Contributions of Civil Society to the Achievement of Health For All

A Summary Synthesis on the Case of Colombia

May 2016

Contents

1. INTRODUCTION 2
1.1 Theoretical and Methodological References 6
1.2 Table of Theoretical Approaches 6
1.3 National Context of the Mobilization for Health 9
1.3.1 Neoliberal Reforms Shaping Colombian Context Since the 1990s 10
1.3.2. Regional and Local Contexts 13
1.3.3 The Dynamics of the Social Mobilization for Health 15
2. ANALYSIS 15
2.1 Capacity Building 15
2.2 Knowledge Production 17
2.3 Dialogues on Politics and Global Governance 18
2.4 Campaigns 19
2.5 Consolidation of the Movement in Local Spaces 21
2.5.1. Consolidations of the Movement in Urban Spaces 21
2.5.2. Consolidations of the Movement in rural spaces 23
3. CONCLUSIONS 26
4. REFERENCES 28

1. INTRODUCTION

For the development of this research project, we formed an interdisciplinary team from the postgraduate programs of five Colombian universities.

1. **Pontificia Universidad Javeriana, Bogotá**: Health Administration; Institute of Public Health
2. Pontificia Universidad Javeriana, Cali: Department of Public Health
3. **Universidad de Antioquia**: National Faculty of Public Health
4. Universidad Colegio Mayor de Cundinamarca
5. Universidad Nacional de Colombia, Bogotá: Faculty of Medicine.

Two research teams were formed, one of students pursuing a masters or PhD and their professors and graduate teaching assistants. This strategy was adopted upon recognizing the common interests between students and professors in supporting the MSP project and studying the relationship between civil society and health gains. The participation of the students was distributed as follows:

For Universidad Javeriana Bogotá: **1)** Jenny Cristina Gutiérrez García, Master of Social Policy student at the Faculty for Political sciences and international relations, supervised by professor Román Vega Romero, who worked on the case of "Peasant women and their contributions to achieving better health in their community: the case of the Peasant Association of Villa del Rio Cimitarra".

Several students in the Public Health Masters program at Universidad Javeriana Cali worked on the following two cases: **1)** Katherine Cuéllar B, of the department of Public Health, under supervision of Yadira Eugenia Borrero Ramírez, worked on *Construction of health citizenship in the context of the LGBT movement in the city of Cali*, and **2)** Gloria Amparo Yonda, Luz Ángela Palacios and Alexandra de la Cruz, students of the Department of Public Health, under the supervision of the professor Yadira Eugenia Borrero Ramírez, worked on *Contributions of the Indigenous Movement of the North of Cauca in the Achievement of Health For All*: *a View from the Perspective of Traditional Authorities and ACIN[1]".*

Deisy Paola Carranza López and Maria Alejandra Contreras Sánchez, students of the graduate program in Social Work at Universidad Colegio Mayor de Cundinamarca under supervision of the professor Diana Yadira Almonacid Rojas, worked on the case *Invisible Struggles: a Study of the Resistance Process of Workers of the San Juan de Dios Hospital*.

At Universidad Nacional de Colombia, three students worked on three different cases: **1)** under the supervision of professor Jairo Ernesto Luna, Public Health PhD candidate Mauricio Torres Tovar worked on *Collective action for the Right to Occupational Health: the Case of Sick Former Employees of Colmotores-Asotrecol*; **2)** the Nutrition and Dietician graduate student Katherine Iovanowa Carillo Noguera on *Peasant Peasant Reserve Area (zonas de reserva campesina) of Valle del Rio Cimitarra, towards achieving food sovereignty and the fulfillment of the right to food for the peasant communities of Magdalena Medio* under the supervision of Néstor Joaquín Mendieta Cruz, lecturer at the Food Safety and Nutritional Observatory at Universidad Nacional de Colombia; **3)** medical student Juan Pablo López worked under the supervision of professor Juan Carlos Eslava on the case *Health and Life in the Rural Community of Valle del Rio Cimitarra*.

At Facultad Nacional de Salud Pública of Universidad de Antioquia, the professors Yadira Eugenia Borrero Ramírez, Maria Esperanza Echeverry López and Mauricio Torres Tovar of Universidad Nacional de Colombia addressed the historical context of the struggles for health in

1 Asociación de Councils Indígenas del Norte – Association of Indigenous Councils of the North

Colombia and specifically *Health For All: The Consolidation of a Social Movement in Health, the Case of Colombia 1990-2015*.

Furthermore, the case of the People's School of Health (Escuela Popular de Salud) of the Intersectional Platform for the Right to Health of Antioquia was analyzed by professor Maria Esperanza Echeverry López at the Facultad Nacional de Salud Pública.

This research project, *Contributions of Civil Society to the Achievement of Health For All*, and especially the supervision of the involved students' theses, required a special collaboration agreement between the participating universities, with the exception of Universidad Colegio Mayor de Cundinamarca and Universidad de Antioquia. Shortly after Médecine pour le Tiers Monde (M3M) and Pontifica Universidad Javeriana agreed to the terms of the collaborative research project. Upon defining the mission, budget and reporting periods of the project, which in turn guided the definition of budget lines and distribution, transfer of assigned resources, obligations, copyright issues and other points contained therein, the collaboration agreement between Pontifica Universidad Javeriana and the other universities was signed. Prior to the signature of the collaboration agreement, the project was approved by the Research and Ethics Committee of the Faculty of Economics and Business Administration of Universidad Javeriana in its sessions on September 23rd and November 14th 2014 and entered in the registry of the research departments of the participating universities.

The work process was initiated after the approval of the collaboration agreement. The contents of the MSP project and its translation were discussed in online and in-person meetings amongst the researchers and tutors. Furthermore, a general project work plan and a protocol for the elaboration of theses in the context of the research project was developed, respecting the autonomy of each student in the definition of the case studies. The approval of the research protocol of each student was subject to the approval of the academic authorities at the respective units or academic programs involved.

The approved case studies correspond to different experiences related to the involvement of civil society in efforts directed towards improving health in urban and rural areas. As not all five MSP project themes have been strictly implemented in Colombia, it was decided to research similar cases reflecting problems and dynamics shaping civil society involvement in struggles for health in Colombia. In this regard, cases addressed Colombian peasants, workers, ethnic groups and issues around gender, LGBT and women and general analyses on the struggle for the right to health in Colombia were put forward. The case studies covered a broad range of themes including the initiatives developed by social movements in relation to the struggle for the right to access health services, issues around the broader social determination of health and the organizational dynamics and processes of social mobilization around the fulfillment of health related rights.

The team of tutors had regular meetings in order to guarantee a comprehensive exchange during project development and to articulate the specifics around the general analysis of the Colombian case. Apart from tutor-student revision and discussion of the cases, virtual and in-person meetings of the entire team were organized to allow for a joint discussion of each case. Each student developed a research protocol including research object, research questions, state of the art, conceptual framework, methodology and work plan, all subject to the approval of academic authorities at the respective universities. The development of research protocols was rather heterogeneous, and, given the different degree and nature of difficulties encountered during the research process, dissimilar results were obtained. Of the eight cases originally foreseen in the collaborative project, five have been completed to date, two have preliminary results and one has no currently reported results.

In an effort to respond to the task of developing a conceptual framework on civil society, construct research categories and a methodological guide directed towards the articulation of the different cases, the research team developed a series of documents, namely: **1)** Guidelines

for the development of the case study reports by students; **2)** Guidelines for the integrated analysis of the Colombian cases; **3)** Conceptual document on civil society from a Gramscian perspective, responding to some researchers' concerns about the absence of an adequate conceptualization of civil society in the MSP research project documents; **4)** Document on research categories for the project on civil society and health from the perspective of the Colombian case studies; and, **5)** Proposal for an integrated document on the Colombian case.

The first document summarizes the MSP project research questions and outlines guidelines for data collection and analysis in the first part of the project, with the evaluation of the themes being included after the empirical analysis on the involvement of civil society in efforts directed at Health For All.

Following the MSP project guidelines, each case study was organized according to the following structure: title, table of contents, short introduction and general presentation of the case (including short section on the methodology), analyses of the case according to the themes defined in the MSP project (outlined above) and implications for the second phase of the project regarding program development, evaluation and research.

The second document defines the analytical strategy for the integrated evaluation of the five MSP programs as well as for the empirical analysis on civil society engagement in struggles for health in Colombia, establishing that all case studies should follow a narrative approach and include evaluations structured according to the general program themes. The integrated analysis of the Colombian case was performed by the research team as a whole, coordinated by the project tutors:Jairo Ernesto, Yadira Eugenia, María Esperanza, Juan Carlos, Diana Yadira y Román Rafael. A narrative report was elaborated on the basis of the synthesis document that reconstructed the history of Movimiento Nacional por la Salud y la Seguridad Social (MNSSS), the case study reports, the matrix of research categories linked to the logical frameworks included in Annex 2 of the document "Civil Society Engagement for Health For All" and the additional research categories defined by the Colombian research team.

The third document contained a literature review of texts in which Gramsci explored and analyzed the concept of civil society. It identifies definitions that the author proposes regarding the civil society, for example: "the extended and complex space where ideological, political and cultural confrontations take place and where the dominant group can define its hegemony" (Gramsci, 1975); or the definition contained in Volume III of the Prison Notebooks, according to which civil society is "political and cultural hegemony of one social group over society as a whole, being ethical content of the State" (28). In these definitions, Gramsci clarifies that civil society does not only refer to elements of the social and economic structure, that is, an isolated social group or subject, community, NGO, workers union or company, a social movement or a political party, nor does it refer to a purely material exchange between individuals. According to Gramsci, civil society is the result of dynamic social relations between social groups (necessarily economical and involving class struggle as described by Marx, but which cannot be reduced to that aspect of social structure), a realm in which **a superstructure is defined and imposed that determines the conception of the world or of ideology serving the intellectual and moral interests of the dominant social groups** in a specific moment in history.

It has also been important to point out that power relations are implied in the relationships between political parties, intellectuals and civil society, defining the degree of political consciousness among social groups involved in the struggle for the transformation of society[2]: **a)** the economic-corporative solidarity that refers to gremial or professional solidarity amongst equals, but does not include the broader social group; **b)** the solidarity among an entire social

2 According to Gramsci, an individual's possibility to change existing social relations depends on his or her capacity to become associated with those who desire to change these relations, while the radicality of the change depends on the number of associated individuals.

group, but limited to the economic and material sphere linked to reformist interests (Volume V, p. 36); **c)** economic and political as well as moral and intellectual unity or revolutionary change; a phase in which "consciousness about the proper corporate interests is attained, but the economically defined corporate circle can and should be converted into the interests of other subordinate groups" (Volume V, p.36).

Such a definition of civil society, which broadens the theoretical framework of the MSP project, allowed us to understand how in the context of the struggle for the fulfillment of basic material needs, individuals and social groups which are exploited, discriminated against and/or oppressed, can build capacity to resist dominant health policies or influence the elaboration of public policies, plans and projects directing their struggles to the immediate satisfaction of their basic needs or towards a broader, more radical and long-term objective of consolidating a new, more inclusive and more equitable socioeconomic, political, cultural and ethical order, which would create the context necessary for the development of a subjective and collective consciousness, autonomy, liberty and emancipation. In order to understand processes of social transformation, Gramsci points at two important conditions: first, the construction of the people's will; second, the development of an alternative understanding of the world, challenging *status quo* through moral and intellectual reform.

