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LESSONS LEARNED IN WORKING WITH INDIGENOUS WOMEN AND HEALTH: THE EXPERIENCE IN GUATEMALA

This document discusses the development of the project "Education and Self-Care in Health as a Means to Strengthen the Participation and Leadership of Indigenous Women in Eight Communities of Guatemala." The project has evolved from its initial service-related objectives to a dynamic process that is succeeding in fully incorporating women as partners in project management. The document includes the lessons learned about gender relations in the indigenous context of the selected populations, and it ends with a series of conclusions and recommendations.

CONTENTS

1. Situation of the Indigenous Population in Guatemala

Guatemala is a multiethnic, multicultural, multilingual nation whose diversity is manifested in four main ethnic communities: an indigenous majority (60%), broken down into roughly 21 linguistic communities (the largest of which are Mam, Kaqchikel, Q'echí, and K'iché); a minority, known as Ladinos, of predominantly Spanish ancestry; the Garifunas (roughly 15,000 people), descendants of the first contingents of Africans who arrived in Guatemala; and the Xincas (2,000 people), of uncertain origin.

The conditions of the country's indigenous population can be seen in the socioeconomic indicators of the geographical area in which they reside, predominantly in the altiplano region. The western part of Guatemala, with more than 80% of the country's indigenous population, exhibits the highest levels of poverty (77% in 1989) and the greatest aftereffects of the armed conflict in the departments of the so-called ZONAPAZ. Among these, it has the most limited access to health services, with an infant mortality rate of 65 per 1,000 live births, maternal mortality of 113 per 1,000 live births (one of the highest in the past four years), life expectancy at birth of 59.8 years, and low birthweight (41.8%, in contrast to 16% for the rural Ladino population). It also has the highest illiteracy rates (75% among women), with average schooling of 1.8 years for indigenous men and 0.9 years for indigenous women.

2. Initial Goal

The need to address the issue of gender specifically in the indigenous context came to the forefront in 1990, when three indigenous women participated in a group with Ladino women during a course on gender organized under the project "Comprehensive Health of Women in Central America" (SIMCA). One of the recommendations that emerged from the course was to place indigenous women in a category of their own, since gender issues are manifested differently in their culture.

Within the framework of the Central American initiative *Health: A Bridge for Peace*, the proposed profile for the project on indigenous women in Guatemala was presented. Costa Rica presented a similar proposal. As a result of this action, donors expressed an interest in developing a subregional project that could link the initiatives. Guatemala assumed responsibility for preparing the project, basing it on the indigenous populations located on the border with its Central American neighbors.

Thus, two projects were presented: a subregional project and a national project for Guatemala. The donors felt that the process should begin with the Guatemalan project in order to evaluate at a later date the desirability of designing and supporting a subregional project focused on the health of indigenous women.

3. Scope

In its initial version, the goal of the Guatemalan project was to create a new model of care suited to the needs of indigenous women. Subsequently, the goal of modifying all health services provided to women across the lifespan was changed to encompass only those aspects of health care related to women's reproductive health. Since the scope was still ambitious, the initial goal was further modified by focusing on the series of modifications that needed to be made in service delivery at the health centers and involving indigenous women in the identification of the needed modifications. This is currently the main thrust of the indigenous woman's project and its long-term scope.

The other expected results were geared toward developing research on the status and situation of indigenous women in the various ethnic contexts and toward achieving greater participation by these women in different local activities. During the reformulation of the indigenous women's project, the scope was increasingly limited to more concrete activities, such as radio broadcasts and the training of health promoters to work with indigenous women.

4. A Problematic Relationship: Gender-Ethnicity-Public Health

The linguistic and cultural wealth of Guatemala, the complexity of ethnic relations, and the neglect to which indigenous women have been subject imposed strong demands from the very beginning of project development. All the social services, and especially the health services, face these problems in attempting to meet the needs of a population with an indigenous majority.

