Experiences with Increasing Access for Indigenous populations in Latin America

Lessons learned

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Content

- Why do we need special strategies to reach indigenous women in LA?
- What have we learned with some examples of success.

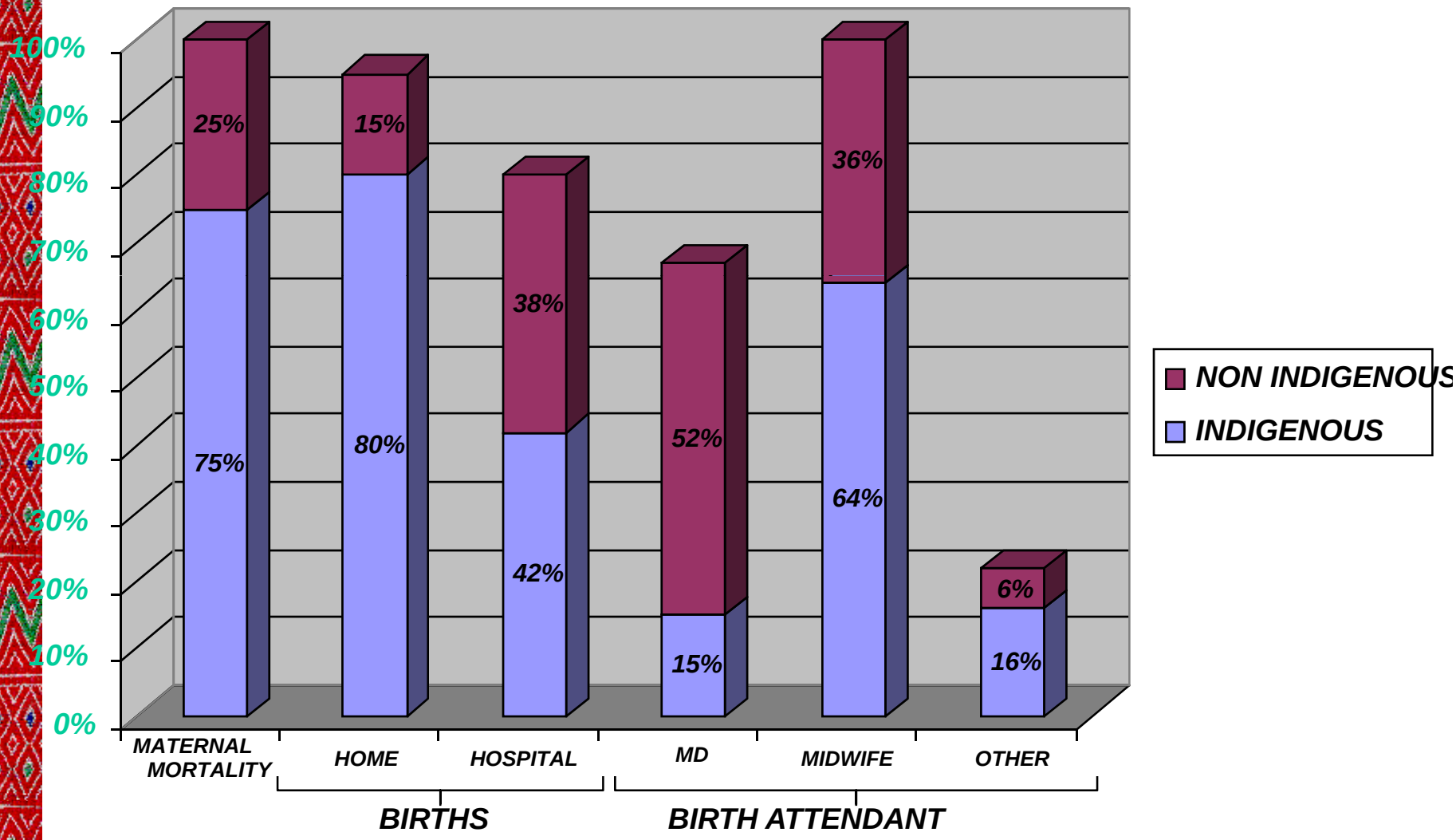
Content

Why do we need special strategies to reach indigenous women in LA?

