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"PLANNING TOGETHER": A METHODOLOGY TO FACILITATE THE DEVELOPMENT OF STRATEGIES AND ACTIONS TO ADDRESS PRIORITY MATERNAL AND NEONATAL HEALTH PROBLEMS IN RURAL BOLIVIAN COMMUNITIES

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John Snow, Inc., 1616 N. Fort Myer Drive, 11th Floor, Arlington, Virginia 22209 USA
Tel: (703) 528-7474 Fax: (703) 528-7480 Tlx: JSI WUR

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Lisa Howard-Grabman
MotherCare/Save the Children-Bolivia

MotherCare Project
1616 North Fort Myer Drive, 11th Floor
Arlington, Virginia 22209 USA

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"PLANNING TOGETHER": A METHODOLOGY TO FACILITATE THE DEVELOPMENT OF STRATEGIES AND ACTIONS TO ADDRESS PRIORITY MATERNAL AND NEONATAL HEALTH PROBLEMS IN RURAL BOLIVIAN COMMUNITIES

Lisa Howard-Grabman

INTRODUCTION

This paper is based on a three-year demonstration project in maternal and neonatal health in the rural Province of Inquisivi, Bolivia. The project was implemented by Save the Children/Bolivia (SC/B) under a subcontract to John Snow, Inc. and was funded by the United States Agency for International Development (USAID) MotherCare Project.

The "Warmi" Project ("warmi" means woman in Aymara, the local language) was initiated to determine how a community-based approach could be used to improve maternal and neonatal health in a very remote setting, in which there is little access to adequate formal health services.

Results of the project to date include a significant decrease in perinatal and neonatal mortality from 75 deaths out of 639 total births at the beginning of the project (1988-1990) to 31 deaths out of 708 total births (1991-1993). Families demonstrated positive changes in health practices such as increased immediate breastfeeding, tetanus toxoid vaccination, hygienic birth, immediate care of the newborn, and increased use of contraceptive methods.

This paper focuses on Save the Children/Bolivia's experiences in participatory planning -- a process that we call "Planning Together." Since every setting has its own particular characteristics and resources, replicating the process presented in this paper will require some adaptation.

BACKGROUND

Save the Children/Bolivia (SC/B) began MotherCare Project activities in 50 communities in the Inquisivi Province of La Paz Department in July, 1990. The goal of the three-year project was to reduce maternal and neonatal mortality and morbidity through affecting the range of behaviors that influence the outcomes of pregnancy, delivery and the neonatal period. A major strategy used to achieve these objectives was the organization of women's groups to increase women's knowledge and awareness of specific maternal and neonatal health problems and of the locally available resources that could be used to address these problems.

Geographical Setting

The rural Province of Inquisivi lies approximately five hours by road southeast of La Paz. The province is characterized by high plains (altiplano), high Andean valleys, and subtropical valleys. The 15,000 inhabitants in the defined project area are predominantly of Aymara (native American) extraction. Quechua migrants are also found in the lower valleys. The province encompasses over 5,000 square kilometers with difficult access to the population. Because roads are poor in many parts of the province, several communities can only be reached after many hours on foot. Means of transport are scarce and unpredictable.

Health Statistics In the Province

In 1990, a retrospective case-control study of maternal, perinatal and neonatal mortality was carried out by Warmi Project staff in the province. According to this study, verified mortality rates were extremely high in this population: for a two-year period of study, perinatal mortality was 103/1,000 births; neonatal mortality 69/1,000 live births; and maternal mortality 140/10,000 births. The most common probable causes of perinatal death identified by the study were: asphyxia, sepsis, trauma, hemorrhage and hypothermia. Probable causes of maternal death included hemorrhage, sepsis associated with intrauterine fetal death and puerperal sepsis, and abruptio placenta.

Health care services in the province are provided by the Ministry of Health. There are two health posts, one in Licoma zone and one in Inquisivi zone, each staffed by one doctor carrying out the mandatory one-year rural medical service and by one auxiliary nurse. Circuata zone is served by a health post staffed by one auxiliary nurse. The posts are stocked with the bare minimum of essential basic medicines and equipment. The reference hospital in Quime does not meet the minimum WHO standards for a health post. Staffed with two to three doctors, several nurses, a dentist and a custodian the hospital cannot cope effectively with major complications which require surgical intervention due to a lack of sterilization and anesthesia equipment and trained staff. An ambulance is available for use by the Quime Hospital but it is often out of service due to poor maintenance, lack of spare parts and lack of funds to purchase gasoline. All health facilities are under-utilized by the population, in part because of economic factors, in part because of socio-cultural factors and in part because of the justified belief that the services are not equipped to deal with more complicated problems. Women with complications during their pregnancies or labors are usually counter-referred to La Paz or Oruro (4-6 hours by road).

