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**Towards Empowerment:
An Exploration of the Red de Mujeres' Participation in Women's Health Promotion**

by

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A thesis submitted to the
Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of

Master of Arts

The Norman Paterson School of International Affairs

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The undersigned hereby recommend to the Faculty of Graduate Studies and Research acceptance of this thesis submitted by Pascale Dominique Méra as partial fulfilment of the requirements for the degree of Master of Arts.

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Abstract

Non-governmental organizations are increasingly forming or supporting women's grassroots groups as a means of implementing participatory health strategies and empowering women. While the principles of participation and empowerment are well-understood, the way the processes unfold in the grassroots context remains unclear. This thesis explores the empowering potential of participatory health strategies for women as they occur in rural Peru. The analysis draws largely on the insight gained from field research conducted with the Red de Mujeres, a women's grassroots organization in Piura, Northern Peru. It examines the extent to which the organization's participation in a reproductive health project has nurtured women's empowerment. The case study demonstrates that while women's participation has clearly brought about personal empowerment in the form of enhanced self-confidence and awareness, this empowerment remains in the hands of a select few with the majority of members left at the margins. It will show that the personal empowerment of leaders does not necessarily lead to collective empowerment. Finally, the case study discusses the factors which inhibit empowerment.

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Chapter One

Introduction

*Before we didn't know our rights, so we didn't claim them.
Now we know them and we can defend them.*

- leader, Bigote

1.1 Why a Thesis on Women's Empowerment?

Since the mid 1980s, the terms *empowerment* and *participation* have gained popularity in the field of international development, particularly in reference to women. These highly charged and interconnected concepts have come to describe both the goals of development as well as the means of remedying a myriad of social problems including women's low status, their lack of access to income-generating mechanisms, and their absence in decision-making arenas.

The principles of empowerment and participation have also been applied to women's health development. Health planners are increasingly realizing that women have not played a substantial role in defining the direction of their health development. As a result, the international health development community exhibits a very narrow understanding of women's health. By emphasizing women's childbearing role and biomedical solutions to health problems, planners have failed to address the broader circumstances of women's lives which negatively impinge on their ability to promote or

protect their health. They have neglected problems which arise from nutritional deficiencies, environmental hazards, domestic violence, women's workload, and aging, for instance. They have also failed to take into account non-biological determinants of ill-health such as women's education level and their position in the social hierarchy.

There is growing support for gender strategies which adopt a more holistic view of women's health and emphasize women's empowerment as a means of improving their ability to safeguard their health. Proponents of the gender and development perspective are calling for participatory strategies which foster women's active involvement in health promotion activities. It is believed that women's participation in their own health development is a powerful mechanism for enhancing awareness and self-esteem. As such, it improves women's ability to protect their health. In addition, participatory strategies are a means of increasing women's voice in local, national and international health planning processes.

Non-governmental organizations (NGOs) are increasingly forming or supporting existing women's grassroots organizations¹ as a means of implementing participatory

¹ Women's grassroots organizations can be defined as any organization at the group, community, or local level which has come together to meet its members' needs (Uphoff 1993). They have community-based leadership and decision-making power. Organizations at this level are referred to in the literature as primary grassroots organizations (PGOs), or 'base groups', and are distinct from grassroots non-governmental organizations which offer services to meet the needs of others (Bebbington and Thiele 1993; Carroll 1992). This is an important distinction as much of the literature lumps women's NGOs and women's grassroots organizations in one undifferentiated category, thereby leading to much confusion.

health strategies. Women's organizations can act as effective intermediaries between health institutions and women clients. They can communicate with health professionals to improve the acceptability of treatments and services, and, at the same time, they can inform women of the importance of seeking care (MacCormack 1992). Women's organizations are also a "forum for women to gain self-reliance and will eventually enable women to obtain real access to resources and power" (UN 1980 in Young 1993: 29). They are thus viewed as a prime medium through which health care can reach women and an ideal vehicle for women's empowerment.

1.2 Thesis Statement

This thesis examines the empowering potential of participatory health strategies as they occur in the context of grassroots women's organizations. Central to my analysis is the qualitative insight gained from four months of fieldwork in Northern Peru² where I explored the participation of the Red de Mujeres in the Centro IDEAS Reproductive Health Project. The case study presented in chapter five critically evaluates the extent to which the Centro IDEAS Reproductive Health Project has nurtured the personal and organizational empowerment of women in the Red de Mujeres. It assesses the participation and empowerment levels of leaders and members and looks at the conditions which strengthen and weaken the organization. The case

² The financial support of the Canadian International Development Agency made this fieldwork possible.

study will further our understanding of the complexities of participatory health strategies. It will demonstrate that awareness-raising amongst leaders does not necessarily lead to the empowerment of the organization as a whole and will discuss the factors which have impeded broad-based participation and empowerment in the Red.

1.3 The Red de Mujeres

The Red de Mujeres is a grassroots rural women's organization in the districts of Salitral and Bigote, Piura, Peru. It was formed in 1988 as a means of implementing the Centro IDEAS³ Reproductive Health Project and increasing women's voice in local and district level health planning. The NGO's health project, which is now in its ninth year, combines the delivery of gyneco-obstetric care and services with individual and collective empowerment goals. The Centro IDEAS has stimulated the Red de Mujeres' participation in consciousness-raising and capacity-building workshops in order to enhance women's ability to promote and protect their health. In addition, the NGO has attempted to increase the Red's collective empowerment by facilitating its participation in the Ministry of Health consultation process. The NGO health promoters believe that the implementation of such a project is a means of developing a "feminine consciousness as part of a process directed towards women's transformation into social actors" (Puente and Castro 1995: 11). The case study in chapter five evaluates the

³ Information regarding the Centro IDEAS, its Reproductive Health Project and the Red de Mujeres will be offered in greater detail in chapter four.

extent to which the NGO's empowerment goals are being reached.

1.4 Rationale for the Choice of Case Study

Peru is an ideal country in which to conduct a study on women's empowerment and participation in health development. Firstly, it boasts one of the largest women's movements in South America (Vargas 1990). The country's cultural and geographical diversity is reflected in the women's movement's multiple forms of expression. Women's organizations are differentiated not only by function, but also by geographic location, class, age, and ethnic group. The women's movement, which developed throughout the 1980s as a result of economic and political crises and the inadequacy of social services (including health), comprises the feminist stream⁴, the popular women's stream⁵, and the stream emerging from traditional public spaces, that is rural peasant groups.

The Red de Mujeres is part of the women's movement which has emerged from

⁴ The feminist stream consists predominantly of urban-based feminist NGOs with middle-class membership. It supports urban and rural based women's groups in a variety of projects including self-help and health education. Feminist groups tend to adopt an 'empowerment approach' which aims to address gender inequities indirectly by supporting grassroots mobilization around practical gender needs (Moser 1989; De los Ríos 1993).

⁵ The popular women's stream refers to lower class urban women who have come together in an attempt to satisfy needs and demands which spring from their traditional roles as wives and mothers by relying on their socialized abilities and skills as women. Examples include mothers' clubs, health committees and communal kitchens, many of which have sprung up in the *pueblos jóvenes* (shanty towns) around Lima and other large cities. It is important to note that similar organizations exist in rural areas but have not received as much attention in the literature.

what Vargas (1990) terms traditional public spaces. It is a particularly interesting organization to study because it is an umbrella organization for all the women's base groups in the Upper Piura Valley and draws on the power and experience of existing local leaders. Moreover, it mobilizes around women's own needs rather than family welfare. The Red de Mujeres has linkages with feminist organizations yet maintains a 'feminine' rather than 'feminist' posture. This is common amongst popular and rural women's organizations. It reflects the different agendas and priorities of each movement and the extent to which women feel that the feminist label might restrict their participation (Vargas 1990).

Second, Peru is an ideal country in which to study participatory mechanisms. In 1990, the State initiated a consultation process with organized civil groups. This process was extended to the health sector in Piura where, since 1995, annual *mesas de concertación* (consultation meetings) have been implemented. The decentralization of the health system has facilitated this consultation process by providing more power to local health centres that are assumed to be more able to work with and for the people. By conducting fieldwork in Piura, I was able to experience and observe the participation of the Red de Mujeres in this process.

1.5 A Note on Methodology

Although I have dedicated a chapter to methodological issues, it is useful here to offer a brief discussion of my approach to research and writing this thesis. Given my commitment to articulating women's experience and the nature of my thesis question, I felt it was necessary to conduct qualitative field research and elaborate a case study based on my findings. Qualitative research methods were deemed the most appropriate means of exploring the issue of empowerment as they offer the participants space to convey their experience. I maintained a feminist participatory approach to research by adopting methods conducive to listening to and hearing women's voices and by bringing these voices to the forefront in this thesis. I chose a case study as the vehicle for transmitting women's voices. Case studies provide insight into the complexities of the participants' life experiences and enable the researcher to "go beyond generalizations by seeking specificity, exceptions, and completeness" (Reinharz 1992: 174).

My desire to privilege the voices of those who participated in my study influenced the way I wrote this thesis. That is, rather than simply fitting the data into existing theoretical arguments, I used the data and theory to illuminate each other mutually. Prior to leaving for the field, I had read much of the Northern and Latin American literature on women's health and participation and therefore had a good grasp of relevant issues and debates. This helped me establish research objectives and

preliminary interview questions and provided a basis for analyzing the local situation. I conducted a preliminary data analysis in the field and conceptualized the major themes, an exercise which in turn allowed me to re-read the literature in a more critical manner, uncovering gaps, inconsistencies and similarities with the reality of which I had been a part. I was then able to write the theoretical framework around the themes which had evolved out of the interviews.

The remainder of this chapter will delineate approaches to women and development and their impact on women's health development strategies. The chapter will conclude with an outline of the rest of the thesis.

1.6 Approaches to Women and Development

Strategies for women's health (and health in general) reflect the assumptions which underlie dominant thinking about development, its ultimate goals, and the process by which it can be achieved. They mirror the firmly held beliefs of Northern development "experts" regarding the causes of and barriers to development in the South and women's place in the process (de los Ríos 1993; Oakley 1989). In order to fully understand the question of empowerment and its pertinence to women in the context of health, it is useful here to discuss approaches to women and development

and their implications for women's health policies and programmes.⁶

1.6.1 Welfare and Women in Development (WID)

Caroline Moser notes that the welfare approach to social development, introduced in the 1950s and 1960s, is the earliest policy concerned *with* women in developing countries (my emphasis)⁷ (Moser 1989). This approach was based on three assumptions: that women are passive recipients of development, that motherhood is the most important role for women, and that women's most effective contribution to development (read: economic development) was through child-rearing (Moser 1989). Women were thought of as mothers and wives, and as backward beings whose traditional beliefs impeded economic growth and modernization, the ultimate goals of development. As such, projects developed within the welfare framework approached women in two ways: they either ignored women altogether, subsuming their needs under those of the family and/or the community, or they concentrated on women's mothering and childbearing roles as a means of furthering family well-being (Young 1993).

Consequently, typical health projects developed within this framework include

⁶ A comprehensive overview of these approaches is beyond the scope of this thesis. The Welfare, Women in Development and Gender and Development approaches are critically examined in Young 1993; Moser 1989; and Marchand and Parpart 1995.

⁷ I have italicized the word 'with' to emphasize that although the welfare approach made use of women for development purposes, it did not necessarily do so out of concern *for* them.

Mother-Child Health (MCH)⁸ services, food aid, and later, population control programmes, each of which target mothers as passive beneficiaries (Moser 1989). Women were given health education, training, and contraceptive technologies in order to enable them to protect the health of their children and family. That women might have health concerns which lie beyond their maternal role was never contemplated. And that they may have a say in project planning and implementation did not enter into the model of planners.

By the 1970s it had become clear that development projects had either negatively impacted on women or simply failed to improve their status. The Women in Development (WID) approach represents the first institutionalized effort to bring women into discussions of development theory and practice. It was developed by Northern liberal feminists in direct response to women's marginalization from the development process and its benefits. WID's underlying assumption is that women can gain equality through economic independence and that this can be achieved by integrating women into the market economy. WID proponents therefore argue for policies and projects which foster women's participation in economic activities. Typical projects include women-only income generation schemes and the introduction of time saving technologies which lessen the burden of women's household chores.

⁸ MCH services are all those which revolve around maternal and child health such as pre-, peri-, and post-natal care, and child nutrition.

The focus later changed to the fulfillment of basic human needs, particularly education, training and health, as a means of alleviating poverty and increasing productivity. WID proponents assumed that training and education for women was an effective means of enhancing the status and productivity of the community as a whole (Moser 1989; Rathgeber 1990; Marchand and Parpart 1995).

The WID focus on increasing women's productivity and income has led to a utilitarian approach to women's health. WID specialists have assumed that improving women's health would enhance their productivity in the workplace, and that reducing fertility rates would reduce the risks associated with childbearing and facilitate women's participation in gainful employment. This led to a further emphasis on family planning programmes and maternal-child health projects. Little effort was made to address other factors which affect women's health.

WID has failed to provide a holistic understanding of women's lives and concerns. By focusing on women's integration in economic production, WID planners have simply transferred Northern liberal feminist ideals to women in developing countries. Policies and practices continue to ignore women's voices and legitimate quick-fix, technical Northern solutions to local problems. Strategies have done little to improve women's self-reliance or alter entrenched patriarchal structures. Lastly, in their emphasis on women's integration into existing models of development (models

which have until now largely perpetuated women's subordinate status in society), WID proponents neither question, challenge nor aim to transform the theoretical and practical implications of modernization and economic growth frameworks.

1.6.2 Gender and Development (GAD)

The Gender and Development (GAD) approach is the result of a dialogue between Northern and Southern scholars and activists. It draws heavily on what has come to be referred to as the empowerment approach to women's development. This approach was developed by Southern scholars and activists who call for solutions which are grounded in women's experience. Its purpose is to foster women's self-reliance and autonomy through bottom-up mobilization (Moser 1989; Parpart and Marchand 1995). Empowerment and self-determination replace modernization as the ultimate goals of development.