Inequalities between indigenous and non indigenous women RH indicators

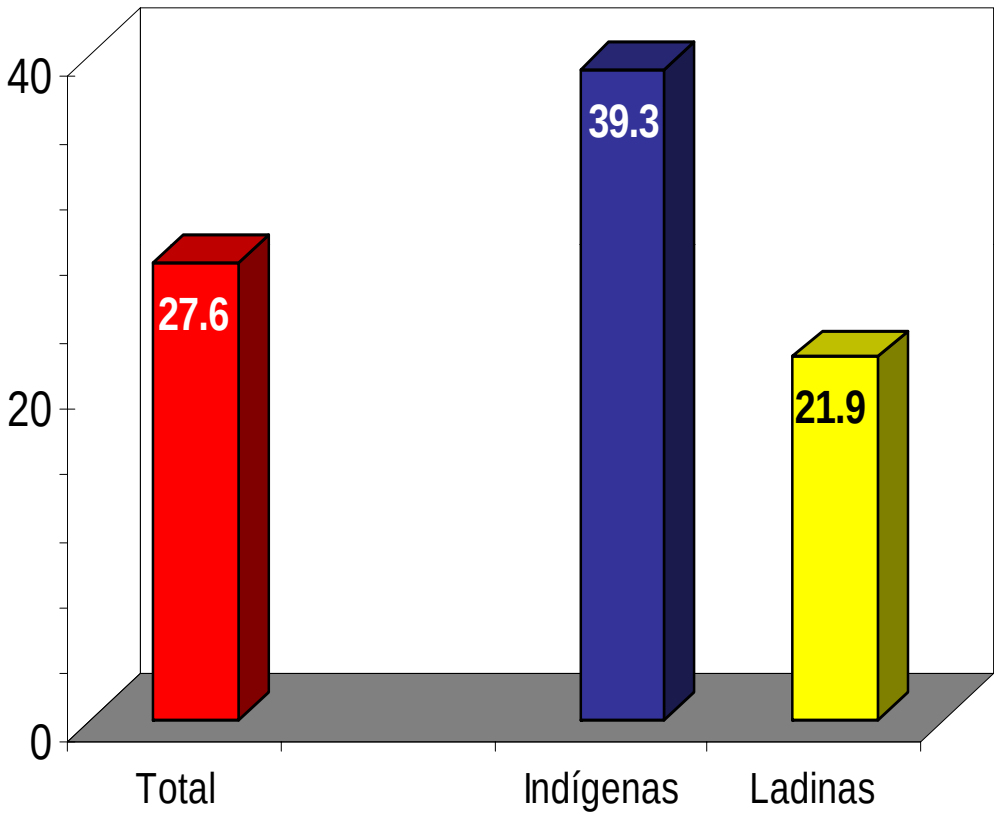
- Maternal mortality among indigenous girls and women is three times higher than non-indigenous
- More than half of indigenous girls have had a pregnancy before age 20.
- 7 out of 10 indigenous girls without primary education have had pregnancy by age 20
- Unmet demand for FP is significantly higher.
- Lack of culturally appropriate sexual education materials.
- Lower births attended in health facilities.
- 70% of births among the Ngobe (Panama) are attended by family members and traditional midwives.

Differences between indigenous and non indigenous women
Maternal health indicators . Guatemala.



Fuente: Línea basal de mortalidad materna, MSPAS. Guatemala, 2000.

Unmet demand for family planning. Women 15-49 years old by ethnic group. Guatemala



Source: ENSMI 2002

Most prevalent barriers

- **Economic:**
  - ❖ Poverty and high levels of migration.
  - ❖ Geographical dispersion

- **Political-ideological-cultural:**
  - ❖ Family planning programmes were viewed as a way to destroy the continuity of indigenous communities.
  - ❖ Important role of the Churches in limiting demand.

- **Gender inequalities:**
  - ❖ Give men power over women´s bodies
  - ❖ Determine the concepts of marriage, masculinity and maternity.
  - ❖ Violence against women

- **Health systems:**
  - ❖ Lack of access to quality RH services.
  - ❖ Health providers and systems insensitive to cultural differences and needs.

  "indigenous women do not want to use family planning services"

  - ❖ Monolinguism

- **Women:**
  - ❖ Fears and misconceptions, especially of older women.
  - ❖ Fears about of secondary effects of the methods.

Different world views, body conceptions, taboos, knowledge.

“ my mother told me that we were born with a set number of babies in our body..those were the babies we should have. Using contraceptives will kill those babies”

Kaq´chiquel women. Guatemala.

“ we have gone through a process of recognizing the internalization of the discrimination and racism. Only when we as indigenous women recognize again our right of giving and receiving affection, the right to feel and decide by ourselves, we will be able to exercise a free, healthy and self accepted sexuality. We will be able to decide when, with whom and how many children to have.

