we look for:

- Restricting the power of public officials
- Monitoring the delegation of power from the citizenry to the State. We, the citizens, give power to the State, but just as easily, we can take it away.
- There is a lot of opacity in decision making and those who make those decisions must explain and justify their actions.

Why do we focus on this?

Researcher Ruano explains the following reasons:

- Because the States of low- and middle-income Latin American countries have become gigantic, complex, and opaque.
- Because they have a lot of discretion when making public policy.
- Because this increase in power in bureaucratic processes has not been accompanied by a similar process of returning power or increasing the power of the citizenry.

How did we learn to support the construction of an active citizenry in health?

Our work has several phases, explains Lorena Ruano.

Phase 1. 2006-2008

We worked in five municipalities and focused on participatory planning. We were trying to follow the pyramid of evidence in public health by doing quantitative studies, making an inventory. However, a lot of resources were needed. Many community leaders abandoned the process, says researcher Ruano. We realized that it was very easy to dismiss the evidence we were carrying. For example, we would say that there was a shortage of medicine in a health center and they

simply did not respond or said, *that was when you went*, *the following day there were more medicines.* So, we said, says Dr. Lorena, this is not working.

Phase 2. 2009-2011

We continued in those five municipalities. We started using mixed methods using Paulo Freire's adult education principles, "Education as liberation". However, we still invested a lot of resources to produce evidence that the authorities did not accept. Again, says Dr. Lorena, we returned to the table, reflected, and concluded that we needed a change. To this was added an increase in income for a large project and we scaled from five to fifteen municipalities.

Phase 3. 2012-2013

In this phase, explains Dr. Lorena, we worked with a conceptual framework for political empowerment. We began working with anthropologists and ethnographers to identify the ways in which indigenous communities named the most common instances of abuse and discrimination, and we also worked on a multidisciplinary model that draws on the use of social sciences.

Within the conceptual framework, we developed the use of tools to identify abuse and discrimination and began to use community assemblies to foster trust between them and us and facilitate agency building, explains Dr. Lorena Ruano. We realized that the indigenous population has felt that the State has never been there for them or has betrayed them many times, likewise, organized civil society comes and asks for things and then leaves. We started to develop a platform to report cases of abuse and discrimination based on text messages. Thus, we saw that the process of political empowerment began at the individual level, trying to increase knowledge of situations of exclusion. Then, says the researcher, we moved on to the construction of collective consciousness and then to the surveillance of public services with the goal of reaching the political power of the citizens.

Phase 4. 2014-2015

In this new phase, says Dr. Ruano, we worked with 35 municipalities and we began to do rapid ethnography. We focused on the collection of audiovisual evidence. We taught indigenous leaders to use cameras, voice recorders, to do interviews. We started using human rights approaches, in particular the right to health. This is how we reached the *Defensores Comunitarios por el Derecho a la Salud* (Community Defenders for the Right to Health). These defenders are recognized by the UN and are trained in the use of the Guatemalan legal framework of human rights, mainly the right to health, in ethnographic data collection techniques, and in strategic work with municipal and health authorities.

What have we achieved?

As a result of this work, says Dr. Ruano in her presentation, we managed to improve the quality of services. There are relationships between civil society, leaders with the Procuraduría de Derechos Humanos (Human Rights Ombudsman) and with specialized prosecutors. We have developed relationships based on trust and we have managed to invest more funds for human resources of health, for medicines, and for ambulances.

How do Community Defenders for the Right to Health work?

In the surveillance cycle, explains Dr. Ruano, the following steps are taken:

1. **Collect evidence**. Not scientific evidence but information that shows the situation of the communities. The defenders collect all this information and contact us at the CEGSS so that we can support them in the follow-up.
2. **Prepare to work with the authorities to which we are going to request help**. We present the evidence to public authorities and ask or demand solutions. We have noticed, says Dr. Ruano, that when we demand to be included in a particular space, we are more listened to than in those where we are freely invited. We use decision trees to help guide the next steps so that the indigenous population we work with and leaders feel comfortable.
3. **Present evidence and demand solutions**. The authorities can react in different ways when we go to these spaces for participation in health, says Dr. Ruano. They can accept that the problem exists and plan its solution, and that can be the ideal solution for us. They may also be nice, but have no intention of solving the problem. They may deny the problem or be openly hostile and threaten defenders. For this, the defenders carry out their strategy and plan, explains the researcher.
4. **Adjust the strategy**. Depending on the problem identified, the level of governance where we must influence is defined, says Dr. Ruano. We go to the Attorney General's Office and all the Prosecutor's Offices with which we work as partners to support the resolution of the problem legally if we cannot solve it administratively. We have protocols for when there are threats, says Dr. Ruano.

5. **Follow-up actions**. We include activities at the municipal level to inform the community and we travel to the capital with the leaders to negotiate with higher level authorities and it is common to work with the Human Rights Ombudsman.
6. **Verify resolution and plan another cycle.** As the last step, says Dr. Lorena, the authorities inform the defenders what has happened. We verify that the problem was fixed, collect evidence, and close the case.

