Women's Empowerment Programs for Improved Health Outcomes;

An Informal Review/Discussion of the Literature

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Mujeres Enlazadas, Promoting Health through Women's Empowerment

Simply within the name "Mujeres Enlazadas" ("Women Linked Together") one gains an understanding of the organization's philosophy, of its goals, and founding principles. In my short time working with this group, I have learned that Mujeres Enlazadas (M.E.) was not an organization built *about* women but *of* women, for women, and strives, in many ways, to be driven by the women in the communities, themselves. The philosophy of M.E. includes not only concepts of better physical health for women, "access to healthier and safer pregnancies and births," but also prominently, ideas of empowerment: awareness (being "well-informed"), capacity building (self esteem, self respect, personal growth by "develop[ing] a better sense of themselves as strong and able, and more capable of speaking for themselves with the capacity to better shape their life experiences"), and participation and action (being involved with their own care, asking questions, making better choices). Through empowerment, it is proposed that women would become better advocates for their own health. The philosophy of M.E. is quoted here (mujeresaliadas.org – Note: M.E.'s new name is "Mujeres Aliadas, A.C."):

> "Women working together have the capacity to heal the world. When women are well informed, enjoy good health, and understand the wonderful capacity of their bodies, they can respect and care for themselves and better care for their families. Their contributions to the world increase in direct proportion to their health and level of self respect and self esteem. Harmony depends on the way we treat our women and girls and the way they feel they should be treated.
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> One of the most significant contributions that our organization can make is to offer women the possibility of and access to healthier and safer pregnancies and births. We believe that well-informed women who are involved in their care will grow through the experience of pregnancy and childbirth and develop a better sense of themselves as strong and able, and more capable of speaking for themselves with the capacity to better shape their life experiences. We believe that well-informed women and girls are more likely to ask questions about their ob/gyn care, make better choices and to access services of an intimate nature."(Madura and Ferguson)

The idea of facilitating the creation of a participatory program in which women would develop existing and uncover new capacities has been discussed as a method of promoting this goal of empowerment. This literature review will discuss existing community-based empowerment programs with emphasis on

their health outcomes, in an effort to better understand what has worked in other settings, what models have the most relevance to the goals of M.E., and how these may influence the development of a community-based women's empowerment program in the Patzcuaro Lake Basin.

Why is it necessary for us to understand Empowerment?

Goal three of the 2009 United Nations' Millennium Development Goals (MDG) Report, to "Promote Gender Equality and Empower Women," acknowledges the global scope and necessity to address the issue of women's empowerment. And although this section doesn't specifically speak about issues surrounding health care interactions or empowerment for health, it is important to note that goal five of the MDG report is to "improve maternal health" (specifically, "Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio," and "Achieve, by 2015, universal access to reproductive health.") (UN 2009)

The connection between empowerment and health, although not directly commented upon in the MDG Report, is discussed in other papers. The idea that health embodies not only physical characteristics of an individual or community but also the social constructs and context in which it is built is the fundamental link of empowerment to health. Through empowerment, one is able to better understand the social determinants of health and better act upon this understanding to alter or improve these underlying factors…consequently, improving health. A study conducted by WHO evaluating SEWA, Self Employed Women's Association, an Indian organization for the "social and economic wellbeing of women," summarizes this idea: "It is believed that in the process of empowering itself, a group or community would tackle the underlying social, structural and economic conditions that impact on its health. As a result, it would gain more control over the social determinants of health."(Aggarwal) Another paper makes a more specific but similar argument, focusing on power relations as a social determinant of health: while "many inequalities in health are a result of power relations that have an effect on the distribution of resources and the development of policy," community empowerment is a means for people to attain "the power they need to redress [these] inequalities." (Laverack and Wallerstein 2001)

The increased attention to these sorts of ideas, health as a contextual entity and empowerment as a means for health improvement, can also be exemplified by the way governing bodies have recently been approaching health. For example, in 2004, the International Conference on Population and Development (ICPD) of the UN in Cairo set forth a definition of reproductive health (sometimes seen in the literature as the 'Cairo definition') that encompasses not only the medical aspects but also social, familial, and relational aspects of reproductive health, encompassing a continuum of life events, processes, and conditions, "ranging from healthy sexual development, comfort and closeness and the joys of childbearing, to abuse, disease, disability and death." It begins by saying that "reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and

processes." (Castle, Traore et al. 2002) Beginning to speak about health in these terms, and not just medically, is crucial for the promotion and implementation of programs that improve health outcomes in their contextual terms, both quantitatively (maternal mortality reduction, for example), but also qualitatively (improved domestic relations, improved self image, improved health seeking behaviors). In communities and on an individual level, people do not talk about health in black and white, having "x" disease or not, but in terms of the relation and impact "x" disease has on family, work, self, social interaction. In this study, for instance, when focus group participants "were asked how to improve reproductive health, their perceived solution was found in the social rather than the biological domain, with their consensus suggesting that improved parent-child communication is the answer."(Castle, Traore et al. 2002)

Ironically, however, it is also important to keep in mind that even "contextually-aware" definitions of health concepts like the one set forth by the ICPD in some ways might still hinder the progress towards understanding health in its *actual* context and social construction. An argument can be made that in many ways this definition may not be the one that is accepted by, and obviously is not the one that's created by, the communities themselves. This can easily lead to local communities, nonetheless, finding "themselves in the role of passive recipients of programmes orientated around definitions coined outside their social world and realm of understanding." (Castle, Traore et al. 2002) This is something to keep in mind throughout discussions of program goals in general and especially during discussions within the communities. I propose later in this review that communities should develop and discuss their own definitions of health, whether "women's health," "birth," etc., and organizations like M.E. should use these as a stepping stone for future discussions, learning from and synthesizing them.

The Social Context: Mexico, the Patzcuaro Lake Basin

Machismo: Machismo has been commented upon both in the literature and in popular culture. It is responsible for the societal construction of gender relations and how males and females define and accept their roles in relation to the other. Machismo is thought of as a "culture," one that "engenders a feeling of entitlement on the part of the male spouse with respect to the power he can exert both explicitly and implicitly regarding, for example, decision-making, household chores, and the frequency of sex." (Pick, Contreras et al. 2006) Because machismo is a part of the societal order, male entitlement and control may not be identified by the female counterpart as a problem, but a way of life, which is exemplified by this quote: "Tolerance and acceptance of inhumane practices and discrimination against women in a community is often justified by customs and tradition." (Pick, Contreras et al. 2006)

Because these attitudes and ideas are so enmeshed in the culture and way of life in Mexico, many violent, discriminatory, and oppressive behaviors go unchecked and continue to occur. A 2006 study by Ortega et al. (not yet read) provides evidence that male control over sexual relations is a very prominent issue, finding that in the Mexican states of Oaxaca and Sonora "most women accommodated their husbands' desire to have sex against their will." (Pick, Contreras et al. 2006) An article in the New York

Times, albeit outdated, also talks about the dynamics of sexual relations between husband and wife in light of machismo attitudes. It discusses that in a culture "where a man's virility is still measured by the offspring he sires," birth control, if existent, is usually governed by the wife in secrecy, in many cases with a looming threat that if caught, she would suffer physical or emotional violence at the hands of her husband (and even her mother-in-law). Interestingly, this article discusses statistics from the previous year (1998), citing that in Michoacan, while "more than 15,000 women underwent voluntary sterilization procedures for the purpose of avoiding future pregnancy…only two male vasectomies were recorded in the same period." (Uhlig 1990) In view of this article, it would be interesting for M.E. to find out current statistics (which the M.E. survey we are now conducting is attempting to do) and attitudes surrounding birth control and gender relations; how many women are getting tubal ligations or using other forms of birth control, how many without their spouse's knowledge…or at the other end of the spectrum, at the request of their spouse (I know that one woman I interviewed said she got a tubal ligation because her husband wanted her to). Understanding the influence of machismo on daily life within the communities seems to be a very relevant point for M.E. In the future, it would be interesting to conduct focus groups in which machismo is a talking-point (although these would probably have to be facilitated by women from the communities, given the sensitive nature of male-female relations).

Domestic Violence: Domestic violence is another contextually-rooted problem in Mexico. A WHO study in 2005 stated that "women who are abused tend to hold more normative beliefs that justify violence against women," perpetuating and promoting a culture of abuse. (Pick, Contreras et al. 2006) Like previously stated of machismo, because of the cultural "acceptance" of domestic violence, many women might not even realize that they are being abused, enhancing the propagation of this behavior. Qualitatively, from the health outreach workers and from others, we have heard that domestic violence is an overwhelmingly prominent issue in the homes of women throughout the Patzcuaro lake basin. And although M.E., itself, is not directing its efforts towards this issue at present because of the sensitive nature of and lack of training in this area, it is definitely a concern and component of the social context surrounding women's empowerment and health here.

To grasp the scope of this problem, a few national studies are cited. (Pick, Contreras et al. 2006) According to a 2003 survey conducted in Mexico by the National System of Statistics and Geographic Information (INEGI), 47% of Mexican women over the age of 15 years who live with a partner suffer from some form of domestic violence. The National Survey of Domestic Violence conducted in 1999 by National Institute for Women (INMUJERES) found that of the domestic abuse experienced, most frequent is emotional abuse (98.4% of all cases), followed by intimidation (16%), physical aggression (15%), and sexual abuse (14%). (Pick, Contreras et al. 2006)

Updated statistics from INEGI were found in a survey entitled **"**Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares 2006. ENDIREH." It looked at domestic violence in several states in Mexico (but not Michoacan) and also national statistics. Looking at the national statistics below, describing incidents of domestic violence (by their partners) reported by women older than 15, "casadas o unidas" (married or in a relationship) in the previous 12 months, one can see the breadth of the problem, even in 2006. 40% of women have had at least one incident, and 6% of all women surveyed had been victims

of sexual violence during the year with their partner. It might also be of interest to note that there was more reported violence by women who did not speak an indigenous language. It is questionable however, if this is an accurate description of violence experienced in homes, especially because this data is self-reported and many factors may influence whether or not women accurately describe their domestic life (lack of recognition of abuse, shame, privacy). It does however draw attention to what is nonetheless a huge percentage of women who are experiencing violence in the homes of Mexico.

