

# Family Planning Among Indigenous Populations In Latin America

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*Approximately 40 million people living in five Latin American countries—Bolivia, Ecuador, Guatemala, Mexico and Peru—retain the language and much of the culture of the ancient pre-Columbian civilizations of the Aztecs, Mayans and Incas. These indigenous people tend to be poor, rural residents with little education. Long an underserved population from a health care perspective, the indigenous population has also proved difficult to reach with family planning services. An examination of two promising projects—one in Guatemala and one in Bolivia—suggests several potentially useful strategies for reaching indigenous people, among them the use of community workers and traditional health practitioners to promote family planning, the provision of a mix of maternal and child health services along with family planning and the employment of bilingual and bicultural staff members.*

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Although fertility rates in Latin America have declined steadily over the past 25 years and the level of modern contraceptive use among women in union has risen (from less than 10% before 1970 to the current level of 48%),<sup>1</sup> these broad advances have been spread unevenly among ethnic and cultural groups. One segment of Latin American society relatively untouched by the contraceptive revolution is the indigenous population of the region.

No single definition of “indigenous” exists, but most agree that the indigenous people of Latin America are descendants of the pre-Columbian inhabitants of the region who retain some or all of their own social, economic, cultural and political institutions. This group is enormously varied, though, speaking hundreds of different languages and ranging from members of small, isolated forest tribes to the millions of Quechua-speaking descendants of the vast Inca empire of South America.

The lack of a standard definition makes it difficult to consistently and accurately identify indigenous people. Multiple fac-

tors unite ethnic groups, including race, culture, traditions and language.<sup>2</sup> However, factors such as adherence to traditional values and cultural identification can be difficult to measure. In Latin America, where governments do not commonly disaggregate statistical indicators by ethnicity, very little national information is available.

Data gathered in surveys and special studies often rely on easily observable indicators, such as dress and language, to identify indigenous people. These, however, are less than adequate for identifying a population in various stages of transition and acculturation. Many indigenous people living in urban areas, for example, speak Spanish and even wear Western dress, but continue to observe traditional customs and maintain strong ties with their rural communities of origin.

As can be seen in Table 1 (page 144), it has been estimated that more than 40 million of the 144 million people living in five countries in Latin America—Bolivia, Ecuador, Guatemala, Mexico, and Peru—are indigenous. The proportion indigenous in each country varies greatly, however, from 14% of Mexicans to 66% of Guatemalans and 71% of Bolivians.

These proportions, from work by Roberto Jordán Pando,<sup>3</sup> are based on an exhaustive examination of census and ethnographic sources and estimates of the number of speakers of indigenous languages. They take into account population growth and new ethnographic and linguistic information. However, other estimates of the size of the indigenous population for these five countries have been made as well; these range between 20 million and 50 million.<sup>4</sup>

Regardless of the exact numbers of indigenous people in Latin America, the size of the indigenous population is such that ignoring it would have important health, demographic and political consequences for the countries involved. Yet family planning organizations and donors have been slow to respond to the needs of this group.

Indigenous people present cultural and linguistic challenges to service providers and share the classic characteristics of a hard-to-reach population: poverty, rural residence and low educational levels. Comparisons from the Demographic and Health Surveys (DHS) show great disparities between indigenous and non-indigenous populations (see Table 2, page 145).<sup>\*</sup> For instance, infant mortality rates and child mortality rates in Bolivia, Mexico and Peru are nearly (and sometimes more than) twice as great among indigenous people as among the nonindigenous (mestizo) population. Similarly, levels of education are very much lower for indigenous women. Moreover, in Mexico and Peru, fertility rates among indigenous women are double those of nonindigenous women, and levels of contraceptive use are substantially lower.

## Barriers to Contraceptive Use

There are multiple barriers to expanded contraceptive use among indigenous people. Some stem from characteristics of indigenous people themselves; others are programmatic, and reflect the failure of the health delivery system.

### Socioeconomic and Cultural Barriers

• *Poverty and illiteracy.* Indigenous people in Latin America are more likely to live in poverty and are less likely to have a formal education than their fellow citizens.<sup>5</sup> Fur-

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<sup>\*</sup>To prepare the data shown in Table 2, we used a variety of operational definitions, including language spoken, interviewer classification based on language and appearance, and area of residence. The definition of “indigenous” is somewhat problematic in the DHS surveys undertaken to date. Only the Guatemala survey explicitly asked about the respondent’s ethnic group. For the Bolivia and Peru surveys, respondents were classified as indigenous on the basis of the language they spoke. Classification of the Mexican survey respondents as indigenous was based on their geographic location and, indirectly, on their language. For the Ecuador survey, classification was based on location.