Watch video in Spanish

Interculturality Program of Maternal Care of the-ESE CXAYU'CE JXUT -Hospitals of Toribío and Jambaló in Cauca

Beatriz Bohórquez Salinas

Manager ESE CXAYU'CE JXUT Hospitals of Toribío and Jambaló – Department of Cauca

Nurse and Public Administrator, with Specialization in Administration in Health and Public Management and Master's Degree in Public Health.

Member of the Colombian Association of Public Health.

She was a manager at the Cooperativa Hospitalaria y Empresarial, manager at Harold Eder - Corinto hospital, and manager of ESE Norte 2.

The Interculturality program in Maternal Care of the-ESE CXAYU'CE JXUT reduced maternal mortality in the area to zero

Dr. Beatriz Bohórquez Salinas begins her speech by explaining that the name of the State's Social Company CXAYU'CE JXUT that includes the hospitals of Toribío and Jambaló, in the north of the department of Cauca, is a Nasa indigenous name that means *happy grass that heals or harmonizes*. It is a plant that lives in our region, says Bohórquez.

We are low-complexity or first level hospitals and we have a very beautiful strategy that we are going to share with you today, says Dr. Beatriz. The strategy is called *Interculturality in Maternal Care*. 96% of the population of Toribío and 98% of that of Jambaló are Nasa indigenous people. In our territory we have the *Path of self and intercultural health care within the framework of the Sistema*

Indígena de Salud Propia e Intercultural SISPI (Own Indigenous and Intercultural Health System), from the life plan of the Nasa Project. On this path, explains Dr. Bohórquez, are the family, the community and the ancestral experts who are very important to us. There are health cheerleaders who support PHC in the context of the family. Community health workers follow this path. Then, the SISPI team that is in the community health centers.

As a complement to care, we have coordination with western medicine in the indigenous IPS (healthcare providers), says Dr. Beatriz. In Toribío is the UNICUSPI - Unidad de Cuidado de la Salud Propia (Intercultural Own Health Care Unit) and the ESE CXAYU'CE JXUT with complementary services such as outpatient consultation, dentistry, nursing, pharmaceutical service, health promotion programs, prevention, and also low-complexity hospitalization, emergencies, basic care transportation, vaccination, childbirth, and newborn care.

The intercultural strategy of maternal care

It is a strategy that takes years. I am from the territory, but I came to ESE CXAYU'CE JXUT two years ago, says Dr. Beatriz. The Maternal Care Intercultural Strategy arose from the identification of institutional barriers and also due to the limitations of pregnant women to access health services from western medicine. There was mistrust and a different worldview. For example, the "cold" in the care of the pregnant woman. It also arose from analyzing maternal and perinatal indicators and the need to reduce maternal and perinatal deaths. There was tension due to the unsafe delivery and fear of attending hospital institutions on the pregnant women's part. It was necessary to involve the leaders and also approach the life plans of the communities from the institutional framework of the territory. We saw the need for there to be a greater sense of belonging from the community and also from health workers. We wanted to build trust with the community so that they could access health services and, furthermore, articulate ourselves in participatory work. Community participation with ancestral knowledge has been fundamental in our strategy.

Lines of interculturality in maternal care

Six lines make up this strategy, explains Dr. Beatriz.

1. Training the health personnel on the articulation that we should have between western medicine and ancestral medicine.
2. Sensitization to all the personnel of the health institution about the importance of respect for the knowledge of both parties.
3. Conversations and sharing of knowledge with the leaders, midwives, and ancestral experts of the territory.

4. Conversations with pregnant women, women of childbearing age, mothers who are head of the household.
5. Design of an intercultural delivery care manual with a delivery care plan.
6. Adequacy of the infrastructure of maternal services, the delivery room, a halfway house or maternity home with an intercultural approach.

According to the manager of the ESE, we carried out an exercise of articulation with the Departmental and Municipal Development Plans and, above all, with the life plans of the Nasa peoples. In Toribío they are called Nasa Project Life Plan and in Jambaló, Global Project Life Plan, explains Dr. Beatriz, manager of ESE CXAYU´CE JXUT. We moved along with those plans. We changed the chip. Before, it was western medicine first and then the community. The population had to be adopted to our health services. Now it is different.

As part of the training, we have diplomas in intercultural maternal care, says Dr. Beatriz, we receive advice from Dr. Susana, who is a doctor, specialist in midwifery and intercultural maternal care. She is our adviser and she is always with us.

Induction to new staff

We give new staff a special induction, says Dr. Beatriz. We explain to them that we abide by western law and also by the law of indigenous peoples. We tell them about our ritual, our worldview of health. We socialize our own guides for childbirth and newborn care, adapted to our context and interculturality.

Sensitization to the personnel of the health institution

This has been a difficult challenge. We have spent years, explains Dr. Bohórquez of ESE CXAYU'CE JXUT. Today I want to recognize the great commitment of the members and collaborators of our Toribío and Jambaló hospitals. Everything depends on the will and the love with which new ideas are received. You have to unlearn a little and keep learning day by day. This awareness was one of the most difficult steps. For example, the medical staff had the vision of not allowing a midwife to enter the delivery room, not allowing other companions to be involved, not allowing the use of alternative non-pharmacological strategies for pain management. However, the ESE Manager indicates, awareness was woven little by little, in order to open the minds of both parties. Also, our elders, our ancestors, said that if the doctors are not going to respect our ritual, it is very difficult for us to open spaces. Agreements were reached in these meetings. It began to define how we were going to respect each other, what the limits were. This was written in our protocols and is documented to build our own delivery care route, says Dr. Beatriz.

