Promoting Equality, Recognizing Diversity

Case Stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples

Latin America

GOBIERNO DE ESPAÑA
MINISTERIO DE ASUNTOS EXTERIORES Y DE COOPERACIÓN
aecid
UNFPA

"Ne kwe monso däredre meriwew ñan rabadre krüte" (Ngöbe)

"Ninguna Mujer debe morir dando vida" (Spanish)

"Ni mayqin warmip wañupunanchu musuq kawsayta paqarimuschkaqtin" (Quechua)

"Ni ma warmisa jiwañapaquiti wawachasiñanja" (Aymara)

"Yon se siuatl moneki mikis kemaj kiseli ichamanka" (Nahuatl)

"No Woman should die giving life" (English)

"Manam chulla warmipas wachakuspa wañunanchu" (Quechua)

"Ni ti gunaa cadi gati' dxi laa gudii guendanabani" (Zapoteco)

Promoting Equality, Recognizing Diversity

Case stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples

Latin America

Table of contents

Foreword


© Carina Wint/UNFPA

Latin America is a region of great ethnic and cultural diversity. Out of the 400 million indigenous persons living in the world, between 30 and 50 million are estimated to reside in Latin America. Bolivia, Guatemala, Mexico and Peru have the largest indigenous populations.[1]

Indigenous peoples, and particularly indigenous women, have the worst socio-demographic indicators and the largest inequalities in terms of access to social services in the Latin American region. Indicators of poverty as well as maternal and infant mortality are systematically higher amid indigenous peoples than non-indigenous populations. Among indigenous peoples, women face triple discrimination linked to gender, ethnic and socio-economic factors.

Nonetheless, in the last 15 years this situation has started to change and empowered indigenous women leaders, organizations and networks in Latin America are playing an influential role.

Empowerment has permitted indigenous women to recognize that they have the ability, capacity and knowledge to influence specific political and social contexts for advancing indigenous women's rights. This is a profound transformation for individuals and communities. Today, in many countries in the region, empowered indigenous women leaders have organized and are networking using their own life experiences as part of their advocacy efforts in order to demand their right to health.

In some countries of the region, more effective social and health policies are starting to address the unacceptable conditions of poverty and discrimination that indigenous women face, although they must still be scaled up.

1. ECLAC, Panorama Social, 2006

Policies that support indigenous women's reproductive health rights lead to the development of "intercultural" approaches and reproductive health programmes and services that avert maternal and newborn deaths and morbidities. These policies have the goal of making reproductive health services more accessible and affordable not only financially and geographically but from a cultural standpoint.

Culturally sensitive reproductive health policies, programmes and norms are starting to be enacted and enforced in health systems, especially at the sub-national levels. Health services are being adapted and expanded with the inclusion of symbolic and meaningful cultural elements and practices that, without jeopardizing quality of care standards, contribute to enhance indigenous women's access to adequate health care. Governmental health systems are beginning to understand and engage indigenous peoples' notions of health and illness, and the traditional medicinal knowledge that links their biological, spiritual and emotional lives.

Nevertheless, it will require concerted negotiations to find a true common understanding between


© Palindrome6996

Western health principles and practices and the traditional knowledge of indigenous peoples. In order to carry out the changes that will definitively enhance indigenous women's access and use of reproductive health services, health systems need to recognize indigenous peoples' rights, including their right to cultural continuity, health and particularly to life.

Intercultural Sexual and Reproductive Health among Indigenous Peoples in Latin America

For many years, UNFPA, the United Nations Population Fund, in Latin America has been supporting the efforts of governments and indigenous women's organizations to establish an intercultural and human rights-centered approach to sexual and reproductive health. In Bolivia and Ecuador it collaborated with the Constitutional reform processes that led to the recognition of sexual and reproductive rights and the right to intercultural health.

LACRO, the Latin America and Caribbean Regional Office, including its country offices are providing and promoting technical assistance for designing or adapting intercultural reproductive health policies and norms, as the reports of Bolivia, Ecuador, Guatemala, Mexico, Panama and Peru demonstrate. This assistance is helping to implement culturally tailored reproductive health models in hospitals and communities, in emergency obstetric care units, and primary health care clinics at national and sub-national levels. New reproductive health models need to be supported so they may continue to address the high maternal mortality ratio and unmet need for family planning that characterize indigenous peoples. We are optimistic that, given the growing understanding and commitment of decision makers and health practitioners that is emerging from intercultural dialogues, these health models will be further enhanced, institutionalized and sustained.

The case stories that follow, show the work being carried out in diverse countries in partnership with Ministries of Health and indigenous women's organizations and networks such as the "Enlace Continental de Mujeres Indígenas de las Américas." Other important partners include Family Care International and ECLAC, the Economic Commission for Latin America and the Caribbean. Significant financial support has been provided by the Spanish International Cooperation Agency for Development, AECID, through the UNFPA/AECID Cooperation Fund for Latin America and the Caribbean; IFAD, the International Fund for Agricultural Development, for Panama; and the Netherlands, for Guatemala.

Without doubt, UNFPA's work in Latin America is generating increased understanding of intercultural sexual and reproductive health issues and enabling those affected to share their learning and best practices. Now, a concerted effort to scale up these policies and services must be made, so that no women or adolescent girl is excluded from her right to sexual and reproductive health, and that "no woman dies from giving life."

Marcela Suazo
UNFPA, Regional Director for Latin American and the Caribbean
August, 2010

"We know what should be done and we must ensure the necessary changes come from within... success requires patience, a willingness to listen carefully, a respect for cultural diversity."

Thoraya Ahmed Obaid

1. Interculturality and Health in the Framework of "Sumak Kawsay " (Good Living)

Ecuador

© Micheal Chung

"(...) satisfying needs, having good living conditions and a dignified death, loving and being loved, healthy growth for everyone in peace and harmony with nature, and the ongoing survival of human cultures."[1]

Good Living implies... that peoples' liberties, opportunities, capacities, and real potential broaden so they can thrive, living up to the standards desired by the society, the territories, and the diverse identities of each person.... Good Living requires redefining what is public in order to recognize, understand and mutually value all citizens-as different but equal...[2]

For indigenous peoples, the concept of health is a complex one; not only does it consider an individual's physical and mental well-being but also his or her balance with nature, with the collectivities of which he or she is a part and with the rich and complex spiritual realm to which he or she is connected. The world view or "cosmovision" of indigenous peoples is intrinsic to their well-being and their concept of health needs to be understood within a social and cultural context. In the Western world, health has been defined as a state of well-being not only an absence of disease; health is generally related to physical health. In the indigenous world within the Americas, the concept is associated with a state of well-being or Buen Vivir (good living), also called by the Kichwa, the "Sumak Kawsay."