General Characteristics of Women In Inquisivi, Licoma and Circuata Communities

The Warmi Project worked in three geographic zones of Inquisivi Province (Inquisivi, Licoma and Circuata) that vary widely in their socio-cultural characteristics. The families in the Inquisivi Zone tend to be more well-established, more traditional, and more resistant to change than those of the Circuata Zone. In contrast, the communities in Circuata Zone are newer, or, if old, have a number of recently immigrated families. Though these new families are also descendants of altiplanic (highlander) people, the fact that they are a self-selected group of immigrants who initiated change implies that they are more interested in, and accepting of, change, progress, or improvement in their lifestyle.

Men and women in the Inquisivi Province are bound by a tight family structure and rigid sexual roles. Traditionally, women have not participated in the decision-making process for community activities; it is usually the husband who has a voice and vote in the monthly community meetings and, if women attend, they are never heard. The village authorities are elected or serve in turn; the only time a woman is found in this position is if she is a widow of a former member and if she owns land.

Not only are the communities led exclusively by men, but in the family, it is the man who most often makes all financial decisions. Most SC/B field staff have witnessed cases of husbands deciding that it would cost too much to send a woman with complications during her labor or pregnancy to the hospital (3-7 hours by road, not including the time spent trying to gain access to transport). The cost of a caesarian, for example, may represent six or more months of cash income. The family is then left to make do with the few available local resources. This not uncommon scenario contributed to the high maternal and perinatal mortality rates in the Province.

Organizing Women's Groups

The isolation of women in such dispersed communities leaves many feeling powerless and alone. One of the first activities of the Warmi Project was to identify existing women's groups and to strengthen those that were interested in continuing to work together. New groups were also organized. The purpose of this strategy was to raise women's awareness that their individual problems are often common to others and that together they are more likely to find solutions.

A common strategy used by other PVOs and NGOs that SC/B chose NOT to use for group formation and strengthening was that of donations to group members including food, materials, etc. This policy was established because experience shows that many women only use the group as a mechanism to receive the food and when the food disappears, so do the women. This strategy is not sustainable, nor is it empowering. Through our experience, we saw that once the group is established and working, its members are often highly motivated to meet regularly to discuss and solve their problems without donations and with or without SC/B staff.

SC/B's experience with women's groups demonstrated that women could, and did, learn to identify and talk about their problems. Many groups developed and implemented strategies to deal with the problems that they identified. Men became more interested in the women's activities. Many women became more comfortable speaking in front of men at community meetings and leaders emerged from within the group. By the end of the project, some of these leaders were working to organize women at the zonal and provincial level. This is a slow process but one that was very empowering for the women.

The women's groups consist of approximately 10-30 members each and meet at least once a month. Many groups meet weekly. The groups function as a forum for learning, decision-making, social contact with others, and a diversion from the hard life shared by all the members.

THE ROLE OF PROJECT STAFF

Philosophy

In keeping with SC/B's participatory approach to its work, the role of project staff is seen as a facilitatory one rather than an educational one. Staff are viewed as project "beneficiaries" along with project participants in the full belief that one of the project goals is self-development for all those involved. Taking the approach that the only lasting form of development is one where the participants take control of their situation and make collective decisions on improving it, project staff then assume the role of assistants in this process, facilitating and aiding the participants in making their decisions and in converting them into actions.

The underlying philosophy relating to staff is the central importance of respect for the project participants and of belief in the latter's ability to identify and find solutions to their own problems. This approach has encouraged SC/B to continuously assess the learning taking place in the areas of knowledge, attitudes and practices both of project participants and of its staff. This constant self-evaluation and openness to learning has led to better acceptance and integration of staff within the women's groups and the community, and, ultimately, to more self-development within the groups. It has also resulted in greater understanding on the part of SC/B of the reality of the women's situation and of the essential need for locally appropriate solutions to their problems.

