

Evaluation of Community Education Interventions  
in Sexual and Reproductive Health Services  
in Urban-Marginal Areas of La Paz, Bolivia

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**CIDEM**



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## SUMMARY

The purpose of this study was to strengthen community strategies to improve quality of care services first implemented as part of a Ministry of Health and Prevention (MSPS) and World Health Organization (WHO) project in 1997-98. That intervention focused on health facilities, and the accompanying community interventions were found to be insufficient. Groups that do not regularly attend health facilities, such as adolescents, men, and women with older or no children, remained out of reach. To reach these target audiences and improve community demand for services, CIDEM implemented a community education intervention focusing on sexual and reproductive health and rights. Research was carried out in public health centers of urban and marginalized rural areas in La Paz.

CIDEM collected both qualitative and quantitative data for this study with a quasi-experimental design. Four health centers were selected, with two assigned to receive the intervention and two monitored as control sites. All four centers previously participated in the MSPS/WHO quality improvement program.

A baseline analysis was conducted during the first phase of the project. Using this information, researchers designed and implemented educational community strategies and interventions in the health service centers. They also developed information, education, and communication (IEC) materials to support the educational sessions and the orientation activities in the health centers. After 15 months, staff conducted a post-intervention impact evaluation. Informed consent was obtained from all participants.

Results showed that the interventions improved access to and utilization of sexual and reproductive health services among men, women, and adolescents. They also increased beneficiaries' reproductive health knowledge, and improved client attitudes and satisfaction with services. Researchers found that efforts to increase knowledge of and demand for reproductive health services must be accompanied by service strengthening measures.

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## ACRONYMS

CIDEM	Centro de Información y Desarrollo de la Mujer (Center for Information and Development of Women)
ENDSA	Encuesta Nacional de Demografía y Salud (National Demographic and Health Survey)
FGD	Focus group discussion
HC	Health center
HCPB	Historia Clínica Perinatal Base (basic perinatal history form)
IEC	Information, education, and communication
INE	Instituto Nacional de Estadística (National Institute of Statistics)
IUD	Intrauterine contraceptive device
MSPS	Ministerio de Salud y Previsión Social (Ministry of Health and Prevention)
NGO	Non-governmental organization
PAHO	Pan-American Health Organization
SEDES	Servicio Departamental de Salud (Departmental Health Service)
SNIS	Sistema Nacional de Información en Salud (National Health Information System)
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infection
WHO	World Health Organization

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## I. BACKGROUND

This research project was carried out by the Centro de Información y Desarrollo de la Mujer (CIDEM) with financial support from the Frontiers in Reproductive Health (FRONTIERS) Small Grants Program. The investigation was initiated in February 2000 and had a two-year duration. The project was developed to continue support of a series of reproductive health interventions to improve quality of care in Bolivia initiated by the Ministry of Health and Prevention (MSPS), with a methodology proposed by the World Health Organization (WHO) entitled: Strategic Approach for the Introduction of Contraceptive Technologies. This approach was pilot-tested between 1995-98 in areas throughout Bolivia, including Health District I of the city of La Paz. The interventions to improve quality of care focused on adaptations in health centers, training providers, and increasing the range of contraceptive methods offered. During that time, significant work was carried out with people of the community, but it focused mainly on women who already frequented health facilities.

Evaluation of the MSPS/WHO project showed that the interventions improved services but did not increase demand among underserved populations. It was concluded that the intervention's impact would continue to be low unless the project could reach community members and create more demand for services. The purpose of the new research was to evaluate the impact of a community intervention on utilization of and community satisfaction with sexual and reproductive health (SRH) services. Both qualitative and quantitative data were collected for this study using a quasi-experimental design. Four health centers were selected, two as intervention sites and two as control sites. All four centers originally participated in the MSPS/WHO program.

The health centers' population catchment areas are presented in Table 1, below.

**Table 1. Catchment Populations of Participating Health Centers**

	Intervention Sites		Control Sites	
	La Portada	Chamoco Chico	Obispo Indaburo	Alto Mariscal Santa Cruz
<b>1999 Population*</b>	10,100	17,980	10,115	6,646

\* Health District 1: Garita de Lima

The majority of the residents in the neighborhoods targeted by the intervention are rural migrants of Aymara culture with a fixed urban residence of more than 10 years. Many inhabitants still have migratory practices, either due to the strong linkages with their places of origin (for example some have rural farms), or because they are minor tradesmen who migrate temporarily between neighborhoods or cities. In general, they are people with low incomes, low education, and poor nutritional status. Some tradesmen with high incomes are also found in the areas, but they are not typical. The basic infrastructure and services are poor, and there are no local NGOs supporting the population (WHO Project, 1998).

Churches have an important influence in the neighborhoods, with Protestant institutions growing to outnumber Catholic ones in recent years. Also, traditional Andean medicine is practiced in this area and is thought to reduce demand for modern health center services. There has also been a proliferation of unlicensed health consultants in considerable demand by the population (WHO Project, 1998).

## II. PROBLEM STATEMENT

Bolivia faces a series of challenges in the area of sexual and reproductive health (SRH). Among other problems, the Bolivian government is confronting a maternal mortality ratio of approximately 390 deaths per 100,000 live births (National Demographic and Health Survey, 1994). Abortion is a leading cause of maternal mortality, and service providers lack basic resources to diagnose and treat sexually transmitted infections. Clients have limited access to contraception, and providers often have inadequate or outdated reproductive health information. To confront these problems, the government is emphasizing improvements in capacity and quality of care in sexual and reproductive health services.

Despite the government's efforts, access to SRH services remains low. However, inadequate coverage cannot only be explained in terms of unavailability. There are other factors that must be considered. For example, SRH programs have focused on maternal and child health, but have left out other important target populations including men, adolescents, and women who are not pregnant or mothers. On the other hand, in addition to delivery limitations (i.e. problem with infrastructure, logistics, supplies, and human resources), demand for services is low because traditionally, the population is distrustful of modern health centers. Furthermore, people do not know their rights regarding access to health services.

It is important to note that it has been difficult to formulate broad sexual and reproductive health public policy in such a diverse social, cultural, and geographic context as exists in Bolivia. Thus, past efforts have had varying impacts in different regions, and among ethnic groups and social classes. A large portion of the population lives in inaccessible rural areas in the highlands, and many people migrate to urban and semi-urban areas in La Paz and El Alto. In these cities they live under marginal conditions, without basic services or access to education or health care (National Statistic Institute, 2001).

Public health facilities offer primary care and SRH services, including contraception, in many urban neighborhoods. However, these services are often underutilized. For example, family planning is often discussed or provided only during antenatal and postnatal visits. As a consequence, adolescents, men, and non-pregnant women without children are excluded from these services (WHO Project, 1998).

Since 1997, the Bolivian government has promoted the fundamental right of free access to health services. Efforts have been made to increase the range of contraceptive methods offered and emphasize clients' rights to informed choice. Despite this, the population is not well informed about the changes in public policy and people remain largely unaware of their rights.

A review of the literature shows that interventions in Bolivia to improve quality of care have focused on health services, and have largely left out education, prevention, and community participation. Health providers have not been trained to interact with the

community. Consequently, fear, distrust, and discrimination characterize the relationship between many health providers and their beneficiaries (Camacho *et al*, 1996).

Quality of care models present two distinct approaches to addressing the above problems: (1) interventions aimed to improve provision of services; and (2) interventions to stimulate client demand for services. In the first approach, interventions are focused on improving quality of care by changing provider attitudes and improving their capacity to interact with clients and offer services that take into account ethnic, gender, and generational diversity, thus not adhering to a rigid model (*NETWORK* en Español, 1993). Interventions to address service provision are important. However, if only these interventions are emphasized, their potential is limited and their impact may be low. Such interventions need complementary programs that simultaneously address client demand for services.

There are several different strategies to address demand for services. Social marketing campaigns inform the public about SRH, including contraception and basic rights to access to services, through mass media channels (e.g. radio, newspapers, television, and posters). Another strategy focuses on community education and information with an emphasis on social groups typically out of reach of SRH programs. Information is gathered on community perceptions of the barriers to SRH service use and how people evaluate their own SRH needs. These interventions are designed to improve communities' access to and demand for services. Even though the social marketing approach can play an important role in community education, diagnosis of community needs and perspectives is needed to evaluate the effectiveness of messages, and to determine which are the most accessible and appropriate media in each community.

### III. RESEARCH METHODOLOGY

This study employed a quasi-experimental design with two experimental health centers and two comparison sites (see Table 2). All four centers participated in the MSPS/WHO program and continued to receive support for improving the quality of their services. Researchers collected both qualitative and quantitative data to evaluate the effects of the intervention.

Intervention sites were chosen based on characteristics of the health centers and their surrounding communities. For example, La Portada made notable improvements in quality of services during the MPSP/WHO project, but did no work with the community to increase access to and demand for services. The population there is more marginalized than in some other areas (i.e. large proportions of the population are Aymara, an ethnic minority, and there is a large migrant population). Chamoco Chico Health Center had by far the largest catchment area of the study sites. It was chosen because it was well known as a good health facility but the area it serves is very spread out with a diffuse population and little community organization.

In the first phase of the project, researchers conducted a baseline analysis. Using this information, they designed educational community interventions and developed information, education, and communication (IEC) materials to support educational sessions and orientation activities in the health centers. During the third phase, a post-intervention evaluation was conducted to determine the impact of the activities. Researchers obtained informed consent from all participants at all stages of the project.