The social and political struggles of indigenous Ecuadorians to have their ethnic diversity and cultural autonomy recognized has become the most important aspect of their demand for interculturality. During the 1990s, the mobilizations and uprisings of the indigenous movement influenced the proclamation of the 1998 Political Constitution of Ecuador. This constitution recognizes Ecuador as multicultural and multiethnic and encourages increasing reflection and awareness regarding living conditions and the health of all the country's peoples and nationalities.[3]

The Ecuadorian state included some of the proposals of the indigenous movement in the 1998 Political Constitution, including the need to respect and promote traditional medicine. The following articles of the 1998 Political Constitution clearly reveal this:

Article 44:
The state will formulate the national policy of health and watch over its application; it will control the functioning of the entities in the sector; it will recognize, respect and promote the development of traditional and alternative medicines, the exercise of which shall be regulated by law, and it will encourage scientific-technological progress in the area of health, subject to bio-ethic principles.

Article 84:
The state will recognize and guarantee indigenous peoples ... the following collective rights: ... To their systems, knowledge and practices of traditional medicine, including the protection of ritual and sacred places, plants, animals, minerals and ecosystems of vital interest from this standpoint."

One of the triumphs of the indigenous movement has been the conformation, under the Ministry of Public Health (MPH), of the National Direction of Health of Indigenous Peoples (DNSPI, in Spanish) in 1999.

In 2002, as part of the process of modernization of the health sector, the National Congress expedited the Organic Law of the National Health System[4], which establishes important guidelines for creating intercultural health models, recognizing the cultural diversity of the country regarding health, and proposing its interconnectedness with the national health system. However, this law did not describe mechanisms and specific strategies for applying that knowledge and its diverse practices, in other words, it did not address methods for effectively promoting interculturality.[5]

The 2008 Constitution of the Republic of Ecuador makes an important qualitative leap in contrast with preceding constitutions, since it not only recognizes

1. René Ramirez, Scretario Nacional de SENPLADES
2. Ramirez R., Plan Nacional de Buen Vivir, Ecuador 2009

3. At global level the collective rights of indigenous peoples were recognized in ILO Convention 169, the WHO/PAHO Health Initiative for Indigenous Peoples of the Americas (SAPIA= of 1993, the Declaration of the Decade of Indigenous Peoples, UN 1994 - 2004.
4. República del Ecuador. Ley Orgánica del Sistema Nacional de Salud. Ley No. 80. RO/ 670 de 25 de Septiembre del 2002.
5. Gonzales D, Mapeo de Normas de Salud e Interculturalidad FCI 2010

"The Sumak Kawsay is a concept rooted in the Kichwa nationality worldview. For the Kichwa, good living signifies reaching a state of harmony among human beings with the community and with nature or the pacha mama. For the first time in the history of Ecuador, a constitutional text recognizes and values the contribution of native peoples to the creation of a new pact to live together in diversity."[6]

"The Sumak Kawsay embraces the holistic ancestral approach that proclaims health to be the harmony of the human being with itself, the family, the community, nature and spiritual forces that determine or explain the limitations of experimental scientific medicine..."[7]

Article 32 of the Political Constitution addresses matters of health in general and sexual and reproductive health, in particular: "Through economic, social, cultural, educational and environmental policies; and the permanent and opportune access, void of exclusion, the State guarantees the right to integrated programs, actions and services of health and sexual and reproductive health care and health promotion. The provision of health services shall be governed by principles of equity, universality, solidarity, interculturality, quality, efficiency, effectiveness, precaution and bioethics, and shall be based on a gender-sensitive and multi-generational approach."

the cultural diversity within the country, but also incorporates the indigenous philosophical principle of Sumak Kawsay (good living), as well as gender-sensitive and intercultural approaches as cross-cutting axes in every chapter.

Health policies and norms

Since 2005, the country has had a National policy of health, sexual and reproductive rights as well as action plans that now include gender-sensitive, multi-generational and intercultural approaches. This policy was created with the wide participation of social sectors.

The intercultural approach is also present in the norms of the National Health System, for example:

- The norms for maternal and neonatal health define guidelines for care during pregnancy, delivery and post-delivery, including emergency obstetric and neonatal care;

- The norms for integral adolescent health include a toolkit that addresses urban cultures and the peoples and nationalities of Ecuador;

- The "Guide for Cultural Adaptation of Birthing Services" addresses traditional practices (clothing, heat, accompaniment, position, food), to be incorporated in the formal health care system.

All these norms are obligatory instruments for the healthcare units and their providers.

Recognition of the multinational, multicultural and multiethnic condition of the country makes it obligatory to find ways to facilitate interaction between institutional services and traditional practices. Progress has been made in the legal and normative frameworks and a sustained training process on intercultural sexual and reproductive health has been provided to traditional midwives and community promoters. This training recognizes the roles of traditional health providers and communities. In order for policies to be put into practice, it is necessary to be able to count on skilled health personnel who are aware, trained, respectful, and understand the views and expectations of indigenous peoples.

By providing technical assistance, supporting the strengthening of national capacities and promoting social participation at both national and local levels, the UNFPA office in Ecuador has been continuously supporting national initiatives during the creation of the legal, political and normative framework for intercultural sexual and reproductive health.

The challenges in Ecuador are still great. The concept of "Good Living" as a lifestyle as well as a rights issue has yet to be fully understood, accepted and guaranteed. As stated in the National Health Plan, this implies "reconstructing what is public,"[8] so that all can understand and value each other as equals while at the same time valuing their diversity.

6. *Larrea, 2008:1*
7. *MPH, 2009b*
8. *Boaventura de Souza Santos*

"We have the right to be equal when we have internalized our differences; we have the right to be different when our equality de-personalizes us. Therefore, we need equality that recognizes the differences and a difference that does not produce inequality."

Boaventura de Souza Santos

2. Promoting, Designing and Implementing Intercultural Public Policies and Health Norms

Bolivia


© UNFPA Bolivia

"The Good Living principle as foundation of our thoughts and our individual and collective actions includes an indissoluble and interdependent relation with the universe, nature and humanity. It requires that a a moral and ethical base is configured to assure the conservation of both the environment and the community as the appropriate space for harmony, respect and equilibrium." [1]

Bolivia has gone through a long process, from the struggles to vindicate indigenous people's rights, initiated in the early 90´s to the promulgation of the new political constitution of the plurinational state.

In this process there have been important achievements, but also challenges and the different social actors' capacity for dialogue has generally prevailed. Several electoral processes occurred, including a constituent process that resulted in the new constitution, supported by 60% of the population through a national referendum.

The constitution currently in effect incorporates interculturality as the core articulating principle of the democratic and cultural movement taking place in Bolivia. In this context, a policy is being drafted that recognizes native rural indigenous justice systems, which benefit the Bolivian people and its 36 nations. In the sphere of public health, new rules, norms and protocols have been developed from an intercultural perspective.

One fundamental principle of the Plurinational State of Bolivia has been the Good Living (Buen Vivir) paradigm, which seeks a balanced relationship of human beings with their environment, and is based on the indigenous peoples' principle that solidarity, collectivity and equilibrium are essential for the attainment of a development that does not sacrifice culture and identity.

In this context, Bolivia has been one of the first countries to ratify the United Nation's Declaration on the Rights of Indigenous Peoples, which became national law No. 3760 on November 7th, 2007.

The new constitution guarantees the right to a universal and free health care system that respects worldviews and traditional practices.