Conversation with leaders, midwives and ancestral experts

In these spaces, ritual themes were taken into account, the cutting of the umbilical cord, the experiences of home birth care, the freedom of different positions to attend the birth, the role of ancestral knowledge in the care of the birth that is not the institutional one. For us, explains Dr. Bohórquez, the important thing is to learn among ourselves that this delivery is safe, that we all work as a team so that this delivery, this mommy, this baby is safe. The management of medicinal plants, the care of the mother, the newborn, how to avoid "cultural cold", food for pregnant women and the benefits of having companions. All this as part of the Nasa indigenous worldview.

Dr. Beatriz explains that at SISPI they have the *Mujer dadora de vida* (Life-Giving Woman) program, which ensures that the birth is attended at home, in the niche of the Nasa indigenous family, that the birth does not happen far away from home. If deliveries cannot be attended at home and need to be attended at the hospital, we as hospitals adapt, says Dr. Bohórquez, so that the mommy and her family feel at home.

Conversations with pregnant women, women of childbearing age, mothers, and midwives

Dr. Beatriz explains that in these sessions with women, families, and midwives, we talk about what a home birth is like, what baths with medicinal plants are like, what position women prefer to give birth in to feel more comfortable and live that experience in a freer, calmer, more respectful way. We have been seeing the evolution of the strategy. Childbirth ceased to be a traumatic experience, says Dr. Beatriz from ESE CXAYU'CE JXUT, to become a beautiful experience, seeing how the birth of this new seed is received by all of us, together, with the family. What this articulation allows is to reduce the maternal and perinatal risk and the establishment of agreements for a safe delivery.

Health Care Manual for Intercultural Childbirth Care and Childbirth Plan with an Intercultural Approach

We have, says Dr. Beatriz, manuals for Intercultural Childbirth Care and a Birth Plan with an intercultural approach. It is a route for childbirth care from the time the mother is pregnant and is detected by community health workers. In the antenatal control we have articulated two healthcare providers and the birth plan. The strategy is being socialized to the pregnant woman and she is choosing how she would like her delivery to be.

Adequacy of the infrastructure of the delivery room, maternal services and halfway house or maternal house

Thanks to the commitment of the Ministerio de Salud (MoH) and the Government of the Department of Cauca, the municipal administrations, the International Red Cross, and the ESE's own resources, says Dr. Beatriz, we have a delivery room from western medicine that has all the technology to ensure patient safety and comply with licensing standards.

In addition, continues to explain Dr. Bohórquez, we have our Intercultural Childbirth Care Room. There are some "chumbes" that hang from the ceiling or from the wall, as the case may be, so that the mother can have greater freedom and choose which position she wants to attend to her delivery. In this room, there is a special decoration that has been done with a *cateo*, which is a review of each element that the room has in the hands of our elders from the territory. They, from their ancestral knowledge, from their feelings, tell us how we should decorate the delivery room, what color it should be, the figures that the "chumbe" should contain so that the room is in harmony and in balance with our mother nature. There are some balls for non-pharmacological pain management and other strategies such as aromatherapy, music therapy, and massage.

In the infrastructure adjustments, a kitchenette was included in the delivery room, which has some volcanic stones that help us heat the room and where the mothers or midwives can prepare the water from medicinal plants. With the agreements made, we have decided which plants are allowed and which are not. They have accepted the agreements, says the manager of ESE CXAYU'CE JXUT.

There is also a chair built with the mothers and midwives' own ideas; they expressed that this model could greatly facilitate the semi-sitting position. Everything has been built on the articulation of western knowledge with the Nasa indigenous ancestral knowledge.

When the birth is in a squatting position, the husband gives strength to the mommy from behind or from the back. Delivery can be on your knees or in the all-fours position, or on the floor, or on a mat, or in bed. There are also deliveries in western medicine ward. The doctor and the midwife together, as a team, receive the baby. What we always hope with our strategy is that it is not something traumatic, but a beautiful experience of receiving life.

Other elements of Intercultural Childbirth Care

The strategy includes a differentiated diet that means culturally hot, not hot in temperature, but there are culturally cold foods that interfere with our worldview. Also, as we said, Dr. Beatriz claims, there are the baths with medicinal plants, the cutting of the umbilical cord that is done with scissors or with the reed that the family brings, which is previously sterilized, according to what the mother,

the family and the midwife have decided in the birth plan. The accompaniment of the ancestral is allowed. The midwife can stay with the pregnant woman throughout her labor, day and night, and for as long as she considers. After delivery, the placenta is delivered, explains Dr. Bohórquez. It is very important for the Nasa indigenous culture to carry out a process with the sowing of the placenta.

For the non-pharmacological management of pain, the husband is given the plant oils so that he can do the massage. The sister, the midwife, the mother, the attending physician, and the nurse may be present at the delivery.

