2008

Pan American Health Organization

best practices in gender, ethnicity and health

# WARMI II

## Building Bridges between the Community and the Health Services with a Gender and Intercultural Approach

Pan American Health Organization
Regional Office of the World Health Organization

# WARMI II

Integrated Health Coordination Program PROCOSI

Building Bridges between the Community and Health Services
with a Gender and Intercultural Approach

Erika Silva de la Vega

Pan American Health Organization
Regional Office of the World Health Organization

PROCOSI

Best Practices in Gender, Ethnicity and Health.
Washington, D.C.: PAHO, 2008

The mention of certain businesses or commercial names does not imply that the Pan American Health Organization approves or recommends them with preference to others.

The opinions expressed in this publication are of the authors and not necessarily of those of the Pan American Health Organization.

| | |
|---|---|
| Author: | Erika Silva de la Vega |
| Editor: | Rigliana Portugal Escóbar |
| Design and Layout: | Román Orellana, Creativa Comunicación & Publicidad |
| Printing: | Artes Gráficas Sagitario SRL. |

La Paz, Bolivia 2008

Se publica también es español (2008) con el título:
WARMI II Construyendo Puentes entre la Comunidad y los Servicios de Salud con Enfoque de Género e Interculturalidad.

***Pan American Health Organization (PAHO)***

Mirta Roses Periago
Director

Marijke Velzeboer Salcedo
Gender, Ethnicity and Health Coordinator

Esmeralda Luz Burbano Jaramillo
Gender, Ethnicity and Health Consultant

***Integrated Health Coordination Program (PROCOSI)***

Wendy Sue McFarren
Executive Director

Ignacio Carreño Ayala
Program Manager

Cecilia Espinoza Hurtado
Administration and Finances Manager

Amparo Ergueta Tejerina
New Economic Initiatives Manager

Rigliana Portugal Escóbar
Head of Communications

***Project Team (2004 - 2005)***

Erika Silva de la Vega
Project Coordinator, PROCOSI

Flor Angulo
Technical Advisor, Manuela Ramos Organization, Peru

Gary Shaye
Executive Director Save the Children

Rosmery Mollo
Ruth Callisaya
Porfiria Mollinedo
Save the Children Facilitators

José Murguía
Executive Director Project Concern International

Mónica Almaraz
Vilma Benavides
Yolanda Medrano
Glenda Vega
Project Concern International Facilitators

# TABLE OF CONTENTS

# PRESENTATION

The "Best Practices Incorporating a Gender Equality Perspective in Health" contest at an observance of International Women's Day was held on March 8 at the Pan American Health Organization (PAHO). The contest aimed to recognize two best practices from the Americas.

To guarantee regional cover, the contest was held using various virtual means of communication and 44 experiences were presented from 18 countries. One of the two best practices selected was:

***"Building Bridges between the Community and the Health Services with a Gender and Intercultural Approach", Integrated Health Coordination Program (PROCOSI).***

By emphasizing empowering women, community participation and a gender and cultural-based approach, this good practice has contributed to reducing maternal and infant mortality in Calamarca and Morochata, two municipalities in rural Bolivia, which are predominantly indigenous. The community promoters worked with women actively participating to empower their members to learn more about reproductive health and their rights and demand and obtain access to quality health care. The women also managed to have men, municipal authorities and health providers work together to strengthen their rights and demands.

The PAHO Gender, Ethnicity and Health Department is proud to present this publication, which provides a model for other institutions to use, replicate and adapt the methodology to other contexts.

Dr. Marijke Velzeboer Salcedo
Gender, Ethnicity and Health Department Coordinator

# SUMMARY

Bolivia has a population of approximately 9 million, with over 37% living in rural areas. The majority of this population is indigenous. The highest rates of maternal mortality are found among indigenous women. Maternal mortality is linked to delays suffered by women when seeking and receiving treatment; they do not recognize signs of danger, which may be fatal; they wait too long before deciding to seek treatment, specifically they take too long to reach the health service establishment; when they do seek treatment, it is lacking. These delays are more apparent in rural and indigenous areas where women often have little or no schooling, can not take decisions about their own health and where the health services are often far away both physically and culturally.

Save the Children and Project Concern International, both members of the PROCOSI Network, worked on reducing maternal mortality rates in two rural municipalities by implementing an educational project. This project (WARMI II) was financed by the Corporación Andina de Fomento (CAF). Women's organizations present in the project area were given the funds needed to implement their own health-related projects.

This intervention demonstrated that a) Educating and empowering women reduces maternal deaths and improves women's sexual and reproductive health and b) The delays that cause maternal mortality in rural, indigenous areas can be reduced by working on low-cost actions that focus on gender and culture where Women's Community Organizations and local promoters help women overcome the obstacles that prevent them from receiving life-saving healthcare services.