**Table 1. Total population and percentage and number of indigenous people in five Latin American countries, 1994**

Country	Total*	Indigenous	
		%	No.*
<b>Total</b>	<b>143.8</b>	<b>29</b>	<b>40.9</b>
Bolivia	8.2	71	5.8
Ecuador	10.6	43	4.6
Guatemala	10.3	66	6.8
Mexico	91.8	14	12.9
Peru	22.9	47	10.8

\*In millions, midyear 1994. Sources: **Column 1**—see reference 1; **Column 2**—see reference 3.

ther, literacy tends to be considerably lower among indigenous women than among indigenous men, and indigenous women are more likely than men to be monolingual, speaking only their native language.<sup>6</sup>

Since both poverty and lack of education are everywhere associated with lower rates of contraceptive use, these factors undoubtedly contribute to the important gap between indigenous and nonindigenous women in knowledge about modern contraceptives (Table 2). For example, in Bolivia and Guatemala, 89% of nonindigenous women knew of at least one modern method, compared with only 43–46% of indigenous women.

• *Residence in rural areas.* Although access to family planning services is often poor in rural areas, this alone does not explain indigenous-nonindigenous differentials: In the countries included in Table 2, levels of contraceptive knowledge and use are lower among indigenous women than among their nonindigenous counterparts even when analyses are restricted to the rural population.

Other factors, such as high infant mortality and conservative values, also tend to support high fertility. Nonetheless, while rural indigenous women have more children than their nonindigenous neighbors, DHS data for four of the five countries show that the ideal family sizes given by indigenous and nonindigenous women are virtually identical.

• *Distrust of outsiders and political unrest.* Indigenous populations share a long history of social and political oppression from the predominant Spanish-speaking population. As a result, many have developed a strong suspicion of the motives of outsiders. Thus, it is not surprising that in some countries, the message of “having fewer children” has been interpreted as a ploy to reduce or eliminate the indigenous population.

In addition, indigenous people have been disproportionately the victims of political violence in recent years. Armed conflicts in

Peru and Guatemala, and more recently in Chiapas State in southern Mexico, have made it particularly difficult to continue to deliver health and family planning services to indigenous people in areas of unrest.

• *Belief systems.* Indigenous communities' dissatisfaction with health services often stems from conflicts between the traditional and “modern” health systems.<sup>7</sup> By failing to consider traditional beliefs, service providers can discourage potential clients. In addition, indigenous beliefs may indirectly limit the acceptance of family planning by fostering fatalism about childbearing. In Guatemala, for example, many believe that a woman is destined to have a certain number of children; thus, to have fewer is to “murder” those who should have been born.<sup>8</sup>

• *Religion.* Despite the Catholic Church's opposition to modern methods, contraceptive prevalence is high in several predominantly Catholic Latin American countries (Brazil, Colombia, Costa Rica and Panama, among others). However, both Catholic and fundamentalist evangelical groups have considerable influence among some indigenous populations of Latin America, and their pronatalist stance reinforces fatalism about childbearing. The Catholic Church has often directly attacked family planning services for indigenous people. In one highlands city in Peru, the archdiocese evicted an agency from its offices in a church-owned building because of its family planning activities. In Guatemala, various churches opposed an integrated program of parasite control and family planning, and the Catholic Church would not allow even the antiparasite campaign into its schools.<sup>9</sup>

• *Social disapproval.* The Ecumenical Development Foundation (FEPADE), a Bolivian nongovernmental organization working with Quechua-speaking populations, reports widespread concern among rural women considering the use of family planning that they will be criticized and ostracized when neighbors realize that they are not getting pregnant with the accustomed regularity.<sup>10</sup> Similarly, in Ecuador, the Medical Center for Counseling and Family Planning (Centro Médico de Orientación y Planificación Familiar, or CEMOPLAF) found that to shield themselves from negative comments, many women in indigenous communities preferred to receive contraceptives from the nonindigenous supervisor (who made sporadic visits to the community) rather than from the volunteer distributor (who lived in the same town).<sup>11</sup>

• *Women's status and male attitudes.* In-

igenous husbands have considerable control over their wives and play a major role in decision-making on family planning. They often oppose family planning for fear that their wives will be tempted to commit adultery.<sup>12</sup>

Also, rumors and misinformation about the health effects of certain methods make men apprehensive that their wives' physical well-being will be compromised. Men can be leery of their wives' going to clinics, for fear that if the women are unable to communicate with service providers, they may be fooled into using a potentially harmful method.

### ***Institutional Barriers***

• *Language.* Few health care workers in the service delivery systems of the five countries on which we focus in this article are bilingual, which makes for communication difficulties with monolingual indigenous clients. Clinics rarely provide interpreters. Moreover, anecdotal evidence suggests that Spanish speakers often believe that indigenous people can speak Spanish but simply are unwilling to do so. Thus, training for indigenous field workers is usually conducted in Spanish, even though the workers may comprehend little of the presentation. The language barrier also is clear in the production of information, education and communication materials: Either there are no mass media and client education materials at all in indigenous languages, or there are only poor translations of materials or messages designed for Spanish-speaking audiences.