GAD is an attempt to rethink and redefine development. Its proponents argue that the problem does not lie in women's invisibility or their integration into development. Rather the problem stems from the goals of development, the underlying assumptions of planners regarding women and the structures and relationships which give rise to women's disadvantage, particularly gender relations (Young 1993).

Gender planning requires an understanding of how society is shaped and a profound questioning of the structures, processes, and power relations which are inimical to women's emancipation (Young 1993; Marchand and Parpart 1996). It requires the recognition that women are not a homogeneous category, but are divided by class, colour, and race, and that women's subordination is a result of multiple and related forms of oppression, be they gender, class, ethnicity and age (Moser 1989; Young 1993; Marchand and Parpart 1995).

GAD proponents therefore stress the need for solutions which do more than address the "symptoms of disadvantage" (Young 1993). For instance, health, training, education and credit projects for women must be coupled with measures to alter prevailing laws, gender relations, institutions and socialization patterns which perpetuate women's subordination. As mentioned above, the formation and empowerment of grassroots women's organizations is increasingly viewed as both a planning goal and a strategy for achieving such changes.

It is important to note, here, that Southern activists and scholars and some Northern feminists have recently challenged the GAD perspective for its reliance on Northern and Northern-trained expertise to solve problems. Parpart (1995) calls for a redefinition of the position and role of development planners. Emancipatory development, she argues, "will occur when development theorists and practitioners

adopt a more inclusive approach to knowledge and expertise, a readiness and ability to 'hear' different voices/experiences, and the humility to recognize that established discourses and practices of development have often done more harm than good" (Parpart 1995: 240). This is consistent with the participatory model of development planning discussed in the following chapter.

1.7 GAD: An Empowering Approach to Women's Health

The GAD strategy has important implications for our study of and approach to women's health and health development. First, where past strategies have treated health provision as an investment in human resources, gender strategies are based on the principle that women's health is a fundamental human right and an end in itself (Kabeer and Raikes 1992).

Second, the GAD emphasis on illuminating the multiple layers of women's lives enlightens our understanding of women's health concerns. GAD proponents argue that welfare and WID approaches have channeled women's health care through MCH, family planning and Safe Motherhood Initiatives⁹, each of which focuses on women's

⁹ The Safe Motherhood Initiative (SMI) was launched by the WHO, the World Bank and the United Nations Fund for Population Activities as an effort to prevent maternal mortality. While conventional MCH and family planning services were more concerned with infant mortality and population growth rates than with maternal health per se, the SMI focused on the well-being of women as an end in itself. Although the impetus to prevent maternal mortality has been undeniably beneficial, the reliance on maternal mortality statistics as the most widely reported indicator of women's health obfuscates important causes of morbidity and mortality among women in developing countries. In its exclusive concern with

reproductive function and motherhood as women's priority health concerns. In doing so, health care systems in developing countries have minimized the importance of female morbidity which lies outside women's childbearing roles, such as occupational and environmental health, for instance. The health sector has marginalized women of reproductive age who are not pregnant, women who are elderly, mentally ill, or disabled, and women who are victims of violence as they do not fit within the realm of pre- or postnatal care (Timyan et al. 1993; Rathgeber and Vlassoff 1993). Moreover, the focus on women as "mechanisms of reproduction (...) discourages the possibility of women thinking of themselves as separate beings with a right to good health for its own sake" (Rathgeber and Vlassoff 1993: 518).

A gender perspective discards explanations which view health solely from a biological perspective. Instead, women's health is understood as "a way of total well-being which is not only determined by biological factors and reproduction, but also by effects of work load, nutrition, stress, war and migration, among others" (Van der Kwaak in Koblinsky, Campbell and Harlow 1993: 35). It offers a new vision of women's health and an alternative approach to health development; it identifies and addresses the broader circumstances of women's lives which negatively impinge on

maternal health, that is, problems that occur during pregnancy, childbirth, the postpartum period and lactation, the SMI does not represent a radical departure from earlier approaches. For a critical examination of this issue, see Edström 1992; Graham and Campbell 1992; Okojie 1994; Aitken and Reichenbach 1994; Koblinsky, Campbell and Harlow 1993; Thaddeus and Maine 1994; and Paolisso and Leslie 1995).

their ability to promote or protect their health, be they of a biological, social, cultural or economic nature (ICRW 1989; Rathgeber and Vlassoff 1993; Paolisso and Leslie 1995). As such, the GAD approach inherently represents a challenge to hegemonic Western biomedical models of disease causation which privilege biological and organic causes over social, economic, cultural or behavioral determinants of health (Puentes-Markides 1992; Paolisso and Leslie 1995; de los Ríos 1993; ICRW 1989).

By placing women's health within the context of their lives, a gender approach elucidates how women's subordinate status in society "is itself a serious health hazard" (Doctor Carmen Barroso of the MacArthur Foundation, quoted in Jacobson 1993; Wallerstein 1992). It is now widely understood that women's poverty, lack of access to education, limited control over resources and marginalization from decision-making power undermines their ability to protect and promote their health. For instance, male dominance in intra-household decisions regarding income expenditure coupled with men's control over women's mobility make it difficult for women to seek medical care for themselves (Vlassoff 1994; ICRW 1989).¹⁰ Moreover, male control over women's bodies and their sexuality places women more at risk of sexually transmitted diseases and restricts their ability to avoid or safely terminate unwanted pregnancies and

¹⁰ While implementing women's income-generating projects has been offered as a partial solution to this problem, it is problematic to assume that women will be able and willing to allocate their increased income to their health (Paolisso and Leslie 1994). Nonetheless, income, coupled with increased status and empowerment which arise from participation in micro-enterprise schemes may have a positive impact on women's health (Rodriguez-García et al. 1996). Research is clearly needed in this regard.

otherwise safeguard their health (Germain 1987).

Women's lack of access to education and health information regarding their sexuality also impacts on their health. As women may not be privy to such knowledge, they ultimately perceive chronic problems such as vaginal infections or acute back pain as normal (Germain et al. 1994). It is noteworthy that even when they are aware of the problem, women may not necessarily view their health as important and consequently choose not to seek care. Several health advocates postulate that basic levels of education enhance women's self-esteem and their ability to adopt new practices, and in turn, increase their control over their health and well-being (WHO 1994b; Timyan et al. 1993).

A gender sensitive approach to health planning would aim to empower women by giving them the resources needed to control their bodies, their sexuality and their lives. This entails going beyond ensuring the availability of health services and medicine.¹¹ It requires implementing policies and programmes to improve women's educational, legal, political and cultural position in society (ICRW 1989; Vlassoff

¹¹ It is now widely understood that the availability of health services does not translate into effective access to and utilization of services by women. Factors which impede women's access to care include transportation costs, time and monetary costs, cultural barriers, quality of care and women's perception of the relevance of services to their lives. These factors negatively impact on women's health seeking behaviour and are largely related to women's status in society (Thaddeus and Maine 1994; Edström 1992).

1994; Merchant and Kurz 1993; Jacobson 1993). Lastly, it calls for strategies which enhance women's voice in local, national and international health planning.

It is useful here to provide an example of how a strategy aimed at women's emancipation would look in the context of women's health. In the case of family planning and women's reproductive health, the focus would shift from improved technologies and delivery systems for birth control, child survival and pregnancy care (technical answers to Third World problems) to comprehensive services which would enable women to regulate their fertility safely and remain free of disease (Germain et al. 1994; Jain and Bruce 1994; Paolisso and Leslie 1995; Eschen and Whittaker 1993). On one level, these services would address education, access to information regarding all methods, and care for reproductive tract infections (RTIs), sexually transmitted diseases (STDs) and infertility (short-term goals). On a deeper level, they would address the more fundamental questions of male control over women's bodies, women's reproductive rights, violence against women, and the gender division of labour. Such a strategy would also incorporate men in the process so as to remove from women the sole responsibility of child-bearing decisions and child rearing. These issues are all linked to women's status in society and are not affected by strategies which aim solely to reduce birthrates or improve physical health (Batliwala 1994).

Lastly, an empowering strategy would bring women's voice into local national and international decision-making arenas (Rathgeber and Vlassoff 1993; Vlassoff 1994). Where traditional development models have adopted health policy proposals and 'silver bullet' solutions which do not reflect local realities, this new vision would foster open, consultative dialogue between women and planners so that women's perspectives on their health needs and potential solutions are integrated into health planning (Rathgeber and Vlassoff 1993).

A first step in this process is to empower women through health promotion and consciousness-raising such that they are able to identify and articulate their needs and make demands on the system. Participatory models of development value women's grassroots organizations for their capacity to mobilize women, to monitor government programmes and policies, and to carve a space for awareness and empowerment to develop (Young 1993). Collective action around women's health provides the environment in which women can analyse and challenge gender ideologies and other power structures which are detrimental to their health (Batliwala 1994; Young 1993; Parpart 1995).

Despite the numerous policies and programmes which promote women's empowerment and participatory health development strategies, it is unclear how such strategies play themselves out at the grassroots level. This thesis will offer insight into

the empowerment process by providing a nuanced analysis of the Red de Mujeres' experience in the Centro IDEAS Reproductive Health Project. As such, it represents a valuable contribution to the literature on women's participation in health development.

1.8 Outline

The remainder of this thesis is divided into five chapters. In Chapter Two, I critically examine the literature on community participation and women's participation in grassroots organizations. These two complementary bodies of literature form the theoretical framework of the thesis. Chapter Three provides a detailed account of the methodology and tools adopted to conduct the field research. It discusses the ethical and methodological considerations I faced before, during and after the field study, and describes the research process and data collection methods. Chapter Four sets the context for the case study, providing background information on Piura, the Centro IDEAS, and the Red de Mujeres. Chapter Five, the case study, offers an in-depth analysis of interviews, focus group discussions, and personal observations. This chapter critically examines the extent to which personal and organizational empowerment have resulted from participation in the Red de Mujeres. The sixth and final chapter will serve as conclusion to both the case study and the thesis. It will discuss barriers to empowerment and offer prescriptions for women's empowerment strategies.

Chapter Two

Women's Participation and Empowerment: Rhetoric and Reality

*If we present a work plan and they aren't going to listen,
then why am I organized?*

- President of the Red de Mujeres, Bigote

2.1 Introduction

Community participation (CP) and empowerment have become buzzwords in international development discourse. With declining government allocations to social services and the realization that past development strategies have done little to improve the lot of the poor in developing countries, planners have been shifting their energies to increasing participation at the grassroots level in all aspects of development, not least of which is health. As with all jargon, the terms participation and empowerment have been subject to myriad interpretations, all of which reflect the objectives and ideologies of development agencies and national governments.

This chapter examines how participation and empowerment have been defined and used as strategies by the international development community. The first section focuses specifically on the health development literature, offering a definition of empowerment as it relates to health and a rationale for participation in health projects and planning. The next section examines feminist perspectives on strategies for women's empowerment. Finally, the third section explores the role of NGOs in

facilitating participation and nurturing empowerment. This chapter provides the framework for analyzing the Centro IDEAS' Reproductive Health Project and the contribution of the Red de Mujeres to women's empowerment.

2.2 Empowerment: A Multi-level Construct

Empowerment is the process by which people, organizations and communities are enabled to take control over and transform their lives (Robertson and Minkler 1994; Israel et al. 1994; Labonte 1994). In the context of health development, empowerment can be defined broadly as a

multi-level construct that involves people assuming control and mastery over their lives and health in the context of their social and political environment; they gain a sense of control to exert political power as they participate in the democratic life of their community for social change (adapted from Wallerstein 1992: 198).

Implicit in this definition is the need to increase consciousness and inculcate a spirit of initiative and self-reliance in the poor and other marginal groups (Rifkin 1990; Rodríguez-García and Macinko 1994). While few studies actually assess the impact of empowerment on health, Wallerstein (1992) asserts that, insofar as empowerment enhances people's participation in health activities and control over their health, it should be considered a health-enhancing strategy.

Empowerment applies to interactive change on three levels: the individual, the organization and the community (Wallerstein 1992; Israel et al. 1994; Labonte 1994).

This distinction, which is discussed below, is particularly enlightening as it demonstrates how empowerment relates to community groups and organizations which, as mentioned above, are prime vehicles for participation and empowerment strategies. All three levels of empowerment are interconnected and must be considered if health development strategies are to improve inequitable social conditions in a sustainable manner.

Individual, psychological or personal empowerment

Individual empowerment is the process by which individuals develop the ability to make decisions and gain control over their lives. It refers to personal transformations such as enhanced self-esteem, skill development, and conscientization¹². Each of these can be achieved through active participation in group activities and decision-making, but do not necessarily require engagement in collective political action (Wallerstein 1992; Israel et al. 1994; Rissel 1994). A minimum level of perceived empowerment is necessary for an individual to become involved in the process of social change. However, empowerment is also needed at a broader level for macro-level societal transformations to occur (Wallerstein 1992).

¹² Conscientization is a process of praxis which involves the development of a sense of identification with a group and the enhancement of self and collective competence (Israel et al. 1994).

Organizational empowerment

Israel et al.(1994) note that organizations can be both empowered and empowering. They are empowering when “they are democratically managed, in which members share information and power, utilize cooperative decision making processes and are involved in the design, implementation and control of efforts toward mutually defined goals” (Israel et al 1994: 152). Organizations are said to be empowered when they are able to identify and find solutions to their problems, achieve equity in resource distribution, and influence policies and decision-making in the larger community to make system level changes (Wallerstein 1992; Israel et al. 1994).

Community empowerment

Community empowerment entails a combination of individual empowerment, a political action component and the redistribution of resources. In an empowered community, individuals and organizations are able to meet their needs through collective efforts (Israel et al. 1994).

