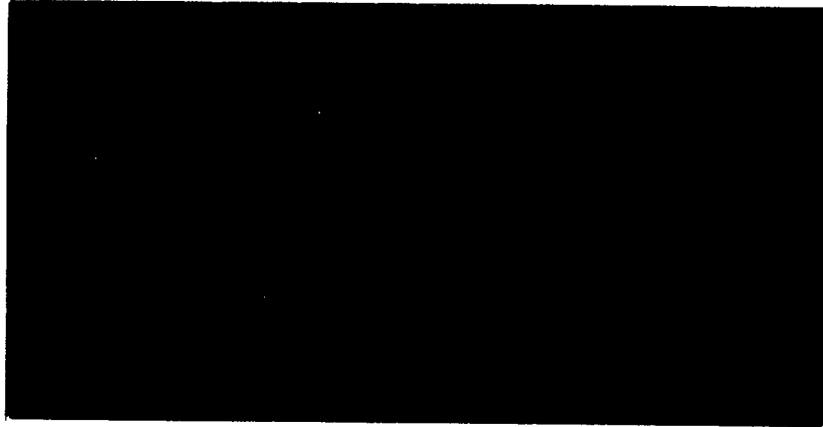
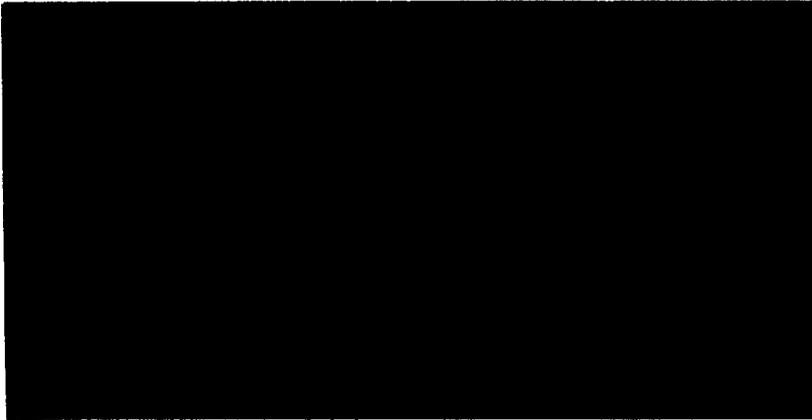


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Family Health International is a non-profit research and technical assistance organization dedicated to contraceptive development, family planning, reproductive health and AIDS prevention around the world.

Begun in 1993, the Women's Studies Project aims to support social and behavioral science research on the immediate and long-term consequences for women of family planning programs and methods; and to help improve policies and programs through increased knowledge of the needs and perspectives of women.

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Two Women's Health Projects  
in Bolivia**

La Casa de la Mujer, Santa Cruz  
CIDEM/Kumar Warmi, El Alto

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By Susan Paulson,<sup>1</sup>  
María Elena Gisbert,<sup>2</sup> and Mery Quitón<sup>3</sup>

Prepared for the Women's Studies Project

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**La Casa de la Mujer**



**CIDEM**

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## Acknowledgments

These case studies profile two women's health programs in Bolivia: the health service and education program administered by La Casa de la Mujer (The Woman's House) in Santa Cruz and the Kumar Warmi (Healthy Woman) Clinic administered by the Centro de Informacion y Desarrollo de la Mujer (CIDEM) in El Alto. Supported by the Women's Studies Project (WSP) at Family Health International (FHI), this is the second in a series of case studies that describe innovative women-centered health programs.

These case studies were researched and written by Susan Paulson, María Elena Gisbert and Mery Quitón. Dr. Paulson, Ms. Gisbert and Ms. Quitón participated in the visits and interviews, and Dr. Paulson was responsible for most of the writing.

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## The Women's Studies Project

The ability to delay, space or prevent childbearing can have a significant impact on women's lives, including their health, employment and emotional well-being. To understand the needs and perspectives of women who seek family planning services and the impact of family planning on various aspects of their lives, the Women's Studies Project (WSP) at Family Health International was begun in 1993. The Project supports a wide range of research, with the aim of providing information that can be used to develop health services and policies that match women's reproductive health needs. In addition to the case studies presented here, the WSP also is supporting case studies in Jamaica and the Philippines.

## Executive Summary

Many women suffer from poor health in Bolivia, where rates of fertility and maternal mortality are among the highest in Latin America. Bolivia's total fertility rate was 4.8 births per woman in 1994, with rural rates significantly higher (INE, 1994). According to the 1994 National Demographic and Health Survey, maternal mortality in Bolivia is 390 deaths per 100,000 live births, with ratios as high as 610/100,000 in the altiplano area (MACRO and INE, 1994). A significant number of maternal deaths, an estimated 27 to 35 percent, are related to induced abortion, which is widely practiced in Bolivia, although illegal. Adequate safe medical abortion services are not available (MPSSP, 1989).<sup>1</sup> The root causes of women's poor reproductive health status are a near absence of health information, education and services, coupled with limited access to contraceptives.

To respond to Bolivian women's urgent needs for reproductive health care and to help affect changes in policies and practices that have excluded Bolivian women, especially poor indigenous women, from information and decision-making, La Casa de la Mujer and the Centro de Informacion y Desarrollo de la Mujer (CIDEM) have developed women-centered health programs that employ integrated approaches to service delivery. La Casa has worked extensively with women in reproductive health service and education, while CIDEM has developed a new approach to health care practices that incorporates a gender perspective.

La Casa's unique characteristics include its offering of multiple and diverse programs to address the complex needs and experiences of women; its ability to build solidarity among

women from diverse sectors of Santa Cruz society; and its emphasis on communication as a way of empowering women. The solidarity of La Casa participants and staff has contributed to an understanding of reproductive health and sexuality as something shared by all women, but experienced by each group of women, and even by each woman, in a unique way, depending on her cultural reality, her class and ethnic position, and her life experiences. Reproductive health services are offered in conjunction with other social services, such as legal services and psychological care, and reproductive health is viewed as one means of improving the lives of both women and men in Santa Cruz.

CIDEM's Kumar Warmi (Healthy Woman) Clinic has developed a new methodology for health care, based on gender principles. The approach includes emphasis on continued education and growth, based on respect for differences; an integrated approach to education and service delivery; and a focus on interpersonal relationships. The project's primary objective is to provide education and health care to women in ways that allow them to share in the knowledge, responsibility and decision-making about their own reproductive health, and to participate in the design of health policies and projects.

CIDEM's approach breaks free of the traditional health service paradigm in two ways. First, it recognizes health as something more complex than medical service and necessarily linked to education, human rights and personal empowerment. Second, it transforms conventional interpersonal relationships, so that doctor and client play more equitable roles in the process of health care.

Although each program is unique, La Casa and CIDEM share some common approaches in their efforts to improve women's health.

- Both programs view women as participants in the design and delivery of health care services.
- Health care is not viewed as an isolated service. It is integrated with other social services and regarded as a vehicle for women's empowerment.

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<sup>1</sup> A study carried out by COBREH (1984) in Bolivia's principal cities found that 25 percent of pregnant women reported having had an abortion at one time, and 52 percent of women of childbearing age reported having had at least one unwanted pregnancy.

- Programs employ new ways of educating and communicating with women — ways that are non-hierarchical and non-didactic.

Two factors compelled us to study these two small nonprofit institutions, whose direct demographic impact is limited. First, these institutions have been able to experiment with new approaches and methods that might not be possible in larger health projects or major hospitals. Second, by examining and disseminating information on these innovative approaches, we hope to contribute to efforts under way at other institutions, thereby multiplying the impact and utility of these two programs.

The objective is not to compare the two projects, nor to apply standard evaluation criteria, but rather to illuminate the many challenging issues faced by organizations working to improve women's health and, ultimately, the quality of women's lives. By sharing the histories of the La Casa and CIDEM projects, their visions, their achievements and their frustrations, we hope to enrich the reflections and actions of others who are trying to improve women's condition and status by advancing their reproductive health rights.

## La Casa de la Mujer, Santa Cruz

### Individuality and solidarity

At La Casa de la Mujer, women are viewed simultaneously as individuals, as family members and as members of a larger society. Consequently, La Casa's philosophy is that women's health is affected — often determined — by relationships, by experiences, and by domestic, political and cultural environments. Health care is one element in an array of services necessary to improve women's quality of life.

As the testimony of one of the participants we met in the clinic illustrates, health is inextricably linked to other aspects of a woman's life. We spoke for some time with Nieves, an energetic woman in traditional dress, whose story offers a glimpse of experiences which, according to La Casa staff, are shared by many clinic participants.

Born in La Paz, Nieves was orphaned at nine years of age and traveled with a brother to Cochabamba to look for work. After making a life for herself in Cochabamba and living there for nearly 20 years, Nieves recently took a bus to Santa Cruz with her oldest child to escape the intense domestic violence she had been suffering.

*I just had to escape, I couldn't stand the pain any more. He bit me all the time. When he drank, he beat me. I ran all over trying to protect my kids. I'd leave them at my godfather's, at my mother-in-law's. I didn't have any family of my own left in Cochabamba. My brother was very good and always helped me, but when he died last year, my husband became even worse.*

*An evangelical pastor helped me. He told me about La Casa de la Mujer, 'There's a place in Santa Cruz where they help women.'*



*First I went to ONAMEFA [National Organization for Children, Women and the Family] in Cochabamba. When they called in my husband, he was just perfect. He said that he wasn't going to do it [beat me] anymore. He signed the papers and all. But two days later he started hitting me again. 'Go ahead now, bring your big men to come and get me,' he said. He beat me so badly that I could hardly move. I could barely drag myself to the bus with my daughter and had to leave my little son with his father.*

*I arrived in Santa Cruz in such a state, and none of the hospitals wanted to receive me, until finally I went to La Casa de la Mujer. Then I came back to La Casa to see the lawyer. I wanted to divorce right away, but she told me to just start working as if nothing could happen to me until the thing calmed down. 'If the man shows up,' she told me, 'bring him here and we'll have a talk.' So I just went about my life and found a job with a room for me and my daughter.*

*When I left my work a few weeks ago, I went to live with a friend from Cochabamba, but now they say that it is a crime to keep a married woman in your house. The neighbors are convincing my friend to throw me out. When I came here to La Casa to ask, the lawyer told me that such a law never existed. I also told her that I had to leave my other job because of the pain in my shoulder, and she arranged for me to come to the clinic to see the doctor. Now I've come to check out my shoulder. I guess he [my husband] broke it, but I don't know because he never let me go to*

*the doctor. It must have healed wrong. I worked for two months as a maid, but my shoulder and chest kept hurting more and more.*

*I never fell in love with my husband. I was deceived. I lived in a little room and worked as a maid, and the gardener of the house had a brother who stopped by sometimes. One day they invited me to dinner, and since I am always obedient, I accepted, and we went to eat at the brother's house. There they served me a beer and another and after that another, and then I don't remember anything else until I awoke the next day with a man at my side, and I said to myself, 'Now I'm pregnant, and my baby won't have a father.' So I just married him. If he finds me now, he'll destroy me. Until his rage passes, I have to hide.*

## **La Casa: an overview**

### **A mission of empowerment**

La Casa de la Mujer is a private nonprofit organization for social development whose mission is "to improve women's quality of life, especially in poor sectors of the society, and to strive for more equitable gender relations for all women through training, services and organizational strengthening aimed to achieve structural changes." The organization seeks to empower women as individuals and to create solidarity among women — steps it deems necessary for the collective survival and structural transformation of society.

La Casa de la Mujer was founded in 1990 and grew out of a local women's movement, which joined with other social and political movements working toward democracy. Over time, the group defined its own agenda. Overcoming sexual, class and ethnic discrimination was considered a fundamental challenge for development. The organization sought to advance women's health rights, which initially took the form of responding to health needs of poor urban and rural women through direct assistance and service. Today, La Casa

approaches women's health in the context of broader social needs, which also include education, potable water, nutrition, healthy environment, preventive health, legal rights, citizenship, reproductive rights and secure livelihood.

One characteristic that makes La Casa unique is its diverse array of programs, which integrate health with other social services necessary to women's well-being. Another characteristic is the development of novel and creative methods to facilitate communication among professionals, outreach workers and grass-roots program participants.

This case study is based on interviews and discussions carried out in February 1996 with different individuals involved in La Casa's activities. Staff members who were interviewed include: Marie Claude Arteaga, head of research; Wilma Ayala, environmental educator; María Luz Bacarreza, nurse in health education and services; Maritza Camargo, psychologist in education and clinical services; Marina Morón, law student in legal services; Estela Sejas, nurse in health education and services; Adela Ramirez, lawyer in legal education and services; Miriam Suarez, journalist and director of La Casa; Ane Mie Van Dyck, nurse and volunteer from Belgium; and Dr. Lourdes Uriona, gynecologist in health education and services.

In the women's health clinic we met the following individuals, who spoke with us about their life experiences and their participation in La Casa: Aida, Eugenia, Marta, María Elena, Nieves, Shirley and Reina. To maintain confidentiality, and as approved by each participant interviewed, we cite only first names.<sup>2</sup> We also reviewed documents from the organization, including the La Casa de la Mujer three-year plan for 1992-95 and the new three-year plan, still in revision.