• *Discrimination.* Indigenous clients may suffer from discrimination and disrespect, partly because of their inability to speak Spanish and partly in accordance with existing practices in the larger society. The subtle but pervasive discrimination against indigenous people in Latin America is not commonly acknowledged or discussed. When CEMOPLAF launched a special radio campaign to attract indigenous users, it found that although the number of Quichua speakers attending the agency's clinic increased slightly during the campaign, overall clinic attendance decreased. Agency staff believed one possible reason for the campaign's failure to be that the bilingual campaign discouraged use of clinic services by Spanish-speaking women.<sup>13</sup>

• *Lack of indigenous personnel in decision-making positions.* Few indigenous staff members are found in the decision-making ranks of family planning organizations in Latin America. This shortage of indigenous professionals is especially acute in Guatemala.

**Table 2. Selected health, social, fertility and family planning indicators for all women, and fertility and family planning indicators for rural women, by whether they are indigenous or nonindigenous, five Latin American countries**

Indicator	Bolivia (1994)		Ecuador (1989)		Guatemala (1987)		Mexico (1987)		Peru (1991–1992)	
	Indig.	Nonindig.	Indig.	Nonindig.	Indig.	Nonindig.	Indig.	Nonindig.	Indig.	Nonindig.
<b>ALL WOMEN</b>										
<b>Health and social</b>										
Infant mortality rate*	121.2	69.2	53.0	40.0‡	76.4	81.7	111.8	48.6	87.8	48.8
Child mortality rate†	188.5	103.7	74.0	55.0‡	135.1	112.6	139.0	61.6	127.7	69.0
% with >primary education	14.3	65.8	24.8	58.6	2.4	21.2	7.3	43.0	14.9	69.8
% whose house has indoor source of drinking water	25.8	68.3	u	u	29.6	53.0	4.4	55.2	23.3	63.4
<b>Fertility and family planning</b>										
Total fertility rate	6.5	4.4	5.2	3.8‡	6.8	5.0	7.4	3.8	7.2	3.2
% currently using a modern method§	3.0	23.9	22.2	47.6	4.5	27.9	16.6	47.2	7.6	35.6
% who know of at least one modern method§	46.1	89.2	75.1	96.5	43.4	89.1	72.3	95.1	70.6	97.2
Mean ideal no. of children§	2.4	2.5	3.2**	3.1‡,**	4.7	3.4	3.9	2.9	2.4	2.5
% who want no more children§	79.8	69.2	64.8	61.9	34.9	53.9	53.4	62.8	84.2	71.1
<b>RURAL WOMEN</b>										
<b>Fertility and family planning</b>										
Total fertility rate	6.7	6.4	5.2	4.7	7.0	6.2	7.4	6.2	7.9	5.6
% currently using a modern method§	2.8	12.6	22.2	41.5	3.0	17.6	16.6	27.2	5.2	19.3
% who know of at least one modern method§	42.6	72.4	75.1	91.7	39.3	89.3	72.3	84.0	79.6	95.4
Mean ideal no. of children§	2.4	2.6	3.2**	3.5**	5.0	3.8	3.9	3.7	2.5	2.8
% who want no more children§	80.7	69.5	64.8	62.4	32.1	47.7	53.4	57.1	84.7	74.0

\*Per 1,000 live births, for all children younger than age one. †Per 1,000 live births, for all children younger than age five. ‡National total, including indigenous population. §Among married women of reproductive age. \*\*Data from 1987 survey. Sources: **Bolivia**—see reference 19; and further analyses of DHS data. **Ecuador**—Centro de Estudios de Población y Paternidad Responsable and Centers for Disease Control (CDC), *Ecuador: Encuesta Demográfica y de Salud Materna e Infantil 1989*, Quito, Ecuador, 1990; CDC, *Ecuador: Family Planning and Child Survival Survey 1989—Final English Language Report*, Atlanta, Ga., USA, 1992; and further analyses of DHS data. **Guatemala**—see reference 25. **Mexico**—IRD/Macro Systems and Secretaría de Salud Subsecretaría de Servicios de Salud Dirección General de Planificación Familiar, *Mexico: Encuesta Nacional sobre Fecundidad y Salud 1987*, Columbia, Md., USA, and Mexico City, 1989; and further analyses of DHS data. (Respondents from the rural areas of the states of Campeche, Chiapas, Hidalgo, Oaxaca, Puebla, Quintana Roo and Yucatan were classified as indigenous.) **Peru**—Instituto Nacional de Estadística e Informática, Asociación Benéfica PRISMA and Macro International, *Peru: Encuesta Demográfica y de Salud Familiar 1991/1992*, Lima, Peru, and Columbia, Md., USA, 1992; and further analyses of DHS data.

In the Andes, many nonindigenous people speak Quechua, but in Guatemala few are fluent in Mayan languages. This lack of indigenous staff members reinforces the perception that family planning is only for Spanish-speakers.