These conditions could be applied to the case of Colombia, where historically, disputes over property rights remain unresolved through democratic reformation, with patriarchal and class oppression, dependence on foreign aid and an inaccessible democratic process hindering the social progress of such groups as peasants, women, indigenous peoples, LGBT individuals, workers, middle-class urban dwellers and intellectuals that could possibly contribute to the consolidation of the will of the people necessary for the transformation. In the absence of these conditions, it has been impossible to constitute broad and permanent social movements or a party where political forces agglutinate and the will of the people materializes, due in part to the violent suppression of a social and political opposition which has hindered progressive social and political transformations, including those related to health.

The fourth document, which was constructed on the basis of group discussions regarding the MSP project contents, the document on Gramsci's idea of civil society and the conceptual frameworks of the case studies—especially those theoretically discussing social movements and collective action—informed the definition of a set of research categories reflecting general MSP project issues, the socioeconomic, political and cultural particularities of the national reality and the conceptual interests of the researchers. The research categories related to the MSP project included the following: Health For All, civil society, civil society activism towards social change, principles for politically and financially supporting civil society, contextual factors that affect the involvement of civil society, beneficiaries of civil society engagement and activism. New or re-conceptualized categories related to the national particularities and the researcher's study interests included the following: civil society contributions to the achievement of Health For All, reconceptualized according to the right to health, social determination of health and environmental sustainability approach; theoretical reappraisal of civil society on the basis of the works of Gramsci; levels of consciousness in civil society in the context of the dynamic relation between civil society and political parties (corporative-economic, reformist, revolutionary change); conditions for civil society to contribute to social transformations according to Gramsci construction of the people's will; alternative understanding of the world; moral and intellectual reform); collective action, social movement, opportunity structure, identity construction; social justice in a society of equals; right to health; diversity; space/territory; and accumulation by dispossession. This document summarizes the Colombian cases elaborated in the context of the MSP project on civil society contributions to the achievement of Health For All.

First, theoretical and methodological references of the case studies are described; second, a general description of the national context is presented, providing insights to understand the struggles to achieve Health For All in Colombia, the regional contexts of the case studies and the

dynamics of the social mobilization for health; third, each MSP project theme is addressed (capacity building, knowledge generation, dialog about politics and global governance, campaigns and the consolidation of social movements in local spaces); fourth, conclusions are presented and project results are discussed with relation to the implications for the second phase of the project, particularly regarding the development of the program, evaluation and research.

1.1 Theoretical and Methodological References

The different cases included in this research on the case of Colombia, utilized diverse theoretical and methodological approaches. None of the case studies adopted one single theoretical approach but rather combined two or three perspectives in order to adequately respond to the singularity of each case and the questions posed by the People's Health Movement. The following table provides a synthesis of the theoretical approaches.

1.2 Table of Theoretical Approaches

Theoretical approaches adopted in the case studies compiled in the research project on civil society contributions to the achievement of Health For All.

Actors	Organization	Number of cases	Theoretical approach
Organization of urban workers and ex-workers	Asotrecol	1	Collective action and identity theory; Human rights approach; Occupational health approach adopted in social medicine
Organization of health workers	Hospital San Juan de Dios	1	Collective action theory; Resistance theory; Social constructivist paradigm
Peasants	Farm Association of Valle del Rio Cimitarra (ACVC)	3	Subaltern theory; Social determination of health
LGBT population	LGBT social movement	1	Collective action and identity theory; Human rights approach; Gender approach
Indigenous population	Association of Councils Indígenas del Norte del Cauca (ACIN)	1	Collective action and identity theory; Human rights approach
Health service users; victims of the armed conflict; workers and caregivers	People's School of Health of Mesa Intersectorial por el Derecho a la Salud MIAS – GGF – UdeA	1	Human rights approach; Popular education approach

Source: Elaborated by the authors.

As displayed in this table, the majority of the cases are theoretically grounded in collective action theory (4 works); another 4 works used the human rights approach; the three cases related to peasants were grounded in subaltern theory and the social determination of health approach. According to the needs of each case, specific approaches were adopted, including the resistance theory, the gender approach and popular education approaches. In the following it will be outlined how each approach was understood and applied to the cases.

The field of social movements (SM) and collective action (CA) is broad and heterogeneous. Within the field, several perspectives can be differentiated: **i)** those that privilege the identification of structural conditions that generate and configure collective action and find expression in what have been called structures of political opportunities (SPO) or to a greater degree in political conflict (CP); **ii)** represented by those theories that privilege the analysis of social processes linked to the consolidation of SM as collective actors, generally referred to as identity approaches; **iii)** approaches that seek to complement the previous and primarily draw from theories developed in Europe and the United States, and **iv)** other theoretical perspectives, especially those that emerged in Asia and Latin America, from subaltern and particularly the Latin American approaches that are characterized by a perspective from below, linked to the defense of the territory and autonomy of social mobilization and organization.

In the Colombian case studies that used the SM and CA theories, complementary views were privileged to read CA and SM, particularly a combination of identity and structures of political opportunities theory, exploring the processes shaping the configuration of collective actors and how those are constructed in situations of conflict and structural changes in public policy and the state model. The analysis of the identity construction process—as in the case of ACIN, the LGBT movement, Asotrecol and the school of popular education—shows that collective identity is constructed through collective action (CA) and individual identities are constructed in response to the specific way each actor understands the right to health as a fundamental human right. The second theoretical stand in this field—the structures of political opportunities theory—contributed to the analysis by allowing for a better understanding of structural elements that are currently being disputed in the struggle for health which shape CA. In this regard, the different works show at least two issues. On the one hand, there is a clear relationship between social mobilization and the processes of social policy reform, health and social security policy in Colombia, the systematic dispossession of legally supported guarantees such as work, territory, retirement pensions, occupational health protection schemes and naturally, also access to health services, which has created indignation and suffering that—not automatically, but through the construction of collective actors—trigger organization and mobilization for the fulfillment of these rights. On the other hand, the cases show that the mentioned dispossession affects each actor in a specific way.

The second approach applied in four cases – ACIN, LGBT movement, Asotrecol and the school of popular education (People's School of Health) – is the human rights approach. This approach recognizes the human rights as fundamental rights that according to the national legislation, the constitutionality and jurisprudence of the Constitutional Court should be universal and non-discriminatory, bound to the condition of citizenship and equitably guaranteed by the State based on the principle of human dignity. At the same time, these rights are recognized as independent from other rights such as the right to work, the right to protection of health at the workplace, the right to retirement, the right to life, the right to territory and are clearly visible in these cases. Similarly, the International Agreement on Economic, Social and Cultural rights in its commentary No 14 defines "health as a fundamental human right, indispensable for the exercise of all other human rights." The universality of the human rights approach is linked to the right to recognition evident in the cases of ACIN and the LGBT movement. Both involve actors that, apart from what is defined in the jurisdiction, call for the recognition of their right to differential health attention, the incorporation of ancestral health practices and the inclusion of health attention models that recognize non-heteronormative gender identities and sexualities.

The previous works required specific theoretical contributions. In the case of the LGBT movement, a gender approach was needed. Following authors such as Lamas and Butler, the gender category seeks to differentiate between the biological and socio-cultural constructions that are made in relation to the biological characteristics, assuming that the power structures that shape the dominant model of heterosexuality and other sociocultural practices that imply forms of domination and control of some over others, explain historically shaped exclusion and discrimination against population groups with non-heteronormative gender orientation and sexualities.

The case on the workers of San Juan de Dios hospital additionally included the theoretical work Quiñones developed on resistance, which complements CA theory from an organizational perspective, considers processes of collectivization and civil disobedience in efforts directed at resolving problematic situations and acting towards political change. The social constructivist paradigm proposed by Berger & Luckman contributed to the data by pointing at the consolidation of collective subjectivities that were configured in the process of resistance, mediated and modified day-to-day by organization and action, that lasted for more than a decade and generated different forms of understanding, explaining what has happened between the actors.

The case on the people's school of health required a popular education approach in addition to the human rights approach. The school has three components: pedagogic, communicative and research. The pedagogic component is based on **popular education**, an alternative paradigm that emerged in opposition to the idea of knowledge being transferred from someone who knows to someone who doesn't and rather values the dialogue, reflection and exchange of knowledge in encounters between people that recreate the world in order to understand and transform it towards a more equitable and democratic society. The communicative component, grounded in the idea of **communication for social change** (CSC), seeks to bring about social transformation, strengthening communication in organizational and participatory processes as a mean to foster collective growth. CSC[3] emphasizes participation and dialogue. Therefore, it neatly complements popular education. The research component is based on **critical research** using social research methods in the construction of knowledge for action on different forms of social oppression and is directed towards the transformation of society. At the school, this translates into tutoring sessions and the systematization of the experience, which is a form of qualitative research that works with the classification, reconstruction, analysis and critical comprehension of lived experiences, e.g., organizational processes at the community level or educational processes. It is an exercise that seeks to understand the process and the factors that define why a process went in one direction and not another.

In the case of Asotrecol, apart from the human rights, CA and SM approaches required frameworks to understand the relation between health and work. In this regard, a social medicine occupational health approach was adopted, which allowed for the characterization of productive processes, work conditions and their impact on the worker's health. At the same time, the approach allowed for an assessment of changes in work conditions in regards to managerial and technical adjustments and their impact on the health and life of workers.

The three cases on the peasants and miners movement of Valle del Rio Cimitarra, apart from using the CA approach, adopted three different approaches: social determinants of health approach; social determination of health approach; and nutritional and food sovereignty approach. The social determinants of health approach proposed by the WHO (2014) describes the circumstances where people live, including the health system. These circumstances are understood as consequences of the distribution of money, power and resources on global,

3 CSC translates into informative seminars as those responsible for each session are also teachers or educators in the organizations that converge at the school, establishing a horizontal relationship.

national and local levels, that respond to public policies. The Latin American Social Medicine approach to the social determination of health allows for the capture of the polysemic character of health, that is: a real object and synthesis of its multiple ontological determinations; as a theoretical object that is conceptualized and thereby made intelligible; and as a field of action where social movements emerge (Breilh, 2010). Food sovereignty requires an understanding of territory and territoriality, governance and governability as well as dietary/nutritional territorial ordering.

Methodologically, all studies were qualitative case studies. One study methodologically corresponded to an ethnographic design – ACIN, two of the experiences were proposed as case studies based on the systematization of experiences – People's School of Health and one of the cases from Valle del Rio Cimitarra, the case on the LGBT movement used biographical methods and all other cases drew from different qualitative methods. The techniques included document analysis, focus groups, in-depth and semi-structured interviews and participant observation. All studies attempted to extrapolate from the particular cases towards the research themes defined by the People's Health Movement, particularly regarding: consolidation of social movements, campaigns and advocacy, the production and dissemination of knowledge and capacity building. Due to the characteristics of the cases and the particularities of the Colombian context, the contributions regarding policies and local governance were limited.

1.3 National Context of the Mobilization for Health

Colombia is located at the upper part of South America. The country possesses an enormous biodiversity, product of its rich geography shaped by coastal areas, valleys and mountains. The biodiversity of Colombia includes aquatic, botanical and animal diversity, with access to two oceans and part of the Amazon. Furthermore, the country possesses cultural diversity, being a multi-ethnic country of indigenous, afrodescendant and mestizo population and its mineral and petroleum basins make it an energetically diverse country. Colombia is furthermore shaped by human diversity, given the resilient quality of its people which in spite of adversaries produced by violence and social injustice, continue to struggle in order to improve life.