Training

In the initial stages of the project, much work needed to be done to enable staff to understand the difference between "educating" and "facilitating." Some staff members found it quite difficult to make the transition from taking a directive role to adopting the stance of listener and facilitator. However, with continual practice and training, their approach changed considerably, and staff learned how to facilitate the problem identification and planning processes rather than direct them.

Staff also received training in technical issues including workshops on pregnancy, birth, postpartum care, care of the newborn, and family planning.

Learning Through Doing
(Don't be afraid to make mistakes and don't think you know all the answers.)

The approach taken with project staff has been one of learning through actually doing. Initially, many staff members were inhibited in their work, believing that they should have answers for every question (which, of course, they didn't). The project has fostered the idea that there is no one correct answer to any question nor any one solution to a given problem. It is only through a process of collective decision-making and action that an issue affecting a community can be resolved.

In the course of the project, staff became more confident in their roles of people who are there to help the group to open up and to realize that they can influence what happens in their lives. In the process, the staff also realized that they do not have the answers to the groups' problems. This realization proved to be particularly important in preventing staff from making promises that SC/B could not fulfill and, thereby, falsely raising the groups' expectations. In addition, staff developed the ability to try different approaches with the groups and to accept that they, too, can make mistakes and should not be afraid to do so. Considerable staff development and learning took place through their contact and work with the groups.

PROGRAM STRATEGY

SC/B developed and implemented this project in the context of its established and proven methodology of Community-Based Integrated Rural Development ("C-BIRD"). This methodology is based on the premise that long-term, sustainable development depends on the capacity of community groups to determine local priorities, plan projects, acquire necessary resources and assume responsibility for the administration and coordination of development activities.

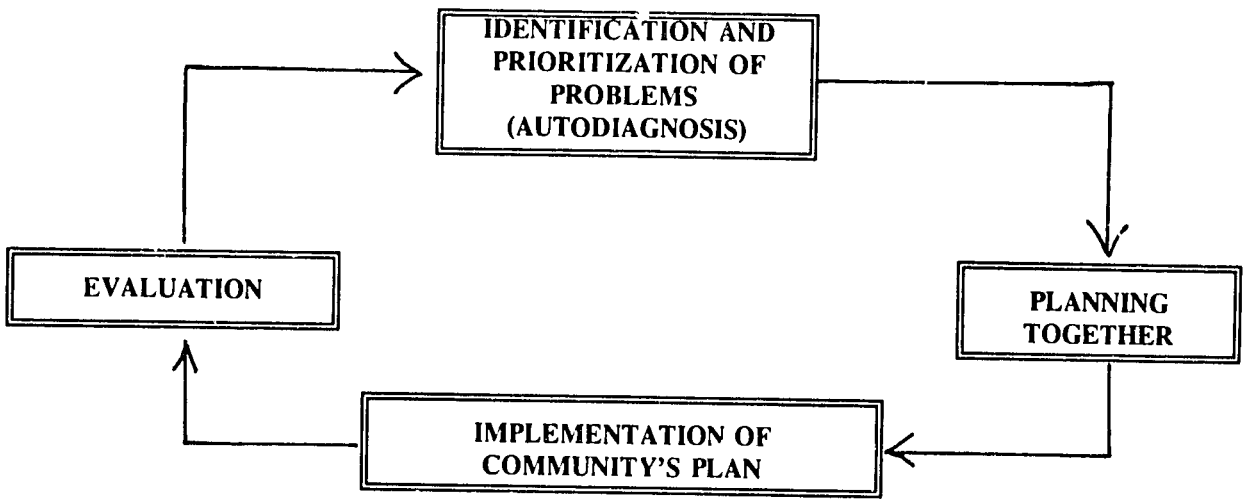
A very important aspect of this project was the evolution of a model for maternal and neonatal health interventions which other PVOs and community groups in Bolivia can replicate in the future.

SC/B believes that maximum community involvement will permit an eventual "phase over," with the expectation that certain benefits will be self-sustaining. As such, this project was designed so that women's groups participating in the project would be able to replicate the process to address other community problems.

COMMUNITY LEVEL PROBLEM SOLVING

The SC/B Warmi Project developed a simple model for community level problem solving. A diagram of the model, "A Community Action Cycle", is presented below. This cycle was the basis for all program intervention. This paper focuses on the "Planning Together" phase, presenting each step of the process as SC/B carried it out and a short summary of the results.

A COMMUNITY ACTION CYCLE



This cycle might be considered obvious by some readers. However, SC/B found that explicitly stating the steps and drawing the above diagram was a break-through in understanding the process, both by staff and community members.