•*Unrealistic donor expectations.* The pressure to achieve numerical goals within a short time frame is one reason why programs for indigenous people do not get started. The heavy initial investment in information, education and communication activities, the high transport and supervision costs associated with rural programs, and the relatively small number of acceptors that programs for indigenous people will generate initially act as a deterrent to cost-conscious donors.

Urban programs typically draw from an educated pool of potential clients, many of whom have already used a method. In rural programs that target indigenous people, a large majority of clients are typically first-time users. One study found that only 10% of indigenous women obtaining a method from a community-based distributor had used one before, compared with 50% of clinic users in a nearby town. Using the traditional measure of cost per new program acceptor, the community-based distribution program came out more than twice as costly as the clinic (\$18.85 per

new community-based distribution acceptor versus \$8.01 per new clinic acceptor). When, however, the cost per first-time family planning acceptor was examined, the cost gap was significantly decreased (\$21.02 per first-time community-based distribution acceptor versus \$16.09 per first-time clinic acceptor).<sup>14</sup>

## Case Studies

### *Family Planning in El Quiché*

Estimates of the size of the indigenous population of Guatemala (a country of just over 10 million people) range between 4.3 million and 7.0 million. Descendants of the Mayan empire, which broke up before the Spanish conquest, the indigenous people of Guatemala live primarily as subsistence farmers in the highlands, and many migrate seasonally to work on coastal plantations. Because they speak more than 20 languages, serious communications obstacles exist. The principal providers of family planning services are the Ministry of Health and the Guatemalan Family Planning Association (Asociación Pro-Bienestar de la Familia de Guatemala, or APROFAM).

El Quiché, a Guatemalan *departamento* (or state), is particularly useful for the study of family planning acceptance, given that both a qualitative study (based on focus groups and in-depth interviews)

and a quantitative survey of a representative sample of women of reproductive age have been conducted there. Results of the qualitative research (conducted in 1990) have been reported elsewhere.<sup>15</sup> Results of the 1992 quantitative study<sup>16</sup> largely confirm the findings of the qualitative study; together, these studies provide useful insights on the perspectives of Quiché-speaking women regarding birthspacing and contraceptive use.

The quantitative study was limited to eight small towns in El Quiché that were relatively accessible and politically stable. Two-stage sampling was used. The first stage consisted of listing all segments for the eight areas (based on 1984 census data) and subdividing these into 113 sectors, of which 34 were randomly selected. In the second stage, all households in each selected sector were mapped, and 30 were randomly selected for interview. One woman per household was interviewed. The interviewing team consisted of one supervisor and four Mayan interviewers (all of them bilingual and bicultural) who had assisted in improving the Quiché translation and then had pretested the questionnaire in the field. All interviewing was carried out between May 1992 and August 1992; the response rate was 95%. (Further details on the methodology

of the study are available elsewhere.<sup>17)</sup>

•*Socioeconomic characteristics.* Only women in union who were of reproductive age (aged 15–49) were included, since they (and their husbands) were the target population for the intervention to follow.\* Of this group of 846 women, 20% participated in some type of activity that allowed them to earn money. Forty-one percent reported themselves to be Catholic, 21% were evangelical, 20% practiced traditional religions and 18% had no religion. More than two-thirds (71%) had never attended school, while 29% had achieved some level of primary education and fewer than 1% had gone beyond a primary schooling. Three-quarters (75%) of the women were unable to read, compared with 48% of their husbands.

Only 12% of the population had electricity, 12% had a bicycle and fewer than 10% had access to any other mode of transportation. Access to mass communication was likewise limited: Only 9% owned a television, and 7% said they watched at least once a day; 8% reported reading a newspaper at least once a week. More than one-half (60%) owned a radio, although only 46% reported listening to it at least once a day.

•*Birth history.* The fertility data showed that these women were of high parity, with almost all (95%) having ever given birth. Women at the end of their reproductive period had had a mean of 8.3 live births, although only 6.6 children were still living. (More than one-third of women with at least one live birth had experienced the death of a child.)

•*Birthspacing and ideal family size.* How receptive was this population to the concept of birthspacing?<sup>†</sup> Only 43% said they considered birthspacing to be “good,” while 31% classified it as “bad” and 26% did not know. Eighty percent of those favoring birthspacing cited reasons related to the health and care of the child; fewer than 5%

\*We included men in the focus-group research to learn more about their perspective on birthspacing and contraceptive use; however, because of limitations on financial resources and time, they were not included in the quantitative research.

†The question on the survey (translated from Quiché to Spanish to English) was “Do you think it is good to use a method or to do something to space your pregnancies?”

‡Since there was a two-year interval between the two studies, one possible explanation for this difference is greater exposure to family planning during the intervening period.

§The question on the survey (translated from Quiché to Spanish to English) was “Do you believe that it is a good or bad idea that the schools give classes to children about the changes in their bodies when they reach adolescence, and other topics?”

of the women cited economic reasons.

