ACKNOWLEDGMENTS

Great thanks to all the women in Buenaventura, Colombia, for their interviews; their information and insights were essential to understand the main issues at work in the persistent racial discrimination in Colombia. These women and their children were my constant inspiration while writing this thesis. Additionally, thanks to Carvajal Foundation and its staff in Buenaventura, they provided me all the support and guidance while I was conducting my study. Thanks to the Center for Latin American Studies at the University of Florida, who awarded me with the Thinker Grant to conduct field-work during the summer of 2012. Finally, a very special thanks to Dr. Charles Wood for his unwavering support and expert guidance throughout this project.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>3</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>6</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>7</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>1 THE COLOR OF CHILD MORTALITY IN COLOMBIA</td>
<td>10</td>
</tr>
<tr>
<td>2 MESTIZAJE AND THE INVISIBILITY OF AFRO-COLOMBIANS</td>
<td>16</td>
</tr>
<tr>
<td>The Invisibility of Afro-Colombians as a Subject of Study</td>
<td>17</td>
</tr>
<tr>
<td>Mestizaje: the Basis of Colombian Society</td>
<td>21</td>
</tr>
<tr>
<td>Legal Recognition: from a Monoethnic to a Multiethnic Nation.</td>
<td>26</td>
</tr>
<tr>
<td>Law 70 of 1993: “Ley de Negritudes”</td>
<td>28</td>
</tr>
<tr>
<td>Visibility through Counting</td>
<td>30</td>
</tr>
<tr>
<td>3 STATISTICAL ANALYSIS OF THE EFFECTS OF RACE ON CHILD MORTALITY IN COLOMBIA</td>
<td>35</td>
</tr>
<tr>
<td>A Conceptual Model of the Factors associated with Child Mortality</td>
<td>35</td>
</tr>
<tr>
<td>Proximate Factors of Child Mortality</td>
<td>38</td>
</tr>
<tr>
<td>Distant Factors of Child Mortality</td>
<td>39</td>
</tr>
<tr>
<td>Socioeconomic and environmental factors</td>
<td>40</td>
</tr>
<tr>
<td>Racism and child mortality</td>
<td>44</td>
</tr>
<tr>
<td>Statistical Study of Child Mortality in Colombia</td>
<td>46</td>
</tr>
<tr>
<td>Dependent Variable: Child Mortality</td>
<td>48</td>
</tr>
<tr>
<td>Independent Variables</td>
<td>50</td>
</tr>
<tr>
<td>Race Differences in Child Mortality in Colombia: Multivariate Analysis</td>
<td>51</td>
</tr>
<tr>
<td>Race effect on Child Mortality by Region and Department</td>
<td>60</td>
</tr>
<tr>
<td>Racial Discrimination Vs. the Myth of Racial Democracy: Child Mortality by Race</td>
<td>62</td>
</tr>
<tr>
<td>4 MECHANISMS OF DISCRIMINATION: ETHNOGRAPHIC STUDY IN BUENAVENTURA</td>
<td>66</td>
</tr>
<tr>
<td>Method</td>
<td>66</td>
</tr>
<tr>
<td>Buenaventura, Valle del Cauca: the Research Site</td>
<td>69</td>
</tr>
<tr>
<td>A Closer View of the Effects of Race on Child Mortality: Studying Relations between Health Staff and Patients in Buenaventura</td>
<td>70</td>
</tr>
<tr>
<td>Colombian Health System</td>
<td>75</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-1</td>
<td>Description of the variables in the statistical models</td>
<td>50</td>
</tr>
<tr>
<td>3-2</td>
<td>Probability of child death regressed on age, place of residence, location,</td>
<td>52</td>
</tr>
<tr>
<td>3-3</td>
<td>The effect of race on child mortality (odds ratio) net of the effects of age</td>
<td>61</td>
</tr>
<tr>
<td>3-4</td>
<td>The effect of race on child mortality (odds ratio) net of the effects of age</td>
<td>62</td>
</tr>
<tr>
<td>4-1</td>
<td>Marital status of Afro-Colombian and white/mestizo women older than</td>
<td>99</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>3-1</td>
<td>Race and Child Mortality determinants</td>
<td>37</td>
</tr>
</tbody>
</table>
THE COLOR OF INEQUALITY: 
RACIAL DISCRIMINATION AND CHILD MORTALITY IN COLOMBIA

By
Maria Juliana Tobon

May 2013

Chair: Charles H. Wood
Major: Latin American Studies

The official image of Colombia is that of a racial democracy, where all members of the lower class have the same opportunities for advancement, regardless of racial characteristics. Parallel and integrated into this picture a pervasive social order in which Colombia is a mestizo nation, gradually erasing the African and native heritage is maintained. Despite the language of inclusion we find in Colombian Constitution, I suggest that the insertion of blacks has not materialized, and Afro-Colombians are still subject to discrimination.

Based on the principle that racial disparities harmfully affect health outcomes, I conceptualized the living conditions of Afro-Colombians through the mortality rate of children under five years of age. I hypothesize that, despite the image of racial democracy, net of the effects of region, income, and education, the probability of death will be higher among Afro-Colombian compared to white/mestizo children, and that color differences in child mortality can be attributed to racial discrimination.

I addressed racial inequality and discrimination using two complementary methods of analysis: a statistical analysis to sample data from the 2005 demographic census; and an ethnographic study in Buenaventura in order to identify some of the
mechanisms that account for the racial differences in child mortality. The quantitative
analysis provides precise estimates of the degree to which racial discrimination
influences the quality of life, as measured by child mortality, while the qualitative results
provide insights into the attitudinal and behavioral mechanisms that explain race-
associated differences in the access to and use of health services in Colombia.
CHAPTER 1
THE COLOR OF CHILD MORTALITY IN COLOMBIA

When songwriter Petronio Álvarez (1922-1966) wrote his famous eulogy to his native Pacific coast town of Buenaventura he could not have imagined that the song would become the anthem of an annual festival held to recognize the “African heart of Colombia,” performed by smiling musicians in rustic straw hats, wearing brightly colored cotton shirts and gowns. The picturesque image, so adored by the country’s white majority and shared by people across the world (in 2010 UNESCO added the musical form, currulao, to the list of Oral Masterpieces), disguises a much darker and rarely acknowledged reality – one of poverty, prejudice and discrimination.

From the beginning of Colombia’s history, Afro-descendants have been denied their humanity, their dignity, their freedom, their opportunities, and their rights (González Sevillano, 1999). Social stratification, in which racial characteristics are a significant component, reproduced the hierarchies established in the colonial era, forming the so-called Colombian caste society (Wade, 1993), with Afro-descendants remaining as slaves until 1851. Likewise, their invisibility was guaranteed in the seventy initial years of the national statistics, which collected no data on Colombia’s Afro-descendant population.

The late twentieth century witnessed attempts to recognize and incorporate Afro-Colombians as an integral part of society. Despite being the country in Latin America with the second largest number of Afro-descendants after Brazil, the invisibility of the population remained until 1993, when the Colombian census included a new variable that identified the respondent’s ethno-cultural background. This timid effort found that 1.5 percent of Colombians identified themselves as Afro-Colombian. In 2005, the
inclusion of a new question, based on physical features, classified 10.62 percent of the population as Afro-Colombian (Estupiñan, 2006). The precise number is still debated, especially within Afro organizations, who claim that 25 percent of the total population is of African descent (Barbary & Urrea, 2004).

The proclamation of Colombia as a multiethnic and multicultural nation in the Constitution of 1991 opened the door to legislation aimed at reducing the disadvantages of the Afro-Colombians, reiterating the ratification of the 1981 United Nation International Convention of Elimination of all forms of the Racial Discrimination (Davis & Sanchez, 2003). The new laws meant the enactment of economic and social policies to reduce racial disparities and to promote affirmative action policies and provide equal opportunities.

Despite these initiatives, in 2011 the United Nations Development Programme released a report on the actual progress toward meeting the Millennium Development Goals (MDGs) in Colombia, differentiated by race. The data presented in the UN report gave a clear picture of the sad conditions that prevail among Afro-Colombians who have the lowest access to fundamental rights set forth in the MDGs, according to Gustavo de Roux, director of the report (“Colombia ‘se raja,’” 2011). The achievement gap between Afro-Colombians and non-ethnic population is noticeable, as in the case of the quality life index, which showed a difference of ten percentage points.

In Colombia racialization is based on phenotype but is also associated with social class and socioeconomic status (Urrea et al., 2010). Regardless of their color, individuals and families with higher capital (social, cultural, educational, and economic, among others) are considered “lighter,” and conversely those with less capital are
considered “darker.” The concept of race is therefore socially and historically constructed, rather than genetically composed (LaVesit, 2005; David & Collins, 2007; Diez, 2012; Hale, 2004; Gravlee, 2009; Jones, 2001; Williams, 2004; and Krieger, 2003), particularly in Latin American countries where people of European, African, and Indigenous descendants have intermixed through generations to an enormous degree (Minority Rights Group, 1995). Race is not dichotomous but relational, based on characteristics granted to groups due to their social, economic, cultural and political situation in national life.

The definition of race has several implications: belonging to a racial group is based on the perception of others, noted not only with respect to physical features, where skin color is the predominant feature, but also on insignias of socioeconomic status. In other words, this social construct precisely captures the impact of social disparities in a specific society, and the impact of racism. Although there are no innate differences between race groups, when individuals are classified into different groups, an “unequal distribution of risks and opportunities is created” (Pachter & García Coll, 2009:256). Based upon on the previous definition of race, the approach to racial disparities must turn from race to racism. Race as a social category, determined by the relations with others, is associated with a complex assortment of disparities in life experience.

According to Williams and Mohammed (2009) racism is “an organized system that categorizes population groups into ‘races’, and uses this ranking to preferentially allocate societal goods and resources to groups regarded as superior” (Pp. 61). They further note that cultural racism is an underlying factor that positions some racial groups
as inherently or culturally superior to others, supporting the derivation of negative attitudes towards the “others” and justifying differential treatment of members of those groups. In addition, Gravlee (2009), Jones (2000, 2001), LaVeist (2005), and Kuzawa and Sweet (2009) call attention to the biological expressions of race relations, of racism as institutional and individual practices that produce and reinforce oppressive systems through which individuals and institutions adversely restrict, by judgment and action, the lives of those whom they discriminate against.

A key question is whether Colombia can be classified as a “racial democracy” (as many claim), where all members of the lower class have the same opportunities for advancement, regardless of racial characteristics. Or is the racial democracy thesis, as Múnera (2005) asserts, simply a myth endorsed by a country of mestizos, whose history has been largely free of racial conflicts and tensions? Thankfully, the once dominant genetic conception of discrimination, where Afro-Colombians were considered inferior to whites, no longer prevails (Wade, 1993). Yet such progress does not necessarily mean that Colombians of African descent have the same opportunities for advancement as their white counterparts.

At present, the debate is whether the poor conditions of the Afro-Colombian population are entirely the result of differences in income and education, or whether, in addition, actual discrimination is at work. This study, which is organized in five chapters, proposes to address racial inequality and discrimination in Colombia by focusing on child mortality, an especially robust measure of a population’s quality life. I hypothesize that, despite the image of racial democracy, net of the effects of region, income, and education, the probability of death will be higher among Afro-Colombian
compared to white/mestizo children. Once the major determinants of child mortality are taken into account, the continued significance of race can be attributed to racial discrimination.

I begin with an introductory Chapter, followed by a review of the literature on racial marginalization in Colombia, and the late recognition of Afro-Colombians as part of Colombian nation-state. In Chapter 3, I propose to conceptualize Afro-Colombians’ marginalization by studying the risk factors of mortality of children under five years of age. Then, I use sample data from Colombia’s 2005 demographic census to carry out a statistical analysis of child mortality associated with the race of the child, controlling for the key determinants of child survival: age of the mother, stratification, education, employment, marriage, housing quality, social support, toxicity, and location. Each of these variables is known to be among the major social, economic and environmental determinants that affect child health outcomes.

Chapter 4 uses data collected via ethnographic field work which I completed in summer 2012 to explore race-related attitudes and behaviors that affect child mortality outcomes observed in the statistical analysis. And finally, I end with a concluding Chapter where I summarize the findings and I discuss the presence or not of discrimination in Colombia according to the conceptual model proposed.

My interest studying racial inequality and discrimination in Colombia was inspired by the quiet desperation and profound sadness that I often witnessed on the faces of so many children, mothers, grandmothers, and aunts that I met in hospitals. With the touching innocence that characterizes powerless people in search of answers to the tragedies that they confront on a daily basis, Afro-Colombian women opened the doors
of their homes and allowed me to understand why their children are at greater risk of death than those of white/mestizo women. The candid conversations I had with Afro-Colombian women helped me understand the complex interpersonal and institutional factors that are the basis of the differences between racial groups in the Colombian population. Invariably the racial considerations were directly or indirectly implicated in the conditions faced by women and their children.

The popular image of a harmonious country free of racial conflict, and without discrimination and racism disagrees with the devastating picture of the living conditions of many Afro-descendant inhabitants in Colombia. Moreover, the visible racial divide between the white/mestizo majority and the African-descent minority is not simply the legacy of historical slavery but is, in addition, the result of contemporary discriminatory practices that reproduce past inequalities in new and evolving ways. Discriminatory practices, as I show in this thesis, operate in many different arenas, including the domain of interpersonal relations and in the structure of institutional arrangements, and they occur as much by commission as by omission (Rodríguez et al., 2009). Far more will be required than the folkloric recognition of Colombia’s African-descent population if the country is to achieve the kind of equality of opportunities and outcomes envisioned by the Millennium Development Goals. Skin color cannot prevail as a determining factor in the quality of life among racial groups of Colombia’s population. Today, routes of freedom are needed not to abolish slavery, but to overcome inequality and discrimination.
CHAPTER 2
MESTIZAJE AND THE INVISIBILITY OF AFRO-COLOMBIANS

With respect to the race relations, the image of Colombia held by most people and also by public institutions is that of a multiethnic “racial democracy.” In a manner similar to the racial ideologies of other countries in Latin America, notably Brazil (Wood & Carvalho, 1988), the racial democracy thesis claims that people in Colombia do not view one another through the lens of race, nor do they harbor prejudices based on skin color. By implication, the racial democracy thesis means that the observed socioeconomic disparities between the white/mestizo and the Afro-Colombian populations are due exclusively to differences in human capital and are not the consequence of racial discrimination.

According to the racial democracy thesis, Colombia’s unique history facilitated a blending of races and cultures into an egalitarian mix rendering racism non-existent. The relevance of the thesis, though widely accepted in Colombia, has been challenged. Múnera (2005), for one, describes racial democracy as a myth endorsed by a country of mestizos, by a nation where all races and cultures presumably have mixed, creating a happy blend of people, despite ample evidence to the contrary (Múnera, 2005; Wade, 1997; & Rodriguez Garavito et al., 2009). The myth of racial democracy supports the denial of racism by the state and civil society, effectively enabling the continued marginalization of Afro-Colombians.

At present, the debate about the causes of racial inequality is whether the conditions of the Afro-Colombian population are entirely the result of differences in income and education, or whether, in addition, actual discrimination is at work. Despite the language of inclusion we find in the Constitution, I posit that insertion of blacks has
not materialized in Colombia, and that Afro-Colombians are subject to discrimination. Beginning with the premise that racial disparities harmfully affect health outcomes (Krieger, 2003; Jones, 2001), the living standard of Afro-Colombians is operationalized through the mortality rate of children under five years of age, a sensitive indicator of differences in the quality of life among subgroups of population (Wood et al., 2010). I hypothesize that, despite the image of racial democracy, net of the effects of region, income, and education, the probability of death will be higher among Afro-Colombian compared to white/mestizo children, and that color differences in child mortality can be attributed to racial discrimination.

The relationship between the Colombian government and racial minorities plays an important role in the contemporary state of health disparities. In this section I begin by addressing racial marginalization in Colombia, showing that the Afro-Colombian population as a subject of study in social sciences and official statistics was virtually invisible until the late 20th century. I further explore the implications of mestizaje as the basis of Colombian society, and finally Afro-Colombian’s legal recognition in the Colombian nation state through the enactment of National Constitution of 1991.

The Invisibility of Afro-Colombians as a Subject of Study

Afro-Colombians are a substantial proportion of the nation’s population, although only the late twentieth century witnessed attempts to recognize and incorporate them as an integral part of society in order to reduce their relative disadvantages. Landmarks include the proclamation of Colombia as a multiethnic and multicultural nation in the Constitution of 1991, the enactment of Law 70 of 1993, and the inclusion in the demographic census of an ethnic-racial variable since 1993.
From the beginning of Colombia’s history, Afro-descendants have been denied their humanity, their dignity, their freedom, their opportunities, and their rights (González Sevillano, 1999). Folklore has apparently been the basis of the attention given to Afro-Colombians, while history books, anthropological studies, and national statistics did not, for the most part, recognize them as part of Colombian society.

“To study black people was not anthropology” was the answer Nina S. de Friedemann received when she proposed to study Afro-Colombians during the 1960s. Anthropologists studied archaeological and contemporary indigenous peoples, but blacks were invisible in Colombian social sciences. Indigenous people have been constituted as the analytical other, while Afro-descendants, in contrast have been rendered invisible (Wade, 2010). Among Friedemann’s most acknowledged publications, her book *Estudios de negros en la Antropología colombiana: presencia e invisibilidad* (1984) examines the circumstances that contributed to the marginal situation of black studies in the development of social sciences in Colombia.

Friedemann claims that the invisibility of black people was a strategy of control. The practice, which began five centuries ago, continues in the present to deny the history of Africans in America and to divert attention from the status of the contemporary black population. The invisibility and stereotyping, as part of a process of socio-racial discrimination (Kepfer, 2004), are tools of communication and information that comprise a system of hegemonic domination by the European thought in its relations to Africa and America. As the thread of racism is based on the way people relate to each other, being excluded, disregarded and even made invisible can be conceived as discriminatory actions towards the Afro-descendant population. Colombian intellectuals,
it seems, have been inclined to condemn blacks to a political invisibility with respect to
social and economic rights.

Múnera (2005) supports this idea of invisibility in social sciences. In his more
recent work, Múnera focuses on two central topics: the intrinsic relationship of the
discourses of Colombian native elites of the nineteenth century on race, geography and
the construction of the nation; and the denied participation of subordinate groups in the
process of national formation. According to Múnera, the key to understanding the
attitudes toward Afro-descendant people in Colombia can be found in the texts
produced by intellectuals in the nineteenth century, which defined the way Colombians
today have come to view themselves and the nation, and which, in addition, contributed
to the invisibility of the country’s black population.

Pedro Romero, the most important mulatto leader in the independence of
Cartagena, who was never recognized in history books as mulatto, illustrates this
tendency. There is an effort by the biographers of Cartagena’s elite to show that
Romero was neither mulatto nor poor, and to dismiss his role in the struggles for
independence (Múnera, 2005). Múnera calls attention to the lack of historical studies
that address the racial question in the analysis of the nineteenth century. This omission
gives the false impression that Colombia has been and currently is a unified nation, free
of racial tensions.

Múnera’s attention to blacks in the Caribbean and mainly Cartagena regions,
however, seems to come at the expense of attention given to indigenous peoples, who
have also been marginalized in Colombian society, and who are similarly considered to
be racially inferior to whites. But Múnera’s oversight appears to be the exception. In
Friedemann (1984) notes that the Institute of Ethnology, which was then the Colombian Institute of Anthropology, mainly focused on the study of indigenous and non-black Americans during the 1940s and 1950s. Peter Wade, who has spent most of his academic life exploring ethnic relations and ideas of race in Latin America, with particular reference to Afro-descendants in Colombia, gives a possible answer to Múnera’s oversight. In the recent edition of Race and Ethnicity in Latin America, Wade noted that indigenous people have been in better shape than blacks. Although indigenous people have suffered terrible discrimination and abuse and still suffer today, “the apparent ‘invisibility’ of black people in Colombia, for example has not been due to a simple process of discrimination – Indigenous people have, if anything, suffered even greater discrimination – but due to the precise mode of their insertion into the structures of alterity” (Wade, 2010:37). In other words, indigenous people have been constituted as the “others”, while Blacks, in contrast fade from view.

The invisibility of Afro-Colombians was further bolstered by the fact that the various agencies of the state failed to collect information on the African-descent population. The last national census to include racial categories (black, white, indigenous, and mestizo) was in 1918. Despite being the country in Latin America with the second largest number of Afro-descendants, after Brazil, the invisibility of the population remained until 1993.