The steps of this cycle were implemented as follows:

1. **Identification and Prioritization of Problems**
   An exercise called the autodiagnosis was developed for use with women's groups in identifying and prioritizing their problems (see Working Paper 16A: The "Autodiagnosis": A Methodology to Facilitate Maternal and Neonatal Health Problem Identification, and Prioritization in Women's Groups in Rural Bolivia).

2. **Planning Together**
   A 5-step process was devised as a vehicle for the women's group to carry out a planning meeting together with other members of the community and local authorities to develop strategies and actions to solve their problems. SC/B also developed a project implementation plan to guide activities at the project level.

3. **Implementation**
   The communities implement their plans based upon their agreements from the "planning together" exercise.

4. **Evaluation**
The project had not yet field tested the community-based methodology for communities to evaluate the results of their actions at the time of writing of this paper. (However, several participatory evaluation techniques were used in the final evaluation of the project in May 1993. Nine community women representatives participated on the evaluation team with 6 external evaluators.) Based on the evaluation, problems should again be identified and prioritized as the cycle begins anew.

It is important to note that in the area of maternal and neonatal health, many interventions to prevent mortality rely on secondary and tertiary level medical care which is often not readily available to impoverished rural communities. The autodiagnosis motivates women to look for solutions within their community context, trying to make the most of their local resources. In the case of Inquisivi, the effective referral hospital is 4-6 hours away in La Paz. This implies that different strategies are needed to confront the problems in these remote communities than in communities that have fairly easy access to services.

THE "AUTODIAGNOSIS": A BASIS FOR "PLANNING TOGETHER"

The "autodiagnosis" is an on-going qualitative research process in which women's groups explore their maternal and neonatal health problems. As such, it allows both the community and the field staff to learn about how women perceive these problems and how they respond to them. Consistent with SC/B's participatory, community-based methodology, this process draws on basic concepts of facilitating the exploration of experiences, attitudes and practices. Whereas, in other more quantitative study methods the interviewers seek specific, quantifiable data, in the autodiagnosis method there are no "right answers," only what the women themselves believe, understand, and do. In addition to raising women's awareness of specific maternal and neonatal health problems, a major goal of the process is to foster the women's confidence in their ability to gather information from their neighbors about topics that concern the community and to learn to prioritize the problems that are identified.

The autodiagnosis was carried out in 50 communities over a period of two years. It consisted of four sessions of approximately three to four hours each, not including external interviews with other women in the community. The four sessions were divided into nine steps. The process varied in some cases as a result of individual group differences and circumstances.

Some people believe that if there is not easy access to services, awareness of the problems should not be brought to light in these communities through an exercise like the autodiagnosis. SC/B strongly disagrees. It is SC/B's belief that problems need to be identified before appropriate solutions can be sought. Women have a right to explore and identify their problems (particularly those that determine life or death) and seek possible solutions to improve their situation, through lobbying for better services, participating in more training and education in preventive practices, establishing community emergency funds, forming better transport links, etc.

The autodiagnosis process was not developed solely for the purpose of identifying maternal and neonatal health problems; more importantly, it serves as a means to empower women through self-reflection, through greater communication, and through learning a process for decision-making as a group -- a process that Bolivian women are not privileged to participate in at the community level. It is also an essential first step in identifying and prioritizing problems prior to solving them.

A more detailed discussion of the Autodiagnosis methodology and results from 25 communities can be found in Working Paper 16A, The "Autodiagnosis": A Methodology to Facilitate Neonatal Health Problem Identification and Prioritization in Women's Groups in Rural Bolivia, (Howard-Grabman, L., John Snow, Inc./MotherCare Project, March, 1993).

PLANNING TOGETHER

"Planning Together" is the second step of the "Community Action Cycle" that is designed to result in community-based action to resolve identified problems.

As with the Autodiagnosis methodology, the "Planning Together" methodology was developed through a series of field trials and adjustments until staff and communities were satisfied with the results. Several exercises originally included in the sessions had to be discarded because they confused the community members or because they distracted the group away from the session's objectives. One interesting example was an exercise that was designed to help the group look for "root causes" of problems that contributed to maternal and neonatal mortality. This exercise was not going well and staff eventually realized that it was because in Aymaran culture there was no concept of "cause" as Western culture understands it. In fact, nobody could translate the word "cause" into Aymara! The exercise was removed from the session and more emphasis was placed directly on the priority problems and how they occur in daily life. This helped the process enormously.

