

Sexual and Reproductive Rights and Health: Perceptions, Problems, and Priorities Identified by Asháninka Women of Peru's Río Ene Region

Giovanna Cavero Mogollón with Astrid Bant Haver, December 2003



Background: ACPC and the Asháninka

Balancing the dual goals of conservation and development, the Association for the Conservation of Cutivireni Heritage (ACPC) is dedicated to protecting the natural homelands and maintaining the cultural heritage of the Asháninka people. With ancestral lands ranging across the forests of Junin, Pasco, Huanuco, and Ucayali, the Asháninka are the largest indigenous group of the Peruvian Amazon.

ACPC has been active in Asháninka communities for over 15 years, maintaining a consistent presence throughout years of violence, territorial encroachment, and social unrest. The consistency of this presence has built a foundation of trust between the organization and the communities it serves, enabling ACPC to broaden its work into areas of higher cultural sensitivity. Recognizing the central role that Asháninka women can play in rebuilding and strengthening their communities, ACPC recently launched a women's program with three main areas of focus: income generation and the sale of traditional crafts; strengthening community-based organizations, which are disproportionately female; and reproductive health.

ACPC developed the reproductive health program with sustained technical guidance from IWHC, basing its preliminary research on a self-assessment methodology developed by IWHC colleagues Movimiento Manuela Ramos in the 1990s. The methodology, known as "autodiagnósticos," uses games and group exercises to help indigenous women analyze their lives, identify their health needs, and reflect on the health care they receive. It has proven successful in empowering extremely poor indigenous women in the Andean and Amazonian regions of Peru, and has since been adopted by other Latin American organizations as the regional model for bottom-up social research.

ACPC first approached IWHC in 2002 for help in designing its reproductive health program around this approach. The Association had been inspired by *Genero y Salud Reproductiva: Escuchando a las Mujeres de San Martín y Ucayali* (Gender and Reproductive Health: Listening to the Women of San Martín and Ucayali), a publication co-authored by Angélica Motta and Astrid Bant, former Senior Program Officer for IWHC's Latin America Program. In 2002, IWHC funded a participatory study to determine future work and raise broader awareness about indigenous women's sexual and reproductive health needs. Throughout the process, IWHC worked to ensure that ACPC conducted its research with sensitivity to gender, and that the Association's priorities were guided by Asháninka women's concerns, needs, and rights.

Given their knowledge of local priorities and dynamics, as well as their history of balancing the desire for cultural preservation with the need for sustainable development among the Asháninka, ACPC was naturally suited to carrying out such a project, and the workshops were a great success. Based on their results, ACPC is now coordinating a concerted effort between the community and the local health system to address the cultural, linguistic, and gender gaps that prevent Asháninka women from realizing their right to sexual and reproductive health. The Association is collaborating with local women on community-level projects and advocacy efforts to address women's health needs, training local women who speak Asháninka and Spanish to serve as community health promoters, and leading efforts to ensure that local health providers—

who are primarily Spanish-speaking men—approach their work with cultural and gender sensitivity. A summary of the workshop follows.

Sexual and Reproductive Rights and Health: Perceptions, Problems, and Priorities Identified by Asháninka Women of Peru's Río Ene Region *

The Association for the Conservation of Cutivireni Heritage (ACPC) has been working with the Asháninka communities of the Río Tambo district of the Peruvian Amazon since 1987. As part of its larger women's program, ACPC's reproductive health program aims to improve Asháninka women's health using a culturally sensitive, human rights approach. Basing their work on the philosophy that women must recognize their fundamental right to adequate health before they can live truly healthy and productive lives, the program's goal is to reconcile Asháninka women's health needs with the principles that structure their natural and social environments.

ACPC launched its reproductive health program in 2002 with a participatory research project supported by IWHC. The results of this project are discussed in detail in the full report, entitled "Salud y Derechos Sexuales y Reproductivos: Percepciones, Problemas y Prioridades Definidos por Mujeres Asháninkas del Río Ene" ("Sexual and Reproductive Rights and Health: Perceptions, Problems and Priorities defined by Asháninka women of the Río Ene"). A link to the full report (in Spanish), as well as a Spanish version of this executive summary, are available at the links below.

Recognizing the significance of the knowledge gleaned from the project, ACPC was motivated to share their findings with a broader audience. It is ACPC's hope that their experience with Asháninka women will serve both as a model for future work with indigenous populations on sexual and reproductive health, as well as proof that such work need not undermine or disrespect traditional beliefs and practices related to health.