According to DANE, Colombia has approximately 49 million inhabitants, 75% in urban and 25% in rural zones; 51% women and 49% men. The Political Constitution of 1991 defines Colombia as a Welfare State (Estado Social de Derechos), organized as a unified, decentralized, democratic, participatory and pluralist Republic, which translates into a presidential political system of representative democracy, a history of bipartisanship, shaped by the exclusion of non-traditional political sectors and a rather limited promotion of civil participation, that has favoured a skewed decision-making process in which the elites have promoted their particular interests and generated profound social injustice, forming the basis of a long-standing sociopolitical conflict, that has led to a civil war which has lasted for more than 50 years.

Since the end of the 1980s, Colombia went through a series of transformations in the context of economic reforms and a progressive limitation of State functions, primarily as a result of public policy guidelines promoted by multilateral credit organizations, especially the World Bank (WB) and the Inter-American Development Bank (IDB) (Homedes & Ugalde, 2005), which promoted structural adjustment measures referring to the need to overcome the external debt crisis.

It is in this context that processes of resistance and social mobilization for health were shaped and a national movement for health in Colombia emerged. In the following, these processes are analyzed in four periods corresponding to presidential periods.

1.3.1 Neoliberal Reforms Shaping Colombian Context Since the 1990s

The transformations imposed by international monetary funds came along with changes in the development model and labor and social security reforms. The labor reform was put forward by Law 50 from 1990 that transformed the labor/capital relationship, generating processes of free labor and deregulation; Law 100 from 1993 defined a new State policy on social security, based on individual adherence to a market-oriented health and pension scheme.

The changes in health policy specifically followed the Washington Consensus, that according to Misas (2002) "generated a corpus, that is, a theoretical-ideological matrix on what is considered a good economic policy" (p. 206). These changes opened new forms of capitalist accumulation through privatization of formerly state driven sectors such as the health or educational sector; an institutional arrangement that did not manage to guarantee the right to health as it maintained a segmentation of the system and rather than promoting citizenship, promoted charity for the poor and made the rest of the population pay (Hernández, 2000; De Currea, 2003).

In this context, the Colombian state developed a dual process that continues to shape public policies in health. On the one hand, following international recommendations promoted by the insurance sector, the country started an intense debate in the late 1980s on the need to transform the former National Health System (NHS). This was supported by arguments on the fragmentation and low coverage of social security benefits (it was estimated that 18% of the population was covered), inefficiency in the use of public resources and the public health system, the persistent economic crisis of public hospitals, deficient quality in health service provision, low competitiveness due to the existence of captive populations, corruption and administrative inefficiency (Borrero, 2008). This debate concluded in the creation of SGSSS (Law 100 from 1993), and strong conflicts especially between the state and trade unions (Borrero, 2008; Uribe, 2009).

On the other hand, the country started political negotiations with the insurgent movement M-19, that resulted in the convocation of a National Constitutional Assembly, which promulgated the new political constitution (PC) in 1991. Although this proposal for institutional reorganization accelerated economic aperture and privatization of different services, it defined the country as a Welfare State (Estado social de derechos), recognizing the need to guarantee economic, social and cultural rights, progressively transferring resources from national to regional and municipal level and making social expenses mandatory and priority. Furthermore, constitutional mechanisms for the protection of fundamental rights were defined, namely Tutelar actions (acción tutelar, AT) and People's action (acciones populares, AP) (PC, 1991). Since then, these constitutional guarantees have been in conflict with the neoliberal proposals that have dominated the executive and legislative branch in the last 25 years.

According to some researchers (Almeida, 2005; Hernández, 2008), the structured pluralism model that was implemented with the SGSSS following the previously mentioned WB recommendations and took shape in the individual insurance-adherence health system—conceived in relation to financial rather than solidarity principles—and particularly in the two schemes: a subsidized scheme for the poor, defined on the basis of focalization; and a contributive scheme for those with the ability to pay and financed by employers and employees. Health insurance is managed by an intermediary that receives a bonus for each affiliated individual and contracts services included in the insurance package, complemented by copayments for using the service.

Additionally, public hospitals were pushed to turn into financially independent "social companies of the state" and introduce labor flexibilization measures. Formally, the state fulfilled its moderating role of the system and the "regulated competitiveness" between insurance companies and public or private service providers. Nonetheless, more than two decades into the implementation of this institutional scheme, the primacy of the market, the extinction of public

insurance schemes, the precarious labor conditions, the permanent hospital crisis, setbacks in public health indicators and multiple barriers in the access to health services are more than evident and alarming (Vélez, 2016).

The effects of the implementation of the new health system were particularly evident in the intensification of the hospital crisis[4] and in setbacks in health indicators, especially the decrease in vaccine coverage, the increase in immuno-preventable diseases, the massive layoff of public hospital workers and the emergence of new problems related to access barriers in health services, closure of hospitals and health centers and the layoff of health promotion agents, amongst other factors which particularly affected remote rural areas (Borrero, 2014; Echeverry-López & Borrero, 2015; Ocampo, 2012).

Between 1998 and 2000, Colombia faced a major economic crisis as a result of adjustment policies that tripled the unemployment rate, fostered state deregulation, labor flexibilization accompanied by massive layoffs especially in the public sector, the creation of new market-oriented institutions in the welfare sector and the increasing configuration of a legislative tendency towards the progressive dismantling of the fragile Welfare state (Estado social de derechos) of the 1991 Political Constitution; a tendency that is evident to this day. These processes led to massive mobilizations of social sectors involved in issues around education and health.

Between 1997 and 1998, it was the public health situation of the country that evidenced the need for organization, pedagogy and critical debate to understand what was going on. This process, put forward as an initiative of different academic sectors, paved the way for the consolidation of a national movement for health (Borrero, 2013), in the context of two instances of intensified social protest about health in 1999 and 2001 (Echeverry & Borrero, 2015).

Since 2002, the national government assumed a neoliberal and authoritarian stance under president Álvaro Uribe Vélez[5], who deepened economic aperture and minimized state provision of services such as health. In social policy, he introduced the social risk management approach, proposed by the World Bank, in which the role of the state is conceived as complementary and limited to situations where individuals, families or communities do not manage to get access to basic services through the market (Echeverry & Borrero, 2015).

In the field of health, this period was crucial as the health insurance scheme as well as the hospital crisis deepened - one of the main causes of protest during the last 22 years - and daily life was seriously affected. This situation persists until today due to the unequal competitiveness between public and private service providers, the disadvantage of the former and policies cutting public subsidies in health service offers, that favoured the non-regulated expansion of private insurance companies. The debt of Health Promotion Companies (EPS), the intermediaries that receive the insurance payments, with the public and private health care providers was estimated to sum up to 2,5 billion Colombian pesos in 2004 (Borrero, 2014). Today, it is calculated to sum up to 5,6 billion Colombian pesos (El Espectador, November 5th, 2015). The unequal conditions of public institutions, that were obliged to become financially auto-sufficient Social Companies of the State and compete in the health service provision market and the rather market than public interest-oriented health policies, were deepened by the health policies put forward by the government of Uribe that favoured capitalist accumulation in the health sector (Borrero, 2014).

4 One of the most emblematic cases refers to San Juan de Dios Hospital and the Mother and Child Institute in Bogotá. Both institutions were emblematic "university hospitals" that formed health professionals, especially those from Universidad Nacional de Colombia, produced high-level technology and had a prestigious role in medical education and research in Latin America and the world.

5 President Álvaro Uribe Vélez was one of the senators who proposed Law 100 of 1993 that created SGSSS.

At the same time, the government deepened the market reforms in the social sectors: using the social risk management approach of the World Bank, the ministries of health and work were joined together in the ministry of social protection, perpetuating the already limited presence of the state in relation to the population living in extreme poverty. The health policy was directed by efforts seeking to strengthen private insurance and debilitate public insurance schemes. When the process of restructuring and atomizing the Social Security Institute advanced, the restructuring of public hospitals deepened and the negotiations on the Free Trade Agreement (Tratado de Libre Comercio, TLC) were initiated, favouring the interests of pharmaceutical companies upon reforming the intellectual property rights legislation, one of the most representative trade unions in the health sector, that had been leading an important alliance between different health actors, was fractured. The 8 years (2002-2010) of Uribe government were crucial for the maintenance of these policies and shaped a socio-economic context detrimental for the wellbeing of the population. The repression of protests and continuous violations of human rights of trade unionists led to a polarization of the subaltern actors (Uribe, 2011).

The 8 years of Álvaro Uribe's government came to a fitting close with the proclamation of the social emergency[6], that resulted in one of the strongest moments of social mobilization in health in the country (Torres-Tovar, 2010A). The people expressed their rejection of the social emergency measures in public fora, online consultations, commentaries in newspapers, radio programs and television as well as in social media, including a group called "all against the 2010 social emergency act in Colombia".

Medical doctors strongly positioned themselves against the act, that sought to cut their professional autonomy even further. Academic sectors argued that the act did not resolve structural problems of the country. Referring to the high risk of deterioration and disappearance of the public hospital network as a result of the definition of minimum contract values in agreements between EPS and public hospitals and the devolution of health promotion and prevention resources to EPS, Secretaries of Health and directors of social companies of the state (empresas sociales del Estado, ESE) also positioned themselves against the act. Patients with conditions labelled as catastrophic and high-cost expressed their concerns regarding their treatment and payment restraints. Several other political sectors positioned themselves against the emergency act. Health workers occupied two churches in Bogotá to express their rejection of the social emergency declaration. Furthermore, several marches were organized in different cities of the country, demanding the withdrawal of the emergency act (Desde Abajo, 2010).

The two four-year terms of Uribe ended with a political defeat in health, accompanied by an important rise in social movements for the right to health and a strong will of several sectors—social, academic and political actors—to develop a new model that guarantees "Health For All," a model organized around a public, universal, free, equitable and highly participative public health system (Movimiento Nacional por la Salud, 2010).

When Juan Manuel Santos assumed office in august 2010 he was confronted with this situation, profound discontent and social pressure to resolve the health system crisis. At the same time he was pressured to unlock the signature of the Free Trade Agreement with the United States, which also had important implications for health and a strong social opposition.

6 The Uribe government declared a state of social emergency through Act 4975 on December 23, 2009, making use of article 215 of the Political Constitution, that allowed for the declaration of such a state of exception when there is a situation that puts economic, social and ecological stability under risk. The government justified this measure arguing that the health sector had a serious liquidity problem that demanded the attainment of additional resources to alleviate the financial crisis of the sector (Torres-Tovar, 2010B).

The Santos government took up an initiative that Uribe had proposed at the end of his electoral period, of a new, the second, reform of Law 100, as a way to resolve the problems of the health system and respond to the protests and social struggles in the field.

In January 2011 Law 1438 was passed in an effort to reform Law 100, but by maintaining the mediation by EPS and leaving out vertical integration, did not essentially modify the health system or resolve the health sector crisis, which led the Santos government to talk about the need for another health system reform—the third—by the end of his first term.

