The role of Traditional and Alternative Healthcare Practitioners in building Reproductive Justice in Colombia

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Description:

Recent historic development and state of art: the use of tradicional medicine in the field of Sexual and Reproductive Health and the professional regulation of midwifes, doulas, "parteiras" (or similars).

Summary:

This pump-priming study, financed by the University of Birmingham (IGI), aims to develop a large-scale interdisciplinary research project on the regulation of traditional healing practices in the field of sexual and reproductive healthcare.

The preliminary research conducted by the PI Atina Krajewska and the Co-I, Calabria, revealed that during the COVID-19 pandemic traditional and complementary medicine (TCM) became particularly relevant in supporting healthcare systems across the world. In Brazil, Mexico, and Nicaragua, indigenous TCM practitioners shared knowledge of remedies historically used to treat respiratory diseases that partially mitigated the spread or effects of COVID-19 in their communities (UN 2022; Paudyal et al. 2022). In particular, Indigenous midwives redoubled their efforts to meet the growing demand for sexual and reproductive care delivered at home. The Office of the High Commissioner for Human Rights recognised traditional midwives as essential emergency personnel as early as at the start of the pandemic (OHCHR 2020). In 2022 the Colombian Constitutional Court found that the government has a duty to integrate indigenous midwifery, as a form of ancestral medicine, into the Social Security System (T-128/22). Other Latin American states have advanced similar policies (PHO 2021). And yet, significant challenges remain. According to the latest WHO Report on TCM (2019) lack of sufficient disaggregated research data, mechanisms to train and monitor TCM practitioners, and expertise within national health authorities as the main obstacles to good regulation and implementation of existing rules.

The project focuses on the role of the traditional midwives in building reproductive justice in societies experiencing intense pluralist tendencies and legal systems committed to legal pluralism. It focuses on Brazil, Colombia and Ghana as case studies. First, it aims to analyse the way in which **different belief systems and worldviews are protected (and integrated) in different healthcare systems in accordance with human rights standards**. Second, it aims to identify particularly **regulatory and implementation challenges in this respect**. The project aims to build collaborations between lawyers, anthropologists, and healthcare scientists.

Case study 2: Colombia

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1. Context

The main categories of traditional healthcare practitioners in sexual and reproductive health in Colombia are: traditional midwives, which comprise Indigenous and Afro-Colombian midwives; and urban midwives and doulas.

Midwives accompany pre-pregnancy, pregnancy and post-pregnancy and facilitate childbirth. Traditional midwives reportedly have an integral knowledge of the human body, nature and plants, which they use to treat common diseases as well (Niño, 2021, p. 18). As such, they exert important functions in their communities, to the point that they are considered "institutions of their territory, a factor of identity and union" (Niño, 2021, p. 18).

Doulas provide guidance and companionship during pregnancy, birth and post-partum, but as a rule do not perform labours. They are not considered agents of traditional medicine, but they do not fit the descriptions of alternative healthcare providers either. Their activity is not regulated as a profession or occupation, but seen as a practice.

Alternative healthcare relates to the practices of Chinese medicine, acupuncture, homeopathy and naturopathy (Article 19 of Law 1164/2007). Alternative medicine practitioners may consult about sexual and reproductive issues, but it is not a special focus of their work. For this reason, this report will not delve into this type of practitioner.[1]

In 2021, out of 616 914 registered births in Colombia, a total of 11 449 corresponded to people who had been attended by traditional midwives (DANE, 2023, p. 13).[2] That amounts to 1.85% of registered births, which coincides with the proportion of births attended at home (DANE, 2023, p. 45). Of these, 70.8% were of women who identified themselves as Indigenous, whereas 7.38% were of self-identified Afro-Colombian women (DANE, 2023, p. 36).

There might be a problem of sub-notification. The census methodology for the Afro-Colombian population is reputed to have led to sub-notification of population data for this group (Lara-Largo, 2022, p. 137). Still, the number of births by traditional midwives in 2021 was significantly higher than in the period between 2009 to 2018, which registered an average of 1% of total of births (DANE, 2023, p. 49). Part of this increase is attributed to reduced number of labours attended in hospitals during the Covid-19 pandemic (DANE, 2023).

Afro-Colombian midwives form a somewhat cohesive group, despite internal disputes (Colombia, 2017, p. 12). They have associations and networks, and **their traditional knowledge is recognised as intangible cultural heritage of Colombia** (Resolution 1077/2017 of the Ministry of Culture). Afro-Colombian communities are concentrated in the Pacific region, in the Departments of Nariño, Cauca, Valle del Cauca and Chocó, mostly in the latter, where the city of Buenaventura is located (Colombia, 2022c, p. 57).

The practices of Indigenous female or male midwives seem to be more diverse. In some groups the functions of midwife and general healer / herbalist are separated. Within an Indigenous group, the knowledge is shared and passed along orally. As it will be explained in this report, Indigenous communities have the right to self-organise their health system (Decree 1953/2014). This right was not extended to Afro-Colombian communities (Lara-Largo, 2022, p. 135)

Births attended by traditional midwives occur throughout the whole territory of the country, but the departments with higher proportion in 2021 were Chocó (28,09%), Amazonas (18,13/%)

1 For further information, refer to: (Aldana et al., 2021)

2 Labours attended by midwives that do not belong to traditional communities were not accounted for by the National Department of Statistics (DANE) in that dataset.

and Cauca (9,63%) (DANE 2023, p. 32). More than 90% of these births took place in rural areas, as the proportion in urban areas has been in decline since 2008 (DANE, 2023, p. 35).