The interconnectedness of individual, organizational and community empowerment is such that empowerment is possible and crucial not only at each level but also across all three levels. However, this does not imply that individual, organizational and community empowerment occur linearly. Although people, organizations and communities may be empowered under particular circumstances at a

specific point in time, they may find themselves unable to act in other situations (Labonte 1994). And, as the case study will show, the conscientization of individuals does not necessarily lead to organizational empowerment, nor does the latter ultimately result in community empowerment. It is thus important to implement interventions in such a way that they stimulate interaction between all levels of empowerment.

It is assumed that conscientization through active participation in health promotion provides the basis for such interaction. It enables individuals, organizations, and the community as a whole to effect social change gradually (Israel et al. 1994). In the context of health care, for instance, the enhancement of awareness and knowledge regarding health matters can potentially give the community a platform from which to challenge the health care system (Israel et al. 1994; Wallerstein 1992; Purdey et al. 1994).

The case study will draw on this discussion to analyse the empowerment which has developed from the Red's participation in the IDEAS health project. It will describe the personal development women experience through their membership in the Red and assess the extent to which enhanced awareness and consciousness has led to the collective empowerment of the organization.

2.3 Community Participation: Rhetoric or Reality?

The institutionalization of community¹³ participation (CP) in health dates back to the 1978 Alma Ata health conference.¹⁴ With the goal of achieving 'health for all by the year 2000', the WHO and UNICEF declared that community participation forms a cornerstone of primary health care and health promotion interventions. This 'people-centred' strategy would represent a departure from the passive acceptance of government-sponsored programs, encouraging 'active' participation at every stage of the health development process (Morgan 1993: 68).

Oakley (1989) and Rifkin (1990) offer several reasons for which community participation must be an integral part of health development programming. Community involvement in health is

1. a basis for increasing self-esteem and self-reliance and encouraging a sense of responsibility;
2. a means of drawing on local knowledge and resources, thereby making services more acceptable, accessible, and cost effective. Communities that invest time, money, labour and materials in health promotion activities will be more committed to the use and maintenance of what they produce;
3. a way of increasing community member's understanding of their health status. This may increase their willingness to take preventive measures. If communities can adopt healthier habits, more rapid improvement in

¹³ For the purpose of this thesis, community will be defined as a group of people living in the same geographical area sharing defined basic values and/or a group of people sharing the same basic interests (Björas, Haglund and Rifkin 1991). Thus, the Red de Mujeres can be considered a 'community' in the sense that it is a group of women who, based on their gender, have come together to meet common goals.

¹⁴ It is important to realize that, although the concept of participation in health was not institutionalized broadly until 1978, citizen participation in health has existed in various forms for many years. Morgan (1993) suggests that by ignoring past community initiatives, development institutions have made 'participation' an ahistorical concept.

- health will be achieved than by increasing investment in services alone;
- 4. a means of increasing the likelihood that health programmes and projects will be appropriate and successful in meeting health needs as defined by local people. This requires dialogue between planners, agencies and communities;
- 5. both a right and a duty.

However, the realization that 'participation' has not necessarily led to the effective adoption of health projects or increased community self-reliance has stimulated planners to review country experiences and revisit the traditional implementation of participatory approaches.

The nature of community participation in health interventions can be distinguished in terms of stages or levels varying from passive or narrow to active or broad, the latter of which is the most conducive to nurturing empowerment within the community (Rifkin 1990, Oakley 1989). Rifkin notes that, despite statements to the contrary, people's participation has generally revolved around receiving benefits and taking part in project activities. In the first instance, the community plays a passive role as recipient of health care services and health education. In the case of women, they would participate by having their tetanus vaccine or attending information sessions on topics such as child nutrition, as is the case in the welfare interventions discussed in the previous chapter.

In the second case, the community is responsible for contributing local

resources such as land, labour, and money to health projects. Citizens might build a village clinic, distribute contraceptives or information on child immunization, or pay for drugs and supplies. They may participate in implementing health programmes and even offer input into the location of a clinic or invest time in running a drug-purchasing scheme. However, they are rarely involved in policy and administrative decision-making (Rifkin 1990).

Participation, here, is a means of devolving to the community the responsibility for carrying out professionally defined health initiatives, providing little to no space for citizen input in actual needs assessments and decision-making. This devolution of responsibilities is a result of the health reform process which focuses on decentralization and has brought about a diminished sense of state accountability, particularly with regard to financing. The mobilization of community resources as a means of free or cheap service delivery has become a way of controlling and manipulating people to serve the needs of health bureaucracies (Zaidi 1994). National governments have exploited the principles of 'participation' to cope with declining social spending. Morgan (1990) cogently states that "the rhetoric of participation is a convenient way for a government to perpetuate the illusion of representative democracy, while large segments of the population are denied access to the political process" (p. 212).

Despite official recognition and support of more 'active' participation as a key element of health programmes, decision-making and management more often than not remains in the hands of professionals (Rifkin 1990). Consequently, health interventions have had limited relevance to local needs and have done little to increase community control over decisions which regard its members. In many situations they have led to a lack of interest in externally promoted health programmes and the ineffective utilization of available health care resources (Oakley 1989).

A broader, more genuine form of participation involves community members in decision-making at every stage of the development process. That is, local people have two crucial roles: first, they support the health services and enable them to function; and, second, they assist in determining health priorities and resource allocation. The Pan American Health Organization (PAHO) has called for 'the active participation of communities, especially women and women's organizations in planning, implementing and evaluating national health programs' (PAHO in Working Group on Women's Health 1990). At this level, community participation, or, as some would prefer, community involvement¹⁵, entails more than needs identification. It can be defined as a social process "which focuses on the ability of these groups to improve their health and

¹⁵ Some prefer to use the term "community involvement" as it implies a more direct form of engagement in activities (Oakley 1989). For the purpose of this thesis, I will use the terms participation and involvement synonymously, adding qualifiers such as 'active' or 'passive' and 'broad' or 'narrow' to indicate the level of involvement.

health care and, by exercising effective decisions to force the shift in resources with a view to achieving equity" (Rifkin, Muller and Bichmann 1988: 933).

The political implications of participation are inescapable. A strategy which confers upon community members a direct role in decision-making requires planners and policy-makers to rethink their position. It calls for an ideology of power sharing between health professionals and local community people, one which fosters self-reliance rather than dependence. In this new relationship, planners must develop mechanisms through which people's demands and needs can be heard. They should set in motion empowerment strategies which permit local people to develop their skills, knowledge and power, thereby enabling them to cope with symptoms of poor health, and to identify and address its causes (Oakley 1989; Rifkin, Muller, and Bichmann 1988).

For active participation in health to succeed, it must be developed on the basis of some form of local organization which can act as a vehicle for involvement. Organizations or groups should be indigenous, based on community structures and mechanisms, and be able to develop as a legitimate and formal representative body. They must develop management and organizational abilities as well as the skills necessary to negotiate with health professionals and policy makers.

With this in mind, Wallerstein (1992) emphasizes broad participation in empowerment education as a critical component of health development interventions. This approach would begin with group analysis whereby participants are given the space to reflect upon their reality, identify their health (and other) problems, critically assess the roots of their problems, and develop collective action strategies to effect change.

The interaction between reflection and action (praxis) is a means of increasing awareness and self-reliance as the first step towards achieving wider community development objectives (Rifkin 1990; Rodríguez-García and Macinko 1994). While such strategies may not eliminate structural issues, they are a means of developing decision-making power and active citizen participation within the community (Wallerstein 1992).

Active participation, should be viewed as both a strategy for empowerment (a means to an end) and an outcome of empowerment (an end in itself) (Robertson and Minkler 1994). It provides the conditions for empowerment to develop and this, in turn, enables people to become more involved.

It is noteworthy that community people may not perceive health services as a priority or an activity in which they see a role for themselves. In these situations,

planners must be willing to support health-related activities as determined by people such as food production, education, housing and income generation rather than narrowly understood health-centred activities such as immunization or family planning projects (Rifkin 1985). In this respect, the ideology behind broad participation is consistent with the holistic definition of health provided in chapter one.

In its broadest form, then, community involvement represents a challenge to the prevailing distribution of resources (power, skills and knowledge) as well as a questioning of the biomedical model of health (Morgan 1993). Rifkin (1990) notes that active participation is the ideal towards which many programmes strive. However, as it requires the health development community and local people to revisit their position vis-a-vis one another, it is also the most difficult to implement.

It is important to note that community involvement in local decision-making does not necessarily bring new voices into the larger political arena. Nor does it translate to substantial control over economic resources and policy decisions (Labonte 1994). Many micro-level participatory development projects either remain small-scale, or grow into a critical mass yet are repressed, co-opted or marginalized (Goulet 1989). If participation is to incite policy level changes, governments and other decision-makers must be willing to share power with local groups and reorient the bureaucracy to support and respond to the community's proactivity (Oakley 1989; Brownlea 1987;

Purdey et al. 1994). Goulet (1989) and Cardoso (in Goulet 1989) argue that participation *must* be linked to political activity in broader arenas for 'genuine development' to be achieved.

While the importance of participation in formal political mechanisms is undeniable, the above claim is problematic as it infers that only those strategies which result in collective political action can be considered legitimate (Robertson and Minkler 1994). In doing so, it ignores the multidimensional nature of power discussed above and minimizes changes at the individual level which can be both empowering and political. The feminist literature on women's participation in community organizations contributes substantially to this argument and will be discussed in the following section.

2.4 Participation and Empowerment Through the Gender Prism

2.4.1 Unpacking the community

A discussion of community participation would not be complete without a glance at the concept of community. Communities are not homogeneous entities, that is, they are composed of people of different race, gender, ethnicity, ages, whose opinions, goals and realities differ accordingly. Consequently, constraints to participation and the form which involvement takes will also vary depending on the nature of the community in question. Interventions which target particular groups within a community must therefore respond to the local context. Although the

heterogeneity and diversity of communities is now widely recognized, the community participation literature does little to enhance our understanding of the participation and empowerment process as it relates to women and women's groups: their limitations and constraints, their role in promoting their own health (rather than that of their families), the impact of participation on their lives, and the link between women's participation and empowerment.¹⁶

This is particularly disconcerting when one considers the crucial role given to women in health development. As mentioned in the preceding chapter, women (as mothers and wives) are largely responsible for promoting family health and nutrition. Because of women's 'natural' care-giving role, their opportunities to communicate with other women throughout their daily activities, and their strong community roots, women's groups are often used as a forum for health education and promotion (Rifkin 1990). Participatory strategies in Peru, for instance, have relied on women's groups to run health and distribution programmes, thereby capitalizing on women's traditional role and voluntary community participation (Barrig 1989; Kabeer 1994; Moser 1989; Labonte 1989; Rose 1990). Women have invested time and energy in cooking, dispensing health care, and attending workshops yet have not been included in the

¹⁶ Examples of articles which discuss the participation of women and women's organizations in health care include MacCormack 1988 and Østergaard 1992. However, they focus more on the contribution of women to child and community health than on the implications of participation for women's empowerment. Equally sparse are accounts of women's participation in women's health projects. This reflects the way in which women have traditionally been included in participatory health interventions and the focus of health research to date.

decision-making process.

Planners have overlooked the constraints which limit women's participation: their low social and economic status, their lack of education, and their domestic responsibilities, to name but a few.¹⁷ Consequently, community participation in health has often done more to overburden women and perpetuate the sexual division of labour than to empower women and foster equity in health (de los Ríos 1993). The literature on women's empowerment and participation in grassroots organizations offers a highly polarized debate around the empowering potential of women's participation in health strategies. Some authors argue that participation in health interventions can be an empowering activity, while others posit that it merely perpetuates state apathy and lack of commitment to social projects and gender equity. The following two sections illuminate the debate.

2.4.2 Practical needs and strategic interests

The distinction between practical and strategic needs and interests has been offered as an important analytical tool in gender planning. It has been used to assess the empowering and transformatory potential of both development strategies for women and participation in women's organizations. Practical gender needs arise from women's

¹⁷ It is clear here that the factors which restrict a woman's ability or willingness to participate in group activities are the same as those which impinge on her ability to seek care.

ascribed role in the sexual division of labour. These include health, nutrition, and economic welfare. It is assumed that addressing these needs does not challenge existing gender roles or address the causes of women's oppression. In contrast, strategic gender interests are those which originate from women's subordinate position to men or other forms of authority in society. These include the attainment of political equality and legal rights and the abolition of the traditional sexual division of labour and other oppressive structures. By addressing these interests, women are empowered to overcome their subordination and subvert the structural framework of patriarchy (Molyneux as discussed in Barrig 1989; Moser 1989).

As a typology, this distinction proves useful in that it clarifies the different levels of political strategies used by women. Grassroots mobilization around practical needs may be a valuable entry point for empowering women and for meeting more strategic needs. For instance, participatory processes of needs identification carve a space for women's voices to be heard. As confidence grows within a women's organization, a different set of more hidden needs may come into view. Thus, a reproductive health project, for example, can create the space for women to discuss the more taboo aspects of health such as reproductive tract infections, sexually transmitted diseases, as well as domestic violence (Kabeer 1994). The discussion of the Red de Mujeres in the following chapters will demonstrate this process.

Furthermore, women are often more able to recognize strategic concerns and more willing to mobilize around them once they have increased their self-esteem and organizational competency through meeting their practical needs. Studies have shown that, although originally formed in response to community subsistence needs, many women's groups in Latin America have begun to address issues of personal significance such as their lack of control over their sexuality and gender discrimination in health care and employment (Kabeer 1994; Vargas 1990; Centro Amauta 1987; Jelin 1990).

Having said this, it is important to note that the practical/strategic distinction has been challenged for its middle-class feminist tendency to perceive strategic interests as women's 'real' interests. Reliance on these concepts as criteria for understanding, assessing and planning development strategies and women's collective action suggests a narrow ethnocentric perception of women's experience. Westwood and Radcliffe argue that it suggests

...a simple dichotomy between 'practical' and 'strategic' gender interests which can be aligned with notions of the public and the private as spheres of interest for women...(and it) does not provide a theoretical base for understanding women as political subjects and actors (1993: 20).