Entidad federativa seleccionada, condición y tipo de violencia	Total		Condición de habla de lengua indígena: Hablan lengua indígena		No hablan lengua indígena		No especificado	
	Abs.	Rel.	Abs.	Rel.	Abs.	Rel.	Abs.	Rel.
Estados Unidos Mexicanos	**21 631 993**	**100.0**	**1 633 808**	**100.0**	**19 985 926**	**100.0**	**12 259**	**100.0**
Sin incidentes de violencia	**12 883 249**	**59.6**	**1 091 055**	**66.8**	**11 783 886**	**59.0**	**8 308**	**67.8**
Con al menos un incidente de violencia	**8 656 871**	**40.0**	**533 088**	**32.6**	**8 119 949**	**40.6**	**3 834**	**31.3**
Emocional	6 927 327	32.0	430 783	26.4	6 492 765	32.5	3 779	30.8
Económica	4 955 279	22.9	278 208	17.0	4 674 714	23.4	2 357	19.2
Física	2 213 941	10.2	176 162	10.8	2 036 481	10.2	1 298	10.6
Sexual	1 292 127	6.0	99 257	6.1	1 192 416	6.0	454	3.7
No especificado	**91 873**	**0.4**	**9 665**	**0.6**	**82 091**	**0.4**	**117**	**1.0**

Taken from survey: "Mujeres de 15 años y más agredidas por familiares, por estado conyugal, tipo y clase de violencia familiar según condición de habla de lengua indígena" (ENDIREH 2006)

Doctor-Patient Relationship: Literature has commented on the impact of these sorts of issues (machismo, domestic violence) on women's self-image and interactions and behaviors with respect to their health. For example, after evaluation of the community targeted by ReproSalud, an action-research project for reproductive health in Peru, it was found that domestic violence "contributed to women's isolation, low self-esteem, and failure to adopt health-promoting behaviours or to use health services." Interestingly, these emotions translated into the health care sector as well: "Women who did use health services often felt that service providers looked down on them and treated them rudely, while they tended to respond passively and subserviently." (Ruth Schuler 1999)

This sort of doctor-patient dynamic, in which the patient takes a passive role, has been noted to be a problem even in countries that are not known for as strong of a "machismo-like" culture. A patient-interview study in 2006 (citing another British study) showed that, of 734 women in a large ob/gyne department, 24% of elective surgery patients and 40% of emergency surgery patients reported that they had no choice in signing the consent form for their surgery, and many didn't have the chance to read, understand, or ask questions about the form (although the latter outcomes were significantly more reported by emergency surgery patients than elective). (Dixon-Woods, Williams et al. 2006) This 2006 study also highlights why, in situations in which patients don't know whether they need or want a procedure, they consent to it. The authors argue that these women have internalized societal rules, a

"ceremonial order" regarding the doctor-patient interaction (much like those internalized by women and men in a machismo society): "these accounts demonstrate that participants in social encounters internalise tacit rules of conduct which guide and regulate behaviour. Women clearly understood that they were expected to sign the consent form." Several of the accounts of women who had surgery done as an "imposed rescue" or "imposition," as classified by the researcher, are very striking. A few examples of women's statements from this study are below (Dixon-Woods, Williams et al. 2006):

"Even in that situation I think I probably could of said no but I didn't have nothing to justify why I was saying no […]. I didn't have anything to come back with to support my decision with why I was saying no and I felt by saying, if I would have said no, then they would have frowned on me and said how can you make that decision and I hadn't got any information at all to support if my decision would have been no." (participant 15, emergency, surgery as imposition)

"It is important, but I don't think a lot of people […] got a choice over it anyway, because even if people didn't want to have it done they would still sign it because they probably felt pressured into signing it. […]Because all the doctors and that are there and they know what they're talking about it and they're telling you that you have got to get the baby out and you're saying no I don't want the operation." (participant 4, emergency, surgery as imposed rescue)

"I'm just questioning you know, "God I just signed this form", why (laughs) you know yeah, it's weird. […] No, no, I wasn't saying yes I wanna go for a caesarean, I was just told to sign this form and so I signed this form." (participant 23, emergency, surgery as imposition)

Interestingly, this study also included one patient, who outright refused to the sign the consent form, a woman with a nursing background. The authors argue that because of her level of medical knowledge, and comfort in doctor interactions, she was more able to ask questions, and not be pressured into consenting to a procedure until she was given a chance to understand it. (Dixon-Woods, Williams et al. 2006) This sort of finding could imply that if women gain more knowledge surrounding their medical situation, build a foundation for their expectations, and become more comfortable interacting with doctors, they would be more able to ask questions about their care and receive the care that they want.

In the context of our work in the Patzcuaro Lake Basin, like in the cases of the women who felt pressured into passively consenting to surgery above, disempowerment almost certainly lies at the heart of many women's health issues. It likely influences the way that women view their "place" not only in the home, but also in the doctor-patient relationship. It impacts if they seek care, and where, the way they interact with health care providers, and ultimately the quality of care that they receive from these providers. If you hear stories like those above from large teaching hospitals in the UK, it is no far stretch of the imagination that many of these same issues in a doctor-patient relationship exist in a machismo society where women are already instilled with feelings of passivity and inferiority in relation to males in their communities (many of which are the attending physicians of deliveries). Gaining insight into the doctor-patient relationship within the hospital system in Patzcuaro would be very interesting, especially because many women choose to deliver at Hospital Regional. What say are women actually having in their mode of delivery (C-section vs. normal)? Are they giving consent? In many instances, just from qualitative review of the maternal health survey, in response to the question, "Did the physician discuss

the risks of a C-section with you?" many women reply "no." This already represents a gap in the communication between the patient and the doctor.

The problem of cultural acceptance of birthing care being the "way it is" can be seen by further reflection on the survey conducted by M.E. ("Encuesta Sobre La Salud Materna"). While this survey is not capturing the need for better birthing care explicitly, it is doing so in a more subtle way, by giving us a glimpse into the expectations of the birthing experience of women; women seem to be accustomed to treatment that meets very minimal emotional needs both in the home and in the health care setting. For instance, when asked to rate the care during their last birth women say "bueno" but in many instances, when discussing further, women bring up issues like "I had to wait for hours, There were no beds available when I arrived at the hospital and they sent me away, I had to travel to Morelia to get attention that I can afford," etc. Women are not receiving the quality of care that they should be receiving for a process that in many ways is more empowering and sacred than any other event in their lives, birth. And what's harder, women do not yet recognize that there is a place for change, another way of giving birth: birth on her terms.

Interestingly and most-relevantly to M.E. goals of improving women's health attitudes and behaviors in the doctor-patient interaction, the authors of a paper on implementation of empowerment programs comment that "a truly empowering encounter would assure that the woman (and her family) would not only receive appropriate information and interact with the health service provider. She would also have the opportunity to analyse the information in relation to her individual situation and life experiences, plan what to do next and explore solutions to the different health issues." (Portela and Santarelli 2003) Thus, to improve the birthing experience, to better physical and emotional health outcomes for women, M.E. needs to tackle the "mentality in which women have little control over what happens in their lives" from the ground, upwards, from the women, themselves. (Pick, Contreras et al. 2006) Only by discussing, addressing, and impacting underlying social and contextual factors will women be able to realize their capabilities, their voices, and their power of change. Because of this, it is necessary to understand existing programs that seek to promote women's empowerment to better health care interactions, quality access, and outcomes of care.

Defining ***Empowerment***

To first understand the value of empowerment of a community, one must begin to build an understanding of what empowerment means. Synthesizing the varying definitions found in the literature is a tedious process, and one that may never be realized given the nature of the empowerment and its existence being very dependent upon contextually-based feelings and attitudes (both societal and individual). However, to broaden the understanding of this concept, I have listed some proposed definitions of empowerment (of communities or individuals, as the case may be) found throughout the literature below. I have then attempted to summarize the overarching themes of these

definitions by breaking down "empowerment" as both a process and an outcome, looking towards other literature for a more comprehensive definition and summary.

<u>*Proposed Definitions:*</u>

Empowerment: "Empowerment is both a process as well as an outcome. As a process empowerment helps relatively powerless people. They work together to increase control over events that determine their lives. It gives them freedom of choice and action. Power or control is not granted to them by other agencies, rather they themselves must obtain it… As an outcome, empowerment is the product of redistribution of resources and decision-making authority. It is reflected in the increased sense of self-esteem in the empowered individual or group of individuals." (Aggarwal)

Empowerment, Community: "Community empowerment is a process that involves continual shifts in power relations between different individuals and social groups in society. It is also an outcome and, in this form, can vary, for example, as a product of the redistribution of resources and decision-making authority (power-over) or as the achievement of an increased sense of self-determination and self-esteem (power-from-within)." (Laverack 2006)

Wallerstein and Bernstein also comment upon community empowerment in terms of both the process and the outcome: "a social action process, people being subjects of their own lives, connectedness to others, critical thinking, personal and social capacity building, and transformed social relations." (Wallerstein and Bernstein 1988)

Empowerment, Women: From the Guidelines on Women's Empowerment, put out by the United Nations Task Force on ICPD Implementation: "Women's empowerment has five components: women's sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally." (Accessed 2009)

Thus it can be seen that empowerment, whether of individuals or communities, can be viewed as both a process, and an outcome, a practice of change, of community restructuring from the inside, outwards. Although in many cases facilitated by an outside force (in our case, Mujeres Enlazadas), the process begins within and changes with the community, itself. It is a continual process of growth, realization of self-worth, hope, and action that evolves with the addition of new ideas, new problems, and new faces within the community group.

In a wonderful review and synthesis of various definitions of empowerment (Kasturirangan 2008), the author discusses several stages in the empowerment process, which can be summarized as:

1. One begins from a place of relative powerlessness, during which one may place blame on oneself for the situation, or accept the situation as it is. (Dr. Christie Kiefer similarly refers to this as "hopelessness," the culprit of a spiral of unhealthy attitudes and behaviors like isolation,

depression, loss of motivation, poor health management: “Hopelessness occurs when one perceives that whatever society has promised in the way of fulfillment to its members is being withheld, through no fault of one’s own, and feels powerless to do anything about it.” (Kiefer 2007)(pg. 184))

2. “Consciousness raising” of the existence of a problem or a need, can lead to the “critical awareness” of various external forces and the societal context within which problems exist
3. This can lead to the identification of barriers (constructed by society, tradition, etc.)
4. Identification and prioritization of goals to overcome these barriers
5. Development of a plan for achieving goals
6. Action and implementation of the plan
7. The process repeats, adapts, changes as new problems and areas of potential change are identified

Dr. Christie Kiefer, like the other sources above, also points out that what we are calling *empowerment* can also be defined as the outcomes of this process, the results of people within communities uniting “to discuss shared problems, make plans, and take action to solve those problems,” which can be summarized as the following (Kiefer 2007)(pg. 188-189):

1. Through discussion, community members can learn that they are not alone, and that others feel as they do (a process that itself, is empowering).
2. Community members begin to trust, find support and friendship in one another as they work together.
3. With each success during meaningful work, members realize that they are more powerful and skillful than they had previously thought.
4. There is a shift of values, away from selfish goals towards the common good of the community.
5. Community members are more able to fulfill basic human needs (for ex., respect and meaning), thus becoming happier and healthier.

Thus, in broader terms, the empowerment process is a means to re-instill hope within a community, to “produce a sense of belonging and meaning” when there is a general sense of hopelessness, to facilitate outcomes on an individual, community, societal or political level: the realization of control, change in power-distribution, and for M.E., change towards healthier attitudes, behaviors, and outcomes.

What M.E. needs to ask of itself and ask of the community, then, is what definition of empowerment do we want to base our work off of? I propose that this is something that should be discussed within the community we are working with, within the context of the community itself.

Case Studies as Evidence: Empowerment of women leads to Better Health Outcomes

It has been shown that empowerment can be used to promote better health outcomes in a community. Laverack, an author of several empowerment and health articles, reinforces this thought: "In the literature on community psychology, empowerment is seen to enhance individual competence and self-esteem which, in turn, increase perceptions of personal control which has a direct effect on improving health outcomes (1)." (Laverack 2006) In an extensive literature review, Laverack also identifies case studies of specific health outcomes (measured by mortality, length of patient stay, quality of life indicators, etc.) related to various "empowerment domains" (Participation; Community-based organizations; Local leadership; Resource mobilization; Asking 'why'; Assessment of problems; Links with other people and organizations; Role of outside agents; and Programme management). (Laverack 2006)

In this section, I will focus on some studies mentioned in this review as well as other studies that I have, myself, categorized into domain categories, that seem most relevant to M.E. goals.

