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RETHINKING DIFFERENCES
AND RIGHTS IN SEXUAL
AND REPRODUCTIVE HEALTH

A TRAINING MANUAL
FOR HEALTH CARE PROVIDERS

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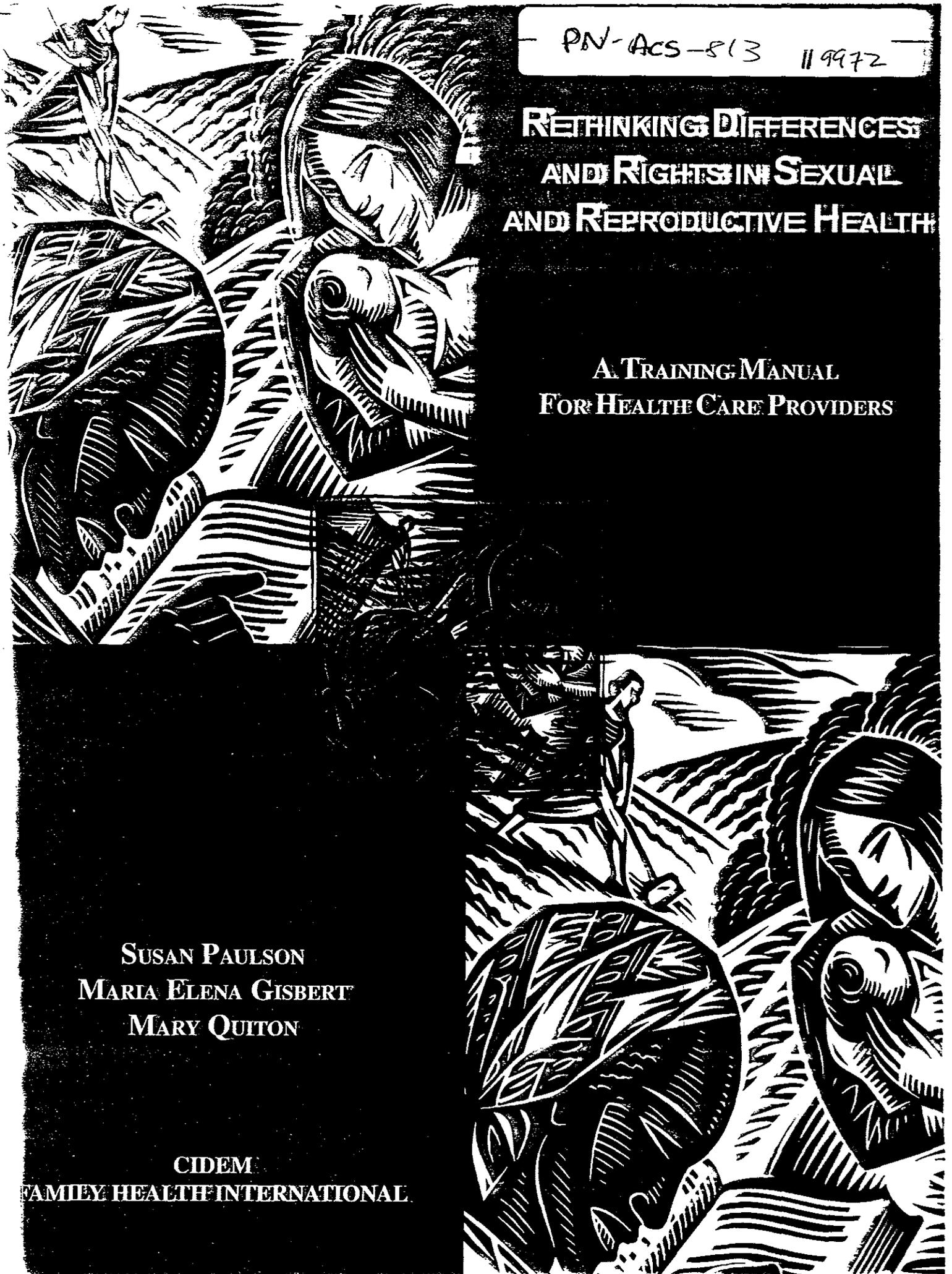


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PREFACE

This document was completed in 1998 and was immediately put to use and tested in training sessions in La Paz and Santa Cruz. The training package was well received and the participatory application process generated modifications, primarily in the exercises and examples given in the four modules. The package may undergo minor changes under the supervision of staff at CIDEM, who are eager to continue applying it in a wider scope of training contexts. We believe that the package in its original form serves as a prototype and will be a useful resource to support training efforts in other cultural settings. For this reason we have translated the document from Spanish to English and are making it more widely available.

The specific target audience for this guide and the training it supports have been the men and women working in sexual and reproductive health who are interested in promoting training or reflections designed to improve gender and culturally sensitive care among their provider teams. On a more general level, the conceptual framework and practical modules are designed to target both private and public health professionals and activists working in the field of sexual and reproductive health. The modules include discussions of issues that vary from administrative visions and decisions to details of service provision that will be useful for all staff. The proposal is that the key ideas of the conceptual framework must be applied across the board to create harmonious and long term change.

Patricia Bailey
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FOREWORD

The Women's Studies Project, carried out in Bolivia with technical and financial support from Family Health International (FHI), culminates with this important effort to translate knowledge generated through research into training materials for health service providers. The goal of this training is to improve the quality of care in sexual and reproductive health by applying a gender perspective.

This training proposal encourages the practical application of gender considerations advanced in Bolivia by governmental institutions and social movements. We are convinced that by linking these gender considerations with sexual and reproductive health, we will be able to contribute to the improvement of health care programs.

Behind this endeavor lies an important belief that needs to be highlighted: the conviction that the reflection and capacity building activities proposed here will promote profound changes, not only in the performance of providers, but also in the health care model itself. By reorienting health care models toward men and women users, health programs and institutions will have a better chance of responding effectively to the needs of the populations they serve.

It is worth emphasizing that this training manual is the fruit of a collective effort. A select group of persons working in health care services, non-government organizations and reproductive health research have systematically integrated knowledge, research data, intuitions, and professional experiences in a profoundly reflective and creative process. We would like to express our gratitude to all members of the Technical Advisory Committee, and to highlight the efforts of Maria Elena Gisbert and Mery Quitón, who worked closely with Susan Paulson to develop the conceptual framework and training proposal, and with Cecilia Olivares, who was responsible for the editing and publication of the document. We are pleased to have collaborated with the Center for Information and Development of Women (CIDEM), whose director Ximena Machicao demonstrated praiseworthy leadership and unflinching conviction of the importance of producing this training guide. There were many challenges during this process, and she overcame each of them.

We would like to thank the United States Agency for International Development (USAID) for its decisive financial contribution through FHI, acknowledging that without this support the effort would not have been possible. Thanks also go to the International Planned Parenthood Federation (IPPF) for authorizing the use of the indicators they developed for evaluating quality care from a gender perspective, the Johns Hopkins University, the Flora Tristan Center for Peruvian Women and Ipas for permitting us to use their videos as part of this training package.

Thus, we present this guide in hopes of contributing to the improvement of sexual and reproductive health care services in ways that permit persons of different ethnic backgrounds, ages, social classes and gender identities to know and exercise their rights fully within the context of appropriate health care services.

René Pereira Morató
Representative of Family Health International in Bolivia

INTRODUCTION

The Bolivian government established a series of progressive sexual and reproductive health policies and implemented programs in the field throughout the 1990s. In spite of these efforts, many men and women still do not have access to sufficient sexual and reproductive health information, much less basic services. In Bolivian society, women have been assigned the principal responsibility for sexual and reproductive health, but both men and women will benefit significantly from services that are more sensitive to gender and cultural realities.

Bolivian rates of fertility and ratios of maternal mortality (MMR) are among the highest in Latin America. Between 1991 and 1994, the total fertility rate in Bolivia was 4.8 children per woman.

Maternal mortality, between 1989 and 1994, was 390 deaths per 100,000 live births. These figures obscure profound differences between regions: in the Eastern Lowlands the MMR falls to 110 deaths, whereas in the Altiplano it is as high as 602 deaths per 100,000 live births per year (INE 1994). These data demonstrate some of the consequences of inadequate sexual and reproductive health care and health education in the country.

Improving the quality of health care is a fundamental step toward achieving significant improvements in the health of the Bolivian population. Yet, the population is characterized by such great ethnic, cultural, socioeconomic and generational diversity that it is impossible to apply a universal model of health care. A gender perspective can be used to better understand the differentiated groups within the society and the dynamics of relations among those groups and their members. This type of understanding needs to be incorporated into sexual and reproductive health policies and programs in order to impact a more significant and more diverse portion of the population.

The training package presented here is designed to promote an approach to sexual and reproductive health care that recognizes different needs and perspectives within a context of

Some of the sexual and reproductive health care services [in Bolivia] are characterized by compassionate treatment and equality of conditions, a warm environment and emphasis on body-soul relations, which is so important to reinforce users' own cultural beliefs. In those services with more humanistic treatment, there tends to be more stable personnel, and the use of native languages promotes the access and acceptability of formal health care services (WHO 1996).

respect for the rights and dignity of men and women. The package includes a conceptual framework, a guide for training activities, and a set of four educational videos.

The concept of gender-sensitive quality care is gaining importance among numerous health care professionals and centers. Changing social paradigms and new information about the benefits of compassionate and comprehensive health care are motivating a growing interest in this perspective. Nevertheless, there are still many doubts about how to practice quality care with a gender perspective in concrete operational terms. To respond to this need, the training package presents a series of conceptual and methodological advances in a clear and accessible manner in order to facilitate an understanding and the daily use by health care professionals in diverse regions of Bolivia, especially in urban contexts.

The gender perspective advanced here is not presented as a new component or additional activity to add to the already considerable workload of health providers. On the contrary, we wish to facilitate an integrated approach that helps providers carry out their work in a more sensitive and efficient manner, resulting in greater satisfaction and success on the part of providers themselves, as well as users.

CONCEPTUAL FRAMEWORK

This conceptual framework serves as a theoretical basis for the training package and provides conceptual tools to critically analyze current health care practices and to promote more fruitful approaches. Interrelated aspects of these new approaches include: equitable interpersonal relationships within health care teams and between providers and users; the possibility for users to be informed and choose freely among alternative methods and treatments; recognition and respect for users' beliefs, practices and experiences in relation to their bodies, sexuality and reproduction; respect for the population's sexual and reproductive rights; technical competence; availability of essential supplies; accessibility of services for different groups of users; and administrative practices that promote equity.

What are the basic concepts that support this type of approach? Here, we emphasize the need to understand and reflect on four interrelated concepts: gender, sexual and reproductive health, sexual and reproductive rights, and quality care. While we provide basic definitions for the training process, it is important to emphasize that these are relatively new and highly contested concepts for which multiple and sometimes conflicting definitions and applications coexist. Each individual and health care team needs to develop its own conceptual and philosophical position through debate, reflection and practice.

■ THEORETICAL AND CONCEPTUAL EVOLUTION

Health care practices are constantly being modified and improved by the generation and introduction of new technology, including medicines, vaccines, diagnostic tools, surgical equipment and contraceptive methods. Similarly, new methods and techniques for provider-user interaction and communication are also transforming health care. The approach developed in this training package is informed by, and contributes to, changes along various philosophical and conceptual paths, among them:

- Change from a provider-centered approach with indicators of success based on the achievement of numerically tabulated professional activities and goals (number of patients seen, number of IUDs inserted, etc.) towards a *user-centered approach* with criteria for success based on user satisfaction, solutions for users' health needs and sustained improvements in the health of the user population.
- Change from an impersonal approach, in which users are treated anonymously and uniformly, to a more *interactive approach*, in which both user and provider are respected as individuals, with their own gender, ethnic, class, and generational experiences and identities.
- Change from a unilateral practice, in which health care providers monopolize information and decision-making, to a more equitably balanced *participatory approach*, in which users and providers share ideas, information, doubts and preferences.
- Change from a narrowly focused approach centered on family planning toward more *comprehensive sexual and reproductive health services* ranging from the prevention and treatment of sexually transmitted diseases (STDs), to pre- and postnatal care and education, to counseling on sexuality and domestic violence.

- Change from a biomedical focus toward a *broader health care model* that incorporates social science, ethics, human rights and respect for the cultural and individual position of each man and woman.

■ GENDER

Gender is a social, cultural and historical system in which specific characteristics and roles are assigned to certain groups of people with reference to their sex and sexuality. We are all born with biological sexual characteristics, which are then associated with social and cultural characteristics. A gender perspective is a theoretical and methodological approach that permits us to recognize and analyze the identities, perspectives and relations, especially power relations influenced by gender systems. It also facilitates a critical analysis of the socioeconomic and political-legal structures that inform these identities and relations, and which are influenced by them.

We understand gender as that which identifies us as women and men within our social life based on different attitudes and forms of behavior, different roles and responsibilities, opportunities, spaces and activities. We learn gender values and behaviors as we grow up, and they influence who we become. These culturally constructed differences are symbolically associated with sex differences, which are biological characteristics that differentiate males and females, permitting sexual reproduction of the species.

Teresita de Barbieri writes: "We are born with biologically sexed bodies, to which we attribute one or another social and cultural meaning. As humans we are historical beings, we are not born in nature, we are born in societies, in a world culturally construed with laws, norms, values, symbols, and collective commitments. All cultures have forms of gender training, and all institutions, governments, schools, churches, families, are pedagogical fields for gender construction. Thus, in all societies, men and women are raised with life philosophies marked by gender" (Barbieri 1991).

Marcela Lagarde (1995) explains that there are two basic concepts of gender in Latin American societies. The first is the traditional gender ideology, which says that all men and

Gender beliefs and practices define roles, opportunities and limitations for women and men, greatly influencing life in all societies. Aspects of daily life shaped by gender include use of language and means of self-expression, dress and appearance, education, work opportunities, family structure and size, and each individual's health (Paulson 1998).

women's characteristics are natural. It assumes that gender categories and identities were created by God, or in accordance with Nature's laws, and are thus immutable. This gender ideology is implemented, guarded and sanctioned by social institutions, which establish parameters for male and female behavior (here, there are only two gender categories: masculine and feminine, as any variation is considered unnatural). In Bolivia, this traditional gender ideology foments conditions

of inequality and unequal value of men and women, exemplified by educational practices in which girls are trained to be self-sacrificing mothers and obedient wives within the domestic domain, while boys are trained to be strong and brave, to lead in the public domain and be heads of the household.

The other concept of gender to which Lagarde refers breaks with this traditional scheme. It defines gender as a category of critical analysis designed to consciously deconstruct the dominant gender order and to contest conventional assignments of social, psychological and cultural characteristics. This gender concept reveals that power differences between men and women are not natural and genetic, but rather historically construed and assigned. This position, in contrast to the first, facilitates efforts to move towards more equitable conditions and relations between men and women (Lagarde 1995).

An important aspect of gender is the manner in which certain anatomical differences are interpreted and managed within each society. Men and women have the same capacity to produce pleasure in each others' bodies, but only a woman can "produce another body" (Torres Arias 1989). On the basis of this fact, Barbieri theorizes that every society assigns a special power to the female body, and establishes the need to keep that body under control: "To assure an effective control of reproduction, it is necessary to take actions to control sexuality.... In other words, in order to control reproduction in such a way that one or more men can claim rights over the product of women's bodies, it is necessary to control access to the female body... Control of women's bodies means to limit women's work in such a way that they can not escape" (Barbieri 1991).