Of special importance are Articles 18, 45 and 66:

Article 18 establishes that:

- Every person has the right to health.
- The state guarantees the inclusion and access to health of all people, without exclusion or discrimination.
- The only health system will be universal, free, equitable, intracultural, intercultural and participative, with quality, warmth and social control… [2]

Article 45 states:

Women have the right to safe motherhood, with vision and intercultural practice; they will enjoy special assistance and protection from the state during pregnancy, childbirth and prenatal and postnatal periods… [3]

Article 66 *guarantees men and women the right to exercise their sexual and reproductive rights …* [4]

In order to apply these rights, intercultural health norms, including on contraception have been devised and are being rolled out.

Decreasing Maternal Mortality: A National Priority

Decreasing maternal deaths is a priority for the state. In 2006, the Ministry of Health's Resolution No. 0348 established adequate cultural protocols for motherhood and newborn care, including the following recommendations:

- To be accompanied by a family member;
- To deliver the placenta to the family;
- To determine their own body position for labor;
- To allow the consumption of liquids and food during labor; and,
- To avoid unnecessary practices, such as enemas, shaving and cutting.

1. *Indigenous Bolivian Meeting, centre and South America for "Good Standards of Living" La Paz, March 19th and 20th 2010. (Caucus indígena boliviano, centro y sud América para "vivir bien" La Paz, 19 y 20 de marzo de 2010)*

2. *Gaceta Oficial de Bolivia, Constitución Política del Estado, febrero de 2009.*
3. *Gaceta Oficial de Bolivia, Constitución Política del Estado, febrero de 2009.*
4. *Gaceta Oficial de Bolivia, Constitución Política del Estado, febrero de 2009.*

Another important breakthrough at the policy and normative level was the inclusion of quality evaluation criteria in service accreditation parameters established in the 2006 **Guidelines for the Intercultural Health Policy of the Vice Ministry of Traditional Medicine and Interculturality.**

These accreditation parameters include the following:
- Obligatory intercultural training of health staff
- Use of local indigenous languages
- Intercultural offices
- Cultural markings
- Architecture approved by consensus
- Indigenous participation in the management of services
- Local food-based nutrition
- Community hostels or waiting homes
- Respectful dialogue with traditional doctors
- Use of traditional plants
- Humanized and intercultural childbirth
- Use of local equipment (hammocks, leather, etc)
- Flextime
- Spiritual and religious support facilities

The model: SAFCI

The family, community and intercultural healthcare model (SAFCI) created by Supreme Decree No. 29601 of July 11th 2008, currently in effect, places great emphasis on health promotion in the community and considers access to institutional care to be an urgent need.

This new model aims at reinvigorating native indigenous rural medicine and ensuring its linkage and complementarity with Western medicine. It is intended to provide health services that take the person, the family and the community into consideration by accepting, respecting, appraising and articulating indigenous rural peoples' biomedical and traditional health knowledge.

Within this context, UNFPA supports both the SAFCI and the creation of sexual and reproductive health clinics in male-predominant and women-based indigenous organizations, linking them to the health care network. UNFPA also supports the intercultural adequacy of health norms and regulations.

UNFPA Bolivia and the NGO Causananchispaj, in partnership with the municipal health care network Vitichi and with the participation of social and institutional workers, designed the municipal strategy for sexual and reproductive health and maternal health care" which takes a culturally contextualized approach.

This strategy validates and is built upon the SAFCI, taking into account the need to promote and integrate health at three levels: the family, the community and the health services. For each level, there is a list of health-care related actions that need to be taken.

As a result of this process, culturally pertinent health-care procedures regarding sexually transmitted infections, uterine cervical cancer and family planning were developed for the SAFCI. These procedures are being implemented throughout the country.

A key requirement of the model is working with local actors, interacting with representatives of the community and using the support of the regulatory authority of the Ministry of Health.

As part of its future work in Bolivia, UNFPA will continue supporting the implementation of the SAFCI, as well as the inclusion of intercultural approaches in the national norms and the unified health insurance plan, *Su Salud*.

An opportunity of the decentralized state is to further enhance its work with regional, municipal and local authorities, and with organizations that oversee the implementation of local health policies, in line with the new constitution.

4 basic principles of the SAFCI:

a. Community participation: *The capacity of self-management of urban and rural communities in the identification, prioritization, execution and follow-up of plans, programs and projects of integral community development in health, in accordance with collective interests versus sectoral or corporate ones.*

b. Intersectoriality: *The coordination between the population and different institutional sectors (health, education, basic sanitation, production, housing, nourishment), in order to act upon the socioeconomic determinants of health, through strategic and programmatic alliances and partnerships.*

c. Interculturality: *The articulation and complementarity between different health systems (conventional medicine, traditional indigenous rural medicine and others), based on dialogue, acceptance, recognition and mutual validation of feelings, knowledge and practices.*

d. Integral and holistic health services: *To conceive health and illness from a comprehensive standpoint, considering the individual an d his or her relations with the family, the community, nature and the spiritual world. The goal is to promote health, prevent illnesses, and attain healing, rehabilitation and recovery in an efficient and effective way.*

3. An Intercultural Approach to Maternal Health

Guatemala

Maternal mortality in Guatemala

Maria López, a community birth attendant, knows that something is wrong... She visited the girl several times during her pregnancy and everything seemed fine, but now her labor is taking too long. The girl gets steadily weaker with each contraction; she looks pale and suffers from severe convulsions and excessive bleeding. Because of the training she has just completed at the local hospital, Maria quickly recognizes these symptoms as signs of emergency, so she seeks obstetric emergency care. Within one hour, the girl is admitted to the local hospital by the community obstetric emergency team. Her life and that of her child are saved on the operating table.

Guatemala has one of the highest maternal mortality ratios in Latin America. While it has decreased significantly in the last 20 years, the figure of 153 maternal deaths per 100,000 births is still too high. One of the targets of the Millennium Development Goals in Guatemala is to decrease this figure by 60%, lowering it to 55 maternal deaths per 100,000 births by the year 2015.

Maternal mortality in Guatemala is associated with high fertility levels among rural and indigenous women. These levels are linked to insufficient education for women, the lack of an intercultural perspective and the need for women's empowerment. These factors limit access to reproductive health services and the use of modern methods of family planning.

As in other countries in the region, in Guatemala maternal mortality is due to insufficient understanding of and response to what are known as the cuatro demoras or four delays:

1) The delay in recognizing alarm symptoms during pregnancy, labour or puerperium;

2) The delay in making the decision to seek help at hospitals and health clinics;

3) The delay caused by lack of adequate access to high quality health services; and,

4) The delay in receiving appropriate care one in the clinic or hospital.

Addressing maternal mortality: an emerging priority

The peace agreements signed by the Government and the political party Unidad Revolucionaria Nacional Guatemalteca in 1996 included the reduction of maternal mortality as one of the country's priorities for the period of peace building, reconstruction and development.

Since then, two important laws have been approved: the Law on Social Development (2001) and the Law on Universal and Equitable Access to Family Planning Services (2005). Without doubt, the implementation of both laws has proven critical in addressing the need for sexual and reproductive health services, including family planning services, and have contributed to the social and human development of the most excluded sectors of the population.