Urban midwives and doulas constitute a smaller group. **They often receive instruction from traditional midwives, adapting them to the urban setting** (Niño, 2021, p. 26). Many of them are part of eco-feminist movements for sexual and reproductive health (Muñoz Cortes, 2022). They may or may not be of Indigenous or Afro-Colombian origin. **This group feels excluded from state protection, because they do not fit into the cultural heritage or ethnic diversity frameworks.** Moreover, they inhabit urban areas, where access to hospitals and doctors is not as difficult, which is a significant reason for home births in remote areas.

Box 1. Summary of midwifery in Colombia

Midwifery has the following characteristics:

i. It is an ancestral knowledge and an expression of the ethnic and cultural diversity of the Nation and therefore, intangible heritage of Colombians;

ii. It is exercised by men and women although it is a predominantly female practice, typical of Afro-descendant communities;

iii. Its main purpose is to accompany gestation, childbirth and the first days of the newborn; but midwives also provide health services, diagnosis and ancestral medicine to the communities; in fact, **in some remote places it is the only source of medical services**;

iv. It is a practice typical of geographically remote communities of the Colombian territory, particularly of the Pacific coast;

v. The geographical distance of the communities and their midwives coincides with places of conflict or violence that put their life and integrity at risk;

vi. Midwifery is practiced by other women who do not belong to Afro-Colombian communities, Indigenous women or women in cities or urban centres;

vii. Midwifery materializes the freedom of women to decide autonomously how to accompany their pregnancy, childbirth and the first days of their baby;

viii. Midwifery guarantees the sexual and reproductive rights of these women, through sexual education, family planning, accompaniment during childbirth and the first days of the baby's life;

ix. It is generally a free activity, which implies an economic risk for those who practice it, since it is also difficult to charge for their services because their users do not have the resources to pay for them; and

x. They suffer from stigmatization and rejection, due to the lack of recognition by the State and the Social Security Health System.

Source: Constitutional Court of Colombia (2022c, p. 59).

2. Literature review

The literature on traditional and alternative healthcare practitioners in Colombia involves three main fields of investigation: health and biology; anthropology and cultural studies; and law and regulation. Paula Giedelman published an extensive literature review of traditional medicine in

Colombia, with a focus on health, ethnobotany and health anthropology (2020, pp. 41–51). The field of law and regulation was not explored in her scooping review.

In the **field of health**, we found that research is concerned with compiling and understanding practices of traditional and alternative medicine and their relation with conventional, mainstream medicine[3] (Sousa, Guimarães and Gallego-Perez, 2021). It also investigates the public health system of Colombia, notably in what regards the need to promote intercultural[4] dialogues around health and differentiated routes for primary care attention of traditional peoples (Guarín *et al.*, 2013; León, Roa and Pabón, 2020; Vanegas Moreno, 2021; Muñoz-Zapata and Ariza Sosa, 2022).

The literature on **anthropology and cultural studies** adopts an ethnographic approach to collect traditional medicine practices across different Indigenous or Afro-Colombian communities (Duarte, 2019; Ramos Lafont, Campos Casarrubia and Bula Romero, 2019; Rosas Riaño, 2021). Sara Duarte (2019) analyses the oral transmission of the knowledges associated to traditional midwifery in the city of Buenaventura. Diana Rosas Riaño (2021) discusses the social effects of giving birth and having periods among Indigenous women of Miritíi-Paraná. Ramos Lafont and colleagues examine the cultural practices of Indigenous pregnant women in the Zenu Reserve, Department of Córdoba (Ramos Lafont, Campos Casarrubia and Bula Romero, 2019).

In addition, there is a body of work concerned with **cultural heritage**, notably since the knowledges associated to Afro-Colombian midwifery in the Pacific Region have been declared intangible cultural heritage of Colombia in 2017 (Niño, 2021). Elisabeth Salazar Niño (2021) gives an account of how the traditional knowledge of Afro-Colombian midwifery has been passed on to students in urban areas, notably in Bogotá, and how these students, once they become midwives themselves, incorporate this knowledge into their practices, despite not belonging to an ethnic minority.

In the field of **law and regulation**, the list of published materials is shorter, and most of the works are Senior, Master's or PhD theses that can be found online. In terms of articles in peer-reviewed journals, Sofía Lara-Largo published an overview of the challenges in health access among Afro-Colombians (Lara-Largo, 2022). Jaime Urrego-Rodríguez (2020) provides a historical account of the Indigenous movement's claim to organise their own health systems. Carvajal Barona and colleagues give an overview of the challenges associated to traditional midwifery in Latin America (Carvajal Barona *et al.*, 2018). For Colombia, they found that the health system does not support midwives as qualified health agents, but that they are seen as local actors capable of sharing information and raising awareness about maternal health (Carvajal Barona *et al.*, 2018, pp. 11–12).