Sexual and gender identities and relations are not uniform, and we need to consider ways in which they intersect with other axes of social differentiation. Gender identities vary with the stages of the life cycle, and the meaning of sex and age varies with socioeconomic and ethnic factors in the construction of identities and relations. We must also take into account family structure, economic organization, division of labor, religious beliefs and practices, and other cultural aspects.

Gender Relations

Gender is a part of all human experience and all social relations, and as such continually influences the value, power and identity of each participant. In general, Latin American societies assign certain political and economic values to men and applaud their roles in public leadership, whereas they assign certain moral values to women and venerate their maternal roles and their functions as transmitters of cultural and religious traditions in the home. These relations are part of social fabrics in which men, in general, have more power for decision-making and action than do women.

Nevertheless, it is crucial to remember that this is not a simple dual hierarchy. Each individual's class, ethnic group and generation influence his or her experience within the gender structure. In

Bolivia, white adult women in the middle and upper classes have much more power for decision-making and action than do adolescent men who are indigenous peasants. While powerful government, church and economic institutions are dominated by men, it is by an elite group of men. The majority of Bolivian men (who are poor, indigenous and poorly educated) do not in any sense "dominate" the society and enjoy very few privileges, even relative to their wives and sisters.

Because we know that gender systems and relationships change, that they have evolved through time and differ across societies, we know that the current situation can change. But since relations of superior power for some and disadvantage for others cross all spheres of life - personal, public, private, practical, symbolic - change must be sought in all of these spheres.

How do we affect such change? Jeanine Anderson (1997) suggests that conflict is inherent in human life. Within a family, conflict between generations is as inevitable as conflict between men and women, due to positions that individuals occupy in the family and society, division of labor and necessary interdependence. Anderson adds, however, that cooperation is also present, as gender systems both channel and regulate relations of conflict and cooperation. Individuals and organizations can make a positive impact on these relations by ensuring that gender conflicts and negotiations are carried out through the democratic processes of dialogue and by refusing to acquiesce to unjust conventions and situations, thus becoming silent accomplices of oppression.

Gender and Health

Working with sexual and reproductive health from a gender perspective allows us to go beyond a biological focus on women's bodies to a better understanding of men and women's socially construed identities and needs, in order to address the social relations that influence each person's sexual and reproductive health. Services and providers can better respond to user populations if they recognize that women and men live and perceive sexuality and reproduction in different ways, and that all of our visions are conditioned by our cultural environments, ethnicity, age and class position, and our sexual identities.

Cultural symbols and values associated with gender identities influence each person's choice, use or abandonment of contraceptive methods. In Latin America, many men seek validation of their masculinity through conquest, the exercise of power and the demonstration of their capacity to father children. Thus, it is difficult for them to use or collaborate in the use of contraceptives. For their part, women who see maternity as a principal form of social recognition and value (because church and family have educated them to believe this; because the gender balance in education, labor and political and public spaces limit their opportunities; and because they see little other possibility for personal and professional growth) may choose to prioritize childbearing at a high cost to their own health and well-being. In addition, we must consider that using contraceptives implies negotiation between a couple, and that many times gender relations are such that a woman does not have the power to influence the terms of the discussion, or a man is denied participation in the decision. These identities and relations are not the only reasons why

many men and women - including those who do not want more children - do not use contraceptive methods, but they are factors that should always be taken into account.

Gender also plays a role in relations between providers and users. Numerous studies have determined that in Bolivia STDs are treated differently in men than in women (Crisosto 1997). When a woman seeks treatment for gonorrhea, for example, often she will be given a course of antibiotics and told to refrain from sexual relations for a certain time period. When a man is treated for the same disease, he is told that his sexual partners probably also have it, and that they should be treated at the same time. Although he is married, it is not assumed that a man's relations are limited to his wife, and providers often indicate that he should contact all partners. Many of the women who are treated alone will become infected again by a partner who was not included in the cure. This unequal clinical practice only serves to reinforce an unspoken social norm that says: "Men have a right to multiple sexual partners, and women should only have relations with their husbands. If women become infected with sexually transmitted diseases, they must suffer the consequences alone."

STDs cause pain and suffering for women and men in different ways:

- 1. The risk of contracting gonorrhea from a single sexual act is 25 percent for men and 50 percent for women.**
- 2. Women's symptoms are less visible. Half of infected women do not know that they are infected, because they do not notice the symptoms or because women consider the symptoms normal. Thus, they do not seek treatment until the infection has reached an advanced stage, causing severe damage.**
- 3. STDs have severe and sometimes fatal consequences for women, including infertility, cervical/uterine cancer and ectopic pregnancy (Dixon-Mueller et al. 1991; Tinker et al. 1994).**

Gender practices and meanings manifest themselves in the religion, science, education, environment, social and economic conditions of each society. They influence sexuality and sexual and reproductive health, together with our perceptions and interpretations of what constitutes health and who is entitled to it. Thus, gender systems may legitimize certain values, practices and beliefs surrounding the sexual and reproductive lives of different actors in such a way as to impair the health of specific groups.

In order to promote sustainable improvements in the sexual and reproductive health of the population, policies and services need to consider these social conditions and issues. A gender perspective helps us to analyze and promote changes in organizations, institutions and communities by moving towards goals of more inclusive, equitable and effective health services.

We must also consider the dynamics of power, knowledge and decision-making in the relations within each family, between providers and users and within governments and other institutions

and the populations they serve. Health services that have addressed these relations and have extended their coverage to include comprehensive sexual and reproductive health needs of women and men, have improved quality care and increased impact on user populations. Processes of positive change also require analysis of relations of power and knowledge within health institutions, in order to transform unequal and stereotyped professional relations that interfere with the provision of equitable quality care.

■ SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health is a general state of physical, mental, social and emotional well-being and not the mere absence of illness, in all aspects related to sexuality and the reproductive system. Sexual and reproductive health is oriented toward developing a positive life and personal relationships and not merely attending to reproductive processes and sexually transmitted diseases.

Current ideas of sexual and reproductive health express a change from earlier biomedical definitions of health and illness toward a more ample concept, which encompasses social science and ethical considerations and promotes men and women's sexual and reproductive rights, together with respect for cultural contexts and individual decisions.

Traditionally, health policies and programs have focused on physical functions of the reproductive system, and especially on fertility control. In recent decades, however, we have begun to understand that personal and cultural experiences of sexuality are intimately linked to the biological health of the reproductive system: that these are two inseparable dimensions of what is experienced as a single phenomenon in human life. Reproductive and sexual health develop interdependently during the life cycle, and affect each person on multiple levels. For example, the physical and psychosocial stress of multiple and closely spaced births may impair a woman's sexual expression, and negatively affect her sexual health (Bassu 1997). In the same way, certain sexual practices and choices can make individuals vulnerable to diseases that cause harm, and even infertility, in the reproductive system.

As early as 1974, a committee of experts from WHO defined sexual health as the integration of physical, emotional and intellectual elements in ways that positively enrich and strengthen personal identity, communication and love. The comprehensive vision expressed here surpasses reproductive and pathological aspects to encompass affection, pleasure and communication, which are important in people's lives (Cerruti Basso 1993) and contribute to improved life and personal relationships (ICPD 1994; Alcalá 1995).

Different definitions and interpretations of sexual and reproductive health coexist. Medical sciences tend to express them in biological terms, while some NGOs and international

organizations tend to emphasize men and women's rights or the provision of information and services (WHO 1997). The training guide presented here develops an understanding of sexual and reproductive health that encompasses these different concerns and takes into account possible tensions between them. Although the concept of sexual and reproductive health should definitely include biological factors, it is also fundamental to consider psychosocial and cultural factors, as well as sexual and reproductive rights. Health is a process that influences and is influenced by many life factors (WHO 1997).

The International Conference on Population and Development (ICPD) held in Cairo 1994, established a new vision of reproductive health that explicitly incorporates sexual health:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. ICPD, Programme of Action, Paragraph 7.2, 1994.

This definition of reproductive health includes a number of points worth considering. First, when we talk of "a state of complete physical, mental and social well-being" we must ask how many people do not have good reproductive health because they do not enjoy mental or social well-being? The phrase "to have a satisfying and safe sex life" should be noted as the first time that an

international document, signed by approximately 180 nations, touched on the theme of sexual satisfaction. Finally, the "right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice" makes reference to the quality of health care.

Continuous efforts of NGOs and women's movements have been important forces behind the broadening of the concept of sexual and reproductive health, especially in the Third World (Correa and Petchesky 1994). These movements have questioned academic, analytical and institutional divisions that arbitrarily separate what is lived as an integral experience. While most services still focus on reproduction, and deal only marginally with sexuality and rights, at the ICPD, world consensus was generated around the need to forge more comprehensive and user-focused reproductive health programs.

According to this vision, sexual and reproductive health services may include, but are not limited to: voluntary fertility regulation; prenatal, birth and postpartum care; tetanus vaccines; support for breastfeeding; infertility treatment; prevention, screening and treatment of STDs, including HIV-AIDS; gynecological examinations; prevention and treatment of breast and cervical cancer; treatment of complications from abortion; nutrition programs; production and dissemination of educational and informational materials; education and counseling about sexuality; protection against violence; training of extension workers; personal and couple counseling; and diverse activities that empower users to take greater control and responsibilities for their own health (Dixon-Mueller 1993; Hardee and Yount 1995).

All men and women, whether or not they have experience with sexual and reproductive health services, may have their own interpretations of what those terms mean, interpretations informed by their culture, age, religion, education and personal health experiences. The health of each population, in turn, is influenced by the quality of care and education available, by the level of recognition of social sexual and reproductive rights, and by gender meanings and roles within society.

In many parts of Latin America, the characteristic called *machismo* emphasizes the sexual prowess of men, measured by the quantity and daringness of their sexual conquests (Barker and Lowenstein 1996). This stereotype pushes men to take serious health risks and leads to unwanted pregnancies, unsafe abortions and STDs (Zeidenstein and Moore 1996).

In Bolivia, women seek health services with much more frequency than do men, due to their reproductive biology as well as cultural roles that determine women's greater responsibility for the health of children, parents and sick relatives. There is a growing consensus, however, that a more balanced participation on the part of men would contribute to health improvements for the whole population. The ICPD Programme of Action emphasizes the importance of involving men more fully in spheres from which they have been excluded or marginalized:

Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child-rearing responsibilities and to accept the major responsibility for the prevention of sexually transmitted diseases. Programmes must reach men in their workplaces, at home and where they gather for recreation. Boys and adolescents, with the support and guidance of their parents, and in line with the Convention of the Rights of the Child, should also be reached through schools, youth organizations and wherever they congregate. Voluntary and appropriate male methods for contraception, as well as for the prevention of sexually transmitted diseases, including AIDS, should be promoted and made accessible with adequate information and counseling. ICPD, Programme of Action, Paragraph 7.8, 1994.

Thus, working with a gender perspective implies increasing emphasis on men, getting men involved and recognizing that sexual and reproductive health pertains to men as well as women. In spite of the above recommendation, services are still predominantly oriented toward women's needs and the fulfillment of women's rights, and many health centers have not fully accepted that men also have sexual and reproductive rights. The failure to explicitly include men in sexual and reproductive health programs clearly limits the chances of achieving greater well-being for men and women. Services overburden women by reinforcing the idea that women are responsible for the health of the whole family and for the regulation of fertility and by not promoting involvement of men. Ormel and Pérez (1997) observe that, although we should continue to respond to the needs and rights of women and to recognize the inequalities that they suffer, men also need information, education and access to services in order to participate more actively in the care of their own health, that of their partners and of their children.

■ **SEXUAL AND REPRODUCTIVE RIGHTS**

Sexual and reproductive rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing, health, security, education and political participation. Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and child care, gynecological health and sexual activity, as well as the resources to carry out those decisions safely and effectively (Correa and Petchesky 1994).

The concept of sexual and reproductive rights, together with the declarations that promote respect for these rights, has a long history. After the Second World War, the Charter of the United Nations (1945), affirmed faith in fundamental human rights, the dignity and value of human life, and equality of rights between men and women. In 1948, the Universal Declaration

of Human Rights included Article II, which proclaims the right of all persons to the established rights and liberties without any distinction based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or any other condition.

Throughout the years, rights were defined with increasing specificity, and the idea of sexual and reproductive rights was addressed explicitly in the Declaration of the World Conference on Human Rights in Tehran in 1968, which proclaimed that parents have the basic right to freely determine the number and spacing of their children, as well as the right to education and information concerning this issue. Later, at the World Conferences on Population held in Bucharest (1974) and Mexico (1984), this paragraph was adopted and adjusted so that the term "parents" be replaced by "couples and individuals."

Other conferences and declarations reinforced the notion that the right to decide about reproduction, as well as the right to access health services, were basic human rights. In 1979, the General Assembly of the United Nations approved the Convention on the Elimination of All

Forms of Discrimination against Women, and signing countries committed to take measures to ensure the full development and advancement of women. One of these measures is a commitment to ensure equal access to health services, including those related to family planning, and to promote the same rights for men and women to decide the number and spacing of their children. This measure also highlighted the need to access information, education and the resources necessary to exercise this right.

Ten years later, the Convention on the Rights of the Child established a set of basic rights for minors, which affirmed the right of all persons to access services for voluntary regulation of fertility. The 1993 World Conference on Human Rights in Vienna reiterated the importance of eliminating all forms of sexual discrimination, together with the need to work to eradicate gender-based violence.

At the International Conference on Population and Development in Cairo, certain sexual and reproductive rights were explicitly recognized as basic human rights.

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ICPD, Programme of Action, Paragraph 7.3, 1994.

The United Nations Fourth World Conference on Women in Beijing reaffirmed earlier consensus on the need to eradicate all forms of discrimination and violence against women and to guarantee

the right to decide freely and responsibly about matters of sexuality and reproduction. The Beijing Platform for Action mentions factors that influence women's health, which are often overlooked as circumstantial.

Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural and poor urban areas, and deficient housing conditions, all overburden women and their families and have a negative effect on their health. Good health is essential

to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment. United Nations Beijing Platform for Action, Paragraph 92, 1995.

Today, the exercise of sexual and reproductive rights by men and women is considered a fundamental basis for a better quality of life. Generally, sexual rights are not distinguished from reproductive rights, rather they are treated as dimensions of basic human rights, the exercise of which constitutes a fundamental strategy for human survival and quality of life.

The acceptance of sexual and reproductive health rights has philosophical, ethical and political implications, as it becomes clear that a large proportion of health problems can be avoided by respecting basic human rights. A confluence of discourse and emphasis on sexual and

To mark the fiftieth anniversary of the Universal Declaration of Human Rights, the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), with the support of organizations throughout the region, presented a gender-focused declaration, including the following text:

- **Article 10. All human beings have the right to autonomy and self-determination in the exercise of their sexuality, which includes the right to physical, sexual and emotional pleasure, the right to freedom of sexual orientation, the right to information and education concerning sexuality, and the right to sexual and reproductive health care to maintain physical, mental and social well-being.**
- **Article 11. Women and men have the right to decide freely and knowledgably about their reproductive life, and exercise the safe voluntary control of their fertility, free from discrimination, coercion, and/or violence, as well as the right to enjoy the highest levels of sexual and reproductive health (CLADEM, 1998).**

reproductive rights and on gender is contributing to changes in health care values and paradigms. "Within this framework" writes Ladi Londoño, "a gender perspective helps us identify great shortcomings, unnecessary medical interventions, as well as the importance of emotional and affective aspects" (Londoño 1996). Quality of life does not only lie in improved infrastructure, reduced rates of maternal mortality and better resources for health care, it is also based on the exercise of and respect for individual autonomy in the intimate matters and sexual decisions of men and women.

