

HEALTH EQUITY AND ETHNIC MINORITIES IN EMERGENCY SITUATIONS

EXPERIMENTS IN COLOMBIA ON INTERSECTORAL ACTION WITH A DIFFERENTIAL APPROACH TO ETHNIC COMMUNITIES

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ABSTRACT

This case study is a detailed presentation of two experiments in intersectoral action, one focused on public policy and the other with a differential approach to ethnic groups. Both experiments were developed by the delegation of the Pan American Health Organization / World Health Organization in Colombia. First, the topic of initiatives and the context in which they have been developed is presented. Then in the following sections, the experiments, their participants and their mechanisms are presented. In the final part, we present the results and the lessons learned.

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1. APPROACH

The case study presented below is a record of the recent experiments of the Pan American Health Organization / World Health Organization in Colombia on the development of intersectoral action, applying a broad approach to public policy and a differential approach to ethnic groups. From both experiments, lessons were drawn which can be used in implementing programs for reducing inequities in health services among the most vulnerable population groups.

2. METHODOLOGY

The point of departure of the case study was a thorough review of the literature on ethnicity, health, and intersectoral relations in Colombia, including reports of different projects carried out among ethnic groups in Colombia by the Pan American Health Organization / World Health Organization. Interviews were then scheduled with key informants from the various sectors and organizations connected with health for ethnic groups.

Afterwards, interviews were conducted in depth with participants representing different sectors and with the team of the PAHO/WHO delegation in Colombia. This input gave evidence of the need for intersectoral management with a differential approach to ethnic groups, and provided a preliminary view of the lessons to be learned on the forms and impact of differential-approach assistance and the factors which exert the greatest influence on sustainability of social and organizational patterns.

The interviews covered inquiries on problem areas to be resolved by the projects or initiatives focusing on ethnic groups, strategies planned for coordination among different territorial jurisdictions, the implementation of these strategies, the results obtained, the principal participants, and the relationships which arose among them. A second series of questions involved the focus of the programs, the manner in which the intersectoral approach was combined with the differential approach in the programs, and the prognosis for applying the two approaches.

Based on the interviews and review of the documentation, the experiments and projects were reconstructed and portions of major importance for formulating and editing the detailed case study in this document were recorded on tape. In the final section, the main lessons learned are presented and a number of conclusions drawn on the future potential of intersectoral action in the country.

3. RESULTS

3.1 CONTEXT

In Latin America, different social groups experience significant inequality and inequity in health services. This situation requires particular attention since it arises from differences in opportunities that persons have for achieving complete social and personal development. These inequities originate in the political and socio-economic structures of their societies and determine living and working conditions. Current evidence of this reality has given rise to forums such as the Commission on Social Determinants on Health [Comisión sobre los Determinantes Sociales de la Salud], where emphasis has been placed on the need to deal with these elements of social structure leading to poverty and inequality, what the Commission itself terms “the causes of causes” (CSDS, 2005).

The current levels of inequality in health represent a challenge to equity in health and social justice, since they show that present policies for dealing with social and economic conditions among the population are not adequately meeting its needs. The weakness of these policies threatens the achievement of global, national and local goals related to strategic frameworks such as the Millennium Development Objectives¹ adopted by the countries of the region. In these countries, the incidence of poverty among specific social groups, mainly aboriginal and black communities, is greater than in the rest of the population. The regional average quality-of-life indicators, for example, are 1.6 times² higher than for these groups.

In general terms, Colombia has recovered from the economic crisis which characterized the late 1990s and has resumed economic growth,³ poverty was reduced⁴ by 8% between 2002 and 2005, and the index of human development increased by 7% between 1991 and 2003.⁵ However, the disparity in distribution of wealth, measured by the Gini coefficient, increased from 0.544 in 1996 to 0.563 in 2003,⁶ and disparities with respect to access to basic public goods and services have increased among

¹ UNO (2000). Millennium Declaration. Available at www.un.org.

² Hopenhayn, M., Bello A., and Miranda F. (2006), Los pueblos indígenas y afrodescendientes ante el nuevo milenio. [The Aboriginal and Black Populations at the Beginning of the Millennium]. ECLAC, Social Policy Series, New York.

³ The gross domestic product (GDP) increased from -4.32% in 1999 to 5.13% in 2005. Cf. Grupo Aval (2006), Indicators/Economic/Gross Domestic Product/History (consulted 27 July 2006). Available at <http://www.infofinanciera.com/oc4j/portales/jsp/gaviframes.jsp>

⁴ From 57% to 49% of the population below the poverty line and from 20% to 14.7% below the line of extreme poverty. Cf. Montenegro, S. (2005), Estimaciones Pobreza e Indigencia en Colombia. Departamento Nacional de Planeación [Poverty and Extreme Poverty Estimates in Colombia. National Planning Department] (Online presentations) URL: http://www.dnp.gov.co/archivos/documentos/GCRP_Presentaciones/Presentación_cifras_pobreza_2005.pdf

⁵ The index of human development increased from 0.728 to 0.781. Cf. Programa Nacional de Desarrollo Humano DNP/PNUD. Agencia colombiana de cooperación internacional. Federación Colombiana de Municipios. Cooperación Técnica Alemana GTZ (2005). Las regiones Colombianas frente a los Objetivos del Milenio. [National Program of Human Development DNP/UNDP. Colombian Agency for International Cooperation. Colombian Federation of Municipalities. Cooperación Técnica Alemana GTZ (2005). The Colombian Regions in Light of the Millennium Objectives] Bogotá: pp.15-16.

⁶ Ministerio de la Protección Social de Colombia, Organización Panamericana de la Salud. Situación de Salud en Colombia. Indicadores Básicos [Ministry of Social Protection, Colombia. Pan American Health Organization. The Health Situation in Colombia. Basic Indicators] 2005, Bogotá, Colombia; 2006, 24 pp.

the regions. In the past decade, deterioration in living conditions has been particularly critical in the case of ethnic minorities, where socio-economic indicators, as shown by the human development index, decreased by about 13 points between 1997 and 2003 (DNP-GTZ, 2006).

At present, the Colombian government is working on a number of framework anti-poverty strategies: these were presented in Document 91 of the National Council for Economic and Social Policy [Consejo Nacional de Política Económica y Social, CONPES], produced in 2005. This document sets the goals and objectives for development in the millennium, emphasizing economic growth through mechanisms providing preferential opportunities to the poor in order to develop and protect their own assets in terms of access to ownership of land and housing, education, credit, and social risk management. With respect to reduction of inequities, current policies seek to strengthen the Social Protection System in reducing vulnerability of the population in areas such as health, labor, professional risks and pensions.⁷ Specifically, the National Development Plan of the present government (2007–2010) is directed to increased recognition and protection of ethnic groups and cross-cultural relations.⁸ Again, as a member of the Andean Community of Nations, the country in 2006 signed REMSAA Resolution XXVII/417 creating the Andean Commission for Intercultural Health [Comisión Andina de Salud Intercultural], to develop institutional policies that ensure a cross-cultural approach in all health-related activities.⁹

In addition, throughout the past decade, institutional and sectoral reforms in the Colombian government led to a redefinition of roles and functions for various public entities. As a result, a process of restructuring and merging of sectors took place at the ministerial level in 2003.¹⁰ This process gave rise to an *ad hoc* relationship between different sectors which lacked a specific orientation to cooperation and coordinated action among government agencies for shared development goals.

This restructuring and the furtherance of political and administrative decentralization created new challenges to which government institutions have yet to adapt. For this reason, cross-sector cooperative programs and initiatives remain at an incipient stage, due to the persistence of a top-down approach at various national and territorial administrative levels. This fact can be discerned in the very recent proliferation of initiatives to reduce inequity and initiatives relating to social health determinants, including the recommendations of the Mission for Eradication of Poverty [Misión para la Erradicación de la Pobreza] (2007), the JUNTOS Network (2007), the Plan for the Afro-Colombian Population in Colombia [Plan para la Población Afrocolombiana] (2007), and the Action Plan for

⁷ Departamento Nacional de Planeación (2005). Documento CONPES Social 91 “Metas y estrategias de Colombia para el logro de los objetivos de desarrollo del milenio-2015” [National Planning Department (2005), Social CONPES Document 91: “Colombia’s Goals and Strategies for Achieving Millennium Development Objectives – 2015]. Available at: http://www.dnp.gov.co/paginas_detalle.aspx?idp=581.

⁸ National Planning Department, 2006.

⁹ These include further development of health-care modalities with a cross-cultural approach, development of information and monitoring systems on cross-cultural health and the health situation of indigenous populations, and development of means for indigenous populations to participate in formulating, implementing and evaluating public health policy. Available at http://www.conhu.org.pe/remsaaxxvii/resoluciones/xxvii_417.pdf

¹⁰ The principal mergers were the inclusion of the Ministry of Government and Justice in the new Ministry of Justice and the Interior [Ministerio del Interior y de la Justicia]; the inclusion of the Ministries of the Environment, Commerce and Development in the new Ministry of the Environment, Housing and Territorial Development [Ministerio de Ambiente, Vivienda y Desarrollo Territorial]; and merger of the Ministries of Health and Labor in the new Ministry of Social Protection [Ministerio de la Protección Social].

Development of a Strategy for Healthy Environments [Plan de Acción para la Desarrollo de la Estrategia de Entornos Saludables] (2007).

This recent state of affairs of intersectoral action and the differential approach on specific population groups contrasts with the fact that Colombia has been a reference point for Latin America for promotion of full legal recognition of rights for these groups, which has created significant advances in areas such as land ownership,¹¹ autonomy, political participation,¹² special jurisdiction, ethnic education, and health.¹³

Since the 1970s, Aboriginal and Afro-Colombian organizations have increasingly affirmed their ethnicity¹⁴, as manifested in the recovery of their land and the strengthening of their own authority and cultural traditions. In the field of health, key points include regulated participation of ethnic groups in the General Social Security System and recognition of Aboriginal rights to traditional medicine.¹⁵ Regulatory instruments such as Resolution 10013 of 1981 and Law 691 of 2001 define a twenty-year process of reclamation of the right to health for the Aboriginal peoples, which can be extended to all ethnic groups. These processes of ethnic affirmation have been brought about in the international context of progressive increase of human rights, including the right of a people to maintain its cultural identity and its differences as a collective entity. Appendix 1 gives a synthesis of the regulatory instruments relating to the rights of ethnic groups.

Colombia is a multiethnic and multicultural country, in which fulfillment of the Goals and Objectives for Development in the Millennium is directly related to the ability to carry out activities directed to disadvantaged population groups. Generally, ethnic groups comprise approximately 14% of the population, 10.27% of the population being Afro-Colombian and 3.3% Aboriginal. These groups are settled on 36% of the national territory (36,600,000 hectares) under collective designations which coincide with two areas characterized by some of the greatest biodiversity on the planet: the Amazon forest and the Pacific coast.¹⁶

¹¹ Approximately 87% of the Aboriginal population of the country have legal recognition of their territory, in the form of reserves.