Regarding unpublished theses in law, we can mention some relevant works. Palma and Guerrero give an account of the legal development of midwifery in Colombia (2020). Dunen Izquierdo, an Indigenous researcher, comments on the legal perspectives brought about traditional knowledge on sexual and reproductive health among the Iku women (2018). Patricia Payares discusses knowledge disputes in the institutionalisation of birth in Colombia (2008).

[3] Throughout this report, the terms "biomedicine", "conventional medicine", "mainstream medicine" and "Western medicine" are used interchangeably.

[4] The term "intercultural" refers to the dialogue and coordination between formal (biomedical) midwifery and traditional midwifery (Izquierdo, 2018, p. 21).

3. Law

3.1. Health and ethnic diversity

The Colombian Constitution of 1991 recognises and ensures protection to the ethnic diversity of the country (Articles 7, 8 and 70). With this provision, it is understood that Colombia is a pluralist, multi-ethnic state (Aldana *et al.*, 2021).

The Law 21/1991 ratified the International Labour Organisation's Convention 169, which establishes, among others, the right of Indigenous Peoples and Traditional Communities to Prior, Informed and Free Consent over policies and regulations that affect their traditional ways of life. Colombia has developed mechanisms of prior consultation in the elaboration of national policies, such as the Decennial Health Plan (Colombia, 2022c, p. 15). Importantly, the Peace Agreement of 2016 has a dedicated ethnic chapter, which was co-constructed with ethnic communities.

The Constitution states that health is an essential public service (Articles 48 and 49), and grants sexual and reproductive rights (Articles 16, 42 and 43). The jurisprudence of the Constitutional Court has established that health has a double connotation: it is at the same time a fundamental right and a mandatory essential public service (Colombia, 2022c, p. 60). The Law 1751/2015 reiterates that health is a fundamental right of its own, autonomous and irrevocable (Article 2). This provision was considered constitutional by the Court in preventive control of constitutionality (Colombia, 2014).

This same Law established that the right to health must obey the principles of interculturality and of protection to Indigenous and traditional communities (Article 6, "i" and "n" of Law 1751/2015). To that effect, the State shall build mechanisms to integrate cultural diversity in health, through the recognition of traditional, alternative and complementary knowledges associated to health (Article 6, "i" of Law 1751/2015). Furthermore, the State recognises the right of Indigenous Peoples to develop their own health systems, notably via the SISPI (Article 6, "m" of Law 1751/2015) (Section 5.4).

Another norm of reference in the field of health is the Law 1438/2011, which regulates the General System of Social Security in Health (SGSSS) and modifies the health service.[5] One of the principles of the SGSSS is the "differential focus" (*enfoque diferencial*), according to which populations with particular characteristics in reason of age, gender, ethnicity, disability or victim status will receive special guarantees and provisions in terms of health. Other norms, decrees and resolutions pertaining the implementation of health policies will be further discussed in the sections below and also in Section 5, about public policy.

3.2. Human Resources in Health

Law 1164/2007 – the Law of Human Resources in Health – establishes that health professions are those with the competencies to promote, prevent, treat, rehabilitate and alleviate health conditions, while occupations relate to the activities that support and complement healthcare activities (Article 18). To exert professions and occupations, one must have academic credentials accredited by a high education institution, except for auxiliary personnel, who can obtain a certificate from a non-formal, legally recognised institution (Article 18).

[5] For an analysis of the SGSSS in relation to alternative and traditional medicine, see: (Aldana *et al.*, 2021).

When referring to traditional medicine, Law 1164/2007 does not use the words "profession" or "occupation" but refers to "practice". This means that traditional medicine can be exerted without a diploma or certificate, by those recognised as such by their own communities, **according to their own mechanisms of social regulation** (Article 20). Akin to professions and occupations, nonetheless, they must be registered in the National System of Human Resources in Health. Article 20 is as follows:

> Article 20. On the practice of traditional medicine
> In accordance with Articles 7 and 8 of the Political Constitution, respect for the traditional medical cultures of the various ethnic groups shall be guaranteed, which may only be practiced by those who are recognized in each of their cultures according to their own mechanisms of social regulation.
> The personnel referred to in this article shall be certified by registration in the National Registry of Human Resources in Health and shall be granted the unique identification. Likewise, the National Government will establish surveillance and control mechanisms for the exercise of practices based on traditional medical cultures. (Colombia, 2007).

The mentioned "surveillance and control mechanisms" for the exercise of these practices 20 have not been established to our knowledge. Section 5.1 will further discuss the regulation of traditional medicine practices in the Human Resources framework.

3.3. Humanised Childbirth

In 2022, the Law of Dignified, Respected and Humanised Childbirth was enacted (Law 2244). It establishes that all women in the process of pregnancy, childbirth and post-partum have, among others, the rights to (Article 4):

- receive comprehensive, adequate, accurate, truthful, timely and efficient care, in accordance with their customs, values, beliefs and health condition.
- have assertive communication with health care providers through the use of a clear, easy to understand, relevant, accessible and timely language according to their ethnic, cultural, social and functional diversity customs.
- be accompanied, if the woman so desires, by at least one person of her choice and trust during the process of gestation, labour, delivery and postpartum, or, failing that, by a person specially trained to provide emotional support. Under no circumstances may a fee be charged to make use of this right.[6]

The Law has a specific article about cultural pluralism (Article 10), according to which "the cultural pluralism related to women and newborns must be recognized and respected, guaranteeing with scientific evidence their life, dignity, integrity and health, before, during and after childbirth" (Colombia, 2022). In a sense, the Law seeks to promote cultural practices related to childbirth as long as they are also considered safe according to scientific standards.