"We thought we'd die if we ate toasted peanuts. We decided to take the issue of retained placentas as our subproject. This doesn't happen because you eat toasted peanuts."

## 1. WHY DID WE DO IT? - *The background*

Close to 9 million people live in Bolivia, a country located in the heart of South America. Sixty two percent of the population identifies itself as part of one of the 37 ethnic groups of the country. The Aymara and Quechua-speaking communities make up the majority of the population (1) which is heavily concentrated in rural areas. Over 37% of Bolivians live in rural communities where living conditions have worsened in the last few years, as compared to the urban zones, and are increasingly unequal. Income-sources are decreasing and 90% of the population is classified as poor (2).

Health indicators show that women in rural areas have on average 5.5 children by the end of their reproductive life, almost double the number for urban women (3). Access to health services is low and home births are still widespread amongst the poorest, a fact reflected in high maternal and infant mortality rates. Given this context, indigenous people, especially women, are the most excluded from the country`s development and display the highest rates of poverty, illiteracy or lack of education

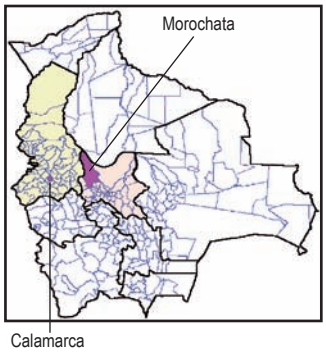
Faced with this situation, the Integrated Health Coordination Program (PROCOSI) identified that a strategy was needed to reduce maternal mortality in rural areas, and recognized that quality health services are not sufficient. Key health determinants affect women's lives causing delays in their search for health care. "Women suffer various delays when seeking timely healthcare. Firstly, they miss the opportunity to save themselves because they do not recognize dangerous signals (first delay), they postpone the decision to seek attention (second delay), take too long to arrive at health service facilities (third delay) and receive substandard or slow attention at the health service facility (fourth delay)" (4). These delays are even more apparent in rural or indigenous populations due to factors such as illiteracy or lack of education in women, which limit women´s knowledge about their own fertility and other aspects of their biology. Other factors include women´s lack of information regarding their sexual and reproductive rights and their inability to make decisions about their own health due to unequal power relations within the couple or the community, among others. In addition, health service facilities are culturally and physically distant and social networks do not exist that promote communications between the community and health service facilities.

If health program designers can identify these delays more clearly and act more strategically it is possible to help improve women's reproductive health and reduce maternal mortality rates.

SOCIOECONOMIC INEQUALITIES
Maternal Mortality
- Urban = 262 x 100 000 nb
- Rural = 563 x 100 000 nb
Infant Mortality:
- Rural: 67 x 1000 nb
- Urban: 44 x 1000 nb
High Fecundity:
- 5,5: rural
- 3,1: urban
Home delivery:
- Quintil poorest: 70,5 %
- Quintil richest: 1,4%
Source: UDAPE

## 2. WHAT WERE WE LOOKING FOR? - *Action plan*

The project was implemented in Calamarca and Morochata, two rural municipalities with high infant and maternal mortality rates in the departments of La Paz and Cochabamba, respectively. The population is primarely Aymara in Calamarca and Quechua in Morochata.




## PROJECT OBJECTIVE

Contribute to the reduction of maternal mortality in the rural municipalities of Calamarca and Morochata by improving women`s Sexual and Reproductive Health.

## DEVELOPMENT OBJECTIVE

To build links between the community and health service facilities with a gender, intercultural and community participation approach.

## EXPECTED RESULTS

- Women's capacity is strengthened to exercise their sexual and reproductive rights and look after their own health.
- Women's knowledge regarding their bodies and pregnancy (anatomy and physiology) is increased. Their capacity to identify changes, alterations and risks to their health is also improved.
- Women and men seek out health care in a timely way for problems that affect their sexual and reproductive health and their children's health.
- Health services facilities adapt their way of working with women to the cultural context and respond quickly to their demands.
- Gender relations among women and their partners are more equal

# 3. HOW DID WE DO IT? *Implementation process*

Approximately 15 years ago Save the Children, a member of the PROCOSI Network, developed an educational strategy for the rural area called "Warmi"; a Quechua and Aymara word that means woman. The strategy aimed to resolve problems at the community level. Later on, the Manuela Ramos Organization in Peru, through its ReproSalud (5) project, adapted, systematized and improved the "Warmi" strategy to work with Women's Community Organizations (WCO) and resolve Sexual and Reproductive Health (SRH) problems in rural and peri-urban areas in Peru.

Based on these experiences, PROCOSI modified the methodology so that it could help reduce the delays related to maternal mortality in Bolivian municipalities. This methodology, which is presented below, is called Warmi II (6).