One area to be addressed, which was not clearly defined at the start of project design, was the link between the gender approach and the ethnic approach in their theoretical and conceptual, as well as strategic and methodological aspects.

4.1 *Gender*

Initially, gender was conceived in three aspects, all tenuously elaborated: gender as a theoretical approach; gender as a work methodology, and gender as a political stance to promote women's participation in light of their marginal status with respect to men.

The hypothesis underlying the decision to begin the process with the indigenous women themselves is that increasing their awareness would serve as the starting point for change, turning these women into active players and changing the way they relate to other women, men, and social institutions.

4.2 *Ethnicity*

The point of departure in this area was the reality of cultural discrimination by the Ladino population against the indigenous population as a whole. In the health services, this appears in the marginalization of and discrimination against traditional medicine and the indigenous population's cosmic view of health and disease. Even during project design, which was a joint effort, there was a glimpse of ethnic conflicts between the predominantly Ladino staff and the indigenous women.

4.3 *Public Health*

Another problem was the lack of autonomous, informed, and active participation by indigenous women in the health centers, since such facilities practice a paternalistic, utilitarian form of community participation that does not allow for interaction with the knowledge, beliefs, and experiences of the population.

In order to resolve this problem, work began with the assumption that health is the product of the living conditions of human beings and not the result of their biological condition. Health, therefore, is not achieved through the efforts of the health sector, but rather, through an intersectoral approach and individual effort (promotion of self-care). This means that the democratization of knowledge and its use are based on essential skills that the population must acquire. The manner in which these skills are imparted should be tailored to the specific characteristics of the population, such as age, sex, ethnic group, religion, and rurality.

In order to articulate these three elements and guarantee positive outcomes for each of them, the following objectives were established:

- to promote the participation of indigenous women in order to empower them and make them aware of the importance of health;

- to ensure that the health services develop a new method of working with indigenous communities;

- to transform the health services, in keeping with the changes proposed as a result of the findings described in this proposal.

For this purpose, the following strategies were proposed:

- joint implementation of the project by staff from the Ministry of Public Health and indigenous women in order to strengthen collaborative efforts and ensure project sustainability:

- the participation of bilingual indigenous women who are geographically close to the health services in order to foster communication between the different ethnic groups;

- the participation of health services selected because of their work with the indigenous population and the fact that they have indigenous staff;

- development, first and foremost, of the participants' gender identity, thereby lessening the ethnic conflict that could arise between the indigenous and Ladino women;

- upgrading of the training of health services staff, particularly the project staff or district delegates, in gender and ethnicity.

5. Project Design and Implementation

It was determined that this project would not address the topic of ethnic discrimination, but rather, gender discrimination in an ethnic context. In order to formulate the project, some 15 to 20 indigenous women from the K'iché and Kaqchikel ethnic groups, the majority of them from NGOs, were brought together in 10 workshops.

The workshops in themselves were an encounter between the Ladino group in charge of project design (an anthropologist, a social worker with experience in gender issues, and a psychologist with experience in health, PAHO/WHO) and the indigenous women. In these workshops the suffering caused by 500 years of discrimination against indigenous peoples was discussed, which created an opportunity for catharsis and denunciations of the weaknesses of the State with regard to the indigenous population. It was also recognized that the indigenous women blamed their health problems on causes such as the lack of education, work, land, and recreation.

The project design was completed in 1991 and presented for approval. The group that had been responsible for the presentation spent a year without financing, which, coupled with the ethnic frictions described, caused the group to disband and led to doubts as to whether the desired outcomes could be achieved.

In 1992, negotiations were held with health sector authorities to determine the municipalities in which the project would be implemented and to identify the individuals within the health centers or health posts who were going to work with the indigenous women. By year's end the funds had been granted, and implementation began.