**Table 2. Intervention Design**

	<b>Support for interventions addressing service provision</b>	<b>Interventions to create new demand for services</b>
La Portada: Intervention	✓	✓
Chamoco Chico: Intervention	✓	✓
Alto Mariscal Santa Cruz: Control	✓	--
Obispo Indaburo: Control	✓	--

#### 1. Data Collection

Data was collected for both the diagnostic phase and the endline evaluation through focus group discussions (FGDs), in-depth interviews, and health center service statistics using quantitative and qualitative methods. The FGDs and interviews were conducted with the target population to evaluate their knowledge of and attitudes about reproductive health, as well as their access to and satisfaction with services. Researchers conducted informal interviews with providers and observed client-provider consultations. Service statistics were also collected from each of the health centers.

### ***Focus Group Discussions***

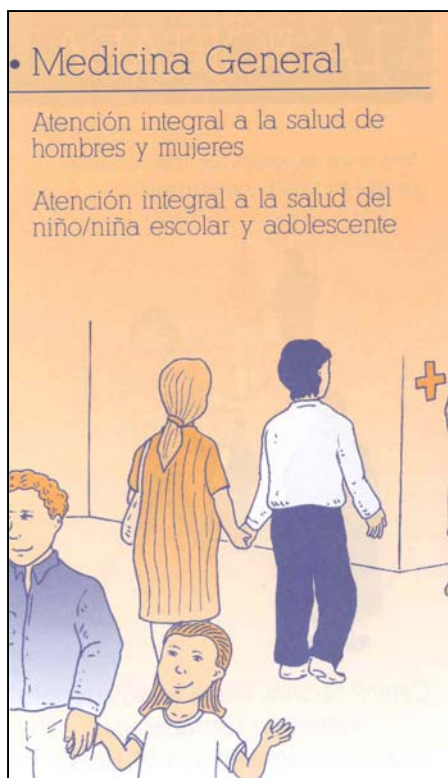
Three populations were targeted for focus group discussions:

1. Priority audiences who do not regularly use reproductive health services (i.e. adolescents, men 20-40 years old, and women in the same age range who had not been pregnant in the past 12 months);
2. Traditional leaders (i.e. elders, both women and men, who influence community views on reproductive health);
3. Other leaders who influence reproductive health opinions (i.e. formal and informal leaders including nuns, teachers, neighborhood committees, traditional healers, religious leaders, and traditional midwives).

In total, researchers conducted eight focus group discussions (FGDs) with key community members. The FGDs took place in health center community rooms or in places chosen by the groups involved.

The principal researcher conducted focus group sessions, after obtaining participants' informed consent, using interview guides designed for the project. Additionally, each participant completed a registration sheet identifying demographic characteristics (e.g. age, work, schooling, knowledge and use of contraceptives, and number of children). A social researcher made audio recordings of each session and recorded contextual information in a field notebook.

A minimum of seven and a maximum of 12 people participated in each FGD session. The adolescent groups were comprised of males and females between the ages of 15 and 20. Most were currently in school or studying a technical career; few were employed.



The married men who participated in the FGDs represented associations or neighborhood committees, as well as independent workers (e.g. tradesmen and bus drivers). Some of the men were unemployed. Almost all of them migrate to rural areas during harvest and cultivation periods, as well as during traditional celebrations in their communities of origin. Men's average schooling is between nine and 12 years.

Women's FGDs were mainly made up of housewives, with some peddlers and market saleswomen. The owner of a drugstore located near the health center also participated in a group. The majority of women were married and belonged to a mothers' club, but few were members of the neighborhood committee. In La Portada and Chamoco Chico, the experimental areas, men have more opportunities than women to join neighborhood groups. It is typical for one woman to

participate for every five men on a neighborhood committee. Women also migrate (usually more frequently than men) to their communities of origin during harvest periods. The average female FGD participant ended her formal education in primary school.

### ***In-Depth Interviews***

Researchers conducted 10 in-depth individual interviews in the homes or workplaces of interviewees using a flexible guide with open-ended questions. The same form was used for men and women. Interviews were conducted with the presidents of neighborhood committees, school directors, a midwife, and a Catholic nun.

### ***Health Center Service Statistics***

The quantitative component in the baseline survey was based on routine service statistics for the following indicators:

- Contraceptive service users
- New contraceptive service users
- Sexually transmitted infection (STI) and reproductive tract infection service users
- Antenatal and postnatal service users
- Pap smear tests performed
- Women under 20 years old who seek contraceptive consultation
- Men under 29 years old who seek contraceptive consultation

Data was obtained from the daily registration books of the National Health Information System (SNIS) and other health center registers. Instruments with similar reporting formats for each population group (i.e. men, women, and adolescents) were used to standardize the information collection process.

Qualitative health center data were collected through observations of reproductive health consultations following a format prepared by REPROLATINA, a Brazilian NGO that works with the WHO strategy. Informal interviews with health providers were also carried out and recorded in field notes.

### ***Impact Evaluation (endline survey)***

The same qualitative and quantitative methodology used for the baseline survey was applied for the impact evaluation. When possible, researchers interviewed the same focus groups and individuals who participated in the baseline survey and educational sessions; however, migration caused some variation in both the participants reached and the methodology. For example, researchers were unable to hold focus group discussions with men during the post-intervention evaluation because the timing coincided with the harvest, and many men had temporarily migrated to rural areas. Instead, individual interviews were conducted with the male participants who could be reached.

### ***Ethical Considerations***

All participants in focus group discussions and in-depth interviews completed informed consent forms during both the baseline survey and the impact evaluation. The completed

forms, as well as the tape recordings and transcriptions, were kept locked in the office in a confidential archive.

## **2. Data Recording and Analysis**

Tape recordings and field notes were transcribed using a word processor, with a number assigned to each line.

The themes originally considered for the analysis include:

- Attitudes and knowledge about the health centers
- Attitudes and knowledge about sexual and reproductive health services
- Needs and demands for contraceptive services
- Knowledge of sexual and reproductive rights

In addition, the interviewees brought up the following topic:

- Barriers and access to health care

Other topics that appeared during the research were:

- Knowledge about sexually transmitted infections, including HIV/AIDS
- IEC strategies in the community
- Community organization and participation

Participants' gender and ethnicity were taken into consideration during data collection and analysis, as well as during the educational interventions, as these characteristics can influence individuals' opinions. More inquiring was necessary to obtain information from women and girls, and from participants of Aymara or Quechua origin, for example. Researchers collected socio-demographic data on all participants, and recorded observations of behavior and gestures during the focus group discussions to provide further contextual information for analyzing transcripts. Results are presented without individual identifiers in separate sections for women, men, and adolescents, as there were substantial differences in the results among the groups.

Quantitative data were entered into Microsoft Excel spreadsheets and researchers analyzed routine service statistics for each health center to determine statistical trends in the indicators listed above. Additionally, national and regional data from the National Health Information Service and the National Statistics Institute provided a comparative framework for the analysis.

## IV. DESCRIPTION OF THE INTERVENTION

The objective of this operations research study was to implement and evaluate community educational interventions to increase client utilization of, and satisfaction with, reproductive health services.

### 1. Community Education Sessions

The project team conducted a total of 32 educational sessions, four sessions for each key audience group. Community leaders and key decision makers were also included in the sessions. Men and women chose evenings and weekends to meet, while adolescents preferred afternoons and mornings. The number of participants varied between seven and 15 for each session. The topics addressed were:

- Sexual and reproductive health
- Sexual and reproductive rights
- Contraceptive methods
- Family violence and gender

Each theme was addressed as a module using a participatory teaching methodology and lasted two-and-a-half to three hours. The principal investigator was responsible for the modules about sexual and reproductive health and rights and the medical advisor conducted the educational sessions on contraceptive methods. A researcher from CIDEM developed and initiated the module on violence and gender.

A female participant commented on the importance of the sessions:

*“There are people who cannot read, so that another form of teaching has to be applied. There are people that do not like to go to the doctor’s, but still they learn about health from their friends who do go... It is good when people participate in these meetings, when people get together, so they can learn.”*

The principle results of the educational interventions were the following:

- Both male and female participants were introduced to sexual and reproductive health issues.
- Participants identified their sexual and reproductive rights and discussed ways to exercise them.
- Male and female participants were sensitized to the issue of family violence and its impact on health.
- Participants broadened their SRH knowledge and learned about specific contraceptive methods, including the benefits, side effects, and correct use for each method.

Developing the relationships with community members and organizations necessary to bring people together was a more time-consuming and demanding process than

anticipated. Thus, it was not possible to organize more extensive educational sessions during the project period.

## **2. Health Center Interventions**

As an additional component of this project, CIDEM continued to support and monitor interventions to improve the quality of care initiated by the MSPS/WHO in 1997. The specific elements of the OR project were:

### ***Training***

CIDEM conducted a workshop entitled “Recognizing and Respecting Differences and Rights in Sexual and Reproductive Health” for providers from each of the four participating health centers. A total of 22 providers attended, including some from district health centers not participating in the study. The following topics were discussed:

- Gender, sexuality, and diversity
- Sexual and reproductive rights
- Quality of care and institutional management
- Contraceptive update

During the workshop, participants discussed all available contraceptive methods, giving priority to those offered by the Basic Health Insurance system. Each provider received a copy of the WHO *Medical Eligibility Criteria for Contraceptive Use*, which CIDEM translated from English to Spanish as a tool to reinforce the information discussed.