We all get involved in each birth, we, the manager, the scientific deputy manager, the strategy leader who is Diana López, the doctors, the nurses, we all participate. A birth is something absolutely important to us. It is a fundamental event in our hospitals.

Intervention and postpartum and puerperium care

The accommodation of the womb is done by the midwife. Breastfeeding is supported with medicinal plants and education from our western medicine. We make a kit for each newborn born in our hospital. The kit has the first change, disposable diapers, and wet wipes, says Dr. Beatriz. We have a bassinet or hammock, which is a request from mommies and midwives to put babies in rooming-in. When mommy wants to rest or do another activity, she can have her baby in the postpartum room.

The maternal house and the tulpa

The maternity home is a temporary home that we have within the hospital infrastructure, says the manager of ESE CXAYU'CE JXUT. The pregnant woman can arrive there with her family up to a week or ten days before the probable date of delivery. It's like a hotel, they can cook, they have bathrooms and rooms. They can have a free stay that is not assumed by the health insurer - EPS but by us to strengthen patient safety and in order to reduce maternal and perinatal mortality. When labor begins in the active phase, they move to the intercultural delivery room. There are some pregnant women who prefer to go to the delivery room of western medicine. Next to the maternal house we built a tulpa, which is a special space where the ancestor or the eldest is and performs the rituals and harmonization to give strength to the mother.

Alliance for Telemedicine

This experience of intercultural childbirth has had the support of the Valle de Lili Foundation. With telemedicine we are constantly trained to reduce obstetric risk.

It has been very useful for managing emergencies, especially that of obstetric hemorrhages. Through the tablets, our doctors receive permanent support and supervision from obstetrician-gynecologists, pediatricians, and neonatologists from the Foundation. They have supported us infinitely, says Dr. Beatriz. These alliances have been free. PHC and public health are the most important things for us, notes Dr. Beatriz.

Strategy instruments

The strategy has several instruments that Dr. Beatriz explains, as follows:

The birth plan: It is like a clinical history of childbirth care in which the family is educated about the strategy. The birth plan defines how each mom wants it. She is a guiding guide, it may be that in the end, at the crucial moment of childbirth, she makes different decisions and these are respected.

The birth certificate: In it, we highlight the joy of the newborn and congratulate the mommy.

The registry of intercultural births: It is the quantitative record of information related to the strategy, how many births we attend, what position the mothers have preferred, number of maternal deaths or perinatal deaths.

Maternal mortality was reduced to zero

The manager of ESE CXAYU'CE JXUT points out that they have increased care for institutional deliveries. Until 2016, they attended close to 200 deliveries in hospitals in the area. Today, on average, we are attending between 360 - 365 deliveries a year, says Dr. Beatriz. This has increased the number of safe deliveries. With the EPS we work so that births are not perceived as an expense but as a way of caring for the economy due to the cost-benefits they represent. They are normal deliveries attended in our institution that, on the one hand, will not reach third-level institutions that may be more expensive, and on the other, they have a very important moral value for us as a community, because if we did not have the strategy, a family would have to move from Toribío to Popayán or Cali, and move away from the territory to have babies elsewhere, and this is very difficult economically, very difficult from the worldview, and very difficult for our feelings, says the manager of ESE CXAYU'CE JXUT**.** I want to tell you, says Dr. Beatriz, with joy and love, that maternal mortality was reduced to zero and until today, we have kept it that way, at zero.

Sharing the experience

We have taken the experience to other spaces and it has been very nice, says Dr. Beatriz. We have been invited to learn about other proposals. We went to the Dominican Republic for the ALAMES Congress of Community Medicine. We were selected as a successful community, participatory and intercultural healthcare provider - IPS. We were in Australia in 2019. The Ministerio de Salud y Protección Social recognized it as a successful intercultural experience with an honorable mention for all the staff of the Toribío and Jambaló hospitals. It has been, says the manager of ESE CXAYU'CE JXUT**,** a great motivation to be able to access these spaces and tell everything we have done in our journey, not only us as an institution but the life plans of the Nasa territory of Toribío and Jambaló, the community, the older midwives, and all of us who have built this wonderful experience.

We have also received visits from hospitals that have wanted to reference and learn about the experience. They have come from the Susana López de Valencia de Popayán hospitals, from the Clínica de la Estancia, from the Hospital de Riosucio Caldas, we are a maternity reference for the departmental health secretariat. We have received visits from the Universidad Libre, the Universidad de Santiago de Cali, and French universities. We are very pleased that the academy is exploring the issue of the adequacy of the territorial context for Health Care services.

Dr. Beatriz Bohórquez ends her speech by saying: PAY, and explains, PAY is a Nasa indigenous word that means thank you. The interculturality of maternal care is our commitment to contribute to the well-being of the mother and her newborn.

See presentation Watch video in Spanish

Community participation at EPSI Anas Wayúu in La Guajira

Beda Margarita Suarez Aguilar

Wayúu woman of Uriana caste

Manager of the Anas Wayúu Indigenous EPS- Department of La Guajira

Doctor specialized in Health Services Management,
Postgraduate in Medical Auditing, studies in Leadership,
Risk Management, and Intercultural Processes.