[6] Some of these provisions had been foreseen in the Resolution 3280/2018 of the Ministry of Health (Niño, 2021, p. 11).

To that effect, the Law 2244/2022 states that health agents should receive interdisciplinary and ethical training and take interculturality into consideration within the processes of care (Article 6). It further establishes that the State "shall train midwives and support the already existing traditional midwifery training processes" (Article 11). Moreover, the State shall develop strategies to enhance the quality and technique of the art of midwifery and to ensure that high-risk pregnancies are redirected to **specialised** health professionals (Article 11). This means that, while midwifery will be promoted as a practice of its own quality, midwives should be able to work i**n tandem with** specialised health institutions.

4. Jurisprudence

The Constitutional Court of Colombia has advanced in the recognition of rights of ethnic communities in what relates to health and traditional medicine. As happens with constitutional courts elsewhere, such advancements have been reactive and case-specific, amounting to a fragmented recognition of rights. At the same time, there have been structural injunctive remedies, such as the T-357 of 2017, which mandated the elaboration of plans and provision of health assistance to 255 Indigenous communities in Vaupés. In all, the **Court enacted decisions that have had or will have a direct, positive impact in public policy,** such as the recent T-128 of 2022, which mandated the State to include traditional midwives in the General System of Social Security in Health for receiving financial assistance during the Covid-19 health emergency. The most important cases are compiled in the table below.

Table 1. Key jurisprudence of the Constitutional Court

Case	Conclusion
T-760 (2008)	The dimension of "acceptability" in health means that health services and establishments must respect the culture of different people and communities. It involves two aspects: i) the creation of the Indigenous health system (SISPI); and ii) the respect for Indigenous customs and beliefs in existing public health services.
C-942 (2009)	Conditional application of the article 20 of Law 1164/2007, according to which **no certificate or diploma can be demanded in the exercise of traditional medicine, including midwifery, by those who have been authorised by their own communities to do so**.
C-882 (2011) and T-485 (2015)	Ethnic communities have the right to produce and employ traditional medicaments and keep their medicinal plants, animals and minerals.
C-313 (2014)	Preventive control of constitutionality of Article 2 of Law 1751/2015, according to which **health is a fundamental right of its own, autonomous and irrefutable.**
T-357 (2017)	Structural injunctive remedy regarding the implementation of the right to health in 255 Indigenous communities in the Vaupés Department.

T-128 (2022c)	Midwives that belong to the associations ASOPARUPA and ASOREDIPAR CHOCÓ must be included in the General System of Social Security in Health (SGSSS) for the purpose of receiving the financial assistance related to the Covid-19 health emergency (Article 11 of Legislative Decree 538/2020). The **Ministry of Health shall abstain from imposing education or training requirements that resemble those of allopathic medicine in order to allow their integration into the SGSSS**.

Sources: T-357 of 2017 and T-128 of 2022.

5. Public policy

In the National Development Plan (PND) 2018-2022, there are 20 agreements ("acuerdos") related to Indigenous health. The government must report yearly on their progress, as well as on the other agreements related to Indigenous issues (Article 219 of Law 1955/2019, of the PND 2018-2022). The report published in 2022 by the Ministry of Health and Social Protection specifies the percentage of progress in the indicators associated to each one of the 20 agreements. Many of them relate to the Indigenous Health System (SISPI), which is the topic of Section 5.4. Two others pertain to gender violence (A12 and A30) and one to sexual and reproductive health and traditional Indigenous midwifery (A28) (Colombia, 2022a, pp. 2–3). The latter is as follows:

Table 2. PND Agreement: sexual and reproductive rights of Indigenous women

Agreement	Indicator	Description	Progress
A28. Agree upon and develop culturally relevant actions in coordination with the National Commission of Indigenous Women (CNMI) and the Health Subcommission of the MPC, for the promotion of sexual and reproductive rights of the Indigenous population. As part of the integral construction of the SISPI, **priority will be given to traditional Indigenous midwifery.**	6393	Methodological route defined with the Health Subcommission and the CNMI	Achieved (Agreement 726 of 2019 between ONIC and Health Ministry)
	6394	% of achievement of actions of the methodological route	10% of the goal for 2021 was achieved

Note: ONIC is the National Indigenous Organisation of Colombia and Indigenous MPC is the Indigenous Permanent Roundtable of Negotiation.

Source: *Informe Población Indígena* (Colombia, 2022a).

We could not find the content of the Agreement 726 online, nor further reference as to where the parameters to measure progress on the indicators have been established.