The ordinary law project presented by the Santos government generated strong social opposition as the initiative maintained the two insurance regimes and accordingly did not confront the inequities between those insured by the contributive plan and those insured by the subsidized plan. Instead of replacing the EPS, the name was changed into Health Service Managers (Gestoras de Servicios de Salud) and their functions were increased by authorizing them to create and guide health service providers, control contracts, and to monitor and pay health service providers. Furthermore, they maintained control over the authorization of health services, freely contracted its own network of providers in primary health service provision, with continued permission to offer individual and collective health care and maintain the prepaid health service business (Torres-Tovar, 2013A). However, this law project did not pass the Congress of the Republic and was archived.

Another legislative initiative put forward by the Santos administration was the presentation of a statutory law project in health (Ley Estatutaria en Salud), which was eventually approved by the Congress of the Republic by the end of 2013 and together with a series of modulations declared constitutional by the Constitutional Court in its ruling C-303 of 2014. The modulations on the statutory law established by the Constitutional Court followed an international guarantee of the right to health approach, but under pressure of diverse citizen, gremial and academic sectors, Santos signed the law. With the statutory law, a constitutional framework was established that defined health as a fundamental human right and recognized that this was not guaranteed by the provision of the health service package (paquete de prestación de servicios - POS). Santos was accordingly obliged to move away from his original idea to limit the right to health to POS and thereby limit the use of judicial tutelage action. Although the sanction of the statutory law was interpreted as a success by social sectors, it did not touch the insurance scheme, responsible for the major problems in the Colombian health system.

This dynamic of Santos' second term, which did not differ from his first term, showed that the initiatives put forward by his administration did not differ from previous initiatives, strengthening a market-oriented model directed towards an individual insurance to treat disease without resolving serious problems related to the guarantee of the right to health.

1.3.2. Regional and Local Contexts

Although national context influences the entire Colombian territory, it is necessary to recognize particularities that shape each region, its social dynamics and politics and obviously also the dynamics of social mobilization and organization for the right to health.

This research included case studies from five regions and/or cities in Colombia: Valle del Rio Cimitarra (located in the region of the Magdalena Medio); the northern zone of the Cauca department (south-western Colombia); the city of Cali, capital of the department of El Valle (also south-western Colombia); the department of Antioquia (north-western Colombia) and the city of Bogotá, Colombia's capital.

Valle del Rio Cimitarra is located between the eastern central mountain range and the western edge of Magdalena Medio, south of Serranía de San Lucas, close to the municipalities of Yondó and Remedios in southeastern Antioquia and, San Pablo and Cantagallo, in the south of the department of Bolívar. This area was only colonized by the end of the 1970s as political

violence shaped the region of Magdalena Medio, extending from Cundinamarca to the river Sinú. The region forms a geographically marginal space with respect to the national project in the sense that it is a product of the combined action between the state and excluded or subaltern social actors that conform spaces in which national political, economic, cultural and military interests find little expression. This brings to light the contrast between spaces integrated into the logic of the political regime and those that form a disintegrated territorial enclave (Alonso, 1997). It has been one of the regions with the most pronounced conflicts over the possession of land, the extraction of minerals, drug traffic and violent opposition to participation in community organizations, social movements or parties involved in political decision-making on a national, regional and local level.

The North of the department of Cauca has been the setting of indigenous and afrodescendant resistance, consisting historically of subaltern actors. It is one of the Colombian territories where armed conflict found its most intensive expressions, given the geographical position that transformed this region into a corridor connecting the Andean region and the Pacific Ocean. Economically, two areas can be differentiated: the low area, inhabited by afrodescendant and indigenous groups, concentrated in the sugarcane industry, which has displaced small peasant economies; and the elevated areas, predominantly inhabited by indigenous groups, concentrating food crops, aquatic reserves and illicit drug cultures. In general, the department of Cauca presents levels of poverty and misery well above the national average. This is even worse for the indigenous and afrodescendant population of the department. This territory has historically been excluded from economic and social development of the country, confronted with the intensification of armed conflict and drug traffic.

Cali is the most important city of southwestern Colombia. Its economic development has been linked to the sugar industry, concentrating capital in a small group of people. Of the three most important cities of the country (Bogotá, Medellín and Cali) this is the one with the highest urban poverty index and the greatest socio-spatial segregation. After Salvador de Bahia in Brazil, Cali has the largest afrodescendant population in Latin America. Since the 1980s,in the context of the state war on drug cartels, the city faced an economic crisis which it has not yet managed to overcome, as its economic growth was fundamentally linked to drug traffic. In spite of the economic difficulties and high levels of poverty, social mobilization in the field of health is rather low, when compared to Medellín and Bogotá, according to previous research (Borrero, 2013, 2014) critical thought in health has not developed significantly, delaying the implementation of the health system in comparison to other cities, especially regarding the transformation of hospitals into social companies of the state (empresas sociales del Estado, ESE) and rather rare autonomous organizational processes in health, concentrating processes of institutional participation, as the LGBT case shows.

Medellin and nearby localities like Valle de Aburrá, represent the second most economically developed region in Colombia, despite also being the most inequitable region of the country (Borrero, 2013). Regarding the struggles for health, the city has been home to several long standing organizational processes as shown in the cases of the Medical Association of Antioquia (Asmedas), which supported trade union organizational processes (Asmetrosalud) and health care users (Asudessa). At the same time and different from Cali but similar to the case of Bogotá, Medellin has a long history of critical thought articulated by actors such as the National Faculty of Public Health at Universidad de Antioquia or the Department of Preventive Medicine of the Medical Faculty of the same university. According to Borrero (2013, 2014) the articulation between trajectories of social mobilization and critical thought in health, strengthened and made the health movement last. Nonetheless, one of the most critical situations has been the presence and dispute over the control of the city between different armed actors: especially paramilitary and in recent years criminal gangs (bacrim) that infiltrated neighborhoods and popular organizations, threatened leaders and started to control local economic circuits. This affected social movements in general and especially the health movement due to the general mistrust,

fear and atomization of the actors. The defense of the public hospitals—organized as company units with 53 points of medical attention in the city—has been an element of cohesion and struggle for the city's social movements.

Bogotá, being Colombia's capital, is strongly affected by the national context and has been a city where economic, labor and social security reforms have been forcefully implemented, as expressed in deteriorated working conditions and the failure to guarantee the population's rights, including the right to health. In Bogotá, the institutionality of the public social security system has been liquidated and hospitals have been merged, which has brought about labor conflicts. The particularity of Bogotá lies in the presence of progressive governments between 2004 and 2015, which drove health policy towards the guarantee of rights rather than mercantilization, but did not substantially modify the labor conditions of the health sector workers. Another particularity is that the resistance and social mobilization in Bogotá has been its anti-neoliberal policy stance.

1.3.3 The Dynamics of the Social Mobilization for Health

The medium term context we described has been shaped by the restriction and mercantilization of social policy and the minimization of the state's role in guaranteeing social rights, the implementation of a privatizing social security reform and a context of high social conflict that has favoured the articulation of actors and their polarization, finding expression in social protest.

Over more than 20 years and in spite of the context of political violence—especially against trade unionists—and governmental repression, the sociopolitical dynamic allowed for the development of important processes of social mobilization and shaped the construction of a social movement for health with an identity defined and directed towards the struggle for the fundamental right to health (Echeverry- López & Borrero-Ramírez, 2015).

The social mobilization has found expression in the National Health and Social Security Movement (Movimiento Nacional por la Salud y la Seguridad Social), which emerged in 2001 and has organized collective action for the right to health in several regions of the country. More recently, the National Alliance for Health (Alianza Nacional por la Salud- ANSA) or the National Platform for the Right to Health (Mesa Nacional por el Derecho a la Salud) or regional initiatives such as Antioquia's Intersectoral Platform for Health (Mesa Intersectorial de Antioquia por la Salud - MIAS) emerged in interpellation with the state and proposing the establishment of a new health system in Colombia, that guarantees the right to health; or more specific expressions that claim the right to health of the LGBT population or more autonomy as in Valle del Rio Cimitarra or in the North of the Cauca department.

2. ANALYSIS

The following description is a synthesis of the case studies carried out in the aforementioned urban and rural areas of Colombia. This part seeks to analyze the five themes defined in the MSP research project in relation to the case studies.

2.1 Capacity Building

As far as training and capacity building is concerned, it is important to point out some educational and formative initiatives that formed part of the social and community processes and allowed to qualify the enforceability and guarantee of the right to life, health, worker, maintenance in the territory, autonomy and collective self-determination. The processes sought to foster the development of knowledge and capabilities related to human rights, strategic planning, right-to-health provision and others through workshops and schools. The formation

process was accompanied by a diversification of strategies to share and deepen knowledge and strengthen capacities.

The cases show that capacity building processes are strongly linked to the cultural and political context of the region or place. In ethnic and peasant processes strong emphasis is put on the collective construction of territorial workplans, including demands that indicate routes towards the materialization of their conception of identity, territory, autonomy and health. In the case of ACIN, indigenous forms of resistance promote participatory democracy in the construction of municipal "life plans", that apart from substantiating the enforceability of the rights and the political struggle for territory, are based on a specific notion of health and collective rights.

In the case of Valle del Rio Cimitarra the capacity building process was primarily related to the elaboration of development plans, such as the plan for the Rural Peasant Reserve Area (Zonas de Reserva Campesina), in which some lines for the development and financing of productive projects were outlined and possibilities for social investment and infrastructure initiatives in contexts of violence and state repression that have characterized this region described. The capacity building exercises included modules on human rights and the international humanitarian right, analysis of political situations and further discussed the management of hydric resources polluted by diverse economic activities. In the health sector, the traning of midwives and community health agents as well as the management of malaria and leishmaniasis and capabilities for citizen-driven primary health care stood at the center of capacity building activities.

In urban areas such as Bogotá, Medellin and Cali, the initiatives are consolidated in collaboration with national educational institutions, international institutions and local, community-based processes, promoting the discussion of specific topics and the improvement of processes related to the filing of collective demands. In the case of the LGBT population the capacity building was directed at the qualification of leaders and health education strategies. For the workers and collectives of HSJD, questions around the enforceability of economic, social and especially labor rights and the reconstruction of the memory of HSJD, as well as territorial organization and issues around primary health care were relevant. This case further showed the degree of diversification in capacity building processes through socialization strategies making use of mobilizations, galleries, bulletins, handbills, etc. that require different capacities in the management and use of alternative means of communication.

At the People's School of Health in Medellin there have been efforts directed at building capacity around the enforceability of the right to health, which includes the improvement of health knowledge, the incorporation of personal experiences in relation to the enforceability of those rights, the participation in public debates and participative construction and further includes the recognition of subaltern actors of change. Nonetheless, there have been some situations that have hindered the achievement of the objective including the unequal development of tutoring sessions, the low replicability of knowledge between leaders and organizations and the low participation of the leaders in other contexts where *Movimiento por la Salud* has been acting.

Finally, it is important to recognize that capacity building processes seeking to improve the capacity to demand the fulfillment of the right to health have been as diverse as the social actors involved in these processes and have resisted inequities, violence and persecution. In this regard, each process responded to the particular needs of the collective action and defended territories, identities and autonomies, work and health care. Similarly, instruments to co-construct and exchange knowledge through assembly strategies, the elaboration of collective action plans, workshops, discussion rounds and schools in which the fundamental premise is the community knowledge and practice, were developed with participation of experts, academics,

leaders and grassroots organizations. Apart from that, communication strategies were developed at local, national and international levels.