Using this new methodology two member organizations from the PROCOSI Network, Save the Children and Project Concern, implemented the project "Building Bridges between the Community and the Health Services with a Gender and Intercultural Approach" from 2004 to 2005. The Corporación Andina de Fomento (CAF) supported the project technically and financially.

## MAIN STAGES IN PROJECT DEVELOPMENT

**Selection of Municipalities**

Selection criteria. Poverty levels, high fecundity rates, high female illiteracy rates, high maternal and infant mortality rates, and rural municipalities with predominantly indigenous population groups.

**Situational Diagnosis**

The Situational Diagnosis was carried out in every community within the municipality. Project implementers collected information about: Existence of Women's Community Organizations, formal and informal community authorities, operations hours, distance and staffing of health service facilities. Information was also collected on transportation routes and infrastructure, road conditions, community and patron saint festivals, agricultural calendar, fair days, etc. Information was gathered on all community aspects that could favor or hinder the progress of the project.

**Selection of WCO**

Those involved in implementing the program organized a contest in coordination with local authorities to select the various Women`s Community Organizations. The WCO dramatize a SRH problem that affects women in their community. Selection criteria included: number of years the group has been in existence, group cohesion, and number of members.

**Baseline**

The NGOs interviewed men and women of reproductive age in each municipality on SRH knowledge, attitudes and practices. Interviewers applied focus group techniques to men and women within the community and also participated in lengthy interviews to authorities and key informants. NGOs also collected information from Civil Registers and Health Services.

**Autodiagnostic**

Project facilitators trough qualitative and participatory techniques tried to understand women's knowledge, values and traditions relating to their lives and SRH. They encouraged women to carry out a self-diagnosis to identify the most pressing SRH problems in their community and furthermore to choose the most relevant issue they wished to focus on during the project.

**SRH Community Projects**

Once women identified their most pressing problem, the facilitators encouraged them to identify the possible key causes of the problem. On the basis of this analysis, women designed the micro project (subproject) they wished to carry out, which was generally educational or informational. The women's organization received resources for the subproject, which it was responsible for implementing, monitoring and supervising.

**Negotiations with Health Services**

The project activities within the health establishments were designed to improve the services based on women's needs. In the budget, women defined how resources would be used to purchase supplies and how to make their stay at the health center more comfortable and adequate to their needs.

**Male Participation**

Once the women were trained, the WCO decided how to incorporate the men into the program. Subsequently, training for infant survival and male SRH begun.

**Community Evaluation**

The WCO directed and presented the results achieved with the subproject to the community and authorities. Women evaluated the expected goals, the carried out activities, coordination and success with health services, number of promoters and stakeholders, the management of resources and implementation, among other aspects.

**Final evaluation**

The evaluation was done surveying women and men in the community using the same instruments and ndicators as the baseline. The qualitative evaluation was done by interviewing promoters, women, health staff, local authorities, etc. Information was gathered from the Civil Registry and Health Services.

## SELECTION OF WCO


Photograpy: WARMI II Project

To have an impact on the population, the project proposed directly targeting over 60% of women of reproductive age (WoRA) in each municipality. The municipality was divided into sectors around a health service facility. A WCO was chosen in each sector to work with 400 to 600 women of reproductive age in their community and outlying communities. Community Organizations were invited by the municipal authorities to enter the contest held in each health sector where the WCO recreated a SRH problem faced in their community for the purpose of the contest. The project worked with local authorities and health workers to choose the organization that showed the best group cohesion, largest number of members and that it had been in existence for the longest period of time. The number of WCOs chosen depended on how many were needed to adequately cover a minimum of 60% of women in all the communities within the municipalities. 5 WCOs were chosen in Calamarca and 7 in Morochata.

## SELF-DIAGNOSTIC

Women from each WCO chosen conducted a diagnostic of the most relevant reproductive health problems facing the women in their community, prioritized one problem, and analyzed it. They identified what they did and did not know about how their bodies function and about the problem they had chosen. In the end the women all decided how they would approach their specified problem.


Photograpy: WARMI II Project

The problem is depicted as a drawing of a tree. Similar to people's health, the tree can be healthy or sick. The body is represented by the trunk and the roots provide food and life. If the roots are not healthy then the fruit will be weak and sick. As with the tree, our SRH problems also have roots and fruits - causes and consequences for women's health and survival.


Photograpy: WARMI II Project

The women used the roots to identify what they believed were the causes of their health conditions and identified the problem. They used the fruits to identify the effects that the problem had on their health.

The self-diagnostic generates information about the women's beliefs and practices and helps health service providers understand a female point of view.

## COMMUNITY PROJECT

Once the diagnostic is complete, each WCO prepares a community project to address the causes they consider that women can influence and change.

This is an educational project because the causes identified as problems are usually expressed in sentences such as, "we don't know how to look after ourselves"; "we don't know why…; " we don't know".., etc.