Participation: Laverack, citing the lack of available literature, was only able to identify a handful of existing programs of community participation and consequential health outcomes. This domain of community participation, however, seems to be the most relevant for the goals of M.E., which, even in its name ("women linked together"), stresses the importance of women-to-women, community, support.

> MIRA Trial: One key study that Laverack did identify, however, is entitled, "Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial."(Manandhar, Osrin et al. 2004) The MIRA (Mother & Infant Research Activities, a Nepali NGO) Makwanpur trial was conducted in the rural Makwanpur district of Nepal. The study enrolled a cohort of 28931 married women of child-bearing age (15-49 years), matching control groups to intervention groups based on population density of the "development committees" (communities defined based on similar ethnic group distributions). Both control and intervention groups received various supply-side interventions (newborn care kits, newborn care training, supplies, etc. given to various health workers and centers), however only the intervention group attended participatory community-based sessions in a women's group setting, once a month, facilitated by a selected, trained locally-resident literate woman. Sessions were based on a participatory communication model, including problem identification, prioritization, and planning surrounding issues of neonatal mortality, based on the Warmi project in Bolivia.
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> Results: **Neonatal mortality rates (deaths in first 28 days/1000) were 30% lower in the intervention** group than the control group (odds ratio of 0·70 (95% CI 0·53–0·94) for neonatal mortality in the intervention clusters compared with the control clusters), and the **maternal mortality ratio was ~80% lower with intervention** than with control clusters (adjusted odds ratio 0·22 [95% CI 0·05–0·90]). Also, there were significant findings (CI excluding the null

hypothesis) for various health indicators: **"women in these [intervention clusters] were more likely than those in the control clusters to have had antenatal care, to have taken haematinic supplements, to have given birth in a health facility, with a trained attendant or a government health worker, to have used a clean home delivery kit or a boiled blade to cut the umbilical cord, and for the birth attendant to have washed her hands."**(Manandhar, Osrin et al. 2004)

Another review legitimizes the results of this study, at least in terms of a causal relationship between community-based interventions and maternal mortality outcomes. In this study, a meta-analysis was performed, combining the results of the MIRA project with those of a RCT by Jokhio et al. (Jokhio, Winter et al. 2005), which also targeted community-based improvements in perinatal health (although through TBA training mainly, not women's groups). **The meta-analysis reinforces the MIRA study's results, showing a statistically significant difference between intervention and control groups with respect to maternal mortality**, with lower MMR's in intervention groups (OR = 0.62; 95% CI 0.39 to 0.98, p = .042). (Kidney, Winter et al. 2009) The authors of this review state that "these [two] trials have already produced valid policy-relevant evidence to show that **neonatal and perinatal mortality can be reduced by community-level interventions to improve perinatal care practices**" and that the evidence from this meta-analysis "suggests that **community-level interventions that improve perinatal practices can [also] reduce maternal mortality**." (Kidney, Winter et al. 2009)

Comments: Laverack comments that in the MIRA intervention, "by participating in groups, [women] were better able to define, analyze, and then, through the support of others, articulate and act on their concerns regarding childbirth. The participation strengthened social networks and improved social support between women and between women and providers of health-services delivery." (Laverack 2006) However, despite Laverack's insistence on this intervention promoting empowerment, the MIRA study, itself, does not comment on any indicators of "empowerment." It is a study concerned with quantitative outcome variables, and despite the beneficial impact on the action-oriented side of the empowerment model, it does not speak directly of the outcomes of the participatory process, of a qualitative impact. Some measures of empowerment, however, will be included in a later discussion of the women's groups.

Warmi Project: The MIRA project investigators conducted a literature review of community-based interventions prior to their intervention, and although it yielded no RCTs, they did uncover the Warmi project in Bolivia, which later used as a model for their own intervention in Nepal. The Warmi project, in collaboration with the Save the Children Federation, USA and USAID MotherCare project, was conducted from 1990-1993, in an area identified based on its remoteness and limited access to modern medical care (the majority, 55% of births were attended by relatives, usually the father of the baby), in order to improve maternal and child health. Their intervention consisted of organizing women's groups, identifying key problems, developing a formal action plan for identified problems, and training TBAs and husbands in safe delivery practices. The 2nd and 3rd components of this intervention were part of a process called "autodiagnostico" (described later in the ReproSalud project as well), which consisted of "(a)

identification and prioritization of problems, (b) group development of a formal action plan, (c) implementation of the plan, and (d) evaluation," done within the women's groups. (O'Rourke, Howard-Grabman et al. 1998) Two case-control studies were conducted (one for the 2 years prior to the intervention, and one for the 2 years following it), in which all births and perinatal deaths were recorded, the deceased infants were matched to infants living at 28 days, and questionnaires were administered to all. The outcome variables included perinatal mortality, women's group participation, utilization of prenatal care/TBAs, and breast-feeding initiation. (O'Rourke, Howard-Grabman et al. 1998) The implementer's manual, which I requested but have not received from POPLine, is cited at the end of this paper, which contains more details about the study design.

Results: Although this wasn't conducted as a RCT, and thus may be subject to more biases, this study did show a **significant reduction in the perinatal mortality rate from 117/1,000 live births before the intervention to 43.8/1,000 after it**. Qualitatively, they also saw a large increase in the numbers of women participating in the groups at the end of the intervention. Following the intervention, **both cases and controls were more likely to use prenatal care** (with a significant increase for controls, but not statistically significant increases between cases and controls). The percentage of cases using TBAs increased post-intervention, but decreased for controls (not significant differences). The percentage of controls who were attended immediately after delivery also increased post-intervention while it decreased among cases ($p=0.058$, "suggesting a difference in the amount of change registered between the two groups."). Also, a **significantly increased number of control infants were breast-fed on their first day of life** following the intervention (25.3% pre-intervention to 50.3% post, Chi^2 = 18.77, $p<0.001$).

Comments: This study speculates that, despite the lack of a distinct control group (like in a RCT), "it seems reasonable that the program was responsible for at least some of the impact." (O'Rourke, Howard-Grabman et al. 1998) This is the assumption that the MIRA trial used, and seemed to verify in its own study population by conducting a RCT. The increased use of prenatal care also was a promising outcome, especially because this study cites another (that I haven't had the chance to read) in Mexico, in which "expanded use of prenatal care was identified as a major determinant of lower perinatal mortality," which could account for the reductions seen. (O'Rourke, Howard-Grabman et al. 1998) In the case of women in the Patzcuaro region, at least from the preliminary birthing surveys conducted, it seems that almost all women are already receiving prenatal care (usually from IMSS clinics), thus the applicability of these sorts of outcomes might not be as relevant. If a similar intervention were implemented in Patzcuaro, it might be more relevant to look at qualitative measures of quality of prenatal and obstetric care received as reported by women, service utilization measures (like those reported in the MIRA trial paper above), and qualitative measures of "empowerment" as primary outcomes, and obstetric complications and mortality as secondary (since, speculatively, these may be more directly related to harder-to-treat medical issues vs. lack of access to medical care, compared to the Bolivia population for example).

Community-Based Organizations: These groups (women's groups, committees, etc.), are identified as "the organizational elements in which people come together to socialize and to address their broader concerns," and through which individuals are able to gain the skills and understanding to achieve better health outcomes. (Laverack 2006) The programs listed in this section use existing women's organizations, an established infrastructure, to achieve empowerment and health goals.

Samoa Project: Laverack sites a project in Samoa, Polynesia, in which the local government created a self-help system with existing women's groups, of nursing care and neighborhood support for women. As a result, women were more able to organize and motivate themselves and each other to achieve health goals, like the construction of health facilities in the community. However, I was unable to find this citation in my own search and thus cannot comment further.

ReproSalud: The ReproSalud project, a project initiated by Movimiento Manuela Ramos, a feminist organization in Peru and funded by USAID-Peru, utilized existing women's community-based groups in primarily rural, indigenous areas of Peru to initiate a participatory empowerment process in groups of women to improve reproductive health. Interestingly, one of its *primary* goals can be described in terms of women's empowerment: "The processes of needs identification, sub-project development and implementation are, in themselves, intended to be empowering experiences for women" and are also intended to create "far-reaching and enduring forms of empowerment, which in turn is expected to have a positive impact on reproductive health." (Ruth Schuler 1999) This project was initiated in 1995, with phase 1 from 1995-2000, during which facilitative support (sub-grants for projects, promotoras educated in reproductive health issues) was provided to women's organizations in 8 regions for the implementation of sub-projects (action plans for "autodiagnosed" reproductive health problems), and phase 2 from 2000-2005, during which time the focus was on adapting and scaling up the project. ((IGWG 2003), (ReproSalud))

Results: Assessing "empowerment" as a primary outcome, inherently, is much more difficult than, for example, in the RCT of the MARI project, which assessed measurable outcome variables with respect to a control group. Some indications that this program was empowering can be deduced from the study description; for example these women's groups were very much self-lead, identifying problems, creating "sub-projects," acting on these plans, and reporting to and finding support (monetary, transportation, etc.) for them from local officials, not under the direction of ReproSalud, but with its facilitation. ReproSalud also came up with a Results Framework to assess the qualitative outcomes of its project. And although I could not find the primary literature on these outcomes, I did find some qualitative outcomes expressed in Master's level review. A central level technical advisor comments on empowerment on the individual level: "**women open their sense of self-worth a lot and feel like people**, these are important, first points, foundations of women's empowerment." The skills that women develop during the participatory process also "help participants demand better medical attention, negotiate with health services or other officials, and change their relationship with their male

partners." (Coe 1997-1998) A quote from a president of one of the CBOs (community-based organizations) provides a reaffirmation that these sorts of programs really do have an impact: **"My experience in *ReproSalud* this year (…) has made me to feel like a woman, not like a big, important woman in my club, but rather that I am doing something for them, and I see that I am doing it and they are appreciative of me. This gives me incentive to continue working and supporting them. (…) Perhaps *ReproSalud* has allowed me to do something for my people, for my community, perhaps if this organization had not appeared, I would be like I was before, just a housewife, going from my job to my house. I wouldn't have gotten to know institutions, entities, and officials."** (Coe 1997-1998) Some measurable outcomes, however, were also recorded that may be suggestive of increased empowerment of women (and/or simultaneous education of men): **decreased domestic violence, alcohol consumption, and forced sex** one year after the initial sub-projects, **increased communication with husbands about family planning and contraception**, and simultaneous **increased utilization of family planning services**. (Ruth Schuler 1999)

Comments: The ReproSalud project is something to aspire to. It was based on a "popular education"-empowerment model, so to speak, from the outset, working with existing community groups to educate about reproductive health issues in a participatory manner and facilitating projects identified and designed by the groups themselves. One thing that this project has, however, that M.E. does not at this moment, is a stable funding source (USAID). Sub-grants covering 90% of the sub-project expenses were provided to each community group, within outlined limits, to undertake the project designed (many were reproductive health education projects in the community). (Coe 1997-1998) I think if funding for the women's groups (which M.E. spoke with already) in the Patzcuaro Lake Basin can be found, it would be a wonderful thing for each of these groups' individual endeavors. However, if M.E. wants to promote an education-empowerment-type program surrounding women's health issues specifically, it may have to take a more facilitative role, like Movimiento Manuela Ramos has done, providing facilitators or "promotoras" specifically to either existing or created women's groups interested in and focusing on women's health issues.