Different local and international organizations, as well as individuals, have also created lists of the sexual and reproductive rights. Here, we present a list of rights taken from IPPF's Declaration of Sexual and Reproductive Rights (1996), from Mari Ladi Londoño's book, *Sexual and Reproductive Rights* (1996), and from the Open Forum for Sexual and Reproductive Rights in Chile (1996). These rights include but are not limited to:

1. The exercise of sexual independence, as well as the right to enjoy it according to one's own preferences, and the right to legal protection.
2. Pleasurable and recreational sexuality, independent of reproduction.
3. Adequate information and knowledge about sexuality and reproduction.
4. Love, sensuality and eroticism in sexual relations.
5. Sexual education that is appropriate, comprehensive, secular, scientific and gender-sensitive.
6. Refusal to engage in sexual activity.
7. Freedom from fear, shame, guilt and other imposed beliefs that inhibit a person's sexuality and diminish his or her sexual relations.
8. Choice of sexual partners, to exercise sexuality without coercion or violence.
9. Nutrition necessary for adequate growth and balanced development of one's body and future reproductive potential, from childhood.
10. Voluntary motherhood, to decide and live motherhood for one's own choice and not by obligation.
11. Complete information concerning the benefits, risks and relative effects of all contraceptive methods.
12. Free or inexpensive contraceptives with current information, follow-up and responsibility on the part of those who prescribe it.
13. Marriage and family or the choice not to have either.
14. Parenthood and the right to decide when to have children.
15. Good quality services for prenatal care, birth, and postpartum care, guaranteed by appropriate legislation.
16. Equal participation by women and men in child care, creatively constructing children's identities beyond traditional gender roles.
17. Effective legal protection against sexual violence.
18. Adoption and right to comprehensive, accessible treatment for infertility.
19. Prevention and treatment of illnesses of the reproductive tract, and the right to make informed decisions about related interventions.

Many of these rights have been recognized internationally and may take different forms of expressions within varying national and cultural contexts. In Bolivia, one important universal right recognized by the Constitution is the right to health. The official document, which Bolivia's delegation presented at ICPD in 1994, affirms the necessity to "improve coverage and quality of services in primary health, with special emphasis on reproductive health" (Ministry of Human Development 1994). The document also emphasizes the importance of respecting women's decisions about sexuality and fertility, together with the democratization of roles within family and society.

■ QUALITY CARE

Quality care is a philosophy of comprehensive and compassionate health care oriented toward the satisfaction of users. It facilitates improvements in services offered to men and women through changes in personal communication and interaction as well as through changes in administrative and technical practices. Quality care strengthens users' responsibility, knowledge and autonomy, their self-esteem and dignity, and the exercise of their rights.

The term "quality care" is frequently used in health services, where it conveys multiple meanings because the concept is neither universal nor homogenous. Quality is different not only for men and women, but for persons of different cultures, ethnic groups, social classes and ages. In other words, everyone has his or her own definition of quality.

Recognizing that the meaning of quality care can vary from one person to another, it is still possible to talk of certain principles that help us to achieve quality care. These include: a focus on the comprehensive well-being and satisfaction of diverse users; the active and equitable participation of all persons involved in the provision of care; the practice of offering options from which users may select, such as different contraceptive methods or birthing positions (Finger and Hardee 1993); the empowerment of users to make free and informed decisions about their own health; and the equitable treatment of women and men, people of different ages, social classes and ethnic backgrounds. Quality care has three interrelated dimensions: quality in administration and management; quality in human interactions, and technical quality.

Quality in Administration and Management

This first aspect is directly related to an institution's philosophy, which transmits ideas, values and attitudes to employees as well as to users (Araujo and Matamala 1995). Quality management encourages a work and health care environment free from discrimination and abuse of power. Key here is the existence or absence of mechanisms that promote the participation of personnel and users in the improvement of services provided. These might include posted policies promoting users' rights or prohibiting discrimination; the use of suggestion boxes; and the organization of participatory and democratic meetings between administration and staff, and between these groups and representatives of the user population.

Therefore, who evaluates quality care? Since the philosophy is oriented toward the satisfaction of users, it is users themselves who should evaluate the quality of services. To improve quality care, we must begin with a philosophy that places priority on user satisfaction (Finger and Hardee 1993). An institutional philosophy grounded in user satisfaction will be manifested in a facility's infrastructure, menu of information and services offered, labor practices and relations, staff treatment and labor policies, the guarantee of confidentiality and privacy during provider-user visit and even in the hours of service. If the institution does not take quality care into account as

a matter of policy, it is improbable that staff will be able to provide the kind of services that satisfy users.

Structural characteristics of a program can promote or prohibit respect for sexual and reproductive rights and the full exercise of these rights on the part of users. For example, every institution needs to consider ways to provide access to targeted groups by taking into account users who need to travel long distances or work long hours, and by adjusting the clinic hours accordingly. Quality in administration and management also means analyzing the different needs of men, women, married, single, and adolescents, and building programs in order to respond to these different expectations and needs.

Each institution expresses its gender perspective in the relations it establishes with the public, from the assignation of resources among different groups of users and providers, to the distribution of tasks and responsibilities within the institution. A gender perspective is key to understanding different groups, to ensuring that services do not favor some and discriminate against others and making sure that programs do not reinforce existing inequalities. For example, many maternal-child health and family planning programs could be improved by questioning and changing their practices of orienting services and information exclusively to women; reinforcing stereotypes that give women sole responsibility for their families' health; and denying the fundamental importance of men's participation.

Quality in Human Relationships

This second aspect encompasses the empathy expressed by providers, time dedicated to each user, sharing of knowledge and respect for each user's opinions and decisions. It also implies respect for differences between people, e.g., a woman in native dress deserves the same understanding and respect as a woman in modern dress; a disheveled adolescent boy deserves the same service as a professional man.

In addition to changes in attitude on the part of workers, quality care requires that users themselves exercise more responsibility and initiative. Providers can facilitate this change by sharing knowledge about health, offering options for

treatments and methods, and supporting users in their decision-making process. Services should offer complete information that permits users to care for their own sexual and reproductive health and to take preventive actions that help achieve a state of physical, mental and emotional well-being.

Respect is fundamental and should always be first. When I consider that the patient is a woman like me, I try to treat her the way I would like to be treated. We need to talk in an adequate way, with a nice tone, and without crude words ... I try to get across my point in a clear way. First, we must know how to listen, and second, know how to communicate, with nice words and a good tone, just what we want the patient to understand. For me, this is basic respect. Testimony of a doctor in a family planning service in Santiago, Chile. (Araya et al. 1997).

Technical Quality

This third aspect concerns adequate equipment and supplies, as well as technical competence on the part of providers. Technical competence requires that health workers apply current and appropriate knowledge, skills and technology using a humane scientific perspective. Indicators for this type of quality include the existence of clear operational norms and procedures, as well as the skill and accuracy necessary in diagnosis, treatment and follow-up of users.

Technical quality includes having the necessary equipment, supplies and medicines needed to fulfill standards (Güezmes 1997), together with maintenance of conditions, the fulfillment of protocols and the availability of competent personnel (Finger and Hardee 1993). Quality equipment and supplies also refer to the general infrastructure of the center (water, plumbing, lighting, garbage disposal) and the conditions, comfort and cleanliness of the waiting and consulting rooms. A crucial aspect of technical quality is the existence of educational programs, covering medical techniques as well as techniques for patient care and communication, for continuous professional improvement for male and female workers.

The three dimensions of quality care outlined above are not independent, but rather they intersect and interrelate in the provision of sexual and reproductive health care. Advances in all three areas contribute to a change from a

María José Araujo and Marisa Matamala (1995) identify four fundamental aspects of quality care:

- 1. Care and resolution of the problems that motivated the visit. This supposes a comprehensive and effective response to the user's health problems, as well as the application of interpersonal and technical skills of the health team.**
- 2. Satisfaction of the user's expectations. Important here is respect for the user's self-determination and individuality.**
- 3. Recognition, promotion and respect for sexual and reproductive rights. Quality care is grounded in an ethical stance that guarantees human and health rights to all men and women, regardless of class, culture, ethnicity or age.**
- 4. Sharing of information and understanding. Providing users with appropriate knowledge and information for their own use will improve their abilities and self-determination.**

unilateral practice in which health professionals monopolize knowledge, information and decision-making toward a more conversational approach in which users participate with their own ideas, doubts and preferences. This new interaction occurs within an atmosphere of mutual respect, in which knowledge and responsibility are valued and strengthened in efforts toward sustainable improvement in the users' health.

Quality Care and Gender

Health providers often reproduce and reinforce gender inequities in their relationships with users and with co-workers. The provider-patient relationship does not take place in a cultural vacuum; providers act on their own gender beliefs and assumptions and within institutional frameworks. In many cases, health professionals tend to overvalue medical knowledge, give privilege to

masculine-scientific discourse and reject other ways of knowing, thinking and talking expressed by patients. Often the sexual prejudices and values of providers and institutions are expressed through doubt, criticism, rejection and even sarcasm toward the way patients understand things, especially female patients, those who come from lower socioeconomic classes, and marginalized ethnic groups. The Beijing Platform for Action identifies numerous ways to promote women's access to health care throughout their lives, which will have to be complemented with ways to promote men's health care in order to build a balanced gender approach:

- Redesign information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality; these services, information and training should be based on a holistic approach.
- Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent; encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics, as well as by ethical principles that govern other health professionals.
- Take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions, as well as inappropriate medication and over-medication of women, and ensure that all women are fully informed of their options, including likely benefits and potential side-effects, by properly trained personnel. United Nations Beijing Platform for Action, Paragraph 106, 1995.

In social environments in which women assume subordinate positions in most relationships, they react to providers in the same way, thus, undermining their potential power as health care clients. In their relationships with health providers, many Bolivian women feel constrained by their fears, shame and timidity; by guilt and moralistic norms; by insecurities about their own knowledge; and by their experiences of physical, psychological and sexual violence. These constraints are coupled by gender related economic and operational difficulties that must be overcome in order to seek health care. All of these conditions limit women's capacity to take greater responsibility for their well-being, take actions that favor their health and exercise their rights.

Men also approach health care from their own gender experiences and are restricted by normative models of masculinity. In Bolivian contexts, these can include pressure for "real men" to resist pain, refuse to seek or accept help and appear strong and physically and emotionally invulnerable. These aspects of "being a man" in Bolivian society impede access to health care. Pressure to demonstrate stereotyped masculine behaviors is especially strong for young men, many of whom do not seek medical care until they are extremely ill.

In considering quality care, providers should recognize these gender norms and stereotypes, their impact on users' health and their influence both on provider-patient interaction and on user follow-up. Providers must understand that they are capable of forging new gender visions and

possibilities, of changing their own behaviors and attitudes through their professional action. They can, for example, encourage and support women users to make strong decisions in favor of their own well-being and to assume new responsibilities for their health and sexuality. They can encourage men to admit that they hurt, seek and accept help and advice and participate in the health care of their children and partners. Better understanding and respect for others, together with improved communication among people from different backgrounds, cannot help but improve relations and processes of diagnosis, treatment and education, and thereby contribute to improvements in the entire population's health.

METHODOLOGY

■ GOAL

This training package promotes gender-sensitive quality care in sexual and reproductive health services with the goal of contributing to sustained improvements in the health of Bolivia's population. The conceptual framework and educational activities presented here systematize a series of theoretical and methodological advances in the area of sexual and reproductive health, and reinforce the positive experiences and abilities of providers. A gender perspective is applied to help participants better understand diversity in the Bolivian population and to respond better to differentiated groups of users and dynamics between them.

■ OBJECTIVES

1. Create opportunities for reflection and action in the field of gender-sensitive quality care.
2. Provide basic tools that providers can use in their everyday practice: key concepts, techniques and practices, criteria for implementing quality care.
3. Develop capacity for critical analysis that permits participants to use key concepts and criteria to recognize, analyze and respond to users' realities and institutional practices.

■ WHO SHOULD PARTICIPATE IN THIS TRAINING?

The present proposal is designed for professionals, technicians and other personnel who work with sexual and reproductive health in both public and non-governmental services operating in Bolivian cities. It is important that diverse actors from every institution participate in the training in order to facilitate comprehensive and consistent efforts towards change, e.g., doctors, administrators, receptionists, nurses, and other staff. Groups should include less than 25 people to encourage maximum participation.

■ TRAINING METHODOLOGY

Training is a process in which everyone learns something, facilitators as well as participants with diverse experiences and education. Participants become protagonists of their own learning to the extent that they commit personally to reflection and change and are willing to share their own experiences and ideas. This pedagogic philosophy is promoted through the following considerations:

Active and Participatory Effort

Active and participatory methodologies will permit the group to construct knowledge collectively, and develop approaches that will be pertinent and significant for the participants. Active participation is different from mechanic activity in which participants learn by repetition. In active participation, different strategies are implemented to compare, question, relate, experiment, analyze, criticize, probe and prove, permitting participants to get integrally involved in the collective construction of knowledge. This participatory process depends on a democratic

and equitable learning environment in which everyone's knowledge and values are recognized and respected, and in which the discourse is not dominated by he who talks with greater facility or she who has the highest position in the institution.

Adapting to the Socio-cultural Context

All people have different ideas, knowledge and experience, organized in different ways. Thus, facilitators must recognize and use as a point of departure the position and tradition of each participant. In this manner, learning is context-specific, knowledge is produced in respectful and equitable ways and the process strengthens the self-esteem of participants whose experiences and knowledge are publicly valued. Involving participants with their own histories and positions means responding to their needs, enriching their experiences, skills and knowledge and appreciating what they do and do not know about the topic.

Education for Change

The training proposed here does not correspond with a traditional transmission of authoritative knowledge from trainer to participants. On the contrary, it implies creating opportunities for reflection and analysis of one's own practices, attitudes and abilities, illuminated and enriched by new perspectives. The goal of this critical reflection is to motivate processes of personal growth and provide the concepts and tools necessary for each participant to advance in that growth.

■ STRUCTURE OF THE GUIDE

The training guide is divided into four sessions, each one with activities relating to a key theme. The total training involves four sessions, each one lasting approximately four and one half-hours.

Module 1: Gender and Sexual and Reproductive Health

Module 2: Sexual and Reproductive Rights

Module 3: Quality Care I: Quality in Human Relations and Technical Quality

Module 4: Quality Care II: Quality in Administration and Management

FACILITATOR'S GUIDE

■ HOW TO USE THESE RESOURCES

This guide is designed to support facilitators who will lead training and reflection about gender-sensitive quality care. It includes general orientation for the proposed approach but by no means intends to limit the creativity of facilitators. Instead, this section offers ideas for applying and adapting the proposal to different learning groups, taking into consideration their specific needs, expectations and socio-cultural contexts.

