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Determinants of maternal health services utilization in the Wayuu communities of Maicao, La Guajira, Colombia

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Introduction

According to the World Health Organization (WHO) the first 1,000 days of an infant's life (nine months gestation and the first two years) is considered crucial to child health and development. The evidence suggests that appropriate care, good nutrition and healthy growth during this period will have benefits throughout the individual's life. The WHO recommends a strategy that addresses antenatal care, promotes universal access to antenatal care, skilled birth attendance and early postnatal care for sustainable reduction in maternal and newborn deaths. Antenatal controls are crucial in providing women with vaccinations, supplements, nutritional counselling and assessment for blood pressure. It is estimated that 60% of maternal deaths occur in the postpartum period with the majority of these deaths occurring close to birth: 45% of deaths are considered to occur within 24 hours after birth (WHO, 2013a). Postnatal controls also provide opportunities to vaccinate and assess newborns, potentially preventing up to two thirds of newborn deaths. Newborns born preterm, with low birth weight, who are sick or who are born to HIV-infected mothers need special care (WHO, 2013b). For this reason, it is suggested that women attend at least four antenatal controls under the care or supervision of a professional, and that the first postnatal control occurs within 48 hours of birth, with follow-up at 3 weeks (WHO, 2013b).

According to Colombia's antenatal care guidelines, the first visit should be with a medical doctor with subsequent visits taking place monthly (by a doctor or nurse) until 36 weeks. At this point visits should occur every two weeks until delivery. (Vecino-Ortiz, 2008). However, a number of factors affect women's ability to adhere to this schedule. Previous studies conducted in Colombia showed that while overall antenatal coverage had increased between 2008 and 2013 there were still gaps between women from different socio-economic groups and different geographical areas (Trujillo, Carrillo & Iglesias, 2013; Vecino-Ortiz, 2008). Socio-economic characteristics such as age, education, economic status, health insurance access and parity affect both antenatal care visits and delivery in a health care facility (Trujillo, Carrillo & Iglesias, 2013). There was also lower coverage in rural areas compared to urban areas, which could be associated with increased distance to health care facilities. Less is known about postnatal care.

The Wayuu people live in La Guajira, Colombia, and in northeast of Venezuela, next to the Caribbean. The Wayuu population in Colombia is estimated to be 144,000, representing 20.5% of the Indigenous population in the country, and 48% of the population in La Guajira. The majority live in rural villages spread across the region.

A substantial reform in the health care system of Colombia in the mid-1990s led to the creation of Empresas Promotoras de Salud (EPS) (Mignone, Nállim & Gómez, 2011). EPSs are essentially health insurance companies. One type of EPSs is for low-income/vulnerable populations. These are non-profit and can be created by local organizations. The Wayuu took this oppor-



A group of young Wayuu girls performing a traditional dance

tunity and created their EPS, Anas Wayuu EPSI, in 2001. Anas Wayuu currently provides health care coverage to approximately 110,000 people in La Guajira, the majority of which are Wayuu.

This report presents data gathered during a pilot study to assess the health care needs and access to services of pregnant women in Wayuu communities. The pilot study was conducted in response to a request from Anas Wayuu for a better understanding of Wayuu women's experience with perinatal controls and care during delivery. This pilot study was designed as part of the field experience for trainees in the International Infectious Diseases and Global Health Training Program (IID&GHPT). This took place in the context of the Practical Epidemiology and Indigenous Health Course held in La Guajira in August 2013. The pilot study was nested in a larger, ongoing study conducted by the Universidad de Antioquia, Anas Wayuu EPSI, Asocambios, Sumuywajat, Secretaria de Salud de Maicao, Mediser and the Universidad of la Guajira, and supported financially by Colciencias. All these institutions provided financial support for the study, including interviewers, logistical organization for the visits to the villages, and transportation. The study focused on HIV prevention, diagnosis and treatment in Wayuu communities near Maicao, La Guajira.

We report the observations obtained during the IID&GHPT fieldwork where surveys were administered to the women of the Wayuu communities. We describe the experience of Wayuu women in using perinatal care and explore reasons that may have limited their access to care.