The lack of data on the African-descent population in Colombia stands in contrast to Brazil. As Telles notes (2007), whereas most Latin America countries have given little official attention to race, the exception is Brazil, a country that provides a model for collecting, formatting and disseminating data on its African-origin population. Brazil has
collected race or color data in six of its seven modern censuses, which began in 1940, and in most annual household surveys since 1976 [...] and it uses five terms: branco (white), pardo (brown), preto (black), amarello (yellow or Asian), and indigena (indigenous)” (Telles, 2007:195).

In the other countries in the Latin American region, including Colombia, Telles (2007) notes that collecting race data is a low priority due, in part, to the assumption that race is considered merely an epiphenomenon of class and regional inequalities and is therefore redundant to other indicators. Moreover, when race classifications exist in Latin American countries, they are so subjective that they do not permit serious analysis of social inequalities. There is no consensus as to who fits into which category or even what categories should be used.

In sum, the invisibility of Colombia’s black population can be attributed to several factors. These include the exclusion of racial considerations in historical treatments of the nineteenth century and, in the twentieth century, the priority that was given to indigenous rather than black peoples. The national myopia with respect to the Afro-Colombians has been further bolstered by the failure, until recently, to identify people of African descent in official statistics, such as the demographic census.

**Mestizaje: the Basis of Colombian Society**

As an expression of discrimination towards Africans and their descendants in countries such as Colombia invisibility has been strong and has taken a variety of forms. Mestizaje, as an ideology of political action, has been one of the ways to keep blacks invisible, and it remains a useful weapon in the hands of political groups who deny Afro-Colombians the right to struggle for their rights (Friedemann, 1993). The mestizaje process is conceived as a racist device, particularly in the organization of
Colombian society, which serves to promote the “whitening” of the population and to sustain the notion of equality of rights and duties among citizens regardless of race (Barbary & Urrea, 2004).

“Through the 19th century, the close association of mestizaje and equality gave the notion of liberty a peculiar meaning in Colombia” (Friedemann & Arocha, 1995:64). In the first years of the Colombian Republic, when the country was dominated by a Creole elite, it was possible to transition from black to white when slaves gained their freedom. The adoption of white values was served as the criterion for identity rather than the revaluation and recognition of an African heritage. After the colonial period, Colombian elites tried to consolidate a social and political order by attempting to remove ethnic and racial distinction in the country. The term mestizo, previously understood as describing the mixture of white and indigenous people, started being applied to Afro-Colombians in order to disguise socio-racial differences and discrimination against them.

Arocha (1998) introduced the concept of Social Darwinism to explain the whitening ideal in Colombia, premised on the idea that progress was tied to the concept of race. He showed how the pyramid of castes was built by gradations of whiteness, which were promoted by the implementation of policies designed to “defend the country’s sovereignty over the tropical-forest frontiers and to develop an international image of Colombia as devoid of ‘inferiors’” (Arocha, 1998:77). Latin American nations have long associated the loss or dilution of African physical and cultural characteristics with the idea of progress. Hence, countries in Latin America have tended to deny what are Afro-descendants in themselves and their culture (Minority Rights Group, 1995).
Among those policies, Law 89/1890 defined savagery\(^1\) as a temporary condition that could be overcome by the integration into Christian (i.e., white) civilization. Similarly, Law 144/1922 was enacted to attract Europeans migrants to Colombia as a way to improve the racial profile of the country through development of a better race, to encourage mestizaje. Arocha included in his paper a revealing quote from Laureano Gómez (1928), president of Colombia in 1950 – 1953: “The black is a plague. In the countries where [the African population] has disappeared as in Argentina, Chile, and Uruguay, it has been possible to establish an economic and political organization with a strong and stable basis” (Pp. 77-78). Based on such assumptions, miscegenation, which was exalted as a way to achieve equality and progress, became a useful means to ignore the diversity and the rights associated with cultural and historical differences. Those assumptions also gave rise to criminal permissiveness regarding the abuse of Afro-Colombians’ rights (Friedemann & Arocha, 1995).

Through miscegenation, the presence of racism in Colombia was denied and located in the past. The national ideology is thus founded on the harmonious ideal of equal relations based on racial mixture. Yet, mestizaje has developed a parallel vision of race relations that has hierarchized Colombian society and justified the superiority of “whites” (Urrea et al., 2010). While some Colombians conceive mestizaje as a “civilizing process” of racial minorities, for others it is the responsible of the “degeneration of the race.” Whatever the interpretation, what has actually taken place in Colombia from mestizaje is the elimination of blacks and indigenous minorities through their progressive fusion with the alleged superior white element.

\(^1\) Term used in the Colombian Constitution of 1886 to define Afro-Colombians.
In fact, Múnera’s (2005) thesis is that the Colombian nation is not the natural result of the proposals advanced by the country’s Creole elite. On the contrary, racial and ethnic conflicts, as well as longstanding regional tensions and visions of gender comprised the historical discourse that led to the construction of Latin American nations. From this perspective, Múnera proposed a main concept to understand the dominance of the elites and the construction of the Colombian nation: Human geography and internal frontiers.

Human geography highlights the idea that the Andes were inhabited by more advanced civilization compared to the coast, the forests, and the eastern plains, which were places inhabited by uncivilized and inferior races. As Wade (1993:53) stated years ago, “Colombia is a highly regionalized country, and for historical reasons race also has a regional dimension. There is the opposition between the “black” coasts, the “white-mestizo” interior, and the “indian” Amazon lands.” The concept of human geography, is the basis of Múnera’s contribution, namely the idea of mestizaje became viewed as the panacea of Colombia’s problems and the means to achieve social and economic development.

Geography acting by itself, as well as the weather cannot determine the consciousness and behavior of men, and the superiority of some over others. The human geography thesis refers to the geography that isolates, that prevents communication between areas, and that strengthens ecological niches (Yunis Turbay, 2004). Colombia is a fragmented country with segments of different colors that are coincident with geographic location. The division by regions that exist in Colombia, based on natural and geographical order at first, and reinforced by the cultural attributes
of the people living there, now imposes isolation and abandonment on the descendants of African slaves (Yunis Turbay, 2004).

The regionalization of the country, the consolidation of different regions by race and by the level of development, has caused enormous inequality in income distribution, as well as exclusion from opportunities for advancement. Some of the areas are mainly conceived as places of exploitation by others. In other words, the Colombia’s fragmentation is both geographical and racial, creating a mosaic of people and places.

Panamá, and its secession from the nation in 1903, illustrates the concept of border, which separates territories where people are previously constructed as barbarians, as inferior, and denied of civilization, subject to legitimate conquest and submission by those presumed to be civilized. In sum, Colombian frontiers show the failure of an inclusionary nation-building project, in which 80 percent of the population (blacks, indigenous, and mulattos) have been denied their rights, and have been condemned to a marginal status (Múnera, 2005).

Building on the idea of mestizaje, Wade’s (2006) central argument addresses its relation to exclusion, and the implications of mestizaje with respect to the link between blackness and poverty. In a manner consistent with his previous work in Colombia, he contends that mestizaje is a paradigm for addressing the internal contradictions within identity, such that “mestizaje always involves a tension between inclusion and exclusion […] becoming mestizo means leaving an indigenous or black identity behind” (Wade, 2006:11). The idea of mestizaje has been seen as a process of national homogenization, thereby hiding a reality of racist exclusion behind a mask of inclusiveness: “Mestizaje [thus] appears as a key terrain for the operation of racism; and
the fact that mestizaje often works in zones of intimacy (sex, the family, the body) means racism lodges deep in the heart of people and society, making it difficult to both see and resist” (Wade, 2010:94).

The significance of mestizaje is related to the ambiguous classification it implies such that its pretended inclusion is conceived as a social mask. “The sliding between being included by non-blacks (we are all brothers, we are all mestizos) and being excluded by them (‘blacks are all animals, a monkey dressed in silk is still a monkey’) defines for blacks in the nation a particular space where they both appear and disappear” (Wade, 2010:92). Furthermore, with respect to the implications of mestizaje and the mask it offers, Wade emphasizes the relation between class and race, highlighting the notion that most Afro-Colombians are poor, yet “the link between blackness and poverty […] is largely controlled by others” (Wade, 2006:14). I assume that this control may be explained by the unequal access to the opportunities for advancement associated with racial characteristics.

Barbary and Urrea (2004) recapitulate the various arguments, noting how the territorial isolation of black populations in the context of a racialized geography, together with the social hierarchies inherited from the period of slavery have underpinned various forms of indirect discrimination, based on the ideology of mestizaje. Since the abolition of slavery in 1851, indirect discrimination has been prevalent in Colombia and it stands out from the inequalities accumulated through the history of social structures.

**Legal Recognition: from a Monoethnic to a Multiethnic Nation.**

The proclamation in the Constitution of 1991 that Colombia is a multiethnic and multicultural nation opened the door to legislation aimed at reducing the disadvantages of the Afro-Colombians. The provisions within the constitution reiterated the ratification
of the 1981 United Nations International Convention of Elimination of all Forms of the Racial Discrimination (Davis & Sanchez, 2003). The new laws meant the enactment of economic and social policies to reduce racial disparities and to promote affirmative actions and equal opportunities. The 1991 Colombian Constitution introduced a break with the past by establishing the basis for recognizing racial and ethnic based differences, and for proposing multicultural policies (Restrepo & Rojas, 2004). It strengthened the legal existence of the Afro-Colombians, allowing them to exercise their citizenship by displaying rather than cancelling cultural diversity.

In 1991, Arocha (1998) pointed out that the main purpose of the National Constitution was to build the nation by pursuing unity through the preservation of ethnic and racial diversity. The big change between Constitution of 1991 and the previous one in 1886 was to redefine the nation from a monoethnic to a multiethnic image of society. Whereas the Colombian Constitution of 1886 was based on one god, one race, and one language, Article 7 of Constitution of 1991 recognizes and legitimizes ethnic and cultural diversity. “Afro-Colombians became visible after more than 100 years during which their territorial domains were denied and their demographic, cultural, and historical presence were canceled” (Arocha, 1998:71).

Despite the efforts during the pre-constitutional period and the sessions of the National Assembly, the recognition of the black populations as part of society, with specific rights has had only a small effect on Colombian society. Article 55, called Article of Transition (AT) – since it will be extended two years later by Law 70 of 1993 – affirms Afro-Colombians’ identity based in their relationship to land. Afro-descendants are integrated without using the terms race, ethnicity or color. “The word negro
remained stereotyped and devoid of qualifiers for non-Indian ethnic diversity” (Arocha, 1998:79). Afro-descendants mobilized to fight against racial discrimination, and to demand their full social inclusion as citizens. In the Constitution, the discourse of Afro-Colombians’ integration is included but it is based on a cultural otherness and a territorial referent. For Afro-Colombians, advancement became a matter of territorial and cultural claims that are local and regional in scope, which leaves unanswered complaints concerning political, economic, social and cultural rights of Colombian black majorities that do not inhabit the rural areas of the Pacific region (Agudelo, 2005).

Paraphrasing Wade (2010), many states in Latin America have enacted legislation that recognizes multiculturality or special rights for ethnic groups as a feature of post-modern nationalism, rather than endorsing idealized notions of a homogenous culture. However, there is no clear break with the stubborn ideologies of mestizaje. “Insofar as the image of the mestizo nation generally made room for a highly controlled and often marginalized sort of blackness and indigenousness, there are continuities with an official multiculturalism that also seeks to control diversity” (Wade, 2010:138).

**Law 70 of 1993: “Ley de Negritudes”**

Following the idea that identities are based on territorial criteria, Friedemann (1993) contends that Law 70 of 1993 legitimized the racial and socio-historical identity of the descendants of Africans who arrived in Colombia 500 years ago. The legal recognition, which was as important as the abolition of slavery in 1851, makes black communities visible and explicitly accepts the role of African descendants in the formation of the nation. As such, the new legal provisions constitute a break with the historical tendency to exclude blacks from consideration. The law therefore opens new possibilities for social and cultural rights that combat formal discrimination.
Barbary and Urrea (2004) are more skeptical about the implications of Law 70. Their concern focuses on the territorial specification, noting that the law can only be applied in certain rural areas, along the Pacific coast, while the majority of Afro-Colombian population lives in cities. The AT-55 and Law 70 thus represent a partial achievement, albeit one that favors Pacific populations (Agudelo, 2005). In other words, for Barbary and Urrea the complete integration of ethnic-racial minorities in Colombian society, with equal opportunities and access to resources, is still pending. This perception is shared by Escobar (2008) who notes that “article transitory 55 and Law 70 were based on the only known existing model of alterity, that of indigenous peoples. Be that as it may, the terms introduced by AT-55 and the subsequent law became the nodal points for the articulation for the first time of a politics of black ethnicity on a national scale” (Escobar, 2008:211).

The effort to include or to uphold Afro-Colombians’ rights has continued in the following years through the enactment of additional laws and decrees seeking to create equal opportunities, gender equality and to promote the social and economic development of the territories inhabited by the Afro-Colombians (González Sevillano, 2012). Yet, the existence of blacks as a distinct group on the national scene had little echo in the Constitution and subsequent laws. Interpretations of various scholars show that the Constitution mentions blacks only minimally and does not acknowledge their cultural and historical particularities beyond their territorial rights. Even though the long-standing forms of self-reference and belonging among the blacks had little to do with the Constitution of 1991 and Law 70, Afro-descendants have come to be referred as black communities, or in legal terms, as black ethnicity.
The notion of ethnicity is based on the argument of the agrarian and ethnic specificity of the inhabitants of the Pacific. According to the Constitution, ethnic group refers to the population that has, among other features, a common culture, territory, language, traditions and forms of government, as seen among indigenous peoples. But do blacks really identify themselves based on those features? The big question is why the narratives of the Carta Magna took the form they did, in terms of ethnicity, cultural rights, difference, and black communities. Is this new construction yet another mechanism that renders the Afro-Colombian population invisible?

In Colombia, the traces left by a mestizo nation-state are structural factors impeding political projects that affirm the ethnic-racial difference as the focus of their claims (Agudelo, 2005). In the case of Afro-Colombians, these difficulties are increased because their identification was always an ambiguous combination of inclusion and exclusion, and their claims goes beyond the recognition of cultural identity. The new institutional framework that recognizes the multicultural and multiethnic character of Colombian nation may represent a moment of social and political transformation, yet there remains a long way to go.

Visibility through Counting

The inclusion-exclusion debate is further reflected in the national statistics, or the lack thereof. After more than seventy years during which information on race was not collected, in 1993 the Colombian census included a new variable that identified the respondent’s\(^2\) ethno-cultural background (Estupiñan, 2006). This timid initial effort found that 1.5 percent of Colombians identified themselves as Afro-Colombian. Barbary

---

\(^2\) The ethnic variable was included among the questions of previous Census only for Indigenous group in identified geographic areas (Hernández Romero, 2010).
and Urrea (2004), along with Telles (2007), who has emphasized the importance of producing statistics on Colombia’s black population, note that the 1993 census was biased if only because many blacks do not consider themselves an ethnic group.

In 2005, the inclusion of a new question, based on physical features (Estupiñan, 2006), classified 10.62 percent of the population as Afro-Colombian. The precise number is still debated, especially within Afro organizations, who claim that 25 percent of the total population is of African descent. The new question preserved cultural identity criteria, but coupled that with a new ethnic category. The new variable thus combines phenotypic with ethnic criteria: Respondents can declare themselves to be Raizal (of the archipelago of San Andres and Providencia) or Palenquero (of San Basilio), or can identify as black, mulatto, or of African ancestry, or white, or mestizo.

Seventy percent of the black population is urban and would hardly identify themselves with the ethnic variables. With this approach, physical appearance, which is of great importance in the social construction of differences, is played down in favor of the ethnic-cultural dimension, implying what Barbary and Urrea called cultural reductionism (Barbary & Urrea, 2004:61). It is difficult for blacks to become visible demographically based on ethnic group identity. For blacks, particularly in urban settings, the phenotypic component is the operating variable of differentiation. The ethnic dimension is an artificial contemporary construction, which is confusing to large segments of the black population.

Despite the language of inclusion in the Constitution, the insertion of blacks has not been materialized. How can the state promote economic and social policies to reduce racial disparities in order to achieve equal opportunities and affirmative action
when no one knows the exact number of black people in Colombia, and when blacks do not even recognize themselves as part of the nation, unless they are part Afro-Colombian communities? “Colombians still tend to perceive themselves as either mestizos or indigenous. After more than a century under a particular form of integrationism, this process of image formation is deeply rooted. […] to replace this binary perception, Colombia must adopt ethnic pluralism as the core of a new conception of national” (Arocha, 1998:84). This will require that Colombians not only increase their ethnic tolerance in their daily lives but also build a new form of consciousness about a notion of equality that does not imply the extinction of cultural diversity.

According to some reports of the United Nations and Telles (2007), it is important to note that beyond cases of abuse based on race, discrimination against blacks is linked to experiences of poverty and marginalization. In Colombia, structural discrimination is present while the myth of mestizaje continues to obscure the existence of racial discrimination. “Despite significant miscegenation, Latin America’s racial inequalities or its ‘pigmentocracy’ consistently shows up in income, education, and other socio-economic data” (Telles, 2007:188).

The absence until 2005 of data differentiated by race has prevented serious studies of the differences between Afro-Colombians and White/mestizos. In 2011, recognized as the year of Afro-descendants by United Nations, the United Nations Development Programme published a report on the achievement of Millennium Development Goals – MDGs- for Afro-Colombians. The report recognized the progress
Colombian government has achieved with respect to the eight goals but focused on the differences that persist among regions and inhabitants.

Colombia has made progress in terms of basic health indicators such as immunization, health insurance, and child mortality, among others. Life expectancy at birth has increased, implying improvements in the health conditions of the inhabitants. Likewise children mortality rates have decreased, from 34.9 per 1000 live births in 1990 to 22 in 2010. However, significant disparities persist, reflecting the lack of equal access to essential health services, especially in the regions where Afro-Colombians are the majority population. In Chocó, where 95 percent of the inhabitants are Afro-descendants, the child mortality rate was 48 per 1000 live births in 2008 (UNDP, 2011), even higher than the national rate twenty years earlier.

Thankfully, the once dominant genetic conception of race, where Afro-Colombians were considered inferior to whites, no longer prevails (Wade, 1993). So, based on the racial differences noted above, and taking into account the racial democracy thesis, the question is whether the conditions of the Afro-Colombian population are entirely the result of differences in skills and education, or whether, in addition, actual discrimination is also at work.

I hypothesize that, despite the image of racial democracy, net of the effects of region, income, and education, the probability of death will be higher among Afro-Colombian compared to white/mestizo children, and that color differences in child mortality can be attributed to racial discrimination. In order to assess the presence of discrimination in Colombia by addressing racial disparities in health, Chapter 3 presents
a conceptual framework based on a review of the health determinants of mortality rates of children under five years of age.

Colombian census data provide operational definitions and proxy indicators of many of the variables in the conceptual framework. Using the available indicators, the statistical analysis is designed to test the effect of each measured variable on the risk of death to children. After controlling for all of the variables, the remaining variance explained by the mother’s race could be attributed to the effect of unmeasured variables, not included in the analysis, such as the levels of discrimination. Documenting just how the various forms of discrimination operate to the disadvantage of the health of Afro-Colombian children is the purpose of the ethnographic fieldwork in Chapter 4.
Child mortality rate is a highly sensitive indicator of differences in the quality of life among subgroups of a population, especially in developing countries where mortality rates are still high (Millard, 1994). Mortality estimates are particularly useful because they measure the net results of a “complex phenomenon involving social, economic, political, cultural, environmental, and biological forces, all varying according to specific circumstances, rather than inputs or intervening variables” (Chen, 1983:219). Mortality among children is therefore the cumulative outcome of multiple processes, and is only infrequently the result of a single disease episode (Mosley & Chen, 1984). “The mortality rate,’ as Young, Edmonston, and Andes (1983,66) put it, ‘is the bottom line of the social balance sheet” (cited in Wood and Carvalho, 2010:123).

According to LaVeist (2005) children mortality rates are often used as an indicator of the general health status of a population. This use is widely accepted for several reasons, but the most relevant is that the value that people place on the survival of their children is shared by all cultures. This means that, with the rare exception of infanticide, people strive to prevent the death of their child. This implies, in turn, that the death of a child could not be avoided, given the scope of the resources available to parents. In that sense, the probability of death among children in Colombia will show the levels of quality of life within groups of population.

A Conceptual Model of the Factors associated with Child Mortality

A major challenge in the study of child mortality is how to conceptualize the determinants of the probability of child death. Whereas it may seem obvious that, for example, higher income is associated with lower mortality, the precise mechanisms that
connect the two are far from obvious. How do socioeconomic factors, mainly understood as income, educational level, occupation, and housing conditions (LaVeist, 2005) affect health outcomes, and, in particular, determine the probability that a child will live to see his/her fifth birthday? Mosley and Chen (1984) made significant headway in this regard by identifying the proximate determinants of child mortality, which are the factors through which all socioeconomic and environmental factors operate.