¹² PAHO – Ministry of Social Protection (2004).

¹³ The Constitution specifies a group of rights for the Colombian population as a whole, and specifically provides for recognition and protection by the State of the ethnic and cultural diversity of the nation, incorporating specific provisions in various areas for ethnic groups (National Constitution, Art. 7).

¹⁴ Ethnicity refers to development of a collective awareness which not only defines a series of relationships among groups within a social order, but is also awareness which changes over time.

¹⁵ The purpose of Law 691 is "...to protect in an effective manner the rights to health of the Aboriginal peoples while guaranteeing their cultural integrity in order to ensure their social and cultural survival, on the basis of provisions in the Constitution, international treaties, and other legislation relating to Aboriginal peoples." Article 21 of Law 691 specifies that "The health-service plans and programs applicable to Aboriginal peoples shall take into consideration Aboriginal knowledge and practice, following the principles of coexistence of multiple approaches to medicine, therapeutic complementarity and cross-cultural relationships. Health activities should thus respect sociocultural particularities and will include activities and procedures stemming from traditional Aboriginal medicine in order to strengthen the cultural integrity of Aboriginal peoples."

¹⁶ DANE (2007) Census 2005. <http://www.dane.gov.co>; CONPES 3310 Acciones Afirmativas para la población Afrocolombiana; DNP (1998) Plan Nacional de Desarrollo de la Población Afrocolombiana. Hacia una Nación Pluriétnica y Multicultural. [CONPES 3310 Affirmative Action for the Black Population in Colombia; National

While they have some characteristics in common, each of these groups has its own peculiarities. In Colombia there are 84 Aboriginal peoples or ethnic groups¹⁷ with a total population of 1,378,884 (3.3% of the national population). They primarily inhabit the rural areas (78%) of the 32 departments [divisions] of the country. Those departments with the greatest Aboriginal populations are Guajira, Cauca, Nariño and Córdoba (60% of the Aboriginals of Colombia). Those departments having the greatest proportion of Aboriginal peoples among their populations are Guainía (61.5%), Vaupés (58.1%), Guajira (42.4%), Amazonas (39.8%), and Vichada (39.6%).¹⁸ These groups lend themselves to differing cultural expression through their own languages, political and social organization, economic and production relationships, ways of management and interaction with the environment, and, generally, their own world outlooks.

The Afro-Colombian groups comprise a population of 4,261,996 (10.27% of the total population), and principally reside in urban areas (72%). The Afro-Colombian population in the departments of Cauca, Chocó, Nariño and Valle is 1,092,230, representing 45% [?] of the Afro-Colombian population of the country. The Caribbean region, which includes the departments of Atlántico, Bolívar, Córdoba, La Guajira, Magdalena and Sucre, have an Afro-Colombian population of 1,194,577, representing 28% of the total Afro-Colombian population. These communities maintain certain identifying features creating a sense of belonging, as well as the social organization and rules which govern them. The communities are sustained by and reflected in specific forms of social and political organization, a common history, and elements of world outlook, interaction and representation.¹⁹ Figure 1 shows the geographical distribution in Colombia of the ethnic groups inhabiting the country.

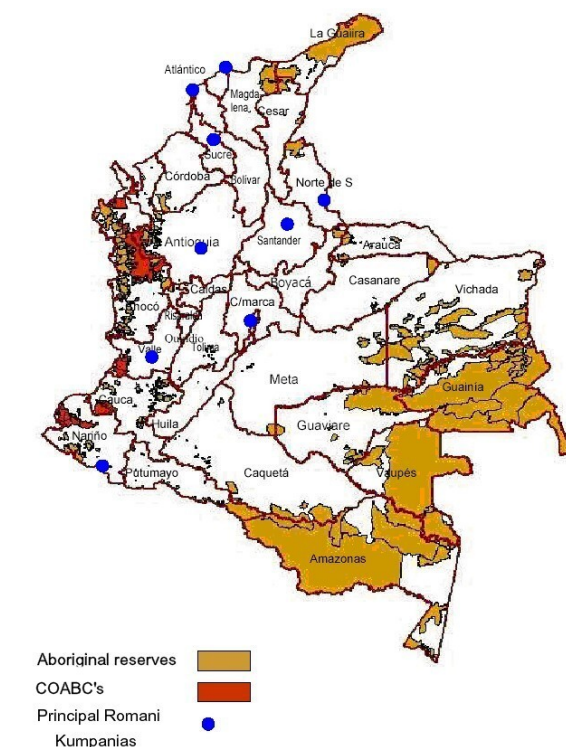
Department of Planning (1998) National Development Plan for the Black Population in Colombia. Towards a Multiethnic and Multicultural Nation]. Bogotá, DNP.

¹⁷ These groups speak 64 different languages belonging to 14 linguistic families and have diverse forms of social organization based on highly structured kinship and community relationships which establish specific conditions such as types of marriages, residence, descendance and filiation; varied forms of government by traditional ancestral authorities and others required for interaction with national society; and types of economies and production with family and community manpower, intended primarily for subsistence or generally balanced small-scale exchange for use and appropriation of natural resources.

¹⁸ DANE 2005; PAHO 2007.

¹⁹ National Department of Planning 2006, pp. 703-704.

Figure 1
DISTRIBUTION OF ABORIGINAL RESERVES, COLLECTIVELY OWNED AREAS OF BLACK COMMUNITIES (COABC) AND KUMPAÑIAS OF THE ROMANI (GYPSY) PEOPLE



Source: DANE, 2007.

The claims of the Aboriginal peoples are part of the 1991 Constitution, together with recognition of most of these rights also for Afro-Colombians, the Raizal population of San Andrés and Providencia, and the Romani (gypsy) people, who have equally asserted themselves as ethnic groups. One of the most important achievements for Aboriginal and Afro-Colombian groups has to do with the bolstering of collectively owned areas in which the cultural identity of these communities can be protected. In this sense, a key point is the assignment of land to Aboriginal communities and collectively owned areas to Afro-Colombian communities.²⁰ Similarly, rulings specific to the sectors have been issued,

²⁰ The 1991 Constitution and legislation under Law 70 of 1993 determined the collective entitlement of traditional lands of the Black communities which inhabited the Pacific Basin (5,600,000 hectares). This policy of collective entitlement for Black communities was intended to recognize and protect the ethnic and cultural diversity of these communities, enhance their organizational processes, and guarantee participation and autonomy in traditional territories. It was also intended to protect the natural resources in these territories and to promote productive alternative development aimed at improving living conditions in these communities. The lands delivered to the Black communities and those currently under adjudication have a total combined area of 5,670,000 hectares, representing 5% of the national territory. To date, 91.5% of the goal has been reached, 149 collective titles have been issued and 5,128,830 hectares have been adjudicated, with benefits to 60,418 families (cf. President's Report, 2006).

increasing coverage in education, affiliation with the Health Subsidy Plan, child welfare with food support, and development of ethnic education projects.

With respect to public participation in decision-making processes, forums created through legislation have been revitalized, including the National Coordinating Board [Mesa Nacional de Concertación], the National Commission of Territories [Comisión Nacional de Territorios], and the Human Rights Commission [Comisión de Derechos Humanos] for Aboriginal peoples; the High-Level Consultative Body [Consultiva de Alto Nivel], departmental, regional and district consultative bodies, and community councils for the Afro-Colombian population. A number of national entities have created specific forums making possible exchanges with all ethnic groups and other institutions, in order to discuss and coordinate policies and proposals for these communities: among them is the Interethnic Committee of the Project for the Evaluation of Needs and Processes of Information [Comité Interétnico del Proyecto de Evaluación de Necesidades y Procesos de Información], which arose to implement the Convention on Biological Diversity.

Organizational activity among ethnic groups has increased in the past few decades with legal recognition of their forms of government under the title of Aboriginal reserves (710) and community councils (150). Each group has established coordination mechanisms and lines of development based on its ethnic perspective, which has formed part of its plans for life and ethnic development. Furthermore, many social movements and networks for women and youth strive for collective action for integration while recognizing differences.

In spite of the above-mentioned developmental activity, inequalities persist between urban and rural populations and among the regions. Chocó (with a high Black population density), Cauca and Nariño (with a significant component consisting of Aboriginal peoples) have consistently been departments with the lowest human development indices throughout the past 14 years⁵. In 2005, 49% of persons belonging to ethnic minorities were in the first and second income quintiles, while 47% had some basic need that was not satisfied (DANE 2007). Similarly, results relating to health showed evidence of differential access to health services based on membership or non-membership in an ethnic group. Figures 2 and 3 show the composition of ethnic minorities by region and their level of access to health services.

Figure 2

COMPOSITION OF ETHNIC MINORITIES BY REGION

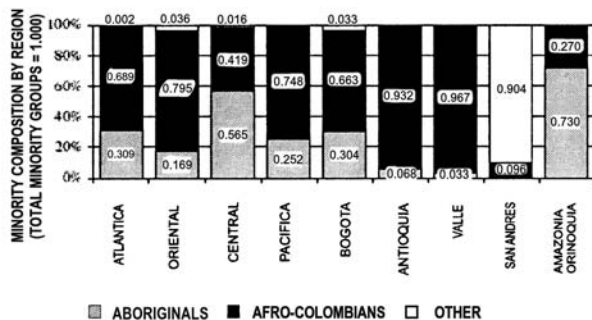
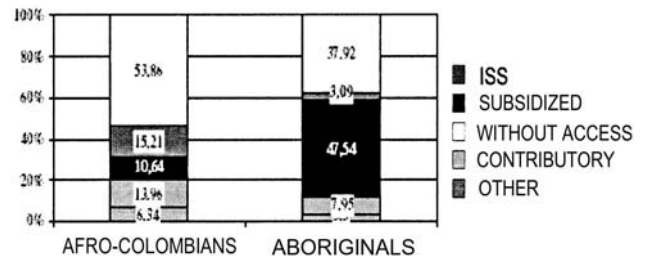


Figure 3

ACCESS TO HEALTH SERVICES



Source: Bernal and Cárdenas, 2005.

The level of vulnerability is more critical in the rural areas due to poor living conditions (e.g. high rates of illiteracy and deficient public services), and barriers to access to health services arising from geographical dispersion, shortage of transportation, unreliable working conditions and the constant threat of forced displacement due to the presence of criminal organizations.

Forty-eight percent of the ethnic-minority population is uninsured and lives in rural areas (DANE 2003). The impact of attacks by armed criminal groups on ethnic communities is particularly severe as these attacks are concentrated in the rural areas of the country. These populations have no insurance, and, whatever their ethnic affiliation, the differences in socio-economic level, access to formal employment, income and geographic location become systematic determiners of inequities in health.

With respect to geographic location in particular, one can see how forced displacement has a disproportionate effect on the Aboriginal peoples and the Afro-Colombian population. While the Aboriginal population is only 3.3% of the population of the country, 18.45% of displaced persons are Aboriginals; and while the Afro-Colombian population constitutes only 10.27% of the national population, 40% of the displaced population is Afro-Colombian. The expulsion and displacement of these communities from their ancestral lands break the link between land and culture and, among these communities, create a deep sense of being uprooted.