Considering the multicultural and rural makeup of the country, it is clear that the fight against maternal mortality must take a comprehensive approach. Recognizing this, in 2006 the UNFPA country office in Guatemala joined efforts with the Ministry of Health, non-governmental organizations, community committees and traditional women's groups to spearhead a broad-scale, innovative intervention in nine departments of the country.

Approach and strategies

A. Developing an intercultural approach

Sexual and reproductive health cannot be seen as an isolated health issue. It needs to be addressed from a holistic standpoint, understood as central to the well-being of women, families and their communities. To address the gender, social, cultural and economic considerations that determine access to and use of reproductive health services any successful approach must be intercultural and grounded in an appreciation of human rights issues.

The project in Guatemala takes into consideration these determinants and seeks to strike a balance between cultivating the values, traditions and cultural practices of local indigenous communities and recognizing the contribution of Western professional medical standards that have been proven to have an

impact on maternal mortality and morbidities. This "intercultural" approach, based on cultural dialogue and understanding, is fundamental for reproductive health programmes and services to be effective.

B. Crucial role of the community educators

One of the selected departments for the intervention was the Department of Sololá, which distinguished itself from other project sites by developing a process of health promotion and education carried out by community educators and birth attendants.

Community educators are women and men selected from their own communities who work with pregnant women, families and community members with the aim of reducing maternal deaths. For this task they have been trained in reproductive health matters such as: reproductive rights, prenatal and postnatal care, family planning, high-risk pregnancy signs and symptoms, the importance of skilled attendance at birth, and the design of emergency plans. In addition, they inform communities on referral services for pregnant women, provide general support to community birth attendants and emergency obstetric teams, and organize talks and meetings with men, involving them in the process.

© Mark Tuschman

The women and men of Sololá feel confident in the community educators, who act as "cultural brokers," decoding information for rural community members and drawing men into education processes. Men feel able to talk "man to man" with the educators, who are predominantly male, and in the process learn how best to support women's health.

C. The community maternity ward

The building of maternity wards near the premises of the public hospitals in each department was a key initiative of the project. Each of these wards has several beds and at least one delivery room.

The basic idea of the ward is to provide a temporary living space where pregnant indigenous women from surrounding communities can have quick access to the hospital while in labour, in case any type of obstetric emergency may arise.

The goal of the initiative is to increase indigenous women's access to and usage of hospital obstetric care without losing the support of traditional birth attendants.

Throughout pregnancy, during labour and in the first weeks after delivery, the woman is assisted by her own trusted birth attendant, who continues her cultural and traditional practices supplemented by additional training. The community birth attendant, as a result of this training, and on-going supervision by the health facility, learns to recognize risk symptoms and arrange referrals for obstetric emergencies.

D. The maternal mortality analysis committees

As part of the project, each department has formed Maternal Mortality Analysis Committees. These groups audit and analyze every maternal death to learn how to prevent similar cases in the future. Comprised of local health personnel, community educators, birth attendants and responsible community members, these committees have enhanced community awareness and sense of responsibility for all pregnant women.

Community members now check on each other to make sure that each pregnant woman is regularly seen by one of the trained community birth attendants in coordination with skilled health personnel.

"My name is William Jonathan. I am from Sololá and work as a community educator. I was involved in the project and understand that the trainings are not only on health issues but on helping people be attended with respect for their cultures."

Main outcomes and challenges

Main outcomes

An average of 10 obstetric emergency referrals are reported in each department per month, each community educator organizes and carries out an average of 30 monthly meetings, and nearly 6000 community birth attendants, countrywide, have been trained.

As a result of this intervention, concomitantly with the positive impact of the laws of Social Development and on Universal and Equitable Access to Family Planning Services, the following main outcomes have been identified:

- The use of family planning methods has increased, lowering unmet need among indigenous and rural populations;

- The number of institutional birth deliveries has increased; and,

- The level of awareness on maternal and child health, hygiene, nutrition, breastfeeding, infections and the use of modern contraceptives has been raised within indigenous communities.

Primary challenges

Despite the above successes, the project also faces key challenges:

- The need to continuously inform women and community members of the project´s aim and strategies;

- The need for community birth attendants to work in their own communities, speaking their own languages;

- The need to raise awareness on the consequences of not receiving skilled birth care;

- The need to improve access to family planning methods for rural and indigenous women; and,

- The need to measure maternal mortality reduction adequately, including at sub-national levels.

4. Reducing Maternal Mortality Indicators

Mexico

The project **"Reducing Maternal Mortality Indicators"** was implemented in the State of San Luis Potosí of the Huasteca Region, between 2002-2007. It was carried out in the municipalities of Aquismón and Tanlajás, which are characterized by a high predominance of indigenous peoples, mainly of Nahualt and Tenek descent.

The Nahualt and Tenek live in scattered communities with poor demographic indicators such as high fertility, high maternal and child mortality, low contraceptive use, and early age at marriage and first pregnancy.

The main actors in the intervention were: the State Population Council of San Luis Potosí (COESPO), the Mexican Social Security Institute, Mexico's anti-poverty program Oportunidades, and organizations of traditional physicians and birth attendants.

The project's primary goal was the reduction of maternal mortality through improving reproductive health services and increasing health coverage in selected municipalities.

Its expected outcomes were the following:
- To strengthen the linkage between traditional health services and institutional health units;
- To increase the demand for family planning services; and
- To improve health indicators by the end of the project.

Key strategies

The project's key strategies were:
- To promote an intercultural approach through the integration of traditional and institutional medicine;
- To promote community participation; and,
- To enhance organizational development in support of the initiative.

Promoting an intercultural approach:
An interactive program was designed to promote an intercultural exchange on the integration of traditional and Western medicinal practices Workshops were offered to traditional healthcare providers and institutional physicians, nurses and community midwives. These workshops promoted a common knowledge based on methodologies for diagnosis and healthcare. Teaching methods and guides were developed and used to train others.

Reinforcing community participation:
A coordination mechanism was created with institutions responsible for health and human development. It promoted active community participation and strong political commitment from government authorities at municipal and local levels.

A community promotion network was also created with the aim of disseminating information on the supply of health services, enhancing community involvement and referring patients to clinics that provide emergency obstetric care.

Enhancing organizational development:
In order to improve the quality of health services, a training model was designed and implemented for health care providers. This model included establishing a Train-the-Trainers network, designing an operations manual, and carrying out workshops for strengthening institutions.

Impact evaluation model

A model was designed and implemented in order to conduct an impact evaluation of the project's effects.

This study found that a number of factors had contributed to its success:

- Enhanced political will and commitment from local authorities;

- Sustained involvement of mass media;

- Participation, coordination and exchange among local authorities and traditional physicians and birth attendants' organizations;

-Support from the Commission for the Development of Indigenous Peoples (CDI) and the involvement of indigenous authorities;

- Coordination, monitoring and facilitation from COESPO, the State's Population Committee;

- Clear agreements for community participation that defined the role of each community agent; and,

- A social audit mechanism, aimed at ensuring transparency in the follow-up process.