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<sup>2</sup> We maintain the use of first names throughout the case studies, feeling that the introduction of professional titles and last names for some of the women would introduce unnecessary hierarchical distinctions among them.

### Cultural, socioeconomic tensions

With a population of nearly 1.5 million, Santa Cruz is Bolivia's second largest city. In comparison with other Bolivian areas, Santa Cruz has the highest contraceptive prevalence rate, the lowest infant mortality rate, and one of the country's lowest maternal mortality ratios.

The composition of Santa Cruz society is complex. This is due in part to old tensions, rising from colonial and national history, and due in part to the economic boom of the 1970s and 1980s. During this time, one sector of society grew very rich very quickly, large numbers of migrants came to the urban center from

tropical colonies and hinterlands, and countless rural families migrated from distant Andean regions.

Today, tensions abound between natives of the eastern lowlands of Santa Cruz, who are called 'Cambas,' and migrants from mountainous Andean regions, who are called 'Collas,' and who suffer discrimination and exploitation on account of their ethnic identity. These ethnic conflicts intersect with contradictions between the extreme wealth and the acute poverty of different sectors of the population, and with the unequal impact of environmental degradation and contamination in different urban neighborhoods.

In spite of class and ethnic differences, much of Santa Cruz society is marked by dominant cultural attitudes, which create conflicting views of women's sexuality. On one hand, sexual relations are a hot topic of conversation and interest in Santa Cruz, and women's

sexuality is publicly emphasized to a far greater extent than in other parts of Bolivia. On the other hand, significant effort is exercised on the part of husbands, fathers, the church and other social institutions to control female sexuality, both physically and psychologically.

At La Casa, ethnic and sexual tensions are seen as important factors affecting women's health. Most health services in Santa Cruz are delivered in a climate perceived by female clients as dangerous and threatening, and the efforts of those who work in the fields of reproductive health and sexuality are often censured. Sanctions include the ousting of reproductive health educators by local men and

the public denouncement of sex education and abortion. Santa Cruz media disseminate stories and images in which police burst into abortion clinics, dragging both doctor and client to jail. Several women we

interviewed expressed terror of clinics, saying they were frightened by newspaper photos that showed a female client arrested while still undressed on a clinic cot.

Participants in La Casa activities expressed fear of lascivious doctors and had heard rumors of sexual abuse of clients. Some men prohibit their wives from going to clinics because "the doctor could see her and touch her in her private parts." Irrespective of the validity of the rumors, these stories reflect a widespread sexualization of the doctor-client relationship. This attitude interferes with health care on numerous levels and restricts women's access to health services, as well as to other social institutions and activities.



Women who do seek health care services may encounter conflicts at home. While La Casa encourages women to take responsibility for their health, sexuality and fertility, its efforts to change women's attitudes often meet resistance from husbands and other family members. La Casa staff members affirm that some men criticize their wives' participation in educational activities on sexuality and reproductive health and try to demean La Casa's efforts by spreading the word that "women only go there to talk about whoring." Workshop participants have even encountered violence when they try to express new ideas and attitudes in their homes. In one case, a woman obtained condoms in order to space her pregnancies, and when her husband found out, he accused her of sleeping with another man.

A central issue for La Casa is the extreme poverty that limits the fulfillment of health rights for many individuals. La Casa's three-year plan explains, "Santa Cruz has a population of 1,351,200 inhabitants, 60 percent of whom live in unacceptable conditions of poverty. ... Particularly in Santa Cruz, the cost of survival has risen in terms of increased paid work for women and increases in their unpaid work. Increasing numbers of women are heads of households, and because of cuts in social services, they mostly have to get by without any help from the state" (Casa de la Mujer, 1995:12, 13).

La Casa sees the women's movement as an important impetus in the struggle to confront these broader social problems. La Casa emphasizes the need to assure that the democratization processes being forged in Bolivia today increase women's participation in the construction of policies that reduce the gap between rich and poor, between city and country, and between men and women.

### **La Casa's beginnings**

A radio program planted the seeds for the idea of La Casa de la Mujer. Radio Santa Cruz, a Jesuit organization, worked for years in grassroots education and literacy and, in 1983, with

the goal of supporting women's lives and organizations, created a new program called "Women of the Pueblo." The radio program aired six days a week for 90 minutes each day, providing information and education for women and facilitating communication among different groups of women. With this program, Radio Santa Cruz provided key support to women organizing in neighborhoods and rural communities and helped them identify their needs and objectives.

During this time, three women, who would later be key in founding La Casa, became involved in a program to educate women in ecological practices and environmental protection. Since the group had no guide for working with women, and moreover, were working with Guaraní Indians who did not speak Spanish well, the women faced extraordinary methodological challenges. In order to communicate, they developed educational techniques involving theater, mime, games and drawings. This experience marked the birth of a creative approach to communication, which would later characterize many La Casa activities.

Miriam Suarez, La Casa's current director, worked with Radio Santa Cruz and also with the environmental education program for Guaraní women. She recalls that talk began about creating a place for women "where their rights are defended, their organizations are strengthened, they are educated, they have fun, they celebrate birthdays, and they get together simply to be together." In 1988 the idea was discussed at the First Departmental Congress of Domestic Employees, and participants there joined the movement. As momentum grew, the Dutch organization HIVOS financed the opening of La Casa de la Mujer as a social development organization. "Before opening La Casa there was a period of communication and coordination between various women's groups who shared the struggle for democracy and equality," Miriam remembers. On May 1, 1990, hundreds of women marched through the streets, arriving at the doors of La Casa. It was the International Day of the Worker, we were workers, and with the opening of La Casa we gave new value to our role."

In this era, members of women's groups in Santa Cruz were discussing feminism, and La Casa offered a space for reflection and debate, as well as an opportunity to put new visions into practice. When La Casa opened, participants identified three immediate and fundamental needs of women in Santa Cruz: legal rights, sexual education and labor training. They developed programs and activities in these three areas, and over the years, have started to explore the connections among them.

During the first five years, the organization functioned in rented spaces. Recently, La Casa took the significant step of building its own center. With special funding, La Casa built a center with clinics, offices, rooms for meetings and workshops, and even a residential area for domestic workers participating in courses. The new center was dedicated on International Women's Day, March 8, 1996, in a moving ceremony that was aired on television and radio, drawing attention to themes of women's rights and violence against women. Currently, La Casa has a team of 26 employees, most of whom work part-time in a variety of institutional activities.

While the new center has permitted the organization to consolidate its programs, this year has also been one of change. La Casa is currently undergoing organizational and program changes in attempts to better integrate its activities and to clarify the relationship between the organization's philosophy and its practices. This year, the principal donor, HIVOS, recommended that La Casa reduce its services in order to focus more on development activities designed to foster strategic changes in society, such as training, preventive health education and the strengthening of local



organizations. HIVOS' recommendation corresponds with concerns of La Casa staff, who had also begun to ask whether their services were too assistance-oriented and how they might continue to respond to the great demand for services in ways that also promote more lasting structural change.

## Reproductive health services

### The link to self-esteem

In La Casa's reproductive health program, health care and health education are complementary efforts. Staff believe that efforts to provide services and education must include efforts to improve women's self-esteem.

One La Casa staff member who sees self-esteem as vital to women's health and well-being is Dr. Lourdes Uriona. Lourdes was working in the State Maternity Hospital in 1990 when she heard about a new center for women and stopped by to offer to help in a Pap smear screening. Recognizing the importance of follow-up care based on Pap smear results, she volunteered to work periodically at La Casa. Since the organization had only a small

space at that time, a corner of a room was partitioned off so that Lourdes could meet with the clients. From the start, the doctor was well received by the women. She is from Sucre and gained the confidence of migrant clients by speaking Quechua and understanding their perspectives. Lourdes joined La Casa staff part-time and is now in her fifth year there.

Lourdes brought to La Casa an unusual socially-oriented approach to medicine. In her first job as a doctor, she spent 18 months in Yapacani, a poor tropical area populated with isolated settlements. There she teamed with a social worker, and as the two visited communities together, they developed an approach sensitive to local realities and based on an integrated understanding of the health and well-being of the families.

From her point of view, the greatest achievement of La Casa's health program has been to strengthen the clients' self-esteem and sense of self-worth.

"These women have become concerned about their own health. A woman often forgets that she is an important person herself, beyond being a mother, daughter and wife. I tell them, 'Think about yourself, too, because if you take care of yourself, you will have the opportunity to look after your children.' I explain to women that their genitals are their daily bread, that we have to look after them and protect them from infection or aggression because they are very important to a couple's relationship."

Many clients learn about the clinic by word of mouth. We met Reina on her first visit to the clinic, and she told us that she trusted La Casa's good reputation because three different people had advised her to come. Reina migrated from Oruro a year ago with her three children and works as a street vendor whenever she finds child care. "I heard that there was a clinic and a center where they would help me, that it wasn't expensive, the care was different, and they could take care of the problems that we have."

Other women learn about the clinic through workshops, Pap smear campaigns, and pamphlets distributed by La Casa staff. María Luz explains, "When we are walking down the street, sometimes we see people that seem to

need help. They are poor, they have three, four, five kids, and we personally invite them to the clinic and give them a pamphlet about La Casa."

Clinic clients include young and mature women from diverse backgrounds. In the clinic we met 17-year-old Shirley, who is studying to be an accountant's assistant and was visiting La Casa for the third time. Shirley, who originally came on the advice of her mother, a nurse's aide at a hospital, commented, "The doctor is nice and gives me information. I tell my friends to come here to get information about birth control methods and everything. The difference is that in La Casa they pay more attention to us. There aren't many places where young people can learn about sexuality. We hear from our friends, and it's not always right."

Aida, a 55-year-old housewife, told us, "It's my sixth visit to La Casa clinic. The doctor heals me. She's the only one I trust. At my age, it's difficult to deal with intimate problems, and with a man, it simply doesn't work. On the other hand, with a woman doctor, one has more confidence. They listen to me here, and in other clinics, they just want our money and don't listen to us, especially to an older person like me. Dr. Lourdes gives me courage, and I can talk to her about all my problems. I had a secretion for a long time and was embarrassed to tell a male doctor."

Eugenia, a 41-year-old farmer, lives in Sombrerito, a village where she tends less than an acre of land, producing manioc, bananas, oranges and avocados. "It's a lot of work, but it's our only option because we don't know anything else." Eugenia has visited the clinic five times, each time walking three miles to the road and then riding a bus for about two hours to Santa Cruz. She initially came because she heard on the radio that La Casa had a woman doctor who offered gynecological care. "That news pushed me to go to the clinic about a problem I had suffered for a long time but kept to myself. The doctor gave me confidence, and so I keep coming back. I tell all my friends in the countryside to get motivated and come

here, and some have come and liked it. In other clinics they give out numbers at seven in the morning, and women who come from the countryside arrive late and have to wait all day.”

Throughout the years, the clinic has adjusted its hours and costs in response to client demand and to La Casa’s economic resources. Currently, the clinic is open only one day a week, on Thursdays. The clinic is so well attended that the doctor often sees clients until 10 o’clock at night. She and the nurses feel a need to offer more hours of care in response to client demand. La Casa’s limited clinic hours are due in part to its desire to avoid taking on responsibility for health services that are the government’s obligation, and in part to the organization’s increasing focus on education and institutional strengthening, rather than services.

Director Miriam Suarez explains La Casa’s philosophy as one that focuses on, not just managing obvious symptoms, but remedying the root causes of ill health.

“While the Ministry of Health tries to treat the illness, La Casa tries to prevent it, attacking the causes through education, information and empowerment of women,” she says. “Illness has multiple causes: lack of power over one’s body, domestic violence, uncomfortable or degrading sexual experiences, depression, lack of legal protection, labor abuses, unemployment and low earnings. Working with the causes is a longer and more complex process, but the impact is more sustainable.”

Miriam emphasizes a lesson learned, which has been central for many women’s health programs: “We realized how important it was to work on women’s self-esteem as a fundamental basis for all educational and transformational efforts.”

According to nurse María Luz Bacarreza, the alliance of health care with health education has helped improve the quality and efficiency of the clinic, in part because the clients have gained improved knowledge and confidence that allows them to trust health providers and to participate more fully in the healing process.

“By going to the neighborhoods to give workshops, we’ve helped to build confidence to the point where women come to the clinic and share the whole story of their lives.”

### **Educating health workers**

A repressive social environment and a strong sense of female guilt about sex make talking openly about many reproductive health issues difficult. Ane Mie Van Dyck, a nurse and volunteer from Belgium, found that in Santa Cruz even health care professionals are embarrassed to talk about reproductive health. Once she visited several pharmacies to check types and prices of condoms. “One pharmacist gave me a big drawer of different condoms to look through, but when another client — who was a man — came in, the pharmacist took away the drawer and hid it behind the counter until the man left. If even the pharmacist feels such shame and fear that someone may see him with condoms, imagine how the domestic workers feel when they need to buy them!”

In order to work effectively with women, La Casa sees communication between health care providers and clinic participants as crucial. The staff has sought to develop new strategies for encouraging and facilitating communication — strategies that enable women to speak openly about their needs and concerns.