Such a dichotomy places gender needs and interests at opposite ends of a linear process, with strategic interests representing the point towards which women *must* move in order to progress to a 'feminist consciousness'. Wieringa (1994) argues that this can ultimately lead to a top down approach where planners analyze the problems

identified by women and decide whether they are considered strategic. This reflects the Northern (and Southern elite) tendency to universalize and essentialize women's experience, thereby failing to recognize that people define and prioritize their needs and interests differently at different times, depending on their cultural and historical background.

In assessing the transformatory potential of development initiatives, one must therefore go beyond simply identifying the needs around which women organize and ask *by whom*, why, how, and within which parameters these needs are defined, prioritized and satisfied (Wieringa 1994). We must understand that the potential for transformation "lies in the extent to which the strategies seek to open up, rather than foreclose on, the possibilities open to women" (Kabeer 1994: 261). We must ask *how* projects are implemented and *whom* they benefit (ibid).

2.4.3 Women's Collective Action: Towards empowerment and social change

The above discussion is closely linked to the debate around the empowering potential of women's grassroots collective action. Feminists have often condemned women's organizations and grassroots struggles for failing to go beyond the realm of survival needs. A number of questions arise from this: does mobilization around basic needs create a space for rural women to construct new gender identities? Does their collective action permit them to forge a space in which to negotiate and question gender

relations?

In her analysis of the popular women's movement in Peru, Maruja Barrig (1989) contends that, because mobilization has traditionally centred around demands for basic needs (practical concerns such as health, water and child nutrition), it has accentuated the existing sexual division of labour and reinforced *marianismo*¹⁸ and has thereby precluded the creation of a different self-image. By participating in self-help organizations, women have merely transferred their domestic role into the public sphere. While the location of their labour may have changed, Barrig argues that the *pobladoras* have remained mother, wife and care-giver without questioning these roles. They have thus fallen short of developing a feminist consciousness, an awareness of their gender identity and their role as social protagonists. As a result, women's subordination and oppression remain unchallenged (Barrig 1989).

An ever increasing body of feminist participatory research with women's grassroots organizations argues that it is possible for women to question and challenge their oppression from within their maternal role. Such research has uncovered more hidden transformations which arise from participation. In order to make such changes visible, we must delve into the historical and cultural context of women's lives.

¹⁸ *Marianismo* is the symbolic embodiment in women of the characteristics of the Virgin Mary.

The Latin American sex-gender system¹⁹ dictates that politics are traditionally a male domain while social reproduction is a female responsibility. These 'appropriate' and 'natural' male and female roles find their source in the discourse of *machismo* (the attitude that women are naturally subordinate to men and belong in the home) and *marianismo*, as defined above. These are "effective cultural resources through which gender identities are constructed in everyday life" (Schild 1994: 144). The state has historically relied on this discourse to legitimate power hierarchies in gender relations and to create and maintain the role of the submissive, nurturing, and apolitical mother.

It is precisely this sex-gender system which has justified and legitimated women's mobilization around basic needs. Women's responsibilities to the family has pushed them to seek alternative means of survival in response to the severe economic crisis of the mid-1980s. Given that these strategies were consistent with women's traditional roles and were therefore not considered 'political', they did not represent a threat to local elites. As mentioned above, the Peruvian government has relied on women's mobilization capacity to cope with budgetary restraints.

Paradoxically, this same sex-gender system has enabled women to politicize

¹⁹ The sex/gender system is defined as "a kind of sub-text buttressing all social practices: the work people may engage in; the forms their relations to authority structures may take; the responsibilities they may have to the community and to the immediate and extended family; as well as the collective activities they may engage in, and their access to a public voice and to decision making power (G. Rubin in V. Schild 1994: 144).

reproductive activities by bringing their fundamentally private and domestic chores into the public and collective domain (Jelin 1990). And, although mobilization around survival strategies may spring from traditionally defined women's roles, it represents a revolutionary political struggle in daily life through which women's empowerment and social change do occur. Schild's discussion of 'doing politics' (*hacer política*) is useful here. She defines 'politics' broadly to include "struggles against limited gender identities, and political learning as acquiring cultural resources to forge alternative identities" (1994: 140).²⁰

Active participation in women's organizations inherently represents resistance to women's disempowered condition. Where women participate at the risk of physical or emotional abuse, the mere act of stepping out of the home is momentous. It symbolizes the recognition of one's agency and the negotiation of power (Vargas 1990). Moreover, while women may move continuously between the private and public space without ever altering their principal role as wife/mother, this does not detract from the value of their participation. Instead, the value should lie in the new spaces the women have created for themselves and in the awareness that mobilization initiates (Vargas 1990).

Grassroots mobilization can provide the space for women to come together,

²⁰ An interesting corollary to this is its implication for Western feminists who, in the same breath, cry out for the recognition that "the personal is political" and condemn lower-class women's organizations for not attempting to transcend the system or for failing to accede to mechanisms of power.

share experiences, and acquire organizational skills. The search for communal solutions enables group members to break their domestic isolation, discuss personal problems and create a sense of solidarity and identity both within the group and with women from other communities. By participating in group activities, women regain their assertiveness and self-esteem to speak in public, an activity which was hitherto associated with the male world (Centro Amauta 1987; Guzmán 1990). This newly found self-confidence empowers women to make decisions and negotiate with their families, community authorities, and funding agencies (Vargas 1990; Lind 1992; Schild 1994; Jelin 1990).

In addition, through the collectivization of reproductive activities which have traditionally taken place in the isolation of the home, women have transformed and politicized issues pertaining to their gender identity (Lind 1992). As a result, they have widened the sphere of political action and traditional gender roles. Within the constraints of machismo, they have begun to explore the social, personal and political significance of being women in their society. Women's collective action has enabled them to construct a gender identity and question traditional gender relations. This process is contributing to a redefinition of domesticity "to include participation and struggle rather than obedience and passivity" (Safa 1990: 361).

This does not negate the fact that women's collective action may not necessarily

result in increasing women's presence in municipal and national decision-making. Nor does it suggest that mobilization around practical needs has succeeded in redressing prevailing structural problems such as the State's inequitable distribution of resources (Barrig 1989). The point here is not to minimize the importance of political struggles which directly confront the state. As mentioned above, these are clearly significant and crucial if social transformation is to occur at a macro-level. However, struggles which bring about transformations at the level of the subject and the family are equally important (Escobar and Alvarez 1992; Lind 1992). An awareness of women's lives and the recognition that "nothing will be the same for the women that broke the silence, that stepped out of the space destined for them" (Vargas 1990: 38) is vital for our understanding of women's empowerment.

2.5 NGOs: Catalysts for Participation and Empowerment

Non-governmental organizations are often heralded for their work with grassroots groups. While their financial resource base is largely dependent on the national political and economic climate and the aims of funding agencies, NGOs are claimed to be less bound by bureaucracy than government agencies and are closer to the people they serve (Rodríguez-García and Macinko 1994; Midgley 1986). As a result, they are more effective at service delivery and able to promote local participation. In addition, NGOs are more capable of implementing strategies which take into account the interdependency of women's needs and the constraints which limit their ability to

participate in development activities (Kabeer 1994).

NGOs are often staffed by people who support the ideology of community participation and empowerment. As such, they are poised to make positive contributions to health programs. By organizing and/or supporting existing women's organizations, they can provide the space for women's health needs and demands to be heard and ensure that they be heeded (Oakley 1989).

At an individual level, NGOs can seek to enhance women's consciousness, thereby altering their self-image and stimulating an awareness of their subordination (Batliwala 1994). At an organizational level, they can provide capacity building workshops which aim to enhance the group's self-reliance, leadership abilities, and the capacity of the organization to design and conduct their own health development activities and participate in political and economic decisions (Midgley 1986; Oakley 1989; Labonte 1993; Robertson and Minkler 1994). NGOs can assist women's groups in accessing resources and help them to engage in dialogue and negotiation with decision-makers (Midgley 1989; Robertson and Minkler 1994). When implemented in the context of a health program, these empowering activities can be seen as a "means of broadening the democratic base of development initiatives for health, thus minimizing monopolization by government and local elites" (Rodríguez-García and Macinko 1994: 8).

The literature on community participation in health as well as that on women's involvement in grassroots organizations has much to say about the value of empowerment and participatory approaches to development. Much is also said about the role of NGOs in creating a space for democratic participation, thereby enabling women to identify their needs, and gain skills and awareness. However, what is lacking is an inquiry into the problems and failures of the grassroots organizations and the internal dynamics of the groups themselves. In order to understand how individual empowerment can lead to organizational empowerment, it is important to understand the conditions (both external and internal) which strengthen and weaken an organization.

The literature also fails to problematize grassroots organizations adequately. Women's organizations, for instance, are portrayed as homogeneous entities in which participation and empowerment appear to be similar for all members. This obscures differences in participation rates, empowerment levels and perceived or actual benefits, each of which may depend on class, age, ethnicity or other factors which restrict participation.

Guzmán (1990) and Rifkin (1990) offer a discussion which is rarely touched upon in the context of women's organizations. That is, the tendency for the benefits of the empowerment process to benefit a small group of people, generally the group's

leaders. In their leadership role, they are the most likely to gain skills and awareness, and group tasks and responsibilities may ultimately lie in their hands. It is problematic to assume that they have the skills, knowledge and willingness to raise the consciousness of their members. While these authors comment on the internal heterogeneity of women's organizations, they do not offer a detailed, nuanced analysis of the dynamics within organizations.

2.6 Conclusion

This chapter has looked at the principles of empowerment and participation in the contexts of health development and women's collective action. First, it has argued that health strategies which aim to empower women must be implemented in such a way that they stimulate interaction between personal, organizational and community empowerment. Proponents of empowerment strategies suggest that active participation in health promotion and consciousness-raising activities is a means of triggering such interaction. The ideal of participation dictates that communities should be actively involved in every stage of the process.

Second, this chapter has shown that mobilization around practical needs such as women's health may be a powerful entry point for empowering women. It has the potential to stimulate micro and macro-level changes. What remains to be seen is how the theory of participation and empowerment acts itself out at the grassroots level.

The case study in chapter four will provide a nuanced analysis of the empowering potential of women's participation around health and will address issues which have received little attention in the literature. The examination of the Red de Mujeres will explore individual and organizational levels of empowerment which arise from women's participation in a reproductive health project. It will also make visible the differences in participation and empowerment rates within the organization and analyze the reasons for such heterogeneity. Lastly, the case study will discuss the problems of the Red and provide an understanding of the conditions which might strengthen and weaken a grassroots organization.

Chapter Three

Who Can Name Experience?

A Discussion of the Research Methodology, Process and Techniques

What is a Canadian girl doing poking around our village?

What could you possibly know about life here?

And, why would a Canadian woman want to study a group of Peruvian women? Shouldn't you be studying your own people?

People you know about?

Man from Salitral

quoted in personal journal - March 12, 1996

3.1 Introduction

Two major ethical and methodological issues arose for me when I considered conducting field work in Peru. Most importantly, I questioned whether I could ethically justify conducting research with a group of women in a context other than my own. And, with an affirmative answer to the latter, I then wondered what methodological approach would allow me to be the most ethical and gender-sensitive as possible. This chapter provides a discussion of the literature through which I gained the insight required to design and carry out an ethical and gender-aware research plan. It then describes the research process and data gathering methods and critically evaluates my field work experience.

3.2 Northerner, Southerner; Outsider, Insider: Who can name experience?

The above quote echoes questions I posed to myself on numerous occasions before, during, and even after the research process. One of my greatest quandaries was

not *how* to make Peruvian women's voices heard, but rather whether I, a Western, white middle-class university student, could legitimately make claims on behalf of a culture foreign to my own.

Who has the right to name experience? Feminists from the South and from minority groups in the North have critiqued the Western feminist tendency to explain women's experience based on their own white middle-class reality. Their blatant disregard for difference has come under severe scrutiny as it assumes that women around the world share the same needs and interests as the Western white woman. Implicit in this is that all women experience oppression the same way regardless of class, ethnicity or race (Parpart 1993; Mohanty 1991).

Southern feminists have built on this argument in their critique of the Western feminist proclivity to essentialize the experience of women in the South.²¹ Chandra Mohanty contends that Western feminist discourse has created the notion of a homogeneous, monolithic "Third World woman"²². The universal application of Western feminist assumptions about oppression, family, motherhood, etc. obscures the diversity and cultural specificity of the lives of women, and thereby impedes feminist progress in

²¹ This issue was raised in the introduction. It is important to touch on it again for two reasons: first, it has critical implications for research with women in developing countries, and second, it has greatly influenced the way I perceive my role as researcher.

²² Mohanty's argument also applies to Western-trained Southern feminists writing about third world women for a Western audience.

understanding and acting upon the oppression of women (Mohanty 1991; Amadiume 1987).

Just as men have defined themselves against the female “other”, feminists in the West have tended to define Third World women in contrast with the dominant reality, that of the Western white, middle-class woman. They represent women in developing countries as the traditional, ignorant, vulnerable and powerless “other” in contrast to Western feminists’ self-presentation as more modern, educated and liberated (Mohanty 1991; Amadiume 1987).

Mohanty acknowledges that not all Western feminists fall into this trap. She commends researchers such as Maria Mies for their context-specific, differentiated analyses of women’s experience. It is through such explorations that we can uncover and understand the needs and knowledge of women. And, by recognising this knowledge as a site of power, we will see that their “vulnerability is neither so clear nor so pervasive” (Parpart 1993: 456). We will then understand that Third World women are not objects or victims, but rather ‘subjects’ who actively resist and negotiate power (Mohanty 1991). ²³

Amadiume takes on Mohanty’s argument, but refutes the notion that Westerners

²³ This perspective is consistent with the ideology behind participatory development and the empowerment approach discussed in the preceding chapters.

have a place in conducting research about Southern women. "Why the interest in us?", she asks (Amadiume 1987: 7) as she joins others in claiming that Western (white) women should work within their own culture. Indeed, many feminists, Westerners included, have argued that successful research is possible only when researcher and participant share similar life experiences or cultural baggage. Some posit, for instance, that only Chicanas are qualified to conduct research on Chicanas or that only victims of spousal abuse can legitimately study victims of spousal abuse (see Rubin and Rubin 1995:37-39; Amadiume 1987). The proposal that researchers can speak only of what they have directly experienced limits the potential of knowledge creation to the point where "no one can ever learn anything from anyone else's experience" (Harding 1992: 178). It rules out the possibility that outsiders and insiders can learn from one another and work together to make relevant changes.