The project also has an organizational strengthening component in order to help it run smoothly, including: training sessions in accounting, monitoring and evaluation, and purchasing materials such as typewriters, calculators, tables, desks, stationery, and others.

*For every 25 to 30 women in each community, the WCO and the community elect a woman, who is literate; speak Spanish, and the community native language. The chosen women is trained as a promoter by the project team and is taught in teaching methods and in the contents of each module. The promoter will then subsequently train 25 women from her community after each module.*

*The project does not use technical or scientific terms. It promotes using commonly used terms in the community, setting goals such as: "we want the women to learn about a specific topic"; and goals such as "x number of women in the grass-root organization", "x number of women in the community".*

Photograpy: WARMI II Project

The third component of the project includes activities to strengthen the quality of health services, from the women's perspective, with sessions on how to negotiate with health workers the quality of care, and the purchase supplies. The WCO then donates these supplies to health services so that the women's stay in the clinic is more comfortable.

When the WCO designed the project, it identified targets such as the following: how many women would benefit, which communities it will work with, how many promoters are needed, what will be the supervisory and monitoring activities, what resources are needed to ensure that the health service is more welcoming and addresses needs, etc. Finally, the WCO worked on a budget to implement the project.

The micro-projects have an average cost of $US 5000; no more than 10% can be allocated to strengthening the grass-root organization and another 10% to the health service. The women's organization receives funding for their project. They are also responsible for implementing and monitoring it.

The women community organization (WCO) chooses a project coordinator and a treasurer. From this moment the WCO has a "core team" responsible for the project, made up of:

- President of the WCO
- Coordinator of the community project
- Treasurer

The core team is trained in accounting and monitoring tools to be used to administer and implement the project.

During the training sessions (27 in all) women's local and traditional understanding is recuperated and linked to the biomedical knowledge. The community promoter then transmits this integrated knowledge to the women in their own language. Each training module begins with an analysis of gender issues that have an impact on the reproductive health aspect being addressed. The training covers 7 modules:

1) normal physiology and gender,
2) pregnancy, pre and postpartum,
3) sexually transmitted infections,
4) contraception,
5) self-esteem and negotiation,
6) living without violence, and
7) essential healthcare for children below the age of 5.

***Ilustrative Activities of Community Projects***

√ Strenghtening of the Women Community Organization.
√ Capacity building of Leader Team Members in project management and organization.
√ Basic Equipment for the Women Community Organization.
√ Selection workshop of community promoters.
√ Training sessions of promoters in SSR modules, communicational and participative techniques, used of educational material, etc.
√ Replica workshops where each promoter at the end of above modules teaches women in their community.
√ Training workshops to the "Core Team" in technical and administrative follow up of the community project.
√ Supervition activities of the "Core Team".
√ Information meetings about the progress of the project to local, municipal authorities and health personnel.
√ Negotiation meetings with health services.
√ Purchase of equipment and materials to be donated to the health services.
√ Community evaluation.
√ Proposed counterpart of Women Community Organizations.

Once the training is finished with the women, it begins with the men using the same modules but excluding the self-esteem and negotiation modules, which are only for women. Male promoters trained the men in the community.

## COORDINATION WITH COMMUNITY AND MUNICIPAL AUTHORITIES

The core team holds meetings with the authorities to maintain a permanent flow of information, receive support and coordinate activities throughout the project.

## PROJECT EVALUATION

Once the activities end, the community project is evaluated over 2 day period in a participative manner by the core team, the female stakeholders, the health workers and community authorities.

The women carry out the evaluation based on the following guidelines:

- extent to which each activity has fulfilled its goals,
- the level of knowledge acquired,
- performance of core team,
- the perception of the community authorities and health workers,
- the knowledge and skills of the promoters.

Photograpy: WARMI II Project

*The results are presented to the community with the help of facilitators. The WCO prepares the results to be presented at the meeting using colorful tables, visual aids and drawings. The presentation compares the initial levels, which led to the project being set up, with the end resultss. Expressions such as: "we're two or three times better, we've doubled or tripled our knowledge" are used.*

## 4. WHO PARTICIPATED?

Various actors were involved in this project and their capacities led to a synergy that gave energy to all activities:

- The Corporación Andina de Fomento (CAF), through their community development branch, was a strategic partner for PROCOSI, providing financing and flexibility so that the WCO could administer the community projects and the project could adapt according to the needs of each community.
- The projects PROSIN and Socios para el Desarrollo provided technical assistance from the Manuela Ramos Organization from Peru and adapted the educational materials to the Bolivian context.
- The Manuela Ramos Organization from Peru transferred the methodology and trained the staff from PROCOSI and the implementing partners.
- The members of the PROCOSI Network: Save The Children and Project Concern International were the implementing partners in Calamarca and Morochata respectively. The leadership and enthusiasm displayed by the Executive Director of Save the Children was integral to the project's success.
- The 12 Women's Community Organizations in the municipalities of Calamarca and Morchata implemented and administered the community projects.
- The Municipal Governments of Morochata and Calamarca.
- The Project Coordinator from PROCOSI who formed synergies with the organizations mentioned above to make the project a success and received the approval of the Ministry of Health and Sports and of the Departmental Health Offices.
- The technical staff from PROCOSI working on Infant Survival supported the transferal of the infant survival module and the Communications staff provided extra material and illustrations more appropriate for use in Bolivia.
- The Ministry of Health and Sports, the Departmental Health Services in Cochabamba and La Paz, and the Health Services facilities.