Data collection and profile of women

Data collected included socio-demographic characteristics, reproductive history, attendance to ante and postnatal controls, reasons for attending or not, health interventions received, perception of the quality of care, place of delivery and presence or absence of a qualified healthcare professional. Trained field workers obtained informed consent from women before conducting interviews in the local language. Fifty-three women from 5 Wayuu communities from Maicao, La Guajira were interviewed. The surveys were administered to women who had delivered at least one child in the last seven years. Of the 53 women, 77% were married and 23% were single mothers, being single, separated or widowed. The average age of mothers interviewed was 31.52 years old (SD: 10, minimum and maximum: 14 and 55 years).

Regarding education, women had attended an average of 5 years of school (SD: 5), ranging from 0 to 16 years. The majority (39.6%) had a level of education corresponding to primary school. A quarter had no education (27.1%) or had attended high school (22.9%) while a minority (10.4%) had attended university.

Looking at their reproductive history, interviewed women had an average of 4 children, ranging from a single child to 12 children. Nine (16%) of them were currently pregnant.

The Wayuu communities at a glance

In addition to the surveys administered to women, students visited these five communities. They were all located in the vicinity of Maicao, La Guajira. These communities were all easily accessible from main roads, and sizes of communities varied between 100 and 200 people. They recorded observations of community characteristics that may impact maternal and child health.

Housing

Housing conditions varied across communities. The dominant building style was a wood frame plastered with mud, while buildings constructed of concrete blocks and cement were less common.

Lack of running water in houses and no electricity was reported for most communities. Some households have generators to provide electricity at night, and some televisions were observed. There was some overcrowding, with reportedly up to nine people sleeping in one house.

Kitchens are separate structures and in all communities the wood stove was enclosed by a wood fence and a roof. In the

community with concrete-constructions, kitchens were also built but none of those observed were used as kitchens (rather as storage spaces). The more traditional kitchen was constructed next door. One explanation offered was that there was no ventilation in the concrete kitchens and smoke from fires could not escape. Kitchens were open to animals, including chickens, goats, pigs and dogs. In general, people were observed to live in close proximity to their livestock.

Bathrooms were not included in main house structures either. In the community with concrete-constructions, bathrooms were included in the houses but none of these were used, partly due to the lack of running water. One reason offered for having bathrooms outside was that people thought the smell of urine would make them sick. Some communities had showers built outside, also enclosed by wooden fences. In other communities there were some conventions as to when and where men, women and children washed, mostly with water carried from wells or tanks.

Water

Access to clean water was a concern in all communities. Water sources included wells, sometimes with wind pumps, rain water collection, or water trucked in every 15 days and stored in containers (alberca). Water from these sources was generally not boiled. However, it was recommended by health care professional to boil it. One community had well water, but drinking water was brought in by truck. This did not always arrive and/or was not sufficient and they would have to drink well water as well, which they linked to diarrhea and other diseases. Where water quality was a concern, limestone was added to water for purification.

Ponds (jaguey) serve as water sources for animals, as well as the community following the rainy season.

Access: physical and to information

In terms of physical access, with the exception of one community which was located in the outskirts of Maicao, access roads to all communities were unpaved with visible erosion damage. Access to all communities was restricted during the rainy season. Main modes of transportation reported were motor vehicles, bicycles and walking. Within communities, households were connected by paths- car accessible roads often ended near the main area of the village.

In terms of access to information, only one community mentioned cell phone access while one did not have any coverage. There were some television sets in communities, and some of the schools had computers although they were waiting for electricity and internet access. Another school had a computer but it had been damaged by sand.

Education

All communities had primary schools, some taking students up to grade 6 and some to grade 9. Schools generally did not have electricity. Primary schools in the communities are staffed by individuals from the community. Schooling takes place in both their own language and Spanish. High school had to be attended in the nearest city- Maicao. Education is free and transportation to school supplied by the government, but in some communities children would have to walk up to two kilometres to a main road for a bus. Others are taken to school by parents, walking, in bicycle or by donkey. In some communities it was reported that children left school after 4-5 years to become shepherds due to lack of interest in school.

Access to health care

Only one community had its own health care facility, in all other communities they would have to travel at least 15 minutes to the nearest clinic, or between 20 and 40 minutes' drive to the hospital in Maicao.