Most of the victims are located in the departments of Cauca (19%), César (15%) and La Guajira (13%). In departments such as Córdoba and Chocó, Colombian Aboriginals have been blocked in by guerrilla bands and paramilitary groups. These blockades, together with the confrontations, displacements, kidnappings and homicides, constitute a humanitarian crisis leading to further deterioration of the already poor living conditions of the ethnic minorities. Figure 4 shows how armed confrontations have intensified in Colombia.

Figure 4

INCIDENCE OF ARMED CONFLICTS IN COLOMBIA 2000 – 2006

Source: Office of the Vice-President of the Republic, 2007.

In these emergency situations, various factors of inequity in health services for ethnic groups come into play, adding to the barriers to access and poor insurance. These factors include the inconsistency between the registration procedures of the General Social Security System [Sistema General de Seguridad Social, SGSS]²¹ and the social patterns of rural dispersed populations (e.g. children in these areas are not born in hospitals and parents register them at different periods); the poor adaptability and coordination of prevention programs which incorporate traditional medicine and epidemiological and cultural profiles; the lack of a monitoring system for morbidity and mortality rates²² which includes

²¹ The SGSS is a social protection system which, through its two components dealing with social security and assistance, seeks to reduce the vulnerability of households, especially poor households, by anticipating possible drops in income through better management of risks. Under the Social Risks System [Sistema Social de Riesgo, SSR], social protection activities are maintained and supplemented by measures established to ensure economic growth (investments, employment, and population income); social policy measures ensuring access to basic social services for the poorer populations; the implementation of focused projects in areas where they are most needed; measures for the protection of markets; and supplementary informal protective measures (Cf. Presidential Office for Social Protection [Consejería Presidencial para la Protección Social], 2002: 131; Guerrero 2006).

²² PAHO investigations (2004) have drawn a number of profiles by region, reflecting how deficiency diseases, infectious diseases and parasitic diseases are the predominant disorders among people of the forest and the plain; dental and periodontal disorders predominate in the Andean region; and in the Atlantic region disorders such as acute diarrheal disorder, acute respiratory infection, malnutrition and deficiency disorders, tuberculosis, dental disorders, and skin disorders are predominant. In the Pacific region, the predominant disorders are tuberculosis, acute diarrheal disorder,

ethnic variables; and the lack of information or knowledge for dealing with health emergencies.²³ Table 1 gives a number of indicators which round out this panoply of inequities for ethnic groups.

Table 1.

SOCIO-ECONOMIC ASPECTS OF
ABORIGINAL AND AFRO-COLOMBIAN COMMUNITIES

	Afro-Colombian Population	Aboriginal Population	Remainder of the Population
Life Expectancy	55 for women 65 for men	57.8 for women 55.4 for men	73 for women 64.3 for men
Infant Mortality Rate	151/1000	63.3/1000	39/1000
Illiteracy Rate	31.3%	24.7%	23% rural 7.3% urban
Health System Insurance	21% subsidized plan 26% contributory plan	No information	23% subsidized plan 36% contributory plan
Inclusion in Secondary Education System	62%	No information	75%
Inclusion in Higher Education System	14%	No information	26%

Sources: DNP, 2004; DANE, 2005; World Bank, 2006; Arango and Sánchez, 2004.

Based on the information presented, the programs treated in this study can be said to arise from disclosure of evidence of deterioration of living conditions of the populations of the ethnic communities. In this sense, the main catalyst for public debate on the need to improve conditions of vulnerability, exposure and health of the ethnic communities has been the impact on them of the escalating armed conflict between the state and criminal forces.

acute respiratory infection, malnutrition, malaria, typhoid fever, yellow fever, and other pathological conditions such as cancer and HIV/AIDS.

²³ Ministerio de Protección Social (2006) *Derechos y deberes de los grupos étnicos en el marco de la protección social*. Bogotá [Ministry of Social Protection (2006): *Rights and Responsibilities of Ethnic Groups with Respect to Social Protection*. Bogotá; PAHO/WHO (2005) Metodología de Concertación para el Diseño de una Política de Protección Social en Salud para grupos Étnicos en Colombia [Coordinating Methodology for Developing a Social Protection Policy in Health for Ethnic Groups in Colombia]. Rodolfo Hernando Moreno, Consultant; Ministerio de Salud [Ministry of Health] (2001) Lineamientos para la concertación y adecuación del plan de atención básica con grupos étnicos en las entidades territoriales [Guidelines for Coordination and Adaptation of the Basic Care Plan with Ethnic Groups in Territorial Entities].

3.2 INTERSECTORAL ACTION APPROACHES OF PAHO/WHO IN COLOMBIA

The Pan American Health Organization / World Health Organization has taken part in and developed intersectoral programs and projects at different levels. This study first presents an experiment in which a pioneer national policy framework is formulated for intersectoral cooperation. Secondly, it presents a series of implemented initiatives based on the differential focus on ethnic minorities, describing in detail one experience in particular which occurred in an emergency situation.

In the interviews carried out for this case study, representatives of the ministries²⁴ and other organizations recognized the importance of the ethnic dimension in the Colombian context and the need for greater coordination and cooperation in activities among sectors. A general review of the opinions on activities carried out by each ministry showed a shared belief that there is considerable evidence of participation of various sectors in initiatives that have not been fully documented, and that evaluations of such initiatives specify only implicitly goals for reducing inequity or dealing with social determinants to health. In particular, it was emphasized how ethnic minorities are beneficiaries of different state programs of universal coverage which lack a differential approach considering their special characteristics.

In these dialogues, conceptual and methodological work on the experiences and perceptions of intersectoral action was carried out, and possible interinstitutional cooperation was outlined. Among the points of potential which stood out at the beginning was the fact that in Colombia a reorganization of government institutions was under way and decentralization of responsibilities, jurisdictions and resources was intensified; a new perspective was therefore lent to coordination of intersectoral initiatives and between jurisdictional levels. In this connection, the launching of the JUNTOS network in 2007 was highlighted throughout the interviews: its objective was to improve living conditions for families in extreme poverty through effective inclusion of poorer households in the government's social networks and adaptation of its social services to the needs of families (its two basic strategies are family support²⁵ and coordination of government entities²⁶).

Also prominent within this type of comprehensive strategies which are being implemented is the Agenda of Cross-Institutional Cooperation and the Intersectoral Action Plan for Development of a Strategy on Healthy Environments (2007). Colombia is the first country in the region where this strategy has been integrated into national public policy. Since this is a pioneering achievement, we

²⁴ Ministry of Social Protection; Ministry of the Environment, Housing and Territorial Development; and Ministry of Education.

²⁵ In the family accompaniment program, a group of accompanying social workers will visit families over five years and guide them on ways to access the programs and services they need. The task of these social workers, who represent the network to the families, is to guide them through the process of improving living conditions and develop working plans with the families, seeking to identify the needs which keep them in poverty.

²⁶ These needs are called basic achievements and number 54 in all. They are grouped under nine headings: identification, income, employment, education, housing, nutrition, family dynamics, banking and saving, and access to justice. The program applies to all families at SISBEN level 1 included in the Families in Action program and all displaced families regardless of their SISBEN level. The program involves 16 institutions: Ministry of the Environment, Housing and Development; Ministry of Agriculture and Rural Development; Ministry of Education; Ministry of Social Protection; Ministry of Justice and the Interior; the Presidential Agency for Social Action and International Cooperation; the National Department of Planning; and the Presidential Office for Women's Equity; Bancoldex; Bank of Opportunities; the Colombian Institute of Family Welfare (ICBF); the National Training Service (SENA); the Colombian Institute of Scholastic Credit and Technical Studies Abroad (ICETEX); the Colombian Institute of Rural Development (INCODER); the National Institute for the Blind (INCI); and the National Open University (UNAD).

shall give below a general description of this framework for intersectoral action in the country, to be followed by an account of the experiments promoted by the PAHO/WHO with an explicit differential approach to ethnic minorities.

3.2.1 A Framework for Intersectoral Action on Health Determinants

After several years of success in implementing the Strategy of Healthy Schools and, more recently, the PAHO/WHO strategy for healthy housing in Colombia, the Strategy of Healthy Environments, between January and July, 2007, acquired for the first time the status of national public policy; it became a framework for intersectoral action specifically intended to intervene in health determinants and reduce inequities in health. Given the type of intervening activities on health determinants²⁷, the nature of this intersectoral action experiment required a broad policy framework at the national level.

The process began in 2006 with an agenda bringing together the government ministries and agencies in the sectors of health, environment, education and international cooperation. In January 2007, the Ministry of Social Protection; the Ministry of National Education; the Ministry of the Environment, Housing and Territorial Development; the Presidential Agency for Social Action and International Cooperation; the National Training Service (SENA); and PAHO/WHO reached an agreement to establish an agenda of cross-institutional cooperation to move forward on the Strategy for Healthy Environments, to improve living conditions among the most vulnerable populations and include within it various cross-institutional activities.

These activities were agreed upon in the “Intersectoral Action Plan” drawn from the Agenda of Cross-Institutional Cooperation signed by representatives of the different entities involved. This plan represents a significant advance towards combining manpower and resources under an intersectoral banner to reduce health risks and promote factors in the environment that protect health, as well as increase the institutional capacity of the territorial entities to implement it.

Under these principles, the purpose of the Action Plan is to improve the quality of life and health of the population in order to respond to the priorities of the country and achieve the Millennium Development Objectives as defined by the Colombian government. Based on advances in various activities carried out in recent years under the Strategy for Healthy Environments below the national level and for different population groups, the main challenge now taken on by the strategy, guided by the Intersectoral Action Plan, is to increase coverage of its benefits nationwide, with participation and commitment of the different sectors and players who are committed to human and social development.

The Cooperation Agenda and Intersectoral Action Plan have been based on challenges in development and health and on the priorities established by the national government for reducing extreme poverty, improving health, and encouraging peace, human rights and a sustainable environment—all this within a framework of increased decentralization. Thus its general proposal, which is to “contribute to preparing territorial entities to establish social processes leading to

²⁷ The four key points for interventions on health determinants, following the typology specified by Diderichsen, Evans and Whitehead (2001) and Mackenbach et al. (2002) are: reduction of the effects of **social stratification**; reduction of **specific exposure** to factors harmful to health; reduction of the **vulnerability** of disadvantaged people to the unhealthy conditions in which they find themselves; and assistance through **health care** in order to reduce the unequal consequences of bad health and prevent further socio-economic deterioration among disadvantaged people.

reduction of risks and encouragement of environmental factors which protect health, particularly in the most threatened and vulnerable environments; and encourage provision of opportunities for development which are secure and sustainable” (PAHO/WHO - MPS, 2007).

The lines of action for achieving these objectives are expressed as implementation of a national management system for the Strategy for Healthy Environments; development of a national system for evaluating the impact on health of social policies, with emphasis on education and housing; and integrated secure and sustainable action to reduce risks and encourage environmental factors protecting health, with emphasis on schools and housing.