■ EDUCATIONAL PHILOSOPHY

We suggest a participatory and equitable approach to training activities that reflects the content of the guide. Among the multiplicity of terms used for educational leader (trainer, monitor, educator, etc.) we have chosen to use facilitator, which indicates a person who promotes and supports the process of participatory construction of knowledge through the following means:

- **Listen:** ask about, listen to and respect the experiences, ideas and opinions that each participant brings to the training.
- **Dialogue:** promote sharing and conversation between participants. Discussion will facilitate the shared interpretation of concepts, and promote the development of critical analysis.
- **Motivate:** prepare and encourage participants to develop new approaches to act and impact the situations, in which they live and work.

Each training session is designed to encourage listening, dialogue and motivation throughout three key processes:

- **Reflection:** activities that motivate reflection about participants' own experiences and ideas are designed to lead each individual to evaluate and question his or her everyday practices and beliefs.
- **Comprehension:** new concepts and information provided in the conceptual framework and other materials are presented in ways that relate to prior knowledge and experience of participants. In each session, the facilitator presents new material through short lectures, videos and charts in ways that encourage participants to relate it to and contrast it with their own ideas and practices.
- **Motivation:** it is crucial to strategize ways in which participants can apply the new materials, ideas and practices in their daily work and to address the obstacles and challenges that may impede such innovation.

■ THE FACILITATOR'S ROLE

Here we make a few suggestions to help facilitators guide the sessions. The first session begins with a forum in which all participants introduce themselves; the facilitator may start by introducing him or herself in a warm and friendly way, and thus, encourage the rest to join in. We suggest that facilitators participate enthusiastically and from their own subjective standpoint

in the introductory activity, and in all following activities in which it is feasible to participate. Once everyone has introduced him or herself, it is important to give a clear introduction to the process. At the beginning of each session and each activity, the facilitator must communicate to the participants:

- the theme of the session or activity on which they will be working;
- the specific objectives of their efforts;
- the methodology for the activities to be carried out; and
- the key concepts and their definitions.

Most activities involve group work. Ideally small groups are self-guided, but facilitators must visit each group to ensure that they are working on the indicated theme and moving toward the stated objectives. In addition to guiding the content of the work, facilitators must ensure that the groups work in a democratic fashion in which the approaches and perspectives of all participants are heard and respected.

In sessions in which groups present their work, the facilitator must:

- allow groups to express the results of their efforts in their own way, respecting the diversity of opinions and ways of knowing and expressing knowledge;
- observe carefully, and later discuss, the relation between the indicated themes, directions and objectives, and the actual results of group efforts;
- intervene to reorient discussions that get off track and do not enrich the topic at hand;
- make a clear synthesis of the ideas and messages presented (often it is useful to discuss the main points and write them on poster paper).

The four-session training ends with a general synthesis and an evaluation of the learning experience in which facilitators should participate actively and honestly.

■ THE ROLE OF PARTICIPANTS

Each participant is encouraged to take an active part in the learning process. Because many individuals are hesitant to speak or perform in public and are accustomed to a lecture format, facilitators must encourage participation in the following ways:

- never forget that participants are adults: regardless of their education and professional training, they all have rich life experiences that should be recognized and built on;
- make it clear that participation in this learning process is a step toward creating more participatory and equitable relationships in the work and life of each participant; and
- from the beginning, make it clear that the training is designed to produce new ideas, approaches and practices, and that participants must prepare to leave behind their old prejudices, attitudes and fears.

■ EDUCATIONAL RESOURCES AND SUPPORT MATERIALS

This training package includes the following materials to support and enrich the process:

1. a conceptual framework which provides the theoretical basis of the training;
2. a central matrix which indicates the key content and activities for each session;
3. a guide to the activities and discussions that make up each session;
4. concept cards that summarize the main ideas and key terms;
5. videos to support reflection and learning activities.

■ NECESSARY MATERIALS

The materials needed to conduct the training are:

1. photocopies of parts of this guide, including concept cards and activity guidelines;
2. a television and VCR;
3. poster paper and markers and/or whiteboard;
4. colored cards;
5. tape or tacks; and
6. planning matrix.

Planning Matrix

TOPIC	OBJECTIVE	SPECIFIC OBJECTIVE	KEY CONCEPTS	ACTIVITIES	TIME	RESOURCES	KEY MESSAGE
Gender, sexual and reproductive health	Recognize the concepts of gender, and sexual and reproductive health.	Identify different gender identities within the social context of the participant. Analyze how gender influences the needs and expectations of sexual and reproductive health. Recognize gender dynamics in health services.	Gender. Sexual and reproductive health.	Who are we? Workshop presentation. How did we become men and women? Construction of concept of gender. Gender relations within sexual and reproductive health services.	4 hours, 30 minutes	Brief texts on gender, and sexual and reproductive health; matrix; question guidelines.	There are different types of users, men and women. The quality of service is improved by respecting and responding to their needs and realities. Gender relations condition all interpersonal relationships among providers, between couples and providers and users. These relationships influence the care given at sexual and reproductive health services.
Sexual and reproductive rights	Recognize sexual and reproductive rights. Identify strategies to promote the exercising of these rights.	Analyze the influence of these dynamics on quality of care. Generate reflection on exercising sexual and reproductive rights from the perspective of personal experience. Be respectful and promote these rights in the daily routine of sexual and reproductive health services.	Sexual and reproductive rights.	Defining our sexual and reproductive rights. Building the concept of sexual and reproductive rights. The promotion and practice of rights in known situations. Create messages that promote sexual and reproductive rights	4 hours, 30 minutes	Question guidelines; brief texts on sexual and reproductive rights; list of sexual and reproductive rights; scripts to analyze.	Identifying and valuing sexual and reproductive rights allows for the respect and adherence to those rights. Services should socialize information, offer options and respect decisions to assist the user in exercising his/hor rights. Respecting the rights of users as well as valuing their opinions improve quality of care.
Quality of care: compassionate care and high technical quality	Develop attitudes and learn methods that will improve relationships with users(male and female), respecting their rights.	Identify and reinforce skills and methods that promote quality of care. Identify attitudes and interpersonal dynamics that promote quality of care. Learn how criteria and techniques.	Quality of care in sexual and reproductive health services. Compassionate care. High technical quality. Instruments to improve the quality of care.	Valuation of our abilities. Presentation on the philosophy of quality of care. Techniques and practices of quality of care: living examples. Conducting consultations with compassionate care and high technical quality. Identify quality of care indicators with a gender perspective.	4 hours	Brief texts on quality of care; summaries of techniques to improve quality of care with a gender perspective; video.	Specific changes in providers' attitudes, practices and techniques contribute to more equitable and effective relationships in improving the health of male and female users.
Quality of care: institutional management	Analyze the organization and institutional administration in sexual and reproductive health programs to identify institutional strategies that best respond to male and female users' rights, needs and possible options.	Develop the ability to analyze institutional policies, structures and dynamics. Identify evaluation criteria for health services from a gender perspective. Identify feasible changes at a personal, interpersonal and institutional level and explore the relationships among them.	Institutional management for equity and quality. Quality of care evaluation indicators from a gender perspective.	Reflect upon the strengths and weaknesses of our institutions(FODA). Make multiple changes towards better care. Evaluation of the educational experience.	4 hours	IPPF indicators proposal for sexual and reproductive health services with a gender perspective; FODA analysis; question guidelines; video, evaluation cards.	Providers' personal and professional practices are developed within an institutional context, which can impede or promote progress in quality of care. Quality depends on efforts that range from the receptionist's attitude, the program's design and administrative management, to national and international policies.

MODULE 1

GENDER AND SEXUAL & REPRODUCTIVE HEALTH

■ SESSION OBJECTIVES:

1. Develop an understanding of two central concepts: gender and sexual & reproductive health.
2. Explore relationships between these two concepts in the field of health care.

■ SPECIFIC OBJECTIVES:

1. Identify different gender identities and experiences in the participants' social context.
2. Analyze the influence of gender on people's needs and expectations in sexual and reproductive health.
3. Identify gender relations and dynamics within the context of health services.
4. Analyze the influence of these dynamics on quality care and the satisfaction of needs and expectations of men and women users.

■ KEY CONCEPTS:

Gender
Sexual and reproductive health

■ ACTIVITIES:

1. Who are we?
2. Introduction to the training
3. How do we become men and women?
4. Constructing the concept: gender
5. Relations between gender and reproductive health

■ TIME:

4 hours, 30 minutes

■ ACTIVITY 1 *WHO ARE WE?*

Objectives:

1. Encourage participants to begin to get to know each other.
2. Generate a context of mutual trust.
3. Introduce the idea of gender difference.

Procedures:

1. Welcome all participants.
2. Ask each participant to choose a card in a color (pink, blue, yellow or green) with which s/he identifies, and writes on the card his/her name, and a salient personal characteristic.
3. Each participant presents him/herself, explaining why s/he chose the color and how it relates to a personal characteristic.
4. All participants tape their cards on a board or wall, arranging them as they see fit (by order of presentation, color of card, interests and characteristics, sex, age, etc.). Discuss the role of gender in personal identities and interpersonal contact.

Time:
30 minutes

Materials:
Pink, blue, yellow and green cards
Markers
Tape

Discussion:
We choose colors and other identity symbols to correspond with (and sometimes to reject) predominant models of femininity and

masculinity. Let us reflect together about the ways in which we develop personal preferences and images and how we are educated with stereotypical gender expectations. Traditionally, pink is associated with girls, who are educated to be dedicated mothers and obedient wives in the private domain. The color blue is associated with boys, who are trained to be strong, manage power and lead in the public domain. If a man identifies with the color pink, is he necessarily feminine, or are there other options for identities?

■ **ACTIVITY 2**
INTRODUCTION TO THE TRAINING

Objective:

Communicate the objectives, content and methodology of the workshop.

Procedures:

1. Introduce the general objectives and philosophy of the workshop, emphasizing the key role of participants as active agents of change.
2. Explain the objectives, contents and methods of each session.
3. Briefly present the conceptual framework and provide a concise definition of each of the four key concepts.

Time:

15 minutes

Materials:

Planning matrix
Poster paper with outline of training process
Four concept cards

Discussion:

Reflect on and reinforce the idea that the success of the workshop depends on the active participation of all and on the sharing and appreciation of each participant's knowledge and experience in the joint construction of concepts and approaches.

■ **ACTIVITY 3**
HOW DO WE BECOME MEN AND WOMEN?

Objectives:

1. Describe and analyze the socialization processes that give shape and meaning to our physical development during the life cycle of men and women.
2. Distinguish between biological characteristics and social identities of men and women.
3. Recognize that gender identities and characteristics vary among ethnic and socioeconomic groups.
4. Recognize and reflect on gender relations, which range from complementarity and interdependency to subordination and exploitation.

Procedures:

1. Describe the method and goals of the group activity.
2. Form four groups, which may be mixed or sex-segregated. Two groups will focus on the life cycle of women, and two groups will describe the life cycle of men.
3. Each group chooses a moderator and presenter.
4. Each group receives poster paper and a photocopy of the matrix to guide this activity (included in the support resources at the end of this session).

5. Participants fill in the columns which describe the development of physical characteristics and social education that contribute to our gender identity at each life cycle stage.
6. After filling in the matrix, each group presents their results to the larger group.
7. Based on the descriptions produced by the groups, analyze and discuss gendered socialization processes, using the issues in the question guide provided with this session, i.e., What are the similarities and differences in the education of boys and girls? What are the social and political implications of this differentiated socialization?

Activity guide:

Distribute a copy of the matrix “How do we become men and women?” to each group, who must fill in the matrix on the basis of their own experiences and observations. On one side they will list physical characteristics of females and males at each age level, and on the other side they will describe what families, schools, media and others tell us, ask us and teach us at each stage of life to encourage us to act like men or women. Participants should reflect on their own experiences and remember. For example, did anyone ever tell them “big boys don’t cry!” or “nice girls don’t get dirty,” or were house keys and late curfews given to adolescent boys while girls were carefully watched? They should compare the expectations placed on a 30-year old woman (which might include that she should be married and raising children) versus a man of the same age (which might include that he should be earning money or establishing a career). When groups meet and present their work, the question guide included with this

session can help to orient the reflection and synthesis process.

Time:

30 minutes

Materials:

Activity matrix: “How do we become men and women?”

Copies of the question guide

Poster paper and pens

Discussion:

Small group activities permit each person to share and apply his or her experience in order to better understand the relationship between biological and social characteristics in his or her own life. The final discussion among the group as a whole allows for comparison and contrast of men’s and women’s experiences, as well as those of people from different generations and varying social, racial and ethnic backgrounds.

Expected results for participants:

1. Learn to recognize the difference between aspects of our identities formed by biological sex and those influenced by social gender.
2. Analyze different forms of gendered education and identify implications of the different values and roles assigned to men and women.
3. Recognize that gender is not homogenous; there are many ways of being men and women.

■ **ACTIVITY 4**
CONSTRUCTING THE CONCEPT:
GENDER

Objectives:

1. Develop an understanding of gender as an analytical category.
2. Relate the concept of gender to observations and experiences discussed in the preceding activity on becoming men and women.

Procedures:

1. Structure the discussion around the gender concept card. One participant reads aloud the first section of the card, and all can discuss what was read and relate it to the activity on becoming men and women. Another participant reads the next section of the concept card and the group continues with a discussion of the ideas raised. The dynamic continues until the group has heard and discussed all parts of the concept card.
2. Conclude with a brief discussion about the different needs and expectations of health care experienced by people of different gender groups, ages, sociocultural, racial and ethnic backgrounds. Emphasize that health care which does not respond to gender differences that affect health, nor to gender relations which influence and interfere with service, will always have limited results.

Activity guide:

Before initiating this session, facilitators should study the section on gender in the conceptual framework and prepare to refer to it during group discussions. Emphasis should be on relating the theoretical and analytical concept of gender to the lived

experiences of becoming men and women that were articulated by participants in the preceding activity.

Time:

30 minutes

Materials:

Concept card: Gender

Discussion:

Gender is a social, cultural and historical system that organizes and gives meaning to many aspects of life in reference to sexual differences. A gender perspective is a conceptual tool that allows us to identify the characteristics, experiences and needs of men and women and to analyze the relationships between them, including the balance of opportunities, power and decision-making abilities.

Expected results for participants:

1. Relate the concept and the analytical approach of gender to the gendered socialization experiences discussed earlier.
2. Recognize on the basis of own experience that many "masculine" and "feminine" characteristics are learned, as are the power relationships that surround them.
3. Affirm that the category of gender helps us to better analyze and address identities and relations in health care.
4. Be motivated by the possibility of transforming some gender attitudes and practices in order to improve health care for men and women.

■ **ACTIVITY 5**
RELATIONS BETWEEN GENDER AND REPRODUCTIVE HEALTH

Objectives:

1. Develop an understanding of sexual and reproductive health as an integrated concept.
2. Recognize that gender is present in and influences all relations surrounding sexual and reproductive health and health care.