Participation is aimed at developing a management and administration model centered on the individual and their community

Dr. Beda begins her presentation with a greeting in Wayúunaiki, the native language of the Wayúu, and with a tribute to the dance of life, beauty, and joy typical of their culture. She explains that the dance is related to the closing of cycles, with the celebration when there is abundance in the crops, when there is the release of a young Majayut from confinement. The Wayúu woman, she says, is the multiplier of our clan, and also when any event that puts individual and collective health at risk is overcome.

The history of the Indigenous Health Insurer - EPSI Anas Wayúu

Anas Wayúu EPSI, says Dr. Beda, is an Indigenous Health Promoting Company made up of traditional Wayúu authorities from the association of councils, traditional authorities, and the Suwuija Association. The first General Assembly

of Authorities was held in April 2001. In June it received the legal endorsement of the Ministerio del Interior (Ministry of the Interior) and the same year, the authorization of the Superintendencia de Salud (Superintendence of Health) as administrator of the government subsidized regime of health for indigenous peoples. It is a public entity of a special nature. Its organic and functional structure is based on its own government structures, represented by its traditional indigenous authorities. Our management, says Dr. Beda Margarita, is based on the application of guiding policies of our authorities, such as cultural cohesion.

The Wayúu indigenous EPSI is only in the department of La Guajira by mandate of its traditional authorities and out of respect for the dynamics of the other indigenous peoples settled in our territory. Social participation is guaranteed in a Wayúu normative context and is in accordance with the social and organizational reality. We have differential strategies to manage risk, and a mechanism to guarantee the authorities the social and cultural permanence and sustainability of the indigenous EPS.

The growth of the institution is carried out according to our operational and financial response capacity. We are in the territories where it is the will of our authorities that we have coverage on. We are governed by the same health legislation that exists in the country and special indigenous regulations, based on international agreements and treaties.

Our population

We have 223,661 affiliates in seven of the fifteen municipalities of the department of La Guajira, says the manager of Anas Wayúu. A similar male-female relationship prevails in our affiliates. 69.83% are of indigenous background. Of them, 66.31% are in rural areas. 23% of the rural area corresponds to the deep Guajira, to the dispersed rural area, explains Dr. Beda.

Context

Our entity is in a territory with a high degree of desertification and salinization, says Dr. Beda Margarita. The Wayúu people are settled in the territory of Colombia and Venezuela, there is no political-administrative division for us, she affirms.

On the other hand, the EPSI Manager continues to explain, there are factors that condition the health of our people: prolonged droughts, the difficulty in obtaining drinking water, inequitable access to education, the little or no purchasing power of the communities, food insecurity, high geographical dispersion, poor quality roads, the fragility of the intersectoral articulation, and the migratory phenomenon that has brought the appearance of emerging and

re-emerging diseases in our territory, as well as conflicts between clans for the return of many people to the territory.

Indigenous System of Own and Intercultural Health

We, says Dr. Suárez, are immersed in the General System of Social Security in Health SGSSS, but we also have our Own Indigenous and Intercultural Health System. Community participation is at the center of the system and is guaranteed by the General Assembly, our highest instance, made up of traditional authorities from the Association of Cabildos and the Sumuwuja Association, explains Dr. Beda Margarita. Accountability and analysis of the different processes of interest for community management are carried out annually. They, says Dr. Beda, elect the *Junta de Control Social* (Social Control Board), made up of authorities; the *Consejo Étnico Cultural* (Cultural Ethnic Council), made up of traditional authorities, traditional doctors, leaders in charge of advising that the differential processes are in accordance with the mandate of the traditional authorities. The Assembly elects the Board of Directors every two years, which approves the Risk Management Plan, the budget for the staff, and elects the manager each year.

Traditional authorities and leaders are also part of user associations. The institution has an ethnic and cultural coordination, led by a Wayúu doctor. In her team there are traditional doctors, palabreros, a social worker, and bilingual guides.

Operational administration and management strategies

Participation, in a macro way, explains the manager of the EPSI Anas Wayúu, is aimed at developing a management and administration model focused on the individual and their community, leveraged on indicators that measure organizational performance, in accordance with the mandate of the traditional authorities and SGSSS requirements.

The board of directors, says Dr. Beda, formulates, together with the EPSI monitoring team, the institutional risk matrix that defines the risks to which we are exposed, quantifies them according to their impact and probability, and formulates indicators to guarantee the permanence of the institution, in accordance with the mandate of our traditional authorities.

Operational strategies of cultural integration

The concept of health that the Wayúu have, says Dr. Suárez, implies living in a territory where there is harmony, where we are not exposed to conflict between

clans, where drinking water is available, and where it is possible to graze and cultivate, and, of course, that we are not sick.

We have worked hand in hand with the traditional authorities, continues explaining Dr. Beda Margarita, in the identification of the health situation from our own and institutional, from the worldview of our peoples and from western medicine, the differential strategies to avoid forms of discrimination beyond language barriers. They have developed culturally appropriate information, education, and communication actions. We have a media plan, explains the EPSI manager, defined by our traditional authorities, and in recent years, with the participation of the *palabreros,* those in charge of conciliation and guarantors of the collective health of our communities. This plan seeks to bring relevant information to the communities in order to strengthen self-care, together with our customs.