To understand the determinant of children mortality rates, it is necessary to trace the links of causality of the social stressors and biological factors involved. Social and economic factors necessarily operate through a common set of biological mechanisms. Mosley and Chen’s (1984) famous framework for the study of determinants of child survival in developing countries, which incorporates biological and social variables, helps identify the factors involved and the relationship between them.

In recent years, numerous scholars have been committed to understand the underlying determinants of racial health disparities in health outcomes (Hummer, 1996; LaVeist, 2005; Krieger, 2003, Diez, 2012, Gravlee, 2009; Dressler et al., 2005; Kuzawa & Sweet, 2009; Giscombé and Lobel, 2005; Jones, 2000, 2001; Williams et al. 2010; Millard, 1994). Their explanations have focused on social explanations where socioeconomic factors and psychosocial stress, which operate through different levels of discrimination, play a major role.

Figure 3-1 expands the Mosley and Chen (1984) framework by positing, in addition to the proximate variables, the factors that potentially affect the proximate determinants, with special attention given to race.
As shown in the center column in the figure, the proximate determinants (maternal factors, childcare factors, infections factors, and injury) have a direct effect on the probability of child mortality. In addition, as shown to the left of the figure, the distant factors (socioeconomic status, levels of discrimination, physical environment, and social support) interact with each other to affect the probability of child mortality.


Figure 3-1. Race and Child Mortality determinants
through their influence on the proximate determinants. Income, education, place of residence, and health care system, among other variables will affect the proximate determinants and indirectly the probability of child mortality.

**Proximate Factors of Child Mortality**

The framework distinguishes four sets of proximate determinants: (1) maternal factors, (2) childcare factors, (3) infections factors, and (4) injury or accidents. The defining feature of a proximate determinant is that all socioeconomic and environmental influences operate through one or more of these variables to determine the probability that a child will survive (Mosley & Chen, 1984).

Maternal factors point to the influence of the mother’s age, parity, birth interval, and maternal nutritional status: “factors [that] affect the mother’s biological resources for providing adequate nutrition to the fetus during pregnancy and during breastfeeding, and [that] may also affect the quality and time of child care throughout the maturation process” (Chen, 1983:206). Several scholars have confirmed that childbearing at very young – under 17 years old – and very old ages – over 35 years old, increases the risk of death. The number of children ever born further implies potential complications. When the mother is a nulliparous, there are often higher risks due to slow labor progress; when the mother is multiparous the risks are related to their previous birth and pregnancy histories. According to Chen (1983), birth intervals below twelve months are also associated with high mortality risk. The number of children may have affected the maternal nutritional status, as well, and it can also influence childcare factors, such as food availability and access to health service.

Another proximate factor of children health is nutritional deficiency. Maternal nutrition and diet during pregnancy influence the level of nutrition of the fetus.
Breastfeeding during the first six months is recommended, to provide the basic nutrients for the first month of life. After this period, the food availability for adequate nutrition is critical for optimal child health. In nearly all developing countries, mortality risk in the childhood years is highest immediately after birth, and declines rapidly thereafter. In some countries, a secondary peak has been observed in the weaning years during the hazardous transition from breastfeeding to supplemental foods.

According to Chen (1983) the main three direct causes of most childhood mortality are infectious diseases, such as diarrhea, respiratory infections, measles, and tuberculosis, among others, as well as protein-calorie malnutrition and trauma or injury. The incidence of infectious disease ultimately resulting in death is influenced by the exposure to communicable pathogens, usually through consumption of contaminated water and food, or the exposure to contaminated air. The exposure is determined by a variety of environmental and behavioral factors, such as housing quality, crowding, access to improved water and sanitation, and personal and house hygiene (distant factors).

Injury or accidents, as well as personal illness control are also involved in children’s health conditions. Personal preventive measures, access to medical treatment, and effective use of health care services are considered imperative to children’s health.

**Distant Factors of Child Mortality**

If the probability of child mortality is directly influenced by the proximate determinants, the question that arises is: what are the determinants of the proximate factors? Viewed in this way, I distinguish between the proximate factors on the one hand, and the “distant factors” on the other, shown at the left side of Figure 3-1. In
order to conceptualize the distant factors, and, in the process, introduce the race-related factors at work, I arranged the distant factors into five groups: (1) socioeconomic status, (2) physical environment, (3) social roles and social support (4) institutional and (5) individual forms of racism.

**Socioeconomic and environmental factors**

Among the distant factors noted in the diagram, the most acknowledged distant determinants of child mortality are socioeconomic and environmental factors (Wood & Carvalho, 1988; Chen, 1983; Mosley & Chen, 1984; Millard, 1994; LaVeist, 2005; Hummer, 1996). As with the other works reviewed, Wood and Carvalho (1988:89) noted that “[i]ncome is a major determinant of the level of mortality, as it measures the level of purchasing power, which, in turn, is strongly associated with nutrition, housing quality, neighborhood quality, access to sanitary services, and access to health care,” especially in countries such as Colombia where the universal health system service is still absent (Colombian Law 100/1993).

Maternal education is considered a distant factor of child mortality, included in the socioeconomic status group. Mother’s education is associated with knowledge of modern health practices, beliefs and attitudes, as well as health behavior such as feeding and child care. In addition maternal education is associated with women’s empowerment, which may influence the mother’s role within the family. Maternal education has an inverse relationship to childhood mortality (Wood & Carvalho, 1988).

Sapolsky (2005) in his study of the relation between poverty and health outcomes contends that, to understand the consequences of socioeconomic status on health, it is imperative to look to the psychosocial consequences, to the stress caused by specific factors. He defines stressor as “anything that threatens to disrupt
homeostasis, the ideal or balanced body where vital measures of human function, like heart rate, blood pressure, among others are in their optimal ranges” (Sapolsky, 2005:96). The response to stressors is manifested in the body and can last for years (Sapolsky, 2005). In that sense, “anything” might be understood as social conditions, culture, economic structures, and political and legal factors (Diez, 2012) involved in the interaction between human beings.

Yet, do all individuals have the same predisposition to feel stress in certain circumstances, and to suffer the same health consequences? According to Sapolsky (2005) and his review of the three approaches (Feeling poor, Being made to feel poor, and Social Capital), psychosocial stressors are not distributed equally among people. In addition, LaVeist (2005) states “people with low socioeconomic status have worse health outcomes because low socioeconomic status places individuals at greater risk of exposure to factors that negatively impact health” (Pp. 171). Low socioeconomic status is associated with poor-quality housing, with higher exposition to environmental health risks and risky occupations. It is not only the inability to respond to a crisis, but also the lack of prestige and respect that being poor implies, as well as the absence of social support. Following this idea of pathogenic responses due to stressors, and based on the conceptual framework proposed, specific economic conditions, such as income, education, and occupational status, as well as the physical environment, such as place of residence, housing quality, and the exposure to infectious agents, significantly influence the women-mother’s health status.

In their study of the influence of a socially segregated world on child development in the first five years of life, Hertzman and Boyce (2010) concluded that children under
five are affected as well by the socioeconomic and environmental stressors. They pointed out that “[s]ocial environments and experiences get under the skin early in life, and do so in ways that affect the course of human development.” (Hertzman & Boyce, 2010:330). Actually, Hertzman and Boyce propose that children are not only affected by the maternal health status, but also by socioeconomic conditions of the family, and the neighborhood in which the family lives. The neighborhood level can affect the availability of social services, the degree of safety, the quality of housing, as well as the availability of social networks, physical distance to health facilities, and schools. Institutional factors can similarly condition access to quality programs like health care, and the degree to which people benefit from other social and economic policies.

Additional stress-related components that affect child mortality might be seen as well as coping resources or buffers that decrease or even eliminate potential psychological or physiological responses to stress situations (Sapolsky, 2005; Schulz et al., 2002; Pascoe & Smart Richman, 2009; Hummer, 1996). Neighborhood conditions, such as community infrastructure, and the social environment, as well as social policies can enhance the quality of life of the population in general. Social roles and social supports as employment, marriage, parenting, and social networks are similarly important as they are understood as protective devices for better health outcomes (Schulz et al., 2002; Hummer, 1996).

As a health determinant of child mortality I also consider the influence of regional inequality (Wood & Carvalho, 1988). Geographical differences in social and economic development are reflected in sharp regional disparities in health outcomes, as showed by the UNDP (2011) report in Colombia. Urban-rural residence is also at work because
“in developing countries today, cities may have an advantage over the rural hinterland. The dangers of urban life [crowding, traffic accidents, etc.] are apparently offset by imported methods of reducing mortality and by the concentration of medical facilities and public health services in cities” (Wood and Carvalho, 1988: 97).

Finally, migration is also included as health determinant. From an ecological perspective, the resettlement of people migrating from rural to urban areas regularly exceeds cities’ capacity to extend infrastructure, sanitary services, and safety to the “new arrivals […] who are relegated, for the most part, to the urban periphery” (Wood & Carvalho, 1988: 119). In addition, Colombia is the country in the world with the second largest number of internally displaced persons due the domestic armed conflict (Rodriguez et al., 2009). More than three million Colombians have been displaced, among which racial and ethnic minorities have been particularly affected. According to Rodriguez et al. (2009) 22.5 percent of displaced persons are Afro-Colombians.

The displaced population suffers from reduced access to health services, food and housing. Geographic displacement is potentially a cause of mortality and morbidity due to events involving violence, but also because of the associated deprivations. Displaced persons are deprived of their former homes, lands, properties or places of habitual residence, and are condemned to the periphery in the cities where they arrive. The higher risks in migrant neighborhoods, associated with poor housing quality and exposure to environmental risks, have the potential to significantly influence child mortality rates. In sum, the forced geographic displacement profoundly affects people’s wellbeing when they lose their livelihood and their homes and household goods.
**Racism and child mortality**

Socioeconomic and environmental factors that contribute to adverse child mortality do not fully account for racial disparities in child health outcomes. According to Hummer (1996) and Dressler et al. (2005) racism plays a prominent role on children’s health status. Racism can affect both the distant factors, as well as the proximate causes associated with children health (LaVeist, 2005).

To include the effect of racism, I considered Jones’ (2000, 2001) categorization of levels of racism, which is shared, to one degree or another, by different scholars (Williams et al., 2010; Williams & Mohammed, 2009; Williams, 2004; Hummer, 1996; Pascoe & Smart Richman, 2009; Schulz et al., 2002). The conceptual categories that Jones proposes illustrate how race relations, which operate at different levels, can compromise the health of a discriminated population: (1) the institutional level, (2) the personally mediated level of discrimination, and (3) the internalized racism.

The institutional level of discrimination refers to normative factors and policies that produce “differentiated access to the goods, services, and opportunities of society by race” (Jones, 2001:300). Examples include the national health system (Jones, 2000), residential segregation (Williams & Mohammed, 2009), and geographic disparities (Williams, 2004). According to Williams and Mohammed (2009), the aspect of the institutional level most widely studied for its health implications has been residential segregation. This focus documents the locational factors that restrict access to education and employment opportunities. Such restrictions influence exposure to various environmental risks, such as exposure to toxins and pollutants, as well as safety and security risks. Residential segregation in addition is thought to prevent access to health care, and expose children and adults due to overcrowd and unsanitary living
conditions (Hummer, 1996; Schulz et al., 2002). The key feature of institutional racism is that the phenomenon is “structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed institutionalized racism is often evident as inaction in the face of need” (Jones 2000:1212).

The individual level of discrimination accounts for personally mediated and internalized racism. The personal mediated level of discrimination is exhibited as a lack of respect, suspicion, devaluation, blaming, and dehumanization of the discriminated population (Jones, 2000). Negative stereotypes play a major role in personally mediated discrimination (Williams, 2004), primarily in encounters between individuals under conditions of time pressure, anxiety and when there is a need for quick judgment calls.

Internalized discrimination, in turn, is evident when members of a discriminated group do not believe in themselves or in others who look like them. Individuals of the stigmatized group accept and internalize the negative messages about their own abilities and those who look like them. “It involves accepting limitations to one’s own full humanity, including one’s spectrum of dreams, one’s right to self-determination and one’s range of allowable self-expression” (Jones 2000:1213). The unequal treatment associated with institutional arrangements and the behavior of individuals are seen as stressors, causing negative emotional responses (Giscombé & Lobel, 2005). I believe these deleterious indications constitute a strong basis for considering racism as a type of stress.
According to Pachter and García Coll’s (2009) assessment of the present state of research on racism, relatively little is known about the specific mechanisms through which racial disparities influence child health. Despite this assessment, I suggest racial disparities play a major role on the health of the children, since many of the factors identified influence mothers and the social environment in which they live. “[T]he key advantage of the model lies in the organization of seemingly disparate measures of environmental conditions; of dietary, reproductive, and health care practices; and of disease states into a coherent frameworks in which they are linked one to another and to child survival on the one hand and to socioeconomic factors on the other” (Chen & Mosley, 1984:144).

In summary, the framework conceptualizes the probability of child death as a function of the proximate determinants of child mortality. The proximate factors, in turn, are influenced, to one degree or another by, the distant factors, shown to the left. Finally, the distant factors influence each other, and vary by racial status in Colombia. The ability to measure many of the key determinants involved in the probability of child mortality makes it possible to find which factors have a greater influence on the health of children.

**Statistical Study of Child Mortality in Colombia**

Whereas no single study is able to measure all the health determinants operating on child mortality (Figure 3-1), Colombian census data provide indicators of many of the key variables. In this Chapter I apply a logistic regression model (appropriate for a 0/1 dependent variable) to analyze the probability of child death associated with the race of the child, controlling for the determinants: Age, Stratification, Education, Employment,
Marriage, Housing quality, Social support, Toxicity/Waste, and Location. The ability to simultaneously include multiple control variables is the main reason the logistic regression analysis is the one of the most extensively used methods in the social sciences.

The statistical study is based on key indicators included in sample data from the 2005 Colombian demographic census (shown in italics – Figure 3-1). The Census is carried out almost every ten to twelve years in Colombia. I use the latest version, which is the first to include among its questions the race variable. I accessed the 2005 Colombian census data through IPUMS-International, a project dedicated to collecting and distributing census data from sixty-two countries around the world, including Colombia. I use the results of a sample of 4,006,168 Colombian citizens, of which 419,808 are Afro-Colombians and 178,525 are women aged 20 to 29 with at least one child born. The data set includes more than sufficient cases to proceed with the analysis.

Of the total cases in the 2005 sample, I focus specifically on women 20 to 29 years of age who have experienced at least one live birth. Because the average age of children is correlated with the age of the mother, limiting the sample to younger women (20 to 29 years old) assures that child mortality refers (approximately) to children in the 0 to 5-age range (United Nations, 1983).

1 Model: Child dead (yes=1; no=0) = α + Age + Regions + Urban/Rural + Years of schooling + Employment status (Employ is the reference) + Ownership of dwelling + Socioeconomic status (Index) + Electricity + Water supply + Trash disposal + Kitchen/cooking facilities + Toilet + Marital status (Married is the reference) + Migration + Number of children born + Afro-Colombian.

2 Restricting the sample to younger women is also advised because it reduces the span of the reference period to which the fertility and mortality refer. When a young mother reports the
The use of a sample data at one point in time departs from the commonly used method that is based vital statistics collected by the state. Direct estimates of deaths based on the vital registration statistics, however, are imprecise in places like Colombia where the state does not have a presence in all the municipalities and departments. The mortality rate based on vital registration statistics is also biased because births often remain unreported, as well as deaths. William Brass proposed in 1964 a method to estimate child mortality based on census data. The method proposes to take as indicator of child mortality the proportions of children who have died relative to the number of children born alive.

Building on the review of the literature on race and racial discrimination presented in the Chapter 2, I predict that the mother’s race will have an independent effect on child death. After controlling for the main health determinants of child mortality described in the conceptual framework, such as socio-economic status, human capital, and physical environment, I expect the probability of child death will be higher for Afro-Colombians. If the race variable continues to be statistically significant after controlling for the major determinants of child mortality, I conclude that racial discrimination is among the causes of higher mortality among Afro-Colombian children.

**Dependent Variable: Child Mortality**

To operationalize the concept of children dead, used as the dependent variable, I computed a measure based on two variables in the census: (1) Number of children ever death of a child, the event corresponds to a short retrospective time period, meaning that her reported socioeconomic status at the time of the census interview is more likely to coincide with the mortality event. When an older woman reports a child death, the mortality event could have occurred in the distant past when her socioeconomic status may have been different from her reported status at the time of the interview.
born: “Has [the respondent] had a son or daughter that was born alive?” The question is coded as a continuous variable. (2) Number of children surviving at the time of the census: “Of the sons and daughters of [the respondent] that were born alive, how many are currently living?” Responses to the question are coded as a continuous variable. The number of children dead is given by the number of children born minus the number of children surviving [(1) – (2) = children dead], for each woman in the sample.

Having calculated the number of dead child per woman, the issue that arises is how best to introduce the mortality indicator into a statistical model. Here I chose to treat the dependent variable as a dichotomy: Women who have experienced one or more child deaths are coded 1. Women who have not experienced the death of a child are coded 0. With a 0/1 dependent variable, the appropriate multivariate statistic technique is logistic regression.

The reason for dichotomizing the dependent variable has to do with the nature of the distribution of child deaths. Despite high rates of child mortality in Colombia, it is evident that the vast majority of children survive. As a proportion of all children born to women 20 to 29 years of age, only a small number of women experience the death of one child, and a very small number experience the death of more than one child. Given this distribution, and because the data are “left-censored” (i.e., there are no negative values), ordinary least squares regression is not appropriate\(^3\).

\(^3\) Negative binomial regression is sometimes applied to count variables that display such a distribution, but the findings do not differ much from the findings generated by logistic regression.
**Independent Variables**

The appendix shows the seventeen measures that were selected for the study of child mortality in Colombia differentiated by race.

**Table 3-1. Description of the Variables in the Statistical Models**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEPENDENT</strong></td>
<td></td>
</tr>
<tr>
<td>Child death</td>
<td>Dichotomous; 0 dead=0, 1 or more dead=1</td>
</tr>
<tr>
<td><strong>MAIN INDEPENDENT</strong></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Dichotomous; Afro-Colombian=1, White/mestizo=0</td>
</tr>
<tr>
<td><strong>CONTROLS</strong></td>
<td></td>
</tr>
<tr>
<td>Mother's age</td>
<td>Continuous, in years</td>
</tr>
<tr>
<td>Mother's education</td>
<td>Continuous, in years of school complete</td>
</tr>
<tr>
<td>Children ever born</td>
<td>Continuous; number of live births</td>
</tr>
<tr>
<td>Location</td>
<td>Dichotomous; Urban=1, Rural=0</td>
</tr>
<tr>
<td>Place of residence</td>
<td>Nominal; Pacific=1, Caribbean=1, Orinoquia=1, Amazon=1, Andina=0</td>
</tr>
<tr>
<td>Employment</td>
<td>Dichotomous; Employed=1, Unemployed=0</td>
</tr>
<tr>
<td>Ownership of dwelling</td>
<td>Dichotomous; House owner=1, No house owner=0</td>
</tr>
<tr>
<td>Electricity</td>
<td>Dichotomous; Electricity at home=1, No electricity at home=0</td>
</tr>
<tr>
<td>Socio economic status (Own a TV, a refrigerator, a radio, and a washer machine)</td>
<td>Index; Own one of the utilities=1, Own two of the utilities=2; Own three of the utilities=3; Own all the utilities=4; Not own none of the utilities=0.</td>
</tr>
<tr>
<td>Water</td>
<td>Dichotomous; Access to piped water at home=1, Not access=0</td>
</tr>
<tr>
<td>Trash collected</td>
<td>Dichotomous; Trash collected by a sanitation service=1, Trash not collected=0</td>
</tr>
<tr>
<td>Toilet</td>
<td>Dichotomous; Improved sanitary services at home=1, Unimproved sanitary services at home=0.</td>
</tr>
<tr>
<td>Kitchen</td>
<td>Dichotomous; Kitchen in a separate room=1, Kitchen in the same room=0.</td>
</tr>
<tr>
<td>Married</td>
<td>Dichotomous; Married=1, Not married=0</td>
</tr>
<tr>
<td>Number of Children born</td>
<td>Continuous, in number of children born</td>
</tr>
<tr>
<td>Migration</td>
<td>Dichotomous; Migrated from the place of born=1, Not migrated=0</td>
</tr>
</tbody>
</table>

Appendix presents a detailed description of the variables entered into the statistical models.
The primary independent variable in the model is race, which is determined by answers to the following question: “According to his/her culture, group or physical characteristics, [the respondent] is known as?” Six possible answers were offered in the questionnaire: (1) Indigenous, (2) Rom, (3) Raizal of the archipelago of San Andres and Providence, (4) Palenquero of San Basilio, (5) Black, mulatto, African-Colombian or of African ancestry, and (6) None of the above. Based on the main interest of the study, to assess the differences between Afro-Colombians and White/mestizo, I recoded the race variable into a dichotomous measure where 1 means being Afro-Colombian (codes 2, 3, 4 or 5), and 0 means being White/mestizo. Indigenas (code 1) were eliminated from the sample.