## THE PROJECT'S GUIDING PRINCIPLES

### WOMEN'S EMPOWERMENT

Photography: WARMI II Project

The empowerment of women was designed to encourage them to be "subjects" of their own lives and to develop an understanding regarding their circumstances and social environment.

The project encouraged the women to become aware of the power relations in their lives and to develop skills and capacities to have a reasonable level of control over their future. The women learned communicative skills to be able to train other members of their communities to explain and negotiate their needs. The WCO became empowered by designing, administering and implementing the community projects.

## MEN'S PARTICIPATION

At the end of the training modules on Sexual and Reproductive Health for women, the men began the similar training sessions, at the request of the women, mainly in the key healthcare practices for newborns and children under the age of 5.

Later on, the men were trained on Sexual and Reproductive Health modules. The training budget and activities were included in the WCO community projects. Male promoters were trained and they in turn trained other men in the community. Each session started with an analysis of the advantages of relationships based on equality, which allow both women and men to live healthy, happy lives.

## COMMUNITY PARTICIPATION

The project created conditions that encouraged women in rural areas to defend and exercise their rights as citizens and to decide which were the best solutions to the problems of a sexual and reproductive nature.

Women's genuine participation implies that they are present during all of the project stages: from problem identification and analysis, trough the design and implementation of solutions, to the evaluation of project activities. As a result, women are not considered passive recipients of goods and services but rather as active agents of change.

## GENDER APPROACH

The gender-based approach in the project was evident in:

- The self-diagnosis; for women to understand and analyze the relations between men and women in their communities. They reflect upon socialization processes and the causes and effects that relations between men and women have on reproductive health.

- Teaching material development and training activities where a gender-based focus was incorporated; women reflected upon forms of discrimination with a focus on women's rights.

- The community subprojects that strengthen women's self-esteem; women can prove to themselves and to the community that they can lead projects, take responsibility in the prevention of reproductive health problems and defend their rights within their personal, family and community environments.

- Men's incorporation into the project: they reflect upon the advantages of relations based on equality so that both women and men can live healthy, happy lives.

*"I've learned about my body and I now know that if I get sick I have to go to a health center", "I've learned about my body and how it works", "I've learned how to be healthy and happy", "...I didn't know there were so many things in my body or what they were for, knowing all this Is going to help me In the future".*

## AN INTERCULTURAL APPROACH

The project focused on the importance of mutual respect and the dignity of all participants; women´s cultural identity, knowledge, practices, doubts and queries were recognized and valued. The training sessions combined western knowledge with women's local knowledge. This integrated knowledge was subsequently transmitted to the women and men.

The work with the men and women was carried out in their own language, Aymara or Quechua, by community promoters (male and female).

## 5. WHAT DID WE ACHIEVE? - *Specific project result*

Increased levels of knowledge and improved attitudes could be seen in two areas:

1) For the groups of women who participated in the training this increase was measured through tests at the beginning and end of the training sessions for each module (entry and exit tests).

2) For all women of reproductive age within the municipality this increase was measured through a survey at the beginning and end of the project. Qualitative information was also gathered from focal groups and in-depth interviews.

*"...we didn't know we had rights but now we do and no one can abuse us, not even our husbands..."*

*"My husband used to make me sleep naked in the patio if I didn't want to have sex, but now the project has taught me that I have sexual rights and I don't let him treat me badly - we even went to the police about it. People say we're loudmouths because we don't let anyone abuse us any more."*

Table No. 1 Proposed and achieved goals

| MUNICIPALITY | PROPOSED GOAL | ACHIVED GOALS |
|---|---|---|
| Calamarca | 1200 WoRA trained | 1701 |
| | 6000 indirect beneficiaries | 8000 |
| | 800 male trained | 800 |
| Morochata | 1800 WoRA trained | 1972 |
| | 8000 indirect beneficiaries | 9510 |
| | 800 males | 800 |

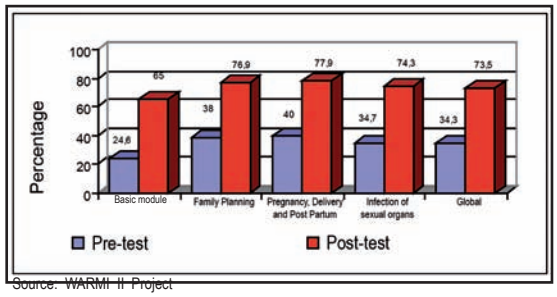
Source: WARMI II Project

## KNOWLEDGE, ATTITUDES AND PRACTICES

There was a significant increase in knowledge, attitudes and practices among the men and women with regards to their health, bodies, and reproductive cycle.