Local health care facilities offered both western and traditional medicine, practiced by spiritual healers. Different types of ailments were treated by traditional/spiritual healers and western medical clinics. One healer reportedly referred certain cases to the western clinic, and in another community the western medicine clinic was described as a site for research. Overall,

healers were trusted, in some cases more so than western medicine and hospitals. Traditional healers acquire knowledge/direction on how to treat people through dreams. Respiratory problems, due to dust and poor living conditions, was reported as common in one village, smoke from cooking fires could also play a role. In discussion with community members, there seemed to be a lack of knowledge of HIV although people may have just been reluctant to discuss this with outsiders/visitors. For pregnant women, care was reportedly accessed in western facilities with some communities stating that all births occurred in hospital. In other communities, however, home births assisted by traditional midwives was preferred. Barriers to accessing care at western facilities mentioned included language (not all women spoke Spanish) and distance to the nearest hospital. Preeclampsia was mentioned as a concern in one community.

Community life

There were no commercial establishments observed in any of the communities. In only one community was a construction projects reported (new house).

Daily activities are shaped by gender, with men having primary responsibility for taking care of the livestock, building houses and increasingly working outside the communities to generate income. It is common that men spend part of the year working in Venezuela, due to its proximity to Maicao. Women have primary responsibility for the household, meals, taking care of the children and weaving/handicrafts. Women, or older children, fetched water for the house and made cheese. In most communities they were also the teachers at the local school (some men). Women can also own their own livestock. In some communities, families eat in a central place.

Women were also predominantly dressed in traditional clothes while men, apart from their shoes and traditional straw hats, were dressed in more Western fashion.

Elders have a great deal of respect within communities.

Although all villages considered themselves Matriarchal, according women special importance, differing practices were recorded in different communities. In some, the mother was considered to be the head of the family, although her brother was sometimes named as key contact person for that village. In others, it was observed that sons had built their houses in the vicinity – or same ‘compound’ – as their father. The girl would move to the husband’s community, or where he wants to live. Polygamy seems widely accepted and widow marriage is allowed. Extra marital relationships were considered common. Community members talked about the high value of women, partly illustrated by the gift men (or their families) have to give a woman’s family to secure her as bride. These gifts were described as usually money, livestock and/or jewelry. Marriage was reported with girls as young as 12/13 years, but more common in older ages (16/17 or in their twenties).

Two rites seemed of special importance. The first is the transition of girls to womanhood, considered to occur with the first menstruation. During this time they may be isolated from the rest of the community, although varying lengths were reported in different communities (2 or 8 months to 1 or 2 years). During this time she will also learn how to weave the hammocks and bags – a major source of income for families.

Another important event is death and burial, although the details also varied between villages. What seems to be fixed is that there is a wake, length depending on the family’s wealth and how far the furthest relatives live (how long it takes them to get there), and two burials. The first burial follows the wake, and takes place within the village grounds. These remains are then exhumed by an elder and a second burial takes place (traditionally in a northern area of La Guajira, although now it is more common to have the second burial closer to the village), to free the spirit of the dead. In one village, it was recounted as happening 15 years after burial, in others 2 years or 5 years.

All communities had a meeting space which is also where guests are received. Usually an open air space with a roof near the home of the community leader. The meeting space is called ‘enramado’ in Spanish. Also a central kitchen and soccer fields

were found in most communities.

In most communities people reported being Catholic but there were some elements of indigenous religion present. These include a belief in a God who provides rain and food, and communing with spirits for healing (bone healer).

Economic activities

One of the main modes of income was selling hand-woven hammocks or bags. Livestock is important, as the amount and type of livestock owned serves as indication of a family's wealth. Increasingly, however, the sale of livestock is also becoming an important source of income in communities— may sell up to 10% of their goats annually. In at least 2 communities selling livestock was now considered the main source of income, especially since other groups have started manufacturing and selling versions of the hammocks and bags woven by women in these communities.

There also seems to be other informal sources of income, most notably the sale of gasoline obtained in Venezuela. There was also mention of people working across the border in Venezuela, and families with households in both Colombia and Venezuela who travel back and forth.

Agriculture is not practiced widely, and there were no reports of agriculture as income generating activity. Although many of the communities had areas under cultivation, these were not large scale undertakings, and often the produce was just traded with other community members for flour or sugar. The desertic landscape of the communities and the lack of running water explained the limited possibilities to practice agriculture among the Wayuu communities.