Primary challenges

The evaluation identified the following main challenges:

- The programme's need to maintain the interest of local and state authorities at different levels and to counteract lack of cultural sensitivity;

- The health system's lack of knowledge of indigenous customs and traditions and their impact on sexual and reproductive health; and,

-The lack of awareness among authorities and health providers from the Ministry of Health;

-The constant changes taking place both at institutional level and in sex education policies;

- The programme's need to reinforce strategies for reaching adolescents and youth, due to constant changes at the institutional level and in sex education policies.

Main outcomes

- The coverage of health services in the municipalities of Aquismón and Tanlajás increased.
- Knowledge and use of family planning methods increased among indigenous women.
- Community members were more able to identify health risk factors.
- Community organizations were reinforced to ensure the transportation of women experiencing obstetric emergencies.
- The coverage of prenatal care increased, especially during the first quarter of pregnancy.
- The number of maternal deaths was reduced to zero in the municipalities of Aquismón and Tanlajás.

5. Interculturality in Health, an Opportunity for Equity: The Case of Otavalo

Ecuador

"For indigenous women, the body is sacred and shouldn't be touched by others. Our modesty is because we feel ashamed to show our body to strangers. Only our mothers see us naked when we're born. After that, no one... You have to cover yourself and not let strangers see you." (Hospital patient)

In 1984, in the midst of the land and culture reclamation struggles of the Peasant and Indigenous Federation of Imbabura (FICI), the Jambi Huasi Health House was founded in the city of Otavalo.[1]

This initiative aimed at integrating indigenous and western health systems by utilizing the strengths of both and adapting them to the specific needs of indigenous peoples.

The Jambi Huasi experience was the starting point for progressing from a non-governmental initiative to an institutional programme, bringing an intercultural reproductive health approach to a public hospital, the San Luis Hospital of Otavalo.

The political events that began in 2006[2] brought about changes in the Ministry of Health, and subsequently in Otavalo. An indigenous doctor was appointed as Director of the San Luis Hospital for the first time, signaling an important commitment to increasing indigenous peoples' access to health services.

Key factors that contributed to the successful integration of an intercultural approach at San Luis Hospital were the municipality's support under the leadership of an indigenous mayor and ongoing strengthening activities at the provincial and regional levels of the Ministry of Health.

Within this framework and with continued support from UNFPA, work began on the creation of a model for reproductive health care in the hospital.

In order to have baseline information against which to understand and monitor the changes that needed to take place, we performed an analysis of the perceptions and practices of indigenous women and of health providers regarding the reproductive health process.

The results of this qualitative study revealed that in order to respond to its peoples' health-care needs, Ecuador must understand the diverse, multi-cultural concepts of health and well-being that exist among them and recognize the variety of different cultural practices that affect their health.

Policy makers were challenged to integrate an inclusive concept of health into public policies and guidelines. The San Luis Hospital in Otavalo addressed this challenge by creating a **"Model of Reproductive Health with an Intercultural Approach"**.

The model

In implementing this model, the main changes achieved to date are as follows:

- Aggregating birth registry data by ethnicity;

- Teaching health providers the basics of Kichwa;

- Posting signs in Kichwa to indicate the hospital's services;

- Training and instructing health personnel in intercultural health and culturally correct delivery;

- Creating a culturally correct delivery room that allows the woman to decide what position she wants for her delivery.

1. Otavalo is a city of 106,373 inhabitants, according to the population projections by provinces. Ministry of Public Health. of Ecuador 2008. The city of Otavalo has approximately 52,084 inhabitants; 52% is indigenous and 48% is mestizo.
2. Rafael Correa of Alianza País was elected president in 2006

Aspects ofthe intercultural reproductive health model that are contributing to increased access to the hospital's services include:

- The participation of traditional birth attendants in the hospital during delivery and the redefinition of their role as key cultural brokers between worldviews;


© UNFPA Ecuador

- The change from white clothing and nudity to the use of dark and warm colors in the delivery room;

- The provision of food according to the patient's customs; and allowing the use of traditional plant infusions;

- The establishment of a community network for the reduction of maternal mortality;

- The creation of a maternity home where indigenous women can go a few days prior to their delivery; and,

- Making it possible for husbands, family members and traditional birth attendants to be present during labor.

This new model of reproductive health care is expanding its services to indigenous and rural communities through the creation of operative units led by traditional birth attendants or midwives. In coordination with the hospital, these traditional midwives map all pregnant women in order to better monitor their pregnancies and provide them with information on possible obstetric risks.

This model is proving to have a positive impact on the empowerment of indigenous women, acting upon cultural and gender determinants, and increasing effective use of medical services.

The main challenge of this model is to achieve its correct implementation and institutionalization with its concomitant increase in health standards and incorporation of lessons learned, while at the same time replicating the experience in other indigenous districts' health centers.

The most important changes achieved with the acceptance of the culturally correct delivery room have been a 9% increase in institutional delivery since 2008, and zero maternal deaths since 2005. This was also achieved through an important promotion of institutional and civil society coordination and partnerships.[3]

3. San Luis Hospital statistical registries.

Various testimonies

"We must join efforts and work in solidarity in the construction of a kind of medicine that, without disregarding the evidence provided by science, consolidates a medicine based on the needs of human beings." (Reporter, Ricardo Hidalgo Ottolenghi) [4]

"We have taken measures so that this process can be disseminated at the national level, in order to achieve the country we all want, a new and healthy motherland." (Mr. Mario Conejo, Mayor of Otavalo) [5]

"For many years we were forgotten, but now health has priority, being the most important factor for human development." (Dr. Gonzalo Jaramillo, Provincial Health Director)[6]

4. Suarez, Lorena, Ciudadanía Informada, 13 de agosto de 2010
5. Idem
6. Idem

6. Step by Step, Pregnancy Care

Mexico

Main outcomes:

After the project was completed, an evaluation was carried out identifying the following changes:

- Women's ability to identify and detect alarm signs during pregnancy increased significantly.
- The number of visits to health units for prenatal care increased 50%.
- Knowledge of family planning methods increased from 25% to 48%.
- The number of PAP tests performed increased from 0.8% to 14.5%.
- Women's ability to identify different types of violence improved.

During two successive UNFPA Country Programmes implemented between 1997 and 2007, UNFPA Mexico supported the project **Step by Step, Pregnancy Care**. This was an initiative aimed to provide sexual and reproductive health care for migrant women day laborers.

The project was implemented in the State of Oaxaca (Valles Centrales and Mixteca regions) by many stakeholders, from government institutions to civil-society organizations. The primary stakeholders were: the Grupo de Estudios sobre la Mujer "Rosario Castellanos" A.C., with the collaboration of the committee for promoting safe motherhood, the Mexican Social Security Institute, the Ministry of Health of Oaxaca and the National Programme for Farming Day Laborers. UNFPA, the National Population Council (CONAPO), and the General Population Directorate of Oaxaca provided technical assistance.

This innovative project aimed at testing and implementing an awareness-creation and training model in sexual and reproductive health. It emphasized a gender-sensitive perspective and focused on safe motherhood and sexual and reproductive health-risk prevention among indigenous migrants.

The expected results of the project were:

- To have developed an awareness-creation and training model based on the experience of working with indigenous migrant communities.