The concept of ideal family size appeared foreign to the majority of respondents. The most common answer to this question was “don’t know” (39%), followed by “God’s will” (32%). Among those who gave a specific numerical answer, the ideal was 5.0 children, slightly lower than the mean number of surviving children among women who had completed their reproductive period.

However, several findings suggested the potential need for birthspacing in this population. Among women who had given birth, only 15% reported that they had wanted the last birth at that time, while 78% claimed that they would have preferred to have the baby at a later time. Of the 123 women who were pregnant at the time of the interview, 19% said they were not happy about being pregnant. Similarly, among nonpregnant respondents, 49% reported that they would not be happy to become pregnant in the immediate future. Finally, 23% indicated that they did not want to have any more children in the future, and another 23% were unsure. Few, however, said that they would consider becoming sterilized (6%).

•*Traditional methods vs. modern methods.* One interesting discrepancy between the qualitative study and the quantitative survey was the relative acceptance of traditional and modern methods. Focus-group results indicated widespread rejection of modern methods; the only “opening” seemed to be in terms of natural family planning. However, when questioned individually in the privacy of their homes, respondents were more likely to report knowing of, having used or currently using a modern method than a traditional method.<sup>‡</sup> Moreover, only 5% of respondents could correctly identify the fertile period in a woman’s menstrual cycle.

In comparison with contraceptive prevalence for Latin America as a whole (58%) or for Guatemala as a whole (23%), however, current use in this population was low: Only 4% used modern contraceptives, and 1% used traditional methods. Among those not practicing contraception, 57% had no interest in ever doing so. More than one-half of the nonusers who would consider using a method in the future had no idea what method they might want to use; the others most frequently mentioned the pill, the injectable or female sterilization.

•*Exposure to mass media messages.* This population had a minimal amount of exposure to messages about birthspacing via the mass media or interpersonal channels. Fewer than one-quarter (22%) had heard

or seen a message in any of seven media that they were asked about; almost all of these said they had heard a radio message. However, the most often cited station was Radio Quiché, a Church-run station that strongly opposes family planning.

•*Openness to family planning messages.* What prospects are there for diffusing messages on birthspacing in the future? Possibly reflecting a courtesy bias, more than one-half of all respondents said they would approve of receiving or would agree to receive messages on birthspacing. Almost all (90%) reported that they would like to have a home visit to discuss the health of their children, although this proportion dropped to 60% if the topic of the home visit was birthspacing. Two-thirds (67%) were open to receiving information on natural methods of birthspacing, but slightly fewer (53%) were interested in information on modern methods. Surprisingly, close to three-quarters (72%) approved of sex education for adolescents.<sup>§</sup>

•*Use of modern health services.* Just over one-half (57%) of the women surveyed had ever visited one of the area’s 19 health centers or 57 health posts. Four percent had visited APROFAM’s clinic in the region, and 1% had heard of an APROFAM community-based distributor.

In summary, the results of the 1992 survey in El Quiché indicated a marked lack of acceptance of modern contraceptive methods and a fair degree of ambivalence toward the concept of birthspacing. There were signs of a latent demand for birthspacing, however, and a minority of respondents in fact wanted no more children. The majority said they were willing to receive more information on birthspacing or family planning, but these topics were of less interest than their children’s health.

Although this information is by no means representative of the larger Mayan population in Guatemala, it nonetheless reflects in concrete terms the nature of the challenge to those interested in promoting family planning and birthspacing to the indigenous sector of the population.

The project in El Quiché was one of the first attempts to systematically evaluate the impact of a specific intervention on population-based outcomes (attitudes toward birthspacing, knowledge of contraceptive methods, contraceptive use and related variables) in an indigenous area. The intervention, consisting of 15 actions, was designed to increase women’s access to contraceptive services, improve the quality of services (especially with respect to the treatment of Mayan clients) and improve the image of the program (in part

by emphasizing reproductive health and birthspacing rather than family planning). This multifaceted intervention became operational in mid-1993, with a follow-up evaluation scheduled for 1996. It will constitute an important step in determining whether improvements in the family planning service environment produce population-based effects.

### *Indigenous Health Workers in Bolivia*

The great majority of the 5–6 million indigenous people in Bolivia are Quechua-speaking or Aymara-speaking descendants of the pre-Columbian civilizations of the Andes. Concentrated in the highlands, they have worked as miners since colonial times and have survived as subsistence farmers in semiarid high plains and mountain valleys. Like most rural Bolivians, they have little access to family planning information or services. (Bolivia only recently began offering public family planning services, and the availability of such services outside major urban centers continues to be limited.)

A recent evaluation provided an in-depth look at the experience of the Bolivian non-governmental organization FEPADE with training indigenous community health workers in family planning service provision.<sup>18</sup> (FEPADE is a rural community development organization with educational and technical assistance programs in health, agriculture and community development.) Most of the 60 Quechua-speaking villages served by FEPADE in the department of Cochabamba are isolated rural communities. Families depend on subsistence agriculture, although some supplement their income with seasonal work in the cities or in coca-growing regions.