Procedures:

1. Read and discuss together the concept card about sexual and reproductive health.
2. Form small working groups.
3. During 15 minutes each group prepares a brief skit that demonstrates a familiar situation in sexual and reproductive health care. The skit should include diverse individuals involved in the care, from the time the user enters the center until s/he leaves. The skits can be based on participants' experiences in stories such as the following:
 - a pregnant 17-year old without a partner seeks care and advice;
 - a middle-aged male factory worker seeks help for STD symptoms;
 - a 35-year old woman who sells food in a street market seeks ways to avoid having more children;
 - an elderly man seeks a consultation for prostate problems.
4. Each group presents its skit for the rest of the participants. After each skit, discuss the different identities, attitudes and characteristics demonstrated by each actor and analyze the relative power relations between actors.

5. Identify positive aspects of the identities and relationships presented and discuss ways to strengthen and reinforce these in order to improve service consistently. Identify negative aspects that impede improvements in care and seek ways of changing or overcoming these factors.

Activity guide:

Before leading the session, facilitators should read the section of the conceptual framework that addresses sexual and reproductive health, and refer to it in presentations and group discussions.

Time:

1 hour, 30 minutes

Material:

Concept card: Sexual and reproductive health

BACKGROUND AND RESOURCES FOR MODULE 1

■ **CONCEPT CARD: GENDER**

Gender is a social, cultural and historic system that assigns certain characteristics and roles to groups of individuals with reference to their sex and sexuality. A gender perspective is a theoretical and methodological approach that permits us to recognize and analyze different identities, perspectives and power balances in the dynamics of interpersonal relations, and supports a critical analysis of socio-cultural institutions and socioeconomic, political and legal structures.

Teresita de Barbieri (1991) notes that human bodies are biologically sexed, and that we attribute social and cultural meaning to these

sexes. Thus, men and women are historical, not natural, beings; we are born in societies where we internalize gender roles, norms and meanings. For Barbieri, sex/gender systems are constellations of practices, symbols, representations, norms and social values that societies elaborate with reference to anatomic and physiological sex differences. Institutions such as schools, governments, churches and families, manage and transmit gener practices. In fact, whole life philosophies are marked by gender.

Traditional ideology or new analytical perspective?

Marcela Lagarde identifies two basic conceptions of gender in Latin American societies. One is a traditional gender ideology that sustains that all feminine and masculine characteristics are natural, that gender norms and roles are created by divine forces (or by biological evolution) and are, therefore, immutable. This ideology is reinforced by institutions that supervise and sanction behavior, guiding the ways in which people become socially acceptable men and women.

In contrast to this gender concept, Lagarde describes another approach to gender that challenges traditional ways of life as a tool for critical analysis. This approach to gender assesses the dominant gender order with the aim of questioning and deconstructing predominant social, psychological and cultural characteristics and relationships. It reveals that attributes of greater and lesser power are not natural, nor genetic; they are socially assigned and, therefore, can be transformed into more balanced relations (Lagarde 1995).

Gender relations

Gender is a necessary element of all social relations -- domestic, labor, political or economic. Gender organization attributes different values and powers according to sexual identity, which influence interactions and relationships among all persons.

Gender identities are not synonymous with sexual dimorphism. Factors such as life cycle, socio-economic and ethnic identity crosscut gender systems, which include multiple sexual and gender identities.

Gender and health

Gender organization and meanings manifest themselves in science, religion, education, politics, economics and the environment and influence sexual and reproductive health, as well as the ways in which we perceive it. This organization legitimizes values, beliefs and practices in relation to the sexual and reproductive lives of individuals in ways that can strengthen or hamper the health of certain groups.

Applying a gender approach to sexual and reproductive health allows us to go beyond a biological focus on women's bodies. It allows us to better understand the socially constructed identities of men and women, and thereby approach the social relationships, which influence the sexual and reproductive health of each person. Health services and providers can better respond to user needs if they recognize that women and men live and perceive sexuality and reproduction in different ways and that the visions with which we approach our work as health professionals are also conditioned by gender factors embedded in our cultures and related to our own sexual identities.

In Bolivia, for example, gender symbols associated with masculinity and femininity influence the choice, use and discontinuation of contraceptive methods and practices on the part of each man and women. Gender relations influence negotiation, decision-making and contraceptive use. Gender roles also play an important part in the relationships between providers and users and affect health outcomes for men and women. Finally, analysis of power and knowledge relationships within health programs and institutions allows us to identify and transform unequal and stereotypical relations that interfere with quality care.

A gender perspective helps us to recognize and respect differences within populations of providers and users and helps us analyze the dynamics of power, knowledge and decision-making within couples and families, between providers and users, and between governments and health institutions and the populations they serve. Health services that consider and respond to these realities, and that broaden their focus to encompass multiple dimensions of sexual and reproductive health of all gender groups, achieve greater success in the goal of improving the sexual and reproductive health of the entire population.

■ CONCEPT CARD: SEXUAL AND REPRODUCTIVE HEALTH

The concept of sexual and reproductive health expresses a change from a biomedical focus on health and illness toward a more comprehensive approach to well-being that incorporates the social sciences and the ethical bases of human rights. In this concept, biological, psychosocial, cultural

and legal aspects of sexual and reproductive health are intimately interrelated, and sexual and reproductive health is understood as a life process which influences and is influenced by a variety of other factors (WHO 1997).

Traditionally, health policies and programs have centered on biomedical aspects of reproductive health and, especially, on fertility control. In recent decades, however, we have begun to understand that personal and cultural experiences of sexuality are intimately linked with the health of the reproductive system. The two dimensions develop interdependently during each person's life cycle and affect each other in multiple ways. For example, the physical and psychosocial stress of closely spaced births can limit a woman's sexual expression and have negative effects on her sexual health (Bassu 1997). Similarly, a sexually transmitted disease can lead to problems in the reproductive system, including infertility.

The Cairo definition

The International Conference on Population and Development held in Cairo in 1994 established a new vision of reproductive health that explicitly incorporates sexual health:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. ICPD, Programme of Action, Paragraph 7.2, 1994.

Sexual and reproductive health services

According to this vision, sexual and reproductive health services can include, but are not limited to: voluntary fertility regulation; prenatal, birth and postpartum care; tetanus vaccines; support for breastfeeding; infertility treatment; prevention, screening and treatment of STDs, including HIV-AIDS; gynecological examinations; prevention and treatment of breast and cervical cancer; treatment of complications from abortion; nutrition programs; production and dissemination of educational and informative materials; education and counseling about sexuality; protection against violence; training of extension workers; personal and couple counseling; and diverse activities that empower users to take greater control and responsibilities for their own health (Dixon-Mueller 1993; Hardee and Yount 1995).

Gender and sexual and reproductive health

The gender roles played out by men and women in our societies have significant influence on their health. In many parts of Latin America, values associated with *machismo* emphasize men's sexual prowess, measured by the daringness of their sexual conquests and the number of sexual relations (Barker and Loewenstein 1996). This type of symbolic system motivates men to take risks with their own health and sets the stage for unwanted pregnancies, abortions, and the spread of STDs (Zeidenstein and Moore 1996).

In Bolivia, women seek and obtain health services with greater frequency than men due to their reproductive biology, as well as gender norms that discourage men from seeking health care and assign women social

responsibility for the health of others, including children, parents, sick friends and relatives. There is a growing consensus that a more balanced participation, including both men and women, would contribute to improved health for all. One of the Cairo recommendations highlights the importance of involving men more fully in sexual and reproductive health issues. "Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child-rearing responsibilities and to accept the major responsibility for the prevention of sexually transmitted diseases" ICPD, Programme of Action, Paragraph 7.8, 1994.

Thus, working from a gender perspective means putting more emphasis on men as well as on women. To date, there is still a predominant emphasis on care and treatment for women and on advocacy for women's health rights and services. Many of those who design health policies and provide health care have not yet accepted the idea that sexual and reproductive health takes two; that men as well as women have sexual and reproductive health needs, expectations and rights.

■ ACTIVITY MATRIX: HOW DO WE BECOME MEN AND WOMEN?

HOW DO WE BECOME MEN?

Life stage	Physical characteristics and experiences that mark us as men	What they tell us, ask of us and teach us so that we become men
0-5 years old		
5-10 years		
10-15 years		
15-20 years		
20-45 years		
45-80 years		

HOW DO WE BECOME WOMEN?

Life stage	Physical characteristics and experiences that mark us as women	What they tell us, ask of us and teach us so that we become women
0-5 years old		
5-10 years		
10-15 years		
15-20 years		
20-45 years		
45-80 years		

■ QUESTION GUIDE FOR GROUP DISCUSSION

- Are the education and socialization that we receive at each life cycle stage the same for men and women? How are they different? Why are they different?
- What effects do the differentiated education and socialization have on the health of boys and girls, adolescents, men and women?
- How does this differentiated education affect women and men's sexuality and reproductive practices? In their adolescence? In midlife? In later years?
- Do men and women participate equally in decision-making processes at home, in

the workplace, in communities and nations?

- Do men and women of Aymara, Quechua and other indigenous populations receive the same kind of gender education and the same kind of gendered opportunities as men and women of European descent?
- Do girls and boys in rural Andean and Amazonian communities receive the same type of gender education as boys and girls in large cities?
- Do the sons and daughters of professional families receive the same gendered training as the sons and daughters of maids and wage earners?

MODULE 2

SEXUAL AND REPRODUCTIVE RIGHTS

■ SESSION OBJECTIVES:

1. Develop awareness of and respect for sexual and reproductive rights.
2. Identify strategies for promoting the exercise of these rights.

■ SPECIFIC OBJECTIVES:

1. Generate reflection about the exercise of sexual and reproductive rights in participants' personal and professional experiences.
2. Motivate commitment to the promotion of rights in daily practices of health services.

■ KEY CONCEPT:

Sexual and reproductive rights

■ ACTIVITIES:

1. Defining our sexual and reproductive rights
2. Constructing the concept: sexual and reproductive rights
3. Promoting and exercising sexual and reproductive rights in familiar situations and contexts
4. Developing messages to promote sexual and reproductive rights in the workplace

■ TIME:

4 hours, 30 minutes

■ ACTIVITY 1

DEFINING OUR SEXUAL AND REPRODUCTIVE RIGHTS

Objective:

Reflect on the exercise of sexual and reproductive rights in our own professional and personal experience.

Procedures:

1. Each participant writes on several cards the sexual and reproductive rights that s/he exercises or would like to exercise (5 minutes).
2. Everyone deposits cards in a box.
3. Each person pulls cards out of the box and reads them, deciding as a group how to organize them into several themes or categories.
4. Participants form groups. Each reads the cards grouped under one theme and uses the discussion guide provided with this session to direct reflection and analysis (25 minutes).
5. The whole group unites. Each thematic group presents its analysis of the rights that they can exercise, the rights that people want to exercise and the obstacles that impede the latter (30 minutes).

Discussion guide:

1. What conditions are necessary to exercise these rights (consider social, economic, cultural conditions)?
2. Do different groups in our society enjoy the conditions necessary to exercise these rights?
3. What obstacles must be overcome before each group can fully exercise its rights?

4. How can we work to guarantee these rights in our work and private lives?
5. How can we promote and guarantee these rights within health services and institutions?
6. Compose a declaration which addresses the specific rights and conditions discussed here.

Time:

1 hour

Materials:

Index cards
Photocopies of discussion guide

Discussion:

All people have sexual and reproductive rights. The specific details of these rights and the exercise of them are expressed differently in different cultural groups, genders, generations and religions. Yet for all people, sexual and reproductive rights are based on the principles of human dignity, liberty and equality.

The promotion and full exercise of sexual and reproductive rights contribute to the improvement of health services and the quality of health care, thereby, causing a positive impact on the health of user populations. It is not possible to isolate sexual health rights from reproductive health rights, i.e., the kind of quality care that improves a population's health depends on addressing both these rights in a comprehensive way.

Expected results for participants:

1. Learn to identify and express sexual and reproductive rights in our own words and in reference to our own lives.

2. Identify actions and attitudes that promote the respect for and exercise of these rights.
3. Identify political and institutional actions that guarantee these rights and promote the exercise of these rights on the part of men and women health care users.

■ **ACTIVITY 2**

***CONSTRUCTING THE CONCEPT:
SEXUAL AND REPRODUCTIVE
RIGHTS***

Objectives:

1. Develop a clear understanding of sexual and reproductive rights.
2. Share information and basic guidelines for promoting sexual and reproductive rights in health services.

Procedures:

1. Using the concept card on sexual and reproductive rights, participants can take turns reading aloud one paragraph each about the history of international declarations concerning sexual and reproductive rights. The group should discuss both the symbolic importance and the real impact of these declarations on the guarantee of and exercise of sexual and reproductive health by men and women in Bolivia.
2. A participant reads aloud the second section of the concept card, dealing with the promotion of sexual and reproductive rights in health services. The group discusses each participant's possibilities of advancing these rights in his or her own work and the opportunities (or lack thereof) that male and female users have to exercise their rights.

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3. The facilitator can display a poster with the list of sexual and reproductive rights provided as a resource for this session. Each participant reads aloud one of the rights on the list. After discussing each of these rights, participants should articulate and add to the list other rights that they feel are important in the context in which they live and work.

Activity guide:

1. Before presenting the section on rights, facilitators should read the section of the conceptual framework on sexual and reproductive rights and be able to refer to the information provided there.
2. Facilitate connections between the specific rights that participants identified in Activity 1 as enjoyed or desired and the international declarations and published definitions of sexual and reproductive rights presented on the concept card.

Time:

30 minutes

Materials:

Concept card: Sexual and reproductive rights

List of sexual and reproductive health rights, printed on poster paper or white board

Discussion:

In order for women and men to take responsibility for their sexual and reproductive health, and to make decisions favorable to their own health and that of their families, both users and providers must know, respect and exercise basic sexual and reproductive health rights.

■ **ACTIVITY 3**

***PROMOTING AND EXERCISING
SEXUAL AND REPRODUCTIVE
RIGHTS***

Objective:

Identify ways to promote sexual and reproductive rights in the daily work of health services and commit to these practices.

Procedures:

Part 1

Form four groups, with each receiving a story that represents different experiences of health care (the complete texts of these stories are included in the support resources at the end of this section). After taking five minutes to prepare, assign roles and read through the scripts, each group presents its story, reading and/or performing the interactions in front of the other groups. The stories include:

1. A woman in indigenous dress seeks fertility control and is demeaned for her traditional practices and beliefs.
2. An adolescent seeks care for complications from an abortion induced at home and receives compassionate and thorough care.
3. A man with an STD seeks care in a health clinic oriented toward women.
4. A young unmarried couple seeks birth control methods and is chastised by the physician who does not provide complete information or promote informed choice.

Time:

25 minutes

Part 2

After all the stories are presented, distribute to each group a discussion guide which will guide reflection and analysis of the stories just performed.

Discussion guide:

In the story we just enacted, in what way do the providers:

1. recognize and respect users' different identities and needs?
2. share information and knowledge?
3. share decision-making and power in efforts to improve the user's sustained well-being?
4. promote the exercise of specific sexual and reproductive rights?
5. impede the exercise of these rights?
6. show sensitivity and respond to users' expectations?
7. consider users' fears and other feelings?
8. facilitate dialogue and communication?
9. explain clearly the importance of treatments and outline preventive actions that the user can take?
10. respect the sexual behavior and cultural practices of users?

Time:

20 minutes

Part 3

1. Once the groups have discussed the above issues, we ask, "What changes in attitude and interaction will help promote the sexual and reproductive rights of these different users?"

2. Each group develops a new script in which the institution and the providers are more successful at recognizing and respecting users' differences and at promoting the exercise of their rights.