- To have validated the model among community health promoters.

- To have developed strategies for disseminating and reinforcing sexual and reproductive health messages at the community level.

The model

The Step by Step Pregnancy Care model sought to prevent maternal mortality by comprehensive means, including the prevention of family violence, the promotion of gender equality and of sexual and reproductive health and rights, and a special emphasis on indigenous migrant populations.

To implement this model, the following strategy and tactics were developed:

Intercultural strategy-
A key strategy was to benefit from the know-how and wisdom of traditional knowledge in indigenous communities. By recognizing and respecting cultural differences, the project sought to to eliminate the barriers that prevent indigenous women from demanding and using sexual and reproductive health services.

This strategy also involved the organization of community forums in each municipality with the participation of midwives, traditional health service providers, and community leaders.

Key tactics:

Communication Campaign - A communication campaign aimed at positioning pregnancy care as a shared responsibility of every man, woman, family member, community, authority, and health provider was designed and implemented in the communities of origin. The campaign included posters, flipcharts, brochures, bags, videos, and t-shirts among other materials. Sexual and reproductive health messages were provided in indigenous languages, as well as in Spanish, with an emphasis on pregnancy care.

Innovative information, education and communication materials were designed and implemented, including:

- A radio programme Luces de Mujer (women's lights);

- Serial videos that offered reflections on gender equality, sexual and reproductive health and rights, and gender-based violence as socio-cultural and gender determinants of health;

- The creation and distribution of health appointment cards with "everything I must know about my pregnancy," printed on them. This campaign was reinforced with radio announcements in the Mixteco and Zapoteco indigenous languages.

- The initiative also created of health posts for pregnant migrant women; designed in a culturally sensitive way and carried out workshops to sensitize and train community health promoters. The objectives of the workshops were to improve maternal health care, eliminate barriers to women's health and reinforce their right to sexual and reproductive health. Special efforts were developed to promote men's involvement in order to enhance community participation and prevent gender-based violence.

© UNFPA México


© UNFPA México

Four training modules were developed:

1. *How do we learn to become women and men?* This module aims at reflecting on gender inequities and their impact on reproductive health.

2. *How should we take care of our sexual and reproductive health?* This module analyzes the concept and components of sexual and reproductive health by identifying the main roles and responsibilities of men, women, communities, leaders, and health providers.

3. *How can we live without violence?* This module focuses on recognizing gender-based violence in its different forms and identifying local resources for preventing it.

4. *How can we ensure safe motherhood?* This module identifies risk factors, pregnancy complications and symptoms, and measures that need to be taken when obstetric emergencies arise. It aims at promoting women's empowerment and self-esteem, while at the same time emphasizing the roles of family members and communities in the prevention of maternal mortality.

Promoting sustainability

During the years 2005 and 2006, specific measures were carried out to institutionalize the model, including:

- The signing of agreements to include the model in the Ministry of Health's plans, programs and strategies;

- The agreement established with the National Programme for Farming Day Laborers (PAJA) to replicate the model in the states of Sonora and Sinaloa;

- The provision of communication and education materials for training local health providers, in order to expand the model; and,

- The level of commitment achieved from high-level authorities.

The main challenges identified were:

- The need to follow up on agreements and commitments;
- The need to enhance health public policies in order to eliminate discrimination based on ethnicity and gender;
- The need to assess and raise awareness of the issues of migrant women, especially in regions of high migration; and,
- The need to guarantee continuous advocacy and training of health authorities and practitioners, especially in border areas.

7. Providing a Home away from Home for Expectant Mothers: The "Waiting Home" in Vilcashuamán

Peru


© Yuri Hooker

Improving access to reproductive health services

The maternal mortality ratio in Peru decreased from 185 per 100,000 live births in the year 2000 to 103 in 2009.[1] Though disparities still remain and the figure is not yet low enough, this progress has been achieved due to health insurance and other social programmes, and by recognizing the need for an intercultural approach to service delivery in rural areas. These strategies have increased the availability and use of reproductive health services. The percentage of births assisted by skilled personnel increased from 72.6% in 2007 to 79.9% in 2009; in rural areas, assisted births increased from 49.4% to 55.4% during the same period.

Despite these gains, geographic, economic, gender and socio-cultural determinants still need to be addressed if the three-quarters reduction established by the Millennium Development Goals (66 per 100,000 live births) is to be attained.

From the point of view of adapting an intercultural approach to reducing maternal mortality and morbidities, two important strategies have been implemented since 2005: providing access to the option of vertical delivery and the establishment of waiting homes.

The establishment of vertical births includes the adaptation of traditional delivery rooms. From a cultural standpoint this has an important symbolic value, since it is believed that during delivery women should push downwards towards mother earth (pachamama), for her protection. Having a family member present during delivery provides the pregnant woman with an atmosphere of care, and the knowledge that she may receive help from a loved one in the process itself. [2]

© UNFPA Perú

1. www.measuredhs.com/pub/pdf/FR242/FR242.pdf, pg 166
2. http://www.theglobalist.com/StoryId.aspx?StoryId=7730

The establishment of waiting homes or hogares maternos near health facilities provides expectant mothers and family members with safe spaces where they can reside, for a short period of time, before and after giving birth.

Building the Vilcashuamán Waiting Home *– a collaborative effort*

The town of Vilcashuamán is about 75 miles (at least a 3 hour drive down a series of winding, unpaved roads) from Ayacucho, the closest city and home to the nearest surgical facility. In this part of the Peruvian central highlands, the people live scattered in small villages. Up until recently, approximately 80% of the women in this region delivered their babies at home, where complications could have tragic consequences.

"These are widely dispersed districts; it can take up to 7 hours to travel from the communities to the health center, and there are areas that are virtually impassable. This is a major risk factor," said Amelia Cabrera, Director of the local community network of Vilcashuamán.


© UNFPA Perú

The Vilcashuamán waiting home was built to resemble the homes of most of the women in the area, immediately giving them a sense of familiarity and security. It has a kitchen, a dining room, two bedrooms with eight beds each, a bathroom, a dining area, an area for educational activities and a vegetable garden.

In 2008, with the participation and commitment of the municipal authorities, the infrastructure of the house was improved. The local government supplied the labor to build a more accessible entrance to the house, plaster and paint the walls, and complete the windows and doors, all of which made the house more pleasant and secure.

Equipping and furnishing the house was a joint effort between users, health staff and local authorities. A number of consultations were held in order to discuss and share the participants' expectations for the home and to discuss issues regarding its management and sustainability.

More than 42 members of the community, including community health workers, women from grassroots organizations and local authorities participated in the consultations, together with 15 skilled health professionals. This group decided the number of spaces and beds the home should have; the type of appliances, furniture and other goods needed to make it comfortable and its rules and operating procedures. The required furniture, bedding, appliances and other supplies were donated by the United Nations Population Fund, Peru.