Perinatal controls and delivery care

Part 1: Delivering at home or delivering in healthcare institutions

Anas Wayuu EPSI provides coverage for pregnant women to access the health care system. Nonetheless, families may incur in costs that are not covered by the health insurance program. Despite a strong cultural attachment to traditional midwifery, women are encouraged to deliver in the formal healthcare system. However, not all women use the services provided by healthcare professionals. To explore barriers and facilitators to accessing services offered by healthcare institutions, we compared the profile of women who delivered in institutions to that of women who delivered at home.

Among the 53 women interviewed, the majority (77.4%) delivered in healthcare institutions while 22.6% delivered at home. Most of the women had a vaginal delivery. Caesarian sections were performed in 21.6% of the cases, mostly (80%) as a result of an emergency, and in a few cases (20%) caesarians were planned. Half of the women who delivered at home were assisted by a midwife or a traditional healer and the remainder by another person. In health institutions, all deliveries were assisted by



Livestock and handcrafting are important economical activities for Wayuu communities

a physician. Interestingly, 44% of the women delivering in health institutions had an education level corresponding to secondary or university level while all women who delivered at home had either no education or a level of education corresponding to primary school. Thus, women delivering at home had a lower level of education compared to women delivering in health institutions.

Both groups had a similar profile in terms of marital status with the majority of them being married (75% at home, 78% in a healthcare institution). Women who delivered at home were less likely to speak Spanish than women who delivered in healthcare institutions. While 76% of the women using healthcare services spoke Spanish, only 58% of the women delivering at home did. This is an important finding (supported by findings from observations) as language may represent an important barrier for accessing perinatal health services.

The Colombian recommendations in terms of prenatal controls are that all women should start prenatal controls before 12 weeks and all women should have at least six controls during their pregnancy (Vecino-Ortiz Al.2008). Among the 43 women who had prenatal controls, only half of them (54%) had the required number of controls or more.

Delivering in healthcare institutions was associated with higher proportion of women attending controls during the last pregnancy or being tested for HIV. While 75.6% of the women delivering in institutions were tested for HIV at some point during their pregnancy, only 60% of the women delivering at home were tested. The same trend was observed for attending antenatal controls. The majority (87.8%) of the women delivering in health institutions reported attending antenatal visits during their last pregnancy while only 58.3% of the women delivering at home attended controls. Among the women who delivered at home, those who attended controls during a previous pregnancy reported earlier attendance for their first control during the current pregnancy (with 71.4% of them reporting beginning controls in the first trimester). In addition to attending antenatal controls earlier in their pregnancy, women delivering at home also had higher numbers of antenatal controls with an average of 7 (SD: 2, min 2 and max 9) compared to women delivering in health institutions who had an average of 5 controls (SD: 2, min 0, max 9), which is one control under the recommended number. It was more frequent for women delivering in health institutions to attend antenatal controls in the second trimester of their pregnancy with 55.6% beginning their controls between three and six months of pregnancy. Early controls (before three months) were less frequent (36.1%) among them. In both groups, attending controls after six months was only occasional with 14.3% of women delivering at home and 8.3% of women delivering in health institutions attending controls at that stage. Hence, a higher proportion of women delivering in health institutions attended antenatal controls. However, compared to women who delivered at home and that attended antenatal controls, these women did not complete the recommended numbers of visits and began their controls at a later stage of their pregnancy.

Overall, the reasons given for the lack of antenatal controls could be attributed to lack of time or resources as opposed to cultural reasons. The reasons most frequently reported were 1) lack of time, 2) distance to clinic or hospital, and 3) costs associated with traveling and/or services. Some remaining concerns were expressed about the availability of the services such as hours of opening, delay in receiving an appointment, or delay in receiving care at the site.

Both groups had a positive perception of the care received. Ninety one percent of the women delivering at home rated the care received as good or excellent. Care provided in health institutions was also well perceived by the women delivering in these facilities, with 90.2% qualifying them as good or excellent. In both groups, the remaining 10% judged the care received as regular in the majority of the cases and bad in two cases. Remarkably, 9.5% of the women reported a lack of knowledge about their right to access services, the location of antenatal services or the need of attending antenatal controls. This appears to suggest a lack of information in the community about services that are offered to pregnant women. This lack of knowledge could be addressed by an enforcement of the educational program in the community.