Between 1985 and 1993, with help from training projects operated by Development Associates and funded by the U. S. Agency for International Development, FEPADE trained roughly 250 community health workers in family planning promotion and service provision. Four nurse-auxiliaries based in the field and two doctors who visited the communities on a monthly basis complemented and supported the work of the community health workers.

Community health workers were either health promoters or traditional providers such as *curanderos* (traditional healers) and *parteros* (traditional birth attendants). Both types of community health workers, who were residents of the communities in which they worked, promoted family planning, distributed methods (pills and condoms), referred users for IUD insertion and carried out primary health care activities. Promot-

ers were chosen by their community leaders and had a more formal relation with the agency than did the *curanderos* and *parteros*. Based at small health posts, they received a monthly stipend of \$6 and were expected to work half-time for FEPADE, promoting health and family planning through home visits and group talks.

Four nurses, two physicians and two educators from FEPADE, all Quechua-speaking, were trained in qualitative research techniques at the start of the study. Between September 1992 and April 1993, FEPADE staff members conducted in-depth interviews with 42 community workers, 19 family planning clients and 12 community leaders. Thirteen focus groups were conducted, each with 8–12 participants. Eight of the focus groups were with community members, four were with community health workers and one was with FEPADE's field educators and agricultural technicians. FEPADE nurses also accompanied community workers on 31 home visits, scoring their performance according to a rating form. In addition, FEPADE nurses and physicians tested community worker knowledge by role-playing simulated client cases with 23 of the community workers.

• *Characteristics of community health workers.* Of 25 health promoters and 17 traditional health providers interviewed, 64% were male. All health promoters were 17–35 years of age, while three-quarters of the *curanderos* and *parteros* were older than 35. All community health workers were Quechua speakers, and most had limited Spanish ability. (Sixty-nine percent spoke little or no Spanish.) Eighty-five percent of community health workers had a primary schooling or less.

• *Recruitment of indigenous family planning acceptors.* Over a five-year period, the program recruited or referred 631 family planning acceptors, about 32% of married women of reproductive age in the 60 communities. Of these women, 37% chose the IUD, 32% the pill, 6% the condom and 25% traditional methods. Although these numbers cannot be construed as a prevalence rate, a comparison with the national rate among rural indigenous women (26% overall, 3% modern methods and 23% traditional methods) clearly shows the impact of FEPADE's program. The program may owe part of its success to the high level of contraceptive use among the mar-

ried community health workers: Fifty-eight percent of promoters used a method (17% modern and 41% traditional), as did 38% of *curanderos* and *parteros* (23% modern and 15% traditional).

• *Provision of information to clients.* Using the scored observational home visits (with the promoters) and the scored role-plays (with all community health workers), FEPADE found that community health workers correctly transmitted the most important basic facts about family planning. Interviews with users confirmed the quality of the information provided by FEPADE community health workers. Among surveyed pill users who had forgotten to take the pill one day, all knew how to correct for their mistake; furthermore, all were taking the pill at a fixed time of day.

• *Family planning promotion.* Despite the receptivity to family planning that commu-

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nity members showed in focus groups and the acceptance evident from the user data, community health workers indicated that promoting family planning in these communities was not easy. Responding to a question about how they were received, one community health worker said that "the community accepts us as health promoters, but when it comes to family planning, some listen and others reject us." Promoters said that they feel good when people listen to them talk about family planning and show interest, but feel "bad when they are indifferent." One said, "When they reject me, I no longer want to educate."

• *Role of traditional health workers.* *Curanderos* and *parteros* did little in the way of direct distribution or client referral, mainly because of lack of contact with clients. In these communities, most traditional birth attendants are male community leaders who are called upon only if family members need help with a delivery; they have no prenatal or postnatal role with their clients. According to the DHS, *parteros* attend only 13% of births in rural Bolivia; the majority of births (58%) are assisted by family members.<sup>19</sup>

However, focus-group data show that some *parteros* take advantage of client

contacts to promote family planning. One traditional birth attendant explained that when she goes to a client's home to assist in a birth, she tells the woman, "now that you have a lot of children, even if it's only two, you can plan your family so as to not have children one after the other, and you should go talk to the nurse about it." Nevertheless, when community members were asked "Who should be providing information about family planning in the community?" no group mentioned the traditional health providers. Rather, they insisted that "the person be well-trained and prepared." The health worker named most often was the doctor, but community members also indicated that "the nurse should explain and help us understand" or that "promoters who know a lot should teach the community."

• *Opportunities and barriers.* Interviews and focus groups revealed opportunities for family planning acceptance as well. Community members almost universally recognized the difficulty of maintaining a large family, commenting that parents with many children must work harder yet still cannot earn enough to feed, clothe and educate all of their children. Neither can they assure their children's future, as there is not enough land to divide among many.