Time:

30 minutes

Part 4

1. Each group presents its "improved story" skit and explains the reasons behind modifications.
2. Finish with discussion about ways to promote sexual and reproductive rights in health care services, including rights and issues not considered in the skits.

Time:

45 minutes

Total time for four-part activity:

2 hours

Materials:

Copies of the scripts
Poster paper, markers
Copies of the discussion guide

Expected results for participants:

1. Appreciate and value attitudes that facilitate the exercise of rights.
2. Identify attitudes that are barriers to the exercising of sexual and reproductive rights.
3. Develop practical strategies to modify services in order to better respect users' differences and promote their rights.

■ **ACTIVITY 4**
***DEVELOPING MESSAGES TO
PROMOTE SEXUAL AND
REPRODUCTIVE RIGHTS IN THE
WORKPLACE***

Objective:

Help participants to formulate communication strategies to promote the respect for and guarantee of sexual and reproductive rights in their own insitutions and activities.

Procedures:

1. Participants form groups to work on proposals to promote sexual and reproductive rights through communication media.
2. Each group decides what type of media they want to use: posters, pamphlets, radio messages, television spots, etc.
3. Groups develop simulated media campaigns that express key messgages about rights and advance strategies to promote them.
4. Each group presents the poster, advertisement or other message that it has prepared.

**BACKGROUND AND
RESOURCES FOR MODULE 2**

■ **DISCUSSION GUIDE FOR GROUP
REFLECTION**

1. What conditions are necessary to exercise reproductive and sexual rights (consider social, economic, cultural conditions)?
2. Do different groups in our society enjoy the conditions necessary to exercise these rights?

3. What obstacles must be overcome before each group can exercise its rights?
4. How can we work to guarantee these rights in our work and private lives?
5. How can we promote and guarantee these rights within health services and institutions?
6. How can we compose a declaration which addresses the specific rights and conditions discussed here?

■ **CONCEPT CARD: SEXUAL AND
REPRODUCTIVE RIGHTS**

Sexual and reproductive rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing, health, security, education and political participation. Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and child care, gynecological health and sexual activity, as well as the resources to carry out those decisions safely and effectively (Correa and Petchesky 1994).

History of sexual and reproductive rights

The concept of sexual and reproductive rights, together with the declarations that promote respect for these rights, have a long history. After the Second World War, the Charter of the United Nations (1945) affirmed faith in fundamental human rights, the dignity and value of human persons, and equality of rights between men and women. In 1948, the Universal Declaration of Human Rights included Article II which proclaims the right of all persons to the established rights and liberties without any distinction based on race, color, sex, language, religion, political or other opinion,

national or social origin, property, birth or any other condition.

Other conferences and declarations reinforced the notion that the right to decide about reproduction, as well as the right to access to health services, were basic human rights. In 1979, the General Assembly of the United Nations approved a Convention on the Elimination of All Forms of Discrimination against Women, and countries that signed the treaty committed to take measures to “ensure the full development and advancement of women.” One of these measures is a commitment to ensure equal access to health services, including those related to family planning, and to promote the same right for men and women to decide the number and spacing of their children. This measure also highlights the need to access the information, education and resources necessary to exercise this right.

The International Conference on Population and Development in Cairo recognized certain sexual and reproductive rights as basic human rights. “These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents” (ICPD, Programme of Action, Paragraph 7.3, 1994). The Fourth World Conference on Women in Beijing reaffirmed earlier consensus on the need to eradicate all forms of discrimination and violence against

women and to guarantee the right to decide freely and responsibly about matters of sexuality and reproduction.

The promotion of sexual and reproductive rights in health care services

Today, the exercise of sexual and reproductive rights by men and women is considered a fundamental basis for a better quality of life (UNFPA 1997). Generally, sexual rights are not distinguished from reproductive rights; they are treated as dimensions of a set of basic human rights, the exercise of which constitutes a fundamental strategy for human survival and quality of life.

Increasing emphasis on sexual and reproductive rights is contributing to changes in health care values and paradigms. “Within this framework” writes Ladi Londoño, “a gender perspective helps us identify great shortcomings, unnecessary medical interventions, as well as the importance of emotional and affective aspects” (1996). Quality of care doesn’t only lie in improved infrastructure, reduced rates of maternal mortality and better resources for health care, it is also based on the exercise of and respect for individual autonomy in intimate matters and sexual decisions of men and women.

■ LIST OF SEXUAL AND REPRODUCTIVE RIGHTS

These rights include but are not limited to:

1. The exercise of sexual independence, as well as the right to enjoy it according to one’s own preferences, and the right to legal protection.

2. Pleasurable and recreational sexuality, independent of reproduction.
3. Adequate information and knowledge about sexuality and reproduction.
4. Love, sensuality and eroticism in sexual relations.
5. Sexual education that is appropriate, comprehensive, secular, scientific and gender-sensitive.
6. Refusal to engage in sexual activity.
7. Freedom from fear, shame, guilt and other imposed beliefs that inhibit a person's sexuality and diminish his or her sexual relations.
8. Choice of sexual partners, to exercise sexuality without coercion or violence.
9. Nutrition necessary for adequate growth and balanced development of one's body and future reproductive potential, from childhood.
10. Voluntary motherhood, to decide and live motherhood for one's own choice and not by obligation.
11. Complete information concerning the benefits, risks and relative effects of all contraceptive methods.
12. Free or inexpensive contraceptives with current information, follow-up and responsibility on the part of those who prescribe it.
13. Marriage and family or the choice not to have either.
14. Parenthood and the right to decide when to have children.
15. Good quality services for prenatal care, birth, and postpartum care, guaranteed by appropriate legislation.
16. Equal participation by women and men in child care, creatively constructing children's identities beyond traditional gender roles.
17. Effective legal protection against sexual violence.

18. Adoption and right to comprehensive, accessible treatment for infertility.
19. Prevention and treatment of illnesses of the reproductive tract, and the right to make informed decisions about related interventions.

This list of rights is compiled from IPPF's Declaration of Sexual and Reproductive Rights (1996), from Mari Ladi Londoño's book, *Sexual and Reproductive Rights* (1996) and from the Open Forum for Sexual and Reproductive Rights in Chile (1996).

■ **STORY #1**
"I DON'T UNDERSTAND ABOUT METHODS"

Rosalía is a 21-year old indigenous woman who met Pedro a year ago. They fell in love and decided to move in together. Pedro works as a mason, and Rosalía left her job as a maid and began to sell food in the marketplace, which gives her more time and freedom to build a relationship with Pedro. In the house where Rosalía worked, her employer and her friends would say that "a woman should take care to not have children too soon" and "men just make babies and disappear." Remembering these warnings, she decided to visit a health center.

When Rosalía arrives at the center, she is impressed by the number of women in the waiting room with babies and toddlers. She timidly approaches the receptionist and asks for a visit with the doctor. She thinks to herself that she would be less frightened if the doctor were a woman but is afraid to say this to the receptionist, who is busy asking her a series of questions about her personal life and noting the answers on a chart. Rosalía answers in a low voice, not wanting

other patients to hear. When the questions are finished, she receives a number and is told to wait her turn.

After an hour and a half, her number is called. Rosalía walks quickly to the consulting room, where she is relieved to find a woman doctor. Her brave "Good morning, doctor" is answered by a kind "How are you, child? Take a seat." The doctor reads the chart that the receptionist filled out and says, "So this is your first visit? How can I help you?"

Rosalía explains that she has recently moved in with her boyfriend and does not want to have children yet because they are saving to buy a house. The doctor answers "Very well, child, it's good that you think ahead, but you must remember that children are always welcome, and that you are young and can care for them well now – when you are older it will be more difficult. Tell me what method you have been using." Rosalía explains that she is using the rhythm method, but is afraid it will fail.

The doctor explains to her that there are several ways of protecting herself, and rapidly lists IUDs, condoms, pills and injections before asking her which one she wants. Rosalía is confused, and has not understood many of the words the doctor has used, but is afraid to tell her so. "Which one do you suggest, Doctor?" she asks, and the doctor says she would like to examine her before making a suggestion.

Rosalía takes off some of her clothing, and when the doctor moves to check her heart, she says, "So much clothing, child. Skirt on top of skirt on top of skirt. Why don't you use western clothing? That way you can

save money – your traditional clothing must be very expensive and uncomfortable." Rosalía does not answer but feels increasingly uncomfortable and eager to leave.

Upon completing the examination, the doctor says that Rosalía can use any method and asks her which she prefers. At that point she is nervous and confused and only says, "I'll talk to Pedro. Perhaps he will get mad at what I choose. Then I'll come back." "Very good," answers the doctor, "I'll be waiting for you to come back, and it would be good if you bring Pedro along so that we can discuss this with him."

Rosalía leaves quickly, feeling that she never wants to come back. She has a bad feeling about the visit. It seemed to her as if the doctor mistreated her and ridiculed her about her clothes, and she didn't understand a thing the doctor said about methods. When she gets home she doesn't share her experience with anyone, nor does she return to the doctor. Three months later Rosalía is pregnant, and plans to travel back to the countryside to have her baby where her mother and sisters can attend to her.

■ STORY #2 "I'M PARALYZED WITH ANGUISH"

Ana is in a difficult situation: Her period is a month late, and she is worried that she is pregnant. Last week she went to the pharmacy to get an injection to "regulate her menstruation," but nothing happened. She then followed the advice of a friend, whose aunt had given her some pills to take, together with strong, very hot oregano tea. Ana also made great efforts to carry heavy

things, and run up and down the stairs of their apartment building.

Six days after taking the pills and oregano, and after several days of intense physical effort, Ana wakes up feeling terrible. Her mother, seeing that she is pale, depressed and overcome with anguish, sits on the bed and asks Ana what is the matter. Ana explodes in tears, and finally tells her what happened, and admits that she is pregnant. Her mother also starts to cry, and asks why Ana didn't trust her enough to confide in her. "The thing to do now, Ana, is get you to the doctor. I'll help you get dressed and take you to the clinic where I go each year for my Pap test."

The wait is not long, but Ana can barely walk when she is called into the consulting room. Ana hardly answers when the doctor asks what is troubling her, but he grasps the situation quickly and has her lie on the table so that he can examine her. When the doctor announces that she is suffering from an incomplete abortion, Ana starts crying again, and her mother tries to calm her while the doctor prepares the anesthesia and equipment for a D&C.

When the procedure is finished and Ana is resting, the doctor invites Ana's mother to sit down and talk. He explains that the methods used by Ana are very dangerous, and that it is important for her to overcome this frightening experience, understand what happened, and to be better prepared in the future. He makes a date for an appointment with Ana the following week. Ana's mother agrees that the doctor should explain "everything" to Ana.

When the girl wakes up crying, the doctor takes her hand and assures her that she will be fine, that she must go home and rest, and that he looks forward to meeting with her the following week.

■ STORY #3 "HOW CAN I TELL THEM WHAT I HAVE?"

In his 34 years, Martin has almost never been in a clinic. His work as a mason did not leave him much free time. His wife has always gone with her sister to prenatal visits and the births of their three children, and it was she who took the children to get vaccinated. When he enters the health center, Martin sees a series of doors marked with signs: Vaccines, Laboratory, Administration, Maternity, etc. He decides to ask at administration, although he is very worried about what exactly to ask for. Martin greets the woman behind the administration desk and asks her where he can find the office that deals with "infections." Without greeting him, the administrator says, "The visit is twelve dollars." Without having received any clarification, Martin pays the fee, receives a number and sits on a nearby bench. The whole time he is thinking frantically about how he can explain what is wrong with him, and hoping that he will be doing the explaining to a man, and not a woman nurse or doctor.

A woman in native dress leaves the consulting room and nods to Martin who, like herself, is Aymara. Soon his number is called and he enters the room, where a doctor and nurse, both women, are talking about the prior patient, commenting on her poor hygiene and ignorance and expressing

their doubts that she will follow through with the treatment they prescribed. They finish their conversation, and the doctor invites Martin to sit down and she asks, "What is your problem?" Martin fights his embarrassment and starts describing his symptoms, when he sees the doctor and nurse exchange a knowing look. When he has finished talking, the doctor explains that in order to know exactly what kind of infection he has, he must leave a urine sample at the laboratory for analysis. She writes out a lab order, explains that he must give the sample before eating the following morning, and makes an appointment for Martin to return a few days later for the results. Martin doesn't dare say anything – he simply nods and leaves.

When he returns with his lab results, Martin must wait over an hour for his turn, and suffers an increasingly urgent need to urinate. He looks around the whole clinic, but only sees doors that say "Women," and is embarrassed to ask for the men's rest room. When he finally gets called into the consulting room, the doctor studies the lab results and writes out a prescription, explaining that Martin, as well as all his sexual partners, must take an entire course of this medicine. She also explains that he must not engage in sexual relationships for the next 15 days.

When he arrives home, Martin tells his wife that the doctor has said that they both might be infected and that they both need to take the medicine. She gets very angry, accusing him of ruining the family with his infidelity and complaining about the high cost of the doctor visit and the medicine.

■ STORY #4 "PLAYING WITH FIRE"

Stella and Marcos are university students. A couple of months ago, Stella had a clandestine abortion and, luckily, recovered without complications. After this frightening experience, they both want to prevent another pregnancy, but are not sure what method is right for them. On a friend's advice, they go to a health center that offers numerous types of methods.

When the young couple arrives at the clinic, Stella and Marcos approach the receptionist, who smiles, greets them and asks them to fill out the medical chart. When they finish, she apologizes for lack of space: two women and another couple are occupying all the chairs. The clinic is in an old house, and the reception area hardly has space for a desk in the corner. Several old magazines lie on an end table, but the lighting is too poor to read them.

After a 50-minute wait, they call Stella's name. When Stella and Marcos enter the consulting room, the doctor is talking on the phone and gestures for them to take a seat. The consulting room is bigger and nicer than the waiting room; it has its own bathroom and several posters about AIDS. After a couple minutes the doctor hangs up and, smiling at them both, asks the motive of their visit. Stella takes the initiative and explains in a low voice that she recently had an abortion and does not wish to repeat it, so they want to get a sure method of birth control. She explains that they want to finish their studies and get married before having children.

The smile disappears from the doctor's face and he responds intensely, "I am glad that

you have come to the clinic, because a clandestine abortion is gambling with a woman's life, especially when it is poorly done. But it is even worse to play at being married and have relations when you know what can happen. You two, who seem like well-bred individuals, make mistakes as if you were uneducated. Young people today dedicate themselves to pleasure and don't think about tomorrow, or about the parents who have invested their trust in you. Returning to the point of your visit, I suggest that you choose a very secure and popular method, the Copper-T IUD. Of course there are other methods, but this is the best one for you. Stella, when was your last period?" Stella answers that she just began that day, and the doctor responds enthusiastically, "Perfect, that is the best day to introduce the IUD, because we are sure that you are not pregnant. Good, are you decided?"

Stella and Marcos do not reply and the doctor suggests that they take five minutes to talk it over in the waiting room while he makes a call. The young couple walks silently to the waiting room, where Stella whispers, "It seems right that today is the day to put in the IUD, but doesn't it have side effects?" Marcos suggests, "Let's go to another doctor. This one made me feel bad – but you decide." "He made me feel bad, too," answers Stella, "but another doctor will just be the same. We've already been through the worst here, let's just get the IUD inserted."