The emphasis should not rest on shared experience, but rather on how the researcher defines her role. To borrow Sandra Harding's sentiment, "I am not to speak *as* or *for* Third World women," nor shall I claim to produce Third World knowledge (Harding 1992: 180 and 184). Rather, I will attempt to articulate their experience based on *their* perspectives and the meanings *they* give to *their* reality. In this, I do not claim that research can be impartial or untainted by the researcher's experience. The researcher's presence in the field, her cultural baggage and the participants' perception of the researcher will clearly affect the meaning which is uncovered.

If 'meaning' is that which "comes from the interaction of self with the context and the phenomena of others" (van Maanen in Hinds et al. 1992: 38), then, the emphasis should lie on the participants' perceptions and context, the researcher's perceptions and context, and the interaction between the two. As researchers, we must take into account the participant's context and our own assumptions and culturally-based biases throughout the entire process. In an effort to do so, I drew out a list of my assumptions, a list to which I would refer during my research to better understand my reactions to the setting. In addition, once in the field, I kept a log of my reflections on how my background affected people's perception of and interaction with me, and how my experience influenced my interpretation of meaning. These notes were an invaluable tool for interview analysis.

Once I had recognized the dilemma I faced and had come to terms with my limitations, I proceeded to search for the methodology which would enable me to conduct the most legitimate, valid and useful research possible. I now turn to a discussion of participatory and feminist research approaches.

3.3 Alternative or Imperative? Embracing Feminist Participatory Research

Given that I had set out to examine the process of participation and empowerment as experienced by the Red de Mujeres, it was imperative that I find a methodology apt to uncovering the knowledge, experiences, perspectives and opinions

of the organization's members and non-members. As the study would assess women's participation in group activities, it also called for a design which would uncover, analyse, and question systematic barriers to their participation. I also wanted an approach which would allow me to take into account both my own subjectivity and that of the participants. Lastly, I was greatly concerned with the issue of exploitation and sought the most reciprocal and horizontal method of inquiry possible. In light of the nature of the research and my personal concerns and convictions, I adopted a feminist approach to participatory research.

3.3.1 Participatory research

Participatory research (PR) was developed in reaction to the dominant positivist approach to social science research, an approach which has been deemed "cloaked in value neutrality, detached from people, and intent on control" (Park 1992: 30). This traditional form of research is based on the premise that there exists *one* objective social reality which can be 'known' and explained through observation and quantification irrespective of the experience of the researcher or the meanings given to social interactions by those involved. In order to remain objective, the researcher must (and can) remain "neutral" and distant from participants at all times (Maguire 1987; Park 1992; Ramphela 1990). The claim that there exists one reality and the disregard for local meanings both call into question the nature of knowledge creation and its relation to power. Whose knowledge is privileged and whose is subjugated? And, what

does this mean for extant power structures and the reinforcement of hegemonic knowledge?

PR advocates argue that dominant research places the most powerful at the centre of the knowledge creation process (Hall 1992). The failure to bring people's own experience and knowledge into the analysis has ultimately perpetuated knowledge based on assumptions and theories of the elite, that is, very often male researchers, academics, consultants, etc. Health research which views health from a strictly biomedical perspective and fails to consider people's perceptions of illness and disease or the knowledge embedded in traditional medicine is a case in point. To redress this imbalance, PR offers an alternative means of constructing knowledge. It brings to the foreground the lives, experiences and knowledge of the less powerful in an attempt to analyse and understand their reality. PR emphasizes uniqueness and calls for context-specific analyses (Hall 1992:17).

In contrast to the dominant paradigm, PR stresses the subjectivity of both the researcher and the participants in knowledge creation. An important component of PR is the ability of the researcher to establish "close, empathic, interpersonal interchange" (Maguire 1987: 20) with the participants so as to gain insight into their experience. PR calls for non-hierarchical, non-exploitative relationships between researcher and researched. It emphasizes 'co-operative enquiry' (Ramphela 1990), that is, a bilateral

educational process where the participant is involved at every stage of the process, from problem identification, to planning, to implementation, to analysis and to action (Hall 1992; Park 1992; Maguire 1987). By enabling marginalized peoples to name their experience and take control of the research project, PR creates a space for them to act out their political and historical agency (Harding 1992). As naming one's experience and having it heard and legitimized by others is an act of power, PR should be viewed as an empowering form of research (Labonte 1994).

PR combines research, education and action. First, it investigates and analyses the problems named by participants. Second, it is a learning experience for both researcher and participants who jointly analyse the cause of the problems. And, third, it combines knowledge with action. That is, the researcher and participants attempt to find solutions and take action to make desired changes (Maguire 1987). In the case of research with victims of spousal abuse, such transformations may include collectively stimulating family and community awareness, petitioning for new legislation, starting a women's shelter, etc. It is important to note, however, that the action component of PR is an ideal which is not always realizable. Time constraints often impede profound critical analysis and action (Maguire 1987: 47).

3.3.2 A feminist critique of PR

While PR offers a more human-centred approach to research, feminists have

criticised it for being as androcentric as the paradigm against which it sets itself (Maguire 1987). Traditional PR²⁴ has privileged male power as a central factor in the construction of knowledge. Social researchers have been predominantly white, upper middle class males who have ultimately placed male voices first, such that “the social sciences have been not only a science of male society, but also a male science of society” (Callaway in Hall 1992). As a result, existing participatory efforts are fraught with male biases (Maguire 1987; Hall 1992; Cancian 1991).

For instance, researchers have tended to rely on existing organizations such as community councils to identify needs and define research goals. The fact that these organizations are generally dominated by men has resulted in a disproportionate number of male voices in the research process. Moreover, little effort has been paid to identifying and addressing the factors which constrain women’s participation in research projects. Due to their marginal involvement in designing research activities and identifying problems, women’s needs and concerns may not be addressed. By neglecting to investigate women’s everyday life, traditional PR has failed to uncover and address oppression in its various forms. Importantly, the use of generic terms such as ‘people’ and ‘communities’ conceals the disparities mentioned above. They lead us to believe that the research represents all people and that benefits which accrue to the

²⁴ I use the term traditional here in reference to PR which has not taken into account gender, race, sexual orientation, etc.

community will also trickle down to women (Maguire 1987: 81)²⁵.

3.3.3 A feminist approach to PR

Feminist and PR approaches maintain similar postures on social science research, especially regarding subjectivity, context-specificity, and reciprocity (Maguire 1987)²⁶. The feminist focus has contributed to our understanding and practice of participatory research. Maguire offers useful guidelines for a feminist approach to participatory research. Her framework draws on the principle tenets of PR and adds the following crucial elements: a central place for gender on its agenda; a central place for inclusive feminism (feminism which celebrates diversity); attention to gender in all project phases; and attention to language use (Maguire 1987: 105-107).²⁷

The attention to gender and inequality is the most distinctive feature of feminist research. When coupled with participatory methods, the feminist commitment to reducing gender inequality and its focus on difference is a powerful means of translating gender and empowerment ideology into practice. Grounded in women's experience, it articulates women's voices and legitimates women's ways of knowing which have hitherto been excluded from mainstream social sciences. These include, for

²⁵ For details on the androcentric aspects of participatory research, please see Maguire 1987: 51-52.

²⁶ For a discussion on the similarities and differences between feminist and participatory research see Maguire 1987: 86-105.

²⁷ For the full list of the tenets of Maguire's framework, see Maguire 1987: 105-107.

example, the knowledge embedded in gossiping (Park 1992: 30).

Moreover, the attention to diversity implicitly warns of the pitfalls of essentialism. That is, the danger of making broad generalizations regarding women's lives based on one's own world view and assumptions, and the risk of having one woman's voice represent all women in the community irrespective of differentials in social position, age, or ethnicity. Either of these situations would lead to research results and action which may be irrelevant to a large portion of the population.

3.4 Pre-departure Preparations

3.4.1 Visualizing the process

The underlying ideology of feminist research and PR was consistent with my desire to conduct research *with* rather than *for* women. Prior to going to Peru, I visualized this process as I hoped it would unfold. Ideally, I would spend the first month or so getting acquainted with the women, the organization and the surrounding area. I would work with the women's organization, assisting them with their promotional and administrative activities. Then, I would conduct focus group sessions with participants to discuss a problem they wished to address, and would make this the focus of my research. I fully intended to facilitate their participation at all stages of the process.

Once we had identified the problem, I would begin individual interviews and group discussions with leaders, members and non-members so as to get broad representation. A preliminary analysis would be conducted with the women and the results devolved to the organization and the NGO. I had hoped that individual and group discussions would provide the space for a critical analysis of the organization's efforts and that participants would feel part of a mutual learning process. As a student researcher, I was not comfortable with the action and transformation aspects of PR. Although I intended to articulate women's concerns to the NGO and hoped this would ultimately lead to open dialogue between the organization and the NGO, I did not feel it was my place to embark on a mission of social transformation. Further, it would have been naïve to think that four months would suffice to set in motion transformations.

3.4.2 Establishing project objectives: an iterative process

I remember feeling very disconcerted when, having just embraced the virtues of PR, I was required to indicate my objectives, research questions and schedule of field activities in a proposal for funding. I felt as though I had betrayed my participants before even having located them. Nevertheless, I wrote the proposal with the understanding that these elements of the research would inevitably change upon discussion with informants in the field. The study aimed to describe and analyse the Red's participation in health promotion and the extent to which it fosters

empowerment.

The original objectives of the research were five-fold:

- 1) to identify the health problems and needs of rural women on an individual and organizational basis;
- 2) to examine the Red de Mujeres in terms of its organizational structure, its responsibilities, its failures and successes, and the process by which it addresses women's health needs;
- 3) to describe and assess the Red's capacity to communicate with and mobilize the community;
- 4) to determine how community, institutions and authorities perceive the mandate and work of the Red de Mujeres, and conversely, how Red members perceive their organization; and,
- 5) to assess the impact and effect of the Red de Mujeres' activities on community women's lives.

These objectives were indeed modified following meetings and preliminary interviews with the Red leaders and the NGO. Greater emphasis was placed on objective numbers two and three, with specific attention given to the following issues: the group's collective identity, autonomy, credibility within the community, and leadership. Early in the study, interviews and focus groups uncovered differentials in empowerment levels. I pursued inquiry into this issue and it ultimately formed the crux of the case study.

3.4.3 Finding a local host organization

The above-mentioned proposal also required that I find a Peruvian non-governmental organization (NGO) to which the research was relevant. The process

began in Ottawa where my advisor Janet Hatcher-Roberts put me in contact with Dr. Pamela Hartigan of the Pan-American Health Organization (PAHO). Dr. Hartigan sent my proposal to Ms. Blanca Fernández, Policy Advisor at the Lima-based feminist research NGO Centro Flora Tristán, who in turn located a field NGO that was interested in my work. The gender and health component of my proposal coincided with the Reproductive Health Project of the Centro IDEAS in Piura. As they were very involved with women's base groups, they accepted my project and offered institutional support for the duration of the fieldwork.

3.5 The Field-Work Experience: Process and Techniques

3.5.1 Getting acquainted with the Centro IDEAS and the Red de Mujeres

Once in Piura, a three week familiarization period provided me with an understanding of the NGO's project and their involvement with the Red de Mujeres.²⁸ During this time I was able to access background literature on the area and accompany the NGO's obstetrician-health promoter to meetings with the Red. It is noteworthy that the health promoters with the best understanding of the Red de Mujeres had recently left Centro IDEAS. A new promoter had taken their place and was unable to provide much insight into the organization. Nonetheless, I met with the ex-promoters once and learned about the reproductive health project and the Red.

²⁸ It is worth noting that the study area was defined by the Centro Flora Tristán shortly before my departure. Consequently, I had no exposure to the Red's activities or the NGO's project prior to leaving Canada. I believe it would have been useful to receive background documents before going to Peru.

The new health promoter introduced me and my study to the group members as well as to the health post workers, local authorities and Ministry of Health officials. The NGO's reputation in the area facilitated my integration into the community and gave my project legitimacy. I was somewhat surprised by the interest that both the NGO and the women in the villages expressed in my project. The NGO felt that an evaluation of the Red would be useful to them, especially in increasing their understanding of the impact on the Red of the recent executive committee elections and the ensuing change of leadership. I had expected apprehension, resistance and skepticism from the Red members, yet, on the whole, they were welcoming and seemed happy to participate in my study. Although it is true that some participants were genuinely pleased to be part of my study, it later became clear that many had originally exhibited willingness out of compliance or belief that they would gain material benefits. This will be discussed further on in this chapter.

The three week familiarization period also allowed me to learn the subtleties of the Spanish spoken in the region. Although I was fluent in Spanish prior to leaving Canada, I knew that I would have to become familiar with new expressions as well as linguistic and cultural idiosyncrasies. This on-going process enabled me to manipulate interview questions to fit the local context.

3.5.2 Selection of participants

The sample and study area were determined in full consultation with the NGO and the group leaders. The study area was first limited to three villages in one district. However, modifications necessary due to potential terrorist activity in one village resulted in the selection of two villages in each district: La Pareja (a village which had recently joined the Red) and Bigote (a village which has been involved since the Red's inception) in the district of Bigote, and Salitral (new) and Serrán (pioneers) in the district of Salitral. The study consisted of a total of 58 people including 32 women from 4 different villages, 9 men, 6 local government officials (2 ex-mayors, 2 district mayors, 1 councillor responsible for health and 1 councillor in charge of women's issues), 4 health workers (the doctor, nurse or obstetrician from each village health post with the longest working relationship with the Red de Mujeres), 3 Ministry of Health officials and 4 members of the Centro IDEAS (director, associate-director, obstetrician/health promoter, male agricultural engineer).