“Ninety percent of the pain experienced by my female patients is rooted in impotence to express their feelings,” says Lourdes. “The stress and oppression that women experience in their lives are often manifested in physical problems, especially gynecological problems.

“In order to respond to this situation, we prioritize conversation. Every consultation begins with an open conversation in which the patient has the opportunity to express her problems in narrative form. We often talk in Quechua, and the patient tells me about her life, and I get a glimpse of where the tensions arise. After that, I gently ask her if she is ready to be examined. Sometimes the patient freezes. I don’t insist but try a different approach. Sometimes we draw the body, and I tell her, ‘I’m like this and so are you. We are both women and our bodies are like this.’ Using the

drawing, she shows me just where and how the pain is. Sometimes I go on to do the examination, and sometimes we wait until the next visit.”

The doctor’s conversational method allows the client and doctor to understand a constellation of symptoms and causes in a holistic manner, rather than focusing on a specific illness. This holistic approach helps avoid situations such as those described by Dr. Rana Bang in a health district in India, where research revealed that 92 percent of the female clients at clinics in two villages had gynecological infections or diseases, which were neither detected nor treated as part of the family planning service (Bang, 1989, cited in Corrêa and Petchesky, 1994).

Lourdes has developed a simple and effective communication technique that facilitates conversation in settings where power differences exist. This technique works in the clinic, between doctor and client, as well as in families, between husband and wife. The basis

of the technique is never to lecture or impose information, diagnoses or decisions, but instead simply to open a discussion by *asking* about the issue of concern. Lourdes suggests to female clients that they try to reduce marital conflict by avoiding unilateral decisions and impositions. She tells them, “When you know something, when you have some information or decide on a plan of action, do not impose your decision or lecture like a teacher. This makes your man feel insecure. On the contrary, you must begin by asking him about the subject —

for example, ‘Do you know anything about how the rhythm method works?’ — so that he gets a chance to establish common ground on which the discussion can unfold.”

Lourdes emphasizes the importance of interpersonal relations in the clinic, as well as at home. “We can’t act cold and superior. We have to share examples from our own lives. I tell the women, ‘I work, you work. We owe each other respect.’ I don’t hide the fact that I also cook, have my baby, which helps build solidarity with the clients. The health staff here is close, and we share a health care philosophy that prioritizes personal relationships. The nurses also converse with the clients and treat them with respect when they are signing in and waiting for their turn.

The situation in which we live tends to isolate each one of us, forcing us to seek out interpersonal relationships, so we offer that in the clinic.”

Participants in La Casa programs also develop positive



relationships and mutual support among themselves. In 1992, for example, a group of domestic workers participating in a health workshop decided to set a shared goal of zero pregnancies in the entire class during the first year after training. In the workshop, they learned about sexual rights and responsibilities and about contraceptive use. After the course they met at the center on Sundays to discuss their experiences and exchange advice, support and friendship. The domestic workers say that solidarity gives them courage, allowing them to discuss and deal with uncomfortable issues.

They also value the chance to laugh together, for example, about the nurse's suggestion that they always carry condoms in their apron pocket, 'just in case.'

### **Participatory education**

La Casa has increasingly linked health services with education, building a strong educational program in reproductive health and sexuality. "It is a mistaken effort to treat gynecological problems without providing sexual education," says Ane Mie Van Dyck. "In the public health framework it is incomprehensible to treat but not prevent illness."

The La Casa team has developed strategies and techniques to respond to two central challenges: first, the ineffectiveness of conventional education courses; and second, resistance to the subject, especially on the part of men. María Luz explains, "Giving courses didn't work because people didn't listen, they just dozed off. Men didn't even want to hear about health education for their wives, much less workshops on *sexuality*."

La Casa's response has involved, on the one hand, developing entertaining activities, games and skits and, on the other hand, trying to involve male partners in these activities. "We're always accepted when we start with games and humor," says Lourdes. "We did a comedy about AIDS and sexually transmitted diseases that made everyone laugh. La Casa brings together very different women, and the games create a space for open dialogue and interaction in which they can connect with each other. Games and drama also allow men to participate with their own points of view without feeling embarrassed or threatened."

Marie Claude Arteaga, current head of research, defined the basic principles which characterize La Casa's learning climate: (1) use simple language and conversational style, (2) create a relaxed atmosphere that promotes interpersonal relationships, and (3) incorporate the lessons in the daily lives of the participants.

La Casa staff facilitate health workshops in poor neighborhoods, with parents of children in child care centers, with domestic workers, with students, and others. The topics include

ovulation and menstruation, hormones and the female reproductive cycle, the female body, female hygiene, male sexual organs, wet dreams, male hygiene and circumcision. While each educational module has a clearly defined content, the varying perspectives, language and attitudes of participants make each experience different. Ane Mie explains, "In the high schools we use the correct names of organs like 'the testicles,' but with mature women in the neighborhoods it's better to say 'the man's balls,' explaining that they are a seed factory."

Ane Mie and María Luz say, "the lessons officially deal with biological topics and hygiene, but we always take off from there to discuss questions of pleasure and sexuality. Many women say, 'It's nothing for me, my husband comes quickly and goes to sleep,' and we explain to them that female sexuality is different, using metaphors from everyday life. 'If you consummate the relation quickly, it is like eating raw cake batter. For a woman it's necessary to stir, taste, season, bake and frost, then we savor the cake with much more pleasure.' Examples like this make everyone laugh, and laughter is a good way to let off steam because we often tense up on these topics."

As an example of their educational approach, María Luz and Ane Mie described a recent workshop about ovulation and menstruation, which they conducted with a dozen participants from a neighborhood mothers' club. "We started with a warm-up activity, in which the women joined in pairs and used paper and markers to draw a naked woman with her genitals. Of course, there was a lot of giggling, and when they finished, each pair presented their drawing to the group. We used this forum to evaluate the knowledge and attitudes of the participants. In this case, for example, there were a couple of drawings with only one hole which served for urination, menstruation and childbirth. After discussing the drawings without criticizing, we took out an anatomically correct drawing and went over it.

"We always start the drama part by saying 'let's play!' With some verbal directions, but mainly by participating physically, we helped the women to form a circle with their bodies, telling them that the circle represented an ovary. Several women crouched in the center of the circle to represent ova. One ovum slowly stood up, growing until it reached maturity, then it broke out of the circle in a move that represents ovulation. Once the mature egg left, we joined hands to close the circle again, and waited an imaginary month until another egg became ready. Once the women became familiar with the game, we moved on to the uterus.

"We arranged ourselves in another circle, which was the uterus, or womb. One woman stayed outside — she was the ovum. Each of us making up the womb held a sweater or blanket, and during an imaginary month, we slowly pushed it out in front of us to form a soft cushion on the inside of the womb. In the first round of the game, the egg entered the womb but did not meet a sperm, so it exited by way of the vagina, and the members of the circle pushed their sweaters out too — that represents menstruation. In the next round, the womb prepared another soft cushion, and when the ovum entered, it met a thin woman playing a sperm. They joined hands to form a fertilized egg, and rested against the soft cushion. In the end, we linked both games to show how ovulation is related to fertilization and menstruation.

"After 'playing,' we always do that part of the session we consider the most important — reflecting and discussing the experience. We began with a game called 'the little bench' in which everyone must run to sit on the 'agree bench' or the 'disagree bench' in response to each topic mentioned. In this case we asked, for example, 'Is menstruation bad blood?' then asked those sitting on each bench to express their opinion. We always try to reinforce correct observations and gently correct mistaken impressions, often using tangible examples from everyday life. In this case we asked, 'When you are preparing for an esteemed guest do you set the table with rotten food?' Of course they said no, they put out the best, and we explained that the body also

prepares its best for the baby. The healthy soft cushion, which is expelled as menstruation, only becomes rotten when it isn't cared for. We give an example of liver, which is largely blood. Fresh liver is good and nourishing, but when it rots it smells bad and attracts bugs. Menstruation is also good when it is fresh, but if we don't keep clean it begins to smell and breeds smaller bugs."

La Casa has published health education materials, designed to promote participation and creativity. One example is the book, *Physical and Mental Health of Women in Poor Neighborhoods* (Health Team, La Casa de la Mujer, 1992b), which presents the results of a survey in the form of a comic book with photos of women and men expressing responses to the questions, often through hilarious gestures and poses. The introduction of the book reads, "Dear friend, in this little book we want to talk about health. Why? Because it's a very important topic which relates to so many fundamental things: life, death, happiness, sadness, strength, weakness, enthusiasm to participate and lack of motivation. We are going to talk specifically about women's health. Why? Because we women grow up, feel, think and live in our own way. Our experiences, our illnesses, our problems and our joys are specifically feminine. For this reason, we decided to ask a lot of women to share their experiences and opinions about everything having to do with physical as well as mental health. In this little book, 300 women from different neighborhoods in Santa Cruz talk about health. Your experiences could be similar to or different from theirs. Our idea is to reflect together, to get to know ourselves better, to better understand other women, and to relate amongst ourselves."

### **Involving men**

La Casa de la Mujer was initially conceived as a space and a set of activities organized by women, for women, with the purpose of empowering women. Nevertheless, teams

involved in all programs discovered that their practical efforts working with women alone rarely solve women's problems, and in some cases create even more conflicts for them.

Like many other women's organizations, La Casa is caught between its commitment to help and strengthen women and the necessity of working with men. "Perhaps working with women alone is not sufficient, especially if we talk about health care," says Marie Claude. "Nevertheless, it is necessary to work with women alone in certain instances and efforts — we need to build their self-worth and empowerment first. Although we are considering gender relations, which implies not forgetting or marginalizing men and the male perspective, we feel it is important that the women participants themselves involve men from their own perspective and their own point of view."

La Casa now seeks to involve husbands and partners of female participants in certain dimensions of learning processes and actions for change and to direct special efforts at youths of both sexes. Such efforts have frequently met with resistance. Men oppose sexual education for their wives and daughters for a number of reasons. Not only are they afraid the women will become promiscuous, they also fear that the women's new knowledge of sexuality will lead others to think they are promiscuous, bringing shame to the family.

"When the man doesn't participate, problems arise," Ane Mie explains. "A woman learns something new that the husband doesn't understand, and he doesn't like to feel stupid in front of his wife."

In health education, as in health services, getting men involved has been one of La Casa's greatest challenges. "In one campaign, we did Pap smears on 47 women, and there was only one who didn't have an infection," says Lourdes. "We've seen that working only with women doesn't solve the problems. In many cases, if the man isn't treated at the same time, our efforts are in vain. In medical terms, the sexually transmitted infections are not cured, and in the family, reproductive health should involve both partners.

"Now, women come for a Pap smear, and we make an appointment for both partners to come in for the results. At first men said, 'Listen, women's infections have nothing to do with us,' but we refused to give the results if they didn't come. We demand that the men come, and they often come in a bad mood. But we don't attack them, just inform them with respect."

Lourdes sees communication problems between couples as a health issue. In one case, a woman said that when she tried to practice the rhythm method, her partner hit her for not letting him have sex during ovulation days. Later, when he found out she was pregnant, he hit her again. Lourdes has found that this type of tension can often be avoided if knowledge and responsibility are shared by both partners. "It doesn't always work, but I've had many cases in which the man comes once to the clinic, and then he becomes a protagonist, learning about everything and even insisting that his wife come for checkups."

La Casa tries to provide a non-intimidating environment, in which professionals relate to men and women equally. Estela Sejas, a nurse in health education and services, has observed positive changes in men's participation, although these cases are still a minority. "Some men come into the clinic with their wives, which is good because they learn about their wives' health issues, and take better care of them. This is a significant change for families in which fertility and sexuality have been points of conflict and resentment."

Lourdes also encourages couples to explore questions of sexuality and sexual satisfaction together. "Women don't tend to see sex as something good for them. They say that it is an act that they have to perform when their husbands want it. A wife must receive her husband, or she is accused of being involved with someone else." Lourdes' approach is to talk with the woman and the man, so that they see that sexual relationships involve both of them.

The La Casa team is convinced that education with couples is optimum, yet they still have much more acceptance and success working with women than with men. "It's difficult to

convince men to participate. With youths, it is easier than with older men,” says María Luz. “Nevertheless, once they get involved, men often come up with a hundred questions and are very active in the workshops. In the neighborhood called April 26th, for example, La Casa organized a reproductive health workshop with parents from a child-care center. Only one man came to the first workshop, and when he saw there were no other men he went home saying, ‘This is a ladies’ thing. What am I going to do here?’ But several men participated in the second workshop, and more in the third.”

## Reproductive rights

### Linking health with other services

In developing the concept and practice of reproductive rights, Third World women have changed the definition of the term (Corrêa and Petchesky, 1994:3). Together with other institutions, La Casa has developed an understanding of reproductive rights that is broader than fertility regulation and encompasses multiple dimensions of feminine health, such as conjugal relationships, psychological well-being, legal rights and citizenship. Important to this understanding is the consideration of structural conditions that can enable or impede the fulfillment of individual rights, a consideration that has motivated La Casa to respond to problems such as unemployment, lack of potable water, environmental contamination, illiteracy and inadequate child-care facilities. La Casa programs include not only health care but other social services that promote the fulfillment of women’s reproductive rights.