### ***Record Keeping***

During the project implementation, the Bolivian Ministry of Health (MOH) introduced a new format for reporting service statistics in their national health information system (SNIS). Because health personnel were not familiar with the format, project staff carefully reviewed the new notebooks to verify information. Some deficiencies were discovered, for example, there was no place to register clients’ first and last names or addresses on the form. Also, specific age groups could not be identified (i.e. to distinguish adults from adolescents) because the SNIS used broad age ranges (e.g. 15-45 years old). After a joint review by providers and project team staff, transitional solutions were established. They were evaluated in the experimental health centers and afterwards the Directorate of District 1 transmitted proposals and recommendations to the MOH SNIS unit.

## **3. IEC Materials**

As a third component of the intervention, the research team reviewed existing information, education, and communication (IEC) materials distributed by community organizations and the MOH and found them to be inadequate. Notably, materials on some issues (e.g. contraceptive methods) did not exist or were only being issued by the MOH. Project researchers designed new IEC materials, with technical assistance from CIDEM, to meet the needs expressed by focus group discussion participants and individual interviewees.

# Derechos Reproductivos

- 1 Derecho a decidir tener hijos/as o no tenerlos, o cuando tenerlos
- 2 Derecho a tener un embarazo o parto en las mejores condiciones
- 3 Derecho a tener información y acceso a los métodos anticonceptivos
- 4 Derecho a tener servicios médicos confidenciales, de buena calidad y respetuosos
- 5 Derecho a contar desde niños/as con la nutrición necesaria para el adecuado crecimiento y desarrollo integral del cuerpo y su futuro potencial reproductivo
- 7 Derecho a optar por contraer matrimonio o no y planear formar una familia
- 8 Derecho de hombres y mujeres a participar con iguales responsabilidades en la crianza.
- 9 Derecho a la prevención y tratamiento de las enfermedades del aparato reproductivo y a tomar decisiones informadas sobre tratamientos e intervenciones
- 10 Derecho a una maternidad y paternidad feliz, libre y sin riesgos



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The researchers designed IEC materials on three topics: sexual and reproductive rights, services offered by the target health centers, and contraceptive methods. The materials were field tested and printed after changes were made. They are brightly colored, use simple language, and include pictures of indigenous women. The contraceptive methods packet contains a series of cards, one for each method offered, with a picture of the method and a description of how it works, who should and should not use it, and possible side effects. The materials were distributed in each community after the educational sessions and provided to both the intervention and control health centers to support SRH services.

## V. CHALLENGES

- Migration posed a major challenge to sustained educational services and investigation follow-up. It was necessary to adjust intervention time frames to the migratory patterns of the participants.
- The communities involved in this project previously participated in various ineffective interventions, so many community members were apprehensive of interviewers. Project staff had to spend extra time earning the communities' trust.
- A maternal death occurred in the La Portada health center during the educational sessions and generated conflicts between the community and the health center, once again affecting, to a certain extent, the credibility of the health center in the eyes of the population.
- In April and May 2001 there were medical strikes and social conflicts that caused a two-month delay in project activities.

## VI. RESULTS

### Key Findings on Client Perceptions and Use of Services

#### 1. Women

The educational interventions broadened women's knowledge about SRH, but some of them still considered it to be important only for pregnant women or those with newborn babies. This perception results from messages broadcast by the official health sector, which promoted antenatal and delivery services under the title of "reproductive health" and, more recently, "sexual and reproductive health."

Service statistics show that few women visit clinics for reasons other than pregnancy related services. However, researchers observed a meaningful increase in the number of women who sought consultation for cancer prevention, family planning, and sexually transmitted infections. The number of consultations related to sexuality, menopause, and infertility are still very low. But, as can be seen in Figure 3 below, the number of clients in the older age groups increased notably during the intervention.

#### Perceptions of Service Quality

Women defined a good health center as one that not only provides good services, but also has medical equipment, medicine, and other modern supplies. It is important to note that despite the fact that many women give birth at home, they value ultrasound scanning. This is an example of the coexistence of traditional and Western medicine in these areas. Women perceive modern equipment like an ultrasound scanner as important, but few expect to deliver at the health center. One woman observed:

*"There is no equipment, things are missing. They tell us to come here, but there is nothing to provide us attention. There is no ultrasound scanning; how will they have their children if they do not see how they are? There are no medicines. It should have a pharmacy."*

The lack of equipment and medicines and a delay in returning test results motivates women of La Portada to seek services at private clinics or more complex public service facilities. This lack of confidence also reinforces use of traditional medicine. For example, many women use herbs in place of modern medications that are too expensive or not available at all. One woman commented on the conflict between doctor-prescribed medicine and traditional herbs:

*"With herbs there are women who have their babies in their homes with midwives. They only give them herbal teas. Also, urinary infections are healed with chamomile baths. This has also been addressed at school. Herbs, however, are even growing down the street. But the doctors do not want this because we reduce the pharmacist's sales. There is no money, this does not help."*

Even if it is not expressed in technical language, technical competency is another influence on women's perceptions of services provided. One woman reported:

*“I suffered when a doctor could not put in an IUD correctly. They were not able to insert it and sent me to many places they said would be able to put it in better. They were not successful, and they caused me much pain. In five years I have not returned.”*

Project staff noted a change in attitudes toward health centers and services in post-test interviews and focus group discussions, particularly in Chamoco Chico. However, this change is attributable primarily to women’s improved feelings of empowerment regarding their health, rather than improved perception of services. Researchers performed periodic observations of client-provider interaction at all of the clinic sites and observed no significant differences in the quality of services offered.

In accordance with previous research findings in the region, women indicated that even though they may have been satisfied with their own service, friends’ and relatives’ experiences weighed heavily in forming their overall opinions. One woman recounted a friend’s negative experience:

*“I will tell you what happened to my friend here in the center. She was going to have her baby...She was admitted to the center but she received bad care...They did nothing for her. The delivery was getting complicated, but they did not transfer her to another facility where she could get better care. Her husband told them: ‘Let me take her, please, she will die.’ He begged them but they would not let her go.”*

Some women stated that male leaders influence whether or not women go to the health centers.

*“I did not go (to the health center) anymore, but I have now returned because (a male community leader) has begged me. He told me ‘they are nice, you have to go, one has to take care of oneself.’ He begged me a lot. I went to the doctor.”*

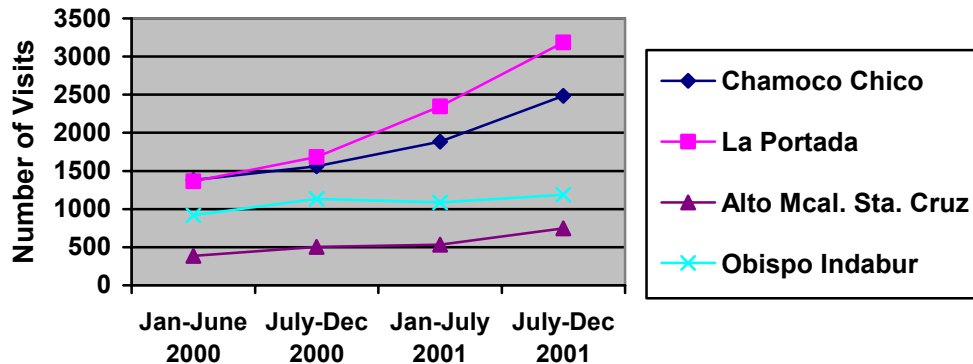
In La Portada, some women said they noticed the services improving: “Before they did not give us attention, they told us off.” Other women do not seek services at health centers because they are afraid of male attendants. However, they indicated being less afraid after the educational sessions.

Figure 1 below shows that the number of client visits to the health centers in Chamoco Chico and La Portada increased dramatically

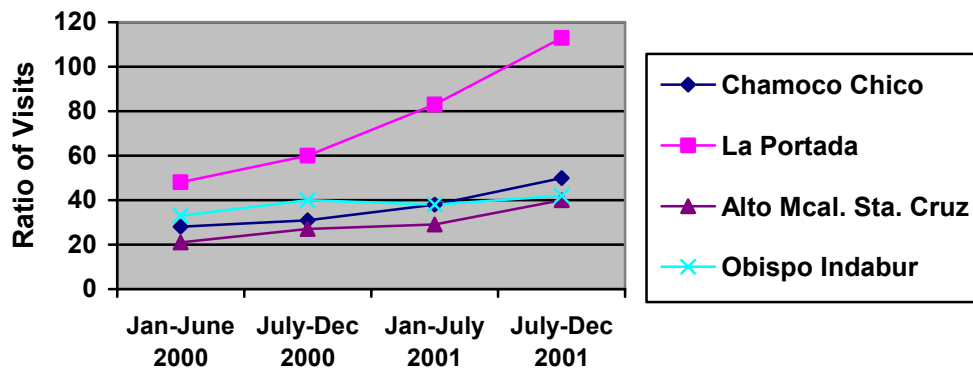


while there were no significant changes in the number of visits to the two control clinics. While it is true that both health centers had more visits prior to the intervention, and Chamoco Chico covers a much larger catchment area, figure 2 shows that the number of visits increased even in proportion to the population. One possible reason for the greater increase in visits in the experimental clinics than the control was that women trusted these health centers more, as evidenced by the focus group discussions.