In order to gain insight into a variety of experiences and perspectives in each community, I selected the 32 women based on their level of participation in the Red. The sample therefore consisted of two leaders, two active Red members, 2 non-active members and 2 non-members from each of the four villages. I defined the term "active" as regular participation in Red activities and NGO workshops. In contrast, a non-active member was one who had limited to no involvement in the organization's

activities.

Participant selection is by no means a straight-forward process, especially when knowledge of the study area is limited. In order to compensate for my own lack of familiarity with the Red and to make the process as participatory as possible, I asked the leaders to assist in locating potential participants. However, while it is true that they knew their community well, their participation in this matter led to unexpected biases. Despite the selection criteria, on several occasions I interviewed 'active' women who had actually never attended meetings and had limited awareness of the Red de Mujeres' mandate. Their participation in Red activities was limited to voting in the 1995 committee elections. I soon realized that these women were the leaders' friends and relatives. Consequently, the interviews uncovered coinciding opinions and points of view from women of similar socio-economic status.

To redress this imbalance, a sociologist at the Centro IDEAS and I tried to establish less subjective, and perhaps more representative, selection criteria for each sub-group listed above. These included a combination of women with children under 12 years of age; women with children older than 12 years of age; women with subsistence level household income; and women with a household income higher than subsistence level. I hoped that these new criteria would allow me to include the more marginalized women of the community in my study. The selection of participants was a continual

process whereby participants suggested women who fit the criteria and were interested in providing their input.

Again, however, I was faced with definitional problems. It was particularly difficult to define poverty and subsistence level income in an area where everyone considered themselves poor. I ultimately relied on their terminology ('poor' and 'poor poor' or 'really poor') and my own observations in people's homes (the presence/absence of television, stove, radio, or other appliances, and the material out of which houses were built).

Moreover, in spite of the new criteria, finding "active" and "non-active" participants remained problematic as these terms were originally based on my definition of activism and assumptions regarding the group's level of organization. The interpretation of 'active member' and 'non-active member' (or 'participates a lot' and 'does not participate') was subjective and did not always reflect the interviewees' actual participation level in group activities. Some "non-active" members believed that voting in the elections or signing forms made them "active" participants. Interestingly, the women's perception of 'activism' and the awareness level of a self-declared 'active' member have become revealing parts of my data. While I acknowledged that several definitions of activism existed in the community, I maintained my own for purposes of informant categorization and selection.

A further problem associated with participant selection was determining a manageable sample size. I knew from the start that the number of participants in this sample was greater than I had anticipated. In consideration of the fact that my field work was limited to four months, I had initially hoped to work with a group of approximately 25 women. However, the NGO strongly recommended I consider all four villages in order to compare and contrast women's experiences based on both district differentials and the length of involvement of the Red in each village. As I was very concerned with making my study useful to somebody other than myself, I acted on their recommendations.

However, I believe that the participatory nature of my research was limited due to the sample size and the spread of the study area. The fact that the participants lived in four different villages made it difficult to include them all in the research process. Moreover, traveling to each village necessarily limited my time and capacity to establish a rapport of trust with the community members. With 58 interviews to conduct and time as my greatest enemy, I felt rushed to collect data and perhaps did not allow myself as much time to become familiar with as many participants as I had wished. As a result, interviews with non-members and non-active members were not as rich or nuanced as anticipated. It is important to note, however, that this lack of detail is also a result of the participants' limited knowledge of the Red de Mujeres and inability to answer questions related to the organization with much clarity. In such

cases, it was precisely their limited knowledge that was revealing and useful.

Lastly, the selection of such a large sample for short-term fieldwork inevitably imposed limits on the range of topics analysed and the depth with which they were explored. I redefined the study objectives to make them as manageable and achievable as possible and therefore did not place as much emphasis on non-members or less-active members as originally planned.

3.5.3 Data Collection: Issues

Compensation for women's time

I was very aware of the time burden my research represented for women. I hoped that my methodology would permit me to compensate them for their time. First, as I did not want to disrupt their daily itinerary, I attempted to conduct interviews with the women as they continued with their chores. This was only successful in the cases where the women had gotten to know me well. Otherwise, participants anticipated my arrival into their homes by changing out of their work clothes and putting on make-up. They usually stopped what they were doing as soon as I arrived.

Second, I thought that participant observation (as described below) would allow me to 'give back' to the participants. However, my participation in their daily activities was not necessarily perceived as 'giving' on my part as they did not receive anything

tangible. I decided to take photos of all participants after our interviews and give them as gifts at the end of my stay. I also took photos of a *vaso de leche* at the request of one participant who wanted to prove to the mayor that it was functioning. Not only were the participants happy, but they were surprised that I had given them back the photos. They explained that others had simply left with their film and never returned. Lastly, I bought gifts as a sign of gratitude for the people who had given me a home for the duration of my fieldwork.

Confidentiality

An important step in qualitative research is ensuring that the participants are well informed of the purpose of the study, the potential uses of data, and the confidential and anonymous nature of all interviews (Rubin and Rubin 1995). My proposal was approved by the Carleton University Ethics Committee, and, in accordance with their guidelines, I requested that all participants of interviews and focus groups read and sign an informed consent form which outlined these points. Where participants were illiterate, I read the form out loud in Spanish and asked that my research assistant or a relative sign it. I followed this procedure despite my reservations about gaining formal informed consent in a context where education and literacy levels are low. I had anticipated that the form may disrupt the research and prove to be problematic for participants (Rubin and Rubin 1995). Indeed, it created tension and suspicion among those who had often signed forms which were ultimately

used for political or discriminatory reasons. The request for signatures was often met with expressions of anxiety and doubt. In this sense, the form was a barrier to establishing trust. I therefore often supplemented the information with long explanations of my research ethics, including my guarantee that I would not divulge respondents names in reports.

As I had hoped to tape-record interviews and focus groups, I discussed the benefits of doing so with the participants and ensured them that the tapes would be for my personal use only. I also explained that interviews would be coded and notes and tapes kept separate from the master informant list. In situations where participants refused to be recorded or where I could sense their discomfort, I relied solely on hand-written interview notes.²⁹

The use of a research assistant

All focus groups and interviews were conducted in Spanish, thereby eliminating the need for an interpreter. Nevertheless, a local woman was hired as a research assistant for interviews and focus groups in hope that a familiar face would put respondents at ease and allow for greater understanding of the subtleties of verbal and

²⁹ Although recording an interview is beneficial because it enables the researcher to concentrate on the participant's words rather than on taking notes, it should not be used as a substitute for hand-written notes. Tapes can be defective, batteries may run out, and background noises of donkeys and chickens can make the discussion virtually inaudible.

non-verbal expression. However, I quickly sensed the women's reticence to speak freely and openly in my assistant's presence. She was more educated than many of the participants and had a condescending attitude towards them. Further, the participants were reluctant to speak out in front of an "insider" as they feared the content of the conversation would be known by all villagers.

I continued on alone until the NGO suggested an urban women who had previous field-work experience. She was well received by the women and was helpful in taking notes and stimulating conversation during focus groups. However, by this time, I was well known in the community and preferred conducting individual interviews alone. I questioned the benefits of working with an assistant at that point as I spoke the language, understood cultural idiosyncrasies and had a good rapport with many of the participants. Moreover, unless the assistant went through the same acceptance and integration process as I had, she may have represented a barrier to open communication.

3.5.4 Data Collection: Qualitative Techniques

As mentioned above, qualitative research techniques were deemed most suited to uncovering people's knowledge, opinions, beliefs and attitudes. The following is a discussion of the techniques employed, that is participant observation, semi-structured interviews, and focus group discussions.

***Participant observation*³⁰**

This qualitative technique requires the researcher's active participation in as much of the informant's daily activities as possible. By observing social interaction and getting to know the lives of the respondents, the researcher is able to gain detailed, context-specific information. Moreover, the researcher's constant presence and observation enables her/him to validate and interpret the information collected and to detect contradictions between respondent testimonies and reality (Kirby and McKenna 1989; Barnsley and Ellis 1992; Morse and Field 1995). It is important to note that this presence inevitably alters the way participant's act in front of the researcher and that this should be taken into account in the analysis. Contradictions should be made visible and analysed.

I partook in participant observation to gain insight into issues which cannot be understood fully through interviews. These include community and intra-household gender relations, as well as the relationship/interaction between the Red leaders, group members, health workers and the NGO health promoters. This technique was valued for its potential to foster trust with the women in the study, to compensate them for their time, and to gain a better understanding of their lives.

³⁰ Participant observation is a research method and should not be confused with participatory research which is a methodology. It can be used within both traditional and participatory frameworks.

Due to the organization level of the Red, my involvement in the group's activities did not coincide with my original vision. As mentioned, I had fully intended to 'work' with the organization in planning, organizing, implementing and participating in activities or projects. However, as the leaders did not regularly work on any one particular project and did not hold weekly meetings as I had assumed, my participation was slightly different from what I had imagined. I attended meetings called by the Ministry of Health and the Centro IDEAS, helped the leaders prepare for safe-pregnancy and International Women's Day marches, and assisted one of them in her recruitment rounds. My involvement in these activities was particularly useful in assessing the extent to which the NGO's methodology was participatory and empowering. By attending meetings, I was able to observe the dynamics and process of meetings, including the interaction amongst members, and between members and the NGO promoters.

My participant observation also took the form of becoming involved in women's daily chores. I helped with the cooking, accompanied them to their farm to pick fruit, took care of the children and washed laundry with them at the river. On the whole, the women welcomed my participation in their daily routine. However, crossing the boundary between public and private life, between 'guest' and 'family' space, required time. The integration and acceptance process was both facilitated and expedited by my decision to live with a family in each village rather than in the isolation of the NGO's

house in which I had initially stayed. Evenings were spent visiting with participants to get better acquainted. The community, particularly the women participants, embraced this more constant presence as they too felt that stronger bonds were forming.

Through this type of daily contact, I developed a relationship of trust and friendship with the women most closely linked to my study. Many of the women commented that they 'had trust' (*ya hay confianza*). They also mentioned they felt comfortable allowing me into their kitchen and serving me their food as I differed from 'the professionals that come here with their pride' (*no es como los profesionales que vienen con su orgullo*). This comment illustrates the value of participant observation in cultivating a more egalitarian relationship.³¹

Although I cannot claim that this type of rapport evolved with all participants, in many cases it resulted in the mutual, open exchange of life experiences both during and outside of interview times. Participants opened their homes and shared their lives with me, engaging in open discussions about maltreatment, sex, and other issues of concern.

My participation in women's activities also allowed me to observe community

³¹This comment also raises questions about the nature of the relationship between the Red members and the NGO workers, a topic which will be discussed in the case study.

and intra-household power structures and women's ways of negotiating and/or resisting this power. In addition, by living in the villages I was able to seek validation and complementary information through informal discussions with participants and community dwellers. This information was well documented in field notes and has proven valuable for my analysis.

Focus group discussions

Qualitative interviewing in focus groups and interviews was deemed most suitable to the research. It is a flexible, iterative, and continuous process whereby the research design takes shape gradually in response to the meaning which emanates from the data (Rubin and Rubin 1995). This ensures that the researcher listens and hears the participant's perspective and incorporates it into the research process.

Focus group discussions are used to obtain in-depth information on the group's perceptions and opinions on a specific issue. They can be conducted to supplement, verify and/or clarify information acquired through interviews and observation. The researcher acts as facilitator while group members discuss the topic amongst themselves. This allows the participants to take the dialogue in the direction they wish and often results in a greater understanding of the problems they deem important, problems which may otherwise be overlooked (Varkevisser, Pathmanathan and Brownlee 1991; Kirby and McKenna 1989; Barnsley and Ellis 1992).

Focus group discussions were used at two stages of the data collection process.³² They were first conducted in three of the four villages with group leaders and active-members so as to have respondents identify problems and help shape research objectives and questions. No preliminary focus group was conducted in La Pareja as it was added to the study area late in the process. While the preliminary discussions provided insight into the group's successes and salient concerns, it was difficult to achieve participation with respect to the actual design of the research. I therefore drew on the results of these meetings to adapt my study objectives and interview questions to the local context. In this way, I ensured that interviews were based on issues raised by group members.

In the last stage of data collection, I conducted a second round of focus groups with four to seven leaders and members in each village. While focus groups are usually designed to obtain in-depth information on one specific issue, the participants in my study requested that we cover several topics at a time so as to limit the amount of days dedicated to this process. These discussions enabled me to verify, clarify and supplement information acquired during the previous months. Topics included women's health, problems identified by the Red de Mujeres, solutions and future action. These meetings were also helpful in revealing dissonance between the Red's priorities and concerns and those of the NGO and the health centre.

³² All focus group discussions were recorded and tapes were copied for participants on request.

In addition to women-only meetings, one focus group was held with five male members of the *comisión de regantes*, a community water irrigation committee. The NGO was interested in discovering the male perspective on the Red de Mujeres and recommended I talk to members of this committee as it has substantial clout in the area. Although I was unable to schedule meetings in all villages, the one in Bigote highlighted male views of the Red as well as their opinion of women's participation in community organizations.

Focus groups proved to be the most insightful, productive and successful data collection technique. Through free-flowing conversation, the participants discussed issues which were relevant to them. Contrary to my original research assumptions, the group members rarely met on their own in the villages to discuss their work. These sessions therefore created the space for them to get better acquainted, to share experiences and to discuss future activities. Moreover, they stimulated a critical thought process through which participants questioned their relationship with institutions and authorities and examined their roles and responsibilities in a different light. Some women demonstrated a renewed enthusiasm for their work and confidence in their capacity to take a more active and autonomous approach. On more than one occasion, the participants commented that the questions had made them think of their situation differently.