In conjunction with the authorities, several health care routes were built, in accordance with our population and epidemiological reality: the gender violence route, the voluntary retirement route, and the dignified death route.

As for the non-allopathic options provided, says Dr. Beda Margarita, there is differential contracting in which we incorporate health promotion and maintenance services from the Wayúu indigenous health perspective. Collective actions are carried out that strengthen protective factors. This has allowed the social and cultural permanence of our town, affirms Dr. Suárez.

We have held knowledge meetings with midwives, with traditional doctors, whose intervention is from a spiritual point of view, with palabreros, and with other traditional health agents who support us and reinforce community vigilance.

In order to guarantee access and continuity of care, we have bilingual transit houses with sentinel teams, which are vehicles adjusted to our territory that can reach both the desert and areas with other vegetation, which carry bilingual and nursing assistants, responsible for monitoring cases of public health pathologies, as well as the transfer of pregnant women so that they can complete their process in safe conditions at the institutional level.

We have, explains Dr. Beda Suárez, a micro-cultural team, responsible for outlining the differential elements incorporated in our care model, and for determining psychological and psychosocial factors of our affiliates through a strategic tele-assistance ally. We have, she says, an induced demand team, with a group of bilingual educational agents, with mobile units that allow access and continuity of services within the communities, due to the dispersion of the territory.

Challenges

Ruling T 302 of 2017 of the Constitutional Court establishes that La Guajira is an unconstitutional state of affairs because there is no guarantee of the right to health, water, or food security. Part of the challenges is to strengthen the intersectorality and to make an adequate and effective intervention of the social determinants of health. Other challenges are legal certainty, the problem-solving capacity of the network within the department, the role of the empowered citizen, the culture of care and self-care, the health of communities, and system resources. Everything accompanied by respect for social and cultural dynamics and our regulatory system. We want to carry out adequate health risk management, says Dr. Suárez,

Closing her intervention, Dr. Beda says that her EPSI is an institution that over the course of 21 years has strengthened processes of equity, gender, and all the people contribute to the health and well-being of the Wayúu people.

See presentation Watch video in Spanish

Citizenry participation: from theory to practice. The experience of the Fundación Rasa – Antioquia

Gustavo Campillo

President Fundación Rasa. Social Support Network of Antioquia

Business Administrator of the Pontifical Bolivarian University, President of the National Cancer Board

We can move from Primary Health Care to Population Actions towards Health

Gustavo Campillo begins his intervention by encouraging a reflection on what Primary Health Care can be. From the perspective of the Fundación RASA, *Red de Apoyo Social de Antioquia* (Social Support Network of Antioquia), he says, we believe that there is a prior legal, institutional legal conception within the health system. We believe that the definition of PHC, Primary Health Care, could even be changed for something more holistic, more complementary that could be Population Actions towards Health. Towards health in terms of well-being, says Campillo, and, from the perspective of Population Care, separate the concept of PHC from health interventions. Going one step further back does not mean going back, explains Dr. Gustavo, but to encompass in a more comprehensive way the intentionality of the actions of care of incidence on individual and collective health.

For us, the PHC has nothing to do with contracting models between insurers and providers of the first level of care. That is only one component and it is part of the universe that seeks a better well-being for the community.

PHC has to be seen from individuals as determining subjects of their own conditions

For us, from the Fundación Rasa, says Campillo, PHC has to be seen, from individuals, as determining subjects of their own conditions, integrating autonomy as a fundamental element in the actions that lead to a better or a bad state of the individuals. It is from there that logical tools are built for self-care processes that have references from the family environment, as the first social nucleus, and even in closed communities.

A family, for example, says Gustavo Campillo, can have a conception of what their health criteria is and, in fact, we see it in the diet of family groups. Food changes, from one house to another house, or within a neighborhood, or a town. For the decisions of these actions, it is necessary to have sufficient enlightenment, education, and information; they are part of what we call Population Health Actions.

PHC from education

Another factor that affects, explains Campillo, is the educational environment. From early childhood we have to address elements that allow us better social interaction, better individual development, better skills, and abilities to care for the body, the mind, and the environment, that is, the environment that surrounds us in order to have better living conditions.

PHC from the workplace

Another factor is the work environment that, somehow, we have not articulated to PHC either. We see it more from promotion and prevention. I believe, says Campillo, that we have a lot of opportunity to modify actions that allow us to articulate not only economic or financial resources, but also individual and collective abilities and human capacities to improve living conditions.

The construction of social network

The proposal is, from those particular views of the individual, the family, the educational environment, the work environment, to begin to build a social network, explains Campillo. We have seen two very beautiful experiences of the importance of the social network, which is not exclusive to an ethnic group or a race or a culture. The social network is the possibility of interacting in differences, to develop skills, and improve conditions and quality of life. It is about having, Campillo explains, a social construction that goes beyond health intervention and that allows individual and collective care of groups and micro-groups, and through that community network, gradually expanding the capacity

for action and the response capacity in better well-being towards localities, territories, even towards regions, wider territorial expansions which facilitate respect among our differences and to build collective strategies that can lead to interventions and impact that get better results.