"Many women die in childbirth, and because of that we decided to create the maternity home and encourage local women to go there to give birth, so they could still follow their customs but be supported by a team of qualified professionals." (Obstetric nurse)

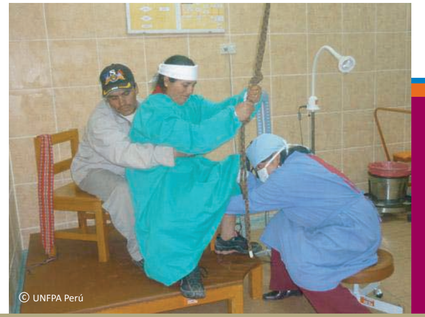
"I am very glad that everyone's contributions were taken into account. We heard women speak about what they wanted to find in the home. This commits us to continue expanding health services throughout rural communities." (Amelia Cabrera)

A home away from home – María's story

Thirty-nine year-old Maria arrived at the Vilcashuamán waiting home with her husband when she was nine-months pregnant. She had heard about the home on the radio. According to the radio message, "You can go and stay there until you give birth. It is the same as being in your own home."

After hearing from the health center's obstetrician that "in the Vilcashuaman waiting home you could stay with your husband and give birth standing up" like the rest of the women in her community, Maria didn't think twice about going.

While waiting to give birth, Maria, together with other women living in the home, prepared meals, received nutritional education and participated in embroidery and farming workshops, activities designed to make her stay more enjoyable and productive.



The road ahead

The success of the Vilcashuamán waiting home has made it a shining example of the significant progress that can be made in achieving mutual understanding and better communication between health personnel and indigenous women within their communities. However, additional efforts to strengthen intercultural dialogue between health professionals and the population still need to be made in order to avoid the type of hierarchical relations that may threaten the provision of quality services.[3]

Over the past four years the number of women coming to the home increased and, to date, no woman staying there has died. The Vilcashuamán Health Center is currently viewed as a skills development center, a distinction that is highly valued by all who have been a part of the effort in this village in Ayacucho, which is gradually recovering from the aftermath of terrorism. Without doubt, this experience of participatory management is worthy of imitation.

3. In 2009, UNFPA has supported the development of a document to systematize the experience of waiting homes so that more houses are built in rural areas of Peru. The document states that the process should be participatory for all stakeholders to ensure an intercultural approach, the basis of this strategy's success.

Strategies like vertical childbirth and waiting homes, that consider indigenous worldviews, are starting to demonstrate success in Peru. The percentage of births assisted by skilled professional personnel increased from 72.6% in 2007 to 79.9% in 2009, with an increase from 49.4% to 55.4% in rural areas. (DHS, Peru, 2009)

8 "Bolsas Semáforo" as a Strategy and Tool to Prevent Maternal Deaths in the Comarca Ngöbe-Buglé

Panama


© Carina Wint/UNFPA

She was twenty-years old… she had had six pregnancies.
Her mother helped her deliver, and she gave birth at home.

José Rodriguez, "Un lamento en la Comarca"

The red, yellow, and green traffic colors are among the most widely recognized international symbols. The bolsas semáforo (traffic-light bags) distributed to Ngöbe women to identify the stage of their pregnancy, have been piloted over the last two years in two health centers of the Comarca Ngöbe-Buglé as a tactic of the maternal mortality reduction programme, where UNFPA, the United Nations Population Fund, provides technical support to the Ministry of Health and the local Ngöbe indigenous women's association, called ASMUNG, with funding from IFAD, the International Fund for Agricultural Development.

The bolsas semáforo were originally inspired by the dignity kits distributed to women during emergency situations. The information women receive in the bolsas semáforo places great emphasis on the importance of institutional pregnancy controls and encourages women to carry their control card at all times. The fabric bags, hand sewn by a volunteer group of Ngöbe women, have a special external pocket for this purpose.

Ngöbe women wear a nagüa, a loose-fitting traditional dress, which makes it difficult to tell when a girl or woman is pregnant. The bolsas semáforo send a clear signal to their peers and greater community members about the status of their pregnancy.


© UNFPA Panamá

© UNFPA Panamá

The ***green bag*** is indicative of the first trimester, during which maternal risks are usually low but during which women must ensure good care. The green bolsa contains toiletries, hygiene products, and information about healthy nutritional habits. Personal care products are among the last in the priority list for poor families, so these products are welcomed. For the Ngöbe, green is the color of life, of nature.

The ***yellow bag***, which Ngöbe women are given during the second trimester of their pregnancies, includes most of the same products as the green bag, with more information on the woman's delivery plan, including tips as to what she needs to discuss with her husband, other family members, and health providers. Yellow represents hope in Ngöbe imagery.

The red bag signals the third trimester and the increased risks associated with that stage of pregnancy, especially for women who decide to give birth at home or have to walk hours to the nearest health facility. The red bag contains products the

woman will need upon delivery, such as sanitary napkins, diapers, and information about her newborn and breastfeeding. Red represents an emergency in the Ngöbe community, a call to action.

The traffic-light colors are also used in an exercise that maps all the pregnant women of the community, allowing health personnel to track the healthy progress of their pregnancies.

The use of the bolsas semáforo is becoming more widespread as an incentive for Ngöbe women to make the often long and difficult trip to a health center or hospital for their regular pregnancy checkups. Women are expected to exchange each bag for the next color at the next trimester's visit to the health center. The original monochrome bags often come back enhanced with hand-sewn traditional Ngöbe designs, a clear sign of their valued usage. Getting more women to visit health centers for pregnancy controls and eventual delivery is critical for the success of the intervention in this area of high maternal mortality.

Over the last 12 years, the UNFPA country office has been working with national and regional authorities of the Ministry of Health and ASMUNG to reduce the four delays[1] that cause maternal mortality in the Comarca. The strategy of this intercultural health model is twofold: to increase and strengthen demand from the rights-holders by facilitating women's empowerment and promoting community organizations that support pregnant women, while at the same time addressing the need for quality health by developing the intercultural birth skills of healthcare personnel and providing equipment and supplies.

Strengthening the demand from rights holders is best done through peers or community members. In the latest iteration of the project, 68 community multipliers--male and female community leaders committed to voluntary work--were trained to deliver information to individuals and families using visual tools regarding human rights, maternal health, family planning, gender equality, masculinity, and intra-family violence prevention, all of which need to be addressed in order to diminish the first and second delays that cause maternal mortality.

1.The first three delays are on the demand side: the first one has to do with the woman recognizing that something is not working with her body; the second delay is around the decision to go to the health center; the third delay is in arriving at the health center. The fourth delay is on the supply side, having to do with the quality and cultural appropriateness of the service offered. (Three Delays Model, Dr. Deborah Maine, University of Columbia. Adapted by PAHO/WHO and UNFPA.)

The Comarca Ngöbe-Buglé is the largest indigenous territory in Panama and also has the worst reproductive health indicators in the country:[2]

Maternal mortality	297.9/100,000 (a)	Pap control	19.8%
Prenatal control	77%	HIV cases	130+
Births attended by professional personnel	34.3%	Cases of congenital syphilis	10 (b)
Adolescent pregnancy	29.8%		

(a) Nearly 5 times greater than the national average of 60/100,000
(b) Of a total of 12 in the country

According to the Ngöbe Bugle Health Region registry system, community health strategies among Ngöbe women, such as the cash-transfer programme of the Red de Oportunidades and the health education promotion programme, including the bolsas semáforo, contributed to increase prenatal awareness, hygiene and care among indigenous pregnant women and adolescent girls.