### Legal support

La Casa’s legal center functions full-time Monday through Friday. The team includes a lawyer (Adela Ramirez), a law student (Marina Morón), and an extension worker (Rosa Chambi). The majority of the women who come to the center for help have problems with either domestic violence or child support. “In most cases, it is women who come with legal problems, and when the problem involves a couple, we always insist that the man come to discuss the problem in attempts to reach an accord by consensus,” says Adela. “Some men come for legal aid, and occasionally a man will request help in contacting a woman and children who have left him, or whom he abandoned.”

The opening of the new center has created so much publicity for La Casa that requests for legal assistance have doubled in the past few months. Due to the increased demand, the team decided to give priority to cases of domestic violence. La Casa usually encourages a victim of violence to obtain a certificate of injury from a forensic doctor and, in serious cases, victims are taken to the police station to file assault charges. Nevertheless, many women do not want to file charges but prefer other forms of conflict resolution. Marina explains, “We must listen to what they want. Many women come to cry, but don’t want to divorce, nor to take legal action.”

Physical abuse within the family tends to coexist with psychological and/or sexual abuse, and the legal team frequently encourages victims to visit the gynecology and psychology clinics. Adela observes that when a woman wants to break off a relationship completely, she tends to resist further assistance, but when she hopes for a reconciliation, she is more willing to participate in counseling sessions.

Conflicts involving child support are the next most common type of case. Since a man is only responsible for children that are legally registered as his offspring on a birth certificate

or a "certificate of recognition," many women begin the struggle by getting men to sign those certificates. Later, when a family separates, a judge may fix a monthly support payment, but it is rarely fulfilled and nearly impossible to enforce. The legal team usually approaches the problem by seeking an agreement between the separated couple.

In addition to helping women respond to immediate crises, La Casa tries to prepare them to face future problems. Reproductive health is an important aspect of this preparation. In situations of domestic instability and violence, in which the birth of another baby might intensify a woman's conflicts and challenges, legal staff encourage her to meet with the doctor to discuss family planning. Legal and health services also work together in efforts to strengthen participants' self-esteem, enabling them to take more responsibility for reproductive health and welfare.

One important La Casa program is the Training Center for Domestic Workers, comprised primarily of young women who have migrated to Santa Cruz from the countryside or other parts of Bolivia. During a two-week live-in program, the women participate in workshops on legal issues, health, sexuality and environmental management. During and after the program, many of the participants arrange for private visits to La Casa service centers. And after finishing the course and taking jobs obtained through La Casa's placement program, some of these women return to the center on Sundays to "hang out" together in their space.

La Casa's domestic worker program demonstrates the multifaceted support offered by the legal team. According to Adela, "what we try to do is educate these women, improve their contacts, help them to know their rights as workers, citizens, women. We educate domestic workers about their rights, and when they have trouble they come back to see us. We work mostly on labor problems, such as failure to pay salary or bonus, physical or sexual abuse, and accusations of theft. We've also done a lot with citizenship rights and documents: A national ID card is crucial, even though it doesn't guarantee full rights of citizenship. We had an arrangement with the Civil Registry to obtain ID cards

more easily, but now they've changed the law and it has become a very lengthy and expensive legal process." Other legal problems experienced by domestic workers include unethical and exploitative employment agencies and employers. La Casa tries to promote clear arrangements between employer and employee, using a domestic labor contract with 16 clauses that define salary, work hours, trial period, tasks required and other terms.

La Casa's legal efforts also extend to advocacy. During the past few years, La Casa, together with other institutions, has worked for passage of a new law against domestic violence. Staff members and participants marched, signed petitions, and joined the Departmental Committee for the law's approval. In 1995, after a long debate, the Bolivian legislature passed a law against violence in the family and domestic sphere. The law defines as a public crime physical, psychological and sexual violence within the family or domestic sphere; imposes sanctions in the form of an initial fine, and of arrest for cases of delinquency or aggravation; establishes simplified and cost-free procedures for denouncing, testifying and proving the crimes; and establishes brigades specialized in protection against domestic violence to provide help to victims. Adela affirms that "while the law and the publicity surrounding it are clearly motivating more women to denounce aggression, we have yet to see whether the expectations raised by the law are fulfilled by state judicial systems, and whether the law really helps to reduce the violence."

### **Psychological counseling**

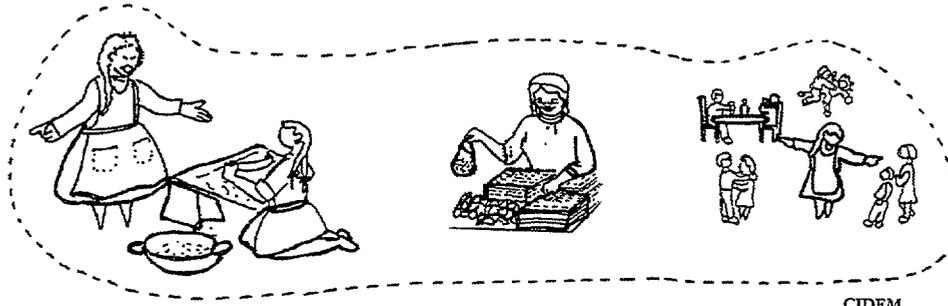
Psychological counseling developed as part of La Casa's health services is offered in coordination with gynecological care. In the psychological center, as well as the health clinic, prevention and cure, causes and symptoms, are closely related. For psychologist Maritza Camargo, "The principal objective of my work at La Casa is both diagnosis and treatment — knowing the causes and knowing the therapeutic response are inseparable."

Maritza gives talks on sexuality to domestic workers and neighborhood groups, focusing on family dynamics.

Describing a series of innovative methods she uses to facilitate conversation and reflection, she explains, "In workshops with domestic workers, we start talking about how the young women imagined Santa Cruz before they came here as migrants — their fantasies about money, freedom, social life — and from there we get into their hopes and desires about boyfriends and sex." Maritza's approach is well-received; so many participants have requested additional sessions that Maritza has organized open workshops at La Casa one Sunday a month to discuss aspects of sex and sexuality.

Maritza finds some advantages in La Casa's reputation for helping women in trouble because it attracts people at times when their tensions and conflicts have become unbearable. "When women come to La Casa, they are often in a state of crisis. We make every effort to get their partner involved at that crucial moment of crisis, when there is more potential for change. When a conjugal relation is in equilibrium, it is very difficult to change."

La Casa workshops and counseling consider women to be part of complex systems that include the couple, the children and the family. "It is not just one person involved in the abuse," Maritza says, "it is always a dynamic of two people, at least. Often a woman will want a man to change within an existing pattern. I help them to see that there are neither angels nor devils, that both are participants in the conflict so they both need to change. For example, women frequently feel depressed and worthless because they are not valued. We see women who complain because they are not valued, and



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yet at the same time they tell their kids, 'Your father is a drunk. Your father is a lazy bum.' I tell them that first, a woman must value herself as a person, value other women and also value her husband."

Miriam Suarez agrees that psychological counseling must consider women as part of complex social networks. "Our psychological workshops are based in the perspective that a woman is a historical subject who interacts with others within a given system," she says. "The principal relations of that system are patriarchal, shaping women who reproduce attitudes and values which respond to that model. For this reason, even situations of machismo and family violence involve men and women."

Maritza's office is decorated in a homey fashion, with rugs and floor pillows that create an informal conversation space. During sessions, she doesn't sit behind her desk in an authoritative posture but moves through the conversational space, trying to connect with clients through gestures. Breaking from the model in which the psychologist asks questions and the client responds, Maritza encourages women and men to participate with her in representations, which help to understand and change the situation. For example, they may use mime or skits to act out what happens when the husband arrives home from work. One of Maritza's favorite positions is seated on the floor at the feet of a client, like a child listening to narratives. It is a position that drastically changes relations of knowledge and authority, empowering clients and giving them more confidence in their own voice and their own

story. These communication methods reflect an effort to overcome the differences of class, culture and power that normally separate participants in a therapy session.

### **Environmental education and action**

Wilma Ayala, head of La Casa's environmental program, says there is an urgent need to see the connections between environment and health. "We frequently treat the symptoms of illness and don't bother to look for causes, such as contamination of food, air and water. There is a strong relationship between health and environment. If we burn garbage, it obviously provokes sore throats and conjunctivitis in our children. We try to encourage people to question their conditions, and demand their rights to a healthy environment."

Wilma explains that for women in poor neighborhoods and for domestic employees, environmental protection is much less pressing than things such as money, which help them respond to immediate needs. "We ask, 'How can we link quality of life to environmental protection?' The work which interests us most is practical work in which local people can be protagonists, can see connections between their actions and their personal well-being and verify the results of their efforts." Thus, much of La Casa's work is at the household level, promoting management practices that directly benefit the family, such as teaching people to separate garbage and sell what has value (bones, newspapers, plastic, cans). La Casa teams demonstrate composting to improve garden soil and growing medicinal herbs and vegetables that are not contaminated with pesticides. Participants learn safer (and often cheaper) ways to use detergents, agrochemicals, toxic materials and insecticides, and they come to appreciate the immediate impacts of these practices on their health and that of their children.

La Casa's team has developed practical educational methods geared to the interests of participating groups. With mothers' clubs, for example, reproductive health education is linked with environmental information in workshops that teach nutrition and natural medicine. There is enthusiastic participation in

these courses, says Wilma. "They know many different things about natural medicines. We trade recipes and ideas, and we prepare cough syrup and calming teas together. In all the workshops, we try to value the practices of participants, their parents and grandparents. At the same time, however, we raise the possibility that some traditional practices may be problematic today in our changing environment. Everyone used to burn garbage, for example, but there was very little garbage — people went shopping with baskets and clay pots. Now, our purchases come in plastic bags and jugs. We ask the people to explain the changes, and they say, for example, that people used to burn bones to frighten away illness, but now there is so much contamination that this doesn't work anymore."

According to Wilma, an important challenge for the environmental program is to respond to the diverse cultural processes of different groups in Santa Cruz. For example, migrants from the altiplano tend to cut down shrubs and trample their yards into hard dirt. In the hot humid climate of Santa Cruz, dwellings with no vegetation become ovens, and in the tropical rainy months, yards turn into mud puddles that breed insects — problems unfamiliar to highland migrants.

La Casa's environmental program reflects its interest in supporting other organizations with common goals. The La Casa team has organized participatory environmental education activities with neighborhood committees, parent-teacher associations, student organizations and mothers' clubs. Historically, most instances of information and organization for environmental issues have included few women and have virtually excluded poor sectors of society; they also have ignored the class and gender implications of environmental problems. La Casa tries to develop these dimensions in order to promote a more complete vision and a more integrated strategy for environmental education and action. La Casa coordinates with the Ecological Association of Eastern Bolivia (ASEO), the League for Environmental Defense (LIDEMA) and International Habitat, often working with families involved with these institutions. La Casa also participates in the Departmental

Casa also participates in the Departmental Forum on the Environment, promoting the participation of poor sectors and women in marches and letter-writing campaigns.

Wilma shared with us a dramatic experience with community action. “The neighborhood called ‘July 16th’ had the bad luck to be near the dump where Santa Cruz municipal garbage trucks unloaded tons of garbage a day. Residents suffered a range of problems: flies formed clouds in their yards and invaded their kitchens; the drinking water they carried from shallow wells was contaminated with parasites and chemicals; children suffered chronic diarrhea and other illnesses. Finally the situation exploded when a whole family died after eating pancakes prepared with poisoned flour which they had found amongst the garbage heaps.

“Women from the neighborhood led a search for alternatives, going from office to office, to denounce the atrocities and demand their rights to a healthy environment. A mothers’ club leader, an elderly woman named Margarita Campo, came to our center. Together we came up with the idea of blockading the dump entrance so that the garbage trucks could not get in. The July 16th mothers’ club organized the blockade, and La Casa called in the media — we brought radio and television stations, journalists and photographers to witness the event so that officials could not negate or disqualify the voices of women protagonists. The mayor had to come and negotiate, and finally they decided to create another dump site further from the city. They compacted and covered up the garbage heaps in July 16th, but there are still contamination problems, and the children are still sick. La Casa helped to arrange for a professional analysis of the water, which confirmed high levels of contamination, and later we helped with a potable water project. Nevertheless, there is still a lot to do. With Adela Ramirez, La Casa’s lawyer, we are planning to study environmental laws and city ordinances in order to better support the people’s struggle.”

All of La Casa’s environmental activities are characterized by participatory techniques, such as drawing, theater and hikes with children and adults. “We have never just taught classes in environment,” says Wilma. “On the contrary, we’ve always worked through participative activities to learn together. In a game about watershed, some participants form a group that is soil, behind them stand a line of people who are trees, and behind them a group representing water. When the water comes running from behind, they break between the trees and carry off the soil. In a second round more people play trees, and they stand together holding onto each other tightly. When the water comes running down the hill it can’t break through the trees and get to the soil.” After participating in gender workshops, Wilma has begun to adopt some activities to facilitate exploration of gender dimensions of environmental issues.