While they are whispering, the nurse walks into the small room and overhears part of the conversation. "It's a difficult decision," she whispers to them, "but I would advise the Copper-T. I've had one in for four years

with no problems." Stella asks her "what problems might I have with the Copper-T?" and she answers "None at all, dear, it's totally safe as long as you get a checkup every six months."

Stella turns to Marcos with a more assured tone and says, "She's right, I will get it inserted today." The receptionist indicates that the doctor is waiting for them, and when they enter the consulting room he announces with a smile, "You've come to a decision, have you? Well let's get to it."

■ DISCUSSION GUIDE:

In the story just enacted, in what way do the providers:

1. recognize and respect users' different identities and needs?
2. share information and knowledge?
3. share decision-making and power in efforts to improve the user's well-being?
4. promote the exercise of specific sexual and reproductive rights?
5. impede the exercise of these rights?
6. show sensitivity and response to users' expectations?
7. consider users' fears and other feelings?
8. facilitate dialogue and communication?
9. explain clearly the importance of treatments and outline preventative actions that the user her/himself may take?
10. respect the sexual behavior and cultural practices of users?

MODULE 3

QUALITY CARE I QUALITY IN HUMAN RELATIONS AND TECHNICAL QUALITY

■ SESSION OBJECTIVE:

Learn methods and develop attitudes that help to improve interpersonal relations between providers and users, and to respect users' rights and identities in sexual and reproductive health services.

■ SPECIFIC OBJECTIVES:

1. Identify and reinforce skills and practices that promote quality care in health services.
2. Become familiar with personal attitudes and interpersonal dynamics that promote quality care.
3. Learn new criteria and techniques for more effective and efficient services.

■ KEY CONCEPTS:

Quality care in sexual and reproductive health services

Quality in human relationships

Technical quality

Tools for improving health services

■ ACTIVITIES:

1. Appreciating our abilities
2. The quality care philosophy
3. Practices and techniques of quality care
4. Human and technical quality in health care interactions

■ TIME:

4 hours

■ ACTIVITY 1

APPRECIATING OUR ABILITIES

Objective:

Identify and reinforce skills, abilities and practices that promote quality care in sexual and reproductive health.

Procedures:

1. Each participant identifies three abilities, skills or practices that make a positive contribution in his/her work. Try to focus on abilities that help us to recognize and respect differences, establish equitable and constructive work relationships, share knowledge and power, and strengthen users and colleagues' skills.
2. Participants write each ability on a card, providing a concrete example of each. Deposit all cards in a box.
3. When all the cards are in the box, each participant draws three, which s/he reads aloud and writes on the poster paper.
4. Participants have a group discussion and analyze the different practices and abilities that promote compassionate quality health care and gender sensitivity.

Time:

30 minutes

Materials:

Index cards
Poster paper
Markers

■ ACTIVITY 2***THE QUALITY CARE PHILOSOPHY*****Objectives:**

1. Introduce the philosophy of quality care.
2. Relate the abilities and skills identified in the preceding activity to the practice of gender-sensitive quality care.

Procedures:

1. Guide a discussion using the concept card on quality care. Different participants can read consecutive sections of the concept card, pausing to discuss alternative interpretations and applications of the ideas presented in each section.
2. Conclude with a discussion about tangible attitudes and actions that participants can take to offer better quality care in their work. Refer to the poster paper that records the positive abilities identified in Activity 1 to see how these can be strengthened and institutionalized to guarantee quality care.

Activity guide:

Facilitators should have read beforehand the section on the conceptual framework that presents quality care, and be prepared to refer to it in discussion. Invite the participants to relate their own abilities presented in Activity 1 to the goal of developing and implementing quality care at an institutional level.

Time:

45 minutes

Materials:

Concept card: Quality care

■ ACTIVITY 3**PRACTICES AND TECHNIQUES OF QUALITY CARE****Objectives:**

1. Observe the practice of key techniques for quality care in sexual and reproductive health.
2. Analyze cases in which different methods that contribute to quality care are practiced.

Procedures:

1. One at a time, watch each of the three cases presented in the video "Hablemos con Confianza," produced by The Johns Hopkins University, plus the case presented in the video "Quality Care in Reproductive Health," produced by the Flora Tristan Center for Peruvian Women.
2. After each case, stop the video and spend 10 minutes discussing what was seen using the discussion guides provided below. Facilitators can enrich the discussions with the summary of techniques for improving gender-sensitive quality care included in the support resources for this session.

First Case: "We were all 18 . . ."

This case emphasizes the importance of respecting the user's age, culture and way of thinking in health care interactions.

Discussion guide:

1. What message does this story convey?
2. What challenges did the provider face in her efforts to put herself in the user's place?
3. How well did the provider carry out her role? Which aspects did she handle well, and where could her approach be improved?
4. What sexual and reproductive rights come into play in this case?
5. What obstacles impede the user from making her own informed decision?

Second Case: "Step by step"

The GATHER method lays out steps to follow that help to ensure better communication with users. This method is not rigid and can be adapted to the needs of each situation and each user (Rhinehart et al. 1998).

Discussion guide:

1. What message does this story convey?
2. How is the couple's relationship presented? What rights does the woman exercise? What rights does the man exercise?
3. What sexual and reproductive rights does the provider promote?
4. What did the provider do well? What could we have done differently?
5. Use poster paper to write out the steps of the GATHER method.
6. Discuss each step of the method in light of participants' experiences.
7. How can we apply each of these steps in our own work?
8. What are the advantages and the drawbacks of the GATHER method?

Third Case: "We all have doubts"

This case demonstrates techniques for listening, respecting users' silences and respecting the users' perspectives as a means of improving communication.

Discussion guide:

1. What is this case about?
2. What is the personal situation of the user? Of the provider?
3. What feelings and fears does each experience?
4. What expectations does the user bring to the consultation?
5. Identify positive attitudes and practices manifested by the provider.
6. How would we act in this situation?
7. In this consultation, was the right to obtain comprehensive information respected?
8. On poster paper note the non-verbal techniques (gestures, looks, facial expressions) and the verbal techniques (phrases of interest, listening, open questions, closed questions, reflection questions) that are employed. Identify an example of each of these techniques in the video.

Fourth Case: "Quality care in reproductive health"

This video demonstrates a user's fears about negative power relations with health providers, revealing numerous tensions and anxieties that need to be discussed and dealt with to obtain quality care.

Discussion Guide:

1. What is this story about?
2. What aspects of interpersonal relations in health care are brought into question here?

3. How can one describe the first contact that the user has with the health care center?
4. What type of power relations are manifested in the different provider-user interactions depicted during the video?
5. Do the imagined stories have any basis in reality? Have participants observed or heard of any similar experiences?
6. What rights are not respected in the imaginary visits?

Time:
2 hours

Materials:
Videos
Summary of techniques to improve gender-sensitive quality care
Poster paper

Discussion:
It is important to emphasize that the techniques presented here do not dictate uniform approaches to all interactions with users. The methods and techniques reflect a range of possibilities that should be selected and applied according to the personal style of each provider and the needs and identities of each user.

Expected results for participants:

1. Learn how to apply for personal use certain techniques that help to improve the quality of human interactions in health care.
2. Understand that gender identities, relations and considerations constantly influence health care interactions, among men, among women, or between men and women.

3. Embrace analytical approaches that promote reflection, critique and improvement of one's own daily work.

■ **ACTIVITY 4**
HUMAN AND TECHNICAL QUALITY IN HEALTH CARE INTERACITONS

Objectives:

1. Identify concrete strategies to improve our daily work.
2. Apply methods to improve the quality of care in sexual and reproductive health services and make those services more sensitive to gender realities and relations.

Procedures:

1. Form groups. Each group selects one technique or method for gender-sensitive quality care, as presented in the videos.
2. Develop skits that demonstrate the application of the chosen technique in a familiar health care setting and situation.
3. Members of each group prepare to act out the skit.
4. Each group presents its simulation of a health service situation in which gender sensitivity and quality care techniques are used.
5. In open debate, discuss the following questions:
 - What advantages does the use of this technique or method provide?
 - What difficulties might interfere with our attempts to practice this method?
 - In what contexts will this method help to improve care?
 - In what contexts will this method be inappropriate?

Time:
45 minutes

Discussion:

The methods and techniques presented in the videos help providers put themselves in the place of users and, thereby, empathize with their health situations and decisions. This effort requires sensitivity to the cultural, gender and generational identity of the user, as well as sensitivity to his or her unique feelings, fears, doubts and needs.

BACKGROUND AND RESOURCES FOR MODULE 3

■ CONCEPT CARD: QUALITY CARE

Quality care is a philosophy of comprehensive and compassionate health care oriented toward the satisfaction of users. It facilitates improvements in services offered to men and women through changes in personal communication and interaction, as well as through changes in administrative and technical practices. Quality care strengthens users' responsibility, knowledge and autonomy, self-esteem and dignity and the exercise of their rights.

Quality is different not only for men and women, but also for persons of different cultures, ethnic groups, social classes and ages. In other words, everyone has his or her own definition of quality. So then, who evaluates quality care? Since the philosophy of quality care is oriented toward the satisfaction of users, it is they who should evaluate the quality of services.

Basic principles help us to obtain quality care: a focus on the comprehensive well-being and satisfaction of diverse users; the active and equitable participation of all personas involved in health care; the

practice of offering options from which users may select, such as different contraceptive methods or birthing positions (Finger and Hardee 1993); the empowerment of users to make free and informed decisions about their own health; and the equitable treatment of women and men, people of different ages, social classes and ethnic backgrounds.

Quality care has three interrelated dimensions: quality in administration and management; quality in human interactions and technical quality.

Quality in administration and management

An institution's philosophy transmits ideas, values and attitudes to employees as well as to users (Araujo and Matamala 1995). Quality management encourages a work environment and a health care environment free from discrimination and abuse of power. The key here is the existence or absence of mechanisms that promote the participation of personnel and users in the improvement of the service. These might include posted policies promoting users' rights or prohibiting discrimination; the use of suggestion boxes; and the organization of participatory and democratic meetings between administration and staff, and between the latter two representatives of the user population.

To improve quality of care, we must begin with a philosophy that places priority on user satisfaction (Finger and Hardee 1993). This philosophy will then be manifested in a facility's infrastructure, menu of information and services offered, labor practices and relations, staff treatment and labor policies, guarantee of confidentiality and privacy

during provider-user visits and even in the hours of service. If the institution does not take quality care into account as a matter of policy, it is improbable that staff will be able to provide the kind of services that satisfy users.

Each institution expresses its gender perspective in the relations it establishes with the public, from the assignation of resources to different groups of users to the distribution of tasks and responsibilities within that institution. A gender perspective is key to understanding different groups, ensuring that services do not favor some and discriminate against others and making sure that programs do not reinforce existing inequalities. For example, better gender balance and more equitable participation could improve the quality of many maternal-child health and family planning programs by questioning and changing current services and information that are oriented exclusively to women; reinforcing stereotypes that give women sole responsibility for their families' health; and denying the fundamental importance of men's participation.

Quality in human relationships

Quality of interactions encompasses the empathy expressed by providers, time dedicated to each user, sharing of knowledge and respect for each user's opinions and decisions. It also implies respect for differences among people: A woman in native dress deserves the same understanding and respect as a woman in modern dress; a disheveled adolescent boy deserves the same service as a professional man.

In addition to changes in attitude on the part of personnel, quality care requires that users themselves exercise more responsibility and initiative. Providers can facilitate this change by sharing knowledge about health, offering options for treatments and methods and supporting users in their decision-making process. Services should offer complete information that permits users to care for their own sexual and reproductive health, and to take preventative actions that help them to achieve a sustained state of physical, mental and emotional well-being.

Technical quality

Technical competence concerns adequate equipment and supplies and requires that providers apply current and appropriate knowledge, skills and technology. Indicators for this type of quality include the existence of clear operational norms and procedures and demonstration of the skill and accuracy necessary in diagnosis, treatment and follow-up of users.

Technical quality includes having the necessary equipment, supplies and medicines needed to fulfill standards (Güezmes 1997), together with maintenance of conditions, fulfillment of protocols and availability of competent personnel (Finger and Hardee 1993). Quality equipment and supplies also refer to the general infrastructure of the center (water, plumbing, lighting, garbage disposal) and the conditions, comfort and cleanliness of the waiting and consulting rooms. A crucial aspect of technical quality is the existence of programs for continuous professional improvement for men and women personnel, which cover medical techniques as well as techniques for patient care and communication.

Quality care and gender

Health providers often reproduce and reinforce gender inequities in the relationships that they develop with users and with co-workers. In many cases, health professionals tend to overvalue medical knowledge, give privilege to masculine-scientific discourse and reject other ways of knowing, thinking and talking as expressed by patients. Often the prejudices and values of providers and institutions are expressed through doubt, criticism, rejection and even sarcasm toward the way patients understand things, especially female patients and those who come from lower socioeconomic classes and marginalized ethnic groups.

In social environments in which certain groups of women assume subordinate positions in most of the relationships in which they engage, these women tend to relate to providers in the same way, thus, undermining their potential power as health care clients. In their relationships with health providers, many Bolivian women feel constrained by their fears, shame and timidity; by guilt and moralistic norms; by insecurities about their own knowledge; and by their experiences of physical, psychological and sexual violence. These constraints are coupled by gender-related economic and operational difficulties that must be overcome in order to seek health care.

Men also approach health care from their own gender experiences and are restricted by normative models of masculinity. In Bolivian contexts, these can include pressure for "real men" to resist pain, refuse to seek or accept help and appear strong, physically and emotionally invulnerable. These aspects of "being a man" in Bolivian society impede

men's access to health care. Pressure to demonstrate stereotyped masculine behaviors is especially strong for young men, many of whom do not take preventative measures, nor seek medical care until they are extremely ill.

In considering quality care, providers should recognize these gender norms and stereotypes, their impact on users' health and their influence both on provider-patient interaction and on user follow-up. Providers are capable of forging new gender visions and possibilities, and of changing their own behaviors and attitudes, through their professional action. They can, for example, encourage and support women users to make strong decisions in favor of their own well-being and to assume new responsibilities for their health and sexuality. They can encourage men to admit that they hurt, to seek and accept help and advice, and to participate in the health care of their children and partners. Better understanding and respect for others, together with improved communication between people from different backgrounds, cannot help but improve relations and processes of diagnosis, treatment and education, and thereby contribute to improvements in the population's health.

■ SUMMARY OF TECHNIQUES TO IMPROVE GENDER-SENSITIVE QUALITY CARE

The video "Hablemos con Confianza," from The Johns Hopkins University, presents three health service stories, and the video "Calidad de Atención en Salud Reproductiva," from the Flora Tristan Center for Peruvian Women presents another health care story. Each of these 10-

minute stories presents a series of gender-sensitive techniques and methods designed to improve interaction and communication between providers and users. Watching and discussing these videos motivates us to reflect on our everyday practices and think about ways in which we can improve. Here we provide a brief discussion of each video.

“Hablemos con Confianza”

1. “We were all 18 . . .”