It is important to note that other women had quite a different reaction to the focus groups. Many of the leaders in Serrán had been involved with the NGO since 1987 and had participated in numerous projects. The NGO had recently left Serrán and it became clear in individual and group discussions that the women felt exploited and abandoned by the NGO. I assumed that they feared their time would be wasted on me as well. This was confirmed when one Red member asked “why should we participate in your study, *señorita*? We always participate and never see anything in return.” Others ended the meetings saying: “we hope we have helped you with your study...hopefully you will be able to use what we have told you”. Although this type of resentment was limited to one village, it served as a constant reminder of the challenges of conducting field work and its implications for participants. This suggests that the participants’ past experience in research or development projects may be more of an impediment to establishing rapport than the researcher’s cultural background.

Another issue related to focus groups is that of group homogeneity. The presence of people of various social classes or positions in society may create tension and/or preclude open conversation. For example, on two occasions, the presence of a school teacher affected group dynamics. In La Pareja, women felt inhibited to speak because “the professor knows the answer, she can comment”. In the male-only group, the teacher, who was enlightened in his ideas regarding women’s role in society, influenced the direction of the conversation. Most men spoke in accordance with the

teacher's views and the one person who clearly saw no role for women outside of the home did not participate actively in the discussion. These situations illustrate the nature of hierarchical relations in Peruvian society.

Although an ideal focus group is comprised of members with similar positions in society, it is not always possible to control attendance. At times, participants invited friends at the last minute and local politeness codes made it difficult to turn them away.

In addition to ensuring that the group is the most homogeneous as possible, it is also important to understand the relationship amongst potential participants. I encountered several problems in Serrán because of my lack of sensitivity to local group dynamics. The functioning of the Red in this village has historically been fraught with factionalism (*divisionismo*). This manifested itself when members failed to attend a focus group because it was held at the vice-president's house. As she herself had suggested it, I did not question the offer. Rather than discussing the problem with me and suggesting the meeting be held elsewhere, the other members simply did not attend. The fact that *divisionismo* largely followed the geographical partition between the upper and lower villages made it virtually impossible to organize a meeting on 'neutral ground'. As I did not have time to conduct separate focus groups, I organized only one meeting in the upper village and therefore heard only

one side of the story. I used individual interviews to hear the other perspectives.

Despite the above-mentioned constraints, focus groups with women were extremely gratifying personally. The final sessions best reflect the confidence which developed over time. The participants spoke freely of their problems, feelings and fears. Two focus groups ended with us all in tears. I was surprised at how openly women spoke about their health problems and marital relations. Many began their comments by saying: “we are amongst women,...” (*somos entre mujeres*) or, “we have enough trust to speak” (*hay confianza para hablar*). I remember how satisfied and grateful I was for experiencing this type of connection in such a short time span. Inevitably, though, along with this feeling came a deep sense of helplessness. When the women began confiding in me about their illnesses, their pain and their grief, I questioned the relevance of my research to their lives.

Socio-dramas

The final focus groups also provided the opportunity to produce a short video³³ of skits, or ‘*socio-dramas*’ in three out of the four villages. Unfortunately, as I was unable to access the NGO’s video camera during my stay in La Pareja, this village is not represented. I had originally hoped to participate in the Red’s community activities such as recruiting members and diffusing information about imminent health

³³ A copy of this video was left at the NGO office in Piura.

campaigns. However, as my fieldwork did not coincide with many of these activities, I was only able to take part in and observe the recruitment rounds of one leader. It occurred to me that the production of skits could benefit both myself, the women, and the NGO in our understanding of the Red's work. The video could also potentially be used in the future by the Red and/or the NGO as a tool for promoting the Red and health campaigns in the community.

The socio-dramas were based on the following scenarios:

- a) woman A (playing a Red member) must try to recruit woman B into the Red. Woman B refuses. Woman A must try to convince her;
- b) woman C (playing a Red member) must try to convince woman D (member or non-member) to go to the clinic for her Pap test;
- c) woman E (playing a Red member) must try to convince woman F (member or non-member) to use birth control.

The topics for scenarios b) and c) were based on participant suggestions. These skits provided greater insight into the participants' awareness and understanding of the above issues and their level of feminist/feminine consciousness. They were also useful in illuminating what members perceive as the major obstacles to women in joining the Red and seeking medical care.

In addition, the skits in Salitral clearly illuminated the discrepancy between women's words and their actions. I had joined one leader on her recruitment rounds and found that her attitude towards potential members was much more indifferent and

patronizing in reality than in the skit. This suggests that, although women may know how to communicate, they may not necessarily be doing so effectively. I looked for indicators of this when analysing my interviews. Thus, the videos illuminate the awareness levels of the women and their understanding of the issues at hand. And, although they do not demonstrate the leaders' willingness to diffuse their knowledge or their effectiveness at transmitting information, they suggest a latent capacity to do so. Lastly, at least one of the skits could serve as a promotional tool within the villages.

Semi-structured interviews

I chose to conduct topical semi-structured interviews as they combine both structured and spontaneous questions. The interviewer is free to modify the question order and content so as to maintain a logical flow of information, thereby letting herself listen to the interviewees and react to what she hears. The interview, then, is an interactive, guided conversation in which the respondents speak freely, offering detailed descriptions of their experience, beliefs and opinions (Varkevisser, Pathmanathan and Brownlee 1991; Kirby and McKenna 1989).

Individual interviews were used to elucidate the health needs of women, the role, mandate and problems of the Red, the Red's capacity to transmit information, and the opinions of each sub-group concerning the organization. All interview guides were

revised on numerous occasions in order to ensure their appropriateness with respect to language, question order and content.

I made appointments for all interviews. In the villages, I walked to the participants' home in the morning and set a time which was convenient for them. Most women were able to see me between 10:00 and 11:00 a.m., and then again after 3:00 p.m. Men were more available in the evenings after dinner. Interviews with NGO staff and village health workers were scheduled verbally and those with officials were requested formally by letter. The sessions lasted from 20 minutes to 1.5 hours, with an average duration of approximately 50 minutes. All participants and key informants (health workers, health officials and NGO members) were interviewed once. Second interviews were conducted with 7 women (leaders and active members) in order to clarify information and delve deeper into certain issues. Due to time constraints, I did not interview all women twice and therefore relied on informal conversations and groups discussions for validation of information.

With respect to interviews with men, I had originally hoped to conduct two in each village. However, I was unable to do so for my time was limited and I had not established a good enough rapport with the men in the community. I realized by my third interview that two of the first male respondents had put up a verbal 'front' "to communicate an acceptable impression to an audience outside the cultural arena"

(Rubin and Rubin 1995: 24). This was particularly evident when discussing their wife's participation in group activities. A great deal of dissonance exists between the responses of men and those of their wives. Interviews with women and field notes based on participant observation have helped fill in the gaps as well as detect and analyse this type of contradiction. Based on the above-mentioned factors, I resolved that one of the limitations of my study would be its partial inquiry into the male perspective and decided to conduct four individual interviews (three in Serrán and one in Salitral) and one male-only group discussion in Bigote.

On the whole, interviews with leaders and active members generated rich detailed data. This is largely due to the fact that they knew the Red's activities, and, because of numerous capacity building and self-esteem workshops, they were more ready and able to speak out. In addition, they knew me from their meetings and were more willing to talk than those with whom I had less contact.

In contrast, it was difficult to have "guided conversations" with the less vocal people. The participants' shyness and my novice status as a researcher made the interview process a constant challenge. As a result of the participant's discomfort with being interviewed, and conversely, my own discomfort in situations where I felt that trust and connection were lacking, certain interviews were brief and less detailed. As mentioned above, this lack of detail was also a result of the participant's limited

knowledge of the Red de Mujeres.

The fact that I was conducting the interviews in Spanish also impacted on the outcome of the process. As I wanted to ensure that participants understood my questions, I became overly attached to my written interview questions and had difficulty stimulating a natural conversation. With time, however, I was able to let go of the questions and my listening and interaction skills improved dramatically.

3.5.5 Feedback sessions: sharing the results

The final stage of the fieldwork consisted of feedback sessions with the women's group, the NGO and the local health professionals in both Bigote and Salitral. The NGO assisted in transporting women from La Pareja to Bigote and from Serrán to Salitral. Preliminary results were presented and discussed with those who attended (all interested community members were invite through an announcement over the loudspeaker). Participants were involved in the process by recapping the problems, solutions and suggestions made during focus group sessions. Although the video was also shown, insufficient time was allocated to discussing its content.

Subsequently, I held meetings in Piura with the NGO and in Lima with Centro IDEAS-Lima and Centro Flora Tristán where I presented and deposited my report of findings. I made recommendations based on participant concerns and suggestions as

well as my own observations and analysis. In turn, the NGO staff members made suggestions and recommended alternate ways of analysing the findings. Upon returning to Canada, I prepared and submitted a report to the Canadian International Development Agency.

3.5.6 A Note on Data Analysis

While I conducted a preliminary analysis in the field, a more rigorous examination of interview transcripts was carried out in Canada for the production of this thesis. I transcribed all my cassette tapes and hand-written notes and embarked on a long process of theme building and analysis. This involved writing memos on my interview transcripts, coding them, and cutting them up into themes. I was then able to go back to the literature to reflect on the consistencies and disparities between theory and reality. I communicated my main arguments and conclusions to the Centro IDEAS and Flora Tristán for validation.

3.6 Final Reflections on the Research Process

3.6.1 NGO-researcher relations

The NGO-researcher relationship is a topic which is worthy of mention as it influences the participants' perception of the researcher and may also impact on the researcher's ability to conduct the fieldwork.

Although my affiliation with the Centro IDEAS proved invaluable in legitimating my presence in the field, it influenced the way community members perceived me. Most people saw me as a donor or health promoter. I was often approached with requests for funding, medical diagnoses, and medication. As a result, participants of my first focus groups attended because they thought it was a capacity building workshop. I soon understood that the women's original willingness to participate in my study was partially based on their belief that they might learn about issues such as sexuality, women's health or self-esteem.³⁴

My association with the Centro IDEAS also made many women feel awkward voicing negative or critical opinions about the NGO. I found myself explaining the purpose of my research and its benefits to participants on several occasions, emphasizing that I did not work *for* the NGO. Once this message was communicated, the women became more liberal in their comments about the Centro IDEAS.

A second issue of relevance is the level of support received from the NGO. As a student researcher, I had expected that one of the NGO staff members would act as field advisor, providing advice on objectives and ensuring the cultural sensitivity and appropriateness of interview questions. However, as mentioned in an earlier section, the women with the most experience in the field had recently left the NGO. The new

³⁴ Incidentally, this illustrates the popularity of the NGO's workshops.

health promoter had limited knowledge of the Red and was not well versed in participatory research methods.

Although both the director and health promoter provided input regarding research questions, sample size and interview guides, their involvement did not necessarily result in developing a more appropriate study. The NGO promoted the Red as a more autonomous and dynamic entity than it actually was. Once in the field, I realized that the way questions were phrased was far too complex for participants and that others were inapplicable. I therefore had to change the content and style of the interview questions to make them more appropriate. This led me to question the NGO's understanding and perception of the Red de Mujeres.

Lastly, one cannot ignore the extra burden that the presence of a student researcher represents on the NGO. As they were drafting the 1996 work plan and preparing for external and internal evaluations, they had little time to spare. Although the Director of IDEAS had scheduled a meeting to present my research to the entire staff, the meeting was never held. This led to logistical problems, particularly with regards to transportation which had initially been guaranteed.

3.6.2 The effects of gender on conducting field research

The fact that I am a woman had several implications for the field research. It

affected the way people perceived me and interacted with me, and conversely, the way I interacted with them.

For instance, the logistical problems I had with the NGO were partially related to my status as a woman. The transportation coordinator was a male engineer who had often been critiqued by female staff for privileging the male-led agricultural program at the expense of gender-related projects. As a woman associated with the reproductive health project, I was caught in the middle of the NGO's politics. Once I understood the local bus schedules and had arranged for my own accommodation in the villages, I became very independent and no longer relied on the NGO. Ironically, at the end of my report of findings, the engineer in charge of transportation commented that: "had we known that you were going to produce such interesting work, we would have given you more support. But, the truth is we really didn't know what you were doing". Many problems would have been avoided had we held a general meeting to present the research project and discuss the expectations of all parties involved. However, had I been a man, I would have perhaps been given the benefit of the doubt from the outset.

My gender also had an important effect on my interaction with people in the field. As mentioned, my involvement in women's daily household chores and other activities enabled me to garner the trust and friendship of many of the participants. It is because of my gender that I was allowed to partake in such activities and ultimately

have open conversations with participants. The fact that we were '*entre mujeres*' influenced the women's acceptance of me and the direction of interviews. Moreover, it increased the level of acceptance from men who allowed me to spend time alone with their wives.

It is problematic to assume that being a woman always leads to acceptance by other women or necessarily makes one an *insider*. In this case, the relationship between gender, ethnicity and class clearly played itself out to my benefit. Despite my concerns about being a '*gringa*', there were moments when being an outsider actually worked to my advantage. The women in the villages were often willing to talk to me openly precisely because I was removed from their context. They felt comfortable that I would not "gossip" about them as other villagers did. Moreover, as a woman raised without the Latin American sense of class structures, I may have reacted more openly to community members than would a Peruvian urban professional, for example. Thus, my outsider status with regards to class and ethnicity enabled me to become more of an insider as a woman.

My gender also permitted me to feel what it is like for women living in Piura. As I was living in their homes, I had to abide by their rules. For instance, I was always accompanied by a man when I went out at night, both for my safety and because a woman walking alone at night was not looked upon in a favorable light. I also

experienced what I considered aggressive male advances. The women with whom I discussed the issue considered that these advances were neither uncommon nor particularly aggressive.

Lastly, my gender made it difficult for me to interview men. Partly because I was unable to get to know them. And, partly because I felt inhibited and uncomfortable asking them about their feelings regarding their wife's participation. The one exception was the man with whom I lived in Salitral. I managed to establish a respectful and friendly relationship with him and we ultimately had a very successful interview.