The initial activities to determine the municipalities and health centers that would be involved in the implementation of the project included the identification of the people

responsible for the project at the level local. Eight municipalities were selected: four from the K'iché area and four from the Kaqchikel area. The individuals selected received guidance from the directors of the health centers, who gave the responsibility for the project to those customarily in charge of community participation activities involving health promoters or midwives. The district executors or delegates were social workers, nurses, and rural health technicians. Here it should be noted that, with respect to the health service hierarchy in the health centers, such personnel have the least power in terms of decision-making; as to midwives, their place in the hierarchy in traditional medicine is not known.

One of the first actions was to call together the indigenous women that would form the women's group or council. The criteria for selecting those who would sit on the council were specific: they had to be women who had already had some type of linkage with the health service, who were community leaders, or who were selected by existing community groups. They also had to be bilingual to facilitate communication with the institutional staff. These criteria, which were based on the experience gained in the workshops on project design, were designed to forge closer ties between the indigenous women and the institution and to build a bridge of communication to monolingual women who had no contact with the services.

Thus, groups of 10 to 15 women were formed who, for the most part, were midwives. These women would subsequently participate in the technical meetings of the health services, in order to describe the health care needs of indigenous women.

Among the delegates' activities with the indigenous women's councils were workshops on gender and health geared to increasing women's awareness about their status and its effects on their health and well-being. These workshops yielded a diagnosis of the health situation of women and activities to increase women's awareness about self-care with respect to their health. The frequency of the meetings varied with each health center and began at different points in 1993.

The start of the project depended on the amount of time that the medical director allowed the delegate, as well as the time that the delegate had to devote to gender workshops as the point of departure for increasing the women's awareness. As expected, the groups that were formed exhibited different degrees of interest and sensitivity with respect to the topic, which also implied the need for different approaches.

One of the first problems that had to be addressed was the fact that the health services' community work with midwives, health promoters, and other agents usually involved a small payment for their transportation and per diem. The level of poverty in which these women live makes it impossible in most cases for them to devote time to self-improvement. The domestic burden borne by women must be reduced or managed

with funds that make it possible for them to overcome their economic situation. Since the women's participation was viewed as volunteer work to improve living conditions for themselves and their community, economic assistance was provided for intensive training but not regular meetings. Furthermore, during the workshops, the women requested training in areas traditionally considered women's occupations—sewing, cooking, handicrafts production—to learn something that could help them to improve their precarious economic situation.

In 1994, the groups made more progress. One of the most valuable activities in self-care was convincing the women to have Pap tests and then to serve as promoters (as part of a team with health workers), setting an example at events to promote testing for cervical cancer for all women in the population. Events of this nature were also held in 1995 and 1996, despite the problems associated with conducting local activities without the support of the other central government health programs.

The impact of the process can be clearly observed in the increasing acceptance by indigenous women of a Western health procedure, the detection of sexually transmitted diseases, and the inclusion of vaginal creams in the list of essential drugs for some of the health services.

Another far-reaching experience, owing to the intercultural nature of the project, was the training provided by specialized NGOs in the utilization of medicinal plants for the treatment of the country's 10 principle illnesses. Providing this information to the indigenous women's councils had a two-fold purpose: to lend greater legitimacy to the work of these women by giving them more systematic knowledge about the use of the plants, and to introduce institutional personnel to the field of traditional medicine.

In late 1996, processing laboratories were installed at three health centers; here, the indigenous women prepare their medicinal plants. This is a process that has barely commenced, due to the need to achieve legitimacy in the eyes of the central government, which has not yet happened.

The project's intercultural approach focuses on two activities: events to promote the Pap test and workshops on the use of medicinal plants. This was not part of the original plan, however. It is the result of both the strategies developed to meet the identified needs and the experience gained in this area.

At the local level, the project has run into difficulties in getting the central government to assume, participate, and accept the programmed activities. Although, administratively, the project is under the Ministry of Health, it is viewed as a group of ad hoc activities that are marginal to the planning at the area and health center level. Consequently, the delegates are considered to be acting on their own and not in the name

of the health sector, which means that the rest of the health workers are not actively involved in the project.