Each of these lines of action is associated with a series of specifically intersectoral activities involving patterns of cooperation among equals as well as along different levels of jurisdiction. (See Table 2). Among equals, the Action Plan links organizations of international cooperation and national government organizations. Along different levels of jurisdiction, the Plan establishes relations between regional and local authorities (governors and mayors), the ministries responsible for the sectors involved (health, education, works, planning, etc.) and community representatives (parents, teachers, students, organizations, community educators, etc.).

Table No. 2 PLAN FOR INTERSECTORAL ACTION FOR IMPLEMENTING THE STRATEGY FOR HEALTHY ENVIRONMENTS 2007 – 2010
A. National management system for Strategy for Healthy Environments <ol style="list-style-type: none">1. Establish the operating procedure of the Strategy.2. Promote inclusion of the Strategy in national social policies3. Promote implementation of the Strategy in the territorial entities4. Establish a community of practice in the territorial entities to obtain shared knowledge on healthy environments.
B. National system of evaluation of the impact of social policies on health, with emphasis on education and housing <ol style="list-style-type: none">1. Establish evaluation methods2. Encourage the application of the evaluation procedures at national and territorial levels.3. Establish a community of practice to obtain shared knowledge for evaluating the impact of social policies on health.
C. Integrated secure and sustainable action to reduce risks and encourage environmental factors protecting health, with emphasis on schools and housing <ol style="list-style-type: none">1. Maintain a portfolio of instruments for carrying out the activities.2. Promote the portfolio of instruments through cross-institutional initiatives in development.3. Identify current evaluation methodologies.4. Identify successful experiences of existing communities of practice.

The roles and functions of the departments involved are described in the Agenda for Cross-Institutional Cooperation²⁸ and arise from the legal framework governing them with no budget commitments. In implementing the Plan, the ministries and agencies have made the following complementary commitments in their sectors:

<p>Ministry of Social Protection</p>	<ul style="list-style-type: none"> • Promote the National Program for Advancement of Culture in Occupational Health through this Strategy. • With the Public Health Branch, manage the inclusion of the Strategy for Healthy Environments as a cooperative procedure for handling collective public-health activities in the National Public Health Plan.
<p>Ministry of the Environment, Housing and Territorial Development</p>	<ul style="list-style-type: none"> • Include a socio-educational component concerning healthy housing among the qualifying factors for social housing projects. • Describe and promote the "sanitary housing" strategy in events organized by the Deputy Minister of Housing and Territorial Development. • Hold the first cross-institutional and intersectoral forum on sanitary housing in Colombia. • Design a strategy for social housing constructors to implement the socio-educational component in order to create an environment favoring family togetherness and healthy growth of children in households. • Implement the "healthy environment" strategies in the project for housing improvement in the Island of Providencia. • Implement the healthy-environment education process in the Colombia–Ecuador border project.
<p>Ministry of National Education</p>	<ul style="list-style-type: none"> • Coordinate this Strategy with the Healthy Lifestyles project which will be implemented by the Ministry. • Support the strengthening of social networks integrating family and community. • Identify, compile and publicize key experiences of territorial entities working on healthy lifestyles.
<p>National Teaching Service</p>	<ul style="list-style-type: none"> • Include content on healthy environments in related training programs. Train teacher-trainers in healthy-environment strategies. • Training programs correspond to occupational profiles defined by each of the sectors, and healthy-environment strategies improve performance profiles but do not correspond to a specific profile. • Develop training activity with content on the application of current instruments.

²⁸ Available at <http://www.minproteccionsocial.gov.co/VBeContent/library/documents/DocNewsNo15693DocumentNo3266.PDF>

<p>Presidential Agency for Social Action and International Cooperation</p>	<ul style="list-style-type: none">• Integrate concepts of healthy housing into the habitat program.• With its own resources, make an annual evaluation of at least one habitat program activity which integrates the concepts of healthy housing.
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3.2.2 Intersectoral action with differential approach in emergency situations

In this section, instances of target-population based assistance are reported. These experiences deal with exclusions from health, defined as the lack of access for groups or persons to goods, services or opportunities for improving or preserving health; they seek to reduce the incidence of inequity, defined as the existence of unjust and avoidable differences in access to goods, services and opportunities (CSDS, 2005; PHAC, 2007). Along these lines, the points of departure of these experiments are reduction of exposure and vulnerability of disadvantaged persons and the reduction and prevention of the consequences of unequal treatment in health care.

Based on what has been laid down by the Commission on Social Determinants to Health (2005), the initiatives developed at this level must include an approach on specific population groups, based on the principle that reduction of inequities in health implies coming to terms with and understanding the social differences which have historically affected the most vulnerable groups in society, and particularly the Black and Aboriginal communities.²⁹

As indicated several paragraphs earlier, while health conditions of the ethnic groups have improved through positive targeting,³⁰ cultural limitations and [the historical lack of political will have been serious obstacles to full exercise of the rights attributed](#) to them, insofar as current legislation cannot be enforced in all areas of the country and has not been adaptable to the practices of local institutions, which have been seriously affected by the armed conflict within the country.

In Colombia, PAHO/WHO has implemented two types of initiatives which include the intersectoral and differential ethnic approaches. The first type includes projects applied generally to these communities, benefiting populations which are primarily Aboriginal or Afro-Colombian, using strategies in which a differential-approach methodology was not made explicit.³¹ The second type includes projects with an explicitly defined ethnic differential approach, where cultural perspectives of the community were considered through methods adapted to its special needs.

²⁹ The Pan American Health Organization has supported various assistance programs on the health of the Aboriginal peoples, in compliance with Resolutions CD37.R5 (1993) and CD40.R6 (1997) with which the PAHO launched the Health of the Aboriginal Peoples Initiative. More recently, Resolution CD47.R18, "Health of the Aboriginal Peoples of the Americas" was issued, establishing a mandate with respect to the Aboriginal communities. Other developments include PAHO (1997): Intersectoral action for health: A cornerstone for health for all in the 21st century. Washington D.C.; and WHO (1986) Intersectoral Action for Health: The role of intersectoral cooperation in national strategies for health for all. Washington D.C.

³⁰ In Decision T-422/96, the Constitutional Court defined "positive targeting" ["diferenciación positiva"] as follows: "...positive targeting for the communities ... consists of recognition of a marginalized status in society which creates victimization and negative repercussions on access to opportunities for economic, social and cultural development. As this occurs in social groups who had been persecuted and unjustly treated in the past, leading to their present poor condition, special legal treatment directed to creating new living conditions has the purpose of establishing social equity and enhancing domestic peace and thereby has constitutional legitimacy."

³¹ Examples of these initiatives include the Healthy Environments – Barrio El Poblado projects in El Chocó, AIEPI Chocó, and Healthy Housing in the department of Nariño.

The main experiments carried out with a differential approach are: Tuberculosis for Aboriginal populations (2002–2006); Psychosocial care in Black communities in Cali and Buenaventura (2004–2006); Improvement of water quality and sanitation for Aboriginal populations (2003–2006); and Collation and exchange of experiences in the organization and management of decentralized health services for Aboriginal populations (2005–2007). This last project was selected for in-depth study and documentation for this case study. Appendix 2 gives a breakdown of these initiatives.

INTERSECTORAL ACTION AND DIFFERENTIAL APPROACH FOR ETHNIC MINORITIES IN EMERGENCY SITUATIONS

PROJECT

“Collation and Exchange of Experiences in the Organization and Management of Decentralized Health Services for Aboriginal Populations (2005-2007)”

Experience in Care in Complex Emergency Situations and a Health Component in the Defensive Plan of the Aboriginal Communities in the North of Cauca

In April 2005, fierce clashes erupted between government forces and FARC guerrillas in the municipalities of Toribío and Jambaló, both with primarily Aboriginal populations, in the department of Cauca. The clashes left many wounded and killed in both the opposing forces and the civilian population, and this latter was forced to abandon their homes temporarily and either seek shelter in the schools of the rural areas or be displaced to neighboring municipalities. As a result of these events, a sensitive humanitarian situation arose as a consequence of crossfire, blockage of roads, lack of food and inability to reach the local hospital to receive medical care.

To deal with this situation, the inhabitants requested aid through the mayors' offices and the traditional authorities of the region, the Association of Aboriginal Councils of the North of Cauca (ACIN),³² from help organizations of departmental and national governments and the United Nations. Guided by the Resident Coordinator of the United Nations (UN) in Colombia, the agencies arrived in the affected area and provided humanitarian help and technical assistance to support the population during the emergency and reconstruction.

The Pan American Health Organization / World Health Organization signed an agreement with ACIN to hire an accompanying consultant with whom they evaluated, organized and strengthened the community system for prevention and emergency care, particularly health care, and coordinated health activities, assigning the following roles to other participating UN agencies:

- UNICEF: emergency and post-emergency psychological assistance and training on management of water and waste disposal.
- United Nations Population Fund (UNFPA): delivery of culturally adapted kits for sexual and reproductive health.
- International Organization for Migration (IOM): formulation and management of a complete reconstruction plan.
- Office of Coordination of Humanitarian Affairs (OCHA): coordination, collection of information and resources management.

This coordination by the PAHO/WHO had the following objectives: (i) to inspect the sanitary conditions of the shelters and make recommendations on emergency health kits; (ii) to train health agents from the Aboriginal organization in pre-hospital care; (iii) to assist in operations at the post-emergency stage; (iv) to evaluate the lessons learned in handling the crisis; (v) to review anticipated health care plans to be adopted in the event of a renewal of hostilities; and (vi) to strengthen the community plan for prevention, care and mitigation of emergencies in the Aboriginal communities affected.

³² A special public entity recognized by the government in 1994. It covers 15 reserves in 256 districts of seven municipalities, with approximately 109,000 inhabitants in 25,370 families. Among these inhabitants, 85% are Paez Aboriginals, 10% are Blacks and peasants, and 5% are from other ethnic groups.

These objectives coincided with those of the “Minga³³ Defence Plan”, which is oriented to the use of comprehensive means of defence and humanitarian help in emergency situations brought about by war in Aboriginal areas. The highest authority in these territories is the General Assembly, which reserves the power to make decisions in different sectors to the extent that whatever is not approved by them does not receive support for implementation. In the Assembly, a council or group of traditional authorities is chosen to carry out administrative work, policies and legal representation on behalf of the governor of the reserve.

These persons define the organizational direction of the Association and its manifestation through the *tejidos* or sectoral development programs, whose scope of work is described in the area life plan *Cxab Wala Kiwe*, which is coordinated with the municipal development plans of both municipalities.

Given this form of organization, rather than selecting an expert in emergencies, a person was selected for the project who had working experience in health and with the Aboriginals and who was prepared for coordinated, collective work with delegates of the Aboriginal communities, serving as a link between the needs and the pace of the institutions (in this case, PAHO/WHO) and the tempo and realities of the Aboriginal communities. This person was invited to attend meetings as an observer in order to become acquainted with the attendees and provide information on the Aboriginal context. At the same time, contacts were also made with the political, administrative and health authorities of the affected municipalities and with ACIN and its community health personnel.