Asking 'Why': This domain can be explained as the ability of the community to be able to assess and question the contextual reasons for its powerless and health conditions, to begin to imagine 'alternate' ways of living. Through discussion, reflection, and action the community begins to become "critically aware" by engaging in a process of "critical thinking." (Laverack 2006)

The Resource Sisters/Compañeras programme: This program was founded in an inner-city area in Florida to encourage government-identified "high-risk" pregnant women to discuss underlying issues for poor pregnancy outcomes, with an administrative emphasis on education and improved pregnancy outcomes. It was funded by the Robert Wood Johnson Foundation, with a match by Florida's Healthy Start Program. There were three components to this program; 1) education of local community women to act as peer counselors, 2)home visits for outreach and case management, and 3)peer support groups. The main focus here are the

‘mother’s circles,’ the support groups. These were created as forums for open discussion, lead by a facilitator who challenged the women to critically think about the root causes of many of the issues facing them, including low birth weight and high infant mortality. The topics for discussion were based around the concerns and issues brought forth by the women themselves. (Lugo 1996)

Results: Qualitative measures were used to identify an increased sense of empowerment of women who attended these groups. For example, the authors site an **increased sense of social cohesion** within the group, stating that relationships many times extended beyond the group setting, and an **increased “sense of ownership of the group meetings**, [with some group members] taking over leadership and assigning group tasks among themselves.” The impact on the peer counselors is also evident. For example, one woman who was originally very scared of using the phone to call public agencies, at the end of her first year, “**not only was able to use the telephone but also served as a strong advocate for services for other women who had not yet found their voices.”** Others cite this program as having opened doors to other opportunities, and work prospects. Another interesting finding from this study was that while, on average, it took three individual home visits by the peer counselor for a woman to attend her first mother’s circle, 45% of the women who attended one group meeting, attended four.

Comments: This study elucidates some of the obstacles that groups, like M.E., trying to engage the community might face. One of the initial obstacles to this program as primarily an empowerment program was the fact that the funding administrators were primarily concerned with improved quantitative measures of pregnancy outcomes and improved education as a secondary goal, not capacity building and empowerment. Because of this disconnect between goals of the administrators and the investigators, there seems to have been some restriction on the amount of time and effort dedicated to promoting and evaluating the goals of empowerment. The necessity of having funders and investigators “on the same page” in terms of primary goals and outcomes is something for M.E. to keep in mind when asking for support. Empowerment cannot be a secondary goal, but must be advocated for as an essential and important component of M.E.’s endeavors (which, at least from the website and interactions within the communities, it seems to be doing). Also, this study provided an interesting note on community familiarity with a group; women only attended groups after establishing a trusting relationship with an outreach worker. Establishing a repertoire within the communities is a very important step to gaining community trust for further program promotion – good thing word about M.E. is spreading fast around the lake!

Photovoice: Laverack discusses a program described by Wang et al., which uses the similar strategy of critical thinking, through a method called ‘photo-voice,’ discussing photographs to facilitate discussion and participation. She applies this method to the Yunnan Women’s Reproductive Health and Development Program, by giving local community women cameras to capture photographic moments later used in group discussion. These images were also used as a tangible example of conditions in discussions with local officials for the establishment of

midwifery programs, daycare centers, etc. This sounds like an interesting approach to improve women's involvement and participation. (Laverack 2006) However, I have not gotten a chance to read the literature on this project.

Developing a program in the Patzcuaro Lake Basin

Defining your own role in the community empowerment process:

Throughout the literature, the need for communities to have control over the program is essential to both their empowerment process and the sustainability of the program. Because of this, organizations "cannot and should not try to empower women. Women who engage in an empowerment process should set their own goals and determine what kinds of resources would be helpful to them in reaching these goals." (Kasturirangan 2008) However, there also exists a place for the "practicioner," a group or individual who has the opportunity to help facilitate the empowerment of a community. Laverack states, "In a programme context, the role of the practitioner is to create opportunities to help others gain more power over the determinants of health, and this often involves a process of capacity-building." (Laverack 2006) "Programs may help women access [necessary] resources. In this way, programs may play a vital role in supporting a woman's empowerment process," without actively "empowering" a community. (Kasturirangan 2008) The role of an organization like M.E., then, should be as a scaffold, providing support as women define their goals, facilitating discussion, encouraging and reinforcing the value of the thoughts and the process, and trying to provide resources that women may be lacking as they develop goals.

Defining your goals:

M.E. needs to identify the key goals of an empowerment project such as this one. Is it only an increased sense of empowerment, or is it expressed as having more control in a doctor-physician encounter, a husband-wife encounter, increased quality of care indicators in health care settings? Identifying key goals from the outset is important, especially later, for the evaluation of the program. (Kasturirangan 2008)

Defining the research approach:

Before beginning, one must define the method of "action-oriented" research that will be used to facilitate the program's success; in essence one must answer the question: *What model will M.E. use to carry out its goal of facilitating the development of a program of women's empowerment?*

Throughout the literature it is mentioned that there exists this dichotomy between what can be called "action anthropology" and classical quantitative research. (Kiefer 2007) It is important to keep in mind one's goals as an "action anthropologist" while conducting "research" about a community's needs, perceptions, behaviors, etc. For example, to contrast, public health specialists involved in programs in a clinical or managerial realm tend to look for measurable empirical outcomes that can be used as

indicators of successful behaviour change (like was seen in the case of the Resource Sisters/Companeras Programme in which the administrators were concerned primarily with quantitative pregnancy outcomes). Anthropologists, on the other hand, seek to understand emic (culturally-defined) or local models of illness causation and classification, the views that are accepted as real, meaningful, and appropriate within a culture, and to focus on the processes and context of decision-making. (Castle, Traore et al. 2002) Because the methods of M.E. take on a more anthropological basis, it is important to keep in mind that the ultimate goals of the program may not necessarily be quantifiable in the classical way. While M.E. wants to improve women's health outcomes and access to care (quantifiable measures), other methods and outcomes need to be sought for its goals of empowerment promotion and capacity and awareness-building within the community.

An interesting take on the various methodologies of action-oriented research is described by Stephan Small in his review of the literature. He describes four types action-oriented research, each slightly different: action, participatory, empowerment, and feminist research. (Small 1995)

Action Research: He cites Kurt Lewin's (usually recognized as having introduced the method) definition of "action research" as "a new approach to social research that involved the researcher trying to change the system while at the same time generating critical knowledge about it." Small further states that this method differs from classic research in several ways, including that whole populations, not samples tend to be studied, the study setting is usually within the community in which the problem exists, the methodology can evolve and change as the study proceeds, the information needed for the study to progress relies on not only on the researcher's skills and experience with social science research, but also the practical knowledge and experience of the "participant collaborators," those in the communities served/studied, and the data, though analyzed by the researchers, is returned to the community for it to act upon. (Small 1995)

Participatory Research: Small cites a definition proposed by Gaventa to summarize this method: "attempts to break down the distinction between the researchers and the researched, the subjects and the objects of knowledge production by the participation of the people-for-themselves in the process of gaining and creating knowledge. In the process, research is seen not only as a process of creating knowledge, but simultaneously, as education and development of consciousness, and of mobilization for action." Thus, this sort of research not only emphasizes research and action, but also education and empowerment; "Through their active involvement in the research process, participants become more aware of their own abilities and resources and learn how to gather and use research knowledge." Participants are involved with the research from its very initial stages, deciding how to design the study, what, where, and from who to gather data, and qualitative methods are usually used, because of the emphasis on personal growth, reflection, and interaction. (Small 1995)

Empowerment Research: This method promotes empowerment as a primary goal of community research and action. Small cites Rappaport in outlining the distinguishing features of this action-oriented research method: "…identifying, facilitating or creating contexts in which heretofore silent and isolated people, those who are "outsiders" in various settings, organizations and communities, gain

understanding, voice, and influence over decisions that affect their lives." This method, like the others, also emphasizes closing the gap between researchers and participants, and even more-so than other methods, emphasizes understanding of different viewpoints by using various data-gathering techniques, highlighting the skills and abilities of those study, and working within the contextual basis of the study: "For example, the criteria for evaluating the success of a social program may be different for the program's participants, implementers, and funders. According to Rappaport (1981), these contradictions are a natural part of human systems." (Small 1995)

Feminist Research: The aim of this method, as described by various sources cited by Small, is a more politicized, ideologically-oriented form of inquiry, concerned with social justice, and can be described as "research for women, rather than about women," involving "respecting differences, treating everyone as being of equal worth, and allowing people to "define their selves and their situations apart from the standards, constraints, demands and agendas of others." Distinguishing is also the emphasis on emotions as areas of insight. (Small 1995)

Clearly these methods have overlapping themes, and various components from each can be extracted to define one's own role as "action researcher" or "action anthropologist." For example, M.E. takes on characteristics of action, participatory, and empowerment research in that it is concerned with problems identified and solutions implemented within the community worked with, in a contextual manner. It agrees with values held by all methods that participants and researchers should act like collaborators and adopts more qualitative-based approaches for research to identify various viewpoints and beliefs. M.E. also works to promote empowerment, as well as education, and action, as the participatory model emphasizes. However, it also wants to create a program that brings to light women's rights in the context of the medical care they receive (feminist model), and wants to promote capacity-building and awareness-raising for self- and community-empowerment as well. The various action-oriented methods outlined by Small can serve as models for the philosophy adopted by M.E., a conglomeration of principles from all of these. As a program is developed and implemented, these are the principles that M.E. should follow, and look towards as it assesses its own progress.

Working with existing community organizations and established infrastructure:

Aligning goals with community goals and the goals of community leaders, organizations, and leaders has lead to the success of many community-based initiatives. "The development of partnerships is an important step towards empowerment and can also lead to an improvement in health outcomes by pooling limited resources and by taking collective action." (Laverack 2006) I have already cited ReproSalud as using existing women's groups. However, other programs have also tapped into existing infrastructure to establish and promote their goals ((Van Rompay, Madhivanan et al. 2008), (Ahluwalia, Kouletio et al. 1999)). The formation of 'cluster communities' ('... voluntary alliances between two or more communities to address common problems, needs and interests') has also been said to be successful. (Laverack 2006)

1. Seeking out appropriate organizations. ReproSalud used an interesting method for identifying women's community groups that could be used to help facilitate its' goals of women's empowerment for improved reproductive health. Health outreach workers hosted competitions, including the presentation of "sociodramas," plays surrounding reproductive health issues, between community organizations to seek out those with the strongest organizing potential and interest. (Ruth Schuler 1999)

   In the case of M.E., however, there doesn't seem to be such a large pool of existing women's groups to choose from. Having reached out to establish connections with the known women's groups in Patzcuaro Lake Region, including the one Veronica is a part of, though, in itself, is helping to facilitate the goals of women's empowerment through various streams of communication and participation. This might also provide a great opportunity to identify key figures for a more health-oriented empowerment project, directly related to M.E.