The environmental education team presented some of its innovative learning techniques in a cloth flip chart and guidebook to facilitate participatory learning about everyday environmental practices. The kit focuses on safe, environmentally sound management of water, food, garbage and detergents and is especially appropriate for women and families. La Casa uses these materials in workshops where participants paint the flip chart, make up stories, and hold discussions in reference to the pictures. They have sold a hundred of these teaching kits to other institutions and are currently preparing more. The team hopes that these materials motivate dialogue and reflection that will change attitudes about daily life, but Wilma warns that the materials alone do not guarantee participatory learning. To fulfill its potential, the chart and guide must be used as tools to empower participants, enabling them to share in information, decision-making and action.

## Linking the past with the future

### Building a broad participant base

In the past five years, La Casa has achieved a number of important goals. Here we will focus on two achievements, unusual in health programs and whose impacts on reproductive health issues have not been sufficiently examined: La Casa's ability to build a large participant base and its ability to build solidarity among diverse groups.

La Casa has built a broad participant base by involving women from many different sectors of society. It has become a reference point for women in many life situations — those who are looking for services and support, as well as those who are seeking an opportunity to serve others. La Casa's broad coverage draws in many women, whose experiences and perspectives have enriched the organization's development. In turn, these diverse participants bring La Casa's approaches and perspectives back to their different social groups.

Building on this broad participation, La Casa has been able to construct solidarity among women, expressed in the strong supportive relationships that currently characterize the organization. In the social context of Santa Cruz, the simple act of establishing relations among women of different social classes is an achievement. Some women in Santa Cruz have criticized La Casa's efforts to build a cross-class women's network, saying, "they're taking people out of their proper roles" and "they are only making the scum uppity."

Miriam describes the internal impacts of solidarity among women: "It's a great achievement for La Casa to have consolidated a space for and of women that maintains its original social components, which are diverse women's groups interested in constructing equity. Many staff members have only a few years of formal schooling, nevertheless they are sound professionals, they have grown and developed valuable practices enriched by their human quality. The team also includes professionals and university graduates, and the human growth of all the participants has taken place within an environment of solidarity and

solidarity among women." Yet even inside the organization, it has been a challenge to deal with prejudices, myths and mistrust among women. "In the beginning there were communication problems, some women refused to participate in the workshops, and saw professional women as their enemies," says Miriam. "But over the years, in spite of our different life histories, we have come to share experiences and discussions which are meaningful for each of us, proving that we can change ourselves, and that we can make changes together."

Working with women from different social, economic and ethnic backgrounds allows a better understanding of reproductive health and sexuality. As a reality shared by all women on the basis of their biological functions, reproductive health and feminine sexuality are universal themes. At the same time, it is increasingly clear that each group of women, and even each woman, experiences her reproductive health and sexuality in a unique way, influenced by her cultural reality, her class and ethnic position and her unique life experiences.

### New methods of learning, communication

One of the first things La Casa teams learned was that it is not easy to educate and provide services to women whose language, perspectives and experiences are different from their own. This awareness has motivated staff members to experiment with new approaches to learning and communication, designed to overcome the life differences among health professionals, well-educated feminists, outreach workers, migrants, adolescents, domestic workers, women from poor neighborhoods and others.

It is not just a matter of finding a common language or using the same terminology. La Casa sees a need to transform the interpersonal dynamics of conversation and learning. Miriam describes the impact of experiments in mime, skits, games, bodily expression, therapeutic drama and especially humor: "In sum, it has made learning a rich process with delicious moments in which folk-knowledge comes together with academic approaches to give

birth to a political position that is eminently feminine, in terms of respecting diversity and in terms of constructing more equitable interpersonal relations.”

### **La Casa's evolution**

La Casa's first phase was shaped by its work in responding to women's needs. Now it is evaluating past experiences in order to plan for the future.

A significant challenge for La Casa is to close the gap between the organization's political goals, foremost of which is to promote gender equity, and its practical work with women, which constitutes the staff's everyday tasks. “We are involved in every single women's issue,” says Marie Claude. “As soon as someone calls us or we hear of some problem, La Casa comes up with a position or action. This attitude demonstrates great commitment, but it drains both the staff and the organization. We need to prioritize, and right now I think that La Casa's maturity permits us to focus better.”

La Casa's diverse experience provides a broad basis from which to construct a theoretical framework that links the multiple dimensions of women's lives. Marie Claude identifies several steps necessary to advance this process. “We've been writing reports, which are no more than lists of activities, which don't include personal reflections or qualitative evaluations. The first thing we need to do is to organize and write down the experiences that are in the heads of all the participants and staff. Next we need to systematize those testimonies, evaluate our efforts and reflect on our experiences. Finally, we will be able to define a theoretical framework that will sustain our future efforts.”

La Casa is known for responding to women's immediate demands with concrete and specific actions. Its new three-year plan prioritizes internal growth, based on philosophical and political reflection, and places less emphasis on action. The plan states, “We want an internal training program, which will allow us to question the role of assistance as a meaningful response to women's problems” (La Casa,

1995:4). La Casa has begun a process of internal education and reflection; its goal is to analyze the institution's processes and its relation to the world around it, to seek coherence between La Casa's utopian vision and its day-to-day practices.

In its health program, La Casa plans to focus more on analysis of and response to the causes of health problems, especially through education and empowerment of women and work with women's organizations. At the same time, however, the organization resists abandoning the health services it has provided for years. A poster in the center addresses the push on the part of La Casa's primary donor for a relative reduction of services: “The reality around us and the experience of work carried out in La Casa's programs demonstrate a massive demand for our services (910 beneficiaries during the 1994-95 period), which means that La Casa must take up the challenge of continuing these services with its own resources.”

Another central goal of the new plan is to clarify La Casa's feminist position and principles. La Casa originally was conceived as a program by women for women, and its feminist perspective has principally focused on empowering women. Yet as one staff member put it, “in some instances our position is in danger of degenerating into a sort of inverted *machismo*.” This type of concern is fueling a growing interest in gender. Some members are currently participating in gender training seminars, and La Casa plans to create an internal forum in which staff can share what they have learned and explore possible applications of gender theory to the organization's work. While the need for more gender-balanced programs is clear, so is the resistance of some members to give up the hard-earned solidarity of their all-women organization. In the next years, La Casa will have to face numerous decisions and changes if it follows through on a move toward internalizing gender perspectives.

## Restructuring the institution

Parallel to the evolution of its goals and vision, La Casa has designed a new organizational and work structure. Staff began to recognize a troublesome isolation of its different programs. Staff also identified as a problem the lack of sufficient fora for exchanging experiences, exploring interrelations between programs and coordinating efforts.

In July 1995, an external evaluation confirmed the need to introduce changes in the organizational structure and in program development. Shortly afterwards, La Casa organized a three-day workshop for all employees to discuss the institution's origins and evolution and to discuss plans for a new phase of growth that incorporates concepts of gender and sustainable development. The results of this workshop became the basis for a draft of a new three-year plan.

According to the new plan, work will be carried out by a series of interdisciplinary teams in the fields of education, research and services, and mechanisms will be established to guarantee interchange and coordination among these teams. The interdisciplinary approach is evident in the research teams' current exploration of the construction of identity among migrant women. In this project, being carried out with special funding from a Danish organization, researchers are considering the experiences and lessons learned in *all* La Casa programs.

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In its work, La Casa has sought to balance efforts to help women address short-term needs and concerns with strategies that will empower generations of women and men to improve their lives. The provision of health care is one tool for current and future empowerment, and it is inextricably linked with other efforts to improve women's lives.

## Case Study: CIDEM, El Alto



### CIDEM's beginnings

The Centro de Informacion y Desarrollo de la Mujer (CIDEM) is a nonprofit organization that conducts a variety of activities with women, primarily in El Alto. This case study focuses on CIDEM's reproductive health project based in the Kumar Warmi Clinic.

Kumar Warmi, which is Aymara for 'healthy woman,' has as its primary objective the provision of education and services that allow women to share in knowledge, responsibility, and decision-making about reproductive health and to participate in the design of health policies and projects. Kumar Warmi's work promotes the fulfillment of basic rights to reproductive health in two ways: by educating and empowering women, and by changing the structures and practices of health care provision.

CIDEM's approach to health care is unique in that it is based on a well-defined gender perspective that permeates the project's concepts, goals, methods and relationships. The approach includes an emphasis on continued education and growth, based on respect for differences; an integrated approach to education and service delivery; and a focus on interpersonal relationships.

Another unique aspect of CIDEM's program is that it breaks free of the traditional health service delivery paradigm. CIDEM recognizes health as an entity much more complex than medical service and something necessarily linked to education, human rights and personal empowerment. In addition, CIDEM's approach transforms conventional interpersonal relationships so that the doctor is no longer the sole active subject who monopolizes medical knowledge, and the client is no longer the timid beneficiary of the doctor's attention.

For this case study, we interviewed key participants in the project and women who attended the clinic. We also organized a focus group discussion with leaders of women's groups, who are members of the Kumar Warmi Health Committee. The committee has served as an advocate for local women's organizations for more than a decade. Another source of information was CIDEM reports and project plans. The following members of CIDEM spoke with us: Ximena Machicao, CIDEM director and sociologist; Mery Marka, member of the health education team; Justina Prado, clinic nurse; and María Antonieta de Saldías, gynecologist-obstetrician at Kumar Warmi Clinic. We talked with the following participants who came to the clinic for care: Cirila, Cristina, Marina, Rosemary and Wendy. The following Health Committee members participated in a group discussion: Judith Ascarrunz, Natividad Condori, Emilia Guitierrez, Antonia Mariño and Celia Perez. The clinic visits and interviews were conducted in February 1996. We held two follow-up meetings with CIDEM staff members to discuss drafts of this study.

### Health services in El Alto

The Kumar Warmi project is located in El Alto, a new city near La Paz that began to grow rapidly about 20 years ago. El Alto's population has expanded at the rate of 8 to 10 percent annually during the past five years, reaching its current total of approximately 450,000 residents. Aside from its anarchic growth, El Alto's notable characteristics include its cold climate, extremely high altitude of 4,000 meters, and lack of basic social services. The majority of El Alto's population is poor, and many families are migrants from the altiplano, who reproduce aspects of rural life within their new urban

habitat. The coexistence of migrants from diverse geographic areas and ethnic and linguistic groups contributes to a complex social environment.

The distressing health situation of women in El Alto has been described in many studies. Major health problems include maternal mortality, sexually transmitted diseases, and complications from early pregnancies and unsafe abortions. According to recent figures from El Alto, 2 percent of women first became pregnant between ages 12 to 14, 43 percent between ages 15 to 19, and 40 percent between ages 20 to 24 (CIDEM 1995b). Thus, almost half (45 percent) of the women were teenage mothers; this has affected their standard of living, in many cases forcing them to leave school, work in poorly paying positions and engage in dependent relationships.

Another factor that contributes to the health problems of El Alto is the lack of access to health care. The survey, *Women and Children in El Alto*, (Basaure et al., 1990), found that 60 percent of women interviewed said they did not seek any medical care when they were sick, 43 percent said they did see a doctor, and 4 percent said they saw a traditional healer. Among women giving birth, 56 percent of women surveyed said they gave birth at home with only family to help, 21 percent gave birth in hospitals or health centers, and 10 percent were attended by midwives. Women of rural origin were least likely to seek medical services in cases of illness or childbirth.

Family planning and contraception are important issues in reproductive health. CIDEM found that 78 percent of El Alto women over age 15 said they had not used any modern method of contraception, while only 5 percent said they were currently using contraception. Sixty-one percent of women did not receive prenatal care, while 39 percent did (CIDEM 1995b).

The obstacles that prevent women from seeking professional health care include economic barriers and negative perceptions of the doctor-client relationship, which are different facets of the central problem of inequality and discrimination. A lengthy study in El Alto (Schuler et al., 1994) focused on reasons for

women's non-participation in health care services and found "style" of health care service delivery is partly responsible. "A principal strategy for fostering this growth in demand [for reproductive health care] should continue to be an emphasis on improving the quality of medical services and encouraging providers to be more sensitive to cultural differences. The style of interaction between service provider and client, while always important, seems to be particularly important in this society." (Schuler et al., 1994: 219).

The reproductive health practices of women in El Alto are linked to their economic participation in multiple ways. CIDEM's three-year plan notes that "due to the impact of the economic crisis provoked by structural adjustment policies, women have diversified their wage-earning activities and have increased their work hours" (CIDEM 1995: 2). Women's form of economic participation is influenced by the degree of (or lack of) compatibility between family responsibilities and earning opportunities. Thus, the number and age of a woman's children restrict or make possible her access to different economic activities. Testimonies by women workers, published in Schuler's study, illustrate this. "With a baby, I could not go to the market to sell," said one woman. "At the market, the people I sell to want to be attended to quickly. They don't want to listen to a baby crying, and the baby does not let you work." Another woman said: "I suffered. ... I used to cry all the time when I had to go to work with both babies. You can't work — you have to carry around a big load of goods and you have to carry two babies. And it was worse when it rained" (1994:213).