With these latter, workshop and information sharing sessions were held as well as sessions in which a procedure was developed for inspecting temporary shelter sites. Displacements to the rural areas and shelter sites limited by fighting were then planned and, finally, with the designation of a team for the emergency care committee, development sessions began in conjunction with the proposal approved by the Aboriginal organization.

To meet the objectives of the proposal, the following strategies were developed:

- a. Creation and strengthening of Permanent Assembly Sites (PAS) – places for temporary shelter, reflection and planning³⁴.
- b. Early warning system, to develop effective means for preventive measures to be taken in situations which threaten life, community integrity and community organization.
- c. Training in human rights and international human rights, community cohesion, and handling of radio and other media.
- d. Strengthening of the Aboriginal Guard as an ancestral expression of defence, directly linked to the Aboriginal authorities as an exercise of their own authority and rights.
- e. A Minga protection zone for the defence of the Life Plan of the Aboriginal peoples: its purpose would be to develop a network of friends, institutions, organizations and movements protecting life and human dignity.
- f. Creation of an emergency community fund.
- g. Provision of personnel for the PAS and Aboriginal Guard.
- h. Community defence farms.
- i. Support of the Life Plan of the Aboriginal peoples.

³³ In the life of the Aboriginal and peasant communities in the Americas, the Minga is an activity based on encounters, community work and cooperation among different persons to reach a common objective.

³⁴ Their purpose is to "provide physical community spaces for reflection, analysis and decision making on the problems and risks borne by the Aboriginal communities of the north of Cauca."

These strategies, supported in the Minga Defence Plan, were established, discussed and approved in community assemblies, and an organized response to the emergency was thereby made more possible. However, at first there were no concrete procedures such as definition of tasks, allocation of personnel and resources, time frames, or monitoring tools that would put these strategies into effect. This situation generated confusion among the community members and leaders over the functions of the PAS and the procedures for caring for the sick and wounded.

PAHO/WHO demonstrated at an early stage the lack of concrete means to counteract the level of exposure and vulnerability of the Aboriginal communities. The community members were aware of the possibility of a critical event happening but did not take into account the magnitude of such an event and did not have specific plans to cope with it. Similarly, neither the territorial and municipal agencies nor the local hospitals had emergency or disaster-relief health care plans.

Once this limitation in emergency coordination was detected, the ACIN began further work on organized preparation of the Prevention, Care and Mitigation of Emergencies plan. To this end, it required the political authority of the ACIN, the *Consejería*, to implement operational procedures and tasks and to allocate personnel. To extend the decision-making authority of this subordinate body, a crisis management committee was formed to deal with various problems³⁵ arising from a sketchy perception held by ACIN's collaborators and community members on the work methods of outside aid providers.

The aid providers present an emergency-oriented profile, considerable previous experience, organized working patterns, precise timetables, a high level of division and specialization of functions, well-defined hierarchical levels, concentration of decision-making power at the higher levels, established monitoring and follow-up procedures, and a proven ability for lobbying and cross-institutional relationships. This is in contrast to the philosophy and practice of the Aboriginal movement and the ACIN, which stress the importance of oral communication in contacts and discussions, collective participation in decision making as a reflection of community thought, the performance of rituals conforming to their ancestral world outlook, the different manner in which they view and handle time, their unhurried day-to-day pace, and relationships with outside institutions which have historically been marked by deception and abuse.

Based on the repeated discussion of these perceptions in groups, an agreement was reached with the *Consejería* to designate a team to draw up the original plan to collect viewpoints from community members, this plan to be approved later by the authorities. After this stage was completed, the

³⁵ High turnover of assistants in each of the *tejidos*, which worked against the continuity of the project and impeded establishment of a work team with clear responsibilities; meetings without preset days, hours or venues; meetings being held at the same time as other important meetings in the organization; resistance of some leaders to the presence in the meetings of persons from outside the Aboriginal organization; unreliable information being used to propose or make decisions, due to the lack of clear means of communication of recent developments, leading to unfounded speculation and multiple versions of the same situation; repeated lack of assistance from the delegates of the community projects of Toribío and Jambaló, thus hindering adaptation to local expectations; failure of the *consejería* to authenticate the working group, either due to lack of a written circular to the *tejidos* or permanent designation of a monitoring advisor; resolution of situations independently of the existence of the group, since advisors review the situation and draw interpretations on it on working days and solutions are implemented directly with *tejido* teams and external supporting organizations; the agenda of a meeting is changed due to the unexpected attendance of persons offering support which is unrelated or out of context, or trying to impose an agenda meeting the specific needs of their own institutions; the resources for immediate care or for reconstruction, offered or promised by various organizations, pre-empt the attention and energy of the coordinators and collaborators of the *tejidos*.

following main agreements with the support team, which provided the base for the Emergency and Disaster-Relief Health Care Plan (PAED), were drafted:

- Elaboration of the functions of a community (self-governed) emergency committee.
- Development of a preliminary profile of functions for each of the *tejidos* in emergency and disaster-relief care and prevention.
- Definition of the broad components of a sequential care plan.
- Coordination of the methodology to ensure continuity in the project.

To create positive expectations for possible future appropriation of the Plan by the traditional authorities and community members, a later stage was considered with the creation of an area plan of emergency and disaster-relief care (PAED), incorporating public participation and subject to evaluation to redefine the type of accompaniment required by the team of aid providers in community projects (municipal order) and in the reserves. With this stage, elaboration of the plan proceeded in coordination with the municipal administrations.

As agreed, PAHO/WHO carried out a survey to evaluate environmental risks and found poor signage and visibility, poor quality in the basic structures of the shelters, battery and kitchens, and poor staffing of the kitchens. Above all, they found that water storage was at a disturbingly low level, as was basic staffing for health care. On the basis of these findings, a project was initiated in coordination with other UN agencies to improve these conditions, a project which combined environmental and psychosocial aspects. Since then, the ACIN *Consejería* has assigned tasks for the coordinator of each *tejido* to develop the PAED, setting in motion an intersectoral operational plan.

The coordinators of each *tejido* composed the ACIN Coordinating Committee for Emergency Care, an example of linkage among Aboriginal authorities and local (municipal) authorities at the same jurisdictional level, coordinated by a facilitator from PAHO/WHO. The areas handled by the Coordinating Committee are given in the following table:

TEJIDO	AREA
CONSEJERIA	In charge of emergency and disaster-relief health care
COUNCIL GOVERNORS	Participation of two delegates of the governors of the 16 councils of the northern area
JUSTICE AND HARMONY	Legal program
ECONOMIC AND ENVIRONMENTAL	Production projects Marketing Environment
PEOPLE AND CULTURE	Health Education Family – Women Youth
PROTECTION OF LIFE	Aboriginal Guard Human Rights
COMMUNICATIONS AND EXTERNAL RELATIONS	Communications
PLANNING	Planning

The roles and functions of the players involved are described below:

(a) *Consejería*

- Coordinate the area committee for prevention and emergency care.
- Meet with traditional authorities to carry out analysis of man-made threats.
- Make governors and community project coordinators aware of the need to organize the PAED and participate in it.
- Review and approve components of the area plan of emergency care.
- Monitor the pace of development of the emergency care plan.
- Manage the resources required to implement the emergency care plan.
- Coordinate and manage respect for human rights in Aboriginal territories with government entities, non-governmental humanitarian aid organizations, and human-rights defenders.
- In charge of public broadcasting of early alerts.

(b) Council governors

- Disseminate the prevention and emergency care plan at the municipal, reserve and district level.
- Create Council committees for prevention and emergency care.
- Manage human, technical and financial resources in the localities to ensure that the plan is being implemented.
- Make use of a system to monitor the plan.
- Carry out and support practice drills in their areas.

(c) Justice and Harmony *Tejido*

- Design, implement and evaluate a training plan for the different tejidos and community members on international humanitarian law, the medical mission and the law itself.
- Strengthen the response capacity of local and regional legal teams; report violations of human rights, international humanitarian law and the medical mission.
- Establish means of coordination between justice in the communities and the regular legal system.
- Support reporting of violations of human rights and international humanitarian law to the competent bodies.

(d) Economics and Environment *Tejido*

- Identify and georeference natural risks for the area.
- Design and manage the portion of the prevention and emergency care plan relating to prevention of natural disasters in the area.
- Encourage production within the communities in order to ensure availability of food in the event of natural or man-made emergencies.
- Train community members to preserve perishable foods.
- Design and carry out a training plan for prevention of natural risks.
- Evaluate the requirements for drinking water and non-perishable foods for emergency situations.
- Design and implement a system to receive, store and distribute food and drinking water from humanitarian aid.

(e) People and Culture Tejido

Education:

- Design and include within the Institutional Education Projects (PEI) training activities for handling emergencies and disasters.
- Design, monitor and evaluate the prevention and emergency care plan in the classroom.
- Plan and carry out the task of escorting children in the permanent assembly sites when required.
- Initial psychosocial support to the children during emergencies and disasters.
- Specification of teaching tasks when working with children in emergency and disaster situations.
- Increase parents' awareness of the need to care for minors in emergencies and disasters.

Women, Youth and Family:

- Plan and carry out training of community members on the management of food, solid wastes and residual water in the permanent assembly sites.
- Promote women's rights and reporting of human rights violations against women and children during complex emergencies.
- Evaluate the need for mats, blankets and kitchen utensils for the area, including storage and distribution requirements.
- Manage and receive humanitarian aid providing the above.
- Work with the Economics and Environment Tejido to obtain and distribute food and drinking water.

Health:

- Develop and implement continuing education programs for medical and paramedical personnel and community health personnel emphasizing pre-hospital and emergency care.
- Inventory of human and technical resources for health care in the event of emergencies.
- Inventory of basic staffing requirements and minimum specification of medication and medical and surgical consumable goods for emergency care.
- Develop and implement the health component of the prevention and emergency care plan.
- Develop and carry out practice drills on health care for emergency cases.
- Coordinate health care with the public hospital network in the event of emergencies.
- Develop and make use of means to monitor community members whose health is affected during emergencies.
- Establish strategies and means to reduce the risk of disease transmission in the permanent assembly sites.

(f) Life Protection Tejido

- Assure the protection of all community members in any event of the Aboriginal movement involving gathering of people.
- Assure surveillance on the movements of persons from outside the communities on Aboriginal territories.
- Immediately inform the consejería or any member of the Community (Self-governed) Emergency Committee of any increase in natural or man-made threats.
- Form and train local groups to rescue and transport wounded persons.

(g) Communications and International Relations *Tejido*

- Assure permanent communication with the national and international friends' network concerning the Aboriginal situation in the north of Cauca.
- Keep community members informed by radio of potential natural or man-made threats and preventive measures.
- Disseminate news by radio on progress in developing the area plan for prevention and emergency and disaster-relief health care.
- In the event of an emergency or disaster, this *tejido* is the sole unit responsible for channeling information to international and national agencies, the press and community members.