2.2 Knowledge Production

Regarding the production and dissemination of knowledge, several elements can be highlighted. First, in relation to the recovery and strengthening of proper knowledge to foster processes that contribute to the achievement of Health For All as well as in the production of knowledge through participatory research in alliance with academic actors. Second, the dissemination of knowledge incorporates the use of new technologies that allowed them to gain national and even international visibility.

In relation to the first aspect and for the rural context, it is important to highlight the experience of ACIN as the struggle for health is strongly shaped by the identity construction process based on ancestral knowledge, similarly as in Valle del Rio Cimitarra where a rapid participatory diagnostic tool was developed.

In the urban context of Bogotá, the experience of Asotrecol relates to the assimilation of knowledge: it was necessary to generate knowledge on work-related diseases in order to strengthen the technical arguments and respond to the demand of the Occupational Risk Administrator (ORA), companies, disability evaluation boards and the judicial system in general. At the same time it was shown to be necessary to acquire knowledge essential to following legal proceedings in order to strengthen the action in relation to the Ministry of Labor, the Public Ministry and the judicial system. As a product of the subordination imposed by the expert knowledge of the ORA technical team and the EPS (financial health insurance intermediaries), they felt the need to search for information and engage in discussions with other workers but also with lawyers, medical doctors and other health professionals. Upon acquiring knowledge on their medical conditions, they disseminated it among the other workers, consolidating a consultancy. The medical-legal knowledge that they acquired accordingly got directly transmitted in one-to-one dialogues and made workers and ex-workers want to seek the support and technical assistance of ASOTRECOL.

Through alliance, ACIN managed to build their own capacity on technical, technological, professional and postgraduate level in the field of health, generating human resource capacities that in spite of involving few people, improved their capacity to argue against and confront the state; a learning process that allowed for the use of mechanisms to judicially demand rights. The professional and postgraduate training of indigenous leaders helped to create a stronger alliance between academics and the indigenous movement that informed analyses on emerging public health problems related to the right to health. In the HSJD process, the knowledge production was guaranteed by the participation in activities with educational entities and social organization and also through the constitution of organizational and gremial networks and local institutions. As a result of these alliances, several students and activists got engaged in the initiatives, which allowed for significant advances in juridical and historical studies on the San Juan de Dios hospital.

EPLS managed to gain space and visibility in academy by positioning popular education and issues around citizenship in health as a research theme. This has also been an important advance for the organizations, for the MS and for public health knowledge in general: obliging academia to think about its educational practice. The learning process of some leaders that were involved in EPLS and engaged in the construction and disseminating of knowledge on health and social rights, might have been the most important achievement as this followed a horizontal perspective where knowledge and experiences are shared under equal conditions and through a dialogue of knowledge. Knowledge production accordingly covered three components: pedagogical, research and communication of social change - aspects that will be detailed in the following.

ACVC developed a collaboration agreement between Cetam Lav and Unipaz in order to develop a study on the recovery of water sources contaminated by mercury deriving from mining activities in the region, low-cost alternative energy projects and the biological characterization of Linea Amarilla and Ciénaga de San Lorenzo.

In the case of LGBT the knowledge production and dissemination strategy has primarily been linked to observatories including the Observatory of Human Rights Violations and the Observatory on the Violation of the Right to Health of the Santamaría Foundation, that especially focused on the right to health of trans women.

In what concerns the dissemination of knowledge on claims and activities, Asotrecol has primarily used virtual spaces. The website and social media allowed to visibilize Asotrecol especially at international level, which has been essential in terms of political and economic support. The experience shows that it is possible to politically approach and direct the transfer of knowledge towards the claims of rights, that it is essential to create spaces for the exchange between the affected and that the use of this knowledge can become an important instrument to challenge the sectors that traditionally hold technical knowledge, which is a resource of power and defines decisions. Furthermore, the experience shows that the use of virtual resources and especially social media, is a highly valuable mean to disseminate knowledge that the organization acquires in time and also serves as a platform for claims, recognition and channel for the consolidation of national and international support and alliances. In the case of ACVC virtual media and written programs have been developed, including Marcha TV, the Rural Press Agency (Agencia Prensa Rural) and Rural Communities in Resistance (Comunidades campesinas en resistencia).

2.3 Dialogues on Politics and Global Governance

The dialogue on politics and global governance found heterogenous expression in the cases that were analyzed for the Colombian case and it has even been difficult to take account of this dimension in some of the case studies.

The indigenous movement participated in several negotiation processes with the state. In the last years, the Constitutional Court obliged the state to establish negotiation and agreement spaces with indigenous groups, such as the permanent table for the concertation with indigenous groups and organizations that was recognized in 2013 and which includes a chapter on health. Nonetheless, it is recognized that the state systematically fails to comply with the agreements, which has obliged the indigenous movement to draw on contentious actions. In spite of the state's breach, the indigenous groups managed to demand a judicial framework for important public policy such as act 1811 from 1990, Law 691 from 2001, Agreement 326 from 2005 and act 1953 from 2014 (the latter recognizes SISPI).

The collective action led by ASOTRECOL shows the vast management capacity as reflected in the alliances, especially at international level. They quickly understood that the problem could not be resolved on local level and sought to influence on international level. The international lobby and particularly the United States have pressured the Colombian government, especially the Ministry of Labor, to carefully manage the case of ASOTRECOL. While it can not be affirmed that ASOTRECOL has the capacity to influence decision making processes of international organizations such as OIT, the United States Congress, or General Motors, it is possible to affirm that ASOTRECOL managed to influence north american society and its trade unions, who started to pressure the national government to address the ASOTRECOL case. In this regard, ASOTRECOL managed to influence governance in different sectors of the national government without touching its fundamental tasks as an organization.

The LGBT movement opened spaces for dialogue and negotiation with the state through the Sexual and Reproductive Health Table, the Departmental HIV/Aids Committee, the municipal

LGBT table and Departmental Congress (Confluencia Departamental), that allowed for the signature of a declaration of intent, the formulation of a municipal public policy which is in approval process and the publication of a public policy on the guarantee and enforceability of lesbian, gay, bisexual, transgender and intersexuals (LGBTI) in Valle del Cauca. Nonetheless and despite the formal advances, LGBT movements agree that in practice, the state systematically breaches the agreements. At the same time they claim that they continue to be seen as "dangerous subjects" to be controlled by the health sector and that public policy guidelines are limited to infectious disease control and prevention.

Finally, it is important to mention that the dialogue with funding agencies regarding the execution of productive projects foreseen in the Sustainable Development Plan of ACVC resulted in important advances and translated the dialogue on politics and global governance into concrete action. The diverse expressions of the dialogues on politics and global governance show the state of the Colombian People's Health Movement, its relative dispersion and lack of projection in the global sphere.

2.4 Campaigns

In relation to the campaigns and advocacy component, the case studies evidence important elements that point at the reasons for social mobilization in defense of the right to territory, autonomy, health and work as well as salary related demands of health workers.

In rural areas, the struggles for the right to health take up several contextual elements defined and conditioned by the struggles for territory, as in the case of ACIN, who understand the guaranty of the right to health as a guaranty of the right to territory, food sovereignty, right to the recognition of ancestral knowledge, self-governance and autonomy in health as well as the right to access interculturally adequate health services constructed in the territory with professionals from the community and based on Primary Health Care (PHC).

In the case of ACVC, campaigns for the right to health and to territory are reflected in the Plan for Development and Protection of Human Rights as well as in the Sustainable Development Plan by ZRC, the local development plan, in the mobilizations directed at the recognition of peasant reserve areas (ZRC) as judicial figures and the political solution of the armed conflict. They are further reflected in the framework proposals and research around agroecology that seek to minimize environmental impact and find more sustainable means of production.

In the urban context and in relation to the cases on the struggles for the worker's health, we identified collective action that seeks to influence institutional, social and trade union actors as well as in the workers employed by the company, seeking recognition and legitimacy of their struggle in order to pressure the company to respond to their demands. This applied to ASOTRECOL. On international level ASOTRECOL managed to make use of the political opportunities in a context shaped by the negotiations around the Free Trade Agreement between the United States of America and Colombia, which allowed for this process of resistance and struggle related to the right to health of workers not to be marginalized or forgotten. In this regard it became an example of the violations of labor, trade union and health rights and the United States made the resolution of this case a prerequisite for the signature of the agreement with the Colombian government. The advocacy on an international level brought international visibility to the problem and turned it into a central issue for the government and US congress and served to demonstrate the problem of the current and former workers of GM in Bogotá and support the dynamics initiated by ASOTRECOL, giving rise to an oppositional solidarity campaign in the United States, which used a webpage and raised funds to support the resistance that found expression in the installation of tents in front of the US embassy in Bogotá.

In the case of the workers of the San Juan de Dios hospital, campaigns were primarily organized around the recognition of the rights of the workers and the struggle for the

maintenance of the institution, standing for quality and equity in health care provision and being recognized as a victim of the health system. The demands articulated in the campaigns were the following: 1) Payment of labor fees, which forms part of salary related demands; 2) reopening of the institution; 3) Access to good health services for all.

The campaigns and advocacy of the LGBT movement are characterized by the struggle against discrimination, the right to life and human rights of the LGBT population; claims regarding the recognition of their rights and against hate crimes, the recognition of the same values of all bodies, the no-pathologization and the right to the recognition of non-heteronormative gender identities and sexual orientations as well as the recognition of transitory gender identities, the right to access other than sexual and reproductive health services, the design and implementation of differentiated health care provision according to diverse gender identities and sexual orientations and against the symbolic violence exercised by state institutions.

These campaigns and advocacy strategies have been accompanied by a broad repertoire of action such as massive marches, the recovery of ancestral lands, street blockades and exodus or major peasant protests, occupations in colonized areas and the pressure for the recognition of ZRC. These mobilizations emerged in rural context but were brought to urban contexts in order to achieve greater visibility and draw on the support of other sectors such as students, academics and activists.

In struggles of ASOTRECOL, the LGBT movement and HSJD, sit-ins have been another form of protest and took place in front of health service provision institutions, the embassy of the United State and developed in the context of manifestations against the closure of public hospitals in the city, making use of social media to visibilize the denial of health service provision due to discriminatory practices, amongst others.

Among the non-contentious measures, the establishment of spaces for dialogue have been important, such as those created by the state to reach agreements with indigenous groups following the proposals by the Constitutional Court. The subcommission of Health of the Permanent Table for Agreement with indigenous groups and organizations recognized in 2013 (case of ACIN) constitutes an example. Other examples include the Peasant, Ethnic and People's Summit where peasant and indigenous communities expressed the problems that most affected them and defined the primary claims to the government and to the state.

Other non-contentious measures include judicial mechanisms such as petitions, tutelage actions, law suits against health service providers when access to health services was denied, access to antiretroviral drugs or treatments for corporal transformations was hampered. The elaboration of reports on the human rights situation and the establishment of observatories on human rights violations have also been relevant mechanisms.