At the same time, the heavy burden of women's domestic and wage work limits their access to health care and fertility control services. Cirila, a young woman who came to Kumar Warmi for legal advice, told us, "I have four children and I have to work. There simply isn't time to go to the clinic, even though there is one right near my house."

## **Kumar Warmi**

### **Responding to women's needs**

When it began activities in El Alto in 1985, CIDEM defined its central goals as educating women about health care, educating women about their rights and supporting women's organizations. At that time, there was an extreme dearth of medical services in El Alto and not a single clinic for women. Many El Alto residents were afraid of clinics run by doctors, who had little knowledge of their cultural practices and beliefs. Poor, indigenous women often perceived that doctors did not respect them as clients.

In response to local residents' repeated requests for health services, CIDEM founded the Kumar Warmi Clinic in 1986 to offer integrated services addressing biological, legal, psychological and sociocultural aspects of women's health, with a complementary focus on traditional medicine, designed to recognize and reinforce the positive practices of women participants.

"The Kumar Warmi clinic grew out of a proposal advanced by the leaders of several women's organizations with which we worked," says CIDEM director Ximena Machicao. "They pointed out the desperate lack of services, and we responded by becoming the first clinic in El Alto oriented to women. We conceived Kumar Warmi as an integrated health clinic, with humane services and alternative methods, but more than anything, as a place for learning about health and about women's rights. The promotion of interpersonal bonds and the creation of women's support groups have been central components of the education program." CIDEM teams have always included Aymara speakers, who help promote greater confidence and understanding among clinic participants.

### **The Health Committee**

In 1986, the year after CIDEM began its work, the Health Committee was created to serve as a nexus between CIDEM and grass-roots women's organizations. The committee

was comprised of approximately 20 leaders of diverse women's groups and was very active until a few years ago, when numbers began to dwindle.

It is impossible to talk about CIDEM's health program without emphasizing the importance of this committee, which has articulated the needs of hundreds of women, and which has worked closely with CIDEM to plan and organize health project activities year after year. Committee members organized scores of workshops facilitated by CIDEM and by themselves, developed proposals for the management of fees for physician care and medicine, and promoted a wide gamut of activities in response to the interests of their respective groups. The committee also helped to design a system, similar to a health maintenance organization (HMO), to improve clinic attendance by members of their groups. They created a system in which members paid a small monthly fee (approximately 25 cents) that gave them and their children the right to attend the clinic as many times as they needed without extra cost. Committee members have spent a good deal of time at Kumar Warmi over the years, building a supportive network and making the clinic a central place for interacting and organizing.

In the past few years, Health Committee participation has declined gradually as many of the grass-roots organizations that sustained the committee disintegrated after food donations were terminated. Without the food incentive, groups suffered absenteeism and women began to seek other alternatives to fulfill their immediate needs. Now that many member groups are not functioning, only a handful of leaders remain closely involved with CIDEM and Kumar Warmi.

Natividad Condori remembers that her group had 50 women, who initially joined to get food donations, and who enthusiastically took advantage of access to health care and pediatric care at Kumar Warmi. "Then things began to disintegrate. First they cut off the food donations, and now they no longer treat children at Kumar Warmi, and many of the



CIDEM

women began to join other groups who knit for money, provide credit and the like. Only a small group of five or six people has stuck with it.”

Emilia Gutiérrez was the leader of a group made up mostly of Quechua-speaking migrants from Potosí. Initially, a few individuals made a tremendous effort to organize and consolidate the group, but as time passed, close to half the members left El Alto because they couldn't get accustomed to life there or couldn't find work. Migration complicates the rhythms and stability of all the groups. When members go home to their rural villages to help in the harvest or to participate in community festivals, for example, they don't come to meetings and they don't pay their fees.

Yet, not all groups have disbanded. Antonia Mariño has been a leader of her well-consolidated group for 10 years, and the group continues to meet faithfully each and every Tuesday. Like many others, Antonia's group was initially created to receive food donations, and for the past eight years, CIDEM has regularly facilitated workshops and discussions during her group's meetings. Antonia says that despite the termination of food donations, the members of her group continue to carry out activities, enjoy mutual support and respond together to challenges of everyday life. “Now we keep meeting just for the sake of friendship, for fraternity. We all know each other, everyone knows me and that is very important to me. We do things together too. We are people with lots of children — my sister has 10 kids, my sister-in-law has 12 — so everything costs a lot.

At Christmas, for example, we buy all the ingredients wholesale and make Christmas cakes together as a group, then each woman takes her part home to her family.”

In spite of their mixed experiences, all of the leaders that we met said they have benefited significantly from the experience with the Health Committee, especially in terms of improving their personal confidence and gaining the respect of their friends and neighbors. “As Committee members we help with everything CIDEM does,” says Antonia. “Women are afraid and we have to set an example. This role isn't just helping others, it gives *me* pleasure to counsel and assist other people. When a person comes and says, ‘Thanks to you I've gotten through my difficulties,’ this makes me feel really good.” Another member adds, “With CIDEM, we did a workshop on natural healing. We learned about the herbs that we know and other things too. I have it all written down in a notebook, and when people ask me for recipes and advice I help them, and I really like to help people.”

One of the most important aspects of the CIDEM project is the sharing of information and methods, and the Health Committee has been key in disseminating CIDEM's health care approach. Committee members have participated in numerous workshops and many have voluntarily invested their time to be trained as “health outreach workers” with CIDEM. These voluntary outreach workers have gained great satisfaction by sharing what they've learned in women's groups and informal settings, yet several have been frustrated in attempts to find paid positions related to their training. Although CIDEM awards training

certificates that are relatively prestigious in El Alto, few participants have found paid work in health projects. CIDEM's director commented, "It is very difficult to go through training, educate yourself, and then have your expectations disappointed. Family members apply pressure and demand that this effort have some monetary compensation. In an exceptional experience, CIDEM was able to hire three of the outreach workers trained in the program, and they worked for many years as valuable members of the CIDEM health team. The experience was very positive, but unfortunately we had to let these women go recently as part of a broad reduction in force."

The current attrition of grass-roots women's groups and of their leaders from the Health Committee has forced CIDEM to rethink its strategy for attracting women to the center and for training outreach workers. Radio programs and Pap smear campaigns, together with word-of-mouth information networks, have replaced women's groups as the principal means of assuring a constant stream of participants and clinic clients. The training program for outreach health workers has been adjusted to a plan for training 'counselors,' who specialize in strengthening self-image and improving women's legitimacy in the public sphere.

### Health services, education

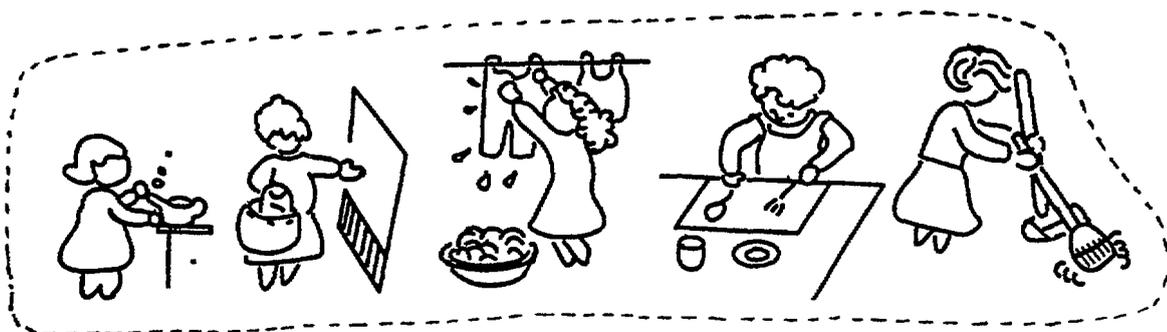
In the early years, a considerable number of women came to visit clinic doctors, and Kumar Warmi began to conduct Pap smear campaigns. A decision to offer children's health care at Kumar Warmi had the anticipated effect of encouraging their mothers to seek medical services as well.

"The clinic grew in response to the demands of the women, often articulated by the Health Committee," Ximena says. "Committee members requested pediatric services, and we hired a pediatrician in 1987. Pediatric services were an important attraction, very effective in bringing more women to the clinic. Many of these women had never valued their own health, had never been to a doctor, but they brought their sick children to the clinic. And once they were there, they sometimes checked out problems of their own."

"Women who brought their children to Kumar Warmi also learned about workshops and meetings, and often came back to participate. The institution has not been able to respond to all participant requests, however, sometimes because they do not coincide with the organization's vision, and sometimes because we don't have sufficient funds. It has never been possible, for example, to respond to the widespread request for dental service, and we discontinued pediatric service in 1995."

In the 1990s, CIDEM and the Health Committee decided to concentrate their efforts in women's reproductive health and rights. Since 1991, the clinic has offered gynecological and obstetric services, educational programs for pregnant women, family planning, sexual education for adolescents, and campaigns for the prevention of cervical and uterine cancer. Currently, some 3,500 women visit the clinic annually.

Today, Kumar Warmi Clinic offers women's health care and fertility control in conjunction with education programs for women, couples and adolescents. The clinic also offers training for outreach workers. These activities share three important elements that



characterize CIDEM's work: an emphasis on continued education and growth, based on respect for differences; an integrated approach to education and service delivery; and a focus on interpersonal relationships.

At Kumar Warmi, education means sharing knowledge and decision-making power. Staff have learned through experience that health education is often more difficult than education about legal issues and women's rights, because health is more intimate and difficult to discuss. The solution has been to view health education as a conversation between provider and client, rather than a lecture by the provider.

A noteworthy characteristic of CIDEM's approach is its emphasis on respect for participants' traditions and perspectives. Workshops and doctor-client visits are not seen just as contexts in which professionals educate clients, but also as contexts in which health professionals continually learn from clients and come to better understand their perspectives. Listening to how women interpret and deal with their problems within their own cultural vision and practice helps the professional staff envision new alternatives, which frequently transform routine medical prescriptions into context-appropriate advice that is more acceptable to the client and, ultimately, more effective in healing her problems.

Without this respect for cultural differences, mistrust can grow among providers and clients. As Schuler et al. noted, this is particularly true in attempts to introduce modern contraceptives. "Another related barrier to fertility control is a deeply ingrained fear and suspicion of modern medicine and medical practitioners, who are not seen as reliable sources of information about modern contraceptive methods. The expectation of discriminatory treatment based on ethnic differences (most doctors and other health personnel are of European or mixed ancestry) is an important contributing factor" (Schuler et al., 1994: 215).

When Dr. María Antonieta de Saldías examines a client at Kumar Warmi, she discusses the problem or problems the client is suffering, how the client can prevent or respond to these problems herself, and ways in

which doctor and client can respond together. She talks with the client about nutrition, herbal teas and natural medicines. One participant, Cristina, exclaimed, "What I like best here is the way the doctor treats us. She's understanding and affectionate with us. She gives me confidence, and I'm not afraid to ask about anything."

Not all clients choose medical treatment, and those who do not are also supported in their decisions. Childbirth is one example. "Most women prefer to have their babies at home, so as part of prenatal visits, I teach them how to have a clean and safe home birth," says María Antonieta. "After the birth, the CIDEM pediatrician used to go to visit and examine the newborn. We also gave courses for midwives in the area."

In her work at the clinic, María Antonieta sees prevention as a key process in which health education and health care are melded, and she strongly encourages women to take an active role in prevention and follow-up care. "For contraceptive use, I insist on regular checkups. After inserting an IUD, for example, I require women to come for a checkup the next week, and then a month later, to see how she is adapting. I am also adamant about prenatal checkups. We try to see that gynecology clients come at least once a year for a Pap smear, and during the doctor-client visit we discuss their general situation and try to identify any problems they might have. We make a visit plan with each client, and generally more than 80 percent of them come for their checkups."

In other social contexts, this emphasis on preventive and follow-up visits might seem excessive. In El Alto, however, the widespread resistance to and ignorance of modern medicine justifies additional clinic visits and one-on-one health education. El Alto residents express fear and suspicion of many medical practices, especially the insertion of foreign objects into the body. This resistance contributes, among other things, to a high incidence of psychosomatic problems related to birth control pills and IUDs and to high rates of early removal of IUDs. Kumar Warmi does

not focus on distributing a certain number of pills or inserting a certain number of IUDs, but tries to assure the continuing use of these methods through supportive checkups.

Kumar Warmi's strong emphasis on prenatal visits stems from the fact that the majority of the clinic's maternity clients are adolescents who know little about pregnancy and childbirth, and whose risk of maternal mortality is three times greater than women between 20 and 25 years of age (CIDEM 1995: 4).

### **Treating body and soul**

Kumar Warmi's integrated approach is based on the belief that many aspects of life influence health, and that health problems are best treated in a holistic manner. Thus, care is not limited to biophysical aspects of medicine but combines psychological and legal support as related dimensions of the clients' well being. CIDEM has also promoted a series of productive/economic projects, has worked to strengthen local women's organizations, and has advocated political and legal changes in relation to health care issues. CIDEM's broad approach to health and wellness corresponds with Corrêa and Petchesky's (1994:1) view that individual reproductive rights mean nothing for poor, marginalized people if social conditions prohibit the fulfillment of these rights.