These local problems become even more acute at the central level. The experience gained by the project in health promotion through radio programs developed and moderated by indigenous women, the production of health education materials, and the strategy of working woman to woman to promote self-care are methodologies that are not accepted as project contributions that ought to be incorporated into regular health activities. Instead, they are considered a local experience.

These methodologies are based on the premise that the knowledge and life experiences of indigenous women have a value comparable to scientific knowledge about health promotion.

PAHO has provided the project with technical cooperation at every level, from its direct work with the indigenous women, where there has been evaluation and validation of the strategies selected, the methodologies applied, and the progress of the project, up to the policy-making, management, and orientation levels, promoting a political stance in support of this issue. At the same time, PAHO has strengthened the country's nascent indigenous women's movements in an effort to support the women's work at the local level. This technical cooperation is based on joint definition of the strategies to follow in the execution of project activities—an activity involving the national counterparts at all levels of care and representatives of indigenous women's groups—and on verification that the activities have actually been carried out, the strategies applied, and the expected results achieved.

6. Historical and Political Context

The project unfolded during a number of critical points in the country's political context. In the design phase (1991-1992), inclusion of the topic "indigenous peoples" was viewed as an initial step in addressing issues related to these population groups, but there was no definite policy in this regard. At the global level, a movement by indigenous peoples to reclaim their rights was taking shape, sparked by the celebration of the International Year for the World's Indigenous People.

During the implementation period (1993-1994), political events that both helped and hindered the project process occurred. In 1993, when the project began, an initial training course that dealt with aspects related to gender and ethnicity was offered in order to articulate the two approaches in the project. The participants were local indigenous women who had been selected to form the indigenous women's councils. Unfortunately, on the first day of the course, there was a coup d'état against the government of President Serrano Elías, which made it difficult to conduct the course. There was even

an investigation by the authorities into why the indigenous women were meeting. Such assemblies were viewed with suspicion and put the women in danger.

The same problem occurred at the local level, to the degree that some women's groups had to inform the mayor that they were meeting to discuss women's health issues. Generally speaking, it was not the time to form local community groups, because of the recent events and the history of massacres suffered by the indigenous population.

Notwithstanding the constraints within the country, the worldwide indigenous movement gathered strength. Thus, in late 1993 PAHO adopted a resolution affirming its commitment to promote the initiative "Health of the Indigenous Peoples of the Americas" (SAPIA).

In 1994, indigenous leader Rigoberta Menchú won the Nobel Peace Prize, an event that sparked a great deal of controversy, especially among Ladino and indigenous groups. The project suffered, because people at the local level considered it to be linked with Rigoberta Menchú, and there was general fear of repercussions.

After the initial two-year testing phase, the project was extended, with the respective reformulation aimed at bolstering indigenous women's leadership in the health system. This was linked to the start of the health sector reform promoted by the Ministry of Public Health, which proposed changes in the health care model. This made it possible in 1995 to transfer the experience gained during the project's testing phase to the geographical areas where the sectoral reform was being carried out with the support of Sweden—reform that was also targeted to indigenous women.

During 1995-1996, the subject of indigenous peoples became an important political issue; the impetus toward a peace agreement and the signing of the "Agreement on the Identity of the Indigenous Populations" lent importance to a topic that had to be addressed and not swept under the table. With the signing of this Agreement, indigenous organizations received strong backing, and women's participation in them was encouraged, underscoring the topic of women in that context. In this climate, indigenous women began to question their status as woman within the indigenous context. Other indigenous women's groups had similar experiences.

During this period, pressure to incorporate the gender and ethnic approach into the new model of health care and into government programs was steadily mounting. The signing of the peace accords in late 1996 marked the beginning of a definitive search for mechanisms and strategies to bring about substantive changes in the status of women and the indigenous population.