   Reaching out to government-based organizations, especially ones like Oportunidades, might be the strongest connection. Oportunidades states that it empowers women by giving conditional-cash transfers directly to women and by creating a system of health education and support from Promotoras, but how effectively is this program currently accomplishing its "empowerment" goals? Barber and Gertler state that "A key component of the educational programme [of the Oportunidades Programme] is empowering women to obtain quality care by providing them with information about care content, encouraging them to speak up for their rights with medical care providers, and giving the cash transfers directly to women." This same study claims that because of women's empowerment, there is a 12.2% increase in utilization of prenatal care services and improved quality of care for women enrolled in Oportunidades. (Barber and Gertler 2009)

   However, the question remains, is this education really the same as empowerment? From the definition(s) of empowerment I proposed earlier, standard lecture-style education (which, although uncertain, is the most likely delivery-method of health information to women in Oportunidades) lacks in a fundamental way, what empowerment processes provide: active, participatory, critical awareness building. If, what women are learning in platicas (monthly health-education lectures) and through interactions with Promotoras is not what they, themselves, identified as important or as a problem, women will not be compelled to "own" the knowledge provided to them, to act on it in the same way as if they had themselves uncovered and acted on their problems. However, by M.E. building a connection with Oportunidades (which it has already begun to do, by conducting platicas), the existing education model might be influenced by a more participatory empowerment model. By changing M.E.'s platicas to be more participatory for instance, and documenting the change of women in terms of esteem, attitudes, and knowledge (with pre- and post-tests, interviews, etc.), Oportunidades, even on a community-level, might be compelled to re-evaluate its information-giving techniques as well. Changing platicas to be more

participatory, and ideally, to be facilitated by women in the communities educated in womens health, would be an effective step towards women's empowerment for health promotion. (Of course, facilitating change within a national and established program like Oportunidades might be dreaming too big. Changing the platicas that M.E. is giving to be more participatory, however, seems to be a good place to start.)

2. Aligning goals. As touched on earlier, aligning goals both with funding organizations and community and government organizations is one of the keys to a successful empowerment program. It might be necessary, especially in the case of community-based women's groups, to establish new groups of women, and identify community leaders specifically interested in women's health promotion.

3. Creating community networks. The fact that the Patzcuaro Region lies on a lake seems almost perfectly engineered for the creation of a women's network. The ideal network in my head is similar to that of ReproSalud's and MIRA's women's groups, each community-based group meeting independently, but all linked together, under the facilitation of peer outreach workers identified within the communities, with supervision by M.E. staff. (Again, this may be more of a long-term goal. For the moment, hosting community-based, facilitated forums for discussion of women's health issues seems to be a more feasible goal, and a more useful one [see the next section]).

Assessing Community needs and priorities:

Several papers cite the identification of a community's priorities and key problems as the first step in developing an empowerment program curriculum/agenda. This necessity is directly linked back to ownership of a program, the idea that "the motivation to improve one's health must come from within the community and cannot come from an outside expert." (Laverack 2006) I will discuss the methods used by several programs to do this sort of community assessment.

> Mali Project: In the development of a curriculum addressing reproductive health in Mali, participatory, qualitative research was carried forth from the very beginning, from the *defining* of a health concept. "[Participants] were asked for their own definitions of reproductive health so that the intervention could be orientated around local perceptions and insights. It was hypothesized that this would increase their ability to relate to the programme and their motivation to participate." (Castle, Traore et al. 2002) In this way, the facilitators of this program did not impose a definition (like the 'Cairo definition' for example) upon the community, but sought one out, one that shined light on not only the medical aspects, but also the social context of reproductive health in Mali.

This type of research, the understanding of "beliefs" not in a skeptical light but as "facts," as an intrinsic system of understanding within the community differs considerably from a quantitative research approach, understanding the statistics around a community's behaviors. However, that is not to say

that both types of research cannot be carried on simultaneously (as M.E. is doing); one must know when it is appropriate, though, to gather "objective" data and when to use local knowledge.

The RCT MIRA Project in Nepal gives a good overview of the steps undergone prior to the development of their intervention (women's participatory groups around neonatal health). The table below summarizes these steps into four parts, including both quantitative and qualitative research, each of which will be discussed later. (Morrison, Osrin et al. 2008)

Table 1 Formative research conducted before the intervention

Part	*Formative research*
Part 1: entry and framework	Familiarization visit Introduction and contact with District Public Health Office Literature review Dialogue with maternal and newborn health actors
Part 2: community profiles, enumeration, care and outcomes	Community mapping Village Development Committee profiling: key individuals and organizations working in the area Census and enumeration of married women of reproductive age Survey of past pregnancy outcomes, perinatal care and demographics
Part 3: availability of services	Audit of services, human resources, equipment and consumables for perinatal care at local health facilities
Part 4: in-depth studies	Qualitative study of care practices and beliefs during pregnancy, birth and postpartum for normal birth outcomes and for maternal and perinatal deaths

Using Quantitative Data to identify areas of inequality:

1. Establish the Framework. In the Castle et al. study, health statistics from published resources were used to first identify major problems regarding sexual health of youth in Mali, on which to outline principle goals for the organization. (Castle, Traore et al. 2002) The MIRA project likewise conducted a literature review of community-based neonatal health research in Nepal and globally and gathered statistics around neonatal health issues in Nepal. (Morrison, Osrin et al. 2008) M.E., similarly, is already gathering data regarding cervical cancer rates, Cesarean section rates, and community intervention projects, via literature reviews (though possible other areas of exploration include stats around utilization of health and family planning services by women, maternal and infant mortality rates, etc).

2. In Part 2 of the MIRA project, data was gathered "to enumerate and describe potential beneficiaries [of the intervention] and to quantify care behaviors and birth outcomes." In this process, profiles of each village were created, including listings of names, activities, locations of local organizations and traditional healers, and gathering demographic, and birth data of women. (Morrison, Osrin et al. 2008) Likewise, M.E. is doing something similar. By conducting

pregnancy surveys with women from each community on the Lake, we are compiling a knowledge-base of where women are receiving care, what type of care, and beginning to understand if, and where, there exists a need for an intervention.

3. The third part of the formative research undertaken by MIRA included semi-structured interviews with medical personnel combined with secondary research from registers to build a sort-of database of the health care infrastructure and referral system. Through M.E.'s doctor/clinic, nurse, and midwife surveys, we are likewise collecting primary data with which to understand the existing medical infrastructure in the area (Clinic locations and names, staff names, titles, and education, etc.) and to identify areas with the most need in terms of women's health care (Where are services lacking? Which services? Etc.). However, more in-depth interviews with medical personnel would be ideal, especially for understanding the Mexican health insurance system, which we just can't seem to grasp, as hard as we may try.

Using a Participatory Method to identify community needs to influence curriculum-development:

4. Elicit a community definition. For Castle et al. this was "reproductive health," for M.E. it would be "women's health," or more specifically "reproductive health," or "women's rights." In the Castle study, after demographic data collection, both women and men were asked 1. If they had heard of the concept of reproductive health and 2. What the definition was. (Interestingly, while women were more likely to emphasize social support, love, and marital relations in the definition, men gave more medically-aligned definitions.) From this information, the investigators were able to identify common themes regarding reproductive health and the community beliefs around it. (Castle, Traore et al. 2002) This might be a good technique to use either when conducting formative research, or even when facilitating group discussions around women's health issues in a group setting.

5. Identify and Prioritize community needs. In their qualitative research, Castle et al. used a method referred to as 'free-listing' to identify the most-cited issues regarding reproductive (and non-reproductive) health affecting the community they worked with. Using this method, analyses of how often an item is cited and where it appears on the free list can tell the investigator a lot about its importance. This methodology is cited by Castle et al. in (38), although I didn't get the chance to read it (Bernard R. Research Methods in Anthropology: Qualitative and Quantitative Approaches. Thousand Oaks: Sage Publications, 1994.) (Castle, Traore et al. 2002) In the ReproSalud project, a method referred to as "autodiagnostico," a series of 4-5 sessions, was used to identify reproductive health problems and single out the one to develop a sub-project around. (Ruth Schuler 1999) This process is described as "employ[ing] qualitative and participatory methodologies intended to facilitate the exploration of participants' experiences, attitudes, and practices related to reproductive health in their lives." (Coe 1997-1998)

6. In-depth studies. Castle et al. conducted in-depth interviews and focus groups with youth and societal gatekeepers to further understand the issues surrounding reproductive health, the social context for the identified problems, how best to solve these, and how to best carry out the organizational goals as well. After analysis of the data collected, the results were presented back to the community for further discussion on how best to facilitate change, and implement a program for change. (Castle, Traore et al. 2002) Similarly, the facilitators of the MIRA project conducted in depth focus groups prior to implementing their intervention, asking local women to convene 27 focus groups regarding care practices during birth, and 24 focus groups around the language of birth and peurperium. The groups were homogenous in gender and ethnicity, and were tape-recorded. The use of a pictorial timeline was used to facilitate discussion around the birth process, and case studies were created of women and infants who had encountered problems during pregnancy. (Morrison, Osrin et al. 2008) The free-listing method was also used in the MIRA project in Nepal, however instead of for needs prioritization free-listing around the words "pregnancy, birth and newborn care" was used to initiate discussion surrounding perinatal issues in a focus group setting. (Tamang, Mesko et al. 2002) In-depth focus groups and/or interviews with women in the communities in the Patzcuaro Lake Basin will be invaluable to M.E. in terms of understanding the key issues and barriers that women are facing, and grasping how women understand, speak about, relate to, and act upon issues regarding women's health, dr.-patient interactions, the birth experience, etc. Ensuring a participatory, non-threatening environment for this sort of discussion, as in these cases, should be a priority. Also, documentation and evaluation of the results from these interactions should be carefully carried out. For example, from the evaluation in the MIRA trial, investigators uncovered a need for an empowerment intervention and a change in the social context because: "The interaction of shame, fear, vulnerability, seclusion and inertia is likely to cause delays in seeking care. Women's low status in the home may affect their ability to act on existing or learned knowledge; it would take great courage and personal strength for her to challenge tradition." (Morrison, Osrin et al. 2008) However, for instance, the need in the Patzcuaro Lake Basin might be one of a completely different nature than we think (from qualitative reports, probably not too significantly different), but this sort of research should be the foundation upon which to build a program, not the supporting documentation for a program already built.

Facilitating change:

The research shows that the model of empowerment and the "curriculum" (what is discussed, when, and how) for such a program should be initiated and developed within and by the community. Much of the focus for facilitating change is a continuation of the process began during the needs-assessment and "formative research" stage as a participatory community-based project. Some say that simply creating a "safe space," a place "for women to gather together and engage in consciousness-raising activities that value each woman's perspective and promote growth," is a method to promote the empowerment process. (Kasturirangan 2008) However, of what I have read, many health/empowerment programs that have been promoted and facilitated by outside agencies, NGOs, governmental programs focus not

only on this “discussion as action” component but also on the facilitation of discussion by peer health workers or facilitators. This distinction, strengths and weakness between facilitation and the creation a discussion space, is something that needs to be looked into further, and needs to be evaluated in terms of the desired outcomes of M.E. and the communities themselves.

It can be argued, for instance, that the facilitation of groups, if done incorrectly, can go against the very principles it was based on, as being a completely community-driven process with discussion of themes and ideas solely regulated and directed by the community members themselves. However, if done correctly, allowing for discussion among members of the group and the facilitator as equal participants, it can in some ways aid in the empowerment process. It might allow for the discussion of issues that may not have been discussed otherwise, sensitive topics, topics that women are shy bringing up without a prompt (for ex. gender relations, doctor-patient interactions, birthing care practices), but that they want to discuss and get feedback from other women about. It could bring to light inequalities or strengths that women had previously not realized and open a completely new forum for thought, discussion, action, and ultimately, empowerment.