According to the proposed conceptual framework, and taking into account the variables available in the Census data, fifteen measures were selected as independent control variables (Table 3-1).

**Race Differences in Child Mortality in Colombia: Multivariate Analysis**

Once I selected the variables, I executed three different models to predict the probability of a child death. I launched a logistic regression, first by race and then I entered into the model, as control variables, the health determinants highlighted in italics in Figure 3-1. In Model 2, I entered the control variables: women’s age, location, place of residence, years of schooling, employment status, and the number of children born. The third model uses the same method, controlling, in addition, for socioeconomic status, housing quality, toxicity, and social roles and support. Based on the Múnera (2005)’s theory of Human Geography, reinforced by Wade (1993), I then applied model 3 to each of region in order to determine which place of residence has the highest race effect on the probability of child mortality.
Table 3-2. Probability of Child death regressed on age, place of residence, location, years of school, employment, socio economic status, house conditions, waste conditions, social roles, number of children ever born, and race. Colombia 2005

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B Exp(B)</td>
<td>B Exp(B)</td>
<td>B Exp(B)</td>
</tr>
<tr>
<td>Age</td>
<td>-0.048 *</td>
<td>0.953</td>
<td>-0.047 *</td>
</tr>
<tr>
<td>Place of residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Region</td>
<td>0.108 *</td>
<td>1.114</td>
<td>0.088 *</td>
</tr>
<tr>
<td>Caribbean Region</td>
<td>-0.334 *</td>
<td>0.716</td>
<td>-0.404 *</td>
</tr>
<tr>
<td>Orinoquia Region</td>
<td>-0.038</td>
<td>0.963</td>
<td>-0.075</td>
</tr>
<tr>
<td>Amazon Region</td>
<td>0.309 *</td>
<td>1.362</td>
<td>0.213 *</td>
</tr>
<tr>
<td>Andina Region</td>
<td></td>
<td></td>
<td>Ref.</td>
</tr>
<tr>
<td>Location (1: Urban, 0: Rural)</td>
<td>-0.004</td>
<td>0.996</td>
<td>0.139 *</td>
</tr>
<tr>
<td>Years of schooling</td>
<td>-0.016 *</td>
<td>0.984</td>
<td>-0.011 *</td>
</tr>
<tr>
<td>Employed (1: Yes, 0: No)</td>
<td>0.018</td>
<td>1.018</td>
<td>0.028</td>
</tr>
<tr>
<td>Ownership of dwelling (1: Yes, 0: No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socio economic status</td>
<td>0.015</td>
<td>1.015</td>
<td></td>
</tr>
<tr>
<td>Electricity (1:Yes, 0: No)</td>
<td>-0.048</td>
<td>0.953</td>
<td></td>
</tr>
<tr>
<td>Water (1:Yes, 0:No)</td>
<td>-0.023</td>
<td>0.978</td>
<td></td>
</tr>
<tr>
<td>Trash collected (1:Yes, 0:No)</td>
<td>-0.154 *</td>
<td>0.857</td>
<td></td>
</tr>
<tr>
<td>Toilet (1: Yes, 0: No)</td>
<td>-0.087 *</td>
<td>0.917</td>
<td></td>
</tr>
<tr>
<td>Kitchen (1: Yes, 0: No)</td>
<td>-0.091 *</td>
<td>0.913</td>
<td></td>
</tr>
<tr>
<td>Married (1:Yes, 0: No)</td>
<td>-0.048</td>
<td>0.953</td>
<td></td>
</tr>
<tr>
<td>Migration (1: Migrant, 0: Not migrant)</td>
<td>0.025</td>
<td>1.025</td>
<td></td>
</tr>
<tr>
<td>N. Children born</td>
<td>0.756 *</td>
<td>2.13</td>
<td>0.761 *</td>
</tr>
<tr>
<td>Race (1: AfCol, 0:White/Mestizo)</td>
<td>0.553 *</td>
<td>1.738</td>
<td>0.248 *</td>
</tr>
<tr>
<td>Constant</td>
<td>-3.538 *</td>
<td>0.029</td>
<td>-4.007 *</td>
</tr>
</tbody>
</table>

R-square 0.005 0.153 0.151

Source: Colombian Census 2005
Sample is limited to women 20-29 years of age who have had at least one live birth
* SS 0.05 or less

The results of Model 1 (Table 3-2) show that children born to Afro-Colombian women have a higher probability of death compared to children born to white/mestizo women. This conclusion is indicated by the statistically significant coefficient for the dummy variable for race, shown at the bottom of the table (+.553). The coefficient’s positive sign indicates that being an Afro-Colombian woman increases the likelihood of experiencing the death of at least one child.
For the purposes of substantive interpretation, the more useful indicator is the odds ratio, which is calculated by exponentiating the B coefficient. If the race variable has no effect on the likelihood of child mortality, then the odds ratio would have a value of 1. If race is associated with an increase in child mortality, the odds ratio would be greater than 1. Similarly, if race is associated with a reduced likelihood of child mortality, the odds ratio would be less than 1. In this case, as shown in column 2, we see that the odds ratio is 1.738. This means that, without including any other variables in the equation, the likelihood of child mortality among children born to Afro-Colombian women is 74% higher compared to the likelihood of child mortality among children born to white/mestizo mothers (treated as the reference category).

The positive race effect on the probability of child death observed in Model 1 could be entirely due to race differences in education and other determinants of child mortality. If that is the case, then we would conclude that the mortality difference between Afro-Colombian and white/mestizo children is caused exclusively by differences in their respective socioeconomic statuses. My contention, however, is that, independent of (i.e., controlling for) socioeconomic status and other determinants of child mortality, the probability of death will be higher among Afro-Colombians. Hence, the central question is whether the race effect observed in Model 1 persists after introducing statistical controls for the major factors associated with the probability of death in the early years of life.

In order to answer this question, Model 2 presents the likelihood of child death by race, net of the effects of age, place of residence, location, maternal education, employment status, and the number of children born. The addition of these variables in
the equation substantially increases the percent of variance explained, to 0.153 in Model 2, up from only .005 in Model 1. The coefficients and odds ratios for the various control variables provide insight into the factors that influence the probability of child death. For each year increase in mother's age we would expect a decrease of 4.7 percent in the likelihood of child death.

Since the largest inequalities in Colombia have been attributed to geographical location (Múnera, 2005; Wade, 1993; UNDP, 2011), Model 2 introduces dummy variables that represent each region, using, as the reference group, the Andina region. According to the Census, 2.2 percent of Afro-Colombians live in the Andina region, the smallest percentage among the different geographic areas, which is the main reason for treating this location as the reference region.

The likelihood of child death of women living in the Pacific region, where 19.7 percent of the inhabitants are Afro-Colombians, increases by 11.4 percent compared to the Andina region (column 4). The probability of child death also increases by 36.2 percent for women living in the Amazon region. In the Caribbean region the probability decreases by 28.4 percent in reference to the Andina region. The dummy variable for Orinoquia is not statistically significant, indicating that this region does not differ from the Andina region. The regional differences observed in Model 2 confirm the importance of geographic location in the child mortality studies.

Model 2 also shows that living in urban areas, compared to living in rural areas, has almost no effect (0.04 %) on the probability of child death, but the result is not

---

4 It is worth recalling that the analysis is limited to women 20 to 29 years of age. The findings therefore do not apply to women in the older age ranges, who, by virtue of having older children, may experience an increase in probability that a son or daughter died as mother grows older.
statistical significant. This absence of an effect for urban residence might be due the fact that the model controls for geographical regions. Whatever the reason, the theoretical prediction of a lower probability of child death in urban areas in developing countries as Colombia, presumed to be due the greater presence of health facilities, is not supported by the results of this model.

As seen previously in the literature review section, maternal education may affect children’s health status due the greater health knowledge and the greater empowerment that education implies. Model 2 shows that for every year of schooling we find 1.6 percent decrease in the likelihood of child death. Given that the scores for the education variable range from 0 to 17, and that each additional year of school reduces the odds of death by nearly 2 percent, it is evident that maternal educational achievement has a large reducing effect on child mortality in Colombia, a finding that is consistent with studies of child mortality across the world.

If greater educational achievement is associated with the enhanced empowerment of women, numerous studies further suggest that empowerment within the household is associated with women’s employment. However, the coefficient for women’s employment in Model 2 is not statistically significant.

The number of children born may have several effects on maternal health, as well as on childcare factors such as nutrition. Other things being equal, larger families are likely to experience higher child mortality if only because there are a greater number of children at risk. But higher fertility also has other effects, not only on maternal health, but also on many factors that affect the welfare of children, such as per capita nutrition, the amount of child care received, and demands on the mother’s time. As noted at the
bottom of the table, each additional child born to the mother more than doubles the odds of child death (odds ratio = 2.13). The number of children born is the variable with the largest effect on the probability of child death in Colombia.

Finally, the race effect in Model 2 (1.281) is smaller than the race effect in Model 1 (1.738). The means that some of the differences between Afro-Colombian and white/mestizo child mortality can be attributed to the other variables in Model 2: maternal age, place of residence, location, maternal education, employment status, and the number of children born. However, the race of the mother has an independent effect on the probability of child death.

Based on Figure 3-1, and considering the variables available in the Colombian Census data of 2005, Model 3 includes additional determinants of children's health status to tease out if being Afro-descendant still explains a variance in the probability of child death in Colombia after controlling for housing quality and socioeconomic status.

Although one of the more valid operational definitions of social status is income, the data set from Colombian census regrettably does not include this important variable. However, other indicators serve as proxy measures, such as the ownership of various household appliances, including the presence in the home of a television, washing machine, radio, and refrigerator. I combined these variables into a composite index, which I labeled "Socioeconomic Status," that varies from 0 (own none of the appliances) to 4 (own all of the appliances). I also introduced in the model as a proxy of socioeconomic status the ownership of the dwelling, and the access to electricity, to piped water, to sanitary services, to trash service collection, and the presence of a
kitchen in a separate room in the house. These variables are indicators of both socioeconomic status as well as housing quality\(^5\).

Marital status and migration status are also predicted to be important because single women and newcomers to an area may be less stable and more vulnerable to risk factors. According to some of the theory reviewed, social support may serve to buffer of the probability of child death (Schulz et al., 2002; Hummer, 1996). The presence of a male is thought to have positive effects due to greater purchasing power, and additional help with respect to sharing childcare children, and how others see the woman\(^6\). Migration is not directly involved in the health determinants of child mortality but arriving in a new place of residence may imply absence of familial and friendship support, as well as community support.

Model 3 includes all of the variables available in the 2005 census. None of the variables which were included in the model as proxy indicators of income, wealth, and purchasing power have an independent effect on the probability of child death (the index of socioeconomic standing, employment status, home ownership). Instead, the results in model 3 show that the effects of maternal age, and maternal education persist even controlling for the other variables in the model. The number of children born continues to have the largest effect on the probability of child death in Colombia. Each additional child increases the likelihood of death by 113.9 per cent. Also, living in the

---

\(^5\) For lack of data I do not address morbidities, but I recognize the incidence of infectious diseases ultimately resulting in death is influenced by exposure to communicable pathogens – fecal-oral or respiratory – usually due to the ingestion of contaminated water and food. The exposure is determined by a variety of environmental and behavioral factors, such as housing, crowding, access to improved water and sanitation services, and personal and household hygiene.

\(^6\) The findings of the ethnographic research, reported in Chapter 4, question the idea that the presence of males contributes to household welfare in Colombia.
Pacific and in the Amazon regions remain associated with an increase in the probability of child death, but their effects were reduced by 2.2 and 12.5 percent respectively.

In contrast to model 2, in model 3 urban residence increases the likelihood of child death by 14.9 percent. When I added to the equation socioeconomic aspects, and social supports and roles, the urban location variable becomes positive and the result is statistical significant. The higher mortality observed in towns and cities is likely due to the fact that Model 3 controls for the effects of childcare factors such as food availability, access and use of health services, as well as maternal health and nutrition. By virtue of controlling for these, and other aspects of urban life, such as crowding, injury, and the presence of infectious agents, the results indicate that, other things being equal, urban residence is associated with higher child mortality.

Among the indicators of housing quality, access to improved sanitary services and having a kitchen in a separate room have an independent effect on the dependent variable. Possessing a toilet rather than a latrine, or other unimproved sanitary services decreases the likelihood of child death by 8.3 per cent. The adequate disposal of feces is imperative in the children’s health status in order to prevent fecal-oral transmission diseases such as diarrhea, that account for a large percent of child mortality in Colombia. In 2008, the World Health Organization –WHO- reported diarrheal diseases were responsible for 4.14 percent of all deaths of children under 5 years of age in Colombia. It also may prevent water pollution through contact with feces, or microbes associated with inadequate fecal disposal.

Having a kitchen in a separate room decreases the probability of child death by 8.7 per cent. Different rooms in the household imply better economic conditions, and, in
addition, a separate kitchen may prevent some respiratory infections if cooking is done on rudimentary stoves, or it may prevent children from getting burned. The analysis of census data finds a statistical significant association between the presence of these two indicators of housing quality, and the risk of child mortality. In addition, access to electricity and to piped water appear to decrease the probability of child death, but the result may be due to chance as the coefficients for the two variables are not statistical significant.

Model 3 also shows that trash collected by a regular service decreases by 14.3 percent the likelihood of child mortality. Toxicities from inadequate garbage disposal can cause lethal infections in individuals, even more so in the case of children who have fewer defenses, thus increasing the likelihood of their death. Neither marital nor migratory status is statistically significant.

Based on the conceptual framework of child mortality, and as shown in the previous regression models, it is evident that the determinants of mortality involve the interaction of numerous variables with one another in complex ways. There is little reason to assume that, for example, the access to toilet, in and of itself, would reduce child mortality. Rather, improved sanitary services are assumed to improve hygienic conditions. But, hygienic conditions can be achieved only with knowledge of the basic principles of good health. Such knowledge, in turn is associated with maternal education, and as model 3 shows is expected to decrease the probability of child mortality. Moreover, maternal education achievement is closely correlated with income, and hence with the likelihood of having piped water, improved sanitary services and electricity. In sum, individual variables alone may not explain the probability of child
death. The variance is due to a complex network of distant and proximate determinants.

With respect to the objectives of this thesis, the result that most stands out in Model 3 is that the mother’s racial classification continues to be statistically significant. The likelihood of death among children born Afro-Colombian women is 20 percent higher than the likelihood of children born to White/mestizo women. More specifically, the results in model 3 indicate that even after controlling for maternal age, place of residence, location, maternal education, employment status, the number of children born, as well as socioeconomic status, housing quality, toxicity, and social roles and support, the race of the mother continues to have an independent effect on the probability of child death. The inclusion of other health determinants of child mortality reduces the effect of being Afro-Colombian yet the mother’s race increases the likelihood of child death by 20 percent. Accordingly, children from Afro-Colombian younger women, in urban areas in the Pacific and Amazon regions, with no education, with a large number of children born, with no access to improved sanitary services, and trash collected services are expected to experience the highest probabilities of death.

**Race effect on Child Mortality by Region and Department**

As noted in Chapter 2, geographical location is an important variable in understanding racial inequality in Colombia. The importance of location is illustrated in Models 2 and 3, which, as we have seen, show significant differences between regions in the probability of child death. A useful way to further explore the geographical factor is to estimate the magnitude of the race effect within each location. This is accomplished by separating the sample into subsamples, and executing Model 3 within each place.
Table 3-3. The effect of race on child mortality (odds ratio) net of the effects of age, urban/rural, years of school, employment, socio economic status, house conditions, waste conditions, social roles, and number of children ever born by region. Colombia, 2005

<table>
<thead>
<tr>
<th>Region</th>
<th>% AfCol</th>
<th>EXP (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andina</td>
<td>2.2</td>
<td>1.018</td>
</tr>
<tr>
<td>Pacific</td>
<td>19.7</td>
<td>1.244*</td>
</tr>
<tr>
<td>Caribbean</td>
<td>15.1</td>
<td>1.096</td>
</tr>
<tr>
<td>Orinoquia</td>
<td>3</td>
<td>0.585</td>
</tr>
<tr>
<td>Amazon</td>
<td>4</td>
<td>1.103</td>
</tr>
<tr>
<td>National</td>
<td>10.5</td>
<td>1.2*</td>
</tr>
</tbody>
</table>

Source: Colombian Census 2005
* ss 0.05 or less

Table 3-3 shows the percentage of Afro-Colombian population in each of the five main regions of Colombia. The second column shows the effects of race on child mortality net of the effects of all of the variables included in Model 3 (Table 3-2). The Pacific region accounts for the larger percent of Afro-descendants in Colombia: 19.7 percent of the population is Afro-Colombian. In second place, the Caribbean region accounts for 15.1 percent of Afro-Colombians, while in the other three regions Afro-Colombians account for four percent or less of the total population. In addition, in the Pacific region, race has the larger effect on the probability of child death in reference to the other regions. Being Afro-Colombian increases the likelihood of child death in the Pacific region by 24.4 percent. The coefficient for the Pacific region is the only one that is statistically significant.

With the purpose of narrowing the geographical area of study in Chapter 4, I also ran model 3, this time splitting the results by the departments that comprise the Pacific region: Antioquia, Chocó, Valle del Cauca, Cauca and Nariño.
Table 3-4. The effect of race on child mortality (odds ratio) net of the effects of age, urban/rural, years of school, employment, socio economic status, house conditions, waste conditions, social roles, and number of children ever born by department. Colombia, 2005

<table>
<thead>
<tr>
<th>Region</th>
<th>% AfCol</th>
<th>EXP (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antioquia</td>
<td>10.2</td>
<td>1.202</td>
</tr>
<tr>
<td>Chocó</td>
<td>68.4</td>
<td>1.172</td>
</tr>
<tr>
<td>Valle del Cauca</td>
<td>20.8</td>
<td>1.402*</td>
</tr>
<tr>
<td>Cauca</td>
<td>24.4</td>
<td>1.144</td>
</tr>
<tr>
<td>Nariño</td>
<td>19.8</td>
<td>1.226</td>
</tr>
<tr>
<td>National</td>
<td>10.5</td>
<td>1.2*</td>
</tr>
</tbody>
</table>

Source: Colombian Census 2005
* ss 0.05 or less

Table 3-4 shows the percentage of Afro-Colombian population among the five departments of the Pacific region, and the effects of race on child mortality net of the control variables used in Model 3 (Table 3-2). Among the five departments taken into account, Chocó is the area with the largest percent of Afro-Colombians (68.4%), followed by Cauca (24.4%)\(^7\). However, race has the larger effect on the probability of child death in reference with the other departments in the Valle del Cauca, where 20.8 per cent of the inhabitants are Afro-Colombians. Being Afro-Colombian in the Valle del Cauca increased the likelihood of child mortality by 40.2 percent. The result in Valle del Cauca is the only one that is statistically significant.

**Racial Discrimination Vs. the Myth of Racial Democracy: Child Mortality by Race**

The main goal of Table 3-2 was to tease out the factors associated with racial differences in child mortality. After including as many indicators as possible from the conceptual framework (Figure 3-1), the results indicate that racial differences persist in

---

\(^7\) I would like to further narrow the geographic area to municipalities such as Buenaventura, where more than 70 percent of the inhabitants are Afro-Colombians. Nevertheless, this was not possible due to small number of cases (801 women from 20 to 29 age).
the probability of child death. When I simultaneously control for all of the most significant predictors of mortality in the early years of life, children of Afro-Colombian women continue to experience higher death rates compared to children born to White/mestizo women.

According to these results and going back to my research interests, it is evident that inequalities between Afro-Colombians and White/mestizo population are due to differences in socioeconomic conditions, but not entirely. If race ceased to explain the variance in the probability of child death after controlling for the effects of social and economic determinants of child mortality, then I would conclude that the mortality gap was due exclusively to the differences in socioeconomic conditions. The findings show otherwise, suggesting that Afro-Colombians are subject to disadvantages other than those associated with lower socioeconomic standings.