In summary, not speaking Spanish was more frequent among the group of women who delivered at home. The language barrier may discourage some women to use healthcare institutions and affect their decision to deliver at home assisted by a midwife, a healer or another person from their community with whom they communicate more easily. In addition, while a high proportion of women delivering in a health institution attended antenatal controls and were tested for HIV, only 58.3% of the

women delivering at home received these services. However, the ones who attended controls began earlier during their pregnancy and attended controls more frequently. Finally, a low but not a negligible numbers of women ignore crucial information regarding pregnancy care.

Part 2: Attending postnatal controls

Another important aspect of maternal child health is attending postnatal consultations. Almost half of the deaths among children under five years in the world happen during the first month of life (UNICEF; WHO, 2013c) and postnatal controls are among the recommended strategies for reducing neonatal death. Yet, postnatal visits remain low in several countries (WHO, 2013c). In this second part of the report, we explore the postnatal care experience of the Wayuu communities near Maicao and the reasons for not receiving postnatal care.

Postnatal visits are underused in the Wayuu community. Half of the women never attended or received any kind of postnatal visits after their last delivery. This observation was similar in both groups, with 58.3 % of the women who had delivered at home and 56.1% of who had delivered in health institutions attending postnatal controls. Surprisingly, 4.9% of the women did not know if they had attended postnatal visits or not, or thought they had attended postnatal care 210 days after delivery, implying that some women do not recognize which services they received, indicating an important lack of knowledge. For those who attended postnatal controls, the first control occurred an average of 27.5 days (SD: 30.3 days, min 1 day, max 210 days) after delivery. The first 24 hours is a crucial period for preventing deadly health complications in newborns as well as mothers. Among the women interviewed, nearly half of them received a postnatal control, with the visit taking place an average of one month after the birth. These observations are of concern and reflect an important lack in postnatal follow-up among the women of the Wayuu communities.

Regarding the reasons provided for limited postnatal visits, only the women who had delivered at home answered the related questions in the survey. The main reason cited was transportation: the distance to the health institution was of concern for almost half (42%) of the respondents, while a quarter of women referred to the cost of the transportation (25%). Cultural reasons and mistrust of western doctors were other barriers to accessing postnatal visits. The non-respect of intimacy by western doctors was also a barrier with 17% of the women reporting not attending postnatal care for this reason. In a few cases, the service was considered too costly or the husband prohibited the visit.

Limitations

One of the main limitations of the pilot study is that communities were selected based on ease of access and they were all relatively close to Maicao – the furthest was 40 minutes' drive from Maicao. As such, observations and data collected may not apply to communities farther from an 'urban' centre or from main roads, which may limit their access to services even more. Although the sizes of the communities varied between 100 and 200 peoples, most were closer to 100 people. As a result, the findings reported here are not generalizable to other communities, and may not reflect the overall perinatal experience in Wayuu communities of La Guajira. This is an important limitation, and needs to be taken into consideration when interpreting the data. It is likely that the most isolated communities face more significant challenges in accessing perinatal care and their experience is not reported here.

Interpretations and Recommendations

This pilot study explored the perinatal care experience of the Wayuu communities in Maicao, La Guajira, Colombia. It identified the issues related to maternal and child health and this report suggests some possible ways to address them. We observed an insufficient attendance to ante and postnatal controls and identified several barriers in accessing the services offered by health professionals. Gaps in knowledge about the availability of the services and the right to access them, financial and transportation limitations and a language barrier were all identified as factors that limit access to perinatal services. Women from the communities may consider that service offered at a hospital in a town in a language and within a medical system that is not theirs, as 'not for them' and consequently tend to not use these services. Some women did not have the

sufficient knowledge of healthcare procedures (and were not sufficiently informed) to fully understand what interventions were done to them or to appreciate the advantages antenatal care could have for their own health or the health of their baby. Strengthening community-based programs to support women during their pregnancy may be a long-term solution that addresses these issues, as well as working more closely with the hospital sector.