5.1. Progressive integration of midwifery into the health system

As mentioned above, the Law 1164/2007, of Human Resources in Health, establishes a difference between health professions and occupations. The subsequent regulations related to this Law, which are the National Policy of Human Resources in Health (2018) and the National Policy of

Human Resources in Infirmary (2022b), state that the health system should progressively integrate traditional and alternative medicines. Notably, one of the objectives of the National Policy of Human Resources in Health is the "progressive integration of traditional and alternative medicine into the health system" (Specific Objective 7) (2018, p. 57). It mentions the following:

> Traditional medical cultures and alternative and complementary medicines and therapies are a reality that must be adequately integrated into the Health System. For this, it is necessary to **organize their training, integrating them to the Quality Assurance Systems of Health and Education**.
> Of special interest is the regulation of the practice of traditional midwifery in Indigenous and Afro-descendant communities (Colombia, 2018, p. 57).

It appears that the so-called regulation of the practice of traditional midwifery has not yet been enacted. So far, the emphasis has lied on capacity development, as it can be noted in the indicators of the Specific Objective 7 (Table 3). The regulation, the study and the means to measure progress in the indicators could not be found online.

Table 3. Indicators for integration of traditional and alternative medicine

Indicator	2020	2025	2030
Harmonization of the training and practice of alternative medicines and therapies.	Regulation enacted		
Study about alternative medicine in Colombia	Concluded		
Health programmes with intercultural focus	30%	70%	100%
Capacity development of traditional midwives (Indigenous and Afro-descendent)	>50%	>70%	>80%

Source: (Colombia, 2018, p. 58)

Capacity-development has been criticised for being unilateral, that is, for passing along knowledge of conventional medicine while neglecting the importance of doctors and nurses learning from traditional midwives (Izquierdo, 2018, p. 15). At the same time, training does not constitute a pre-requisite for them to exert their practices (Article 20 of Law 1164/2007) (Colombia, 2009, 2022c). This goes in hand with the principle of autonomy of ethnic communities enshrined in the Constitution.

The National Policy of Human Resources in Infirmary (2022b) has five guiding policy approaches: **gender; interculturality; rights; humanised care; and territory.** The intercultural and territorial approaches recognise that Colombia is a multicultural state with regional inequalities, and that conditions should be granted for the equal development of the profession in different territories and across cultural particularities. The Strategic Plan 2022-2031 annex to the National Policy of Human Resources in Infirmary, however, does not contain any actions related to promoting an intercultural and regionally sensitive approach to the development of infirmary as a profession.

5.2. Birth certification policy

In 2021, the National Department of Statistics (DANE) and the National Civil Registry Office issued a joint resolution authorizing the members of the Association of Midwives of the Chocó department (ASOREDIPARCHOCO) to certify births to which they attended, by using the form "Notification of Birth for People Belonging to Ethnic Groups" (Resolution 3676 of April 26, 2021).

This resolution was an important novelty in the system. As per article 49 of the Decree 1260/1970, only doctors or nurses could certify births for the purposes of civil registry (DANE, 2023, p. 15). In 2017, a modifying decree allowed certificates issued by midwives to be accounted for when registering extemporaneous births (article 2.2.6 12.3.1 of Decree 1069/2015, modified by Decree 356/2017) (DANE, 2023, p. 16). Still, the claim to be able to certify births for the normal registry procedure was a common complaint amongst traditional midwives, which felt neglected and disrespected by this forbiddance (Colombia, 2017, p. 10; Duarte, 2019, p. 31).

Since the resolution was expedited, the DANE has been offering training sessions to midwives on how to fill in the forms, with the support of the UNFPA, via the project "Partera Vital" (Box 2). In the Chocó department, 73,3% of the 318 traditional midwives have had access to the form, while 60,87% attended training sessions for the purpose of learning how to use it (DANE, 2023, p. 44).

The form was intended to bring standardization and increase acceptancy rates in civil registry offices. So far, there have been problems in a minority of cases. Some civil registry offices have not been accepting it, either by lack of knowledge of the Resolution or unwillingness to do so (DANE, 2023, p. 44). This suggests that the DANE and the National Office of Civil Registry should also make efforts to raise awareness and share information among local civil registry offices as well.

5.3. Ethnic route in health services delivery

In the past years, the Ministry of Health has issued resolutions pertaining the so-called "ethnic route" in service delivery. The "ethnic route" translates into paying special regard to the needs and specificities of ethnic groups as recipients of public health (Colombia, 2022c, p. 15). It means that public health providers must take into consideration, for service delivery, the traditional knowledges and practices of traditional communities (Article 21 of Law 691/2001).

According to the Resolution 3280/2018 of the Ministry of Health, there should be a special route for prenatal and maternity care of ethnic women, with the purpose of articulating traditional knowledges of midwifery with conventional medicine (6.2.1 of Annex 2). In particular, traditional midwives are trained by health agents to learn how to identify risks and how to guarantee aseptic and sanitary conditions during birth. They may elaborate a birth plan together with health agents, to determine, for instance, the conditions under which the labour may occur at home or in the hospital.

This process is not without **tensions**. Midwives complain that, after being trained, they do not receive any financial support to purchase the disposable materials that they were taught to use, such as gloves and, during the Covid-19 pandemic, masks. Moreover, they say that some of the practices discouraged in training are deeply rooted in their traditions, for instance, the one of using sand to collect blood during birth (OPS/OMS *et al.*, 2018, p. 21).