**Figure 1: Health Center Visits by Women 20 Years and Older**



**Figure 2: Ratio of Health Center Visits by Women 20 Years and Older to Total Population**

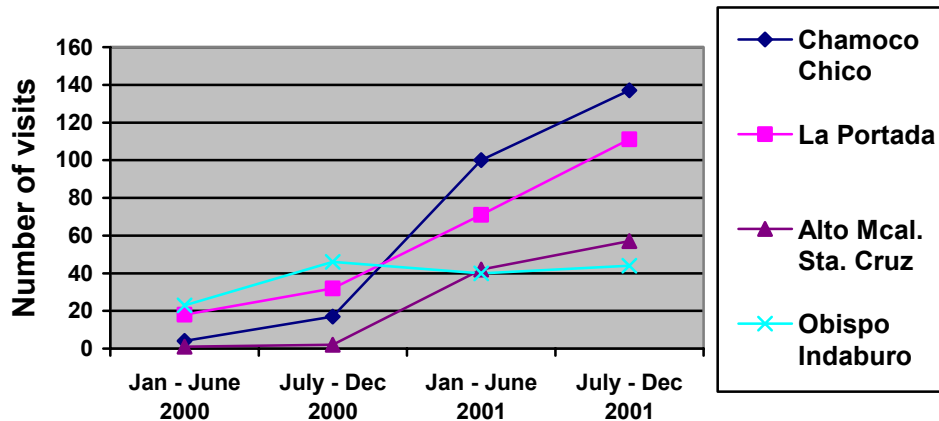


### Community Organization Plays an Important Role

Because community organizations are so influential in Bolivia, service delivery managers use them to generate participation in activities and educational sessions. In La Portada, community solidarity is a value that has not been diluted by urbanization. Economic, social, and cultural activities represent socializing opportunities for women and stores, marketplaces, schools, churches, and health centers are appropriate places to address diverse issues of daily life, including health.

This situation is different, however, in Chamoco Chico, where faster urban growth has occurred and solidarity and neighborhood linkages are weaker. For the women of this neighborhood, it is more difficult to organize moments to share their experiences and knowledge. So, the women who attended the educational sessions there assigned fundamental importance to community organization. For them, belonging to an organization is an important way to remain informed and to make friends with female neighbors. These women have since organized, forming a women's health group with the objective of communicating health information to more women in the community.

**Figure 3: Clinic Visits by Women 50 and Over**



### Contraceptives

There was an important change in women's perceptions and use of contraception. Before the educational interventions, few women reported using a contraceptive, and others did not know about or had not even heard about particular methods. Due to experiences recounted by friends and relatives, many participants thought that contraceptives caused health problems. For example, amenorrhea caused by contraceptive injections was perceived to be unhealthy. One woman reported:

*“One does not know the consequences [contraceptive use] can have. For example, a friend said there is a monthly and quarterly injection, but the quarterly stops menstruation. Others have told me that it is dangerous for it to stop.”*

The educational sessions increased women's knowledge about contraceptive methods with health facility data showing changed use patterns (see Figure 4, below). Also, women became less fearful of side effects, although some concerns remained. The main concern cited was the return to fertility, suggesting that patient orientation and counseling sessions should focus carefully on providing clients with correct information.

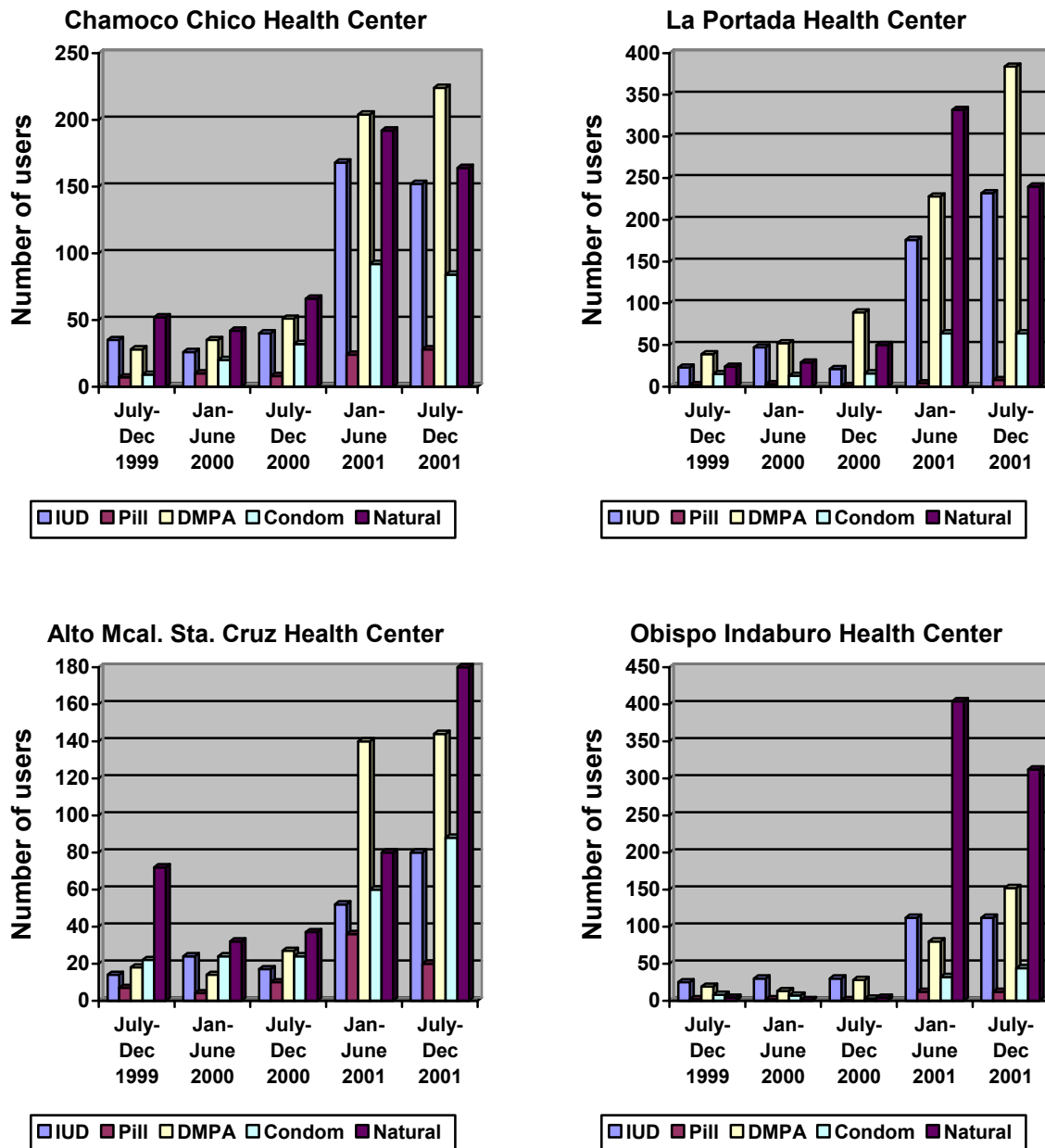
Post-intervention interviews in La Portada revealed that some women received misinformation about certain methods. Some commented:

*“It is frightening because they told my friend that when the IUD is taken out, she will not be able to have children.”*

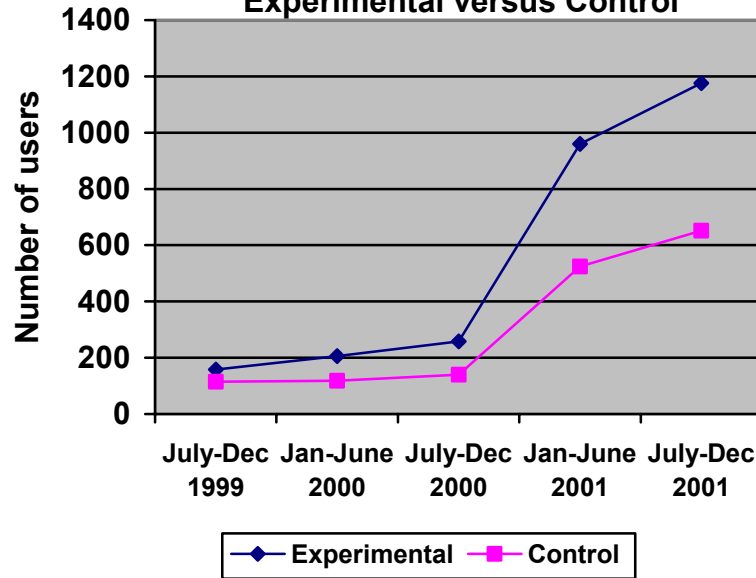
*“I had pus in my breast, and they told me that it was because of the IUD that I had for more than four years.”*

Joint contraceptive decision-making needs to be addressed more thoroughly with both men and women. Even after the intervention, many women reported that men should decide how many children the couple should have. Joint decision-making was discussed with both men and women in informational sessions, and continued attention must be paid to this matter to affect changes in attitudes.