Improving communication between communities and health institutions and information outreach

The barriers identified that prevent Wayuu women to successfully complete their ante and postnatal follow-up were in relation to two different aspects: 1) lack of communication between the communities and the health care system, and 2) gap in the knowledge about health requirements during pregnancy. Both could be addressed by the implementation of local program. Given that transportation was an important barrier to accessing care services, such a program would have a strong outreach component. First, this program could train community members as community-based workers who could inform women of health care needs, options available and their right to access the services. Given the language barrier, these workers could also accompany women to their antenatal and postnatal visits. This may encourage pregnant women to access antenatal controls and delivery services in hospitals. As women will already have had contact with healthcare workers, there may be some familiarity and women may be more inclined to accept healthcare professionals' advice in terms of child health and be encouraged to deliver in their facilities. Being supported throughout the pregnancy may facilitate access to care by creating a climate of trust. This would also address the problem of the language barrier. Community workers speaking the local language in addition to Spanish could connect the women from the communities and the professional health workers and facilitate access to health interventions. An efficient program would fill the gap between health care providers and community while reinforcing women's autonomy and increasing their knowledge of safe motherhood. Community workers could also provide counselling on nutrition, be trained to recognize risk symptoms and make sure women take their supplements, perhaps even distribute them. Following delivery, home visit programs such as the one recommended by WHO could be part of the local program of pregnancy support and would also contribute to increase postnatal care among the Wayuu women. As well, Anas Wayuu's recent proposal for capacity building of traditional Indigenous midwives (Anas Wayuu, 2013) may be of significance, as it may increase the understanding between the western and the traditional systems of care.

Gaps in knowledge about pregnancy complications and risks, rights to access health services and the importance of pre and postnatal care could also be addressed by including an educational component in the local program. An educational component would contribute to creating awareness among women of the importance of pre and postnatal controls, the numbers of visits to attend, the type of health interventions they should expect and the reasons to attend them. We observed that



Traditional healer explaining the use of plants and seeds for traditional medicine



Wayuu women preparing a traditional meal

women who were not using the institutional services were less likely to be educated. Girls are married at young age in Wayuu communities and tend to leave school after four or five years of education. An educational program should then be designed to reach young women but also women with no or low levels of education. This implies that schools may not be the most appropriate venue to deliver this type of information. A trained local community worker, easily accessible to pregnant women, could deliver the information directly to them and promote the subsequent use of health services for controls and delivery. A community worker program could be a powerful strategy to improve access to natal care, but it needs to be companion with a proposal of economical compensation for the time devoted to this activity by the local worker. In Colombia, the community work is voluntary and non-profit, and some times, local volunteers cannot afford to dedicate their time to the local program having to make their living as farmers or shepherds. A compensation system, in accordance with Colombian laws, may encourage the full involvement of the local worker to the promotion of natal care usage. However, a lack of resources could represent an important obstacle for the implementation of such a program.

Culturally sensitive approach

To be successful, interventions would have to be culturally sensitive and take the local context into consideration. Given the importance of elders in all communities, they could serve as important gatekeepers to the community. However, when planning any programs to improve maternal-child health, it will be important to take into account the variation in traditions and practices observed between communities despite their geographic proximity. This suggests that the local context will need to be assessed more closely before any interventions are planned or implemented. There may not be a clear, singular culture. Also, despite the high value of women, and the matriarchal nature of the communities, there were still some practices reported that could affect the health of women such as early marriage and extramarital relationships.

Interventions could leverage existing spaces or traditions that could further maternal-child health. These include community meeting spaces or traditions such as the transition to womanhood. Educational programs could take advantage of the community space and implement regular information sessions in the community. Knowledge passed along during this time could include information on maternal and child health, or other health issues.

The implementation of a local program of support should take into consideration the cultural context and include the local authorities. Traditional midwives or healers could become involved in perinatal care and lead the local program of pregnancy support. As midwives and healers are more likely to be elderly and may have a limited use of Spanish, they may not be the ideal candidate to bridge health system and the community. However, they are of importance among the Wayuu communities and are well trusted. Their involvement may bring a climate of trust around health interventions with pregnant women. Consequently, it would be beneficial for the local resources to work in partnership with them.

Financial and transportation issues

Finally, barriers related to cost of going to town for antenatal care and delivery, as well as transportation difficulties (at times also related to cost) may be overcome with more support targeted to families with pregnant women or with children with less than two years of age.

Concluding Remarks

Here, we highlighted the barriers that limit access to perinatal care among women from the Wayuu communities. Efforts are needed to improve the communication between health care providers and communities. A more efficient partnership between local and institutional health providers will facilitate delivery of information to women and build trust in institutions by harmonising traditional beliefs and western practices. Reinforcing educational programs and providing local resources to minimize communication barriers will contribute to improving access to pre and postnatal care. These are pillars of mother and child well-being and essential requirements for a healthy community.

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