Examining the size of the effects of the determinants included in model 3 (Table 3-2), I conclude that the most important predictor of child mortality is the number of children born, followed by the effect of place of residence. Race appears to be the third most important variable, having a larger impact than housing quality, toxicity, and maternal age and education. Why does race have an effect on child mortality net of the statistical effects of proximate determinants such as maternal factors, and distant determinants such as socioeconomic status, physical environment, and social roles and support?

According to Figure 3-1, the answer points to institutional and individual levels of racism. Afro-Colombian women may be discriminated against in terms of health care system or other government policies associated with the determinants of child mortality.
in ways that not already accounted for in the statistical models. Likely factors include maternal health, nutritional status, and the availability and use of health services. In addition, Afro-Colombian women may live in more hazardous areas within cities, due to migration or residential segregation, which in turn may affect the accessibility to adequate health services, food, as well as the exposure to infections factors, and injury. Whatever the actual causes, the findings of the statistical models nonetheless suggest that, beyond the negative effects of lower socioeconomic status, place of residence, and housing quality, there are additional costs associated with being Afro-descendant in Colombia.

In sum, the statistical analysis allows me to measure discrimination indirectly, inferred by the variance explained by the mother’s race (white/Afro-descent). Severe inequality remains between the White/mestizo and Afro-Colombian population, reflected in racial differences in the survival probabilities of children born to Afro-Colombians and White/mestizo parents. The mother’s race is associated with child mortality after removing the effects of social and economic determinants such as employment status, maternal education, physical environmental, and social roles and support.

The statistical model estimates the presence and magnitude of the effect of racial discrimination on the probability of child death, yet it is nonetheless silent with respect to the actual mechanisms of discrimination. Hence, the qualitative analysis in Chapter 4 will allow me to identify ways in which racial discrimination increases the probability of death among children born to Afro-Colombians women through mechanisms not accounted for in the statistical models.
In order to use an ethnographic approach to explore the mechanisms of racial discrimination within Colombia’s health care system, it is necessary to narrow the geographic focus. The findings in the previous section, specifically the findings shown in Table 3-4, suggest that Valle del Cauca is an appropriate place to get an in-depth understanding of the other factors involved in Figure 3-1.
CHAPTER 4
MECHANISMS OF DISCRIMINATION: ETHNOGRAPHIC STUDY IN
BUENAVENTURA

Method

The statistical analysis of Colombian census data shows that, controlling for socio-economic status, human capital, and geographic location, the mother’s race has an independent effect on child death. The higher probability of child death among children born to Afro-Colombians serves as an estimate of the magnitude of race-based inequality. Because these differences cannot be explained by socioeconomic differences (which are controlled for in the statistical models), I infer that the disparities between whites and Afro-descendants can be attributed to unmeasured forms of discrimination. In other words, the statistical model allows me to measure discrimination indirectly, inferred by the variance independently explained by the mother’s race (white/Afro-descent).

The statistical model estimates the presence and magnitude of the effect of racial discrimination on the probability of child death, yet it offers little insight into the actual mechanisms through which racial inequality and discrimination put Afro-Colombian children at greater risk. Hence, to complement the empirical analysis, and with the goal of gaining an in-depth understanding of race-related attitudes and behaviors that affect access to health care and therefor child mortality, in this Chapter I narrow the focus of analysis and adopt an approach that uses two complementary methods of ethnographic data collection: participant observation and semi-structured interviews.

Participant observation is a data collection technique that includes analyses of relevant documents, interviews, and observation (Flick, U. 2009). Qualitative analysis
allows me to identify the specific ways in which racial discrimination that influence the probability of death among children born to Afro-Colombians women.

To carry out an in-depth analysis of the behaviors that work against Afro-Colombian children, I spent five weeks as a participant in the “Hospital Departamental” of Buenaventura. I focused attention on the moment of encounter between women seeking health care for their children and the provision of it by the health care facility. The goal was to analyze the relationships that define this encounter as a way to identify the attitudes and the behaviors that determine the quality of the health care that children receive. The empirical indicators which were expected to vary by the mother’s race include variables such as access to and the quality of the services provided, differences in the amount of time women wait for service, and race-related attitudes and beliefs on the part of the clinics’ staff and professionals.

I collected evidence of the practices and processes that affect racial differences through semi-structured interviews among patients and health professionals. I started my interviews in the third week of fieldwork, after first gaining a better understanding of the issues at hand. I then narrowed my focus to the problems of interest. The process of modifying the target of my interviews along the way is consistent with the “Grounded Theory” approach, which assumes that the information gathered early in fieldwork should influence and sharpen the content and the objectives of interviews carried out later in fieldwork.

I also met with representatives of others organizations involved in children’s health care: Municipal Health Secretary of Buenaventura, “Instituto de Bienestar Familiar – ICBF,” “Medicos sin fronteras,” midwives’ association – Asoparupa, Carvajal
Foundation, and Profamilia. My purpose was to assess the health care system in Buenaventura, to understand its weaknesses and to become aware of the proposals that have been advanced to address them. The people with whom I met invited me to participate in some of their activities, which was an opportunity to meet and interview additional informants.

During the interviews I became interested in the socio-economic role of Afro-Colombian women, and how that role affects their children’s welfare. I spent time observing the three most important market places in Buenaventura: “Pueblo Nuevo,” “La Playita,” and “El Centro.” I also had a chance to meet members of the “Proceso de Comunidades Negras – PCN,” one of the key actors in the struggle to reduce the social exclusion that afflicts the Afro-descendant population in Colombia.

Many of my informants mentioned the Hospital Universitario del Valle del Cauca (HUV), the health entity to which patients are remitted in Cali. On the basis of these observations, I added that health facility to my study. I spent two weeks in Cali, where I did participant observation in the emergency room of the HUV. I also met professors of the “Universidad del Valle,” interested in the marginalization of Afro-Colombian population in the Pacific coast, and who have expertise in the study of neonatal and infant mortality and maternal health.

All total I interviewed 37 women, 15 members of the clinical staff, and more than ten key informants who were members of local organizations in Buenaventura and Cali. The sample size was determined by the redundancy principle, whereby additional people were interviewed until no new significant information was obtained. Using semi-structured rather than structured interviews (as in the case of social survey analysis), I
had the flexibility to tailor my interviews according to the reactions and the realities that emerged in the field.

**Buenaventura, Valle del Cauca: the Research Site**

Buenaventura is a city far from the Colombia’s more important urban centers, located in the department of Valle del Cauca, mostly visited by big trucks loaded with merchandise. The vehicles come and go, passing through Buenaventura on the way to the port, which, since the economic opening of the country (1990 - 1994), has become the most important port for Colombia’s international trade (Pérez, 2007). Although today more than fifty percent of the nation’s commerce comes through Buenaventura, its inhabitants still wonder what happened to the social investment that they once thought would result from their strategic location.

In contrast to the port’s economic boom, the city suffers from numerous difficulties associated with poor infrastructure, weak educational facilities, and a low quality health care system. The picturesque view of the Pacific Ocean does little to lessen the sadness and hardships people confront in their daily lives. I wondered how many of the Bonaverenses could enjoy the view, how many of them were in a position to see the ocean as a place to rest rather than as a garbage dump, as a source of diseases, and as a dangerous place for their children.

Since its founding in the early nineteenth century, the national government viewed la nueva villa de Buenaventura, as it used to be called, as a transshipment point in the transit of products and goods (Aprile-Gniset, 2002). Its geography, characterized by swamps and mangroves, and its high temperature and humidity, were always considered obstacles to the progress of a city. Despite these disadvantages, 342,610
people live there nowadays, and, according to the 2005 national census, more than 70 percent are of African descent.

I selected Buenaventura as the research site in the department Valle del Cauca because Afro-descendants make up the majority of the population. In addition, according to the statistical analysis the effect of race on the probability of child death is larger in Valle del Cauca. Among the others department of the Pacific region, Antioquia, Cauca, Chocó, and Nariño, I inferred a higher presence of discrimination in the geographic area of Valle del Cauca. I therefore concluded that the city with a large number of Afro-Colombian inhabitants in the department of Valle del Cauca was the most suitable place to carry out the study.

**A Closer View of the Effects of Race on Child Mortality: Studying Relations between Health Staff and Patients in Buenaventura**

After I explained my interests in observing the delivery of health services in the facility to Marleny, the head nurse of the Hospital Departamental in Buenaventura, she introduced me to Dr. Bacca, the doctor in charge of the emergency room. Dr. Bacca, a white man from Popayan, epidemiologist, and longtime resident of Buenaventura, was skeptical of my interests and dismissed the purpose of my study on the grounds that: “here we learn to see everybody as equal; there are no blancos, no negros, just patients looking for health services.” It did not take long to realize that his view that the delivery of health services was blind race was largely a fiction.

Dr. Bacca escorted me to the emergency waiting room where I was to carry out my observations. The room is huge hall furnished with four wooden benches, each only big enough to accommodate five people, who sit in a row and wait to see the doctor. The room was full of sad-faced children, women in silent resignation, and gaunt old
people. This time I didn’t need to “fight” the security guard for access to the hall, and I had the opportunity to appreciate the conditions in which the health services are delivered.

The hospital rooms are modest, with many stretchers, but little in the way of medical equipment. Most of the stretchers are rusted, without blankets, and the patients have to carry their fluids themselves. The majority of them lie down on the floor until one of the plastic chairs or the stretchers becomes available. Clearly, there is insufficient space to deal with all of the sick visitors. Two rooms are set aside for children and their companions, usually their mothers. The miserable conditions are reflected in the demeanor of the children. An atmosphere of sadness and hopelessness overwhelms the place and the people in it.

The emergency waiting room. It was 11 in the morning, in 95-degree heat, with the stifling humidity characteristic of places near the sea. No air conditioning or even a fan was placed in the room. A large window on one side, crossed by iron bars, increases the feeling of anxiety and isolation. Sellers of fruits, chontaduro and mazamorra are on the other side, ready to satisfy the hunger of anyone who is sentenced to spend long hours before receiving the medical care they came for. A counter with no one on the other side, and stacked high with piles of medical records, augments the feeling of abandonment and lethargy. Nothing happens very fast in the room.

I had to stand near the window because all the places on the benches were already taken. During the first forty-five minutes, no doctor, nurse, or staff member appeared to call someone to the emergency room. Suddenly, an ambulance arrives.
The security guard, with a gesture of displeasure, approaches the medical staff in charge of the ambulance and, without even knowing the nature of the emergency, says: “there is no room here for anyone else, go look elsewhere.” The ambulance staff, apparently used to such comments, pays no attention. Two Afro-Colombian girls with their mothers climb out of the vehicle. After a long discussion with the guard, and after taking his time to review various documents, the girls were allowed to enter the waiting room.

Finding no one at the counter, and after waiting several minutes, one of the doctors who came with the two Afro-Colombian girls went into the emergency room looking for service. He came out accompanied by a nurse, who took the girls’ health records, which she placed in the pile with the others, and showed the women to the benches where they were told to wait. Before leaving the room again, the nurse announced that “in about ten minutes we will have water, and we will start with laboratory tests.” Apparently the hospital had lacked drinking water for two days.

The medical staff started to call patients. Many people complained of the slot allocation system and about the long waiting times. Two mothers gave up in frustration and decided to leave the facility with their children, claiming that, actually, their children’s health was not that bad, and that they would probably recover with homemade remedies. Now that more room was available, the two Afro-Colombian girls, their mothers and I found a place to sit.

**Andrea.** A despondent look, an undernourished body, and an almost inaudible voice were the traits that called my attention to Andrea. She is an eleven-year-old girl barely taller than the average height of a four year old, dressed in yellow pajamas,
transparent enough to see that her bones stuck to her skin. During her wait before being attended she did not stop sobbing, crying out for her mother “mammy mammy mammy,” and receiving no consolation or love from the woman who was with her. It was only then that I realized that the woman with her was not her mother.

Carmenza, her aunt, the woman who accompanied Andrea, told me the girl arrived the night before from the countryside, sent to the city because of her failing health. Andrea's mother apparently suffers from mental problems, and, as is usual in Afro-Colombian culture, her older sister has taken care of her. Andrea's father, seeing his wife's illness, left them many years ago. Carmenza confessed that she was unable to care for Andrea because she already has six children, including a one-year-old baby who waits on the other side of the window: “I asked one of his sisters to bring him, in order to breastfeed him, because today we did not even have money for his milk.”

Earlier in the morning Andrea and Carmenza went to “Medicos sin Fronteras,” a health facility for children without a medical care plan. In “Medicos sin fronteras” the doctors diagnosed her with a severe malnutrition and quickly referred her to the Hospital Departamental. Andrea had all the symptoms of kwashiorkor (Howard & Millard, 1997), a common form of severe malnutrition that in most cases leads to death. Abdominal swelling, redness of her hair, and skin depigmentation were evident. But, no doctor in the Hospital Departamental seemed to be alarmed by her situation. Two hours have gone by and no one had come to see ask the reason she is there.

Carmenza, realizing just how long time they had been waiting, said “the purpose is to cure her and give her to the ICBF¹, but I will wait until five, and if by then we have

¹ Instituto Colombiano de Bienestar Familiar: Colombian Institute devoted to the integral protection of families and children through the administration of the national family welfare.
not been attended I'll take her back to my house and send her tomorrow to her sister in Bajo Calima [the rural area where she lives].” It was becoming apparent that the long waiting times are a serious problem that causes patients to abandon the hospital before receiving the attention they came for.

Meanwhile, Leslie, the one-year-old girl who came with Andrea in the ambulance, became desperate. Her mother had given the child soup, fruit, and a bottle of milk but was no longer able to entertain Leslie who grew tired of waiting. Like Andrea, Leslie and her mother have been clamoring for medical attention since six in the morning. “I never come here for that reason ... I always take my children to a pharmacy or to ‘Medicos sin fronteras’ ... We get attention fast and most of the time they give us the medicines,” said Patricia, Leslie's mother.

Since the ambulance arrived, no one else has come into the emergency room. Many of the patients who had been waiting have left or have been called for laboratory samples. Suddenly, at 4:10 pm, a white woman shows up at the emergency room door holding her son, in the company of her husband. They had no need to negotiate with the guard, who let them through without questions or interference. A nurse immediately came to the counter, obtained the identity documents of the child, who was admitted to the observation room after only a few minutes. An hour later, the three left, thanking the staff for the good service provided.

The prompt medical attention the white child received, compared to the slow service delivered to Andrea and Leslie, not only caught my attention, but also that of the two Afro-Colombian women who had been waiting for over four hours. Why didn’t Andrea and Leslie get the same medical care? Were their health conditions not serious
enough to be admitted to the observation room when they arrived? In what ways were their situations different from the white boy's? Is there a protocol for who does and who does not receive care?

In order to understand the disparities these cases illustrate, my goal in this section is to understand the determinants of health care provision in Buenaventura by focusing on the Colombian health system, the quality of service, the Afro-Colombian culture, and finally, the physical environment itself.

**Colombian Health System**

Doctors are quick to explain the situations described above by pointing to a single culprit: the Colombian health system. “Since the enactment of Law 100 of 1993, providing health services is completely different,” one doctor notes. All of the health staff I interviewed agreed that the guiding principle of the new law, rather than equity, was exclusion via a subsidized system. The quality of service, as well as the provision of medicines, and treatments by the contributory regime differs radically from that which is provided in the subsidized regime. The difference between the two systems is due to differences in the Mandatory Health Plan.

In the two cities where I did participant observation, doctors stated that in the Hospital Departmental of Buenaventura, as in the Hospital in Cali, attention is given to all patients, but at great difficulty. The lack of medical professionals, equipment, and infrastructure in general, makes it impossible to provide ideal services, comparable to other health institutions. Dr. Torres, head of Pediatric Intensive Care Unit at the Hospital Universitario del Valle, noted an inherent relationship between the care given to children in the subsidized system and the risk factors of children in the contributory regime.
**Colombian health care system: Law 100 of 1993**

In order to achieve universal coverage, the Colombian health system was privatized in the early 1990s, following the recommendations of international aid agencies (Sachs, 2001). The decision was in keeping with the World Bank and the International Monetary Fund contention that individual private health insurance systems are more effective compared to previously established national public health structures for overcoming inequities in health care in low- and middle-income countries, such as Colombia (Alvarez *et al.*, 2011). Following the neoliberal reform, the Colombian national health system is now a market-oriented health care program (De Vos *et al.*, 2006).

Because “health systems are the vehicle through which health services are delivered” (Skolnik, 2012:88), understanding the structure established by policies, like the Law 100 of 1993, is therefore critical to appreciate the provision of health services in Colombia. Since its enactment, the Colombian health reform has been inaccurately (De Vos *et al.*, 2006) considered an unqualified success, so much so that it has been treated as a model for Latin America. It was claimed to be so successful that the World Health Report 2000 considered it among the fairest system in the world. However, the reality in the provision of health care in Colombia is far from the spirit of the public policy. The new system’s promises of universality, improved equity, efficiency and better quality are still pending.

To understand the reform of 1993, it is imperative to know how the preceding health system was structured. Before 1993, Colombian health system was composed of three subsystems: (1) the Public Subsystem, based on a network of hospitals and health centers serving the unemployed and low income people, financed by state
resources that were sent directly to health care delivery institutions; (2) the Compulsory Social Security Subsystem, a network of health centers and hospitals covering employees, financed by contributions from employers and employees; and (3) the Private Subsystem, composed mainly of private institutions covering the high-income population, who could afford private services.

“At the end of the 1980s, some 40% of the population was covered by the public sector and 18% by the social security, while 17% used private health services. This means that about 25% of the population remained without any coverage” (De Vos et al., 2006:1606). This health system was considered largely unfair, since approximately 25 percent of the population was not covered, and personal income was used to determine access to health care services (Ministerio de Salud Colombia, 1991:64). The reform of the health system through the enactment of the Law 100/1993 was promoted as a solution to address the inequalities of the Colombian health service.

The reform basically withdrew the Colombian state from delivering health care, and adopted, instead, a system that would be finance by selling services. According to the Law 100/1993, the new system is composed of two subsystems: (1) the contributory system, which is tailored to individuals who can pay, such as employees and independent workers; employees contribute 25 percent of the payment and their employers contribute 75 percent, and the payment is based on the salary. And (2) the subsidized scheme, which targets socio-economically disadvantaged people.

In addition, the reform introduced a new player into the system, the Health insurance companies, called EPS [Empresas Prestadoras de Salud]. In both regimes, the EPS are in charge of the administration of health care for each individual
accordingly to the basic benefit plan that was drawn up. The basic plan, which includes medical procedures, hospitalization and medicines that the insurance must cover, differs from one subsystem to the other.

Law 100/1993 also ruled that public hospitals and health centers would not continue to receive financial resources directly from the state but would compete with private institutions for EPS contracts. The main issue is that EPS did not always contract services with public hospitals but created their own clinics and health care to deliver services. However, in rural and poor urban areas private services do not exist; public hospitals continue to be the leader in the provision of health service, with limited resources, inadequate infrastructure and insufficient health staff.

Different reports and studies show remarkable increase in the social insurance coverage\(^2\), yet this perception is not shared globally. Regardless, the main critics have focused on the packages which vary from one system to the other, which means differences in the provision of medication and professional attention. “The subsidized system is generally only half of a reference of standard of what is possible and necessary in Colombia” (De Groote \textit{et al.}, 2005: 130). The proposed goals of universal coverage and equitable access to high-quality care have not been reached.

Health prevention and promotion are probably the greatest victim of the reform. The most of the budget were invested in individual health insurance, and resources assigned to health promotion were reduced. In addition, it is clear that the reform only strengthened the private sector (De Vos \textit{et al.}, 2006). The role of the state as a regulator and leader of public health was left behind. The neo-liberal model in Colombia

\(^2\) According to Colombian Health System, in 2009: 46.6% of the inhabitants are in contributory system, and 52.5% in the subsidized.
not only failed to address previous problems but also made some things worse. Twenty years since the enactment of the reform have shown that the private sector has benefited and that market mechanisms have accentuated social inequality in Colombia. Colombian health system since 1993 has not been able to address problems of accessibility, equity and efficiency. A big gap exists between the theoretical objectives of the law and its actual implementation.

Regarding the main purpose of this study, data from Health Secretary of the department of Valle del Cauca in 2009 show that 61% of Afro-Colombians participate in the subsidized system, 24% participate in the contributory system, and 10% have no access to health care. By virtue of being relegated to the subsidized system, it is evident that the type of coverage alone is an indication of institutional discrimination (Jones, 2000, 2001). Understanding the structures established by policies like the Law 100 of 1993 is therefore critical to formulating policies to achieve greater equity in the provision of health services.