Resolution 2626/2019 of the Ministry of Health, which adopts the Model of Comprehensive Territorial Action (MAITE), foresees among its lines of action a differentiated route for ethnic communities, which recognises their particular needs and beliefs. A principle of MAITE is that health should be accessible to all, regardless of income and location, even if in remote and isolated areas (Vanegas Moreno, 2021, p. 18). Notably, the ethnic route of MAITE foresees that "new profiles"

should be recruited in health, including midwives and community leaders, as part of a continuous process of integration and capacity-building (Vanegas Moreno, 2021, p. 18).

The Ministry of Health identified the reduction of maternal mortality as one of the areas where the country is lagging behind. It then devised a National Plan for Reduction of Maternal Mortality (Colombia, 2023). Strengthening social and community networks around sexual and reproductive health **with an intercultural perspective** is one of the six pillars of the Plan's strategy (Colombia, 2023, p. 4). The actions proposed to strengthen such networks are to establish "roundtables of knowledge exchange" and to develop communication strategies with an intercultural perspective (Colombia, 2023, p. 5). There is nothing specific in the Plan about midwifery.

5.4. Own service delivery

As highlighted by the Constitutional Court (Colombia, 2008), health being culturally acceptable means that: i) cultural diversity should be respected in service delivery, and ii) Indigenous communities have the right to their own health system (Article 329 of Constitution, Law 169/2001 and Article 6, "m" of Law 1751/2015). This latter dimension was object of regulation in the Decree 1953/2014, which creates a special regimen for Indigenous territories to put in place their own health, education and justice systems.

Notably, the Decree 1953/2014 created the figure of the Indigenous System of Intercultural Health (*Sistema Indígena de Salud Propio Intercultural* – SISPI) (Articles 77 to 88). The SISPI is a special regimen of health services created by and for Indigenous Territories. Each Indigenous group organised in a territory can design how health services will be provided through their SISPI (Article 81). The system is intended to be articulated with and complementary to the SGSSS, and to function under the guidance of the Ministry of Health and Social Protection. SISPIs will be implemented progressively, according to the initiative of each Indigenous territory (Article 88). While an Indigenous territory does not have a SISPI, health services are provided by the SGSSS in the already existing institutions (Article 88) (Section 5.3 above).

In 2016, the Ministry of Health published the "Methodological Guide for the Construction of the Contents of the Components and Implementation of SISPI". It is a result of debates held in the Health Subcommission of the Indigenous Permanent Roundtable of Negotiation (Decree 1973/2013). The Guide establishes three subsequent stages for the creation of a SISPI (Colombia, 2016):

A. Diagnostic of the Indigenous group in what relates to: sociocultural aspects; demography; territory; conception of health and well-being (*bien vivir)*; health conditions and risks; human resources; physical infrastructure for health; status of information systems; network of public services; and status of registry in the SGSSS;
B. Action Plan: building an action plan encompassing the five elements of SISPI, which are: ancestral knowledge; political-organizational; knowledge building; own intercultural healthcare; and administration and management (Article 77 of Decree 1953/2014);
C. Coordination and articulation for implementation: to establish agreements for financing and implementation of the SISPI.

According to the progress report of the National Development Plan 2018-2022, the indicator associated to "guaranteeing the own, intercultural health provision for Indigenous Peoples, financed and progressively implemented while the SISPI is regulated" (F18) is the percentage of financed Indigenous Health Systems (Colombia, 2022a, p. 3). The indicator has reportedly been met, since funds have been directed to Indigenous groups in different stages of development (Colombia, 2022a, pp. 14–15).

To our knowledge there is no publicly available data on the number of SISPIs that have been created so far. Regardless of the status of SISPI creation, some Indigenous groups already have their own health institutions (*Instuciones Prestadoras de Salud Indígena* – IPSI). To illustrate, for the provision of health services, the Misak people, of 16 000 inhabitants, has two IPSI in their territory, besides one Social Company of the State (*Empresa Social del Estado* – ESE) (OPS/OMS *et al.*, 2018, p. 10). The Misak IPSI's programmes of maternal and child health count with midwives and traditional doctors, who can prescribe traditional medicines based on herbs and perform home labours and vertical labours (OPS/OMS *et al.*, 2018, p. 11).

5.5. Cultural heritage

The Ministry of Culture included the knowledge associated to the traditional midwifery of the Pacific Region in the Representative List of Intangible Cultural Heritage of Colombia and approved its Special Protection Plan (*Plan Especial de Salvaguardia – PES*) in April 25 of 2017 (Resolution 1077). The Special Protection Plan is designed for the purposes of maintaining, promoting and strengthening the cultural manifestation to which it refers (Niño, 2021, p. 14).

According to the Resolution, the knowledge of the Afro-Pacific midwifery composes a "system of practices and techniques involving the care with the body and the use of plants, which was developed mostly by women of the Pacific region to attend to the female reproductive cycle and diagnose and treat diseases in the communities in general" (Colombia, 2017, p. 3). The Resolution further explains the elements of this system of knowledge, such as oral transmission, the protagonist role of women, the connections with the territory, and the fortification of community ties.

The Special Protection Plan was developed by the Association of United Midwives of the Pacific (ASOPARUPA). The Plan compiles challenges related to the practice of midwifery and presents six lines of action, which are: institutional strengthening; intersectoral cooperation; knowledge transmission; grassroots work; entrepreneurship and social economy; and communication strategy.