This story explores the difficulties that a provider faces in putting herself in the place of a young user. It makes clear that the provider brings to her patient her own personal biases, and that her fears, doubts and opinions influence interactions. The video deals with the provider’s personal history on two levels: how the situation affects the provider’s own beliefs and feelings, and how it affects her interactions with the user. The reflection leads us to consider differences between provider and user and to understand the role that these differences play in the provision of health service. The story emphasizes the importance of empathy as a key element that enables the provider to listen to and respect the position and decisions of the user.

2. “Step by step”

This story presents the method GATHER, designed to encourage and improve communication between provider and user through the following steps: greet the user; ask the user about him or herself; tell the user about his or her choices; help him or her to make an informed choice; explain fully how to use the chosen treatment or method; and return visits should be welcomed and encouraged. This method is not rigid and there is no need to follow the steps in order. It is a general guideline that

allows for a comprehensive and systematic interaction with users, ensuring respect for their rights and decisions, which can easily be adapted to different cases.

3. “We all have doubts”

This story demonstrates verbal and non-verbal techniques for achieving better communication with users. It encourages providers to pay more attention to the messages they are sending and to the messages expressed by the user. The following examples demonstrate the type of techniques presented in this video.

Communication Technique	Example
Open-ended question	“What brings you here today?”
Specific question	“How old are you?”
Directed question	“Are you interested in changing your method?”
Reflection question	“How has it been for you using this method?”
Invitation for clarification	“Do you have any doubts about this?”
Silence	Wait patiently for user to gather his/her thoughts and bring up his/her issues
Smile or nod	Nonverbal message that expresses encouragement, confidence

4. “Quality care in reproductive health”

This video demonstrates a whole series of stories depicting different relationships that might develop during a user’s visit. These relationships are influenced by the life experiences and beliefs of each participant, especially their experiences in relation to sexual and reproductive health. In some of the imagined stories, the providers feel they know everything and have no need to listen to or respect the user’s opinion. The various imagined stories contrast with the final visit,

in which the provider shares knowledge and power in a respectful and equitable way, setting the scene for a gender-sensitive quality consultation.

MODULE 4

QUALITY CARE II QUALITY IN ADMINISTRATION AND MANAGEMENT

■ SESSION OBJECTIVES:

1. Analyze the organization and administration of sexual and reproductive health programs.
2. Identify institutional strategies that facilitate more effective responses to the identities, needs, rights and possibilities of different users.

■ SPECIFIC OBJECTIVES:

1. Develop capacity for critical analysis of sexual and reproductive health policies, institutional structures and management practices.
2. Learn criteria for evaluating health services from a gender perspective.
3. Identify feasible and possible changes that we can make on personal, interpersonal and institutional levels.

■ KEY CONCEPTS:

Institutional administration and management for equity and quality
Criteria for institutional assessments of gender-sensitive quality

■ ACTIVITIES:

1. Criteria for evaluating gender sensitivity and quality care
2. Assess and improve institutions in which we participate
3. Reflect on institutional strengths and weaknesses
4. Multiple changes towards better care
5. Evaluation of the learning experience

TIME:

4 hours

■ ACTIVITY 1

CRITERIA FOR EVALUATING GENDER SENSITIVE AND QUALITY CARE

Objectives:

1. Become familiar with IPPF criteria for gender-sensitive quality care in sexual and reproductive health, and understand how these criteria are applied.
2. Identify factors in institutional organization and function that promote or impede quality care.

Procedures:

1. Introduce the background and basic concepts of the IPPF evaluation criteria (included in session resources). If possible, circulate copies of IPPF literature concerning gender-sensitive quality care.
2. Present the list of quality criteria, written on poster paper. Distribute photocopies of the list to each individual.
3. Ask each participant to read one criterion aloud.
4. Discuss and comment on the IPPF proposal for institutional assessment.

Time:

30 minutes

Materials:

IPPF'S proposal for institutional evaluation
List of IPPF criteria on poster paper

Photocopies of IPPF criteria
Copies of IPPF publications concerning
gender-sensitive quality care

■ **ACTIVITY 2**
ASSESS AND IMPROVE
INSTITUTIONS IN WHICH WE
PARTICIPATE

Objective:

Apply gender-sensitive quality criteria in a simulated institutional assessment.

Procedures:

1. Participants divide in groups; preferably, each group will gather participants who work in or know one particular institution.
2. Each group identifies one health project or institution to assess. It is not necessary for participants to have exact knowledge of all aspects of the institution, as they will simulate an assessment based on the familiarity that they have, and on approximations concerning information they lack.
3. Each group uses the IPPF evaluation criteria as a basis for assessing the chosen institution. In many cases participants will have to invent details; they should feel free to imagine missing data in order to construct a complete institution for the simulated assessment.
4. Once the criteria have been applied, the group carries out the most important stage of the assessment, which is to interpret the results, identify the strengths and weakness of the institution and make recommendations for improvement.
5. Participants join together so that each group can present the most interesting

and important aspects of its assessment and conclusions.

Activity guide:

The desired result of this activity is NOT to produce an authentic evaluation of a real institution; it is to provide skills and experiences that will prepare participants to participate in such an evaluation in the future. We choose to focus on projects and institutions with which we are familiar because it facilitates a more meaningful learning process. It is not necessary that each group stick to exact and verifiable details; what is important is that participants learn to identify and evaluate pertinent criteria and - most importantly - to reflect on, discuss and interpret the profile which emerges from the evaluation and to make recommendations based on this interpretation.

Time:

1 hour, 30 minutes

Materials:

Photocopy of sheet explaining the IPPF proposal
Photocopy of list of IPPF criteria
Poster paper
Markers

Expected results for participants:

1. Get to know criteria for evaluating gender sensitivity and quality care, as proposed by IPPF.
2. Gain experience through simulated assessment of a health care project or institution.
3. Develop capacity for critical analysis of aspects of the institutions and programs in which we work.

■ ACTIVITY 3

REFLECT ON INSTITUTIONAL STRENGTHS AND WEAKNESSES

Objective:

Identify and reflect on opportunities and strengths for improving gender-sensitive quality care in specific sexual and reproductive health projects and institutions, as well as weaknesses and threats to be overcome.

Procedures:

1. Form the same groups that worked together in the preceding activity.
2. Distribute copies of the sheet explaining SWOT, which is a method for analyzing the strengths, weaknesses, opportunities and threats in an institution and its context.
3. Ask each group to carry out the SWOT analysis on the basis of the institutional profile developed during the prior assessment. Seek strengths and opportunities that will enable the institution to develop respect for gender differences and identities and to develop a comprehensive and compassionate approach to sexual and reproductive health care.
4. Join together so that each group can comment on the process and share the most interesting things that they learned in the application of SWOT.

Time:

1 hour

Materials:

Sheet describing the SWOT method
Poster paper
Markers

■ ACTIVITY 4

MULTIPLE CHANGES TOWARD BETTER CARE

Objectives:

1. Reflect upon across-the-board changes that are necessary and/or possible in health services.
2. Apply ideas generated in sessions on gender, sexual and reproductive health, rights, and quality care to the problem of incomplete abortions in Bolivia.

Procedures:

1. Watch the video *El aborto: Un problema de salud pública*, produced by Ipas and the Bolivian Ministry of Health.
2. Form groups to discuss the video, oriented by questions in the discussion guide.
3. Bring the entire group together to continue the discussion.

Discussion guide:

1. How do the gender identities and relations predominant in Bolivia influence the situation of the user in this video?
2. Considering this reality, what gender considerations need to be taken in the response to and treatment for this case?
3. What role do men play in this situation (sexual partner, father, persons who help women get medical help or accompanies them to the clinic, provider)?
4. What special attention does a woman need to recover from this type of experience?
5. What does the idea of *comprehensive* sexual and reproductive health care have to do with this case?

6. What is the policy of the institution depicted in the video concerning sexual and reproductive rights of men and women?
7. What rights do women have when they suffer an incomplete, illegal abortion?
8. How can we characterize the human relationships within the institution depicted in the video? Among personnel in that institution?
9. Do these relationships have anything to do with the kind of care that is provided to the woman suffering an incomplete abortion?
10. What changes can be made by all kinds of actors within the health care center in order to provide more compassionate quality care for women who arrive needing help for incomplete abortions?

Activity Guide:

The video fosters a critical analysis of institutional policies and providers' attitudes and practices. Training in earlier sessions about gender analysis and sexual and reproductive rights allows participants to address the problem of incomplete abortions in a new light.

Time:

45 minutes

Materials:

Video
Discussion guide

Discussion:

Women who have decided to interrupt a pregnancy and end up with an unsafe and incomplete abortion have suffered trying experiences. Even though providers may not approve of the woman's decision or action, it is their duty to provide her with

quality care and treat her with compassion. Each woman has her own unique story, identity and situation, but they all deserve quality care.

Quality in human relationships, technical skills and institutional administration are interdependent. To better address any health issue, such as incomplete abortion, we need to work on all levels in an integrated manner.

■ **ACTIVITY 5**
EVALUATION OF THE LEARNING EXPERIENCE

Objectives:

1. Evaluate the development of knowledge and understanding among participants.
2. Appreciate the diversity of understandings and approaches generated on the basis of individual experiences and education.
3. Verify the level of motivation that has been generated to initiate the process of personal, professional and institutional change.
4. Identify advances in participants' analytical capacity and ability to develop strategies for applying gender-sensitive quality care.

Procedures:

1. Each participant, including facilitators, fills out an evaluation form without identifying themselves. Place evaluations in a box.
2. As a group, discuss the seven questions on the evaluation form, and any other questions or issues that arise. Facilitators may read and share some of the written evaluations as part of the discussion.

Time:
15 minutes

Materials:
Photocopies of evaluation sheets

BACKGROUND AND RESOURCES FOR MODULE 4

■ IPPF'S PROPOSAL FOR INSTITUTIONAL EVALUATION

IPPF developed a guide to assess the relationship between a focus on gender and improvements in quality care and management within institutions that provide sexual and reproductive health services (Cardich et al. 1998).

Recognizing the need to bring together work carried out on gender-focused quality care, IPPF organized a conference on the theme in Lima in 1995, which brought together professionals with a great deal of experience in reproductive health, women's health, human rights and gender. The objective of the conference was to develop a set of criteria for gender-sensitive quality care. On the basis of existing studies and documents, and together with the experience of those participating, the group came up with a long list of criteria. They also worked on ways to carry out institutional analysis based on these criteria and formulate recommendations and corrective measures to help institutions improve their quality and gender focus.

Proposal for evaluation and improvement
Quality care and gender sensitivity require changes in focus and in attitude within the

institution, which naturally requires political and personal commitment, dedication and time. The evaluation proposal is designed as an instrument to support and accompany this process.

The proposal includes evaluation criteria, methodological orientation, a review of existing practices and materials and the formulation of recommendations within an integrated plan that requires the participation of diverse actors within the institution and an external consultant specialized in the field.

■ CRITERIA LISTED IN THE IPPF PROPOSAL FOR EVALUATING GENDER SENSITIVITY AND QUALITY CARE

1. The existence of policies that prohibit sex discrimination in hiring, salaries, benefits and promotions.
2. The existence of policies that prohibit abuse of power and sexual harassment within the institution.
3. The existence of policies and procedures that promote the development of all staff, independent of sex.
4. Percent of users who find the service hours convenient.
5. Mechanisms that do away with the requirement of spousal consent before a woman can be treated.
6. Presence of a declaration that promotes the empowerment of women within the mission statement of the institution.
7. Mechanisms through which users' opinions can be known, including evaluation sheets and studies to evaluate user satisfaction.

8. Mechanisms to promote programmatic changes in response to users' requests, complaints and suggestions.
9. Percent of administrative positions held by women.
10. Percent of users who were addressed with respectful titles and not called by diminutive or pejorative names (little mother, dear, my child, my queen, etc.).
11. Percent of users who note that providers greeted them.
12. Percent of users who note that providers looked them in the eye during conversation.
13. Presence of educational activities in the waiting room (educational talks, videos, group discussions led by personnel).
14. Existence of sufficient number of chairs in waiting room.
15. Percent of user visits in which the provider discussed reproductive health issues, such as prevention of STDs and AIDS, breast and cervical cancer or unwanted pregnancy.
16. Percent of user visits in which the provider discussed sexual health issues, such as satisfaction with sex life, presence of sexual abuse or mistreatment, risks and ways of contracting STDs and AIDS, feelings of guilt or low self worth in sexual relations, partner's attitudes about fertility control, advantages and drawbacks of different methods.
17. Use of educational materials in provider explanations.
18. Percent of staff who feels that the workplace is equitable.
19. Percent of providers who report that they provide advice and information to users who ask about abortion.

20. Provision of Pap tests, breast exams, analysis of vaginal secretion and STD tests.
21. Percent of personnel that promote the practice of double protection, regular Pap tests and self breast exams.

■ SWOT ANALYSIS

SWOT is a tool for conceptual analysis that permits us to explore and address the underlying structural causes that generate institutional situations. It also enables an analysis of the dynamics between what goes on within and outside of an institution or program in question. In order to carry out this analysis, we need to examine the dynamics inside the institution, as well as external factors that condition institutional change. The analysis is carried out through group discussion and characterization of each of the following four elements, followed by group interpretation and analysis of the dynamic relationships across the four elements (Wolff et al. 1991).

What does SWOT mean?

S: Strengths. What strengths exist within the institution? What positive aspects, abilities, qualities make the institution in question stand out? These may include: unity and solidarity; human, technological or financial resources; good organization; threshold ideas; infrastructure or equipment, etc.

W: Weaknesses. What weak points exist within the institution and how can they be addressed? These may include: lack of knowledge; inadequate infrastructure or resources; hierarchical and non-democratic organization; etc.

O: Opportunities. What positive situations outside the institution support its growth and help it achieve its goals? These may

include: financial support; changing values and paradigms in the social context; favorable political or historical situations; innovative methods and ideas; etc.

T: Threats. What external situations threaten to impede the progress of the institution? These may include: politicization of certain aspects of the work; economic or political instability; conservative social pressure against change; conflicts concerning resources; etc.

■ DISCUSSION GUIDE VIDEO ON POSTABORTION CARE

1. How do the gender identities and relationships predominant in Bolivia influence the situation of the user in this video?
2. Considering this reality, what gender considerations need to be taken in the response and treatment of this case?
3. What role do men play in this situation (sexual partner, father, persons who help women get medical help or accompanies them to the clinic, provider)?
4. What special attention does a woman need to recover from this type of experience?
5. What does the idea of *comprehensive* sexual and reproductive health care have to do with this case?
6. What is the policy of the institution depicted in the video concerning sexual and reproductive rights of men and women?
7. What rights do women have when they suffer an incomplete, illegal abortion?
8. How can we characterize the human relationships within the institution depicted in the video? Among personnel in that institution?
9. Do these relationships have anything to do with the kind of care that is provided to the woman suffering an incomplete abortion?
10. What changes can be made by all kinds of actors within the health care center in order to provide more compassionate quality care for women who arrive needing help for incomplete abortions?

■ EVALUATION FORM

Date & Place of workshop

1. Describe an idea that developed during the training that affected you personally.
2. Comment on a concept or proposal that caused confusion, raised doubts, or that you rejected for whatever reasons.
3. What topics and methods explored in the sessions are related in some way to your own work?
4. What topics or methods have nothing to do with your work, or were irrelevant to you?
5. In which topic or method were you most interested? Why?
6. Did the workshop satisfy your expectations for learning? Why or why not?
7. What suggestions do you have to improve the workshop?

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