Focus-group participants also agreed that for the mother's health and the children's well-being, women should wait 2–4 years between births. One woman observed that in 2–3 years, "the mother can recover," while another pointed out that with a 3–4-year interval, "there are no more problems in taking care of the kids." A man observed that "when the children come one after another, our women get old faster."

Although participants in the focus groups generally recognized that family planning is a way of avoiding closely spaced births or controlling family size, a lack of knowledge of methods was plain, and myths and rumors were prevalent. FEPADE staff, community health workers, community members and users repeatedly mentioned lack of knowledge and ignorance as important obstacles to greater use of contraceptives. One community health worker said that "there is a lot of ignorance, and since this is so new for them, it is difficult for the farmer to understand."

Another factor, fear of side effects, was evident: "They [methods] cause stomachaches and headaches"; "when women using contraception drink *chicha* [an alcoholic beverage common in the Andes], it's bad for them and can cause hemorrhage"; and "the women get skinny and their backs begin to hurt." Fear of medical

examination and shame at being observed by the doctor were also mentioned.

Other important barriers identified were religious opposition, opposition by spouses and fear of ostracism by friends and neighbors. One woman commented that "the evangelicals say that contraceptive methods should not be used, only natural methods." One man said, "It's a sin, since in the Bible it says that it is a sin," while another stated that "women became adulterous." A community health worker noted that "the woman always says, 'What will my husband say?' while the man says, 'It depends on her.'" Despite the opinions expressed, one-half of the focus groups agreed that the couple, not just the husband, should decide about family planning.

• *Recommendations for FEPADE.* Community members recommended that FEPADE health workers give more talks to community groups and make more home visits to couples, "with the promoter accompanied by the auxiliary nurse so that the conversation will be more valued and respected." Others recommended "speaking more frequently, until they understand well," and "paying no attention to the people who say bad things" about family planning. FEPADE staff members believe that increased and improved training of the agency's agriculture and education workers in family planning will boost community health workers' confidence in family planning promotion and distribution. They hope that these improvements will translate into more and better-informed family planning acceptors.

### Reaching Indigenous People

Both the FEPADE experience and the findings in El Quiché demonstrate that despite the difficulties of reaching large, underserved populations of indigenous people in Latin America, attempts to provide family planning services to such populations in recent years have been relatively successful. However, these have been small, experimental programs run by non-governmental organizations; a larger effort involving public-sector providers will be required in the long run. On the basis of the experience accumulated to date, however, there are several ways in which agencies can design better programs.

Like APROFAM and FEPADE, most programs in the region use community workers as a cost-effective way of reaching indigenous communities. As community members (and often having been chosen by their community leaders), they enjoy a high level of trust. In an operations research project conducted between 1986 and 1989,

Ecuador's CEMOPLAF tested service delivery strategies using community volunteers in 85 rural, Quichua-speaking communities. In a little more than two years, the agency recruited 1,475 family planning acceptors, or about 16% of married women of reproductive age in the communities.<sup>20</sup> Since the pilot experience, CEMOPLAF's indigenous program has continued to grow, and it now covers five provinces. In 1993, the agency recruited 7,600 indigenous family planning acceptors.<sup>21</sup>

One disadvantage to using community workers is their high turnover rate.<sup>22</sup> Another, specific to indigenous programs, is the need to provide training in the workers' native language, using techniques appropriate for adult nonreaders. A scarcity of bilingual trainers skilled in participatory teaching methodology can be an initial stumbling block for some agencies. In recognition of this obstacle, Development Associates and APROFAM developed a manual of training exercises for nonliterate community workers that has been used to train in Quechua and Aymara in Bolivia and in Mayan languages in Guatemala.<sup>23</sup>

Whether indigenous communities will accept family planning services not accompanied by related maternal and child health services has been frequently debated. Nongovernmental providers of family planning services may recognize the multiple needs of indigenous communities but lack the resources needed to provide interventions other than family planning. An early APROFAM effort to offer primary health care through trained indigenous promoters was dropped, in part because of the very high cost per acceptor.

Most program managers nonetheless believe that a mix of services helps attract indigenous clients and facilitates their acceptance of family planning. FEPADE's initial approach to integrating family planning into its ongoing primary health care effort combined nutrition education and breastfeeding promotion with education on the benefits of birthspacing.

Staffing a program with bilingual or bicultural personnel eliminates the language barrier in reaching indigenous people. However, this is more easily accomplished in the Andes (where there are only one or two common indigenous languages) than in Guatemala (where there are 23). Further, educational levels are higher among indigenous people in the Andean countries. For example, indigenous people in Guatemala average 1.3 years of schooling, compared with a mean of 5.5 years in Bolivia.<sup>24</sup> Thus, in Bolivia, where almost one-half of the population is bilingual, many

health care professionals and service delivery workers are fluent in both Spanish and an indigenous language. This is rarely the case in Guatemala.