The Plan created the Protection Council (*Consejo de Salvaguardia*), which is charge of coordinating its implementation across the four Departments of the Pacific Region. The Protection Council handles institutional dialogue within and outside the midwifery network. The Plan will be monitored twice a year and revised every five years. Since it dates from 2017, it was supposed to be reviewed in 2022, but no information regarding a revision process could be found online.

6. Relevant institutions

The main governmental actors are the Ministry of Health and Social Protection, the Ministry of Culture and the Department of National Statistics (DANE). The Ministry of Culture oversees the implementation of Special Protection Plans, including the one of Afro-Colombian Midwifery.

The Ministry of Health manages the public health system and oversees the councils of the different professions. Within the National Council of Health Professionals, there are six committees,

among which the Committee of Alternative Medicine and the Committee of Traditional Medicine (Article 7 of Law 1164/2007).

The Department of National Statistics generates data on population, health and birth rates and produces reports with special focus on Indigenous and Afro-Colombian groups. Moreover, it coordinates the project on midwifery statistics called "Partera Vital", which is funded by the United National Populations Fund (UNFPA) and the Spanish Agency of International Cooperation for Development (AECID) (Box 2).

Box 2. "Partera Vital" Project: Phase 2

In 2022, the United Nations Population Fund (UNFPA), in collaboration with the Spanish Cooperation (Agencia Española de Cooperación Internacional para el Desarrollo - AECID) and with the support of the National Administrative Department of Statistics (DANE), launched the second phase of the "Partera Vital" project.

Its aim is to further enhance the collaboration between UNFPA, ASOREDIPAR CHOCÓ (Association of the Interethnic Network of Midwives of Chocó), and ASOPARUPA (Association of United Midwives of the Pacific) to advance sexual and reproductive rights in the Pacific Region. By fostering partnerships and synergies among various stakeholders, the project seeks to guarantee rights for all individuals, particularly those facing barriers to accessing services and those who reside in remote areas.

During the first phase of the project, launched in 2020, a notable achievement was the integration of traditional midwives from Chocó into statistical and registration systems. This step facilitated the completion of live birth forms by midwives. It was enabled by the Resolution 3676/2021 of DANE.

Source: https://colombia.unfpa.org/es/news/comienza-segunda-fase-de-partera-vital-en-choco

In terms of Indigenous institutions, we can highlight: the National Indigenous Organisation of Colombia (ONIC), the National Commission of Indigenous Women (CNMI) and the Health Subcommission of the Indigenous Permanent Roundtable of Negotiation (Decree 1973/2013). These three organisations were mentioned in the 2022 progress report on Indigenous health of the National Development Plan (Colombia, 2022a, p. 3). Their objective is to contribute to the design and implementation of health policies to Indigenous Peoples, under the framework of operationalisation of the SISPI.

Relevant research institutions are the Interdisciplinary Centre of Development Studies (CIDER) at the University of Andes and the National University of Colombia. The CIDER, through the researchers Diana Ojeda and Jenny Muñoz, intervened in the process T-128/2022 of the Constitutional Court.

There are several social movements and associations dedicated to the topics of sexual and reproductive health and rights and traditional midwifery in Colombia. Table 4 compiles some of the key organisations that have been active in the past years.

Table 4. List of civil society organisations and midwifery associations

Organisation	Scope	Website

National Movement for Sexual and Reproductive Health in Colombia	Country-wide umbrella organisation	https://www.movimientossr.com/
National Federation of Traditional Midwives of Colombia	Umbrella organisation of the Pacific Region created in 2023. Gathers 6 grassroots organisations: ASOREDIPARCHOCO; ASOPARUPA; La Cigueña; and associations of midwives of the Telembi sub-region of Nariño, of the Sanquianga sub-region of Nariño and of the Timbiqui municipality in Cauca.	http://www.parterastradicionalescolombia.org/inicio/
ASOREDIPAR CHOCÓ	Association of the interethnic network of midwives of the Chocó Department. Focus of phase 2 of "Partera Vital" project (DANE/ UNFPA).	https://www.instagram.com/rediparchoco/?hl=en
ASOPARUPA	Association of midwives of the Pacific Region. Led the draft of the Special Protection Plan of Traditional Midwifery (2017). Focus of phase 2 of "Partera Vital" project (DANE/UNFPA).	https://www.instagram.com/asoparupa/?hl=en
La Cigüeña Midwifery Association	Association of midwives of the municipality of Tumaco (Nariño). Mentioned in the PES (2017).	N/A
APARIR	Association of doulas in the city of Cali (Valle del Cauca).	https://asociacionparir.org/
Colombian Network Birth in Peace (Red Colombiana Parir en Paz)	Program of the Infirmary School of the University of Cauca to consolidate academic and scientific knowledge and establish networks.	N/A

Note: Muñoz Cortes (2022) notices that within the Movement for Sexual and Reproductive Health there is a group called "Las bien paridas".

7. Challenges

The main challenges related to midwifery and doulas in Colombia relate to the **fragmented nature of protection, the tensions between traditional and conventional medicine, the lack of financial compensation, the difficulty in keeping traditions alive, and regulatory barriers to practice**.