This section describes the "Planning Together" methodology step-by-step and includes an example of one community's plan which resulted from the process.

PLANNING TOGETHER OBJECTIVE: To define strategies and actions to resolve the problems identified by the women's group through a process of planning together with the group, and with local authorities and other community members.

SUMMARY OF PLANNING TOGETHER PROCESS

Aim:	To define strategies and actions to resolve the problems identified by the women.		
Activity:	A planning together meeting with the women's group, with other members of the community and with local authorities.		
Time:	At least 3-4 hours (plus socio-drama)		
Procedure:	**A.**	Preparation (including socio-drama)	
	B.	Steps of the meeting	
	Step 1.	Women present their priority problems	
	Step 2.	Community identifies barriers to solving the problems	
	Step 3.	Community identifies strategies and realistic, concrete actions	
	Step 4.	Community formalizes agreements in a written document	
	Step 5.	Document is signed by all and meeting is adjourned	

1. PRELIMINARY PHASE

The group needs to prepare prior to organizing a planning meeting. The group members who participated in the autodiagnosis should review the results and decide how they are going to present them to other community members during the planning meeting. They should consider the following points:

- What priority problems did they choose?
- Why did they choose them?
- Who can best explain the process to the group? Does this person want to make the presentation directly to the group during the community meeting? Would it be better for a few people to make the presentation? Who will do what?

PREPARATION OF A SOCIO-DRAMA TO IDENTIFY BARRIERS TO SOLVING PROBLEMS

The women's group should choose some of their members to prepare a socio-drama (skit), taking as the main theme the problems identified in the autodiagnosis. They should consider the following when preparing the socio-drama:

- The scenario presented to illustrate the problems must be a real one.

- They need to display difficulties or barriers to solving the problem so that the audience can identify them. They must take into account that they will need to stop the socio-drama for a few moments whenever the participants identify a barrier. The actresses will need to rehearse the socio-drama in preparation for the meeting.

- How will the women present the process of the Autodiagnosis, the results and the socio-drama? Preparation must be made for charts, drawings, red cards for the socio-drama, stories, costumes, etc.

- Who should attend the planning meeting?
  The women's group needs to take into account people who have influence within the community and who can help in finding solutions to problems (e.g. MOH staff, teachers, community authorities, "parteras" [community birth attendants], etc.).

- When will they meet?
  Availability of the people attending the meeting must be considered.

- Who will invite the participants? How will they be invited? By person to person contact? By letter? (In Inquisivi, letters convey a greater seriousness of purpose and are therefore recommended.)

- What materials will they need to conduct the meeting? Who will be responsible for preparing the materials?

The women need to organize all of these details before holding the meeting.

It is a good idea for the women's group to rehearse their presentation prior to the meeting. They will then feel more secure and confident in their roles.

PLANNING TOGETHER

The planning together process requires a meeting of at least 3-4 hours duration. More time may be needed depending on the women's group and on the level of depth and detail that its members desire. It is important that people with some understanding of maternal and neonatal health problems and/or political influence attend the meeting as they can help to look for realistic solutions and formulate action plans that can be implemented.

2. STEPS OF THE PLANNING TOGETHER MEETING

The step-by-step process is described below. This process, as with the autodiagnosis, is flexible and can be changed if the group has a special need. The facilitator has to rely on his or her creativity to find techniques and methodologies which suit the group. If a particular step is not appropriate for the group, another approach needs to be tried instead.

STEP 1: PROBLEM PRESENTATION BY THE WOMEN

Aim: The group will learn about the problems identified by the women and will know why they are priority problems.

Activities

1. The facilitator introduces the women to the audience, explaining that they have carried out good work in investigating and identifying problems with maternal and child health during the first month of a baby's life.

2. The women present their autodiagnosis experience according to their plan.

3. The facilitators asks the audience for comments or questions on the presentations. S/he congratulates the women on their presentation.

STEP 2: IDENTIFYING BARRIERS TO SOLVING THE PROBLEMS

Aim: The community participant will understand what a barrier is and will identify barriers to solving the problems portrayed by the women.

Activities

1. The facilitator demonstrates what a barrier is, using real life experiences of those present. (10 minutes)

   Possible questions:

   -- What is a barrier?

   -- Can you give an example of a barrier that you have in your life?