Regardless of the setting, though, simply hiring bilingual or bicultural staff may not guarantee heightened sensitivity to indigenous issues. Urban bilingual staff members in particular may reject much of their native culture and share many of the stereotypes of their nonindigenous colleagues. Sensing this, people in rural indigenous communities may view such individuals with suspicion.

Reaching indigenous people through traditional health practitioners is an attractive concept, and agencies have attempted to utilize these providers to bridge the gap between cultures, with varying degrees of success. The FEPADE evaluation demonstrated the importance of examining the role that these practitioners play in the community prior to launching a major programmatic effort: In Bolivia, only a small proportion of deliveries are supervised by traditional birth attendants. By contrast, traditional practitioners attend 60% of all deliveries in Guatemala, including 78% of deliveries among indigenous women.<sup>25</sup>

Program managers agree that any strategy targeting indigenous people must incorporate members of indigenous communities into program design, implementation and evaluation. APROFAM, FEPADE and institutions in Ecuador and Peru have educated and trained indigenous community leaders in family planning and reproductive health; these leaders have then provided advice on program implementation and have helped to promote program activities. In Ecuador, community leaders trained by CEMOPLAF laid out an action plan for implementation on their return to their communities. In Bolivia, FEPADE trained campesino union leaders and members. Communities also donated space, furniture and equipment to programs. A common failing of work with leaders was insufficient program follow-up, with the result that the leader lost enthusiasm for program promotion.

Although many family planning organizations typically target women, in indigenous communities it is important to involve men. Thus, some agencies recruit male community workers; about 50% of CEMOPLAF's volunteer community workers are men, as are most of FEPADE's promoters.<sup>26</sup> An advantage is their ability to approach men regarding issues that may be considered delicate and that a female promoter might be embarrassed to discuss. On the other hand, they may be

less successful in reaching women; thus, some agencies have recruited husband-wife promoter teams. FEPADE experimented with this approach, only to find that couples visited by the promoter teams were embarrassed to have such sensitive topics raised in mixed company.

Meanwhile, indigenous men often accompany their wives to clinics, especially when clinic staff members are not bilingual. Since the men usually speak more Spanish than their wives, they act as interpreters and advocates. Involving indigenous men in clinic visits offers an excellent opportunity for educating them regarding family planning and other health interventions.

Finally, some agencies have been able to accommodate the concerns of religious and political leaders by contacting them early in the program development process and by providing them with adequate information about the program and the institution. Agencies have also involved political and religious leaders in program planning and in town meetings to discuss activities. Even where local leaders remain opposed to family planning, agencies observe that their public attacks serve as free advertising and spur latent community demand for services.

Agencies have also learned that the political structure of indigenous communities can be complicated and difficult to navigate. Often, dual sets of authorities exist—traditional and modern. Dealing with this structure becomes a complex and time-consuming task for family planning agencies. However, religious and political barriers can be surmounted. As one Peruvian agency, commenting on its successful pilot program, noted: "We demonstrated that the indigenous population agrees to and shows its need for family planning. Therefore, the myth—manipulated by sociologists, the Church and political authorities—that the Andean villager rejects family planning has been shattered. Now what is needed is an aggressive expansion of family planning services for the indigenous population."<sup>27</sup>

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### Resumen

*Aproximadamente uno de cada tres residentes de cinco países latinoamericanos—Bolivia, Ecuador, Guatemala, México y Perú—son descendientes de los habitantes precolombinos de la región. Estos pueblos indígenas, que frecuentemente tienen su propio idioma, vestimenta y costumbres, generalmente son pobres, poco instruidos y residentes de zonas rurales. Como resultado de ello, los programas de planificación familiar que se llevan a cabo en esta región no siempre tienen éxito en el suministro de servicios. El examen de dos promisorios proyectos—uno en Guatemala y el otro en Bolivia—sugiere varias estrategias potencialmente útiles para alcanzar a estos pueblos indígenas entre—ellas, el uso de trabajadores comunitarios y de practicantes de salud tradicionales para promover la planificación familiar, el suministro de servicios mixtos de salud materno-infantil junto con la planificación familiar y el empleo de personal bilingüe y bicultural.*

### Résumé

*Près d'un résident sur trois dans cinq pays d'Amérique latine—Bolivie, Equateur, Guatemala, Mexique et Pérou—descendent des habitants précolombiens de la région. En*

*règle générale, ces autochtones, qui possèdent souvent leurs propres langues, habillement et coutumes, sont des résidents pauvres et relativement non instruits des zones rurales. Il s'ensuit que les programmes de planning familial de la région n'ont pas toujours réussi à leur fournir des services. Une étude de deux projets prometteurs—un au Guatemala et l'autre en Bolivie—suggère plusieurs stratégies qui pourraient s'avérer utiles pour venir en aide à la population autochtone, dont l'utilisation de travailleurs communautaires et de guérisseurs traditionnels pour promouvoir le planning familial, la prestation d'un mélange de services de santé maternelle et infantile ainsi que de planning familial, et l'embauche de travailleurs bilingues et biculturels.*