The case of the School (EPLS) has its particularities, as it is not a social movement but rather a strategy used by social movements based on popular education, where a multiplicity of social organizations converge and create an organizational dynamic, articulated to other forms of systematic struggle by social movements in Medellin. This especially applies to those organizations that participated in all three course cycles of the school and share an identity around capacity building strategies based on popular education. With regard to motivations, the organizations emphasized the need to learn how to defend the right to health, share experiences with others and politically qualify themselves. This category of MSP does not strictly apply in this case, as the primary contributions of EPLS relates to the construction and generation of capacities.

2.5 Consolidation of the Movement in Local Spaces

The Colombian case studies addressed the role of civil society and particularly of activists and workers' organizations, communities, health service users, academics and politicians regarding the generation of organizational processes, networks and social mobilization around Health For All and apart from national dynamics, examined the consolidation of the movement in two contexts shaped by the respective places and times: **i)** urban spaces and **ii)** rural peasant, mining and indigenous territories.

In the following we will describe the characteristics of the consolidation of the movement in relation to the respective case study objects in rural and urban spaces, seeking to identify possible relations between the spaces, at the national and global level and finally draw some conclusions in relation to the research project questions.

2.5.1. Consolidations of the Movement in Urban Spaces

In the following we will describe the experiences of the association of current and former workers of the automobile industry Colmotores, the workers of the San Juan de Dios hospital and surrounding neighborhoods in Bogotá, the LGBT movement in the city of Cali and the organizational processes detonated by the Intersectorial Table for the right to health of Antioquia through the People's School of Health (Escuela Popular de Salud, EPLS).

2.5.1.1. Workers for the Right to Health at the Workplace

Since the end of 2009 and the beginning of 2010, Colombia witnessed the emergence of Associations of sick workers as an expression of resistance, struggle and mobilization around the right to health at the workplace. ASOTERCOL was one of the associations that emerged during that time, their constitution dating to May 2011.

The emergence of these associations did not yet configure a social movement for the right to health at the workplace, but did mark the beginning of social mobilizations that claim and demand that their illnesses of labor origin are recognized as such, treated and that workers receive social and economic benefits according to the specific case.

The creation of these associations strongly relates to the identity former workers managed to construct with respect to their illness, demanding its recognition and the fulfillment of labor and social protection rights. Furthermore, these associations emerged in response to the weakness or disinterest of trade unions in mobilizing around these issues.

In the case of ASOTRECOL, the creation of identity amongst workers was adopted as a key strategy and made it possible to show the commonalities in the identified problems both in terms of the similarities in the pathologies among workers exposed to similar working conditions and in the treatment by Colmotors, the Labor Risk Administration entities, the disability qualification boards and the judicial system.

2.5.1.2. Workers and Communities Supporting the San Juan de Dios Hospital

The case of San Juan de Dios hospital evidences several forms of organization around the defense of the hospital, the right to work, the right to health and the right to the city by workers and the communities, in opposition to the privatization of the hospital and urban renovation strategies in the area of the city where the hospital is located. Two groups shaped the workers' organization of the defense of the hospital: the organization of hospital departments and the consolidation of two general collectives called Community Table: City Health Region (Mesa Comunitaria Ciudad Salud Región) and the San Juan for All group (Grupo San Juan de Todos).

The first group adopted two forms of organization and resistance. The first was a group of workers that performed daily assistance at the installations in order to comply with their work schedule and thereby defend their right to fulfill the work contract, defend the hospital against

liquidation and privatization threats and apply pressure for the reopening of the hospital and at the same time realize capacity building and political as well as artistic identity formation activities. The second group consisted of families of workers that found themselves obliged to adapt the installations of the hospital to residential needs, given the loss of their economic capacities to maintain their residences. This last group is organizationally more disparate. They seek permanency at the installations until the recognition of their benefits and to further establish individual links with community processes outside the hospital.

Apart from the previous organizations that have been involved as workers of San Juan de Dios hospital, there is a second group of community organizations with which some workers are associated,that have defended the right to health, the San Juan de Dios hospital, the permanency in the territory and the right to the city. The study included the Community Table: City Health Region (Mesa Comunitaria Ciudad Salud Región) and the San Juan for All group (Grupo San Juan de Todos).

Communities living in the neighborhoods surrounding the hospital as well as external activists working on dispossession and privatization in urban renewal plans involving the two hospitals and another seven related institutions, participated as members of the Community Table: City Health Region. Given the amplitude of the characteristics and the number of participants, this community organization was not very stable nor did its activities dialogue with government projects or influence relevant discussions.

The San Juan for All group called for the participation of social activists and community members and organized an open-to-the-public school for capacity strengthening around health topics as a strategy for social mobilization, claims and network strengthening.

It is important to note that within the consolidated organizations of workers, each individual generated external networks that helped to conform groups of activists who dedicated efforts to the defense of San Juan de Dios hospital and managed to make the problem known to the public. Several workers pointed at the invisibilization of the organizational processes and related this to the lack of confidence in these types of organizational processes. Furthermore, they gave little importance to the trade unions of the hospital and the Maternal-Child health institute.

2.5.1.3. Actors of the LGBT movement

The LGBT movement of Colombia emerged in the 1970s, led by the university professors León Zuleta and Manuel Velandia in Medellín and Bogotá. In Cali, the first organizations emerged in the 1990s, constituted by homosexual men that transformed HIV/Aids help groups into processes of organization and visibilization of diverse sexual orientations. This processes served as a seed for leadership that made it possible to articulate around common themes and make these visible.

In 2000 and under the influence of the NGO Planeta Paz, the discussion on sexual orientations was placed on the city's agenda and some of the people that participated in the help groups became the first members of the Spiritual Project Quirón. Later some other organizations appeared that addressed these issues through arts, culture and academic reflection in an effort to diminish stigma and discrimination.

With Angelino Garzón from an independent party assuming the governance of Valle del Cauca in 2004, the LGBT movements were more systematically recognized in the department and found spaces for dialogue with the state, eventually evolving in a recognition of the movement as a social and political actor.

When in 2009 Álvaro Miguel Rivera, one of the most visible and active figures of the movement, was killed in Cali, the movement's organizational processes weakened and its activities were temporarily suspended.

2.5.1.4. Convergence of Organizations at Escuela Popular en Salud

The People's School of Health (Escuela Popular en Salud, EPLS) is a popular education strategy implemented as an expression of the health movement: Intersectorial Table for the Right to Health of Antioquia (MIAS) in alliance with the Bogotá NGO Grupo Guillermo Fergusson (GGF) convened three times in the period between 2011 and 2016. The National Faculty of Public Health accompanied the third versioón of the School through its research group *Right to health and social struggles for health in Colombia*.

The EPLS of the Intersectoral Table for the Right to Health of Antioquia (MIAS) is a space of convergence for 23 social organizations from Medellin and some municipalities of Antioquia: health care user associations, patient groups, victim committees, trade unions, organizations of students, professors and pensioners, as well as health gremia.

The organizations of EPLS follow a specific organizational dynamic, coming from different traditions of social struggle in health and other social movements over several decades. Those that have participated in all three EPLS course cycles have an organic articulation with the health movement of Medellin and its repertory of struggle.

This year, EPLS will have a fourth conference and will address the theme of health and peace. The EPLS has made important contributions to the social movement in Medellin and has enriched the dialogue between academia, social movements and popular organizations.

2.5.2. Consolidations of the Movement in rural spaces

In the following we will describe how social movements consolidated in rural spaces, discussing three case studies carried out in Valle del Rio Cimitarra and indigenous communities in the North of the department Cauca.

2.5.2.1. The Peasant and Mining Movement of Valle del Rio Cimitarra

The following description of the consolidation of the peasant and mining movement of Valle del Rio Cimitarra corresponds to three cases that were studied in the region, linked to the experience of the Peasant's Association of Valle del Rio Cimitarra (ACVC). AVCV is a result of the history of experiences, triumphs and frustrations in the peasant and mining struggles of the region.

Community processes around the now non-existent National Peasant’s Organization (Asociación Nacional de Usuarios Campesinos, ANUC), the struggles of small miners, the Land committee of survivors that in 1983 exploited the possibilities of colonization of new territories as a form of resistance against the persecution, displacement and dispossession from their lands, the Cooperative of Medium-side peasants of Antioquia – COOPEMANTIOQUIA that unite in the 1980s to facilitate the autonomous commercialization of agricultural products, avoid the abuse of speculators (Mendoza & Molano, 2009), the regular use and construction of territories, the preservation of the environment, facilitate access to food, resolution of conflicts and negotiations with the state as well as the promotion of community action boards. Furthermore, the Peasant's Coordination of Magdalena Medio, that led the 1982 exodus of the communities towards Barrancabermeja and in 1985 promoted the big march from San Pablo to Cartagena and walked along the Magdalena river for 40 days, the Association of Communal Action of Yondó – ASOCOMUNAL, that in the middle of the paramilitary offensive against the Patriotic Union (Unión Patriótica, UP) and peasants of the region, served as platforms of dialogue with local authorities and the acquisition of credits and machinery for the community crops (Mendoza & Molano, 2009).

After passing through different forms of organization, the peasants and miners constituted the ACVC in 1996 in an assembly of leaders of 120 community action boards from Sur de Bolivar, in the Northeast of Antioquia and the center of Valle de Rio Cimitarra. It has been through this

massive organization that peasants, coca growers and small miners of Valle del Rio Cimitarra were able to confront the crisis in agricultural production, demanding access to land ownership, claiming the recognition of territory and territoriality, participating in the elaboration of public policies, demanding social investment by the state, calling for garanties for the exercise of political rights by the rural population, confronting state and parastate violence and seeking political solutions to the armed conflict.

In the process of organization and mobilization, the communities and leaders consolidated yet other forms of organizations, complementing the activities of ACVC. We highlight the following: mobile and fixed cooperatives that according to the circumstances of the armed conflict allowed to transport food with mules from one village to another and supply the peasants affected by police, military and paramilitary blockades that were set up to hinder the food supply to the guerrillas, with what they needed (ACVC, Rural Press Agency, 2003). This rich experience of cooperatives, including COOPEMEANTIOQUIA, that existed before ACVC, shaped the renaissance of the Farm Cooperative in 2015, the National Multi Active Cooperative for Peace (Cooperativa Multiactiva Nacional por la Paz, COOMUNALPAZ), which was constituted to get rid of intermediaries that were AZOTAN rural areas with their manipulation of the prices. Furthermore, we highlight the permanent regional table for peace of Magdalena Medio (Mesa regional permanente por la paz del Magdalena Medio), that already existed in 1999, as well as the National Platform for Work on Peace of Magdalena Medio (Mesa Nacional Del Magdalena Medio de Trabajo por la Paz), which emerged during the exodus of 103 days and focused on the defense of the lives of Valle del RIo Cimitarra settlers and their human rights. Finally, we highlight the CREDHOS organization (Regional Cooperation for the Defense of Human Rights - Cooperación Regional para la defensa de los derechos humanos) and the Program for Development and Peace of Magdalena Medio (Programa de Desarrollo y Paz del Magdalena Medio, PDPMM), that articulated with the National Table. In the field of human rights and international humanitarian right, the Cooperation of Humanitarian Action for Coexistence and Peace in Northeastern Antioquia was created in december 2004 (Cooperación Humanitaria por la Convivencia y la Paz del Nordeste Antioqueño - CAHUCOPANA) as a response to the humanitarian crisis that raged in Northeastern Antioquia[7]. In an effort to channel activities directed at the enforceability of the rights, including the right to health care, basic sanitation, food and housing, etc. and demand social investment, the Communal Table for Decent Life was created in Yondó in 2005, and was extended to all municipalities under influence of ACVC.