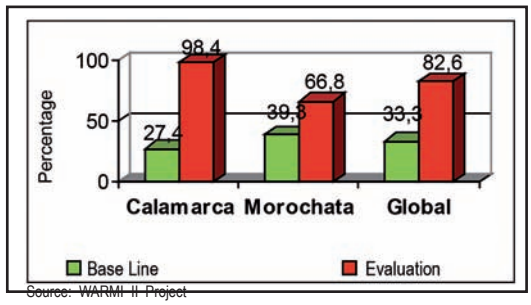
Knowledge levels increased in all subjects included in the program by over 95% on average in both municipalities.

Graphic No. 1 Global Results of initial and final tests of each module in women of reproductive age




Source: WARMI II Project

Graphic No. 2 Women who know how contraceptive methods work




Source: WARMI II Project

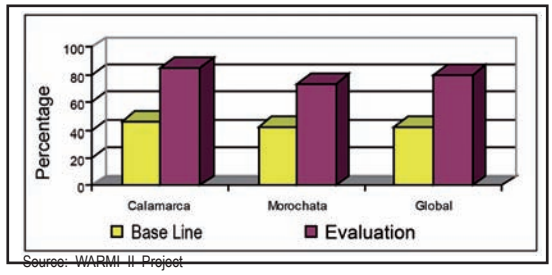
*At the Chullpa K'asa Health Center in Morochata, the health workers say that "there's been an increase in requests for smear tests. Before the project started the training workshops in the communities, the women never came for testing but now they do."*

## RELATIONSHIP WITH SIGNIFICANT OTHER

Positive changes occurred in family relations, especially between couples. Specifically these included changes regarding violence against women as well as joint decision making regarding important issues.

Women are now able to decide how many children they wish to have as well as when to have them. They are able to make decisions about their bodies, health, and to have sex when they wish to. They are able to express their feelings and thoughts openly in public. Finally, they are also able to express their right to live in a violence-free environment, to receive prenatal check-ups and healthcare during their pregnancy and their right to life, and others.

Graphic No. 3 Percentage of women who decide with their partners when to have sexual intercourse



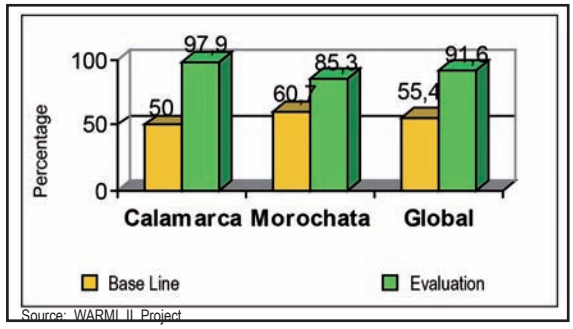

Source: WARMI II Project

As a result, a significant change has occurred in power relations and in men's and women's attitudes regarding how to satisfy their needs, including health needs. This change has improved the standard of living within their communities and was achieved respecting cultural traditions and patterns.

## USE AND WORKING OF HEALTH SERVICES

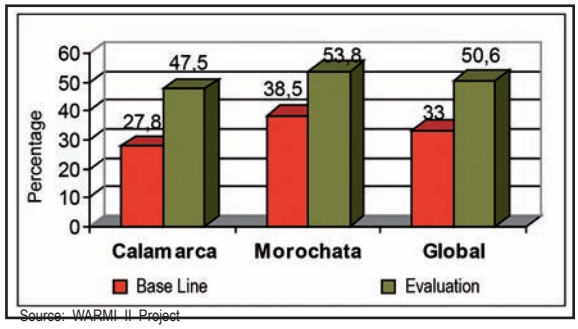
Another important project outcome is seen in how the population uses the health services and how the community establishes conditions for their operation (opening hours, staff treatment of patients, quality of attention, etc).

Graphic No. 4 Women in search of adequate care when acknowledge at least two dangerous signs during pregnancy




Source: WARMI II Project

Graphic No. 5 Women who report having at least four prenatal control visits during pregnancy

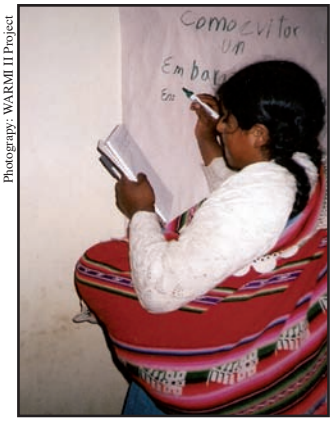



Source: WARMI II Project

From their own perspectives, women identified factors that affected the quality and care given in health services. Through the project, women could affect changes in health services. For example, the rooms were improved by putting in wooden floors, curtains and screens. The beds were upgraded and mattresses, blankets, sheets, towels and curtains were purchased. The women decided to install kitchens in order to warm food and heaters were bought to keep the maternity wards warm.