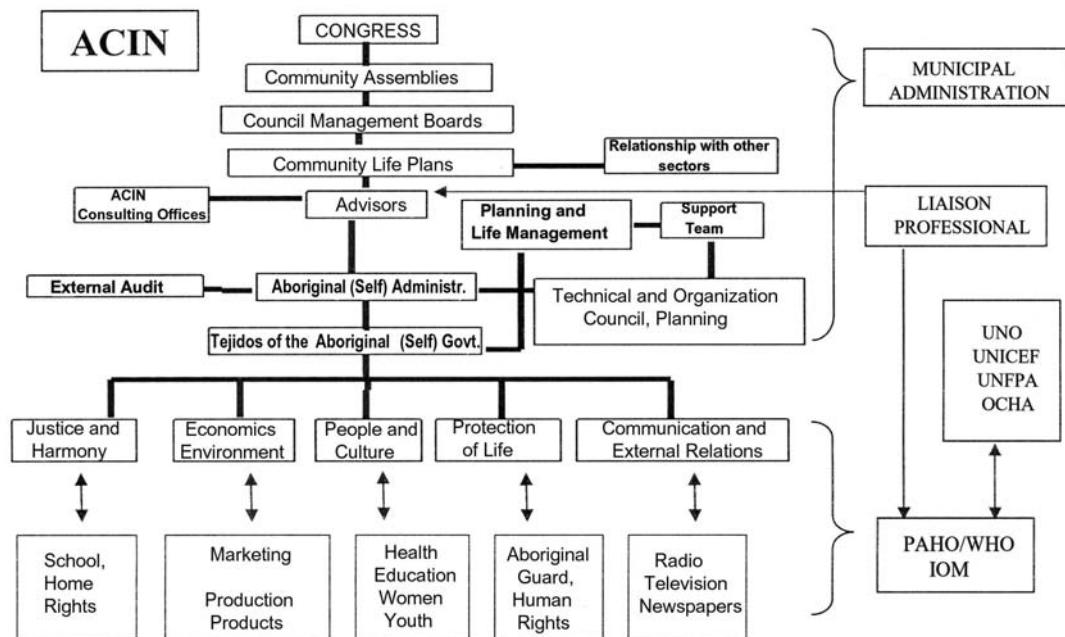
(h) Planning

- Operational secretariat of the Community Committee for Prevention and Emergency Care.
- Work with the Economics and Environment *Tejido* to characterize natural threats in the area, and with the *Consejería* to determine man-made threats.
- Coordinate and harmonize the work within the ACIN for prevention and emergency and disaster-relief care.
- Monitor the development of PAED in ACIN.
- On-site coordination of all aspects of care for victims of emergencies or disasters.

These functions are correlated with the participants given in Figure 5.

Figure 5

**PARTICIPANTS, *TEJIDOS* AND PROGRAMS – ACIN
EMERGENCY AND DISASTER-RELIEF CARE PLAN**



Two stages and eight components were considered for putting the PAED into operation. The first stage was carried out with priority placed on the area itself, while in the second stage support was sought for community and council projects. Implementation of the PAED involved management of municipal and department resources by way of the Basic Care Plans provided for in law as well as resources transferred to the reserves from the central government. In addition, the ACIN handled resources for individual projects for international, government and non-governmental organizations (some of them included in the Comprehensive Reparations Plan supported by IOM).

The Colombian health system defines insurance as a strategy for health care. The provision of services is decentralized and organized along levels of care: the municipality is responsible for care at complexity level I, while the department is responsible for care at complexity levels II and III. Within this legal framework, care for the Aboriginal population is handled in the first instance through insurance, which in this case study is provided by the Aboriginal Association of Cauca [Asociación Indígena del Cauca, AIC], an agency administering funds from the Subsidized Plan linked to the Aboriginal organization of the department. Uninsured persons are treated with funds for treatment of the uninsured poor provided by the hospitals and the State Social Enterprises [Empresas Sociales del Estado, ESE].

The care of persons injured in any emergency or disaster is primarily the responsibility of the network of regional public providers. However, the ACIN Health Program has personnel on site who are mainly promoters of health and auxiliary nursing personnel and who are, as previously mentioned, the first persons in contact with the communities and, as members of these communities, fulfill their health-care responsibilities within the reserves. In this way, ACIN health personnel are responsible for assuring adequate prehospital care and making an initial sorting of injured persons so that they can be properly directed for treatment elsewhere based on their condition.

In this context, the development of the general components of the PAED with participation and approval of the members and authorities of the community yielded a series of commitments among authorities and other community members, expressed in terms of specific responsibilities which enabled the inhabitants to make the PAED sustainable over time. This series of commitments/components of the Plan and the personnel in charge of them are given in the following table:

COMPONENT	PERSONNEL IN CHARGE
Adaptation of the organizational structure	Traditional authorities of the area and health personnel – persons in charge of emergency and disaster-relief committees established by the traditional authorities.
Strengthening of the capacity of health personnel from the communities for emergency and disaster-relief care	Promoters and auxiliary nursing personnel from the communities – collaborating professionals in the health program – Personnel of the ACIN health program.
Development of the Home Plan for Prevention and Emergency Care	Economics and Environment <i>Tejido</i> – Planning – Governors – Education and Health <i>Tejido</i> – Councils – Communications and Life Protection <i>Tejidos</i> – Health personnel – Aboriginal Guard – Members of the committees for emergency and disaster-relief care.
Improvement of Permanent Assembly Sites	ACIN advisors – ACIN Planning – Persons in charge of municipal projects – Aboriginal Guard – Education and Health <i>Tejido</i>
Reinforcement of support personnel at Permanent Assembly Sites	Aboriginal Guard – teaching personnel and health personnel from the communities – Women and Family <i>Tejido</i> – ACIN health personnel
Increase in capacity to supply food, drinking water and medication in case of emergencies	Area committee
Increased coordination with and response capability of the public hospital network	Managers – hospital directors – technical advisors – local hospital officials
Increased coordination with and response capability of municipal administrations in emergency situations	Mayors – government councils – members of the local emergency committee (CLE)

4. IMPACT

ACHIEVEMENTS

- The main achievement of the experiments presented in this case study is the effect on the social determinants of health. In terms of health equity, the first experiment has led to the emergence of a public policy in which tools for intersectoral action with a differential approach for vulnerable populations are explicitly defined in its objectives and procedures.
- Secondly, given the impact of armed conflict on ethnic minorities, the creation and adoption of an emergency and disaster relief care plan, together with the reinforcement of the health component of a hundred-year-old Aboriginal defence plan and institutional development in health care among the municipalities, have made a difference in the vulnerability and exposure of ethnic minority populations.

Other important results of intersectoral action and the use of the differential approach are as follows:

- Institutions can produce increasingly detailed information on the health determinants and conditions of ethnic minorities; this capacity has been increased by intersectoral strategies, making it possible to disseminate this information among the ministries and other executive agencies responsible for policy maintenance and assessment. The various current programs have made it easier to provide health diagnoses and epidemiological profiles of ethnic minorities.
- Increased coordination and integration of the initiatives of the other sectors involved, which, from the ethnic perspective, has led to increased recognition of the need of affirmative action for the Aboriginal, Black, Raizal and Romani peoples.
- Coordinated development of the differential strategy in social protection policy for health, with respect to ethnic groups in emergency situations.
- Creation of specific health care modalities for certain populations and territories, which reduce their exposure and vulnerability.
- The ministries most involved in development of policies which govern intersectoral action in the country (Social Protection, Environment and Education) have specifically responsible divisions and focal points for work with ethnic groups, creating opportunities for coordination with Aboriginal organizations and Afro-Colombian consultative bodies.
- The Ministry of Social Protection and other agencies have published documents on the rights and responsibilities for health of ethnic groups and have defined the means by which care can be accessed by Aboriginals who are forcibly displaced, recognizing a double vulnerability arising from membership in an ethnic group and from displacement.
- A perceptible convergence in public policy has begun to appear on the need to deal with and mitigate the determinant factors of health through integrated strategies which involve different sectors.

- There is more significant participation of ethnic organizations (particularly Aboriginal) in social participation forums on health, as well as greater interest and increase in control, as demonstrated by the creation of health-providing organizations established and formed by these populations.

LESSONS

With respect to the form and process of intersectoral action

- The affirmation and dissemination of government policy frameworks such as the millennium development goals and objectives has set the stage for intersectoral action, insofar as agendas and cooperative agreements among official bodies and other partners are thereby more easily established.
- Intersectoral action has a clear, persuasive logic of application when the type of collaboration to be expected among the different sectors involved is specified. Once established, intersectoral action requires clear instructions which define the roles, responsibilities and functions in the activities.
- Emergencies are a clear call for action and reconstruction, but in contexts where the authority of the government is weakened, they are also opportunities for achieving greater control and self-sustainability in initiatives which, probably, would be unattainable with greater government presence.

With respect to resources

- The concept of time in agrarian or rural communities conflicts with the efficiency and promptness with which external aid and cooperation is deployed. Means of bringing the communities closer together may be invalidated due to clashes in world outlook and therefore sustainability of intersectoral action may be affected.
- The differential approach yields new specific information on populations and their general living conditions, which may help reveal cultural mechanisms which are still hidden to outsiders.

With respect to processes and structures

- Aboriginal accountability practices are a valuable cultural and political element and a form of institutional capital, assuring a distribution of responsibilities for generating socially desirable results in a manner different from that familiar to external observers.

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APPENDIXES

Appendix 1

REGULATORY TEXTS RELATING TO ETHNIC GROUPS IN COLOMBIA

The following presentation of regulatory texts is taken from the Project of Adaptation and Extension of Social Protection Policy in Health to Aboriginal and Other Ethnic Groups, under agreement between the Ministry of Social Protection and the Pan American Health Organization in 2004. The articles of the Constitution relating to ethnic groups are presented first, omitting articles which protect in a general manner their rights as citizens of the republic. Laws and regulations of major importance are then presented.

<i>Regarding fundamental principles</i>	
Art. 7	The State recognizes and protects the ethnic and cultural diversity of the Colombian nation.
Art. 8	It is the obligation of the State and of all persons to protect the cultural and natural wealth of the Nation.
Art. 10	Establishes the languages of the ethnic groups as official languages in their territories and provides for bilingual education in these territories.
<i>Regarding rights, guarantees and responsibilities</i>	
Art. 13	Establishes freedom and equality of all persons and prohibits any form of discrimination.
Art. 63	Establishes the communal lands of ethnic groups and reserve lands as inalienable, imprescriptible and non-seizable.
Art. 68	Ethnic group members shall have the right to an education which respects and enhances their cultural identity.
Art. 70	The State has the responsibility to encourage equal opportunity of access to the culture of all Colombians.
Art. 72	Establishes as belonging to the Nation and as inalienable, non-seizable and imprescriptible, the archeological heritage and other cultural elements which define national identity; and specifies that the means for repatriating articles now in private hands and the special rights of ethnic groups situated in areas of archeological wealth be regulated by law.
Art. 93	The provisions of international treaties and covenants ratified by Congress which recognize human rights and prohibit their limitation in special cases shall apply domestically.
Art. 96	Awards Colombian citizenship by adoption to members of Aboriginal peoples who share border areas, with application of the principle of reciprocity based on public treaties.
<i>Regarding laws and the legislative branch</i>	
Art. 171	Defines the special constituency for the election of senators by Aboriginal communities.
Art. 176	The law may establish special constituencies to assure representation in the Chamber of Deputies of ethnic groups, political minorities and Colombians living abroad.
Art. 246	The authorities of the Aboriginal peoples may exercise jurisdictional powers within their territory in accordance with their own rules and procedures, as long as these are not contrary to the constitution and laws of the Republic. The law shall establish means to coordinate this special jurisdiction with the national judicial system.