Furthermore, it seems that policy implementation levels are low, and that the proliferation of legal instruments – plans, action plans, methodological guides, special routes and the such – is not followed by action. Monitoring often refers to progress in the elaboration of new legal instruments to guide action rather than progress in the activities and projects themselves, as noticed in the case of the Indigenous health agreements of the National Development Plan 2018-2022 (Colombia, 2022a).

7.1. Fragmented regimes of protection

As seen throughout this report, Indigenous midwives, Afro-Colombian midwives, and urban midwives and doulas each have different frameworks of protection to their practice. Indigenous groups can create and operate their own health systems, but not Afro-Colombian communities (Colombia, 2014; Lara-Largo, 2022, p. 135). Afro-Colombian midwives of the Pacific enjoy special protection under the cultural heritage framework, which does not apply to Indigenous midwives. Urban midwives and doulas operate in a legal limbo, whereby their activities are not forbidden, yet at the same time they are not promoted or recognised. In all, these groups have different claims and position themselves differently before the legal system.

7.2. Midwifery as a practice

Midwives exert a practice, not a health profession or occupation (Duarte, 2019, p. 31; Palma and Guerrero, 2020, p. 98; DANE, 2023, p. 13). Midwifery was once recognised as a health profession in Colombia, as assistants to nurses (Payares, 2008, p. 63). In 1991, the Decree 2759 recognised midwives as community agents with specific functions (Payares, 2008, p. 71). Yet, in the Conpes Document 91 of 2015, it is said that midwives do not correspond to international standards of qualified personnel in health (Payares, 2008, p. 72). As of today, the practice of midwifery is not properly regulated.

There is no diploma or higher education degree on midwifery. On the one side, this goes in line with Article 20 of Law 1164/2017 and case law of the Constitutional Court (C-942/2009 and T-128/2022), according to which traditional midwives cannot be demanded any certificate or diploma to exercise their practice. As per the constitutional principle of ethnic autonomy, ethnic communities have the right to regulate who can exert health-related occupations amongst themselves.

On the other side, urban midwives and doulas wished to be recognised as health agents (Muñoz Cortes, 2022, p. 19). This claim departs from a need for greater social recognition and improved financial compensation. Without a diploma or certificate, they cannot officially be part of the human resources in health, in terms of the Law 1164/2017. They also feel excluded from consultation processes on matters of health led by the government, which tend to focus on traditional midwifery (Muñoz Cortes, 2022, p. 21).

In conclusion, in Colombia, "midwifery enjoys legal recognition as a traditional knowledge, associated to the protection of culture and the right to diversity, but not as a legitimate health practice and even less so as revindication and exercise of sexual and reproductive rights" (Izquierdo, 2018, p. 43).

7.3. Regulatory barriers to practice

The literature identified two important regulatory barriers to practice: doulas and midwives not being able to accompany women into the hospital during labour (OPS/OMS *et al.*, 2018, p. 13; Duarte, 2019, p. 31); and midwives not being able to certify births, which was considered denigrating (Colombia, 2017, p. 10; Duarte, 2019, p. 31).

However, two recent regulatory changes might change this scenario. One is the Law 1422/2022, which grants women the right to be accompanied by a person of choice during labour (Article 4). Regarding the other barrier, in 2021 the National Department of Statistics (DANE) issued a joint Resolution with the Civil Registry Office allowing Afro-Colombian midwives to certify

newborns for the purposes of civil registry, as long as they are affiliated to an association in Chocó and fulfil the specific form (Resolution 3676/2021). It remains to be seen how these changes will affect practice.

7.4. Financial sustainability

Traditional midwives do not necessarily receive financial compensation for their work (Lara-Largo, 2022, p. 136). They help when asked, mostly by low-income people, and also carry out community-oriented work (Duarte, 2019, p. 29). They may receive payments in natura, such as food items. As part of the Special Protection Plan's line of action on social economy, the ASOPARUPA association is envisioning new sources of income for midwives, by selling herbs, natural products and even travel packages. Urban midwives and doulas typically charge for their services but their gains remain small.

7.5. Training and intercultural dialogue

Traditional midwives sometimes receive training in hygiene and sterilisation for childbirth and in health risks associated to pregnancy. Many midwives consider capacity-development sessions as an opportunity to enrich their knowledge and increase the safety of procedures. For instance, in a research conducted with 25 female and male midwives of the Wayuu People, all of them answered that they would like to receive specialised training (OPS/OMS *et al.*, 2018, p. 17). Others, however, fear that training would jeopardise what is traditional in their practice (Izquierdo, 2018, p. 15). To them, the unilateral nature of these training sessions implies a hierarchically superior position of Western medicine, which they reject (Izquierdo, 2018, p. 15).

7.6. Keeping traditions alive

There has been little interest of new generations in learning the knowledges associated to traditional midwifery, whose transmission is mostly oral (Colombia, 2017, p. 11). Another difficulty in maintaining traditions is the loss of natural ecosystems due to forced migration. The armed conflicted intensified rural-urban migration patterns in the Pacific region, and midwives have lost access to the plants and herbs of their territories of origin (Colombia, 2017, p. 16). There have been efforts, however, to start collective gardens and street gardens.

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