With women assuming the direction of ACVC[8] in replacement of their male partners that were persecuted by the Uribe Vélez government since 2007, the organization assumed a new dynamic, with gender equity not simply referring to women assuming leading positions at ACVC but rather reflecting in a growing number of women getting affiliated to ACVC, the establishment of female committees and scraps as well as the articulation to organizations such as CAUCOPANA and the political and organizational qualification after years of rather passive participation in marches, accompanying their husbands in meetings and cooking for them in contexts recognized as chauvinist.

The struggle for the reactivation of the ZRC led to the first national meeting of ZRC in august 2010, that resulted in the constitution of the National Association of Farm Reserve Areas (Asociación Nacional de Zonas de Reserva Campesina, ANZORC). In this meeting a committee was established that gave impetus to the activation of ZRC of the VRC and it was decided that the

7 Given the enormous displacement due to the extension of the military and paramilitary offensive from the village of Cañaveral to the village of Carrizal de Remedios, the communities of the village Lejanías attempted to constitute a “humanitarian refuge of resistance” that was frustrated by the terror that the peasants experienced, but eventually resulted in the constitution of a human rights defense organization.

8 Since 2003 and 2004 women have been participating in ACVC activities, particularly in the committee for health and productive projects of the community action boards of the territory.

ZRC proposal would be projected from territories all over the country. In August 2011 a national meeting of indigenous, agricultural and afrodescendant communities for land and peace in Colombia took place in Barrancabermeja that promoted the peasant, ethnic and poplar communities' commitment for peace and political solutions to the armed conflict. The struggle for peace, land and territory joined together peasant and popular movements since 2010 and eventually resulted in the constitution of the social and political movement Marcha Patriótica, which is conformed of a variety of organizations from around the country and concentrates the support for a political solution to the armed confrontations between the state, businessmen and FARC-EP. ACVC through ANZORC today forms part of the Peasant and Popular Summit (Cumbre Campesina y Popular), a platform for different rural processes and organizations[9] that since the peasant strike of peasants and indigenous groups in 2013, assumed a central role in the peasant and rural struggles for an integral peasant reform.

The peasant, mining and coca grower organizations have always been accompanied by the Communist Party and Unión Patriótica (UP), before its genocide - paramilitary forces supported by parts of the government and the private sector killed around 4000 members - and after returning as a judicial figure in 2013.

Acting as a peasant and cooperative movement including COOMUNALPAZ, ACVC no longer restricts its activities to the colonization and resistance in a specific territory by assumed national character, particularly in its expression as ACVC-National Agricultural Network (Red Agroecológical Nacional), which allows for a solitary peasant economy approach, defends and promotes food sovereignty and independent management and agricultural autonomy in the territorial control and the construction of territories and territoriality, as well as economic, social and political activities. The struggles constructed a social and political subject that not only defends the corporative interests of the peasants but also proposes transformations in terms of democracy, social justice, peace and national sovereignty.

2.5.2.2. Indigenous Movement

The struggles for health of the indigenous movement can be divided into five periods: the first period comprises the creation of the CRIC between 1971 until 1987, when health was nearly invisible and the struggles were focused on autonomy and the recovery of land.

In the second period, between 1988 and 1996, health was strongly positioned on the agenda by the VIII Regional Conference of CRIC, Toez-Tierradentro in 1988, that defended the organization of regional and national meetings on health and communications directed at the state, demanding this right. Furthermore, the health situation of indigenous groups was described and a step was taken towards Act 1811 from, 1990.

The period between 1997 and 2001 corresponds to the creation of an independent institutionality shaped by the new political opportunities offered by the state through Law 100 from 1993. In this regard, the X Regional Conference of the CRIS, that took place in Silvia - Cauca, created the indigenous EPS—Indigenous Association of Cauca (AIC)—as a health insurer and the IPS-I as a health service provider, seeking to guarantee the right to health according to the worldview of indigenous communities.

The period between 2002 and 2010 corresponds to the validation of the proper and intercultural health system (Sistema de Salud Propio e Intercultural, SISPI) among the

9 Of the Cumbre Agraria, Étnica, Campesina y Popular form part of the following organizations: Mesa de Interlocución Agraria - MIA, Marcha Patriótica, el Coordinador Nacional Agrario - CNA, Congreso de los Pueblos, Proceso de Comunidades Negras - PCN, Mesa de Unidad Agraria - MUA, Coalición de Movimientos y Organizaciones Sociales de Colombia - COMOSOC, Organización Nacional Indígena de Colombia - ONIC, el Movimiento por la Constituyente Popular - MCP, Federación Nacional Sindical Unitaria Agropecuaria, FENSUAGRO, Asociación nacional de Zonas de Reserva Campesina – ANZORC y Asociación Campesina Popular

indigenous groups and its national recognition. Since 2002, in the zone conference of ACIN in Jámbalo the consolidation of SISPI was defined. Between 2011 and 2015, the struggle for auto-governance in health became autonomous and in 2011, Law 1450 recognized the SISPI as public policy.

3. CONCLUSIONS

The Colombian case study shows that global and national movements articulated around Health For All and the right to health do not always connect to regional and local processes which follow objectives and promote struggles that do not necessarily fit global or national processes but rather respond to regional and local contexts and needs. This obliges us to re-think articulations between global and national processes with those efforts at the local level directed at the fulfillment of the right to health.

This is why capacity strengthening, the generation and dissemination of knowledge, dialogues for policies and governance, the development of campaigns and the consolidation of movements towards Health For All or enforceability of the right to health, have assumed different forms according to the social actors involved, the circumstances and local contexts of social inequality, discrimination, violence, persecution, sociopolitical violence and resistance. In this regard, the cases we examined show that each process responds to particular needs and includes the defense of life, territories, identities and autonomies, work, health protection of workers, health care and the recognition of difference.

The form and content of each component described in relation to the urban movements is diverse and strongly linked to social processes around the right to health at the workplace, resistance to privatization in health care and dispossession associated with urban renovation projects related to health care businesses and medical tourism, as well as the recognition of the right to health in the context of the recognition of the right for social citizenship of sexual diversities and in more general terms, the struggles around the definition of the health and social security system, its provision guaranties and access to health care.

In rural, peasant and mining contexts, the form and content of the previously mentioned components rather relates to the relations between social movements and political forces that define the dynamics of the peasant and indigenous struggles seeking to guarantee popular and proper health service provision in the absence of official health services or the claim for autonomy of indigenous and peasant communities, the creation of social, environmental and cultural conditions for health, food sovereignty and nutritional security.

In this study we found that although local processes do not necessarily appear to be connected to each other, nor to national movements dedicated to the defense of the right to health and social security, nor to regional and global dynamics of the People's health movement, these processes have been influenced by the People's Health Movement struggles and MSP approaches by national activists and locals linked to these movements, especially in urban and ethnic-indigenous contexts.

The exploration of issues around capacity building, knowledge construction and dissemination as well as the consolidation of social movements in local processes contributes to the understanding of the ways civil society has established links to SPT, in spite of the circumstances shaped by repression and violence against those that dared to challenge the hegemony of class, ethnicity and gender.

The cases of Valle del Rio Cimitarra suggest that the relationship between social movements and political parties can bring about ethical-political transformations of the social movements and victories in health. These cases show that the consolidation of the peasant, mining and coca growing movement in contexts of high levels of repression and violent confrontations profited

from its close relation with left-wing parties as these contributed to overcome purely individual, family and gremial interests within the movement, define the character of the struggle and of the identity construction and practice as social and political subjects and adjust the horizon of transformation, allowing for a shift from material transformations of the living and working conditions towards more profound changes that propose structural economic, social and political reforms. At the same time, the cases show that struggles for health are implicit in struggles for living and working conditions at the core of most of the social movements' outlook and transcend levels of consciousness and corporative or sectoral action.

Finally, the Colombian case studies show that achieving Health For All and the right to health is not restricted to victories in health service provision but relates to the day-to-day of the collective actors, its needs, living and working conditions and accordingly involves the guarantee of individual and collective rights such as the right to territory, food sovereignty, the right to work, to recognition and respect regarding differences and the right to full participation of subaltern social actors.

4. REFERENCES

ACVC. (9 de Diciembre de 2003). Agencia Prensa Rural. Recuperado el 25 de Abril de 2015, de http://www.prensarural.org/acvc20031209

ACVC. (2010). Informe sobre la situacion minera y de derechos humanos en el Nordeste Antioqueño. Agencia prensa rural.

ACVC. (2012). Plan de Desarrollo Sostenible de la Zona de Reserva Campesina del Valle del Rio Cimitarra. Barrancabermeja.

ACVC gana premio de emprendimiento. (19 de Noviembre de 2014). Semanario VOZ.

Almeida, Celia. Reforma del Sector Salud y equidad en América Latina y el Caribe. Revista Gerencia y Sistemas de Salud, 4(9), 2005, 6-60.

Alonso, M. A. Conflicto armado y configuración regional. El caso del Magdalena Medio. Medellín: Editorial Universidad de Antioquia 1997.

Borda, F. (Noviembre de 1998). mamacoca.org. Recuperado el 21 de Abril de 2015, de Guia practica del ordenamiento territorial en Colombia: http://www.mamacoca.org/e_book_Compendio_rural/Orlando_Fals_Borda_guia_practica_ordenamiento.htm

Borda, O. F. (2000). Acción y espacio, autonomías en la nueva republica. Bogotá: Tercer mundo.

Borrero-Ramírez, Yadira E. & Echeverry López, María E. Balance de la investigación nacional sobre acción colectiva y movimientos sociales por la salud en Colombia. Rev. Gerenc. Polit. Salud, Bogotá (Colombia), 13 (26): 76-89, enero-junio de 2014

Borrero-Ramírez, Yadira E. La reforma del sector salud y los conflictos clasistas en Colombia: el caso de la Ley 100 (Trabajo de Grado - Maestría en Sociología). Universidad del Valle - Facultad de Ciencias Sociales y Económicas, Santiago de Cali. 2008.

Borrero-Ramírez, Yadira E. "Luchas por la salud en Colombia 1994-2011: hacia la construcción de un Movimiento Nacional por la Salud. Tesis para optar el título de PhD en Salud Pública, Universidad de Antioquia, Medellín, 2013.

Borrero-Ramírez, Yadira E. Lucha por la salud en Colombia. Cali: Pontificia Universidad Javeriana, Colciencias, Universidad de Antioquia, 2014.

Bravo, A. M. (2009). En medio del Magdalena Medio. Bogotá: CINEP

Breilh J. Epidemiología: economía política y salud. 7ª ed. Quito: Corporación Editora Nacional - Universidad Andina Simón Bolívar; 2010. p. 35-44

Breilh J. La determinación social de la salud como herramienta de transformación hacia una nueva salud pública (salud colectiva). Rev. Fac. Nac. Salud Pública 2013; 31(supl. 1): S13-S27. http://www.scielo.org.co/pdf/rfnsp/v31s1/v31s1a02.pdf

Campesina, V. (22 de Enero de 2006). Via campesina.org. Recuperado el 21 de 03 de 2015, de http://www.hegoa.ehu.es/congreso/bilbo/doku/bat/soberania_alimentaria.pdf

Campesino, L. (Marzo de 2015).