The Peer Facilitator Model:

Many countries already have in place a peer-health educator model on a community level to provide basic primary-care interventions. In Tanzania, for example, the responsibilities of village health workers (VHWs) include “educating village residents on a myriad of health topics, such as recognizing danger signs during labor and delivery, distributing prenatal vitamins, referring pregnant women to health facilities, and providing postpartum follow-up.” (Ahluwalia, Kouletio et al. 1999) In the context of the Patzcuaro Lake Region, Promotoras, Oportunidades-affiliated community based health workers interact with women in the communities. To what extent, however, Promotoras educate, or facilitate health-related discussion with women still needs to be explored.

Expanding on existing or establishing new programs of peer advisors on a community-level may provide an appropriate route for “addressing health care issues within the social network of the community which can translate into increased trust in the health care system and empowerment of community members to adopt proactive rather than reactive behaviors relative to personal health.” (Hurd, Muti et al. 2003) Also, imbedded within peer facilitation or peer education programs usually is a train-the-trainer component. A review of community based health projects, among many other papers, comments on this in a very positive light: “The cultural and social value of trained local women who pass on their skills and knowledge to other women from the same and neighboring communities establishes not only networks of skilled women, but also a means for them to shift their position within society, to support each other, and to increase or consolidate their spheres of influence.”

This section will discuss several papers written about implemented peer health educator programs.

> Community-Based Reproductive Health Project (CBRHP): A collaborative project in Tanzania with CDC, CARE, and Tanzania’s MOH; The first of two goals of the CBRHP was cited as “community capacity building and empowerment through participatory training and supervision

of [established] VHWs [(Village Health Workers)].” (Ahluwalia, Kouletio et al. 1999) Like argued throughout this review, this sort of community-based initiative likewise was initiated because of the growing body of literature supporting the “importance of community participation for establishing ownership, effective problem identification, equity, and institutionalization of maternal and infant health programs.” Part of the focus of this project was to engage community members to participate more fully in health-related decision-making and problem-solving.

An outline of the program steps undergone by the CBRHP (Ahluwalia, Kouletio et al. 1999):

1. Initial Assessment. This program, like those above, went into the communities to assess what the main barriers and issues surrounding safe deliveries were, of which transportation to the medical facility in case of obstetric complication was the primary concern.

2. Training of Trainers (TOT): participants were from CARE, MOH, NGOs focusing on women’s issues, elected officials; 1-week training and field work to ID necessary steps to facilitate the development of a transportation plan and supportive supervision of VHWs

3. Development of “Action Plans” for both transportation and VHW supervision (including asking the village chairman to call a village meeting to discuss the issues, a transportation fund, involvement of VHWs, etc.

4. Training of VHWs: the trainers (above) went on to educate the VHWs in community involvement

5. Collaboration: trainers worked with VHWs on transportation plans and community leaders to identify additional community-based ways to support the work and recognize VHWs

6. Expansion: Trainers from 32 villages have been trained, 160 participants (inc. VHWs, village leaders, TBAs, women’s group leaders, etc.) trained via 1-day workshops on community participation, developing village plans for emergency transportation and supportive supervision

7. Community Involvement: community-wide meetings were held to discuss drafted plans from the 1-day workshops, get input, and refine, before implementation

8. Future Evaluation: CBRHP will work with communities to establish criteria for assessing and evaluating the supervision and transportation plans (I have not read about the evaluation of this project)

   Results/Comments: I have not yet read the evaluation of this project, and cannot comment.

The Perambalur Education and Prevention Program (PEPP): This program utilized similar steps as those described above (training of trainers, education of community members) in an effort to engage a wide cross-section of community members in a program based on principles of

"increased empowerment, participation, and community competence" to increase awareness of HIV and STIs in rural communities in India.

An outline of the program steps undergone by PEPP (Van Rompay, Madhivanan et al. 2008):

1. Collaboration with existing NGOs: A Community Advisory Board (CAB) was created consisting of 15 NGO (women self-help groups, schools, skill-training programs) leaders

2. Development of Information, Education, and Communication (IEC) materials: Cartoon-based (due to low-literacy) IEC materials were developed and pre-tested in community women's self-help groups, by HIV counselors in a hospital setting. These materials were based on the "Health Belief Model" (which I have not read about).

3. Training Outreach Workers. NGO field staff (Outreach Workers, OW), Women's Self-Help Group (SHG) leaders (Peer Health Educators, PHE), Barbers (Barber shops = all male-environments w/ sexual discussions); 6, 4, 2- day training, respectively. OW paid by their NGOs, while PHE and barbers received modest stipend for training; Pre- and Post-Session Evaluation, need to pass Post-Session evaluation to receive business cards, certificates, and "health education kit."

(To overcome stigma and fear of condoms, games were used in training of barbers)

4. Outreach and Referrals. PHE in women's SHG, informal education in Barber Shops, some OW put on skits, plays, entertainment as education in the streets of communities. Referrals made to HIV clinics, gov't hospital and support groups, providing free transportation.

-102 PHEs conducted a series of 3 sessions (1st = anatomy, 2nd and 3rd = HIV/STIs with education materials) for 607 Women's SHGs (~9000 women); **pre-2nd and post-3rd session evaluation scores of women attending SHGs were 57 and 75%, respectively (two-tailed paired t test, p< 0.0001).**

(A trained PHE using a flipchart for education)

-20 OW supervised and supported PHEs and Barbers, also 47 programs to general public and 218 programs to local communities, 57 street theatres, 37 HIV awareness rallies

5. Evaluation. Monthly meetings for PHE and OW, while OW visit barber shops. After 1-year period: quantitative results from pre-/post-session questionnaires from training, and women attending self-help groups (SHGs); qualitative results from focus group interviews with educators and general public (women from SHGs and barbershop customers); discussions with OW, PHE, Barbers

Results: Qualitatively, the author notes that “as the program progressed, the **trained peer educators and the general public gradually gained confidence in talking more openly about sensitive topics and expressed satisfaction in noticing changes in attitudes and risk behaviors**.” From focus group discussions, some findings include the positive impact that this sort of program has on the Peer Health Educators themselves: "I was looked down when I went for PEPP training in the beginning. But after my interaction with them on the subject I learned in the training, **their outlook changed. And now they are very eager to learn new information from me;**" **"We surprised people who ask us how an ignorant woman is able to speak on different subjects so clearly;"** "The people are fascinated by our new status with a kit bag, ID card and different social identity... Many ask us to get them also a similar job (PHE)." The Barbers also discussed the impact this program had on them: "This work does not affect our profession and we are happy and proud to do this service... **(We are) able to answer even intricate and difficult questions on HIV/AIDS; questions of educated and school learning people also;" "Discussions surrounding sex were very free and frank; ordinary people will not speak and discuss freely with doctors (Barbers)."**

Comments: Something that M.E. has been promoting all along is not only the impact that community participation in a program has on the women acting as participants, but also that on women acting as facilitators or outreach workers. The sort of reaction by outreach workers, feelings of empowerment, of being able to answer questions even of educated people, of being looked at differently by community members, and seeing oneself differently, has been noted in

another paper as well, and is a component of peer-based programs that should not be downplayed.

Implementing a Train-the-Trainer program:

I did not find much on actual curricula used to train the trainers, and I believe that this is an area for future research. Contacting authors of the papers cited throughout this paper (PEPP, CBRHP, MIRA, Bolivia Warmi project, etc.) would be the most beneficial resources for this source of information. One paper that I did find that outlined their approach to training the trainers is outlined here.

> Empowerment of Village Health Committees (VHCs): This project was started by the Department of Health, Punjab, Pakistan to improve Primary Health Care in the Sheikhupura of Pakistan. The primary focus of this paper was the workshops conducted with the VHCs (VHCs were created and elected by villagers, consisting of a cross-section of village members) to promote local participation in primary health care. The training workshops were conducted in a participatory manner, emphasizing that the facilitator was equal to the participant. Workshops were conducted within the villages, consisting of 6 people chosen by the VHCs, and were centered on community-awareness, organization, and development.

An outline of the sessions undergone to train VHCs (Tareen and Omar 1998), facilitated by someone from the health field (each bullet below indicates a separate session during a two-day workshop):

1. "How people define and understand health." The facilitator used the common themes to create an accepted definition by the group.
2. Understanding the health system. Used the example of a shop, and the key components necessary for successful business (shopkeeper, shop services, customer) to create a metaphor for the health care system. The participants used the same concepts to ID the key components of the health care system
3. The role of community. "Following these two sessions, participants would themselves often realize the role of communities, concluding that to promote an individual's health in a society-which essentially depends on mental and physical well-being-the community was equally responsible."
4. The importance of dialogue to achieve a common goal. This session initiated with an activity: 2 people need to draw a picture jointly, holding the same pen w/o talking. Follow up discussion involved what helped/hindered them in the exercise, application to everyday life, ID'ing the main "point" of this exercise: "Often it was agreed that resources were available in the community but, as in the exercise, the absence of dialogue was a hindrance."
5. Community Organization to achieve a common goal. Discussions began with a theme familiar to participants (the creation of Pakistan as a separate country) with key points: Although once a dream, now a reality, despite necessary struggles. Then broke off into

smaller groups to answer the posed question: what structure and qualities are needed for a group to achieve their objectives.

6. What is Development? Discussions tended to lead back to health outcomes as a result of interactions with the environment, or economic factors
7. Threats for development in the village: Participants ID problems in the community. Facilitator asks "But Why?," leading participants to ID key underlying factors to problems, and to rank them.
8. Road to Development. This involved two exercises, a drawing and a play acted out, with discussions to follow. Themes included: the need for a personal will and motivation, some external help, "To alleviate problems it was essential that people be helped in a way that enabled them to help themselves."
9. "Empowering the People." Discussion tying together the problems villagers encounter, the idea that if empowered, they have the potential to contribute to and sustain efforts to reduce problems themselves, brainstorming: solutions to the problems, resources needed and where to find them, how can implement and sustain solutions. Created a road map towards solution: time-schedule, tasks to be accomplished, leaders of each task (also monetary contribution) to be implemented.

Results: The authors state that by engaging VHC members and community-members chosen by the VHCs in sessions about community-awareness, participation, and development, it "**enables them to become change agents in their own development, not passive beneficiaries of assistance. It was clear that communities can improvise and innovate to find suitable solutions. They could appraise a situation, weigh the various possibilities, and define their own input.**" (Tareen and Omar 1998) This, as stated earlier, is, itself, empowering; people becoming their own agents for change, developing their own community action plan.

Comments: This is a good example of an education-empowerment program that could work for training of both facilitators, and also facilitating women's groups. Having small group sessions that build on the previous session, with a facilitator to combine all ideas into cohesive and communal thought provides continuity and consolidation to the thoughts of the participants. The fact that this sort of program also incorporates a session on the development of an action plan, with defined roles and responsibilities for each participant, is an important component of an empowerment process. (Kiefer 2007) A similar, participatory education method may be used if, for example, through discussions with women, M.E. were to discover that the communities were in need of a similar peer education-empowerment program (ex. a system of peer facilitators for health discussions). This curriculum (or an adapted version) for training of group facilitators seems like a viable way to educate about the importance of community involvement, participation, and empowerment while simultaneously using the same method to promote their own empowerment and participation. The fact that this method was participatory in approach also speaks to the idea that every step of program implementation or facilitation can and should

be a community effort, something discussed, identified, and implemented by community-members.