In 1997 a new stage is beginning with the creation of a forum on women where, it is hoped, this topic will be addressed in greater depth and in a pluralistic manner.

7. Lessons Learned

One of the important areas to address with regard to indigenous populations is how gender identities and gender relations are constructed, based on the cosmic vision of the indigenous population. This will be possible as more in-depth research becomes available.

In preliminary qualitative research efforts, findings indicate that in the K'iché, Kaqchikel, Q'echí, and Mam populations gender discrimination is manifested in a variety of ways:

- midwives charge more or the family pays them more when a male child is born;

- even without an in-depth investigation, greater mortality from tetanus has been identified in infant boys, which may be associated with rituals related to the birth of a male child;

- new mothers are given chicken broth when a male child is born, since it is believed that giving birth to a boy requires considerably more effort than giving birth to a girl;

- breast-feeding sessions for male infants are longer than for female infants, since it is believed that their requirements are greater than those of female infants;

- among the Mam group, women are sold to men and given back if they do not fulfill their traditional reproductive function; they can then be sold again. In one case involving a woman who needed a cesarean section, the husband said that since the operation would cost him Q1,500.00, while a new woman would only cost him Q400.00, he would not authorize the operation;

- women monitor and care for the sick at home but cannot hospitalize a child or themselves, even if the situation is serious, without the authorization of the father or husband, as the case may be;

- women sit on the ground and not in a chair, because they have the right to contact with the earth since they are equally fertile;

- the agricultural work done by women supports or is essential to the sowing and harvesting of crops on their own parcel of land or on the large farms where they migrate for work. They perform the same work as their husbands (with their children on their back) but receive lower pay, or their husbands receive payment for all work done by the family group;

- women have an exhausting work schedule; on large farms they prepare meals for the agricultural workers from 2:00 a.m. until 10:00 p.m. in overcrowded and unhealthy conditions;

- indigenous women are victims of domestic violence and are forced into sexual relations prematurely after giving birth;

- there is a division of labor between the genders such that domestic chores and childrearing fall to women and the planting and harvesting of crops fall to men. Women work alongside men in many areas and keep them company in the process. There are some aspects of domestic life in which men participate and are not reluctant to do so, such as gathering fire-wood and cooking, but there are others that they seem to find impossible to assume, such as making tortillas;

- at social events, the women always sit at the back; they sit together as a group on backless benches. When women have been nominated to lead committees, the men have refused to accept it;

- male and female stereotypes differ from those found in the Ladino population but are no less patriarchal. In indigenous populations, men identify strongly with paternity since children become part of the work force at a very early age. In some groups, the men are actively involved when their wives give birth. Differences in the role of the female midwives and male birth attendants found in some communities have not been studied, nor have the links with other figures in traditional medicine.

It is important to understand that learning to visualize the gender discrimination in indigenous populations is not an easy task because of the Ladino filter through which people interpret what they see. In order to prevent this bias, gender discrimination is defined in terms of the injustices that the women themselves identify in their lives. This is the point of departure for raising awareness and creating intolerance of what they perceive as discrimination.

This is an important point that should be understood as a process that develops at its own pace—a process in which the vast experience of those in the health system must be prevented from influencing the women's own perceptions.

It is important to understand that the internalization of gender status is a long and painful process that at the same time gives power and value to the work, activities, and life experiences of women. At one of the health centers, in answer to a physician's question about how knowing about gender had helped her, a member of the indigenous women's council responded that she had learned how to negotiate roles and privileges

with her husband and children. Others noted that it was nice to be able to attend meetings and workshops about women and their feelings, adding that it allowed them to do something other than work all day long.

In a country like Guatemala, where the indigenous population is in the majority and where the health services are operated by and made up of nonindigenous personnel, it is necessary to strengthen identification among women, Ladino and indigenous, in order to deal more easily with ethnic differences.