CEPAL. (1999). Consensos urbanos. Aportes del Plan de Acción Regional de América Latina y el Caribe Sobre Acentamientos Humanos.

CEPAL. (2009). tercera Reunión de Seguimiento de la declaración de Brasilia. Centro Latinoamericano y Caribeño de Demografia.

CINEP. (s.f.). El programa de desarrollo y paz del Magdalena medio. CINEP.

CMA. (2002). Informe Cumbre Mundial por el derecho a la alimentacion. Roma: Organizacion de las Naciones Unidas para la Agricultura y la Alimentación.

Comité de derechos sociales economicos y culturales. (1999). 20º periodo de sesiones. Ginebra.

Consejo nacional de política económica y social. (31 de Marzo de 2008). Documento CONPES social. Politica NAcional de Seguridad Alimentaria y Nutricional (PSAN). Bogotá, Colombia.

DANE. (2005). Departamento Nacional de Estadistica. Recuperado el 26 de Mayo de 2015, de Censo general 2005: http://www.dane.gov.co/index.php/estadisticas-sociales/necesidades-basicas-insatisfechas-nbi

DANE. (2013). Departamento administrativo Nacional de estadistica. Recuperado el 26 de Mayo de 2015, de http://www.dane.gov.co/index.php/estadisticas-sociales

De Currea, Victor. El derecho a la salud en Colombia, Diez años de frustraciones. Bogotá: Instituto Latinoamericano de Servicios Legales Alternativos y Ediciones Ántropos. 2003.

De Sousa Santos, B. Epistemologías del Sur. Utopía y Praxis Latinoamericana [en línea] 2011, 16 (Julio-Septiembre) Disponible en:<http://www.redalyc.org/articulo.oa?id=27920007003> ISSN 1315-5216

De Sousa, J. F. "Sistematización: un instrumento pedagógico en los proyectos de desarrollo sustentable". En: Revista internacional Magisterio. No.33 junio-julio de 2008. Bogotá. Página 10

Delgado, A. Anotaciones a la política del partido comunista, En: Controversia no. 190 (junio 2008). Bogotá: IPC, FNC, CINEP, CR, ENS, 2008. En: Bogotá D.C http://biblioteca.clacso.edu.ar/Colombia/cinep/20100926125523/anotacionesalapolitica.pdf

Echeverry-López, María E. & Borrero-Ramírez, Yadira E. Protestas sociales por la salud en Colombia: la lucha por el derecho fundamental a la salud, 1994-2010. Cad. Saúde Pública. 2015, vol.31, n.2, pp. 354-364.

Echeverry, María E. Acción colectiva por la salud 1994-2002. Medellín: Documento de trabajo. Sin publicar. 2011.

Equipo Desde Abajo. Editorial: Contra la emergencia social, frente amplio por el derecho a la salud. Edición No. 154, febrero de 2010.

Godelier, M. (1989). Lo ideal y lo material: pensamientos, economías, sociedades. Barcelona: Taurus.

Gramsci A, 1975. Quadernos de la Cárcel. Edición Crítica Del Instituto Gramsci. Organizado por Gerratana V, Turín, 1975. Citado por Semeraro G, 1999. Gramsci e a Sociedade Civil. Editora Vozes, Petropolis, RJ, Brazil

Gramsci A. Cuadernos de la Cárcel (Tomo III). Edición Crítica Del Instituto Gramsci. A Cargo de Valentino Gerratana. México, Ediciones Era, 1985 (Primera Edición en español)

Gramsci A. Cuadernos d la Cárcel (Tomo V). Edición Crítica Del Instituto Gramsci. A Cargo de Valentino Gerratana. México, Ediciones Era, 1979 (Primera Edición en español)

Harvey, D. El "nuevo" imperialismo: acumulación por desposesión - Socialist register 2004 (enero 2005). Buenos Aires: CLACSO, 2005. http://biblioteca.clacso.edu.ar/clacso/se/20130702120830/harvey.pdf

https://www.dnp.gov.co/programas/agricultura/estadisticas-del-sector-agropecuario/Paginas/Resultados-de-Pol%C3%ADtica-P%C3%BAblica.aspx

Hernández, Mario. El derecho a la salud en Colombia: obstáculos estructurales para su realización. Revista Salud Pública, 2(2), 2000, 121- 144.

Hernández, Mario. El concepto de equidad y el debate sobre lo justo en salud Revista Salud Pública, 10(1), 2008, 72-82.

Homedes, Nuria & Ugalde, Antonio, A. Las reformas de salud neoliberales en América Latina: una visión crítica a través de dos estudios de caso. Revista Panamericana de Salud Pública, 17(3), 210-220, 2005.

INER. (2000). Magdalena Medio, Desarrollo regional: Una tarea común Universidad-Región . Medellin: Universidad de Antioquia.

Misas, Gabriel. La ruptura de los 90 del gradualismo al colapso. Bogotá, Universidad Nacional de Colombia, 2002.

Laza C, Ruiz C, "El saber de la partera tradicional del valle del río Cimitarra: cuidando la vida.”. En: Colombia Avances En Enfermería ISSN: 0121-4500 Ed: Universidad Nacional De Colombia Bogotá v.27 fasc.2 p.113 - 126 ,2009

Ley 135 de 1961 (Diciembre 13) “Sobre reforma social agraria DIARIO OFICIAL. AÑO XCVIII. N. 30691. 20, DICIEMBRE, 1961. PAG. 801 disponible en http://www.incoder.gov.co/documentos/Normatividad/Leyes/Leyes%201961/ley_1961_135.pdf

Londoño D.M. y Atehortúa G.J. Los pasos en el camino de la sistematización. Decisión ENERO - ABRIL 2011 disponible en http://www.crefal.edu.mx/decisio/images/pdf/decisio_28/decisio28_saber5.pdf

Machado, A. (2009). La reforma rural, una deuda social y politica. Bogotá: Gente Nueva.

Mejía M.R. La sistematización como proceso investigativo o la búsqueda de la episteme de las prácticas. Planeta Paz Expedición Pedagógica Nacional Programa Ondas de Colciencias disponible en http://www.cepalforja.org/sistem/sistem_old/sistematizacion_como_proceso_investigativo.pdf

Mendoza, C. y Molano, F. (2009). Voces de la Historia. Reconstrucción de las memorias de la ACVC. Disponible en: http://prensarural.org/spip/spip.php?article1861

Midgley, G. 1997. Mixing Methods: developing Systemic Intervention. In: Mingers, J., and Gill, A. (Eds) 1997. Multimethodology. England: Wiley

Movimiento Nacional por la Salud y la Seguridad Social. Por una salud con principios. Desde Abajo, Edición 155. Marzo de 2010.

Moreno S, C A. y Zamora A, E. A. Acumulación capitalista y nueva espacialidad en el magdalena medio. Ciencia Política; núm. 13 (2012): Espacialidad, política y acumulación de capital 1909-230X disponible en http://www.bdigital.unal.edu.co/38594/#sthash.AsyffaZ1.dpuf

Mujica, J. M. (1 de Noviembre de 2012). Grupo de estudios en ciencia politica y administracion publica. Recuperado el 15 de Abril de 2015, de GECIPAP: http://gecipap.blogspot.com/2012/10/el-ordenamiento-territorial-en-el.html

Naciones unidas. (2010). El derecho a la alimetnacion adecuada. Folleto inforativo No 34. Ginebra: Naciones Unidas.

Ocampo, Dayan. Perfil de la acción colectiva en salud motivada por la crisis hospitalaria en Colombia, 1994 - 2008 (Tesis de pregado). Medellín, Colombia: Facultad Nacional de Salud Pública “Hector Abad Gómez”. Universidad de Antioquia. 2012.

OPI. (2011). International Peace Observatory. Recuperado el Mayo de 2015, de Contexto regional el Magdalena Medio: http://www.peaceobservatory.org/es/124/contexto-regional-el-magdalena-medio

OPI. (2014). Observatorio de Paz Integral del Magdalena Medio. Recuperado el 5 de Mayo de 2015, de http://www.opi.org.co/paginas/cartografia.htm

Ospina R. Unión Patriótica Expedientes contra el olvido Centro de Memoria, Paz y Reconciliación 2012 ISBN: 978-958-8411-52-1 http://centromemoria.gov.co/wp-content/uploads/2015/05/Union-Patriotica-expedientes-contra-el-olvido.pdf

PAHO/ OMS Carta de Ottawa para la promoción de la salud disponible en http://www1.paho.org/spanish/HPP/OttawaCharterSp.pdf

Paez, Y. A., & Garcia, J. A. (2013). Diagnostico del territorio Magdalena Medio. Barrancabermeja: Centro de estudios regionales del Magdalena Medio.

Peña, Y. t. (2010). El ordenamiento territorial y su construccion social en Colombia: ¿un instrumento para el desarrollo sustentable? Revista Colombiana de Geografia.

Pérez Martínez. La conformación territorial en Colombia: entre el conflicto, el desarrollo y el destierro Cuadernos de Desarrollo Rural (51), 2004 http://www.javeriana.edu.co/ier/recursos_user/documentos/revista51/61_90.pdf

PRENSA RURAL http://prensarural.org/spip/spip.php?article17444

Redacción Salud. Crisis del sistema de Salud. Deudas a hospitales y clínicas ya suman $5.8 billones. El Espectador, 5 de noviembre de 2015. Recuperado de: http://www.elespectador.com/noticias/salud/deudas-hospitales-y-clinicas-ya-suman-58-billones-articulo-597295

República de Colombia. Constitución Política, 1991

Rodríguez, De La Torre y Miranda, La salud mental en situaciones de conflicto armado Biomédica 2002;22:337-46 disponible en www.revistabiomedica.org/index.php/biomedica/article/download/1183/1298

Romero, C. M., & Molano, F. (27 de Enero de 2009). Voces de la hisoria. Agencia prensa rural.

Stedile J. y Martínez De C. Publicado como capítulo del libro BRASIL SEM FOME, editado por el Ministerio de Desenvolvimento Social-MDS, Brasilia, abril de 2011 http://www.alainet.org/images/SOBERANIA%20ALIMENTARIA%20es.pdf

Torres– Tovar, Mauricio. Balance del gobierno de Uribe en el tema de salud. Ocho años de inseguridad social en salud. Desde Abajo, Edición No.157, Junio de 2010A.

Torres-Tovar, Mauricio. Colombia: declaratoria de emergencia social. Salvavidas para el negocio de la salud. Le Monde Diplomatique, edición Colombia No. 86, febrero de 2010B.

Torres-Tovar, Mauricio. Lucha social contra la privatización de la salud. Bogotá: Ediciones CINEP, 2013.

Uribe, Mónica. La contienda por la reforma del sistema de salud en Colombia (1990-2006) (Trabajo de Grado-Doctorado en Ciencia Social). Colegio de México, Centro de Estudios Sociológicos, México, DF, 2009

Uribe, Mónica. (Coord.). ¿Mercado regula o competencia sin control? Las reformas de la salud en Colombia, 1995-2011. En Los vaivenes de las políticas sociales en Argentina, Colombia, Chile, México y Uruguay (pp. 33-80). México: Editorial Porrúa y Universidad de Guanajuato, 2011

Vélez, Marcela. La salud en Colombia: pasado, presente y futuro de un sistema en crisis. Bogotá: Editorial Debate, 2016.