María Antonieta observes that many women do not come to the clinic for medicine but because they want to be heard. These women experience pain on more than a physical level, and the response should be multifaceted. According to the doctor, "Most of our cases are complex problems, which require cross referencing in health, legal and psychological care. An abused woman comes to the clinic with complaints of physical problems, and when we are talking I may realize that she needs psychological support to strengthen her self-esteem or legal orientation to protect her from the beatings. Both are crucial to her reproductive health."

Kumar Warmi does not define a doctor-client visit as a simple one-time encounter; rather, the team does everything possible to integrate one visit or workshop with the next,

and to make health care an ongoing relationship that develops over time. An approach that integrates support for different dimensions of health over time allows for the introduction and exploration of new topics and ideas during successive doctor-client visits. María Antonieta says, for example, that the percentage of clients who ask for contraceptives is quite low (14 percent in 1994). "They are afraid. They think that it is going to hurt them. Machismo also affects the situation — men prefer that their wives are always with child so that they can't go with another man." Yet, although most clients come to the clinic for other reasons, she finds opportunities to bring up topics of sexual education, sexually transmitted diseases, and contraception during the conversations that take place as part of doctor-client visits.

CIDEM attempts to transform the vertical relations between health professionals and clients that have been the norm in Bolivia by offering a friendly and supportive environment, in which clients can talk about their daily experiences and in which they can ask for and receive information and personal support from the staff. The interpersonal relationships that develop in this context give strength and confidence to the participants, enabling them to take a more active role in caring for their own health. The doctor and nurse speak Aymara and they take the time to listen not only to the clients' physical problems, but to "problems of the soul."

María Antonieta believes that CIDEM's approach to health care is quality-oriented. At the clinic, she treats between 280 and 300 clients each month, but she emphasizes that the mere number of clients that she sees is not so important to her as is the proportion of clients whose health situation improves, and who fulfill prevention measures and checkup visits. It is a philosophy shared by CIDEM staff. "CIDEM is not interested in how many patients I see, but rather that I care for them well," María Antonieta says. "I have the freedom to listen to them until they are finished with their stories."

Participants interviewed perceive substantial differences between Kumar Warmi and other clinics. Several observed that in other health centers the doctor-client relationship is

distant and commercial, and the doctors don't respect women's capacity to understand and care for their own health. One young mother commented, "At the health center and at the hospital they don't explain what you have, how to look after yourself. They explain nothing. They just say, 'Take this. It's going to cost you this much.' They deal with you very quickly, and they are aggressive. Only at CIDEM's clinic they explain everything and take their time with us." A Health Committee member added, "In other clinics they just want to insert the Copper T (intrauterine device) and earn money. They don't do a gynecological examination first, they don't explain about the Pap smear, or tell us that with the Copper T we shouldn't have many partners because there is a greater risk of infection, nothing. CIDEM tells us all this."

#### **From clients to active participants**

The women who visit Kumar Warmi are not only patients, clients or beneficiaries of the institution's work. They are participants who actively share in decision-making about reproductive health.

When Kumar Warmi first began, staff members visited mothers' clubs in El Alto to talk about health issues and to motivate individuals or groups to associate with the clinic. Most of the early participants lived close to the clinic in District III of El Alto. Over time, the radius of participation and action widened, mainly through personal contacts of participants, who shared their experiences and invited friends and relatives to visit the clinic. A series of radio programs about different health issues has attracted more women, especially from different neighborhoods, and nurse Justina Prado confirms that today clinic clients come not only from El Alto, but also from rural provinces and from the capital, La Paz.

Participants who are migrants from rural communities often require a different type of discourse and treatment. Migrants, who make up a large part of El Alto's population, frequently speak only Aymara or Quechua, they often are illiterate and may never have had

contact with medical services. The clinic is sensitive to these common characteristics and also tries to respect the great diversity of cultural orientations that exist among different migrant groups.

Another group with special needs and experiences is adolescents, especially pregnant girls. "The majority of our pregnant patients are adolescents, and they are embarrassed about their situation," says María Antonieta. "There are many teens who simply don't go to the doctor during their entire pregnancy because they are afraid of how people will look at them. And it's true that some people will see a pregnant teen and say ugly things right to her face! That's why they stay at home until the baby is born, without a single checkup. We want to open a clinic just for adolescents so that they will not feel embarrassed, and so that they can share experiences and support amongst themselves. At first, we are going to establish certain days only for adolescents, so that they have their own time, and we've also scheduled discussion groups to help strengthen the self-esteem of pregnant teens."

Since Kumar Warmi opened 10 years ago, the cultural and socioeconomic characteristics of participants have become more varied, as have their motivations to participate in the clinic. Initially, women's organizations in El Alto were driven by access to food donations, and participation in the clinic was motivated by access to inexpensive health services, especially for children. Ximena Machicao, CIDEM's director, notes that as the project has evolved, she has seen increasing numbers of participants motivated by concerns for their own reproductive health and by the desire to learn about health issues, "There is a tremendous desire to learn and understand things better, even amongst women over 50 years old."

#### **Personal growth**

CIDEM stresses learning and personal growth among its staff, Health Committee members, voluntary outreach workers, and other participants. Personal growth is not understood as improved economic, professional, or social status, but as an internal

process that generates autonomy, confidence, and responsibility, permitting an individual to construct a healthier and happier life. To further this vision, the organization promotes learning, reflection, and the improvement of self-esteem and interpersonal relations.

The life stories of Health Committee members express clear visions of personal growth.

These women do not seem to view their leadership as a hierarchical achievement but as an experience of personal enrichment and solidarity with others. Natividad Condori, who has received a great deal of education in reproductive health, does not take advantage of her superior knowledge to establish herself as an "expert." On the contrary, she describes a practice of participatory learning grounded in women's everyday lives. "We get together a group of women and I ask them, 'How many children do you have? How are your children?,' like that, and sometimes they ask something, or mention a problem, and from there, I respond by telling them things about health, fertility control, like that, always conversing in relation to their lives and their concerns."

Antonia de Saldías relates how she uses her personal traumas and challenges as examples to motivate other women in the group. She believes that learning through such examples is effective because women can identify profoundly with experiences similar to their own. Antonia has faith that her personal experiences, which have shaped her attitudes and behaviors,



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will contribute to a more equitable society. "Before I worked day and night, Saturday and Sunday and my birthday, too, without pay. I was a victim, a subordinate, who did everything for my husband and children. Now I've changed. I've taught my children to help me. In my home, my brothers were always favorites. Now I teach my sons and daughters the same chores and expect the same from them. This way there is going to be more equality in the future."

### **Family dynamics**

Personal changes experienced by participants have led to further changes — and sometimes ruptures — in family dynamics. Knowing their rights has motivated women to change their behaviors, and these changes have triggered diverse reactions within their families. For some women, the changes led to greater tension, "My husband told me, 'When you go to those workshops, you get a big mouth. Why

do you want to change?’ ” Yet others were surprised by positive support. “My husband said, ‘It’s about time women wake up. Why didn’t you go to those workshops before?’ ”

Marina, a 20-year-old mother of two, who visited the clinic, described the impact that CIDEM education has had on her marriage. “I told my husband everything that I learned. At first he was furious. Since he is a high school graduate, he did not want to learn anything from me. Now we have both managed to change.”

To address this type of familial tension, CIDEM conducted a series of family planning workshops for couples, which were very popular. “CIDEM believes that to work with gender we must work with women and men,” comments María Antonieta. “We are constantly trying to incorporate the husbands and partners of the women in our activities, and also we work with young people of both sexes.”

Justina, a nurse at the clinic, notes that other changes in family dynamics are evident in the fact that more mothers want their daughters to learn everything that CIDEM teaches. Committee members told us that when they were adolescents, their mothers didn’t explain anything to them, and they didn’t even know what menstruation was. One woman saw the blood of her first period and thought she was dying of cancer. Another remembers having received one piece of advice from her mother: “Don’t let a man touch you or you’ll get pregnant!” Although the topic of sexuality has traditionally been repressed, even within the home, the women we spoke with were convinced of the need to educate their daughters in reproductive health.

“Many women don’t know how to talk about reproductive health so they bring their daughters here so that I can explain it to them. Even the midwife brought in her daughters,” says María Antonieta. “Sometimes we get together a group of teens and do a workshop, or we just go to someone’s home and chat with a group of adolescent friends.” Thanks to this type of outreach, the median age for Kumar Warmi participants has been growing younger.

### **Assuming responsibility for reproductive health**

Gaining the confidence and self-esteem necessary to take responsibility for reproductive health is not an easy process for many women. Natividad Condori explains: “First everyone was embarrassed, they didn’t want to see a woman’s body or a man’s body, not even on the flip charts. Some women were mad or scared and said, ‘The [contraceptive] methods are going to hurt us. On the radio, it says that they give us cancer, make us bad women, hot for other men.’ But Ignacia came from CIDEM to work with our group, and she conversed with us in Aymara, which gave us more confidence. Now we know about our bodies, that we should not be ashamed, that there is nothing wrong with us.”

In terms of her personal experience, Natividad says she learned that she has the ability to control her body. “I learned that we could stop having a baby every year and later have more if we want. I didn’t know that. I had a baby every year, every year another baby. I didn’t know that it was our decision.”

Another Health Committee member admitted that she had shared the doubts and fears of other women in her group. “At first we were all afraid and embarrassed to do the Pap smear. We’d heard that it hurts a lot, and we’d never been seen by a doctor before. Now that we’ve participated in the workshops, we value our bodies, and we also know that we need to take care of ourselves.”

Not only have Kumar Warmi participants come to value their health, they also have come to value the knowledge they have gained and to feel confident sharing that knowledge with other women. Ximena Machicao emphasized as a fundamental achievement the fact that women participants speak on the radio to announce events and to talk about women’s health issues. “That gives them confidence, it opens new possibilities by giving them a public presence that they have not experienced before, which definitely increases their self-esteem.”

Health Committee member Emilia Gutiérrez is an example of a Kumar Warmi participant who has shared her reproductive health knowledge with other women. She boasts that she has become a family planning evangelist. “We’ve gotten used to talking about these things, and now when I see a pregnant woman with a baby on her back and another holding her hand, I just want to go right over and talk with her. Sometimes we talk a little, just joking, or conversing like this, and sometimes it works out, and she gets interested. Even at parties, or anywhere at all, I talk about family planning. My family laughs at me, but I’ve managed to influence all of my sisters and sisters-in-law, too. They’ve all ended up with only two or three children.”

Kumar Warmi participants have made a significant impact by sharing information in informal settings — among relatives, friends, and neighbors. The multiplier effect has been especially visible in the number of women who come to the clinic, often for their very first doctor visit, thanks to the encouragement of other participants.

### **Community partnerships**

CIDEM has made it a policy to coordinate with other organizations that work with women or with health in El Alto. CIDEM provides workshops and training to groups, such as mothers’ clubs and women’s groups supported by Programs para la Mujer (PROMUJER), ONAMFA and CEMSE and works with the Interinstitutional Women’s Committee for El Alto. One of CIDEM’s principal objectives is “to coordinate actions with governmental institutions, advancing alternative proposals and policies which benefit women’s health.” In the governmental sector, CIDEM currently coordinates with the Regional Secretary of Health, and has an arrangement with El Alto City Hall to provide care to poor women who participate in public works projects. CIDEM also works with the government’s Project for Improving Primary Care in planning and implementing of training, research, and other activities related to women’s health.

One of CIDEM’s most innovative partnerships involves several clinics and hospitals that provide obstetric service in El Alto. While Kumar Warmi Clinic provides prenatal care, it has never attended births. Through the years, clinic participants have frequently refused to go to clinics or hospitals for childbirth. One young mother explained her reasons: “At the hospital they scold us, even when we are suffering labor pains. They say, ‘Why are you yelling? Did you yell like that when you were with the man?’ My neighbor works at a hospital where the doctor told them, ‘You shouldn’t show affection to the patients, they will just manipulate you.’ ”

To respond to this widespread fear and resistance, CIDEM developed agreements with several clinics based on the following terms: The clinic’s medical personnel agree to participate in workshops facilitated by CIDEM on humane health care and commit to practice the philosophy presented in the courses. For its part, CIDEM agrees to refer its childbirth clients, who carry special cards indicating that they are CIDEM clients, to these centers.

Testimonies of women who have received care in these collaborating centers indicate that health treatment has improved substantially. A young committee member, Celia Perez, contrasted the trauma she experienced during the birth of her first child and the positive changes with the second baby, born at a hospital participating in the CIDEM agreement.

With the first child, “I went to the hospital with labor pains, and they put me in a room. It hurt a lot, and I shouted for help, but nobody paid attention to me. Even when the baby came out, the doctor didn’t show up, and I felt totally abandoned. Many women, especially those in traditional dress, accept abuse from doctors because they think doctors are superior. With CIDEM I learned that they have no right to treat me like that. The second time I went to give birth, I told the doctor, ‘I am going to cooperate with you, and I want you to cooperate with me,’ and it was much better.”

Another woman recounted how her treatment at a health care facility improved. She arrived with a CIDEM card and was received quickly and respectfully, even though other women were enduring labor pains while waiting in a long line.