Increase in the number of pregnancy controls in the Ngöbe Region[3]:

2006: **3,732** 2008: **14,056** 2009: **20,096**

2. Contraloría General de la República, 2007, 2008.
3.Statistics Department, Ngobe Bugle Health Region, Ministry of Health

Community participation

Through the work of community members and multipliers, who are critical actors in the initiative, communities develop a heightened sense of solidarity and commitment to making every pregnancy safe. A case in point: Carlos Vigil, an agronomist, was meeting with a group of Ngöbe farmers in the Pilón community, Mironó district (one of the four districts where the project operates). This community is two and a half hours driving from San Félix where the Hospital del Oriente Chiricano is located and, at the time, the road was in very poor conditions. Mr. Vigil tells us that before he learned about the four delays that cause maternal mortality, he would not have stopped his workshop to help any pregnant woman. But he had learned about the project. And when he saw a woman and her husband walking in the direction of San Félix, he recognized the red bolsa semáforo the woman was carrying and realized that she was in her last trimester. He decided to postpone the meeting and gave the couple a ride to the hospital.

The bolsa semáforo have come to represent a key link between the community and healthcare services, closing the circle in which everyone concerned anticipates and contributes to the arrival of a new member of the indigenous community in the arms of a healthy mother.

9. Community-based Social Auditing

Social actors contribute to the implementation and oversight of policies and laws that recognize and respect the rights of individuals in the most unprotected sectors of mainstream society.

Bolivia

A fundamental element in the new structure of the Plurinational State of Bolivia is the involvement of social actors and organizations in steering the cultural and democratic changes taking place in the country. One of their tasks is to perform social auditing and oversight of the new constitution, which clearly states the role of civil society in order to guarantee that these responsibilities are being fulfilled.

Among the key articles of this new constitution is ***Article 241:***
"Civil society will be organized to define the structure and composition of participation and social auditing... State entities will generate opportunities for participation and social auditing by society."[1]

One of groups participating in this movement is the Confederación Nacional de Mujeres Campesinas Indígenas Originarias de Bolivia, Bartolina Sisa, which was created on January 10th, 1980 in the city of La Paz as a Trade Union Organization. The Bartolinas, as they are known, has played an important role in the promotion of indigenous women's rights, particularly their right to participate more actively in the social and political spheres of society.

Its main objectives are:
-To organize rural, native and indigenous women in a culturally embedded and unitary identity;

-To achieve a strong organic structure of national scope;

-To strengthen the participation of women at all levels; and,

-To develop joint actions with the predominantly male organizations and the Central Obrera Boliviana (the Bolivian Workers Union).

1. Gaceta Oficial de Bolivia, Constitución Política del Estado, febrero de 2009.

The Juana Azurduy Bonus

In line with the n constitution of the plurinational state, the government has requested the Bartolinas to play a key social audit role, in the oversight of the Bono Madre Niño-Niña Juana Azurduy or Juana Azurduy Bonus.[2]

This award is an incentive for mothers to seek health services throughout their pregnancy and for child delivery. Equally, it motivates them to fulfill the protocols of integral growth as well as the development controls of the child from birth to age two, and to create appropriate intervals between births.

"Up to May 2010, a total of 843,938 persons received this bonus and another 582,137 were registered."[3]

© UNFPA Bolivia

Among the strategies used by the Bartolinas to promote women's rights is its involvement of elected representative members at all administrative levels: councilwomen and mayors at the municipal level, departmental assemblywomen at departmental level and national assemblywomen and ministers, at the national level. This strategy is being used with respect to the oversight of the Juana Azurduy Bonus programme.

In their new role as social auditors, the Bartolinas are participating as observers of the Juana Azurduy bonus programme, ensuring that all women receive this benefit, especially indigenous women who live in remote rural areas. They also identify obstacles that need to be addressed in the implementation of the bonus.

To strengthen this oversight role, the UNFPA country office in Bolivia has developed a series of training resources related to safe motherhood and social auditing. They have been designed with the participation of indigenous women who validated their cultural pertinence, and appropriate use of language. Presently, seven brochures and two booklets have been produced and are being used in this ongoing social auditing function.


© UNFPA Bolivia

2. *The "Bono Juana Azurduy" is a benefit that grants $us 250 to the women in state of pregnancy and during a period of 2 years after the childbirth, to ensure childbearing in maternity hospitals, health controls and follow-ups*
3. *Reporte Ministerio de Salud y Deportes, Bolivia abril 2010*

Editorial team

"Promoting Equality, Recognizing Diversity:
Case stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples in Latin America"

Directorate: Marcela Suazo, UNFPA, Regional Director for Latin American and the Caribbean, UNFPA

Concept, Coordination, and Edition: Sonia Martinelli - Heckadon, Regional Desk Advisor for Latin America and the Caribbean, Programme Division-UNFPA

Supervision: Luis Mora, Deputy, and Ana Elena Badilla, LACRO Gender Advisor, Latin America and Caribbean Regional Office

Text Contributions from UNFPA Country Offices: Bolivia: Jaime Nadal, Monica Yaksic, William Michel, Alejandra Alcerreca; Ecuador: Jorge Parra and Lily Rodríguez; Mexico: Diego Palacios, Alfonso Sandoval, Blanca Espinosa and Gabriela Rivera; Guatemala; Leonor Calderon, Jeske Paijmans, Ana Luisa Rivas, Alejandro Silva, Sabrina Morales; Panama: Laura Flores, Martha Icaza and Ana de Obaldía; Peru: Esteban Caballero, Gracia Subiría, Dorina Vereau, Jorge Córdoba and Amber Bauer.

Editorial and Administrative Assistants: Nora Castedo, UNFPA LACRO and Ashby Anglin, P.D.

Graphic Design: Yovana Lasso, Consultant

Editor: Rachel Cline

Acknowledgement

The editorial team also acknowledges the insights provided by the following UNFPA staff: Luz Angela Melo, Human Rights Advisor and Azza Karam, Culture Advisor of the Gender, Culture and Human Rights Branch of the Technical Division; and Trygve Olfarnes, Regional Communication Advisor of the Media and Communication Branch, IERD.

UNFPA would like to express its gratitude to the National Institute of Indigenous Languages, INALI of Mexico, especially to Mr. Vicente Marcial, Mr. Victoriano Hernández, and Mr. Iván Oropeza Bruno, for their support in translations of quote to indigenous languages of Mexico.

Special thanks and appreciation to Miranda Mars, Mathew Barker - Peru For Less, Alex E. Proimos, Pedro Salvador, Micheal Chung, Nick Jewell, Mark Tuschman, Miguel Reyes Pérez, Yuri Hooker and Carina Wint for their courtesy and beautiful photos.

UNFPA acknowledges the generous contribution of the UNFPA/AECID Cooperation Fund for Latin America and the Caribbean, its supported the work of UNFPA on indigenous issues in five countries of Latin America as well as the design and printing of this publication.

Panama, August, 2010

© Alex E. Proimos


© Pedro Salvador


© UNFPA Bolivia