Individual actions + collective actions

We have, says Campillo, elements in the country's health system, such as promotion and prevention actions, in charge of insurance, which are contracted and directed individually by risk management, which could be added without including additional costs to these group interventions of the communities, of the family groups, to have a better result in collective health and a lower cost. They can also include, explains Campillo, the collective intervention plans, financed from the territorial entities that are disjointed today from the promotion and prevention activities. We could, as the health secretary of Cauca has just shown, articulate promotion and prevention plans for individual actions with plans for collective interventions focused on specific populations. This could lead to greater and better results in the preservation of health and, therefore, in people's quality of life.

Social determinant factors

Undoubtedly, Gustavo Campillo explains, social determinant factors cannot be disjointed from population actions in search of an ideal state of health. We cannot talk about promotion and prevention, collective interventions or Primary Health Care when there is no drinking water, when there is educational violence, when there is bullying, or when there is no security. These elements make it necessary to articulate the processes between individuals and their collectives, and among the entire response capacity of the State.

We have very generous regulatory frameworks, but they are aimed at benefits and not at the capacities and abilities of individuals. At Fundación Rasa, says Campillo, we believe that having other strategies that add to these actions that have resources from legal life, are necessary and they are showing us, with the examples we have just seen, that they are absolutely successful.

The insurance that we have does not mean access and access does not necessarily mean benefits. Access means equity and equity is not only related to the provision of comprehensive or extra-mural services associated with health service providers.

The potential of participation spaces

Regarding the spaces for citizen participation, Campillo explains, we empower them, we try to make them exist, so that there is real and effective participation. The spaces for citizen participation in the health system are those that are directly related to the associations of users of the health service providers or the EPS, the community participation committees in health, COPACOS; the district, municipal, and departmental territorial health councils, among others.

But we have not involved other community actors that have an impact on a better state of health, for example, sports leagues, sport is health. Sports league leaders should be trained, informed, and empowered to transfer knowledge and information related to healthy lifestyle habits.

The ancestral knowledge

We have already seen in the experiences of Cauca and La Guajira how ancestral knowledge is a determining element in individual and collective self-care. This is fundamental and I believe that the risk managers of both insurers and providers do not involve these other actors in the response capacity to have Primary Health Care which, I insist, we should call it differently.

The participation of diverse population groups

Youth organizations, organizations for the elderly, are spaces that we have not strengthened, and that we could intervene in a positive way so that they join in the result that we have as a goal in the Colombian health system.

We have to do many things so that the perspective is not only interventionist from the point of view of care, but also from the inclusion of these population groups, to have a better approach to local realities and intervene in those decisions. I insist that the term should not be Primary Health Care, but Population Actions towards Health.

Watch video in Spanish

Panel
Innovative PHC Experiences in Colombia based on community participation

Jorge Sotelo Daza

Consultant in public health management processes, models and health systems
Secretariat of Health of the Department of Cauca

Beatriz Bohórquez Salinas

Manager ESE CXAYU'CE JXUT- Department of Cauca

Beda Margarita Suarez Aguilar

Wayúu woman of the Uriana caste. EPSI Manager Anas Wayúu- Department of La Guajira

Gustavo Campillo

President of the Fundación Rasa - Department of Antioquia

Moderator: Luis Gabriel Bernal

Member of the PHCPI and World Bank Facilitation Team, Professor at the School of Medicine and Health Sciences of the Universidad del Rosario in Bogotá..

Dr. Luis Gabriel Bernal, panel moderator, begins this part of the webinar, referring to the growing evidence on the benefits of community participation in the planning, development, and monitoring of Primary Care actions and services. The panelists answer questions from the audience.

The voice of community participation today is not heard as it should be

Dr. Jorge Sotelo Daza, from the Secretariat of Health of Cauca, answers the question about the definition of community participation. He says that social and community participation is a dynamic that exists in reality, and the health system must be able to link to that dynamic. In a certain way, he points out, participation in the health system has been stigmatized in some settings, and regardless of what the plans, programs and projects say, in the territories the concept of social and community participation has been considered as an element that must be included. However, the voice of community participation today is not heard in the broad framework of what it should be. If we look at participation as a broad process in the social field of health, where life is made, it broadens the concept of community participation so as not to make it instrumental, but to take from that essence, the elements that allow it to be effectively inserted as a way of assembling ways of caring for health. In this sense, community participation manages to link the possibilities that this community force has to achieve the highest possible level of health.

We provide water to communities despite the fact that we are not an institution with the responsibility of doing so

Dr. Beda Margarita Suárez, from the EPSI Anas Wayúu of La Guajira, answers the question: How, from an EPS, are actions in defense of the territory and access to water included? She says that in the work groups led by traditional authorities, the first thing is to listen to the traditional authorities' needs, expectations, and proposals on how they want the intervention to be carried out, respecting our regulatory system and social and cultural reality. Although, she says, we are an EPS, we have a strong social and cultural component. We have tank trucks for water supply. There are many communities that are in scattered rural areas. A schedule is drawn up so that everyone can, to the extent possible, access this liquid, which is a determinant that conditions the health of our Wayúu community. We provide water to communities, even though we are not an institution with the responsibility to do so. We do it because it is the mandate of our traditional authorities.