   -- What are the barriers to solving our problems with maternal and newborn health?

   -- Why do these barriers exist?

(Examples of some barriers: People do not recognize that there is a problem; people do not think that the problem is important; there is no transport available; there is not enough money or people do no want to spend it on medical services; maltreatment by health personnel; there is nobody in the hospital to help; etc.)

2. Presentation of the socio-drama

* A red card is handed out to each participant. Once everyone has a care, an explanation is given.

"The women will now present a socio-drama showing what can happen in reality when the problems we have identified occur in the family. Every time you (the audience) notice a barrier to solving the problem, you should hold up your red card. The socio-drama will stop while we write down the barrier on the sheet of paper. The socio-drama will then continue."

* The group that prepared the socio-drama begins their presentation. When the audience identifies a barrier, the actors "freeze". The facilitator notes the problem that has been identified on a piece of flipchart paper. The socio-drama continues until it is finished, with the facilitator making a list of all the barriers identified by the audience.

STEP 3: IDENTIFYING STRATEGIES AND REALISTIC, CONCRETE ACTIONS

Aim: The community will identify strategies and concrete realistic actions which will help to lessen or overcome the barriers identified.

Activities

1. All community participants (including the women's group members) divide into two groups, one group of women and the other of men so that the women will be more likely to actively participate because men won't dominate their discussion. Both groups work with the list of identified barriers, taking each one in turn and discussing how the community can deal with them.

   At this stage the facilitator should stress that the plans they come up with must be very practical and realistic. The participants themselves will be putting the plans into practice and must therefore develop strategies and decide on actions to which they will be able to commit themselves.

   Questions to support the process:

   * What resources does the community have to deal with this problem?

     -- material resources
     -- people
     -- other (time, etc.)

   * What else do we need to confront the problem?

   * Is it possible to get what we need? How? Who can help us? When? (specific dates, times if meetings are to be held, who will be responsible, etc.)

   * When they have finished, the two groups present their strategies to the whole group.

   * The facilitator asks if everyone agrees with the recommendations. The participants discuss whether the recommendations are realistic or not and whether they will solve the problem.

   * The group reaches a consensus on the strategies and actions to be put into practice.

STEP 4: FORMALIZING THE AGREEMENTS IN A WRITTEN DOCUMENT

Aim: The group will draw up a written document of the agreements reached amongst them in order to put into practice the strategies and actions or dealing with the barriers to problem solving that hey have identified.

Activities

1. Using the strategies prepared in the previous step, the group writes up a final document of all the agreements. The document must contain at least the following:

   -- Specific identified strategies with concrete, detailed actions;

   -- Dates (and hours, if applicable) if every action (including the date of the evaluation meeting to assess progress towards achieving their goal);

   -- Person(s) responsible for each action; and,

   -- Names of all the participants.

(It is suggested that the participants organize themselves into working groups or "committees" with one person responsible for each group. These working groups may be written into the document as a formal mechanism for carrying out the work plan.)

STEP 5: CLOSURE OF THE PLANNING TOGETHER MEETING

Aim: The participants formalize the agreements among themselves.

Activities

1. The facilitator congratulates the group for its good work and reminds the participants that these are real agreements. If they want to solve the problems that they have identified, they must fulfill the promises upon which they have agreed.

2. Everyone signs the document. If participants are pledging the participation of an institution, they can include their official seal as well. It is recommended that the document be made as formal as possible (i.e. with signatures, seals, stamps, etc. to project the seriousness of the participants' commitments.

3. The facilitator states that the group will meet on the date set to evaluate the results of the actions they have taken. It is always advisable to set the date for the next meeting during the planning together session.

3. EXAMPLE OF RESULTS OF PLANNING TOGETHER IN ONE COMMUNITY

The community of Circuata conducted its "Planning Together" meeting in May, 1993. A direct translation of their plan is presented here as an example of one community's work.

ACT FROM THE PLANNING TOGETHER MEETING IN CIRCUATA

In the canton of Circuata, Inquisivi Province in the Department of La Paz, a meeting took place at 8:30 at night on Friday, May 21, 1993. At the meeting were present members from the women's group, parents and adolescents, and Mr. Jose Perea, Humberto Ignacio, both functionaries of the MOH and Basilio Cachi and Romelia Antonio from SC/B. The meeting was called and agreed upon by the women's group on May 6th with the objective being to realize the "Planning Together" exercise.