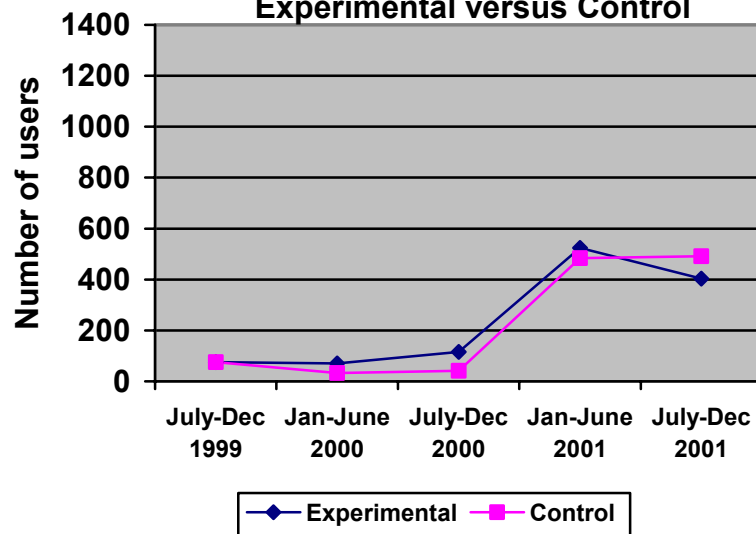
**Figure 4: Number of New Contraceptive Users in Each Health Center, by Method**



**Figure 5: New Modern Method Use:  
Experimental versus Control**



**Figure 6: New Natural Method Use:  
Experimental versus Control**



As can be seen in Figures 4-6 above, modern method use in the experimental clinics increased dramatically during the intervention period, compared to the control. Important to note, the increase in new modern method users did not diminish the number of clients using natural methods. Instead, natural method use also improved during the intervention, in both experimental and control clinics, presumably due to the increased number of clients seeking services and the quality of care activities implemented in each of the sites.

## Cancer

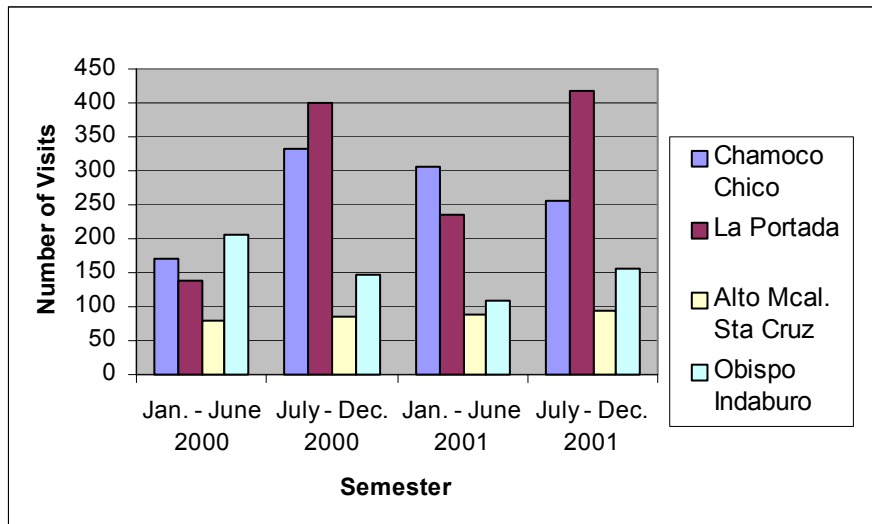
Women were very interested in learning more about breast and cervical-uterine cancer. Although aware of cancer, many knew little about it and some had misinformation. A common belief was that uterine cancer is due to blood clots caused by an injury or by carrying heavy things. The link between the human papilloma virus and cervical cancer was identified, but poorly understood as a cause of cancer. One woman stated:

*“[Cancer] develops because one has relations with many men, or if the husband himself has relations with other women and afterwards he is with his wife again and infects her with some illness.”*

Women reported that although health providers perform Pap smear tests to screen for cervical cancer, few performed breast exams or taught patients how to do self-examinations. During the educational sessions, women were taught about breast cancer and learned how to perform a self-exam. Improving information and access to services for uterine and breast cancer is an important part of this intervention.

Beginning in January 2001, the national basic health insurance system (SBS) incorporated Pap smear testing into its services. As expected, the number of clients increased, particularly in the intervention clinics. But as Figure 7 shows, the figures were not consistent from one semester to the next. Among possible explanations, women mentioned that even though the service is now offered for free they were charged for the associated consultation. Many women mentioned that their Pap smear test results arrived late or were lost, and that the exam did not lead to a timely diagnosis.

**Figure 7: Visits for Pap Cytology by Women Aged 25 – 59**



## Family Violence and Women’s Rights

Evaluation results show that women were interested in further exploring issues of family violence and gender equity addressed in the educational sessions. Continued efforts must be made to inform women of their rights and provide them support in exercising them.

In one of the educational workshops, participants discussed human rights and how they apply to both men and women. The workshop facilitator posed the following question:

*“There are laws for women’s as well as for men’s rights, but men exercise their rights much more often than women. What can we do to promote equity?”*

There is little knowledge about institutions that can support women who experience domestic violence, and women don’t know how to access support. They suggested that women should be taught about these institutions and the mechanisms they should follow to be sure their accusations are effective. While the women agreed that information and education are important, they also said that joining together would help them demand their rights. For them, being organized was fundamental.

## **2. Men**

Adult men reported that general illnesses including tuberculosis and malnourishment are the most frequent problems in the area. They said that for men, as well as for women and adolescents, the key factor affecting health is poverty. They also argued that other problems like alcoholism influence their general health, but that the effect on women and children is greater because of associated increases in domestic violence.

When sexual and reproductive health was addressed before the interventions, men hardly spoke about themselves, arguing that this issue was more relevant with adolescents. One man observed:

*“Well, men’s health, the drama of young men who do not take care of their health, the drinking...People that drink three or four days [per week], this damages them. They turn very bad and catch all kinds of illnesses.”*

Men said they know little about their sexual and reproductive health because they do not have access to education and do not speak about these issues with their parents, wives, or relatives. The majority of men mentioned that they acquire knowledge about sexuality and reproduction through experience and observation. Generally, this happens during adulthood, a social age marked by fatherhood and other symbols related to heritage and authority that occurs from age 15 on. One man reported:

*“My parents brought me up in a very conservative manner. I learned almost naturally. But I raised my children in a different way because here in the city, everything is visible, we could say. I think that one has to move ahead to address the issues so that the children do not get confused...”*

Before the interventions, some men mentioned that they had heard about SRH through their children, who had learned about it in school. However, many said they did not agree with these lessons taught in school because they might encourage children to initiate sexual activity too early. After the educational sessions, however, many men

mentioned that it was very important for them to know and speak about these issues. Nevertheless, some of them were skeptical about the changes that this process could generate. In fact, one man stated, “We have been motivated with talks...but they have made us dream because everything remains the same.”

Other men said that their attitudes have changed. Now they can speak openly and with more information about sexual and reproductive health topics with their wives, children, and friends. Despite the change, adults still consider adolescents to be the most at risk for sexual and reproductive health problems and maintain that they should be the main target group for educational actions.

### **Perceptions of Service Quality**

Men’s concerns with health services centered on infrastructure and specialty services like ophthalmology, cardiology, and general surgery. They identified personnel turnover as an important factor affecting service quality. In Chamoco Chico the men explained that having the same doctor on staff for more than 10 years increased client trust.

Men continued to assert that sexual and reproductive health services were only for women and newborns, but they believe they are good services because they perceived that women use them often. They said they do not go to health centers for services because of fear, lack of information, or orientation. One man reported:

*“Men often do not come because they lack orientation and fear consultation. Men come when they are ‘one step away from death,’ not when they are fine, walking.”*

Others mentioned that some men who want to consult clinic staff for treatment of sexually transmitted infections (STIs) feel ashamed and invent other symptoms while being treated:

*“Men seek general medical services for cough, cold, stomach ache; nobody consults for gonorrhoea, syphilis. Sometimes because we feel embarrassed we want to consult a male doctor because we do not trust a female doctor. The same happens with women.”*

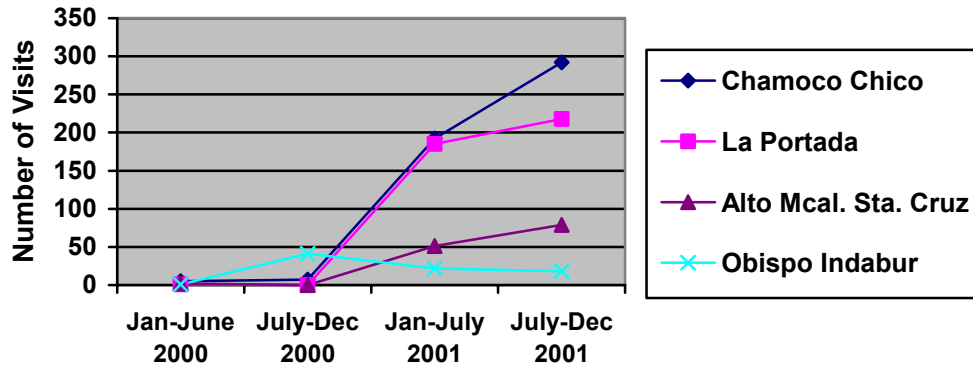
Men know that STIs exist, but often don’t believe they are at risk of contracting them. Many mentioned that they had heard about STIs including HIV and syphilis, but always commented that young men are more likely to become infected. One man observed:

*“I think it is important to talk about venereal diseases, AIDS. Youth have the right to have sexual relations if they are not married, but they must take care of themselves.”*