Developing a curriculum for facilitation of women's groups:

Some papers outline a type of "curriculum" for facilitators to use as a guide for the group sessions that they are participating in (much like the sessions outlined above, where each session has a theme for discussion). A paper on implementing education-empowerment programs for improved maternal and newborn health from 2003 outlines in a very general way what such programs should focus on (Portela and Santarelli 2003):

Table 1 Overview of interventions in the priority areas

Priority areas of intervention	Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	Increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health	Strengthening **LINKAGES** for social support between women, families and communities and with the health delivery system	Improving **QUALITY** of care, health services and interactions with women and communities
Intervention topics	Self-care	Human rights	Community financial and transport schemes	Community involvement in quality care
	Care-seeking behaviour	The role of men and other influentials	Maternity waiting homes	Social support during childbirth
	Birth and emergency preparedness	Community epidemiological surveillance and maternal-perinatal death audits	Roles of traditional birth attendants within the health system	Interpersonal and intercultural competence of health care providers

The authors state that "a comprehensive strategy, with interventions from each one of the four priority areas, is recommended" in order to "contribute to the empowerment of women, families and communities to increase their influence and control of maternal and newborn health, as well as to increase access and utilization of quality skilled care by women and their families." This paper also argues, as M.E. has, that in the context of an education program, education alone is not sufficient: "different evaluations of these efforts often show an increase in knowledge, without the corresponding changes in practice. As a result, neither true appropriation of knowledge nor long-term behaviour change nor local ownership of the processes occurs. Thus, it is inherent that these approaches do not lead to empowerment." Thus, the priority of an empowerment program for improved health outcomes should be based on, "not the introduction of knowledge but the creation of knowledge," a principle of the socio-interactionist theory in which learning by doing, within the appropriate context, is promoted (other principles are cited below). (Portela and Santarelli 2003)

Table 3 Key principles of a socio-interactionist approach

- The educational process should start from the participants' knowledge (texts and representations) in order to strengthen or weaken it, present and analyse new external knowledge and create a new knowledge derived from the confrontation of both sets of knowledge.
- The educational process should enable a conceptual attainment of knowledge as well as abilities to further acquire knowledge, in order to permit an autonomous intellectual capacity to continue one's own education. This can be summarized as learning to learn.
- Knowledge expressed and learned has to be linked to social, historical and cultural realities.
- The educational process should be a learning experience that allows the participant to be responsible for his/her own development, in order to reinforce the capacity for critical analysis of his/her own formation and the formation of the other participants.

This sort of approach, integrating capacity-building and awareness-raising, with improved interactions with health care facilities and improved health attitudes and behaviors can be incorporated throughout an empowerment intervention. This sort of participatory approach has been discussed in the preliminary phases of program implementation (specifically formative research), but can also be used to develop educational materials (like M.E. is doing by integrating input from M.E. staff for platicas), and conduct groups focusing on problem identification and solving. The participatory methods used by the MIRA project in Nepal will be used as a model of this sort of education-empowerment program.

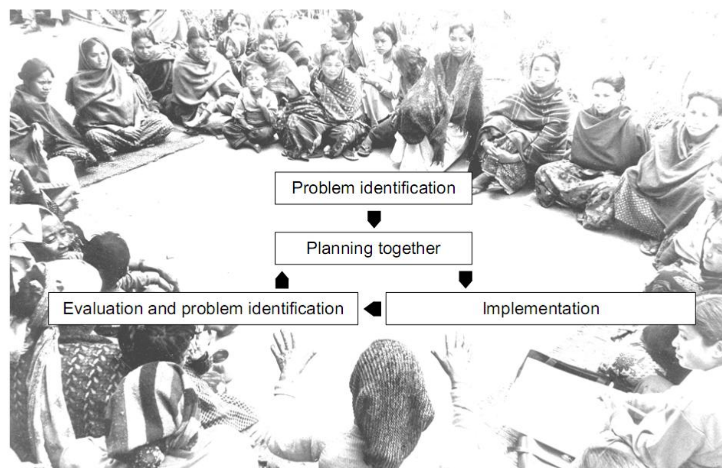
The MIRA project in Nepal, focusing on improving neonatal health outcomes, after conducting its formative research, identified a need for women's participatory groups to discuss, share experiences, and alter the social context in which neonatal and other pregnancy-delivery related issues arise through varying community-driven action plans. To do this, locally-based women were employed (paid) and trained in facilitation techniques to facilitate monthly women's groups (in coordination with the local female Community Health Volunteer, who, though unpaid, was in charge of running women's health promotion activities). Each facilitator was in charge of 9 meetings a month in 1 of the 12 village development committees (each with a population of ~7000). Facilitation supervisors, after national recruitment and interview, were also employed to provide support for community visits and meetings to the facilitators. The first ten meetings of these groups ("curriculum" outlined below) were based on the Warmi model (O'Rourke, Howard-Grabman et al. 1998), and the facilitator's used a manual (of which I have a copy) to help guide the groups through each session, including games and different strategies for participation. (Morrison, Tamang et al. 2005)

Women's Group Monthly Session 1-10 Outline (Manandhar, Osrin et al. 2004)**:**

Phase	Meeting	Aim
Introduction		
	1	To introduce the study to the group

Phase	Meeting	Aim
	2	To discuss why mothers and newborn infants die and how the intervention will work in the community
Problem identification		
	3	To ascertain how women understand maternal and neonatal problems
	4	To find out about maternal and neonatal problems in the community
	5	To understand the frequency of maternal and neonatal problems and to identify strategies to obtain information in the community
Problem prioritisation		
	6	To share information from other women in the community and to prioritise three important maternal and neonatal health problems
Planning together		
	7	To discuss possible strategies for addressing the priority problems
	8	To discuss involvement of other community members in developing strategies
	9	To discuss preparation for a meeting of community members
	10	To hold a meeting involving other community members to discuss the activities of the women's groups, the priority problems identified by the groups, and possible strategies, and reach consensus

Because this section focuses on how to organize and facilitate participatory women's groups in community action cycle for empowerment and health outcomes, I will outline and cite some examples from the facilitator's manual of ways that MIRA accomplished this.



Visual depiction of the Community Action Cycle (Morrison, Tamang et al. 2005)

Introduction (Sessions 1 and 2): The first session was used to stimulate discussion about the work of MIRA (for ex. the manual includes: “Discuss what the participants have heard about MIRA and what they think are it’s activities,” and “Show the women MIRA’s logo and clarify the meaning of MIRA and its work.”) It also included the use of a “piggy back game” (which to me, sounds like it is too physically demanding, since it involves carrying others) to explain how different organizations work with communities in different ways, some “carrying” communities, while others (like MIRA) want to “hold hands” and work together with them. The second session used a story, flow charts, and a game to stimulate discussion of perinatal problems, their social, econonomic, and medical factors (for ex. “why” did the outcomes, baby’s death, in the story happen?), and possible solutions to these factors. (MIRA 2005)

Problem Identifications (Sessions 3-5): These sessions also used story-telling as a discussion-point, and introduced the concept of “learning together” to identify views about maternal and neonatal problems in general. Specific problems faced in the community were elucidated by using a picture-care game. Women were asked what their problems they have encountered in pregnancy or what neonatal problems they have seen, were given a picture card representing this problem, and the woman in turn, asked the rest of the women “to describe the problem which she sees in the picture, what it is called (if it has a particular name), what causes this problem, what to do when this happens, if you don’t do anything what happens and is it common here?,” engaging women to discuss directly with others. Facilitators also asked how to go about finding out information like statistics, etc. and what the best approach would be, including having the women participants conduct interviews with family/friends and record their findings in some way. (MIRA 2005)

Problem Prioritization (Session 6): Each group prioritized three problems of pregnancy and newborn infants with a justification why these were the most important. (Morrison, Tamang et al. 2005) The manual reminds the facilitators that “A problem should be: frequent, severe and feasible.” (MIRA 2005)

Planning Together (Sessions 7-10): TBAs and Female Community Health Volunteers were asked to attend session 7 to discuss their roles and local health facilities, while sessions 8-10 each focused on one of the prioritized problems. (MIRA 2005)

The manual also includes 3 more sessions, which are oriented around solidifying the strategies outlined for the prioritized problems, preparation for a community meeting to discuss the problems, and facilitation of a community meeting. (MIRA 2005) However, although these sessions weren’t specifically outlined in the literature, the hosting of community meetings was: “A community meeting was planned and organized by the groups to enable increased community participation and to legitimize the work of the group. The community was invited to hear what the women's group had been doing, and to participate in planning together strategies.” (Morrison, Tamang et al. 2005)

Results: **Of the 111 women's groups, 100 continue to meet and discuss perinatal and maternal issues, and 77 actually developed and implemented strategies** targeting identified problems. Some of the implemented strategies included: a "mother and child health fund, locally produced clean home delivery kits, management and production of stretchers, and awareness-raising through video shows." Other interesting results were that women often defined the seriousness of a medical problem differently than the allopathic model does, **identifying a need for simultaneous perinatal health education** which was accomplished not through direct education, but participatory education, facilitation through the use of a picture card game (different from that above). The card game involved matching differently-shaped cards (each representing a home-care, prevention, or health institution activity) to cards representing different perinatal problem and facilitating discussion around this problem.

Examples from the picture card game used for participatory health education. (MIRA 2005)

In terms of "empowerment outcomes," there was **increased participation by women in local health services and advocacy even outside of the groups**; for example, in response to women's complaints of a lack of privacy and furniture in the clinic they attended, the group contacted a local forester for furniture and collected money for curtains, one woman sparked discussions around newborn health on a local bus with a cassette tape from the group-developed video, the video's theme song was sung at a women's festival. **10/12 facilitators were asked to attend other community meetings and activities**, indicating a sense of community recognition and status. "One group put a sign on the door of their meeting place indicating a **sense of ownership**." The quantitative markers of health outcomes were already discussed earlier.

Some issues around the facilitation manual, which was considered by the facilitators to be an "essential resource," however, were brought up by the authors: "The manual was designed as a reference guide but evidently became more like an instruction booklet, as the strategies most commonly adopted during community meetings were those given as examples in the manual." The authors cite "**To truly facilitate, and not be directive, is a difficult technique to learn**, especially in a hierarchical society where the facilitator's education has emphasised rote

learning rather than independence of thought." And although facilitation abilities increased with time, the ability of "the facilitator to manage the chaos and unpredictability resulting from a truly participatory process was often lacking." (Morrison, Tamang et al. 2005) The authors also note that **fatalism**, the idea that "one has no personal control over one's life circumstances," "affected both the way people viewed themselves in relation to a problem, and also the power and capacity they believed themselves to have in overcoming it." (Morrison, Tamang et al. 2005)

Comments: The MIRA project, as noted earlier, showed evidence for drastically improved quantitative health outcome measures in terms of neonatal and maternal health. A qualitative study on empowerment outcomes, however, has not yet been conducted to my knowledge (despite the authors stating that it was in the works). However, the few qualitative outcomes that they did list in this article seem to promote the notion that these participatory groups surrounding identified women's health issues (identified through qualitative and quantitative techniques used in the formative research process described earlier), are improving women's health attitudes and behaviors in a pro-active way. Women are not just receiving information passively, but are engaged in the discussion and problem-solving of identified issues, actively participating in health-related advocacy in their communities and within their groups. I think a key component of the approach that MIRA took, and the reason it was successful, was its bottom-up nature. They did not go in with a set agenda of what to fix, but first ask the communities what needs fixing, and facilitated groups to help them find solutions to these issues. I think what MIRA strived to do was create a program in line with the principles laid forth by the socio-interactionist theory, but struggled to effectively make it a participatory approach. In theory the goal of "facilitation and dialogue and creating knowledge rather than providing the messages and the solutions" (Portela and Santarelli 2003) is what all empowerment programs should try and achieve. However, in practice, as seen in the MIRA project, this is a lot harder to do. Training facilitators in facilitation skills, if M.E. were to try and implement a similar sort of project in the future, would require teachers with very specific and specialized skills in communication and interaction within a group setting. Otherwise, I feel that, if preliminary discussions within the communities show that there is a need for this type of intervention, I think that developing a similar program would be a wonderful way to facilitate education in a contextual way, while simultaneously engaging women in discussions and improvements to their own health, an empowering process.