After initial words of introduction, the agenda was set:

1. Brief introduction
2. Presentation of reproductive health problems prioritized in the autodiagnosis
3. Identification of obstacles or barriers
4. Presentation of a "socio-drama"
5. Search for strategies to solve the problems
6. Agreements

An explanation was given to the participants about what the meeting would consist of and brief brainstorming exercise was done with the participants on their ideas about problems of reproductive health.

Presentation of problems by the women. - The SC/B field supervisor introduced the women who were to present the problems prioritized in the autodiagnosis relating them to what happens in reality.

1st problem: Malpresentation, presented by Mrs. Sonia Perea.
2nd problem: Hemorrhage in pregnancy and birth, presented by Mrs. Elena Celis.
3rd problem: Edema, presented by Mrs. Cristina Pauca.

The participants ratified the problems mentioned above and made comments about them.

CIRCUATA PLANNING TOGETHER

IDENTIFICATION OF OBSTACLES/BARRIERS: After an explanation about what an obstacle is, with several clear examples from real life given, paper and markers were distributed to each participant so that each participant could draw something that represented an obstacle based on the three problems mentioned earlier.

PRESENTATION OF THE SOCIO-DRAMA: While the participants identified obstacles in drawings, the socio-drama was prepared. Then the socio-drama was presented. It was about a family with four children and a woman who had the same problems that the women had presented above which finally led to the woman's death. While the socio-drama was being presented the participants raised their drawings representing obstacles each time that they observed an obstacle faced in the socio-drama. The facilitator wrote down each obstacle as it was mentioned.

LIST OF OBSTACLES OR BARRIERS IDENTIFIED:

* There is no ambulance
* There aren't sufficient economic resources
* They don't go to the health post
* There is no doctor
* There is not enough food (poor diet)
* Lack of transport
* Little awareness of prenatal care
* Lack of confidence in the partera
* Detached husband, doesn't think of his wife
* Untrained partera
* Young mother
* Many children

The participants recognized and ratified the above as barriers that fundamentally obstruct solutions to problems that ultimately lead to maternal and neonatal death.

CIRCUATA PLANNING TOGETHER -- Continued

IDENTIFY STRATEGIES AND SPECIFIC, CONCRETE, REALISTIC ACTIONS Through criteria, opinions, suggestions and interchange of ideas on: What the community can realistically and concretely do to confront the identified obstacles; as well as identifying the resources the community possesses. The consensus reached was the following:		
STRATEGIES/ACTIVITIES	**WHEN**	**PERSON RESPONSIBLE**
Request an ambulance for the town	When town meeting is organized	Whole town and authorities
Economic Resources * Payment to help in complicated deliveries, if family is poor * Generate funds by working and selling products * Loans to families if they need help * If the family has resources and the husband doesn't want to spend money for a difficult birth, the women's group will bring it to the authorities' attention.	When difficult deliveries occur	Women's group, husband and authorities
Nutrition * Improve nutrition through family gardens * The women's group will sell vegetable seeds, from which funds will serve for loans mentioned above.	Continually support this activity	Women's group
Means of Transport * Search for other rapid means of transport	When difficult delivery occurs	Husbands, partera women's group
Prenatal Care * Raise awareness of prenatal care * Pregnant women should go to the partera or to the health post.	From May 21, 1993 onward.	Husband and mothers

CIRCUATA PLANNING TOGETHER -- Continued

STRATEGIES/ACTIVITIES	WHEN	PERSON RESPONSIBLE
Detached Husbands * Orient husbands	From May 21, 1993 onward.	Husbands, partera, health personnel
Untrained partera * Conduct orientation and training in courses that exist in the future.	From May 21, 1993 onward.	Partera, MOH, SC/B
Young Mothers * Orient and train adolescents in sex education.	From May 21, 1993 onward.	Mothers, Bolivia Episcopal Conference
Many Children * Orientation, training and family planning methods.	Continue with visits from AYUFAM* or others	Interested couples, AYUFAM/other NGO

Due to the fact that it was getting late and the facilitator noted that some participants were tired, the agreements were finalized and the results were reviewed.

Agreements -- The group decided to draft the present document as a testimony to their agreements. It will be signed by all of the participants, with words of thanks to the audience for their active participation, the meeting was adjourned at 10:00 the same night.