Following the specifications provided by the law, I considered it important to highlight the guarantees provided to indigenous people, but not to Afro-Colombians. All members of the indigenous communities have guaranteed the access to health services through the subsidized scheme, while, according to data above, fully 10% of Afro-Colombians in Valle del Cauca have no access to health care.

Health: from a human right to a profitable business

As I previously pointed out, Law 100 introduced a major change that differentiated between companies that provide health, the EPS, and health institutions, “IPS” [Institución Prestadora de Salud]. The IPS are what we regularly call hospitals or health facilities; and the EPS are companies charged to collect the monetary
contributions from individuals and the Colombian State, depending on the system, and
to pay to the IPS for every service provided to patients. This new mechanism has been
criticized because payments to the IPS are often delayed, and because of restrictions
that apply to prescribing medicines and ordering lab tests and medical procedures.
According to Dr. Bacca, since this mechanism was established, health service changed
from a human right to a profitable business.

However, the greatest damage to the service is reflected in the time doctors
devote to each patient, which is no more than fifteen minutes. “It is difficult for a doctor
who sees more than thirty-six patients a day to have the time to explain to each person
her situation, to understand her context, and to work with her to find a solution to health
problems,” confessed a doctor in one of our encounters. The gap between the
management guidelines and the realities faced by Afro-Colombians women in
Buenaventura exacerbates the situation: Does it make sense to ask a woman to take
care of her baby’s health by washing bottles with water and soap and boiling them when
the mother has neither piped water nor electric services?

Francia, one of the employees in Buenaventura’s health department, reinforced
the doctors’ statement: “To improve the quality of health service delivery we need to
humanize and professionalize medical attention. It has become common to request
fewer tests, to not follow patients care, and to not provide appropriate medicines.”

Health infrastructure has also been affected by changes in the health system. It
has been more than a year since the Hospital Departamental in Buenaventura has had
an ambulance. Triage personnel responsible for prioritizing health needs were released
from the health staff, exacerbating the waiting time before attention. The building
conditions I already noted are part of this troubling scenario, although the staff does not necessarily see it as a problem. As one member the staff put it: “As the people who usually come here live in misery, they feel very well cared for in the facility.” The opinion was not shared by mothers who expressed little confidence in the medical staff or the treatments given, and even suspected corruption in the overall management of the facility.

Yet, does the poor infrastructure harm everyone in equal measure? Andrea’s and Leslie’s long waiting time, compared to the son of white parents as well as the presence of an Afro-Colombian infant on an incubator on June the 12th, with a sign: “Damaged, smell something burning - date: June 5th” indicate that Afro-Colombians are more likely to be harmed by the poor conditions of the health care system.

Making matters worse, Buenaventura is burdened by the absence of health care specialists. Delays receiving payments, as well as the economic and social adversities that afflict the city are among the factors that prevent doctors from staying in or moving to Buenaventura. Internal control in the various facilities is inefficient. Doctors know full well that, even if they do not follow protocols, they are not going to lose their jobs if only because there are no others to replace them.

**Austerity: a guiding principle of the system?**

The division between EPS and IPS means that each treatment, every surgery, and even in some cases laboratory tests need EPS authorization before the service can be provided. Mothers must not only cover transportation costs to get to the facility, but they also have to invest their time and economic resources to get the medical attention they deserve. Nurses note that the recurrent problems patients face discourages them from seeking medical attention. “Moms are victims of administrative procedures that
require that every medical procedure be authorized in advance. The time and money it costs discourages women from finding the required health care for their children.”

Mayra has faced this situation since her second child was born. She is a nineteen year old Afro-Colombian woman who has already experienced the loss of a child…and she never wants to go through that again. After her first child died she refused to become a mother again, but inadvertently became pregnant anyway. She was working in a company that makes air fresheners and, in her opinion, the exposure to chemical products caused her child, Alejandro, to be born with a harelip. Since his birth, Mayra has been devoted to her child’s health although nearly a year has passed and her EPS from the subsidized system has yet to approve the surgery her son needs.

Alejandro finds it hard to breath and to eat, which prevents Mayra from working, thereby aggravating their socio-economic condition. Alejandro’s father provides no help. He left Buenaventura a few months before his son’s birth and he has had little contact with them ever since. Mayra has family support, mainly from her mother, who lets them live in her house, but who refuses to help care for Alejandro. “Until he has his surgery, my mother does not even want to carry him in her arms; she is scared.”

Alejandro and Mayra’s situation occurs more often than I expected. Since her birth, Tania is been on the hospital’s critical care waiting list for a treatment that is vital for her to continue living. Her waiting took three months and a half, during which she acquired a hospital-induced infection. Despite the fact that her EPS never authorized the treatment, the hospital was prevented from referring her to another facility, as usually happens, and she therefor did the treatment at her own expense. A doctor
found the medical equipment necessary for free, when Dora, her mother was about to initiate an Acción de Tutela.\(^3\)

In less severe cases, bureaucratic protocols also affect the provision of basic services. Tatiana, a four years-old Afro-Colombian girl, spent more than twenty-four hours before getting an orthopedic cast to repair her broke arm. “How would you explain to a four-year-old girl that she has to endure the pain because there is no doctor available to attend her?” asks her mother. “According to the nurses, the only way to get the orthopedist’s attention is when the broken bone breaks through the flesh.” When the girl finally received treatment the next day, the mother had go to the EPS to authorize the treatment before they were permitted to leave the hospital.

In other words, Esperanza not only had to wait for specialized attention for her daughter for an entire day, which meant that she could not get to her job for two days, but she also had to go to the EPS. Getting there cost more money, and meant she had to leave her daughter alone in the hospital lobby.

Failure to receive service in a specific health facility because of the EPS is another recurring problem. The delays that are caused by this policy might be understandable when the service required is not an emergency, but not when a woman is about to deliver a baby. Derly was seven months pregnant when she experienced eclampsia. She confessed to feeling that Juan José was moving less and less, but no doctors in any health facility wanted to care for her because her health care policy did not pay for expenses at this early point in her pregnancy. Without even checking her condition they said that she had to wait until the full nine months before they would see

---

\(^3\) Acción de tutela: Colombian judicial remedy for the purpose of protecting constitutional human rights. This legal mechanism is commonly used to request a required health service.
her. As a result of the eclampsia, Derly convulsed, which finally got the doctors’ attention. Juan José nearly died because of absence of care by the Hospital Departamental, and he spent one month in critical care.

Today Juan José is a year old, with no evident health consequences, but he is at high risk of developing some, as is the case of Steven, Isaura’s grandchild. Isaura is an Afro-Colombian woman who had six children, all delivered by midwives. She nonetheless brings her daughters to the hospital to give birth because she is no longer able to pay for midwives. When one of her daughters, Marlyn, was about to deliver she was the victim of medical malpractice.

Isaura brought her to the health facility at six in the afternoon, and the doctors refused to care for her because it was not the right time for the delivery and the subsidized EPS did not cover the cost of her consultation. They told her to wait at least six more days before returning but when they got home, Marlyn started her contractions. So, Isaura came back to the hospital at midnight. The doctors again refused to provide care for her, and left her lying on a stretcher for another two hours. After waiting more than six hours, Marlyn was finally admitted to the delivery room. By then the doctor realized the baby was not in the right position, that a lot of time had passed, and complications were likely.

Today Steven is a three-year-old boy who is unable to go to school because he cannot speak and he has a learning disability. Isaura sadly concluded: “We do things in advance, trying to prevent situations like this one from happening, but we cannot avoid medical malpractices…to this day Steven is suffering the consequences.”
In contrast to the stories told to me by the five Afro-Colombian women, I was impressed with Carolina and her ability to demand and to obtain the care she really needed. Carolina, a white/mestizo woman, is twenty-three years old with three children. Her last birth was about a month before I talked to her. She told me that when she started her contractions she went to the nearest health facility. Unfortunately, no gynecologist was available to care for her. She was not willing to wait any longer, so she decided to go to the Hospital Departamental, where she knew doctors were obligated to care for her: “It was not just one life, there were two lives in danger and my baby and I received the best care...they saved our lives.”

Today she holds her beautiful and healthy baby and is grateful for the care she received. Why was Carolina’s experience so different from what the other mothers experienced? Why do Afro-Colombians women not feel able to demand their rights, as Carolina did?

... It is a free service!

As data from the health secretary of Valle del Cauca showed, the majority of Afro-Colombians are in the subsidized system. In effect, what that means for Afro-Colombians is that they are not allowed “to demand.” Vanesa, an Afro-Colombian woman, nineteen-years old with two kids, told me: “We are not paying, the government does, so we just get what they want to give us. Moreover the health staff always tell us that it’s our own fault for having so many children, when we don’t even have money to pay our health care.”

Vanesa’s statement is repeated over and over by her neighbors, friends, and others Afro-Colombian women. In the subsidized system neither doctors nor the health staff in general are accountable to patients. The mothers feel they do not have the
same rights as women in the contributory system because they do not pay. It seems that “help” from the State merely reinforces the discrimination the Afro-Colombian women already experience. Diana, one nurse in charge of the pediatric program, confirmed this suspicion. “In this hospital most of the doctors provide care to children for free, so I just give appointments at seven in the morning to all the mothers… after all, the mothers can wait, but the doctor cannot.”

Afro-Colombian women perceive that the doctors care for them differently compared to other patients. One frequent complaint is that doctors always prescribe the same drugs whatever disease was diagnosed. “Acetaminophen and Loratadine⁴ … apparently those medicines work for every illness,” Vanesa ironically whispered. Lacking confidence in the services that they do on occasion get, and not feeling empowered to make demands of the system, women are faced with two options: they can pay for services somewhere else, or simply not come to the health facility, as they correctly see it as a waste of their time.

**Paying for the doctor Vs. not going to the doctor**

After four months of medical consultations for severe stomach pains, and after many colon treatments, Carla, a fifteen-year-old Afro-Colombian girl finally realized that she was actually pregnant. Only when her aunt paid for an ultrasound did she find out that she was four months along. Carla’s experience is not unusual, which is the main reason it is common to hear women say that “I would rather pay for a private consultation than beg the doctor to authorize some tests.”

---

⁴ Acetaminophen is used for moderate pain and headaches. Loratadine is usually prescribed for allergies.
Yolima, an Afro-Colombian woman who works in a community service agency teaching human and constitutional rights to young children, revealed she does not like the health service that the Hospital Departamental provides: “I always said that the service we got from the Hospital Departamental is not good enough; we bring our kids there when they are sick and doctors do not even examine them...sometimes there is not even a doctor there.” According to her experience, care in other facilities in the subsidized system does not differ that much. They have to get to the facility early to get a medical appointment, and then wait for five days for an appointment, “so I decided to take Wilmer [her six-old-year son] to a private physician... I’m never satisfied with the care they provide, so I prefer to pay.”

In other words, for the women I interviewed payment means better service, a correct diagnosis, and not having to wait in line all day. As Esperanza claims, while she was waiting with Tatiana for the orthopedist, “a paisa [white man] that paid for service, was treated immediately, never mind that other patients were here before him. Surely if I had the money to pay for the cast, the nurses would have called the orthopedist immediately and Tatiana would not have had to wait a whole day in pain.”

In addition to the decision to pay for health care, women sometimes opt to leave Buenaventura when a specialized treatment is required. Mayling, an Afro-Colombian woman with financial resources emphasized, “I scheduled my delivery in Cali, because here [in Buenaventura] I or my baby would have died. Doctors never detected the low platelet count I had during my pregnancy.” And she added, “I fear going to the Hospital Departamental, not only because the infrastructure is depressing, but also because
here in Buenaventura everything depends on who you are, and which health system you are part of.”

Paying for a doctor or travelling to Cali for proper treatment are options that are only available to women with the financial ability to cover the expenses, which is rarely the case among the people I encountered. As in the case of Vanesa, Dilia, and Cristina, the only alternative was not to bring their kids to the doctor except when they are very sick.

Vanesa goes on to note that “always doctors first attend to the lightest, and leave us, the darkest, to the end. Once, I brought Lina [her five years-old daughter] to the hospital at 7:30 in the morning and the doctor saw her at 6:30 in the afternoon. He put us at the end of the line and he said to me that I would have to kiss him in order to have care for my daughter... of course I kissed him, Lina needed care.” Another recurring situation Vanesa pointed to happens when the child’s condition is not an emergency, and the doctor refers the child to another unit for consultation, which can take as long as a full month. “So, why go to the doctor at all?” Vanesa questioned. She prefers to bring them the medicines that she has at home. Wasting neither time nor money, she just waits and sees if they got better.

Vanesa’s option is a common practice among the Afro-Colombian women I met. Dilia, very honestly states that she only brings her children to the doctor when they are really sick. After all, she added, “they are very healthy, they even don’t get the flu...and if so I know what the doctor is going to prescribe them, acetaminophen and loratadine, so I don’t waste my time going to the hospital.” Cristina, as well, confesses she never brings her three children to the doctor, “they are very healthy… I think due to their
nutritional status; my grandmother always gives them soups, and I give Emulsion de Scott\textsuperscript{5} as my dad gave me and my siblings."

Mothers consult doctors and go to health facilities only when their children are seriously ill. Preventive practices or periodic medical checkups are unknown. The health care system thus affects the outcomes that a health system can achieve, both directly, through patient treatment, and indirectly, by encouraging or discouraging use of the services." (Jamison \textit{et al.}, 2006:96). Yet, is the Colombian health system the only mechanism preventing the appropriate health care for Afro-Colombians, or other factors are also involved?

\textbf{Do Afro-Colombians women receive better treatment in the contributory system?}

Lilia is a thirty four year old Afro-Colombian woman with four children. Her husband is an entrepreneur and has the ability to pay for a contributive health care, but Lilia is not satisfied with the service. “Everything must be done by phone, as if that will not cost you; you can even be in the facility, but you have to go outside, buy minutes\textsuperscript{6} and call to get an appointment.” In addition and according to her experience with the service, paying is no guarantee of good care. With frustration, she told me for the last fifteen days she’s experiencing a serious pain in one hand but her EPS has not approved the order to take an x-ray.

She emphatically says that she often brings her children to the doctor. “I know many mothers here [in neighborhood Santa Fe] say our kids are 'all terrain,' but every

\textsuperscript{5} \textit{Emulsion de Scott} is a vitamin supplement derived from codfish oil.

\textsuperscript{6} Although more people own cellular phones in Colombia, the actual amount of minutes people can afford is not high. A common practice is to buy minutes for $200 pesos (around 20 US cents).
“Time my children have the flu, or stomachache, or diarrhea we take them to the pediatrician.” It is worth noting that she was the only mother I talked to in Buenaventura who referred to her children’s doctor as a pediatrician. One interpretation of this difference is that she is getting a better health service, delivered by a specialist.

By virtue of paying into the contributory system we can infer that Lilia is better off compared to women in the subsidized system, she is nonetheless very categorical with respect to her perceptions of discrimination. She prefers a black doctor rather than a white/mestizo one. “White doctors always use gloves, as though repulsed by Afro-Colombian patients… they try not to touch us when they are examining us, and to not spend the time needed, as if they were in a hurry.” As with the other Afro-Colombian women I interviewed, Lilia confirmed that the lightest people get health service before her, and that many times she gets no service at all. “Doctors usually say that they ran out of time, and you have to come back another day … and all patients who were left waiting were negritos.”

She too complains that she always receives the same drugs, regardless of the reason for the consultation, compared to white children who are prescribed appropriate drugs. “White parents get into the room, talk to the doctor, and they get the prescription needed… instead, we get palliative drugs. I know sometimes the EPS doesn’t provide particular drugs, but if the doctors were to ask me, I would pay for them as long as my child gets better.”

During my observation I witnessed the very situations that mothers mentioned. I was in the lobby of the critical care unit in the pediatric Hospital Departamental in Buenaventura, when a white/mestizo mother arrived. Two Afro-Colombian mothers had
been waiting for more than three hours for the ophthalmologist. When the doctor finally arrived, she only addressed the white woman and treated her first. “I didn't sleep thinking about your baby, give her to me I'm going to care for her first... I've been worried so much for her.” The Afro-Colombian mothers rightfully wondered why their children were not considered as important as white children who were also born prematurely and suffered from the consequences of low-birth-weight. The Afro-Colombian mothers concluded that the only answer was discrimination.

On another occasion I witnessed a more complex situation. As usual I was seated in the lobby of the health facility, and an Afro-Colombian woman came into the room. She was different from the other women I encountered. She was not only with her husband, a white/mestizo man, but she was also dressed as a well off woman. After she spent a few minutes figuring out where to sit, she chose to sit next to me. I could feel how the other women in the waiting room rejected her.

It was not until one of the nurses showed up that I understood why the other women were not as friendly as usual. Maria José and her parents spent fewer than ten minutes in the lobby before Diana, one of the nurses, appeared, greeted them and escorted them to the doctor. It was the first time I saw nurses being nice to patients and actually knowing their names. Even though Maria Jose’s visit was a follow-up, and not an illness, as was the case for other children waiting in the room, she nonetheless got attention long before the others. The event was not lost on the other women in the room, “You see, that’s what we say, nurses and doctors always give priority to the lighter and better off people.”
The case of Maria Jose further reveals the way the white privilege can be achieved through marriage to a white man. For the health staff, Maria Jose and her mother were not Afro-Colombian, and therefore “deserved” the attention accorded to white/mestizo people.

The stories and testimonies recounted here show that the structure of the Colombian health system is one of the key determinants of child health and account for some of the differences in mortality between Afro-Colombian and white/mestizo children. The subsidized and contributory systems differ in terms of infrastructure and equipment to be sure, yet they are also similar in that Afro-Colombian women in both contexts suffer from an almost complete lack of agency. Their lack of power deprives them of the right to demand the health services to which they are entitled. It is through these mechanisms that racial discrimination in the provision of health care became painfully evident.

As a social construct based on phenotype (in which the skin color is the most visible feature) race, “governs the distribution of risks and opportunities in our race – conscious society.” As a consequence, race “impacts health and results in race-associated differences in health outcomes that are large in magnitude” (Jones, 2001:300). Health-related discrimination can occur at multiple levels of social organization. As Jones has noted, “institutional racism” is the outcome of differential access to the goods, services and opportunities of society by race. At an individual level, Jones refers to “personally mediated racism,” which is based prejudiced assumptions about the abilities, motives and intentions of others, which results in differential actions toward others according to their race. Both institutional and
personally mediated forms of racial discrimination are clearly documented in what I witnessed during my participant observation in health clinics, and is expressed in the stories told to me by the women that I interviewed. Racism can also find expression in the internalized “acceptance of stigmatized races of negative messages about their own abilities and intrinsic worth” (Jones 2000:9), as many of the observations in the next section illustrate.

**Afro-Colombian Culture**

In the two weeks since I saw Andrea waiting in the lobby of the Hospital Departamental, I was unable to reach her aunt, as I wanted to know what happened to the girl. Apparently none of the health professionals I spoke to even remembered Andrea. “Who are you talking about? It is very difficult to remember a particular girl with all the patients we have every day” was the answer I repeatedly got when I asked about Andrea.

It was on a particularly cold day in Buenaventura, with non-stop rain and thunder that I learned what became of the girl in the yellow pajamas. Rain seemed to add another layer of difficulty getting to the hospital, and the emergency room was completely empty when I arrived at 8 o’ clock in the morning. However, half an hour after my arrival, a young Afro-Colombian woman exited the emergency room and came into the lobby. Her crying was impossible to avoid as she was quite devastated. I was wondering what had happened to the young woman but I hesitated to address her.

Suddenly Carmenza, Andrea’s aunt, appeared at the entrance of the lobby. I knew right away that something bad had happened to the little girl. I realized that the woman in distress was Andrea’s sister, and I heard her say that the child had just died. Andrea’s severe malnutrition, diagnosed two weeks ago, was the cause of her death.
According to the doctor, “She was just not strong enough to stay alive, and her heart just stopped beating.”

One of the clinicians, resident Rojas, then called the two Afro-Colombian women to the front and apparently told them what they needed to do to receive the girl's body. Immediately, Carmenza and Andrea’s sister left the facility. Resident Rojas, who looked overwhelmed, stayed in the lobby for a while. As I had met him before, I asked him what happened to Andrea. Rojas’ answer was sharp and revealing “Definitely Afro-Colombian mothers are very irresponsible ...that is the main reason their children die. They can see that their kids are undernourished, and suffer from vomiting and fever but they prefer to wait.” With that harsh judgment, he stood up and left the lobby.

**Mothers’ noncompliance: blaming the victim**

Physicians repeatedly told me, and told each other that “Afro-Colombian children are always at greater risk than other children.” They attributed this outcome to many causes, but in my conversations with them several themes dominated their narratives. “Noncompliance is the main cause… Afro-Colombian parents are irresponsible; they don’t take appropriate care of their children. It is so obvious. You go to their place and you realize kids are always by themselves, they don’t have proper nutrition... it seems Afro-Colombians children are left on their own from the moment they are born.”