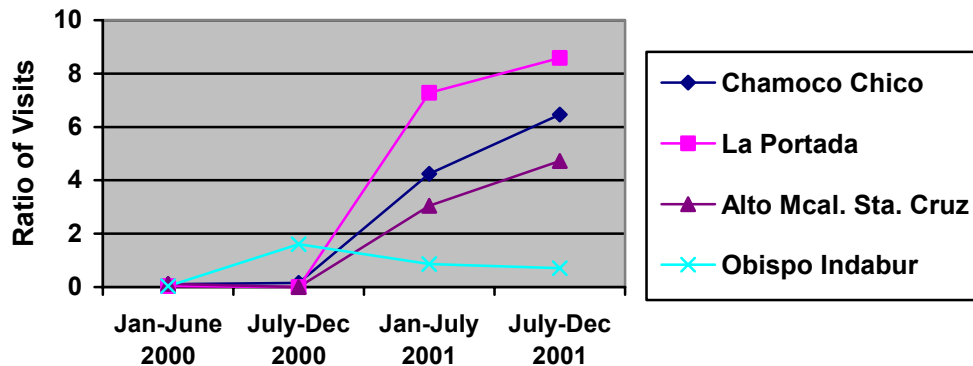
Older men reported that they do not go to health centers because they do not believe they are at risk for STIs. Furthermore, infections are considered a confidential issue, so men prefer to be treated by doctors who don’t know them. This may be one of the reasons so few men seek STI consultations at the La Portada health center. Many men reported that they would travel to distant health centers for treatment because word would get around if

they attended their neighborhood clinic, particularly in La Portada. It is important to guarantee confidentiality and to follow up with men who attend clinics from far away.

**Figure 8: Health Center Visits by Men 20 Years and Older**



**Figure 9: Ratio of Health Center Visits by Men 20 Years and Older to Total Population**



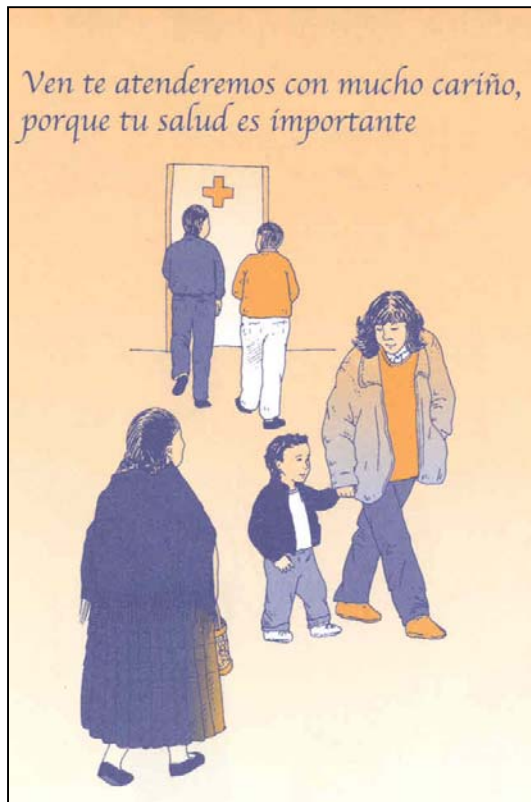
### Contraception

At the beginning of the intervention, men said that family planning is a topic that concerns women and that the researchers should speak to them about it. Only one man interviewed said that he and his wife use an IUD because they decided only to have two children. Most men knew they could get contraceptives at the drug store or health center but said they did not because they were afraid of rumors.

Men agreed that health providers should be consulted when choosing a contraceptive method because of the effects on the woman’s health. They reported that they and their wives had heard the IUD has the fewest side effects, as one man observed:

*“My wife used Depo-Provera injections two years ago for two years, but she gained a lot of weight. She switched to an IUD because we do not want children yet...Doctors said that the injection is not always convenient because it makes one gain weight...My wife did not feel good being fat. Now she uses the IUD, one week, and she is fine.”*

In the post-intervention interviews, men mentioned:



*“Many people need contraceptive methods, not only women. Women are willing but their husbands become jealous.”*

*“I still think it is the man who decides how many children he wants, even though we said in the talks that the woman also has the right to say she does not want anymore and can use the IUD or another method.”*

*“It is a problem with the husbands. One has to recognize that we are male chauvinists, we also want to control the women, so I think that to speak more with the husbands in other talks like this is important.”*

*“I have learned a lot. For example, earlier I distrusted the IUD because of what I had heard...that it made the womb rotten, that it made women turn crazy. But with the talks, I have been convinced that it is not like they say.”*

Despite the attitudes reflected in the post-intervention interviews, statistical information shows that few men go to health service centers for contraception. However, there has been an increase in couple consultations at the clinics.

### **Cancer**

Although men consider cancer to be an important topic, they know little about it. Like women, they believe that cancer is caused by injury. After the interventions, men said they would like providers to be trained on these topics so they can better meet their educational and service needs.

### **Sexual and Reproductive Rights**

Men were generally unaware of sexual and reproductive rights issues. In the post-intervention interviews men reported that sexual and reproductive rights refer to having sexual relations with protection to avoid an STI or an unwanted pregnancy. They spoke about the right to decide how many children to have and when to have them. Like women, they agreed that these issues must be addressed because there is a lot of sexual violence in their neighborhoods.

*“From 18-30 years old...is the most dangerous age for men. Because there is not opportunity to study, they finish school and begin work in mechanical workshops. The majority...work among men, they start to drink every weekend*

*and look for girls to satisfy the drunken man's desires. Women start to work in restaurants and are paid little, 50 to 100 bolivianos, and the bosses tell them if you let me touch you or have relations with me, I will increase it to 150, and if she refuses he fires her. So the solution for the girls is to get married fast, because once they have finished school, they will not receive support in their homes, and if they get married their bosses will respect them more."*

Men thought that sexual abuse could be decreased through educational interventions. One commented:

*"I also think that rape would diminish if men were informed, because many men do not have a conscience, especially when they are drunk, and this should change. Women should also denounce (sexual abuse) even from their own husbands, and so men would be afraid and I think would watch themselves more."*

### **3. Adolescents**

Adolescents generally have more information than adults about sexual and reproductive health, but they are not used to talking about these issues. In the post-intervention evaluations, almost all adolescents mentioned that they were exposed to the presentations on sexual and reproductive health.

Male adolescents were more outspoken than females about sexual and reproductive health topics. Many mentioned they had heard about sexuality and reproduction in school and in HIV/AIDS public awareness campaigns. They initiated discussions and, in some sessions, became competitive in voicing their knowledge and opinions.

In La Portada, the adolescents said that some males buy contraceptives or talk about sexual issues to show off and project a macho image. They also said that youth in the neighborhood are "conservative, good people" and many abstain from sex.

Female adolescents had greater difficulty than males speaking about sexual and reproductive health topics in mixed-gender focus group discussions. Some expressed their opinions, however, said they did not want to speak in front of the males for fear that the boys might "think bad things about them." One girl said:

*"Generally we do not speak about the issue because it is taboo, as my companions said. At our age nobody gives it much importance, and it is not discussed in our homes. Well, at least nobody has talked to me about these topics. Only when I was in 10<sup>th</sup> grade were we given a presentation, and I learned about abortion and sexual relations."*

Focus group participants asserted that sexual and reproductive health information is transmitted more effectively among peers of the same gender, and that very little information is transmitted from parents to children. The adolescents gave examples of topics they address with their peers including menstruation, decision-making power,

respect during sexual relations, fear of pregnancy, and use of contraceptives. Males highlighted peer pressure to have sex.

### **Perceptions of Service Quality**

Both male and female adolescents felt excluded from health center services. They said that medical staff assume youth do not get sick, and that the health centers only offer services for mothers, children, and old people.

Parents', doctors', and teachers' opinions about sexual and reproductive health influence adolescents' attitudes toward and access to sexual and reproductive health care. The teachers interviewed said that adolescents often come to them with questions about sexual and reproductive health instead of going to the health centers. Because many adults are misinformed about the safety and side effects of contraceptives, adolescents are, by extension, biased against them as well.

Some adolescents who had good experiences at the health center said that it is important to be informed by clinical staff rather than by drugstore employees or friends. One observed:

*“In the health center they have given us this information about sexual union because I didn't know anything about that. The doctor and nurse informed me about safe sex and contraception, and I shared this with my classmates. I told them why they have to protect themselves, and how they have to protect themselves, and when to do it because they have to plan ahead. Nowadays, if they do not want to have a child there are so many contraceptives they can use. I tell them to go to the center – to ask the doctor, the nurses – that they will tell them correctly.”*

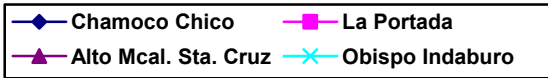
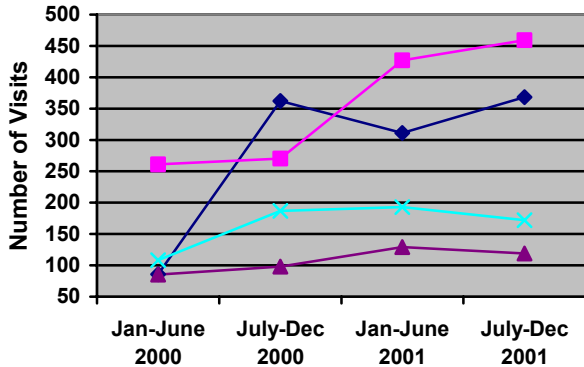
After the educational sessions the adolescents of Chamoco Chico and La Portada had broader knowledge about the health centers in their neighborhoods and the services they offer. In La Portada a community health fair publicized health center services; however, the adolescents demand for services remains low. In contrast, adolescents in Chamoco Chico gained trust in the health center, reflected in the increased number of consultations (see Figures 10 and 12 below). They said the health center “opened its doors to adolescents” as a result of the intervention. In fact, the educational sessions and other adolescent project activities occurred at the Chamoco Chico health center.