Following is a brief description of the research methodology, the results obtained, and a list of preliminary actions to improve indigenous women's reproductive health and protect their rights, based on the knowledge gleaned from the women of Río Ene:

Objective

The principal objective of the research was (1) to identify and analyze Asháninka women's health practices and priority concerns and (2) to use the knowledge obtained to develop and implement local projects and initiatives aimed at improving women's reproductive health.

Workshop Structure

A total of 107 women between the ages of 12 and 55 from four Asháninka communities (Cutivireni, Camantavishi, Quempiri, and Anexo Yotayo) participated in the two-day research workshop. First, participants retraced their personal life histories to gain insight into their own reproductive life cycles and gender identities. Through the information shared, workshop leaders were able to determine how the participants understood broader concepts such as health, illness, and wellbeing.

To determine the women's most pressing health needs, workshop leaders showed overheads with illustrations of health-related issues (for example, early pregnancy, hemorrhaging, and vaginal infections) and asked the participants to prioritize them by vote. Using a "tree of causes and

* Adapted from the Spanish executive summary of the full study.

consequences,” workshop leaders then determined women’s depth of knowledge about these health issues: their causes, consequences, and potential solutions, as well as what resources were available for addressing them.

Summary of Results

The Asháninka understand wellbeing as the maintenance of equilibrium between the community and its surroundings, encompassing the individual’s relationship to family members, the community, and the natural environment. Illnesses are understood as physical manifestations of a disruption in the spiritual and supernatural forces that maintain this equilibrium. Recovering from illness is understood not only as an end in itself, but also as a means of reestablishing this equilibrium.

The phases of a woman’s reproductive life cycle are based in ritual and myth, with great significance placed on the transition from childhood to young adulthood. The Asháninka mark this transition with a series of initiation rites that recognize not only physical changes in the woman, but also the expectation that she will now assume a new set of roles and responsibilities within the community. The average age of marriage for women is between 15 and 19, but it is not uncommon for girls as young as 12 to be married shortly following their first menstrual cycle. Considering that many of the health problems identified by Asháninka women result from early sexual activity, and that 48 percent of the Asháninka population is under the age of 15, a clear need exists to educate adolescents about the intertwining themes of health, sexuality, and gender.

When asked to identify their most pressing health concerns, women mentioned early marriage and pregnancy, sexual violence (including marital rape), high number of children, and internal pains and hemorrhaging. Among the Asháninka, women’s sexuality is understood in terms of men’s needs and expectations. Women “please” men and provide them with children for fear that if they fail to do so, they will be abandoned. Women put their desired number of children at 4 or 5, but given difficulties associated with contraception and men’s desire for large families, the average number of children per woman is 7 or 8. Women acknowledge that children constitute a valuable extra labor force for the family and the community, but they also recognize that having so many pregnancies does not allow for an adequate standard of health and nutrition within the family. They also point out that frequent pregnancy and childbearing accelerates the deterioration of their own health.

Violence against women is both physical and psychological, a by-product of the power imbalance in married couples. Men decide how many children women will have and often coerce women into sexual relations or accuse them of infidelity if they resist sexual advances. Women internalize this behavior as legitimate given their subordinated roles in the social structure of the communities.

Although women have access to a range of modern contraceptives, they avoid them, fearing adverse health effects and opting instead to use traditional methods of contraception based on medicinal herbs and plants. The community suffers from a marked lack of information about the variety of contraceptive methods available, their side effects, and their appropriate use. The women use the public health system as a last resort, primarily because they are not accustomed to being examined and often feel ashamed. Other reasons include language and cultural barriers with local medical staff, who are primarily Spanish-speaking and male, and the high cost of prescription drugs.

Future Actions

These findings indicate a clear need for investments in Asháninka women's health at both the community and policy level, and IWHC is supporting preliminary programs and initiatives designed by ACPC in response to this need. As a first step, women from within the communities who speak both Asháninka and Spanish will be trained to be sexual and reproductive health promoters, and organized to plan and execute small-scale projects and local initiatives. Based in Asháninka villages and intimately aware of their community's health need and concerns, these health promoters will help to bridge the linguistic and cultural gaps between Asháninka women and local service providers, who are primarily Spanish-speaking and male. They will also be in an ideal position to advocate for Asháninka women at the local policy level.

In order to raise awareness of indigenous women's perspectives on their own sexual and reproductive health needs, ACPC will share their research findings with local health providers and decisions makers. It is ACPC's hope that this increased awareness, combined with pressure from Asháninka health promoters, will help generate the necessary political will among decision makers to design programs and policies that are sensitive to gender and culture, and informed by women's own perspectives on their health.

To read a Spanish version of this Executive Summary, please visit <http://www.geocities.com/acpcweb/prmujer.htm>.

To read the full report in Spanish, please visit <http://www.geocities.com/acpcweb/salud.htm>.