<i>Regarding territorial organization</i>	
Art. 286	Territorial entities consist of the departments, the districts, the municipalities and the Aboriginal territories.
Art. 287	The territorial entities have autonomy in the management of their interests within the limits of the Constitution and the law. They have the following rights: government by their own authorities, exercise of powers in their own jurisdictions, administration of resources, imposition of taxes and sharing in national revenues.
Art. 329	Aboriginal territorial entities shall be formed subject to the Law Respecting Territorial Organization, and their limits shall be established by the national government, with the participation of representatives from the Aboriginal communities, upon advice of the Commission of Territorial Organization. The reserves are considered collective property and are inalienable. The relationships and coordination of these entities with those territorial entities of which they are a part shall be determined by law. PARAGRAPH: If an Aboriginal territory is located in two or more departments, its administration shall be carried out by Aboriginal councils in coordination with the governors of the respective departments. In the event that it is decided that this territory form a territorial entity in itself, this shall be done in compliance with the requirements specified in the first clause of this article.
Art. 330	Establishes that the Aboriginal territories be governed by councils formed and regulated according to the customs of the communities, and defines the functions. Exploitation of natural resources shall be carried out without harmful effect on the cultural, social and economic integrity of the Aboriginal communities, and for such exploitation, the government shall favor the participation of representatives from the respective communities.
Tr. 55 ³⁶	Congress shall issue a law (70/93) recognizing territorial rights for the Black communities, promoting development of their economy, and establishing means to protect their cultural activities.
Tr. 56	While the law referred to in Art. 329 is being issued, the government may dictate the required fiscal regulations and other provisions relating to the functioning of the Aboriginal territories and their coordination with other territorial entities.

Source: PAHO-MPS (2004).

Specifically in the field of health, there are various constitutional provisions which state the rights and obligations of the State in the full exercise of the right to health. Articles 48 and 49 present the set of principles which orient the provision of health services. Two essential points may be mentioned here: (1) all residents in the national territory have an inalienable right to social security: this implies that its provision, under the aegis of the State, is obligatory; and (2) health is a public service under the responsibility of the State; this implies that it is a service that the State provides either directly or by way of private entities expressly delegated by it and dedicated to promotion of health.

³⁶ Although this clause refers to Black communities, we have inserted it in this body of statutes due to the role played by the Aboriginal constituents for its inclusion.

The framework of constitutional rights supported by the Health Social Security System in Colombia follows:

Article	Content
48	“Social security is a mandatory public service which is provided under the direction, coordination and control of the State, subject to the principles of efficiency, universality and solidarity, and in the terms established in law. All residents are guaranteed the inalienable right to social security. The State, with participation from the private sector, shall progressively expand the coverage of social security.... Social security services may be provided by public or private agencies.... The funds of social security institutions shall not be directed towards or used for other purposes....”
49	“Health care and environmental hygiene are public services under the responsibility of the State. All persons are guaranteed access to services which promote, protect and restore health.... The organization of health services is decentralized and is based on levels of care, with participation of the community. The law shall indicate the terms in which basic care for all residents is mandatory and free of charge. All persons have the obligation to obtain complete health care for themselves and their communities.”
50	“All children less than one year of age who are not covered by any type of protection or social security shall have the right to receive care free of charge at any health institution receiving contributions from the State.”
365	“The provision of public services is an inherent social purpose of the State. It is the responsibility of the State to assure effective provision of these services to all residents of the national territory”.
366	“The general welfare and improvement of the quality of life of the population are the social purposes of the State. Meeting unmet needs in health, education, environmental hygiene and drinking water shall be a basic objective in its activities. For this reason, public expenditures for social purposes shall take priority over any other allocation in the plans and budgets of the nation and the territorial entities.
356	“Unless otherwise specified in the Constitution, the services under the responsibility of the nation, departments, districts, and municipalities shall be determined by law upon initiative of the government. For purposes of covering the services provided under the responsibility of the departments, districts and municipalities, and issuing adequate funds for the provision of such services, a General System of Participation (SGP) in these entities shall be created. Districts shall have the same competence as municipalities and departments with respect to distribution of the SGP as provided in law. To this end, Aboriginal territorial entities, once constituted, shall be beneficiaries. Similarly, the law stipulates as beneficiaries Aboriginal reserves if these have not been established as an Aboriginal territorial entity.”

Statutes

The statutes which defined health policy towards ethnic groups prior to the 1991 Constitution were directed to ratification of international treaties and agreements, with the exception of Law 10 of 1990 which organized the National Health System, incorporating the principles under which Decree 1811 of 1990 could be carried out. Through laws issued under the 1991 Constitution, the policy of the General Social Security System in Health and the allocation of funds gradually evolved. In the case of Law 691, the statutes represent an effort to regulate matters relating to Aboriginal peoples in the field of health and social security.

1. **Law No. 31 of 1967**

Through this law, the International Labor Convention was approved, respecting the protection and integration of Aboriginal and tribal populations in independent countries; this convention had been approved in the 40th session of the General Conference of the International Labor Organization in Geneva in 1957. The convention dealt with topics relating to the application of the social security system to Aboriginal populations. “Existing social security systems must progressively extend, whenever feasible, ... (a) to persons belong to these populations, ... and assure that (1) governments take on the responsibility of placing adequate health services at the disposition of these populations; (2) the formulation of these services is based on a systematized study of the social, economic and cultural conditions of the populations in question; and (3) implementation of these services is coordinated with application of general measures to further social, economic and cultural development.”

The main provisions relating to ethnic groups are given below in chronological order from 1967 to now, with no other purpose than to show the process in which the provisions have been produced, either as instruments to regulate others at a higher level or in response to community pressure.

2. **Law 74 of 1968**

Through this law, the International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted in December 1966 by the United Nations General Assembly, was approved. Article 27 of this covenant stipulates that “... in states where there are ethnic, religious or linguistic minorities, the persons belonging to these minorities shall not be denied the rights which they possess, in common with other members of their group, to maintain their own cultural life, to profess and practise their own religion, and to use their own language.” In addition, Article 11 establishes “the right of each person to an acceptable level of life for him/herself and his/her family, *including* adequate food, clothing and housing and ongoing improvement of his/her living conditions.” The Committee on Economic, Social and Cultural Rights clarified the term “including,” noting that this right, for each person, must also include access to basic hygiene services and drinking water as a fundamental requirement for a state of well-being and a decent standard of life.

3. **Law 16 of 1972**

Through this law, the American Convention on Human Rights, Pact of San José, Costa Rica, signed on November 22, 1969, was approved. Article 10 of this convention stipulates that “the family is the natural and basic element of society and must be protected by society and the State.” The State is the guarantor of social security for all family members, without regard to “...race, color, sex, language, religion, political opinions or national or social nature or origin...”³⁷

4. **Law 10 of 1990**

Through this law, the National Health System was reorganized, adopting the following basic principles: universality, citizen participation, community participation, subsidiarity, complementarity and integration of functions. Although this law was repealed in part by Law 100 of 1993, it specified that health service at all levels was a public service under the responsibility of the nation, with basic

³⁷ Article 1(1) of Law 16 of 1972.

services to be provided free of charge for all residents of the national territory, noting that “its coverage extended without any discrimination to sections of the population consisting of Aboriginal peoples located in different areas of the country”³⁸. The law formulated a decentralized organization of the health sector along the following lines: the first level of care was the responsibility of the municipalities, while the second and third levels were that of the departments. The central government assumed the direction, surveillance and control of this system. The financing of the health services would be drawn from the funds of each territorial entity and the transfers from the central government (*situado fiscal*) for health.

5. **Law 21 of 1991**

Through this law, issued on March 4, 1991, Convention 169 Concerning Indigenous and Tribal Peoples in independent countries, adopted in 1989 by the 76th session of the General Conference of the International Labor Organization in Geneva, was approved. This statute, following Law 89 of 1890, has been transformed into the most important tool for guaranteeing the rights of the Aboriginal peoples and other ethnic groups. This Convention “recognizes the aspirations of the Aboriginal peoples to take control of their own institutions and modes of life and of their economic development, and to maintain and strengthen their identities, languages and religions within the framework of the states in which they live³⁹.” Articles 24 and 25 stipulate that “Social security plans shall be extended progressively to the peoples in question and shall be applied without any discrimination.” Governments shall ensure that adequate health services be made available to the peoples in question, or alternatively that means be provided to these peoples which will allow them to organize and provide such services under their own responsibility and control, so that they can enjoy the maximum possible level of physical and mental health. As much as possible, health services shall be organized at the community level, ... shall be planned and administered in cooperation with the peoples in question, and take into account their economic, geographical, social and cultural conditions, as well as their methods of prevention, treatment practices, and traditional medication. The system of sanitary assistance shall give preference to training and employment to sanitary personnel from the local community and shall concentrate on primary health care; at the same time, close links shall be maintained with other levels of sanitary assistance. In addition, provision of such health services shall be coordinated with other social, economic and cultural measures adopted in the country.

6. **Law 60 of 1993 (repealed)**

Through this law, the powers with respect to health, education, drinking water, basic hygiene and housing were distributed among the municipalities, departments, districts and the national government. It expanded on the topic of *situado fiscal*, i.e. funds transferred from the central government to the territorial entities, and current national revenue, specifying their nature, form of administration, persons in charge of spending the funds, manner of distributing the transferred funds, the requirements to be presented by the departments and districts to the ministries of education and health for administration of the transferred funds, and the manner in which the funds would be transferred to the territorial entities. It made special provision for decentralized management and provision by the municipalities of health and education services. Finally, it elaborated on how

³⁸ Castillo Napoleón. The Aboriginal Communities in Colombia and Their General System of Social Security in Health. Attorney General of Colombia, Imprenta Nacional [National Press], August 2003, p. 42.