Figures 10-13 (below) show that more adolescents visited health centers in the intervention sites than in the control sites. Figures 11 and 13 show the ratio of visits in terms of population size in the health center catchment areas to avoid bias by population size. Although improvements in service utilization are less dramatic when considered as a ratio to all adolescents, both intervention health centers outperformed the control centers serving male adolescent clients (Figure 13), and the La Portada health center has a substantially higher number of visits by female adolescents (Figures 10 and 11).

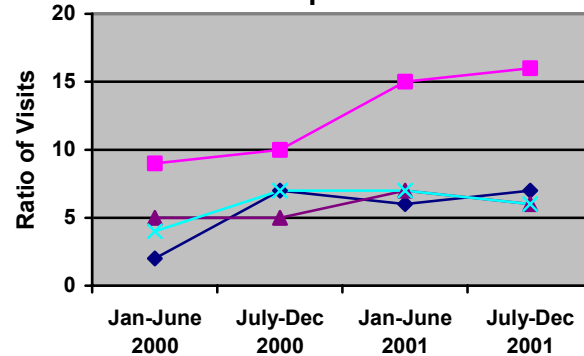
Despite the increase in consultations, some adolescents in La Portada maintain that their health center fails to offer youth-friendly services, mainly due to the cost of consultations

and medicines. They also mentioned that the center does not offer privacy to adolescents. One adolescent recounted a story about a 15-year-old girl who was scolded in the clinic waiting area for coming for a pregnancy consultation. Discussions suggest that many adolescents are fearful of reproach if they seek services at the health clinic.

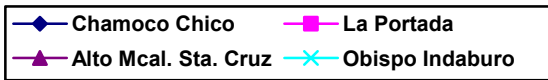
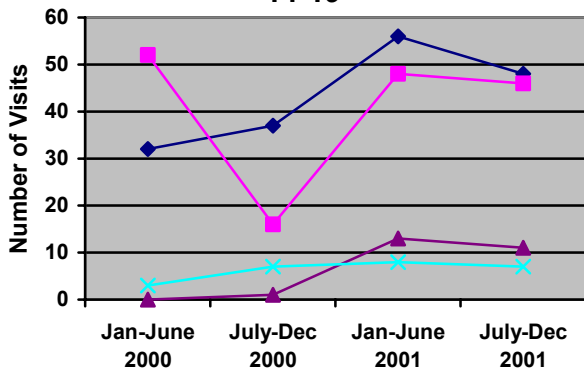
**Figure 10: Number of Health Center Visits by Adolescent Girls 14-19**



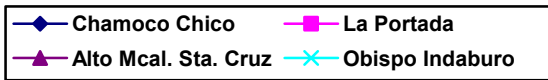
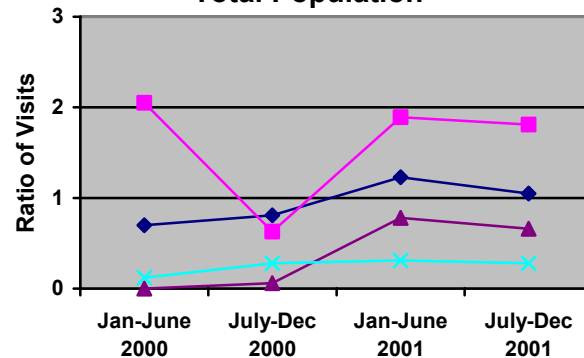
**Figure 11: Ratio of Health Center Visits by Adolescent Girls 14-19 to Total Population**



**Figure 12: Number of Health Center Visits by Adolescent Boys 14-19**



**Figure 13: Ratio of Health Center Visits by Adolescent Boys 14-19 to Total Population**



### Contraception

Focus group discussions showed that male and female adolescents use contraception with doubts and lack information on correct usage. The females, and a few males, had heard about almost all contraceptive methods (e.g. IUD, pills, condom, monthly and quarterly injectables, natural family planning, breastfeeding, and vasectomy). One of the boys

referred to withdrawal as a method, describing it as “when one’s penis is tied“ (making a face and moving his hands as if cutting). One female commented:

*“I think [contraception] is very important because it is us women who suffer the consequences, not men in the majority of cases...One can always get pregnant or something like that. It is women who suffer contempt by people, mainly by men, if they have had relations, if they have their baby -- I think mainly because of that. If they have an abortion, they can never become mothers. I think this is important.”*

Misinformation was common among both males and females. They were suspicious of the pill’s side effects and had heard their mothers and other people in the neighborhood say that the IUD causes cancer. It is also commonly believed that babies are born with birth defects if contraceptives are used for a long time.

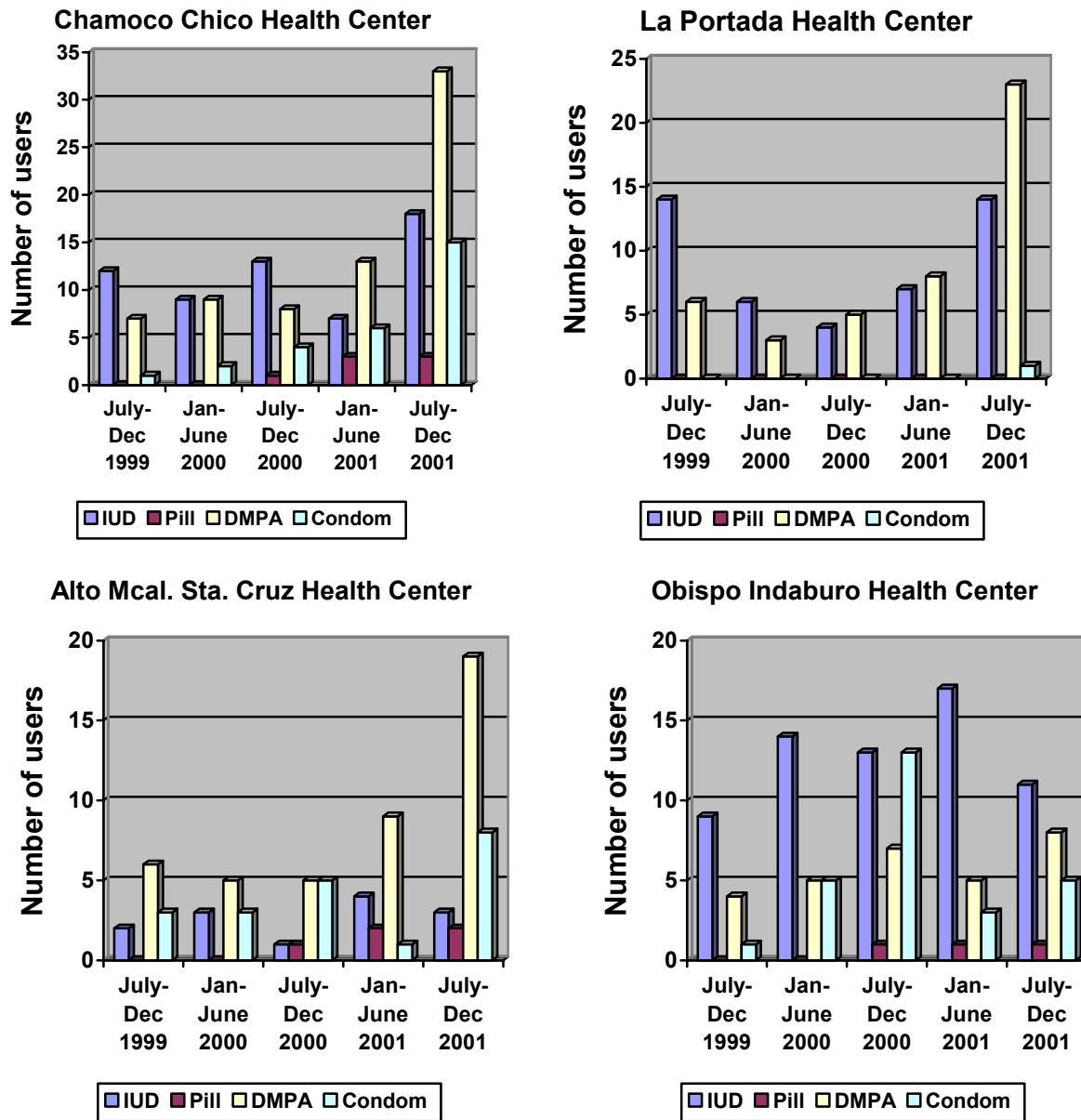
Condoms were the method they were most interested in learning more about and the method used most often by adolescents. Many adolescents do not know how use it, including when to put it on and how to remove it from the penis.