Rejection of the ideas and practices of indigenous populations has been and continues to be the customary reaction in the health services at all levels of care. This has been the experience in places that underrate the value of life experience in health care, as in the case of women and midwives, the latter of whom are looked down upon by the health services. However, installing a laboratory to process medicinal plants in the health services and having indigenous women process the plants has sensitized the staff that work with the women's councils. Together, under the responsibility of the indigenous women delegates, indigenous women have provided care to patients using medicinal plants, an experience that has opened the way to greater awareness among the local medical staff, who now view the treatments warily but do not reject them outright. To open rigid medical training to aspects of traditional medicine and the Maya's cosmic vision of the health and disease process is a difficult task, which is made even more so because it is based on the demands of women.

8. Conclusions

- Indigenous women are very aware of the discrimination they suffer at the hands of the State, the health services, and any Ladino that works with them.

- The indigenous women and women from the institutions are beginning to recognize the need to exchange the oppressive power structure that holds them down (the hegemony of Western scientific knowledge over everyday traditional empirical knowledge; Ladino hegemony over the indigenous population; state hegemony over civil society) for another type that empowers the powerless.

- Even with many limitations, indigenous women are becoming increasingly convinced that they can accomplish things on their own, assessing their own potential and participating consciously in the search for alternatives for women's health.

- Progress in the personal growth of indigenous women is reflected in greater autonomy and less dependency on the health services. Health workers at the centers involved have viewed with amazement the potential of organized indigenous women as promoters of women's health.

- Literacy is a need perceived by indigenous women once they become aware of the gender situation. Many women in the councils have started their own literacy groups, even though they themselves have had only minimal schooling.

- Gender identification is the immediate mechanism for finding common ground between Ladino and indigenous women.

- Indigenous women have a holistic concept of health problems, which is beginning to take hold in the field of public health.

- Indigenous women have no autonomy as individuals. Ensuring that the project captures the feelings and thoughts of indigenous women, based on their day-to-day experience, is a challenge.

- Indigenous women identify very closely with nature and reproduction.

- The poverty of the indigenous population often makes meeting basic needs the top priority, which sometimes means that the project must include some benefit to productivity.

- There are similarities in the gender discrimination experienced by indigenous women and Ladino women, although they take different forms.

9. Recommendations

- In projects with indigenous women it is a good idea for them to participate from the design stage on and for them to be the direct beneficiaries.

- In order to guarantee the work from the planning of a project to the acquisition of the financing, especially with indigenous women, it is necessary to consider a bridging fund.

- In projects involving indigenous women, it is a good idea to combine representatives of indigenous women leaders with indigenous midwives, in order to balance operational experience with political experience.

- In health projects, it is necessary to consider funding for activities to promote literacy and strengthen productive activities.

- There is a need for more in-depth research on the construction of gender identities in the various indigenous contexts, as well as gender relations.

- There is no need to wait for the results of more in-depth research before beginning the changes that promote better health service delivery to indigenous women. Systematic transformation of the services can begin, based on the discrimination identified.

- Midwives play a pivotal role in the work with indigenous women; more research is therefore needed on their role as women leaders in the community.

- Activities among indigenous populations should transcend local experiences and have an impact on public policy.

REFERENCES

- Arquidiócesis de la Verapaz. *Acercamiento a la realidad de las mujeres indígenas de las áreas rurales de la Verapaz.* Diagnóstico, Centro de Investigación y documentación CIID, 1996, Guatemala.

- Ministerio de Salud Pública y Asistencia Social-OPS/OMS. *Sistematización del proceso de organización y funcionamiento de consejos de mujeres indígenas.* Proyecto Liderazgo de la Mujer Indígena, 1996, Guatemala.

- Solares, Jorge. *La etnicidad como factor de riesgo en salud en Guatemala.* OPS/BID, unpublished document, 1991.

- Tay, Alfredo. *Análisis de situación de la educación maya en Guatemala.* Ministerio de Educación, UNICEF/GTZ. Guatemala, 1996. Version modified and updated by Eva Sazo de Méndez.