In this section I analyze what is behind the “noncompliance” to which physicians often refer, noting that, when we talk about Afro-Colombians, we have to examine the link between race and socioeconomic status. In Colombia, to be negro and to be poor are virtually synonymous, each expressing the exposure of Afro-Colombian children to social and economic stressors.
Clinicians claim that education is the principal factor when I asked them to explain why they think Afro-Colombian mothers are noncompliant. “Education is essential in the care and follow up of children. In this hospital we don’t keep records by race, but I’m certain that babies of Afro-Colombian mothers are prone to higher mortality… at least I’ve seen dying more often Afro-Colombian children than whites,” expressed Dr. Garcia, a resident in pediatrics. She added, “it could be due to a way to avoid reality, but Afro-Colombians neither accept nor understand the difficulties of infants. For them, children’s conditions are not taken seriously.”

In keeping with this idea, Dr. Velasco, clinician and head of health secretary in Buenaventura, highlighted that Afro-Colombian mothers wait a long time before they bring their kids to doctors due to ignorance, rather than negligence. “When we are on call and we get an emergency at 4:00 in the morning, we are certain there is a black kid in the lobby. Last night, a three-year-old boy, with an ear pain for three weeks showed up with his mother at 2:00 in the morning. His mother decided to wait, until yesterday, when the infection had already compromised many parts of the ear. Because of the delay the child is going to lose the hearing on that side. Three weeks earlier I would have been able to treat that child, but not yesterday.” In Dr. Velasco’s view it is low levels of education and the absence of common sense, which cause the difficult situations that clinicians face.

Fear of going to the hospital is another factor the doctors I encountered pointed to. Doctors are seen as bearer of ominous tidings, and that might be a reason why patients and families avoided talking to them and prefer, instead, to talk to nurses or social workers. The cultural barriers between the women and physicians were noted by
Mayra, an Afro-Colombian mother: “I feel that they [the doctors] speak to me in another language.” The discomfort that Afro-Colombian’s feel is so great that women, when they go to the doctor, prefer to see the psychologist or the social worker. They even turned to me, hoping that I could help. As Millard (1994:260) notes, “The doctors, perhaps unwittingly, tend to disdain people who come to them from rural areas, especially when those people who come for help are members of a minority group.”

Physicians recognized the social and cultural differences between them and their patients in Buenaventura. “As a doctor here in Buenaventura, my main challenge has been how to relate to Afro-Colombian patients. Afro-Colombians prefer to turn to traditional practitioners, and to try ‘home remedies’ before coming to the hospital, which is the last thing they want to do.” In order to underline his argument Dr. Garcia noted the presence of a power relationship between physicians and Afro-Colombians. According to Dr. Bacca, the negative attitudes that Afro-Colombians hold against doctors are because they have yet to overcome the legacies of slavery. “To this day, they continue to act as slaves, they present themselves as less than us [White/mestizo].”

Rosa, an Afro-Colombian nurse, brought another element into the explanation, claiming that culture is the culprit, the residue of an ancestral legacy. “Because Afro-Colombian women remember that their grandmothers or mothers had their children in the backyard, and didn’t pay much attention to their kids, they think that they can do the same. They are not aware of childcare, they are extremely calm and they don’t take any preventative measures, not even coming to the doctor for periodic checkups.” In order to support her conclusion, Rosa went on to say that “among Afro-Colombians,
culture and traditional beliefs are most important. On a recent home visit, the lady told me that her neighbor had two little twins with a rare skin problem. The children lose layers of their skin every day... The explanation the mother has given to this illness is the exposure to an eclipse, and for that reason she refuses to bring them to the doctor. Her children are condemned to live with that suffering for the rest of their lives."

Coupled with the idea of cultural values, Patricia, the head nurse of pediatrics in Buenaventura indicated that the age of the mother is an important determinant of noncompliance. "When we see a child with major health difficulties it is often the case that his or her mother is a young girl of about fifteen or sixteen years old. After their fifteenth birthday, Afro-Colombian girls see a child as a life project, as an opportunity to leave the painful situation they face at home. Contrary to their expectations, when a girl gets pregnant her situation gets worse. Those kids become unwanted, even rejected from the moment of gestation." Luz, another Afro-Colombian nurse, shared Patricia's point of view. "Younger mothers have a harder time handling their children, diapering them, and breastfeeding. They are not ready to be mothers, and reject the arrival of the baby into their lives."

From a more comprehensive perspective, Xiomara, another Afro-Colombian nurse, provided me an additional interpretation of the cause of noncompliance by noting the absence of Afro-Colombian men when women bring their children to the clinic. Mothers are responsible for their children without receiving support from their male partner. According to Xiomara, the man plays an important role in obtaining appointments, ensuring that clinicians treat the child on time, and providing proper care. The absence of Afro-Colombian men was something I noted during the time that I spent
in the various health facilities. The lobbies were always filled by mothers with their children. They were sometimes accompanied by grandmothers, sisters, or neighbors, but never by the husband or partner.

In addition to the isolation of Afro-Colombian women, Xiomara further noted women’s lack of self-esteem. “Every day they say to me that I may be able to get the needed medicines but they cannot. They insist that no one is going to pay attention to them but, if I go, they will get what they need.” Xiomara’s observations highlight the sense of powerlessness that Afro-Colombian women have internalized, which could be one of the reasons they avoid bringing their children to the clinic until the very last minute, when they have no other choice.

Finally, Xiomara highlighted the absence of education as a barrier to the health care of Afro-Colombian children. “I try to give them tools to take care for their children, but explaining good practices to Afro-Colombian women is very difficult, and is contingent on their level of education. Another problem is that Afro-Colombian women wonder why they need to change the things that they learned from their mothers. With them, we have to repeat everything over and over, especially with respect to nutrition and the importance of breastfeeding. Likewise Afro-Colombian mothers do not seem to understand that they need to play the role of guide and protector for their children. For them children represent the guarantee of a family and a source of financial support.”

The explanations that health care professionals advanced in order to explain why Afro-Colombian women were noncompliant also offered key insights into the many stressors that children confront. Among the issues that became evident was the composition of the households in which they live, the role that mothers play within the
family, and the various ways that economic constraints shape the options and choices that people make.

**Afro-Colombian households: matrifocal families**

According to 2005 Census data, Afro-Colombian women twenty years of age and older in Buenaventura are more likely to live alone compared to white/mestizo women (Table 4-1). An observed difference of more than six percentage points among the two races reveals the idea Motta (2002) develops, namely that the matrifocal family prevails among Afro-descendants in the Colombian Pacific coast. When the Afro-Colombian family structure is viewed from the standpoint of the patterns that prevail in Western societies, the conclusion is that Afro-Colombian families are unstable. The fatherless home, where the mother or grandmother plays the central role, is thought to be the legacy of high rates of male migration when men leave the home in search for employment opportunities (Motta, 2002).

Table 4-1. Marital status of Afro-Colombian and White/mestizo women older than 20 years in Buenaventura by percentages

<table>
<thead>
<tr>
<th></th>
<th>Afro-Colombian Women</th>
<th>White/mestizo women</th>
</tr>
</thead>
<tbody>
<tr>
<td>With a stable couple</td>
<td>58.65</td>
<td>65.81</td>
</tr>
<tr>
<td>Alone</td>
<td>41.35</td>
<td>34.19</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Census data 2005

While Western society views men as economic providers, this notion does not apply in all cultures. In places where matrifocal arrangements predominate, women are the main providers for themselves, their children and their husbands. This cultural pattern further weakens the ability of Afro-Colombian women to make the Colombian health system work for them. The importance of a male presence was evident in my
earlier observations in the emergency room. When a mother was accompanied by a man, it was easier to get past the guard at the door. Similarly the presence of a man meant that the doctors were more attentive and the child was more likely to receive proper treatment. In other words, my observations show that the absence of fathers is among the factors that place Afro-Colombian children at a disadvantage in the health care system.

The fragile state of the Afro-Colombian family associated with male migration was evident in my encounters with women I met. Yolima, the Afro-Colombian women who teaches human rights, lives with her son Wilmer, and a friend who also has children. Yolima’s partner left her before Wilmer was even born. He left in search of employment, and now finds himself in jail in another Colombian state. Wilmer has never met him. Mayra, Alejandro’s mother, the child with harelip, is in much the same situation. Like Yolima, Mayra was pregnant when her partner left Buenaventura to launch a hairdressing salon. As a result, both Yolima and Mayra are left on their own to provide for themselves and their children.

It is worth noting, however, that the physical presence of a man in the household does not necessarily mean that the family is better off, as can be seen in the case of Vanesa, Dilia and Lilia. Because the man who lives in the house with them is not the father of the children, he refuses to take on father’s role. As Vanesa, Dilia, and Lilia, as well as other women I interviewed explained: “he [referring to their partner] doesn’t pay attention to them, I think he doesn’t even care about them, about their health, their education, their food… he just worries about having enough money to drink and to play dominos on Friday night.”
In other words, for the Afro-Colombian women I encountered, living with a man does not mean that they get economic or emotional support, or receive any help raising their children. Mothers are the only ones responsible for their children, although there seems to be a difference between younger and older women. Younger women who found themselves as single mothers tended to think of their difficult situation as the result of a misfortune, and that their lives would be better if their partner had not left. Older women were under no such illusions. Yolima and Cristina made it clear that they thought that they were better off not having a man in the household as this made it easier for them to manage their scarce resources more effectively. Nevertheless, all of them agreed that, when it came to seeking health care, it was better to have a man present, as was the case with the white women they met in the health facilities.

The disadvantages associated with being a single black mother was often what prevented Afro-Colombian mothers from taking their children to the doctor. Without a male present, they knew that it would be hard to be admitted to the emergency room and, once inside, it would be difficult to receive the health care that they came for. In other words, the noncompliance that nurses and physicians observe has less to do with the lack of education or lack of motivation among Afro-Colombian women and more to do with the way that black women respond to at the economic burden that they confront as single mothers and to the way in which they contend with the discrimination and male-centrism that they face when they enter health facilities.

**Informal economy**

Although the women I interviewed were well aware of their children’s need, they confessed that they often postpone visits the doctor because each visit meant that they had to pay for transportation, had to lose a day of work, and had to find someone to
take care of their other children. “I always prefer to give them the ‘home remedies’ I
learned to prepare from my mother, or give them the medicines I have on my nightstand
before spending money on transportation ... Don’t you realize that we spend entire
days with nothing to eat,” Vanesa tells me in one of our conversations.

The difficulties that female headed households face are even greater among
Afro-Colombians living in Buenaventura. Because the Colombian census 2005 did not
provide data on income, I supplemented the information that I gathered in the
neighborhoods that I visited with the result of a survey carried out by Carvajal
Foundation in February 2012. The survey provided information on 9,254 individuals, of
which 83% were Afro-descendants. The unemployment rate was 17%, but the most
striking information concerns those people who were classified as employed. In this
group only 26% worked in stable occupations; 32% were independent, and 19% do
what the organization labeled “rebusque”, which means odd jobs.

According to the survey, 58.93% of people fell below the income poverty line and
18.71% are below the extreme poverty line. Comparable figures for the country as a
whole are 37.2% and 12.3%, respectively (DANE et al., 2012). I am not able to identify
specifically if Afro-Colombians are more likely than other groups of people in the survey
to experience these conditions. However, that is likely the case if only because Afro-
Colombians represent 83% of the cases that were included in the survey.

The harsh conditions that poor people face on a daily basis are evident at noon,
when lunch would normally be served. In many instances, members of the household
just wait until the end of the day, hoping, at the very least, to have some “aguapanela”

---

_Aguapanela or agua de panela_ is an infusion made from panela, which is a hardened,
concentrated syrup from the sugar cane. Many claims have been made about the beneficial
and a piece of bread before going to bed. “If we have dinner, we wait until lunch the next day and then until breakfast the next day. We try to save, because we don’t have that much ... but actually we experience many difficulties” said Vanesa, as Francisco, her two year-old child, begged for another piece of the bread they had for breakfast.

Of all of the Afro-Colombian women that I met only Yolima, Esperanza, and Mayling had regular jobs. Jaime, who works at Carvajal Foundation and has lived in Buenaventura for the last ten years, told me that “very few Afro-Colombians are entrepreneurs; for them to be independent means having a plato and stand on the street to sell chontaduros, to sell fish, or to sell fruits or vegetables. They live day to day, their slave legacy has denied them the possibility of looking to the future; for them there is no future only the present.” These comments shed some light on what the Carvajal Foundation’s survey called rebusque, which is to do whatever it takes to make some money, whether it is cleaning a house, washing clothes, or selling minutes for cellular phone.

The varied livelihoods is evident in the case of Cristina, who makes a living dying and straightening hair among her neighbors, and Vanesa who sometimes sells fruit juice on the street, or works as a maid in homes owned by white Colombians. Isaura sells fish that her husband catches as a fisherman, while Chava, a sixty-five year old Afro-Colombian woman, gets up at 4:00 in the morning to supply her plato before people go off to work.

effects of aguapanela, based on beliefs of having vitamin C, and rehydrating minerals. Since panela is a relatively cheap, locally produced food, most of the people from the lower quintiles in Colombia obtain the majority of their caloric intake from it.
In Pueblo Nuevo, or La Playita, visitors can buy meats, fruits and vegetables, as well as textiles, shoes and all kinds of commercial products. The distinction between the products is associated with the characteristics of the sellers: “negros” are responsible for selling anything that is associated with food, and “paisas” sell fabrics, as well as shoes and a few other items. These divisions are also evident in the spatial distribution of the activities. While paisas have stores, which are clean and organized, the places where food is sold are dirty and smelly, overrun with stray dogs that prowl between the stalls eating scraps and sniffing the trash.

Children of Afro-Colombian mothers are abundant in the Plaza de Mercado. Some of the children are hard at work telling potential customers where to find the best prices and the highest quality products. Others gather beneath their mother’s skirts or sit on the floor as their mother cooks food. The conditions that I observed in the market point to the health risks that children face as their mother’s struggle to make a living. In addition to the unhealthy environment, the fact that single women have no one else to help them with childcare means that their children are especially vulnerable. The result is a combination of factors that threaten the survival of children: poverty, the mother’s need to work, and the fact that women are mostly on their own, with no one else who can look after their children. In the next section I explore the physical environment in the neighborhoods in which the women and children live.

**Physical Environment**

Throughout this Chapter I have called attention to the features of the physical environment that Afro-Colombian women and children confront, noting the poor infrastructure in the health facilities and the unclean conditions in the Plaza de Mercado where many women work. I now turn to the characteristics of the neighborhoods in
which they live, focusing specifically on Santa Fe, one of neighborhoods in which I met a number of women and their children. Because I established a good rapport with the women living there, they invited me into their homes where I was able to see firsthand the bedrooms, kitchens and toilets, even their clothes.

**Santa Fe**

Santa Fe is a neighborhood built in an area in Buenaventura that was “invaded” by the residents who live there. It is located on the bay, which means that most of the houses are constructed over the water, known as “viviendas palafíticas.” The public transportation that serves the area does not make it all the way to Santa Fe, but “I can meet you at the nearest bus stop” said Vanesa, who had invited me to her house. I took a bus, which took me more than an hour to get from where I was staying (very close to the Hospital Departamental) to the bus stop. Vanesa was waiting there to escort me into the neighborhood. She was quite insistent that I never try to enter the place on my own: “you always have to be with me or with Cristina [my other key informant].”

As soon as Vanesa saw me she said, “I told you, we are pretty closed,” adding that “Today, the entrance to the neighbor will be very easy, the tide is low ...so don’t worry.” We started walking down a path which was initially paved. The stores and houses on both sides were comforting, but it was not long before the paved trail turned into a dirt path, making its way though a garbage-filled uninhabited zone. We passed over a railroad track and then went through a tunnel that went under the main highway. After forty minutes of walking we finally arrived in the neighborhood.

I realized immediately that what Xiomara, one of the nurses at the Hospital told me days before was true, that “those women walk for hours to get to the main avenue,
and then, when they can, they take a bus to bring their children to the hospital… The health facility is not accessible to them.”

The distance between the neighborhoods and the health facilities often has deadly consequences. Mayra’s first child died because she was too late getting the child to the doctor. The child suffered two convulsions during the hour and a half trip to the health post, and by the time that they arrived at the clinic, there as little that the doctors could do. In addition to being far away, the clinics close after five o’clock in the afternoon, and the only services provided are delivered by an orderly. With tears in her eyes, all that Mayra could say was “There was nothing I could do to save his life.”

As I continued to walk, I saw no grass or trees anywhere, just stones, mud, and piles of garbage. Vanesa showed me the football field where children spend most of their day, but in contrast to what I expected to see, the playground was a hazardous place where children could be easily hurt. Stray dogs wandered the area looking for food in the trash that is thrown into every corner of the place. The dangers that were so evident to a visitor like me seemed to be invisible to the people living in Santa Fe.

The way to Vanesa’s house is not long, but full of “obstacles” that the residents have found ways to get around: sand bags to prevent flooding, old mattresses on the ground to make it easier to get to the bridge, and wooden planks that connect one house to another. While we were walking, Vanesa showed me their friends’ houses, and her parents in law’s place. There was no sign of drugstore or pharmacy anywhere to be seen.

She explained to me how they came to live here. “A long time ago, I wasn’t even born, my father invaded this whole terrain with two other friends. When people came
here from the rural area or from others districts he sold them a spot to build their houses. When I got pregnant with my first daughter, my father gave me the land to build my house... you’ll see.”

The uneven wooden boards that serve as a bridge do not provide a safe path to the house. There are large gaps between them and there are no side rails to prevent you from falling off. The wood itself is weakened by being repeatedly submerged under water when the tide comes in, but the residents seem used to it. According to Vanesa, “We are still able to get around. You just have to learn how to do it. Look at those kids. They learn to use these bridges from the time that they learn to walk.”

Stunned by the risks that the bridge presents to the children of Santa Fe, who come and go all day long on their own, Vanesa told me very casually: “everyday a lot of children fall down, but all the neighbors are very helpful, and whoever is closest just pulls the kid out of the water.” But what if someone is not around, I asked her? Vanesa does not respond immediately. After a pause she said: “well in that case the child drowns. It is the law of life, is it not? Not everyone can live.”

When I arrived at 8:55 in the morning, the place was calm and silent, but as the day progressed you could hear music coming from the radios that played salsa, vallenato, and the characteristic Pacific genre, currulao. In the evening the volume of the music increases, but not, it seems, as a source of entertainment but, rather, as a way to drown out the loud noise coming from the movement of the containers and machines on the dock in the bay.

Living above the bridge

After a long journey, we finally arrived at Vanessa’s place, who looked very excited as though a very important visitor was about to arrive. She cleaned the house
very early before I arrived to devote her time to me that day. When she opened the
door, the children jumped up to greet me. Lina wore a very short apple green shirt and
pink shorts that seemed more like pajamas than clothes, and her bare feet do not stop
moving, showing all the energy she has. Francisco was wearing blue jeans with no
shirt.

I looked around to see who else was in the house with them, but no one was
there. Lina and Francisco were alone, just as many clinicians claim. “I thought Teo was
with the children,” I said to Vanesa. “It is evident that you are not from here. Today is
Saturday, he left yesterday afternoon, and probably will not return until Monday
morning.” Without her partner’s support, Vanesa is alone most of the time, assuming
the entire responsibility for her two children.

I estimate that the house was around twenty square meters. It is composed of a
lounge area at the entrance where Vanesa has a television, four plastic chairs, a very
small table, a stereo, and the kitchen. Vanesa insisted that we keep going as she
wanted to show me the bedroom and the rest of the house. In the kitchen, she has rice
cooker, refrigerator, and stove. On the table were a piece of bread and butter they had
this morning for breakfast. To enter the room where Teo, Vanesa and the two children
sleep, I have to push aside a piece of cloth arranged as a curtain to separate the
sleeping space from the living room.

Two beds next to each other took up practically the whole room. No traces of
sheets nor pillows or blankets on the beds were evident, just the mattresses. On a shelf
next to the two the beds, I saw the medicines Vanesa mentioned that she often gives to
her children. Along one of the walls, a sheet makes a closet where Vanesa keeps her
clothes and those of all the members of the family. The space she showed me made it clear that no one in the household had very much to wear, especially Francisco whose clothes fit into a small suitcase.