³⁹ Morales Osorio, Gladys Eugenia: Organization of the National Experience Related to Regulation of Health and Aboriginal Communities in Colombia. Departmental Health Directorate of Cauca, Popayán, September 2002, p. 16.

municipalities would participate in the current national income, defining rules for allocation of funds to the various social services and participation of the Aboriginal reserves. In health matters, the funds were to be invested as follows: “... *payment of salaries and fees to physicians, nurses, health promoters and other technical and professional personnel and, where applicable, their social benefits and their social security contributions; payment of benefits for access by persons with unfulfilled basic requirements to health care, access to essential medication, prostheses, orthopedic equipment, and social security health system; preinvestment and investment studies in the construction, staffing and maintenance of municipal hospital facilities, health posts and health centres; vaccination; health promotion; surveillance and monitoring of environmental hygiene and consumables constituting a risk factor to health; financing of programs of supplementary nutrition for vulnerable groups; welfare of mothers and children; school food; and programs for senior citizens and persons with physical or mental disabilities in any type of care...*”

7. Law 100 of 1993

With this law, issued on December 23, 1993, the Comprehensive Social Security System was created and other provisions were specified. The law regulated Article 48 of the Constitution, which states that “Social Security is an obligatory public service which is provided under the direction, coordination and control of the state, subject to the principles of efficiency, universality, and solidarity...” The contributory and subsidized health systems were established through this law, as well as health systems for the Aboriginal communities; through this law, the Aboriginal communities would form part of the subsidized health plan (Art. 157), and the National Health Supervisory Agency would be empowered to authorize Aboriginal health support enterprises to serve as health promoting enterprises (Art. 181).

8. Law 70 of 1993

The purpose of Law 70 was to recognize the right of Black communities to collective lands. The first part laid down the definitions and principles to be taken into account in its interpretation. The procedure was then formulated for recognizing the collective property of the Black communities, and rules given governing the use of the land, protection of the environment, and exploitation of mineral resources. It also established the means for protection and development of cultural identity, and, finally, provided for planning and promotion of the economic and social development of the Black communities. With respect to health, the law, taking as its point of departure the recognition and protection of ethnic and cultural diversity, established the following provisions: (1) forest exploitation operations must give priority to proposals of the Black communities, and these must be included in the implementation of the various projects; (2) in mineral exploitation, measures must be adopted to prevent and control any environmental deterioration which would affect human health, hydrobiological resources and renewable resources; (3) it is an obligation of the state to take steps to ensure that the Black communities know their rights and obligations with respect to labor, education and health; (4) the state shall guarantee economic and social development in a manner consistent with the culture of the communities; and (5) mechanisms must be provided to allow recognition of the intellectual property of the Black communities who develop plant varieties or make use of knowledge relating to medicinal, food, handicraft or industrial uses of the plants or animals of their natural environment.

9. Law 162 of 1994

With this law, the Convention on Biological Diversity was approved. In the preamble of the Convention, the participating states recognize the value of biological diversity and the close relationship of the Aboriginal communities with biological resources, among other considerations. The objectives of the Convention are to preserve biological diversity, promote sustainable use of biological components, and allow fair and equitable access to the benefits obtainable from the exploitation of genetic resources. To this end, a series of measures was specified which the states must take in order to preserve the components of biological diversity, both in their natural habitats and outside them. In the case of the former, the Convention specifies that the participating states, through domestic legislation, respect, preserve and maintain the knowledge and practices of the Aboriginal communities which allow for sustainable use of biological diversity. It also specifies the need to expand such practices, with the participation of the communities. The Convention then defines the commitments of the states with respect to genetic resources, access to technology, technology transfer, and scientific and technical cooperation.

10. Law 19 of 1996

The purpose of this Protocol is to commit the signatory states to adopting the measures required to convert economic, social and cultural rights into reality. To this end, the following rights were defined: the right to work, right to join a union, right to social security, right to health, right to a healthy environment, right to education, right to cultural benefits, right to establish a family and to protection of the family, children's rights, protection of seniors, and protection of persons with disabilities.

11. Law 691 of 2001

This law, issued on September 18, 2001, regulates the participation of ethnic groups in the General Social Security System in Colombia. Its purpose is to guarantee, on the basis of respect and protection of ethnic diversity, access and participation of the Aboriginal peoples in health services. Among the principles underlying this law, the principle of ethnic and cultural diversity is emphasized in order to make possible harmonious development of the Aboriginal peoples, and the authoritative status of traditional Aboriginal authorities in the health system is recognized. It specifies that Aboriginal persons participate as affiliates in the subsidized plan, with exceptions as specified in Art. 5. It describes the benefits plan, making it clear that both the mandatory plan and the basic care plan must adapt to the world outlook and values of the Aboriginal peoples. It obliges the National Social Security Council in Health to define the content of the Mandatory Health Plan of the Subsidized Plan for the Aboriginal Peoples and further provides that this plan include a food subsidy for expectant mothers and children under five years of age. It lists the financing sources for affiliation of the Aboriginal peoples and mentions the possibility of setting the value of the UPC (per-capita payment unit) at as much as 50% higher than the normal UPC value, depending on geographical factors, population density, epidemiological profiles, and other factors. It defines steps for administering the subsidies and benefits, empowering the Aboriginal authorities to create the Aboriginal Health Administration Agencies [Administradoras Indígenas de Salud, ARSI]. It specifies selection and collective affiliation of the respective community to the ARSI. With reference to public participation, the law sets out the principle of agreement in defining benefits plans and in any health activities for Aboriginal peoples and establishes that an Aboriginal representative participate in the Territorial Boards for Health Social Security.

12. Law 715 of 2001

This law repealed Law 60 of 1993 and thereby reorganized the system of funds and jurisdictions of the territorial entities, creating the General System of Participation [Sistema General de Participaciones, SGP]. In this law, the principles giving direction to this new system were listed in the first part, to be followed by regulations relating to the health sector and then provisions governing its organization. The final part defined the inclusion of general purposes [*propósitos generales*], listing the purposes and the percentage of funding to be directed to each of them. In the area of health, the law defined the powers and functions to be attributed to the country, the departments (as entities in charge of directing, coordinating and supervising the health sector and the General Social Security System in their territory), the districts and the municipalities. It listed the components of the health sector which would be funded from the General System of Participation and established the form in which benefits and subsidies for the poor would be financed. With respect to Aboriginal communities, the law, in its paragraph on common provisions of the General System of Participation, presented the manner in which the Aboriginal reserves would be included in the System, describing the means by which funds would be transferred and administered. It stipulated that of the total funds comprising the System, 4% would be deducted annually in advance; in the specific case of the Aboriginal reserves, 0.52% would be assigned to them. Article 82 recognizes the right of existing reserves duly accredited by competent authorities to receive funds from the SGP, as long as they do not comprise Aboriginal Territorial Entities, specifying in Article 83 that funds for the Aboriginal reserves would be distributed in proportion to the participation of the population of each reserve out of the total Aboriginal population reported by DANE. “Notwithstanding the specification in Article 83 of the sectors to which the funds for the Aboriginal peoples would go, the law indicated that priority use of these funds is for satisfaction of the basic needs of ‘...health, including affiliation to the Subsidized Plan; pre-school, basic primary and middle-school education; drinking water; housing; and farming and livestock development of the Aboriginal population.’ In the area of health, the rule gave reference to Chapter III of Title III of Law 715, which provided for a clearer explanation of the purposes of distribution of these funds, taking into consideration the financing or cofinancing of benefits on demand in a progressive manner up to achievement and maintenance of total coverage, the provision of health service to the poor where they are not covered by benefits on demand, and in the advancement of public health activities, defined as high-priority for the country and, naturally, for the Aboriginal population by the Ministry of Health, now Social Protection.”⁴⁰

13. Law 740 of 2002

With this law, the Cartagena Protocol on Security in Biotechnology of the Convention on Biological Diversity was approved. The purpose of this Protocol is to ensure an adequate level of protection in the transfer, handling and use of modified living organisms which may have adverse effects on biological diversity or carry risks to human health. It elaborates a series of procedures for the importing and exporting of biotechnically modified living organisms. With respect to imports, Article 26 specifies that when making a decision in this area, the participating countries may take into account, in a manner compatible with international obligations, socio-economic considerations linked to the effect of modified living organisms on conservation and sustainable use of biological diversity in the context of Aboriginal communities.

⁴⁰ Castillo Napoleón. The Aboriginal Communities in Colombia and Their General System of Social Security in Health. Office of the General Prosecutor, Imprenta Nacional [National Press], August 2003, p. 46.

Appendix 2. Projects Carried Out by PAHO/WHO – Colombia					
INTERSECTORAL MANAGEMENT AND DIFFERENTIAL APPROACH TO ETHNIC GROUPS IN COLOMBIA					
Project	Duration	Sectors	Participants	Benefiting population	Results
Reinforcement of the DOTS/TAS strategy for Aboriginal peoples in Colombia	2002–2008	Education and health	Ministry of Social Protection, Institute of Health, CIDA, PAHO/WHO	Municipal and departmental health teams in Guanía, Guajira, Cesar, Amazonas, Magdalena, Santa Marta, Vichada and Nariño	<ul style="list-style-type: none"> • Strengthening the network of diagnostic and treatment services • Identifying factors of non-adherence to treatment • Producing material for training and disseminating information • Forming and strengthening networks among microscope analysts to increase opportunity for and quality of diagnoses. • Training of skilled personnel • Increasing program management ability
Psychosocial care for Black communities in Cali and Buenaventura	2003–2006	Health and education	Ministry of Social Protection, displaced persons' organizations, community councils, church social outreach, international solidarity	300 displaced and vulnerable families primarily of African descent; 2 community councils in Buenaventura	<ul style="list-style-type: none"> • 300 families received legal advice on access to rights and responsibilities, psychosocial care, and help in arranging for housing subsidies. • Strengthening of organizations for displaced persons of the area and the women's group • 30 social workers trained • Training materials
Health of Aboriginal populations through improvement of water and sanitary conditions	2002–2006	Public policy, education and health	PAHO, GTZ, Ministry of Social Protection, Aboriginal Organization	5 rural Aboriginal communities	<ul style="list-style-type: none"> • Public policy guidelines in water and basic sanitation for Aboriginal peoples. • Methods: education projects for healthy housing for Aboriginal persons. Book: We established healthy environments for our Aboriginal peoples (bilingual) • Demonstration model for water supply and basic sanitation • Analysis of the situation and data base of Aboriginal communities and monitoring system • Water and Sanitation Inventory: Aboriginal populations of Colombia.
Compile and share experiences in organizing and managing decentralized health services for Aboriginal populations	2003–2006	Justice, economics, culture and education	ACIN, local hospital personnel, IOM, PAHO, UNICEF	Four reserves: 90% Paez Aboriginals; 34,000 (Toribio) and 14,000 (Jambaló)	<ul style="list-style-type: none"> • Health component of the Minga Defence Plan. • Emergency and Disaster Prevention, Mitigation and Care Plan of the ACIN • Strengthening and coordination of the ethnic health school • Promoters and Aboriginal Guard members trained in pre-hospital and complex-emergency care. • Cultural exchanges between ACIN (Colombia) and Cotachi (Ecuador), TCC: modalities of Aboriginal health care. • Health guidelines from the Aboriginal perspective.