The donations had two effects; women gained a sense of ownership over the health facilities and more women visited the centers.

Photography: WARMI II Project


Photograpy: WARMI II Project

## SOCIAL EMPOWERMENT

Social empowerment and capacity building to prepare and implement productive and social projects (making and selling handicrafts, education projects for the community, placing women in public posts, etc.) are other significant results.

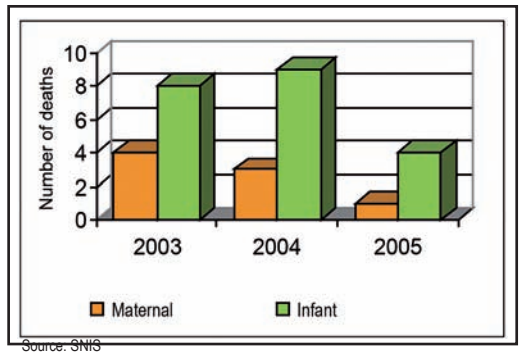
Because the women have developed the skills necessary to exercise their reproductive rights, they have also started to exercise their citizens' rights and take part in community development. Now women participate effectively in community activities, are listened to and respected when they give an opinion, and have begun to fill public offices in their unions and town halls.

Understanding how to develop a subproject and implementing it, has helped the women to develop their ability to analyze and prioritize problems. This is evident through their writing of new projects for social and economic development in their community, which they are now presented to different financers and being managed by them. They have also negotiated to have some of their demands included in the Municipal Annual Work Plan and Municipal Laws.

## IMPACT ON HEALTH

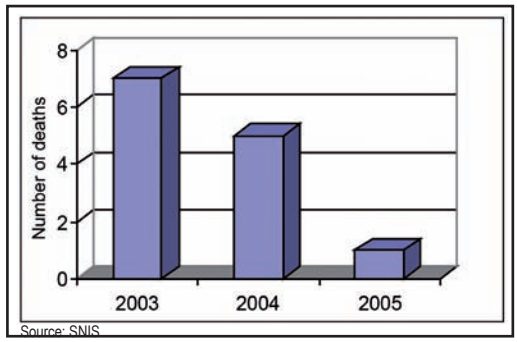
The results and impact on health is observed in a drop in maternal and infant deaths in the project communities as compared to before the project. Maternal deaths fell by approximately 75% and infant deaths by 50%.

Graphic No. 6 Maternal and infant deaths




Calamarca

Graphic No. 7 Maternal deaths*




Morochata

*Infant deaths were not reported

## 6. HOW DO WE SUSTAIN IT?

To guarantee that the results are sustained, the project design and implementation included the following steps:

- Working with existing WCOs in the community, who learned to design and administer projects to solve problems in the community. By strengthening these organizations technically and administratively, these organizations became key actors in local development and guarantee sustainability. On the other hand, the WCO as an organizational unit helps the women's demands to be more viable when negotiating with the local governments and health services. This also makes it easier for the women to participate in other areas such as a political arena and unions. This again reinforces women's self-esteem and respect.

- Replicating training sessions with community promoters and in the local language. Promoters continue their work even when the project is over.

- Transferring knowledge to teenagers. In the post-project phase, girls between the ages of 9 and 13 were identified who had learned about Sexual and Reproductive Health from their mothers. This demonstrates that women are making a conscious effort to spare their daughters from unwanted experiences that they themselves experienced. In this manner the newly acquired knowledge is passed down to future generations.

- Motivating to study and to learn to read and write. The women stated that they felt prepared to learn to read and write; those who already knew wanted to start reading again. Some women who were illiterate started literacy courses at the end of the project.

- Including men. At first the men were in opposition to women administering economic resources, were unhappy with the changes in their partners and were curious about the activities being held. However, after speaking with the women, the men started to work with them, help organize the meetings, prepare snacks and look after the smaller children while the women attended the sessions. The biggest success was that the men recognized that it was important for the women to learn and asked to also be included in the training sessions.