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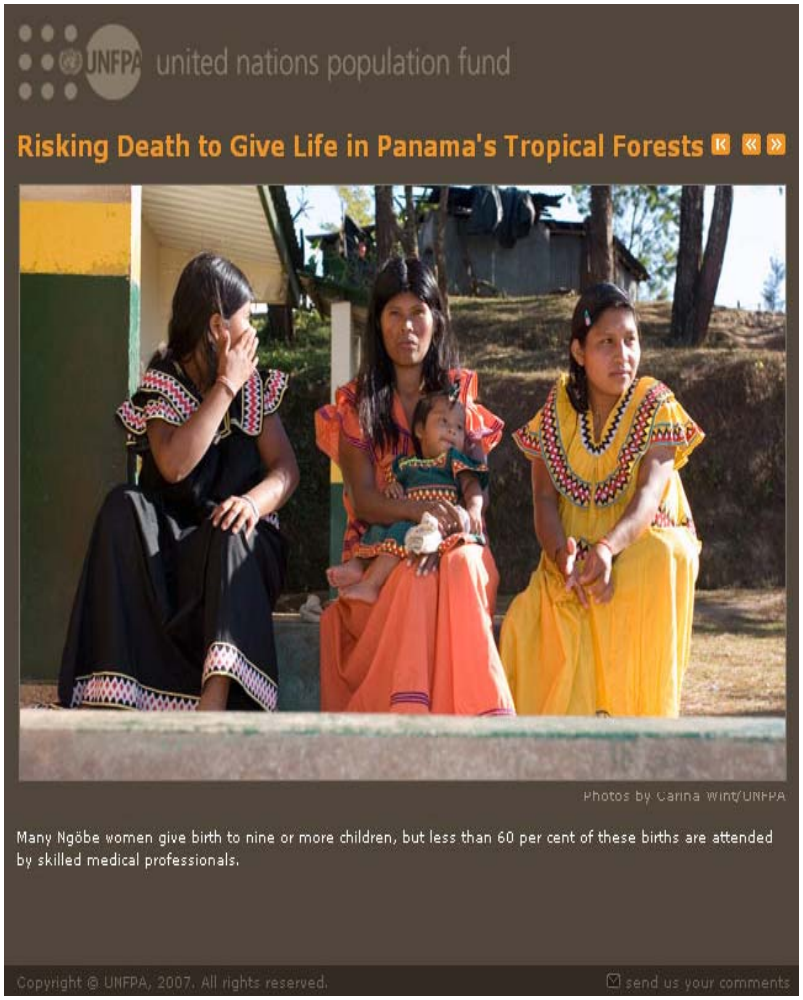
What have we learned with some examples of success.

General principles

- Need to know and take into account in the design of the services or programmes the context and acknowledge the diversity.
  - Research
  - Antropology



- Acknowledge that indigenous women have specific needs and visions that need to be taken into account by the health services and health providers when designing programmes and that they are not a homogenous group.

- Provide information that helps women decide (language, radio, by trusted personnel).
- Have options to mantain confidenciality and discretion.
- Involve and train community leaders, health workers.
- Involve men.
- Start from maternal health and birth spacing.
- Provide different contraceptive methods.
- Invest in training indigenous professionals, especially women.
- Get to know their RH practices, especially FP methods.

- Acknowledge the difference between the older and younger women and men.
- Focus on the young!

Diferent types of approaches and programmes

Project to improve the reproductive health of Ngobe women in Panama

- Based on a community based programme
- Long term partnership between the Ngobe Women´s Association, community leaders, the health system and and other private partners
- Emphasized reduction of maternal mortality
- Stressed the importance of voluntary FP
- Women empowerment

A national model was developed for the Ngove population.

Intercultural models of health care: Jambu Huasi Otavalo, Ecuador

- Is a consolidated authentic "intercultural health model" where two different health systems coexist and complement each other.
- Operating under the assumption that health needs can only be addressed successfully within their own social and cultural context, Jambi Huasi adopted a rights-based approach, grounding its integrated services in respect for cultural traditions, social solidarity and reciprocity.
- Turned into a community movement, demonstrating how local empowerment can change an entire health system and positively affect social and economic development.
- The model is being scaled up and has had positive results in RH in general and FP specifically.

Bilingual Literacy Programme in Quecha and Spanish in Bolivia

- Adult education programme with an intercultural and gender perspective institutionalized by the MOE is reaching 135,000 persons (77% women)

- Use of innovative methodology based on culturally sensitive “generating words”, women not only learn to read and write but they become increasingly empowered, recognizing their need for continued RH services and education, denouncing violence, demanding obstetric care and voluntary FP and exercising their rights within family and community contexts.

Opening opportunities for indigenous young women and girls in Guatemala.

Population Council

- Works in their context and opens opportunities through training of young women leaders that then work with girls and their mothers.
- They negotiate safe spaces for girls with community leaders.
- Peer education, mentorship
- Sexuality education, access to RHS.
- Work with families and communities

Some Results

- Increase social network in and outside the comunity.
- Sexuality education, reproductive health, FP and STI and HIV.
- Young leaders are values as a “community resource and an “accesible role model”
- Girls stay or go back to school
- Leaders highly motivated to continue their studies