The number of adolescent contraception users increased in all four health centers during the intervention (see Figure 14 below). Improvements at the Alto Mariscal Santa Cruz control site can be attributed in part to efforts by the youth center, which had been operating there since 2001 with the support of an NGO specialized in working with this age group. The contraceptive mix offered in the intervention centers also improved considerably in the second semester of 2001. However it is important to note that the Catholic Church, which is located on the same public square as the health center, has a very strong influence in La Portada, and may contribute to the limited method mix and low use among adolescents there. This health center was also influenced by a project introducing the Standard Days Method (i.e. using a necklace to keep track of fertile days and abstaining on them). They also said that it is difficult for them to obtain contraceptives at health centers because they still feel ashamed, so they often go to the drug store. This probably accounts for the low rates of condom use among adolescents attending health centers.

Even though youth still believe some family planning methods are harmful, they believe using a method without clinical supervision causes many of the problems. Males and females said that they obtained information on contraception from different sources, including the educational sessions by CIDEM, at school, and at the health center. They also mentioned the church as an important reference. However, they said that the church speaks about marriage and not about contraception. One participant in the Chamoco Chico area remarked:

*“What I have seen is that the church cares that a child is welcomed and is not a nuisance. They want a child to be born within a marriage so he/she has the love of their parents. But it also happens that some young women have been raped; who are victims of assaults and get pregnant, and they feel pressured to reject their babies. I think that the church should welcome them too and teach them about family planning, but instead they reject them.”*

**Figure 14: Number of Adolescent (14–19 years old) Users of Contraceptives, by Method**



Source: Health Center service statistics

### Sexually Transmitted Infections

Before the interventions, male adolescents spoke more than females about sexually transmitted infections including HIV/AIDS. They reported that STIs are transmitted through sexual relations, poor hygiene, and contaminated syringes and they think that having sex too frequently and with multiple partners are the main risks for contracting infection.

Girls mentioned that STIs affect women more than men and can be recognized because “there is pain in the womb,” “women cannot walk properly,” and “there are violet marks in the woman’s parts.” In the post-intervention interviews, female adolescents expressed more clarity about STIs and how they are transmitted. They referred to blood and unprotected sexual relations.

The discussions suggested that many adolescents in the area had experienced symptoms of STIs and had purchased medication at the pharmacy rather than at the health center. Health center statistics confirm that although the frequency of STIs in men and women is one of the main reproductive health problems, consultations to prevent or treat STIs are low relative to the estimated number of cases.

It is important to mention that, according to the adolescents, gang hazing is very common in these neighborhoods. These youth are often required to initiate sexual relations, usually unprotected, under the influence of alcohol. Adolescents observed that STIs are common among the gangs. However, they say that gang members often do not recognize the symptoms of an STI or know how to prevent them, and they do not go to health centers for testing and treatment because they fear reproach, shame, and lack of confidentiality.

### **Sexual and Reproductive Rights**

Before the interventions, adolescents related sexual and reproductive rights to the right to love, children’s rights, the right to live, and the rights to have an education, parents’ love, freedom, and free choice. In the post-intervention interviews, they mentioned that sexual and reproductive rights refer to having correct and adequate information about all contraceptive methods, avoiding STIs due to unprotected sexual relations, being conscious about how many children to have, having sexual relations without violence against women, and not subordinating women. Others mentioned that, in their opinions, access to family planning is still poor and thus related to the number of aborted pregnancies resulting from sexual violence. Family violence is a major concern. Adolescents said they did not realize that family violence could affect sexual and reproductive health. One participant said:

*“I know a family with 11 children, and it is not the only family that I know like this. The husband drinks and hits his wife. The wife is a laundress and makes skirts, and the husband has abandoned them. I met her when she had nine children, and every time he returned to the house...he was drunk. I do not know what else happened, but I heard a racket, and some time after she appeared with a baby. So I assume he forced her. She had babies and appeared beaten. She even has a small baby now and is old.”*

An adolescent in La Portada said sexual and reproductive rights are the choice to have sexual relations and enjoy sexuality, but said there is no place for adolescents to “enjoy their sexuality.” Youth are often prohibited from having sex at home, cannot afford a hotel, and are deterred by policemen in the parks.

**Ideal family size**

Adolescent focus group participants said families in their neighborhoods have an average of five or six children. They questioned policies that encourage contraceptive use as a means to reduce poverty. Several youth said they thought that many large, poor families were “happy families,” suggesting that the cultural preference for large families could contribute to low contraceptive use.

## **VII. DISSEMINATION AND SUSTAINABILITY**

This research is part of the Ministry of Health and Prevention's efforts to improve the quality of care, and, more specifically, to continue to support health centers where injectable contraceptives were recently introduced. The research experience and results were presented to health authorities at the district, departmental, and national levels. The lessons learned from this project will provide useful examples for future experiences in other regions and results will be disseminated through local publications and, if possible, national workshops.

To guarantee the sustainability of the experience, researchers based the interventions on resources already existing in the health system and produced educational materials for distribution in the community. Activities initiated during this study will continue to be supported by the National Quality of Care Improvement Strategy of the Ministry of Health and Prevention, with funds provided by DFID and with technical assistance from the Population Council. Educational activities will be strengthened so that the centers can be used as models for educational experiences for the rest of the country.

CIDEM organized workshops to disseminate the information in June 2002 in the main cities of the country: La Paz, Cochabamba, and Santa Cruz. The dissemination activities reached an audience composed of representatives from the Departmental Health Services (SEDES), international agencies, NGOs that work in sexual and reproductive health, and women's organizations that work to promote human and sexual and reproductive rights.

## VIII. CONCLUSIONS AND RECOMMENDATIONS

This research showed that educational activities play an important role in improving access to sexual and reproductive health services. Consequently, it is important to incorporate participative educational strategies in quality of care intervention approaches based on increasing demand for services.

However, the study also demonstrated that it is necessary to reexamine which educational strategies are most appropriate and effective in this social and cultural context. The economic, social and cultural situation, power relations, gender inequity, discrimination, and sexual and domestic violence were shown to be factors that influence sexual and reproductive health in the urban and semi-urban areas of La Paz. This research penetrated very complex cultural environments that cannot be impacted with educational activities alone.

### **Lessons Learned**

- Educational interventions have to be tailored to meet the needs of the community.
- It is important to show gratitude to training participants. Each person who attended an educational session received a certificate and was made to feel important. For some of them, it was the first time they had ever received a certificate
- Groups established during the intervention can be motivated to take further action in the community, as seen among the adolescents of La Portada and the women of Chamoco Chico. In both settings the educational sessions motivated them to organize and become part of neighborhood committees.
- Participants were surprised by and distrustful of the informed consent forms. Many had never encountered them before and did not understand their meaning. Others were afraid to sign because they felt they were committing to something or accepting an obligation.
- Involving community leaders is necessary to gain trust and motivate community members. Many of the women and men interviewed were contacted through storekeepers, market leaders, presidents of civil organizations, health center doormen, teachers, and nuns.
- Health center assessments showed that care was inadequate and needs improvement. Community members want clinic staff to be trained, and increases in service utilization will require providers to use their time more efficiently.

Results showed that pedagogic methodologies based in popular education, which emphasize “knowledge dialogue,” are very useful to promote changes in health behaviors and knowledge. Improving knowledge based on the subjects’ own experiences with sexual and reproductive health was an important mechanism to introduce new concepts, clarify doubts, and sensitize the participants to the importance of SRH. The educational sessions on SRH, rights, knowledge of contraception, violence, and gender were important channels to improve clients’ access to SRH services and help them make informed decisions.

The intervention's impact on client demand for services were clear in the health center statistics, but this does not mean that they were satisfied with the services they received. Many participants believe that treatment and confidentiality remain inadequate. Adolescents still do not have a separate counseling area; resolution of this issue is still in progress. Client orientation services have been consolidated and will continue to be strengthened. Intervention strategies based on increasing demand, such as educational activities, must be complemented by improvements in the quality of health care services. Improvements are being made in the health services sector as problem areas are identified. This research supports the theory that improvement in quality of care have to be addressed in an integral manner, taking into account clients and those not using health services, health center conditions, and existing technologies.

The impact of community educational sessions should not only be measured in terms of demand for services. Qualitative observations of how community members reflect and discuss their own values and practices in SRH should also be considered. For example, adolescents' discussions about their lifestyles showed increases in their awareness of STIs. Some men changed their attitudes considering SRH issues as taboo; now they are more open and show interest in other themes such as prostate cancer and sexual dysfunction. Initially men reluctant to discuss sexual and reproductive health and had many fears due to lack of information. After the interventions it was often fathers who sent their sons to educational sessions. Women in the communities learned that it is necessary to get organized to contribute themselves to changes in health.

In general, the importance of introducing community education and participation strategies based on demand became clear for officials in the health district and health center staff. This process requires support from the introduction of methodologies through the process of institutionalizing them in the health system. It is important to train teams in charge of community extension in these strategies to achieve sustainability.

In terms of cost and benefits, participative educational strategies demand time and confront a series of limitations, depending on the social dynamics of the participant subjects and changes desired in the health center. However, in the medium and long-term, benefits of such projects are much greater when compared to other demand-based strategies, such as social marketing. These benefits are related to two fundamental issues that arose in this research:

- Participants are potential actors to support initiatives or actions by the health center or other organizations working in favor of health care improvements; and
- Although still incipient, organizations of groups of adolescents and women were created. These organizations can become forums for individuals to exercise their sexual and reproductive rights effectively.

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