LIST OF PARTICIPANTS

Bertha de Sipe	Betty Miranda	Clara Munoz	Alejandra Sipe
Felix Clamani	Hugo Miranda	Cardenio Laura	Sonia Perea
Angelina Endara	Sahara Andrade	Hilde de Siles	Elena Celis
Sandra Celis	Margoth Cardenas	Emma Miranda	Lisia Celis
Celia Jimenez	Cristina Fauca	Soraida Rocha	Victoria Celis
Rufina Ayca	Olga Estrada	Carmen Ayaviri	Augustina Calatayud
Delma Bonifacio	Senóvia Mavia	Juaha Aranda	Mary Villar, ... etc.

* AYUFAM is a local NGO that collaborated with SC/B to provide reproductive health services to communities that requested them.

ACTIONS TAKEN BY COMMUNITIES IN RESPONSE TO IDENTIFIED PROBLEMS

The next step in the "Community Action Cycle" is to implement the strategies developed in the "Planning Together" sessions. Several examples of actions taken by the communities to improve maternal and neonatal health follow:

1. Developed a manual for "parteras," community birth attendants, and four booklets for women on reproductive health (pregnancy, labor/delivery, postpartum care and care of the newborn) with technical assistance from SC/B and CIEC, a local NGO.

2. Produced safe birth kits and sold them to pregnant women in the community.

3. Held training/education sessions on topics such as family planning, hemorrhage, retained placenta, etc.

4. Solicited and succeeded in initiating family planning services in Inquisivi province through an agreement between SC/B and AYUFAM, a local service provider.

5. Established emergency funds through women's group income generating projects such as communal gardens, sewing mosquito nets, and running general stores.

6. Solicited and initiated a credit program for women which is now being piloted by SC/B in four communities.

7. Solicited and are now implementing a literacy training program with women's group representatives serving as the literacy trainers.

8. Local authorities invited women to participate in general community meetings to which they were never welcomed before.

9. Wrote to the MOH to request improved health services offering a community counterpart contribution.

10. Selected parteras (community birth attendants are not traditional in Inquisivi) to be trained in safe birth practices at the referral hospital in La Paz and in on-going classes in Inquisivi. (One zone's authorities decided to establish a price scale for the parteras' services, thereby legitimizing their presence and their services.)

Many of the communities participating in the Warmi Project were involved in this phase at the time that this paper was written. SC/B will soon be field testing the facilitation guide for participatory evaluation. Some of the methods that appear in the facilitation guide were used during the final evaluation. Nine community women leaders served on the evaluation team. Ten communities were visited and local authorities and parteras from all the Warmi Project communities participated.

CONCLUSIONS

To date, over twenty communities have participated in the "Planning Together" phase of the Community Action Cycle and have developed their own plans and strategies to confront maternal and neonatal health problems at the community level. This process was new to many of the women who participated in it, and through it they have learned that they have a voice and can set the community agenda. Many men learned that women can be important community resources and they have seen the value in women's organizations to help promote community development. In the Warmi Project final evaluation in May, 1993, community authorities were asked to prioritize the project's interventions according to what they believed to be the most important for improving women's lives and health. With few exceptions, the leaders chose "organization and strengthening of women's groups" as their first priority.

Group planning was a foreign concept to many of the women who took part in "Planning Together." Although planning is often done at the individual and family levels in the context of planting, harvesting, etc., most women found the process a new, sometimes intimidating and sometimes liberating experience. It was often necessary to use small groups, dividing men and women, to enable the women to fully participate in strategy development. When the large community group served as the decision-making mechanism for strategy formulation without prior input from smaller, same sex groups, the women's participation was noticeably diminished.

Though it seems obvious, the "Planning Together" experience in Inquisivi demonstrated the importance of developing methodologies within a cultural context, taking into account basic concepts of causality, planning, and the role of fate in other areas of community life.

The qualitative goal of women's empowerment was a guiding force in the development of the Warmi Project methodology. When certain methods were judged to possibly result in lowering women's self-esteem, they were discarded and other methods were sought. The willingness of SC/B field staff and community members to admit that methods were not suitable and to suggest new methods helped to improve the entire process and contributed to staff and community members' personal growth.

In conclusion, the Warmi Project final evaluation results show very positive trends. Communities have begun to take action and families have chosen to substitute some of their more harmful reproductive health practices for new, "improved" ones that they have determined to be realistic and acceptable. As a result of this, maternal, perinatal and neonatal mortality are on the decline in these communities.