According to CIDEM's director, "The institutional agreement has contributed to the fact that women referred by CIDEM are treated better than they were before, partially because the staff in these clinics has been educated in humane treatment, and partly because they want to keep the agreement to assure more clients. There is much to be done along these lines. What is important is that the women know that they have rights, that they are valuable people, and that they don't have to accept any kind of humiliation or abuse in the hospitals or clinics they attend."

## Looking back, looking ahead

### Concentrating resources

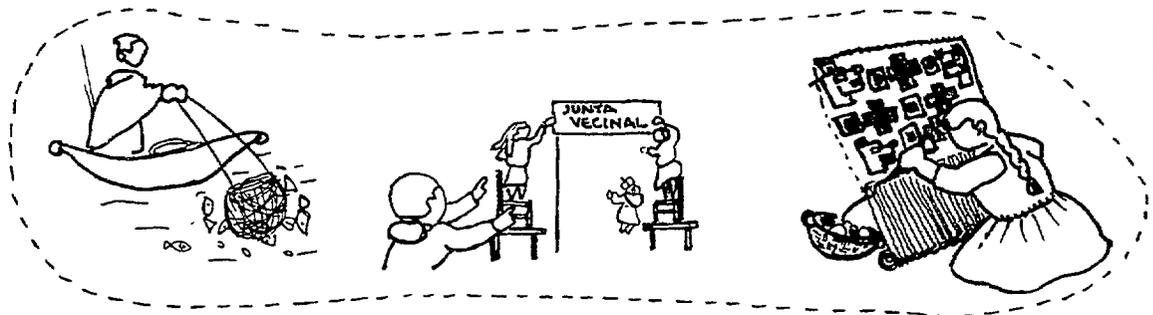
CIDEM was one of the first institutions to work in El Alto with health, legal, and educational services. In consideration of reproductive health services that government and private institutions are increasingly providing, CIDEM is currently adjusting its programs to reduce or eliminate some of the services it has offered over the years, in order to concentrate its resources in areas where it can make a greater impact.

Many clinic participants are opposed to the changes. They prefer that CIDEM consolidate its existing programs and even return to offering pediatric services. "I hope that CIDEM gets its own building for a clinic, so that it will

be more secure and everyone will be more confident about the future," said one Health Committee member. "I want CIDEM's health program to expand and build clinics all over Bolivia," said another. "There are many people who need this type of clinic. Due to fear of doctors, or because they don't have money, many mothers and children die each year in Bolivia."

While sensitive to these concerns, Ximena believes the most important impact CIDEM can make at this time is to disseminate information about its methods of incorporating gender into health care service and delivery. CIDEM has developed a plan for transferring the clinic to another organization so it can concentrate on training others and sharing its institutional philosophy with private and government health care organizations. CIDEM has been contracted for a training consultancy with the Centro de Investigación, Educación y Servicios (CIES) and is finalizing an arrangement to conduct workshops with the National Secretary of Health. CIDEM also continues to publish a series of books, many of which help to disseminate its experiences and approaches to women's education and health care.

CIDEM's shift from service delivery to training represents a move toward financial self-sufficiency and institutional sustainability. It is becoming increasingly difficult to obtain funding for integrated health service projects such as Kumar Warmi, especially on a medium-to long-term basis. At the same time, given the clinic's objectives and the participant population, it would be virtually impossible to establish a sustainable service program with operational costs covered by client fees. By securing its role as a consultant to other organi-



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zations, CIDEM will be in a stronger position to educate and lobby for new policies and political positions, which justify public investment to improve the reproductive health and well-being of poor residents.

### **Achievements: education, transformation**

One of Kumar Warmi's most significant achievements is the development of a new methodology for reproductive health education and care. The basis for the methodology is two-fold: continuous education and growth of health care staff, grass-roots participants and group leaders; and, the transformation of doctor-client relationships.

The effects of continuous education are evident among CIDEM's staff and program participants. Guided reflection and discussion among staff promote a better understanding of the problems at hand and a better quality of work. This educational process has helped to connect daily practice with theory.

Each month CIDEM organizes a workshop for all members of the organization, with objectives related to personal and institutional growth. An important feature of staff education is the exploration of the experiences and customs of grass-roots participants, which ultimately enriches and broadens the staff's knowledge, attitudes and practices. The institutional emphasis placed on learning from local women reinforces staff efforts to engage in a dialogue with program participants as part of their professional duties. Over time, most CIDEM members have come to comprehend principles of participation, equity and gender, and those who do not internalize these concepts tend to leave the organization.

The development of new perspectives on the part of the staff parallels changes among participants. While CIDEM staff members begin to understand the attitudes and practices of women participants and to comprehend their different life situations, participants, in turn, begin to internalize concepts important to CIDEM, such as women's rights, self-esteem, and women's participation in decision-making.

Continuous learning and dialogue — within and among professional teams and participants — are key to transforming the vertical relationships that traditionally characterize medical service in Bolivia and other parts of the world. CIDEM sees a clear need to change the prevailing balance of power in order to share knowledge and encourage participants to share in the decision-making process. Experience has taught CIDEM staff that changes on both sides — on the part of health professionals as well as clients — are necessary. It is not sufficient to “empower” women clients and urge them to demand their rights, given well-established hierarchical power structures. And, given the timid and submissive attitudes of women clients and their lack of knowledge and confidence, neither is it sufficient to educate medical professionals about the concepts of equitable relationships, gender perspectives and humane treatment. It must be a joint effort in which both groups learn and change.

CIDEM's experiments with different techniques for doctor-client visits have helped establish more equitable communication styles, which have ultimately led to increased client cooperation and improvements in client health. Through education and strengthening of women's groups and through training at other health care institutions, CIDEM has managed to influence players on both sides of potential doctor-client encounters outside of Kumar Warmi.

### **Rethinking parameters of success**

CIDEM's experiences have generated several lessons that have wider application. The first is that it is necessary to establish alternative parameters of success to complement conventional indicators used to evaluate health programs.

CIDEM's director acknowledges that, “In terms of coverage and cost/benefits, our service ranks low in relation to other nongovernmental organizations and in relation to parameters established internationally and by the Bolivian Secretary of Health. We don't seek a massive impact in terms of quantity, we seek quality.”

Normally the efficiency of a reproductive health project is measured by variables, such as number of client visits, number of intrauterine devices inserted, number of pills distributed, number of Pap smears done, in comparison to funds spent. The justification and sustainability of Kumar Warmi has been frustrated by the prevalence of these indicators, which measure the operative efficiency of a clinic but fail to measure the quality of services, or even the impact that the services have on the clients' health and well-being.

According to CIDEM's three-year plan, the first objective of its health service is "to enable women of El Alto to participate actively in the identification of their integrated health needs and in the search for solutions." Other objectives include: "to offer educational and prevention programs together with health care for women," and "to offer integrated health care to adolescents, working from a gender perspective." Considering these objectives, it is clear that we cannot evaluate the *active* participation of women by simply calculating the number of workshop participants, nor can we verify the provision of *integrated* health care from a *gender perspective* by simply counting the number of doctor-client visits. The criteria that matter most to CIDEM are absent from the indicators generally used to evaluate health programs.

Kumar Warmi's experience underscores the need to identify parameters of success, which reflect qualitative changes in the participants and in the target population. We need to learn how to determine the extent to which reproductive health knowledge and responsibility have been internalized by participants, and how participation has affected health and well-being in the medium- and long-term.

One suggested option is to analyze clinical records, in order to evaluate women's health and health problems over longer periods of time and to determine what kinds of actions they have taken for preventive health, fertility control and health education. Among the indicators of success mentioned by different people involved in the project were:

- How many participants say that their overall health and well-being has improved as a result of participation in Kumar Warmi's activities?
- In what ways have participants initiated or become involved in other health activities or projects after their Kumar Warmi experience?
- How many women who come for the pregnancy test then follow up with consistent prenatal care?
- What are the rates of consistency for scheduled checkups or return visits related to IUD insertion, pills and Pap smears?
- To what degree and how do participants share their knowledge and experience with others?

New methods for evaluating health project impact should be linked to questions about cost and benefits. For a health project to be sustainable and provide continuous service to its target population, it must maintain fees that are reasonable for clients and costs at levels justifiable to its funding institution. In terms of conventional criteria, and in the current political-economic context in Bolivia, the participative and integrated approach developed by CIDEM could be too expensive to be sustainable, much less self-sustaining.

Presently, CIDEM is involved in the challenging process of constructing alternative frameworks for planning, evaluating and funding — frameworks true to the organization's goals and methods and, at the same time, acceptable to the National Secretary of Health, funding institutions, and the larger medical community.

### **Gender perspectives**

Practical experience gained implementing the Kumar Warmi project has enriched CIDEM's understanding of gender. Today, CIDEM's administration, technical and professional teams, as well as its many grass-roots participants and leaders, have internalized gender. It is a living philosophy, expressed in one's way of relating to others and in expressing

one's own identity. We will comment on the expression of this gender perspective by focusing on three gender principles evident in Kumar Warmi programs: recognizing and respecting differences; striving for equity in participation and decision-making; and empowering women to be active participants in their own health care.

**Differences.** Kumar Warmi was founded in response to the specific needs and perspectives of women in El Alto. Yet the clinic's programming also recognizes and respects differences among women: cultural and linguistic differences; different beliefs and practices relating to reproductive health; and different identities and needs of adolescents versus mature women.

**Equity.** In Bolivia, as in many countries, access to health services has historically been unequal in terms of sex, class and ethnicity. Many women do not have enough money to obtain health care; for others, clinics are too far from their homes, or there is nowhere to leave their children during clinic visits. For many women, especially indigenous women, access has been limited by fear of mistreatment, misunderstanding or humiliation.

Kumar Warmi has provided access to people who had been excluded or marginalized from existing health services for various reasons. Thanks to its policy of low costs in general and free services for impoverished families, its location in a working-class neighborhood on a public bus stop, its warm family atmosphere, and, most of all, its humane and respectful treatment of poor and indigenous women, Kumar Warmi has made a small contribution toward more equitable access.

Nevertheless, mere access to health services rarely guarantees equality in doctor-client relationships or client participation in health care decisions. Here CIDEM has taken the concept of equity a step further. CIDEM medical staff have learned to share with their clients not only knowledge, but power over reproductive health issues. Staff help women learn about their bodies, how they work, and how to care for them. They also teach that women have rights to control their bodies and

their reproductive health. This knowledge places women in a stronger position, enabling them to be a partner in reproductive health decision-making.

**Empowerment.** Gender theory has helped us understand how, in our societies, the category "woman" has been construed as "the other," and the other has become an object to be controlled.

CIDEM tries to break out of the classic hierarchy in which the doctor is the "expert" who diagnoses the problem, and the client is the passive subject who accepts his/her prescription. At Kumar Warmi, a doctor-client visit is not seen as an objective diagnosis but as a dialogue in which both participants share experiences, opinions and ideas in an effort to construct an understanding of the problem and find an appropriate response. CIDEM's work with grass-roots leaders and its educational workshops are based on the idea of constructing knowledge together, rather than unilaterally disseminating facts.

One of the more challenging lessons CIDEM has learned is the difficulty of applying gender principles to administrative and operational procedures. While its members strive to share power and decision equally, organizations need someone to take specific responsibilities and to make decisions. CIDEM continues to work on constructing equitable, participative and empowering work relationships within its institution.

Kumar Warmi's example makes it clear that most health projects oriented to women do not incorporate a gender perspective. In fact, many women's health projects reproduce forms of gender discrimination; for example, by treating women as a homogenous group, by maintaining control over medical information and decision-making, by establishing vertical relationships in health education and doctor-client visits, and by defining women as clients and beneficiaries. For CIDEM, gender principles are not just workshop topics or project titles; these principles govern the content of health education, the delivery of health care, and the interpersonal relationships among clients and providers.

## Conclusion

La Casa de la Mujer and CIDEM represent organizations at two different stages of institutional development. La Casa is a young organization characterized by tremendous energy and commitment to action, while CIDEM is more mature, and in a decade of experience, has had the opportunity to reflect on and interpret its practical experiences in relation to its theoretical and political positions.

There are similarities in the two projects. Both understand reproductive health as a state of physical, mental, and social well-being. Health is viewed as a fundamental human right for women and, therefore, implies the right to the information, power and resources necessary to make decisions about fertility, childbirth, child raising, gynecological health and sexuality. The two projects offer integrated services and education to support multiple dimensions of participants' well-being. Both are principally designed and administered by and for women.

Yet the organizations' philosophies and approaches differ. La Casa de la Mujer has an *action-oriented* approach, directed toward helping and empowering women and grounded in a strong analysis of Bolivia's class system. CIDEM has focused increasingly on transforming health care and educational *processes* from an analysis based on gender theory. CIDEM's work underscores the need to develop new ways of evaluating and measuring the successes of women's health programs — evaluations that do not rely on numbers alone to gauge the impact of service delivery and education.

Through their different approaches to the delivery of health care services and education, La Casa and CIDEM reflect the complexity of women's lives and experiences and the need to develop multiple approaches to improve the quality of women's health.



LA CASA DE LA MUJER

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