A small room on the way to the bedroom is arranged as a backyard to do laundry and to wash dishes. A blue container stores water. Slightly embarrassed, Vanesa apologized for the clothes that were still out, explaining that there was no water to do the laundry. No piped water or sewer services are present in the house. To collect water, Vanesa has to go to the entrance of the neighborhood with the big blue cube, where water is available twice a week, or wait until it rains. Very cleverly, Vanessa and Teo, like many local residents, have built a waterway to collect rain water. Water is very limited among people in Buenaventura, and the water they do get is of poor quality. Neither Vanesa nor the other women I met attempt to boil or treat the water. They are far too busy working and taking care of the children.

At first glance I could not see any toilet, so I asked Vanesa about it, and she showed me the hole they made next to the blue cube. “We don’t really have a toilet, we have a ‘baja mar,’ which is a kind of latrine where the waste just goes out to sea.” The main concern of the ‘baja mar’ is when the tide rises, and the sewage water comes into the houses.

The wood to build the house was collected by Vanesa and Teo from leftovers from a construction project that was carried out several years ago on the dock. “As Teo was working in the dock at that time, he picked up every piece of wood they discarded,” confessed Vanesa, and she continued, “Teo built the house, and made the electrical connections... he knows how to do that kind of work.” The homes of other women living
on the bridge were very similar to Vanesa’s, consisting of a living room that houses the kitchen, a bedroom where everyone sleeps, and a patio used to store water and do the laundry. As the women put it, “We just have the basics.”

In several conversations with the clinical staff at the Hospital, and especially with Dr. Bacca, I was told that “People who come here don’t care about the poor infrastructure of the facility because they are used to living like this or even worse.” My visit to Santa Fe confirmed that the difficult circumstances in which the women live, not only due to the lack of basic needs, but also due to the risks to which they are exposed. Women live in constant fear that the tide will destroy their house, that their children will fall into the water and drown, and that the trash and lack of sewage facilities exposes them to disease.

Contrary to the views held by the staff at the clinic, the women are not satisfied with the situation in which they find themselves. Some are ashamed of their houses, and are always looking for something better. Nor do the women accept the poor condition of the public clinics, as is evident in their preference for going to the “Medicos sin Fronteras.” According to Wendy, “In Medicos sin Fronteras everything is clean, they always have sheets to put on stretchers, and the lobby is comfortable...we feel they treat us as we always have desired.”

Wendy is sixteen years old, she left school after she got pregnant, and she lives with her mother and her three younger brothers. Wendy feels ashamed of her house, of having to share a room with her mother and siblings, and of the darkness and misery that prevails in the place. When we entered she could only say “this is my modest home.” She confessed that she does not like the hospital, and went on to put into
words what the other women clearly thought: “I think we deserve better things, but just because we are poor and black we only get the ugliest, the dirtiest, and the worst.”

Finally, Lilia, and Mayra do not live in the bridge, and their houses are somewhat different from the others I described. They are bigger, with several rooms, and the kitchen and living room are divided. They have piped water albeit just twice a week, preventing them from using the flush toilets they have installed. They also have a latrine, and, like their neighbors on the bridge, they too have to store water. In other words, the physical environment is similar everywhere in the neighborhood, even for those women who are in a better economic position.

...It is also a problem of violence

The precarious conditions that I found in Santa Fe and in the houses that I visited were not the only problems that women and their children face. What has made their situation even worse is Colombia’s armed conflict, which has a major impact on them when access to health is considered. I never thought that members of armed groups were actually in the neighbors I visited, but from the first day of my visits there my informants advised me not to enter alone. And toward the end of the day, there always came a point when the women I was talking to said that it was time to leave. When I began to realize that there were only certain times of the day that it was safe to be there, I began to pay closer attention to a risk factor that I had not previously considered.

One day I was by myself, as none of my informants was available to accompany me, and I thought I already knew the neighborhood sufficiently well to be safe. Suddenly, after I had encountered some women and spent some time with them at their houses, I heard the sound of a motorcycle, which surprised me as I had never heard
that sound in the neighborhood before. Two men on a motorcycle showed up
brandishing a machine gun. I did not need someone to tell me it was time to leave.

Several days later, when I met with Vanesa and Cristina, they explained what
happened. “The two men you saw in the motorcycle are responsible for patrolling the
neighborhood. They decide who is able to live there, who has to leave the area, and
who can enter. That day they did not know you were there; you did not have their
permission. But don’t worry, you’re fine, you’re with us.” I realized that the conflict that
Colombia has experienced is not isolated phenomenon limited to the mountains and
rural areas, as it is often thought. The conflict is here, in the city, in the neighborhoods
where the women and the children I have met live.

**Why Buenaventura?**

Because it is the Colombia’s main seaport, and because of the presence of
Ecopetrol pipelines in the Valle del Cauca, Buenaventura is a strategically important
location, and a target for armed groups. Confrontations between rebel groups are
common, as well as battles between those groups and the military and police. Bullets
often stray into the neighborhood putting at risk people who have nothing to do with the
conflicts around them. “Those men,” as people refer to them in Santa Fe, not only
control the outsiders who come and go, but also control the movement of people who
live in the neighborhood.

“Between six in the afternoon and five in the morning we never leave our houses
because we know we can get in serious trouble” Cristina and Vanesa said. “We don’t
like to share this information with you or others, but we have to do as they say.” So
what happens when you have to go out when your children need medical attention, I
asked. “Well, that’s why we first turn to home remedies or to a neighbor who is a
traditional healer. If we really need to leave to see a doctor, we have to ask the men for permission.”

Further conversations with Vanesa and Cristina called my attention to another troubling aspect of all this, which is related to way that the men in the neighborhood patrol are viewed by the younger women who live there. According to Vanesa and Cristina, “the power, money, and recognition that these men represent are attractive to the girls, but, in the end, all you end up with is another child that you have to raise by yourself.” It was then that I realized that the first child born to Vanesa, as well as other women such as Wendy and Meryneyer, were the result of such relationships. “We tend to say that, after we are fifteen years of age, our lives are going to change. What we didn’t realize was that the change that happened to us was giving birth to a child that the father never recognized as his own, and that we had to take care of on our own.”

The information that I collected in the field work that I carried out confirmed the relevance of many of the elements noted in the conceptual framework (Figure 3-1). The geographic distance of the neighborhoods alone is sufficient to explain why women find it hard to get their children to the health post. But, the health status of children born to Afro-Colombian women is severely compromised by the independent, and interaction effects of a wide range of variables. These include: the institutional and personally mediated discrimination (Jones, 2000) that occurs within the health care system, the poor quality of the clinics and services that are available, the matrifocal households in which the entire burden of economic support and child care falls on the mother, and the consequences of living in houses that lack running water and sewage facilities, as well as the risks associate with living in neighborhood that are both unclean and unsafe, and
which are located at great distances from the health clinics, in places where public transportation is not available.
CHAPTER 5
CONSIDERATIONS ON THE COLOR OF INEQUALITY IN COLOMBIA

In an era in which Afro-Colombians have become visible through legislation and statistics, and at a time when researchers and organizations of various types have begun to recognize the poor living conditions that characterize the African-descent population, the statistical and ethnographic findings presented in this thesis assume particular relevance. Differences in the likelihood of death in children under five years of age between Afro-Colombians and White/mestizo are one way to provide an empirical estimate of the magnitude of the race-related disparities in the quality of life among subgroups of the Colombian population. The universal value placed on human life, and the daily struggle that mothers and families engage in to protect the fate of their young children, gives a compelling and humane interpretation to the otherwise abstract statistical idea of “risk to life.” Based on a conceptual framework of child mortality where socioeconomic, environmental, and levels of discrimination impact proximate determinants (maternal factors, childcare factors, infections factors, and injury), which in their turn affect child mortality, this study has addressed the actual conditions of Afro-descendants among Colombian population.

The constitutional recognition of Afro-Colombians and the explicit recognition of their land rights, as well as some actions against discriminatory attitudes cannot be ignored. But these initiatives, though laudable, have not been enough, as evident by the persistent differences between Afro-Colombians and White/mestizo in terms of a variety of measures, including the probability of child mortality. Evidence of these differences in the present day have roots that stretch far back into Colombia’s past, including slavery, which lasted until 1851. Since then, other factors have played a role
in the marginalization of the Afro-descendants, such as geographic isolation, a national ideology that promoted the image of an idealized mestizo society and the wide acceptance of the racial democracy thesis.

As Colombian census data provide operational definitions and proxy indicators of many of the variables in the conceptual framework, the statistical analysis section tested the effect of each measured variable on the risk of death to children. I applied a logistic regression model to analyze the probability of child death associated with the race of the child, controlling for age, stratification, mother’s education, employment, housing quality, social roles and support, toxicity, and location. I executed different models to predict the probability of a child death. I first executed a logistic regression that included race alone, and then, in the second model, I entered some of the health determinants identified in the conceptual model. The third and final model included all the variables available in the 2005 census.

The three models provide empirical support for three main conclusions regarding the relationship between race and child mortality in Colombia. First, when the mother’s race is considered alone, it is evident that the likelihood of mortality among children born to Afro-Colombian women is about 74 percent higher compared to the likelihood of mortality among children born to white/mestizo women. The second conclusion concerns the effect of the various demographic and socio-economic variables. In a manner consistent with the results of studies of the determinants of child mortality in other countries, the data for Colombia indicate the importance of variables such as maternal age, place of residence, location, maternal education, employment status, the number of children born, housing quality, toxicity, and social roles and social support.
The third conclusion – which is central to the objectives of this thesis – is that the race effect continues to be statistically significant even after controlling for all of the other variables. Other things being equal, the likelihood of death among Afro-Colombian children is 20 percent higher compared to white/mestizo children.

According to these results, it is evident that inequalities between Afro-Colombians and White/mestizo population are due to differences in socioeconomic conditions, but not exclusively. The findings suggest that Afro-Colombians are subject to disadvantages beyond those associated with lower socioeconomic standings. I attribute the remaining variance explained by the mother’s race to the effect of unmeasured variables, such as the presence of discrimination.

Afro-Colombian women may be discriminated against in terms of health care system or other government policies associated with the proximate determinants of child mortality, such as maternal health, nutritional status, availability and use of health services. In addition, Afro-Colombian women may live in more hazardous areas within cities, due to migration or residential segregation, which in it turn may affect the accessibility to adequate health services, food, as well as the exposure to infections factors, and injury. Whatever the actual cause, the findings nonetheless suggest that, beyond the negative effects of lower socioeconomic status, place of residence, and housing quality, there are additional costs associated with being an Afro-descendant in Colombia.

The statistical models provide good estimates of the degree to which variables are associated with one another. However, the variables taken from the demographic census do not tell us much about the day-to-day experiences of mothers seeking health
care for their children, or about the institutional arrangements and the subjective
attitudes that influence access to health services. Put another way, the statistical
results measure outcomes – in this case, higher mortality among Afro-Colombian
children – but do not reveal the processes that produce the observed outcomes. To
address the latter, on-the-ground fieldwork is an appropriate strategy.

In order to narrow the geographical area of study to conduct the fieldwork, I ran
the logistic model with all the variables available in the 2005 census, splitting the results
by regions and departments. Among the five Colombian regions, the Pacific presented
the larger effect of race on child mortality; and among the departments that comprise
the Pacific region, Valle del Cauca showed the larger effect of race. I was not able to
pursue narrowing the geographical area, due to small number of cases. But based on
the number of Afro-Colombian inhabitants, I choose the municipality of Buenaventura,
where more than 70 percent of the people are Afro-Colombians, to conduct my
fieldwork.

The ethnographic fieldwork sought to understand some of the practices involved
in various levels of discrimination, which operate to the disadvantage of the health of
Afro-Colombian children. To carry out an in-depth analysis of the behaviors that work
against Afro-Colombian children, I spent five weeks as a participant in the “Hospital
Departamental” of Buenaventura, and two more weeks in the “Hospital Departamental”
of Cali (another city of the Valle del Cauca department). My focus was on the moment
of encounter between women seeking health care for their children and the provision of
health care by the health care facility. The goal was to analyze the relationships that
define this encounter as a way to identify the attitudes and the behaviors that determine
the quality of the health care that children receive. The empirical indicators that I expected to vary by the mother’s race included variables such as access to and the quality of the services provided, differences in the amount of time women wait for service, and race-related attitudes and beliefs on the part of the clinics’ staff and professionals. In addition, I collected further evidence of the practices and processes that affect racial differences through semi-structured interviews among patients, and health professionals.

Through the many stories told to me by the women that I met in health facilities or in the different neighbors I visited, I confirmed the relevance of many of the elements noted in the conceptual framework. The health status of children born to Afro-Colombian women is severely compromised by the independent, and interaction effects of a wide range of variables. These include: the institutional and personally mediated discrimination (Jones 2000) that occurs within the health care system, the poor quality of the clinics and services that are available, and the matrifocal households in which the entire burden of economic support and child care falls on the mother. Also important were the consequences of living in houses that lack running water and sewage facilities, as well as the risks associate with living in neighborhood that are both unclean and unsafe, and which are located at great distances from the health clinics, in places where public transportation is not available.

The testimonies showed that the Colombian health system (one of the key determinants of child health) accounts for some of the differences in mortality between Afro-Colombian and white/mestizo children. The subsidized and contributory systems differ in terms of infrastructure and equipment, and the majority of Afro-Colombian
population gets coverage from the subsidized system. The tendency for Afro-Colombians to find themselves allocated to the inferior state health program is not due to a conscious or deliberate policy. As such, it is an example of what Jones and others refer to as “institutional racism.” Yet, Afro-Colombian women in both the subsidized and contributory systems suffer from an almost complete lack of agency, depriving them of the right to demand and to receive the health services to which they are entitled.

Personally mediated forms of racism were also quite evident in the stories that women shared with me. Doctors, nurses, and the health center staff repeatedly expressed highly prejudiced attitudes and endorsed racist assumptions about Afro-Colombian women. It was abundantly clear that the medical personnel had little sensitivity to the material circumstances that black women face, little confidence in their ability to care for their children, and little respect for Afro-Colombians in general. Such attitudes and assumptions had real consequences: the children of black women were treated last, treated least, and sometimes never treated at all. When black children suffered or died, the explanation for the outcome was frequently based on explanations that put the blame on black women themselves, a clear example of “blaming the victim.”

A culture of racism is also manifested in a perverse process whereby black women themselves accept the negative messages that they receive regarding their own abilities and self-worth. The sense of powerlessness that Afro-Colombian women have internalized was one of the reasons they avoided bringing their children to the clinic until the very last minute. It likely accounted also for the tendency for black women to more or less accept the situation rather than protest against the poor treatment they receive.
In addition, my observations showed that the absence of fathers is among the factors that place Afro-Colombian children at a disadvantage in the health care system. For the Afro-Colombian women I encountered, living with a man does not mean that they get economic or emotional support, or receive any help raising their children, although there seems to be a difference in getting the health service needed. Hence, there appears to be a strong gender component to the personally mediated forms of racism to which black women are subjected.

The geographic distance of the neighborhoods where the women I met was sufficient to explain why they find it hard to get their children to the health post. The distance between the neighborhoods and the health facilities often has deadly consequences. Yet, the result is a combination of factors that threaten the survival of children: poverty, the fact that women are mostly on their own, with no one else who can look after their children, and the residential segregation experienced in terms of accessibility to health services and hazardous conditions to live.

In sum, the ethnographic approach revealed that race plays a major role in structuring the distribution of risks and opportunities in Colombian society, thereby causing large differences in health outcomes among sub-groups of population. Following the conceptual framework of child mortality, institutional forms of racism revealed by the health system, as well as the individual level of racial discrimination (women’s lack of self-esteem, longer waiting times, and differential treatment) are clearly acknowledged in what I witnessed during my participant observation in health clinics, and is expressed in the stories I documented.
In that sense, the statistical analysis and the ethnographic study confirmed the hypothesis: despite the image of racial democracy, net of the effects of region, socioeconomic factors, social roles and support, and physical environment the probability of death is higher among Afro-Colombian compared to white/mestizo children, and that color differences in child mortality can be attributed to racial discrimination. In other words, this study presents empirical evidence that Afro-descendants in Colombian society remain marginalized.

In order to break the cycle of discrimination, interventions must address both the distant determinants of child mortality as well as the proximate factors, as defined by the conceptual framework I presented. Interventions at the institutional level are needed. In fact, Colombian government should introduce a “positive discrimination” (Bondía, 2011): providing benefits and stimulating abilities to those who have been systematically excluded within the nation, as Afro-Colombians.

Multiculturalism and multiethnicity have been argued as not inclusive devices of minorities in Colombian society. The proclamation of a color blind society camouflages not only the different races part of the nation, but also the differences in privileges and struggles among them. It is imperative to contest the social systems that create racism not only with respect to the health system, but also in terms of others structures might discriminate as well, such as the education system, work system, and religion system, among others.

More generally, the Colombian government and civil society should begin a national dialog about racism in order to recognize its presence and combat its consequences. Then, mechanisms by which institutional racism operates, as in the
case of the health system, must be identified. And finally, the political will should be mobilized to eliminate discrimination and to achieve the complete integration of the African descent population into Colombian society.
# APPENDIX
## DESCRIPTION OF VARIABLES

<table>
<thead>
<tr>
<th>Type of variables</th>
<th>Name of variables</th>
<th>Description</th>
<th>Cases</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent</td>
<td>Children dead</td>
<td>Children dead</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Children surviving</td>
<td>Children surviving</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td>Independent</td>
<td>Afro-Colombians</td>
<td>White/mestizo</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afro-Colombian</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>In years</td>
<td>178525</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td>Years of schooling</td>
<td>Minimum 0</td>
<td>178525</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Location</td>
<td>Urban</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Place of Residence</td>
<td>Pacific</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caribbean</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Orinoquia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amazon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Andina</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td>Control</td>
<td>Employment</td>
<td>Employ</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unemployed</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Ownership of dwelling</td>
<td>House owner</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No House owner</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Electricity</td>
<td>Electricity at home</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No electricity at home</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Socio economic status (Own a TV, a refrigerator, a radio, and a washer machine)</td>
<td>Own one of the utilities</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Own two of the utilities</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Own three of the utilities</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Own all the utilities</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not own none of the utilities</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>178525</td>
<td>%</td>
</tr>
<tr>
<td>Type of variables</td>
<td>Name of variables</td>
<td>Description</td>
<td>Cases</td>
<td>Measure</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td>Water</td>
<td>Access to piped water at home</td>
<td>178525</td>
<td>%</td>
<td>74.80</td>
</tr>
<tr>
<td></td>
<td>Not access</td>
<td>178525</td>
<td>%</td>
<td>25.20</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Trash collected</td>
<td>Trash collected by a sanitation service</td>
<td>178525</td>
<td>%</td>
<td>60.20</td>
</tr>
<tr>
<td></td>
<td>Trash not collected</td>
<td>178525</td>
<td>%</td>
<td>39.80</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Toilet</td>
<td>Improved sanitary services at home</td>
<td>178525</td>
<td>%</td>
<td>79.30</td>
</tr>
<tr>
<td></td>
<td>Unimproved sanitary services at home</td>
<td>178525</td>
<td>%</td>
<td>20.70</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Kitchen</td>
<td>Kitchen in a separate room</td>
<td>178525</td>
<td>%</td>
<td>87.30</td>
</tr>
<tr>
<td></td>
<td>Kitchen in the same room</td>
<td>178525</td>
<td>%</td>
<td>12.70</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Married</td>
<td>Married</td>
<td>178525</td>
<td>%</td>
<td>73.50</td>
</tr>
<tr>
<td></td>
<td>Not married</td>
<td>178525</td>
<td>%</td>
<td>26.50</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Number of Children born</td>
<td>Minimum 1</td>
<td>178525</td>
<td>Mean</td>
<td>1.91</td>
</tr>
<tr>
<td></td>
<td>Maximum 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migration</td>
<td>Migrated from the place of born</td>
<td>178525</td>
<td>%</td>
<td>37.90</td>
</tr>
<tr>
<td></td>
<td>Not migrated</td>
<td>178525</td>
<td>%</td>
<td>62.10</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Colombian Census data 2005
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Maria Juliana Tobon earned her Master of Arts in Latin American Studies from the University of Florida in 2013, and her Bachelor in Political Science from Javeriana University, Cali – Colombia, in 2008.

She has been the recipient of several honors and awards including an academic Scholarship at Javeriana University, as well as the Colombian Scholarship Colfuturo to pursue her Master in Latin American Studies at the University of Florida. She was also a recipient of a Thinker Grant at the Center for Latin American Studies at the University of Florida.

While pursuing her master’s degree, Maria Juliana Tobon worked as a graduate assistant for the Center for Latin American Studies, mainly in the USAID Grant “Building Human Rights Capacity in the Colombian Caribbean,” and in the Latinamericanist Newsletter. Previously, her work has focused on the formulation, implementation and evaluation of projects with social impact in Colombia.