Adapting with a community:

M.E., like any community-based program should grow with the community, "be reiterated, changed or modified according to evidence elicited from social exchages and social relations" with the community. (Castle, Traore et al. 2002) This open-endedness was part of the "community action cycle" that programs like MIRA's and ReproSalud engaged in on a small scale, in that women's groups identified their own problems to pursue and solve, and after the intervention process, were more-or-less autonomous. However, it is interesting to note that some programs have shown this sort of evolution in drastic ways, shifting focus to a completely different problem. For example, in project in China, the

focus moved from piglet husbandry and income generation to creating a system of "barefoot doctors" to attend the medical needs of communities without medical access. During a project to improve literacy in Indonesia, women later shifted their focus on improving access to clean water. (Manderson and Mark 1997) These examples show that once engaged in one empowering and self-sustaining activity, women readily are able to identify and work towards the improvement of their own situation by identifying other issues to tackle. They also draw attention to the fact that what an organization thinks is a priority may not be what the community thinks is. Thus, M.E. should be a receptacle for the community's needs and wants, responding to and evolving with the community.

Assessing and Evaluating Project Success with respect to Women's Health Outcomes (quantitative) and Attitudes and Access to health care (qualitative):

Programs listed in these discussions have evaluated outcomes both qualitatively, through observations, interviews and focus group discussions, and also quantitatively, through pre- and post-test measures, RCT and case-control surveying techniques, etc., the various outcomes measured in each case, depending on the respective program's goals.

It is important to also keep in mind that just because someone doesn't reach some indicator of empowerment as it was defined in the outset it doesn't mean that she isn't "empowered." For example, if looking at utilization of formal counseling services, someone may not use these services, but may be getting support from church, family, other sources, and in this way be "empowered." (Kasturirangan 2008) Some outcomes might not even be determined until after a program is well under way, until a qualitative effect can be observed within an individual, the group, or the wider community. As the investigators from MIRA state, an affirmation of what M.E. has already been thinking: "it may be that the process of implementation is more beneficial than the strategy itself. Through implementation, interaction between the wider community and the group may be increased, knowledge about the group may spread, and more people may become interested and involved in issues of perinatal health." (Morrison, Tamang et al. 2005) Thus, in this case, qualitative outcomes need to be evaluated almost as they occur; one can hypothesize what different outcomes may be at the outset, but in some cases the scope of a program's effect cannot be discovered until after its implementation. Like the rest of the process of implementing a program, then, the evaluation is just as contextually-based, and requires sensitivity towards culturally and community-held beliefs.

The over-arching theme from these papers, however, is the importance of evaluating what the measures should be, on a case-by-case basis. For example, "programs designed to empower should consider whether simply increasing a person's sense of control over their lives is sufficient. When the ultimate goal of the program is to make change in society…programs may need to work harder to assess the actual changes that have occurred in women's lives as a result of the program activities." (Kasturirangan 2008) These sorts of measures would most likely be best assessed qualitatively. If education is a large component of a program, pre- and post-test measures are likely appropriate. When health service utilization or concrete health indicators like mortality rates are sought, surveys focusing on quantitative measures should be conducted. However, all of these outcomes are related to

measures of empowerment; the difference between qualitative and quantitative measures lies in the aspect of empowerment measured, the process or the outcome. The process leads to feelings of empowerment, having a perceived increase sense of control, self-esteem, a decreased sense of hopelessness or fatalism. The outcomes lead to tangible increases in one's level of control over resources or improved status in a social context, for example. What does M.E. want to accomplish? I think the answer to this question needs to rest within the communities – what do they want to accomplish? And for this, more research needs to be done.

Barriers and Obstacles Encountered:

In the literature, it is noted that community-based participatory programs encounter problems that traditional research and program implementation initiatives don't. These barriers are tied to the very foundation of empowerment programs. Larger organizations, primarily funding groups, may question the promotion of empowerment as a primary program goal, the community-based techniques used to achieve goals, the accuracy or the validity of outcome measures purporting increased empowerment, the open-endedness of the program. One study discusses these sorts of concerns, in the context of family planning programs: "Despite the optimism of the Cairo Programme of Action, some fear that rates of contraceptive use and fertility decline may be undermined if resources are diffused in pursuit of gender equity and women' s empowerment. Others fear that empowerment could 'rock the boat' or that women are simply not ready for it. Still others argue that family planning programmes already empower women in the reproductive sphere, and that other potential forms of empowerment are outside the scope of family planning or reproductive health programmes." (Ruth Schuler 1999) There is likely still a lot of demystifying to be done when trying to find support or even funding for a community-based participatory empowerment program.

Other obstacles also stem from the nature of the program, itself. Because of the very community-based, contextual nature of this sort of approach, a lot cannot be concretely established from the outset, even including the specific goals or outcomes of the program. This all needs to be based on community input, needs and priorities, only elucidated by discussion within the communities, research of statistics, etc. Also, as mentioned before in the case of MIRA, being able to implement a truly participatory program is a challenge; One needs to be trained and observed very carefully by someone who is specialized in facilitation and communication in order to prevent facilitation from becoming direction.

If, when, and how, to incorporate men into the project also needs to be determined. In the later stages of the ReproSalud project, which initially involved women solely,"women often asked that men also be included, often motivated by the fact that men opposed their wives' participation." In some instances, bringing up issues like contraception and family planning have lead to severe retaliation and violence by the husbands of women involved, like that documented by the Novrango project in Ghana. (Ruth Schuler 1999) These examples suggest that, at least in the future, there will most likely be a need to address gender relations directly. Some projects, like in Nicaragua, have targeted male-counterparts directly (Sternberg 2000) (although I have not read this article). However, projects like ReproSalud have

left the decision of when and how to involve men in the program in the hands of the women involved, which has a different dynamic that a program initiated *for* men from the outset; Movimiento Manuela Ramos describes it as "working with men on women's terms." (Ruth Schuler 1999) A good overview of ReproSalud's methodology for implementation and evaluation of its men's programs (mainly summarizing and citing a paper entitled "Involving Men in a Project Based on Women's Empowerment" by Leau, C., 2003) can be found here: http://www.jhuccp.org/igwg/guide/chap4.html (IGWG 2003) When, how, and of what purpose to involve men in a project such as one undertaken by M.E., however, is definitely an area for investigation much later in the future.

What to do now, realizing this program:

Throughout the literature, it has been stated that empowerment is not a process that we can bestow upon the community that we are working with. The community, itself, needs to engage in a process of problem prioritization, barrier identification, goal setting, and work towards the realization of their goals. Who are we to say what is important to the women of this community? What M.E. could and should be doing, on the other hand, is helping to facilitate the creation or location of resources so this community can begin to realize and act on their goals (for ex., transportation, child care, providing a safe space for women to talk about issues affecting them, creating a women's center with empathic and good care for women's health needs, facilitating group discussions).

Throughout this paper, I have discussed the steps that other programs have taken in their own efforts to help communities realize their needs, goals, and actions. These can be summarized as 1. Identifying and partnering with community, government, medical groups and bodies with aligning goals, 2. Assessing community needs and priorities both qualitatively and quantitatively, and 3. Facilitating the development of a program to target community needs. M.E. has already taken the initial steps of building rapport within communities through platicas, surveys, and discussions, beginning discussions with governing and medical bodies (community "hefes," IMSS, UNAM) and community women's groups about partnerships and links, and has begun the formative research process (the identification of women's health needs and gaps via the birthing survey, and building a understanding of the medical infrastructure, patterns of service utilization by women, mapping of medical providers including nurses, doctors, traditional midwives via doctor/clinic, nurse, and midwive surveys). Further steps, however, should be taken to do more qualitative assessment of health beliefs, barriers, services, and behaviors by holding in depth interviews and focus groups with doctors/nurses/midwives and especially, women in the communities. The papers outlined here suggest that a participatory approach to group discussions, facilitating problem identification and problem-solving, even in the needs assessment process is a way for women to become actively involved while critically considering the social context of their health attitudes and behaviors. The use of stories, games, anecdotes are some of the methods used in facilitated discussions.

Developing and implementing a program is a process that should be decided with the communities, and discussed and thought about throughout the in-depth interviews and discussions with women and health workers. I have discussed the facilitation of women's groups as a possible intervention for discussion of women's health issues, birthing practices and services, etc. using a peer facilitator model (and including train-the-trainer programs). However, there are other questions that should be looked into further: What are the benefits of simply providing a safe space for discussion in the context of a women's health center, like that proposed by M.E.? How does a case-worker approach (one-on-one) for education-empowerment compare with the participatory group approach? And on a more immediate level: How can we adapt the participatory methods used by others to make M.E.'s platicas more participatory, and less directed? For this latter question, I propose that M.E. discusses this with its staff. The use of games like educational card-game used by MIRA is one option (however, this would most likely require a smaller-group setting and more time beyond the one-hour allocated to platicas). A case story, on the other hand, might be a good way to reach the entire group at once, and to spark discussion and critical thought in smaller break-out groups which could reconvene and share with the larger group. Hand-outs, educational materials, something that Leslie already discussed with M.E., could also be developed within the group and social context for more immediate use during platicas. While these steps seem small in comparison to the interventions I wrote about, they are ones that I think will make a big difference in the way that the communities think about and process the information that M.E. discusses with them now.

In the long-run, however, I think there is a lot room for growth of Mujeres Enlazadas and the communities it works with. Through discussions, through listening, and really hearing what women have to say about the care they receive, their concerns, and their wants through focus groups, through women's discussion groups, and platicas, M.E. can be a great resource for the communities. Mujeres Enlazadas already has the foundation to help women achieve their goals…Its philosophy reflects that: "When women are well informed, enjoy good health, and understand the wonderful capacity of their bodies, they can respect and care for themselves and better care for their families." What Mujeres Enlazadas simply needs is a few more hands and bit more time to learn from, learn with, and evolve with the community it serves.

I finish with a gorgeous quote that reflects what M.E. has been saying, feeling, and should aspire for in terms of an empowerment program; A reflection on women's participatory groups, cited in the paper discussing the ReproSalud project: 'The perspective is integrated because health has to do with empowerment, with self-esteem, with income generation.. And when it is their [the participants') turn to train other women they reflect very seriously, they talk about the differences between men and women, and how these differences result in inequality or subordination of women. It's as if they had been waiting... to name something they have felt all their lives....It is no longer "This is the way it is and it is always going to be this way." They feel: "We can change, we can change ourselves, and we can change the relationships between men and women, relationships with our children and with our partners."' (Ruth Schuler 1999)

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