*Many women say that they never spoke but just sat at community meetings at one side, "...like a piece of furniture, but now we talk and give our opinion. I never used to talk but now no one can shut me up, I'm not as shy and I've learned a lot." "My husband was always insulting me, he called me stupid and asked what I could possibly know and told me I should stay quiet in a corner but now I know I can learn anything I want and I'm not stupid like my husband said...."*

## 7. WHAT HAVE WE LEARNED? *Experiences and lessons learned*

Woman's education and empowerment reduces maternal mortality rates and improves Sexual and Reproductive Health. The delays linked to maternal mortality can be reduced with low cost interventions at the local level, helping women to overcome the obstacles that prevent them from receiving treatment that can help save their lives. Actions such as:

- improving the knowledge of how the body functions,
- increasing community's knowledge of complications that may indicate that a woman's life is in danger,
- educating women, their partners and families, about when to search for help and where to go when complications arise,
- improving women's status so that they feel capable of taking key decisions concerning their health,
- improving the links between health service providers and communities,
- improving the relationship between the health services and the community based on how the community defines quality healthcare,
- encouraging communities to have a transportation plan In case of an emergency,
- ensure that women receive quality healthcare in health service facilities.

"The project started with the idea of only working with women of reproductive age, but local conditions demonstrated that it is also necessary to work with children and men so that the level of knowledge and shared experiences would break the vicious circle that replicates the problems down through generations."
Rómulo Rodríguez. Cultural and Community Development Department. CAF. Caracas, Venezuela. Personal communication.

## WHAT FACTORS MADE THIS EXPERIENCE A TRANSFORMATIVE ONE?

Among the most important factors, we should mention:

- A clear conceptual framework. The project revolved around tackling the 4 delays that put women at risk of dying when seeking and obtaining health care. Key to the project's success was understanding the delays confronted by indigenous women in rural areas and adapting a participatory, educational methodology to responded adequately to these problems.

- The participatory self-diagnostic which provides women with time to reflect upon their Sexual and Reproductive Health problems and issues that affect their lives. This helps women to see that they are not alone, that other women suffer from the same problems and that it is much easier to solve them in a group. On the other hand, the self-diagnosis helps provide for a space of intercultural knowledge exchange between NGO project facilitators and the women within a spirit of respecting ¨the other¨.

- Community promoters carry out the training sessions in the local language. The female promoters were chosen by their community and shared the same living conditions, culture and language. This generated a more horizontal learning process, adapted to local conditions, with greater sustainability and greater acceptance.

- WCO´s administration of funds and implementation of the subprojects. One of the most important factors for the project's success was that the funds were transferred to the WCO to run the project. This step increased women's self-esteem, empowered them and their organizations, and it strengthened local organizations. This allowed

women to enter spaces traditionally held by men and to become more respected within their communities.

- Improved quality of Health services based on women's perspective and demands. This is another innovative concept since it is usually the provider who decides how services should be improved from a biomedical point of view. The project generated an intercultural dialogue between the community and the health services and encouraged women to offer their opinions and express their needs: correspondingly health service staff listened and changed their practices according to women's demands.

- Didactic material. The teaching materials were designed so that women with little or no schooling could understand them allowing the most excluded to participate.

## WHAT PROBLEMS DID WE FACE?

At the beginning of the project the men and local male authorities reacted negatively, particularly to women's administration of funds and to the educational sessions. In order to ensure men´s support for the project, it was important to socialize it among the different organizations and the general public. This process should not only occur at the beginning of the project but throughout.

## OUR RECOMMENDATIONS

Taking into consideration the model's effectiveness, the importance of the results achieved and the need to apply it within other contexts similar or different to Bolivia, we believe that it is possible to implement this type of project if the following considerations and recommendations are taken into account:

- The methodology is applicable to rural and indigenous populations where schooling levels are low.
- Management staff within implementing and financing organizations should understand the importance of women's empowerment to community development.
- Implementing NGOs or organizations should consider transferring funds to Women Community Organizations, so that they can carry out and administer their own projects.
- The methodology should be closely followed because each step in the process is built upon the previous one.
- Training materials should be adapted to the local context and language.
- Promoters should belong to the community and be selected by their community.
- Women's community organizations should already exist in the project intervention area.

## 8. BIBLIOGRAPHY


(1) Instituto Nacional de Estadística. Censo de Vivienda y Población. La Paz; 2001.

(2) Unidad de Análisis de Políticas Sociales y Económicas UDAPE. Organización Panamericana de la Salud OPS. Caracterización de la exclusión en salud en Bolivia. La Paz; 2004.

(3) Instituto Nacional de Estadística. Encuesta Nacional de Demografía en Salud ENDSA. La Paz; 2003.

(4) E. Ransom and N. Yinger. Making motherhood safer: overcoming obstacles on the pathway to care, Population Reference Bureau, Washington, DC .February; 2002.

(5) Estrategia del Proyecto ReproSalud. Movimiento Manuela Ramos. Lima; 2003.

(6) Programa de Coordinación en Salud Integral PROCOSI. Construyendo Puentes entre la Comunidad y los Servicios de Salud con un Enfoque de Género e Interculturalidad. La Paz; 2003.