The Wayúu world is simple

When asked how the impact of community participatory action is measured, Dr. Beda Margarita of Anas Wayúu says that they use the indicators defined in Resolution 3280 of the Ministerio de Salud. We have seen the increase in institutional deliveries in safe conditions and this has strengthened the practices of midwives within the communities. It has also improved the relationship between delivery and caesarean section. They have allowed us to rely on traditional health agents to intervene in deliveries in a very young population. This has had an important effect and has contributed to the reduction of morbidity and mortality in the community.

To carry out a population characterization with a differential approach, says Dr. Beda, the participation of traditional authorities, leaders, educators, young people, and traditional health agents is important. They all have important elements so that the result is a model of Comprehensive and Intercultural Care in dignified and appropriate conditions that respect the social and cultural reality of the Wayúu people. Dr. Beda complements this by saying that they received support from the Universidad de Antioquia on issues of methodology and ethics. We have indicators, she explains, defined with our authorities based on the motto: *the Wayúu world is simple*. What we need to know is how the process is going, if fewer women are dying within the communities, if they are less complicated, if more children are attending the different programs and plans for the psychomotor development of minors. We have instruments in Spanish and in Wayúunaiki. For specific cases, we rely on the *Consejo Mayor de Palabreros* in the validation and construction of routes to intervene in the different situations that are part of the complex reality of health in the Wayúu people.

Effective listening has been strategic in Cauca

To the question about how they have carried out the dialogue of knowledge with the community for the appropriation of cultural practices of care that materialize in an adequate use in the health services of the ESE, Dr. Beatriz Bohórquez from the department of Cauca, answers that it has been built on effective listening which has been strategic to allow them to make contributions and feel empowered. The strategy is built by them. When we hear them, we help to shape it, but it is the citizens who guide the work that is going to be done. Obviously, explains Dr. Beatriz, there are limits and rules of the game. We tell them you have to comply with the minimum standards for patient qualification. What we do with the intercultural approach must be documented, socialized and it must demonstrate that there is adherence of health personnel and midwives. For example, there is a plant that we jointly agreed that we are not going to use in delivery care, it is the brevo. It is a plant that can have a harmful effect at the time of delivery care. The ancestors accepted it, the midwives also gave in, and

the health personnel remained calm because there are no unsafe practices. Everything is in a protocol. When there is evidence, the clinical management guidelines can be certified and they accept us to enable ourselves with an intercultural approach.

The value of learning to listen to our elders

Dr. Beatriz Bohórquez talks about the value of learning to listen to the elderly. They have their skills to guide the path of what to do and what not to do and what are the precise moments to act. Respect for knowledge is important. Although the view of the doctor who was trained to provide care with a western approach is important, we must also respect the midwife who, for many years, has been attending deliveries with her measures and strategies. It is simply a very participative sharing of knowledge, explains Dr. Beatriz. Listening and jointly building all our agreements with a great sense of belonging, that is the key to success, that all the actors feel involved, respected to maintain the strategy over time.

The first step is to defend the rights so that people do not get sick

When asked about the key factors to advocacy in health, Gustavo Campillo says that although PHC interventions are basic, they are cost-effective, they do not in themselves mean a reduction or containment of health spending. The first step, he points out, is not to defend the rights of sick people, but to defend rights so that people do not get sick. We must prevent sexually transmitted infections, almost all preventable. Some diseases, such as orphan ones, are not preventable because they have a genetic origin. We can focus spending, says Campillo, on fundamental needs and postpone the consumption of system resources for diseases that are controllable or preventable. When a person is in a disease condition, he must have a minimum requirement that the State must guarantee. They are opportunity, early diagnosis, completeness, continuity. A system like ours, clarifies Campillo, is very divided. What do we gain from doing PHC to ensure that a person does not get sick, if when they get sick, we do not care for them adequately and with lower expenses that lead us to consume what we save in PHC? Gustavo Campillo wonders. A comprehensive view of the system is required with the involvement of the individual, of their micro-communities, of their micro-environments, of the local, of the territorial, affirms Campillo. Guaranteeing the protection of the rights of people who are already affected and that we could have avoided is not an achievement, it is perhaps a failure, Gustavo Campillo ends by saying.

The Consejo Municipal de Medellín approved an agreement on the vital minimum of connectivity

On the role of social networks in participation in health, Gustavo Campillo says that virtuality today allows an important penetration to bring information, education, response capacity from the individual and the collective. However, he affirms, we have a very large problem of inequity in access to information technology. I do not know, for example, if there is a health application in the Wayúu language to give the example of Dr. Beda Margarita. And if we had it, do we have sufficiently robust connectivity to guarantee the continuity of that communication?

In Medellín, he says, something very interesting has just happened, the Municipal Council approved an agreement on the vital minimum of connectivity to allow access to computer networks, that is to reduce gaps. Nobody will be able to cut off the Internet. They will have to maintain a basic connectivity as a vital minimum. But do we have connectivity in all areas? That is the question. So, networks are very necessary in Primary Health Care to provide tools so that people can have self-determination that leads to self-care, but we need to close the communication gaps.

Watch video in Spanish