3.6.3 Participatory research: myth or reality?

One of the prime tenets of participatory research is that participants must be actively involved in decision-making throughout the process. Linked to this is the notion that this process will create a democratic, horizontal relationship, and thereby transcend the researcher-researched dichotomy. Implicit in this are two assumptions: first, that it is possible to foster an egalitarian relationship between researcher and researched, and, second, that given the opportunity, people will become actively involved in the research process.

Egalitarian relationships

Despite my attempt to create an environment of mutual learning and my non-

hierarchical attitude, I did not succeed in establishing an egalitarian relationship with participants. My status as a student and the underlying class and income differentials were automatic barriers. While I had thought that being a student would help to attenuate power asymmetries, it in fact served to accentuate them in certain circumstances. The participants perceived me as a purveyor of knowledge and treated me in the same way they would the more educated (elite) members of society.

Despite my assiduous attempts at clarifying my role and explaining the notion of mutual learning processes, many women played a passive role in focus groups. No matter how much trust had developed between myself and the women, most still viewed me as someone who could teach them, or, in other cases, as someone who was using them for my own benefit. As such, I do not think they believed they had an active role to play in the study.

This was largely due to the history of exploitation in so-called participatory development projects and deeply entrenched hierarchical relations. Ramphela confirms that the “capacity of people to form ‘new habits of mind’ to break free from traditional hierarchical relationships” is limited (Ramphela 1990: 3). Thus, in situations where hierarchical divisions are so deeply ingrained in society, the creation of egalitarian relationships between researcher and participant may be an unrealisable ideal, particularly in short-term studies.

Participation

I have often reflected on the extent to which I was able to include the research participants in my study. The NGO helped shape the research in terms of the sample and the questions. And, as mentioned, I transmitted my final conclusions to the health promoter and director for validation, thereby involving them in the final process.

However, in certain respects, I failed to include the participants to the degree that I had intended. As mentioned above, my agenda was determined in large part prior to leaving Canada. While I adapted the objectives to the local context, the major theme had been defined in response to a gap in the existing literature. My research, then, was not initiated at the request of the community. I was also unable to include participants in the actual data analysis process.

Having said this, it is important to note that while the participants did not participate in data analysis, they were involved in planning, implementation, and problem solving as much as possible. I revised my objectives and interview questions based on problems raised during focus groups. Although the women did not actually state that they wanted these issues addressed, topics were selected based on the importance given to them during the meetings. Park notes that “although a community may have ‘feelings’ about problems requiring attention, it rarely articulates those feelings as ‘topics for investigation’” (Park quoted in Maguire 1987: 44). As such, the

researcher's interpretation of what is deemed important necessarily comes into play.

An important question here is *who* participates in the research process. While I attempted to involve non- or inactive members of the Red, I did not create an adequate space for them to articulate their needs and opinions. This was largely due to time constraints and their lack of experience in attending meetings. The NGO advised against inviting them to participate in a focus group as they were not accustomed to speaking in public. I therefore conducted individual interviews with them and relayed their concerns to the Red and the NGO during my presentation of findings. Thus, although I made these voices heard locally in my reporting (and in Canada in my thesis), they remained marginalized from the research process.

Only the most active members and leaders of the Red were able to benefit directly from participating in the project as they attended focus groups in which problems and solutions were discussed. As mentioned above, the NGO had invited them to numerous self-esteem workshops wherein they gained the confidence to speak in public, and were thus able to contribute to my meetings. This project facilitated the involvement of the most 'emancipated' women and left the most powerless in the margins. This is not an uncommon occurrence, however. Ramphela suggests that the "capacity of people to participate tends to perpetuate the invisibility of certain disadvantaged segments of society" (Ramphela 1990: 6).

Action and Empowerment

With the participants' involvement in the presentation of findings, we were able to communicate priority concerns and required changes to the NGO and the health centre. Having left the field shortly after the final meetings, I cannot judge whether this information has been acted upon. Ideally, one would present detailed findings and elaborate and implement a plan of action with participants prior to leaving the field.

I have no illusion that the participants felt significantly empowered by their involvement in my project, for this would have demanded far more time and experience on my part. Hall confirms that "it would be an error to assume that naïve or unrooted use of participatory research results in strengthening the power of the powerless" (Hall 1992: 24). Nevertheless, I feel confident that the leaders perceived some benefit from participating in interviews and focus groups. Many confirmed that the questions raised incited reflection on their work. They commented that they "made us think about things we never really thought about before" and "helped us learn about our organization". Moreover, by the end of the project, the leaders were speaking in terms of their 'work' and their 'contributions' to health development, thereby indicating a change in the way they perceive their organization. They no longer spoke of themselves as mere beneficiaries of the NGO, but rather recognized an active role for the Red in the community. Thus, on a small level, the research project was deemed to have been useful to its most active participants. It is my intention to send a synthesized version of

this thesis to the NGO in hope that the health promoter will discuss it with the women in the Red.

3.7 Conclusion

This chapter has offered an examination of the ethical and methodological considerations involved in conducting field work. It has also described and critically assessed the process and approach I adopted in my research on the Red de Mujeres in northern Peru. My conviction to adopt a feminist approach to participatory research and privilege the voices from the Red de Mujeres is evident in the case study. My arguments are built around their words which I cite on numerous occasions. I have remained as faithful as possible to their expressions and their way of speaking by translating them literally, making modifications only when required for grammatical coherence.

Chapter Four

Contextualizing the Red de Mujeres

4.1 Introduction

This chapter will set the context for the case study of the Red de Mujeres. It is divided into three sections. The first will offer background information on Piura, focusing particularly on traditional gender roles in the area. This will provide the reader with the social context in which women of the Red de Mujeres participate. The second section will describe the Centro IDEAS Reproductive Health Project. The third and last section will describe the Red de Mujeres and explain its participation in the project. This chapter paints a picture of the ideal of participation as defined by the Centro IDEAS. Chapter five will explore the reality of participation as women in the Red de Mujeres experience it.

4.2 Research Context

4.2.1 Piura

The field work component of this research project was conducted in the districts of Salitral and Bigote, in the Alto Piura Valley, Province of Morropón. Situated 115 km inland from the coastal city of Piura in Northern Peru, the two districts harbor 16,452 inhabitants. The proximity of both the mountains and the coast has resulted in a highly heterogeneous population composed of people of Black, Indigenous and Chinese

ethnic backgrounds.

Despite water shortages, soil degradation and the absence of a regulated irrigation system, the area lives mainly from subsistence and cash crop agriculture. Main crops include corn, cotton, rice and marigold. Daily wages for agricultural labor are seven *soles*, or, approximately four dollars.

The distribution of social development funds in Peru have been oriented to the Andean region of Cusco as it ranks highest on all poverty indicators. It was not until the 1980s that Morropón began receiving increased investment and these have largely privileged infrastructure over social projects. The construction of roads has had a positive impact in that it has facilitated access to the city, thereby enhancing trade and market opportunities as well as stimulating contact between urban feminist groups and rural women's organizations such as the Red Nacional de Promoción de la Mujer and the Red de Mujeres (Puente and Castro 1995). However, it has also resulted in a rise in rural to urban migration (mainly by men and young women) which ultimately burdens women in terms of their triple work-load. Many are left alone at home to take care of the children, the housework, and the *parcela*³⁵, while others have taken on the added responsibility of traveling to the city to purchase fish or produce which they then sell in their villages. The intensification of women's work-load is aggravated by structural

³⁵ *Parcelas* are plots of agricultural land which are the result of land reform.

adjustment policies which have exacerbated the economic crisis in the area (Puente 1995; Instituto de la Mujer 1993).

Where there have been investments in social development, these have typically included the following: emergency relief programmes for acute and short-lived problems such as the 1990 cholera epidemic; State sponsored welfare-type projects such as direct feeding programs and Mother-Child Health; and child nutrition projects implemented by multilateral and international agencies. These projects have all drawn largely on the voluntary labor of women's organizations for their implementation (interviews with Luz María Gallo and Victor Pineda at IDEAS-Piura, February 12 and April 29, 1997). This has meant the consolidation of women's organizations such as the *Club de Madres* and the *Vaso de Leche*³⁶ in Piura, an important factor since the Red de Mujeres draws on the mobilization experience of these groups. However, the fact that these projects have generally not fostered 'active' participation (as defined in chapter two) has significant implications for women's involvement in the Centro IDEAS reproductive health project. This will be illustrated in the case study.

³⁶ The *Vaso de Leche* (or Glass of Milk) is a government-sponsored direct feeding program which provides a daily glass of milk (usually a mixture of soya and oatmeal) to children from low-income families in both urban and rural areas. The *Vaso de Leche* and community kitchens both rely on volunteer women (Moser 1989).

4.2.2 The National Health System

The National Health System comprises the Ministry of Health, the Peruvian Social Security Institute (IPSS), and the health services of the armed forces and the national police, the regional governments, and the *municipios* (municipal governments). The local level of the National Health System comprises Local Health Systems (*sistemas locales de salud*) which target specific communities and are in principle characterized by community participation in planning. As most people in rural areas are not covered by the Peruvian Social Security Institute (IPSS), their only alternatives are local Ministry of Health clinics which, in some villages, are either lacking or severely inadequately equipped (Instituto de la Mujer 1993; PAHO 1994; Mesa-Lago 1992). The four villages in which this research was conducted, that is Bigote, Salitral, La Pareja and Serrán, each have a health center or health post presently staffed by a doctor, obstetrician and/or technician. This is significant because the leaders in each village have direct contact with local health professionals.

4.2.3 Gender roles in the *campo*

Gender roles and the sexual division of labour in the Piura countryside are largely determined by *machismo* and *marianismo* as defined in chapter two. An understanding of the extent to which these pervade all levels of life is critical to our analysis of the meaning of participation for women in Piura.

Machismo is reflected in the household division of labour. Reproductive work is exclusively women's domain while production (in this case agriculture) is usually the responsibility of men (except where women are heads of household). Typical female domestic chores include cooking, cleaning, washing, caring for children and husband, and carrying wood and water. Men's participation in housework is limited to carrying home fruit, hay or wood back from the *parcela*.

Women also play a large, yet unvalued, role in productive (income generating) work: they 'help' their husbands in the fields, are responsible for raising small animals for home consumption and market, sell products out of their house-front store, and make and sell bread, *tamales* and/or *chicha* (a corn based alcohol). They are also increasingly participating in agricultural activities, although this is considered 'help' rather than 'work'. Despite these productive activities, women's labour is classified as housework and is unpaid, or is a subsistence-level activity which is poorly remunerated. Moreover, women's lack of access to credit limits their potential for autonomous activity (Cetrero, Tocre and Pineda 1996).

A woman's work day begins when she rises at six or seven o'clock in the morning and does not end until she goes to bed at nine or ten o'clock. Her day is filled with household chores, child tending, and productive and community management activities. Women's work is made particularly strenuous due to the fact that they travel

on foot, often carrying heavy loads on their head. Generally speaking, their leisure time is limited to watching the evening *telenovela* (soap opera) before going to bed (for those who have a television). In contrast, a man's work day consists of seven to eight hours of agricultural work.³⁷ While this is indeed arduous labour, it ends once the man returns home from the *parcela*. By virtue of their gender, men have the privilege of traveling by donkey, horse or bicycle (if they own one). Men have the time and space for leisure activities such as soccer, outdoor television and drinking. From three o'clock until dinner, and then again in the evening, men and boys fill the central *plaza* and other public places. Women are generally missing from the picture.

Despite women's hand in both productive and reproductive activities, intra-household decision-making power is also male-dominated. Decisions concerning agricultural production and animal husbandry, for instance, are rarely negotiated within the household. Men also make decisions regarding income allocation, except where it concerns basic necessities such as food. Men's control over the use of income has significant implications for women. For example, even though each of the sample villages have electricity and water systems in place, neither system was working at the time I conducted this research because families had not paid their monthly bills. This

³⁷ This discussion draws on interviews with women regarding their daily activities and their husbands' daily routines. It is consistent with other reports of women's work schedules in Peru. A Red member profile by Puente and Campos (1995) states that members of the Red work an average of sixteen hours a day. Hernández (1995) presents similar data from women in Andean regions.

has made women's work more difficult.

Men's control over income also affects women's health care seeking behaviour as they may not allocate limited resources to health. This is exacerbated by men's control over women's mobility. Women's freedom to access health services is particularly restricted when invasive procedures are involved. These include the Pap test and the insertion of a contraceptive which both require the physician to see women's bodies. In the case of family planning, the problem is intensified by local beliefs that families should have as many children 'as God sends' and that children are a sign of male virility. These beliefs are deeply inculcated in both men and women.

The patriarchal system extends beyond the household to community and national social, political and economic institutions. The history of machismo has led both men and women to under-value, and in many cases, restrict women's participation in community organizations which do not focus on health or child welfare. Women's mobility and daily contacts are largely controlled by men, be they husbands, fathers or brothers. In cases where men are absent, an older woman, most likely the mother-in-law, will make decisions for younger women. Women must seek their husband's permission to join a group or committee and to participate in meetings and workshops. Thus, women have come to participate most actively in women-only community survival organizations such as the *Club de Madres* and the *Vaso de Leche*. As

mentioned, these are welfare organizations which target poor women and undernourished children and are supported by the municipal government and the PRONAA (*Programa de Nutrición Alimentaria*).

Although women participate along with men in other organizations, they do not form part of the executive committees. As a result, they generally do not engage in the decisions regarding their community. They have traditionally attended general meetings as passive observers rather than active participants. Further, despite women's increased participation in agriculture, men have exclusive decision-making power in 'productive' organizations such as the *Comité de Productores* and the *Comisión de Regantes* (Producer's Committee and the Irrigation Commission) (Cetrero, Tocre, and Pineda 1996).

With respect to the formal political system, women have run in municipal elections and there is presently a female councillor in Salitral. Many leaders and members of the Red de Mujeres voted in the 1996 municipal elections. Nonetheless, the majority of women in Salitral and Bigote still do not possess their *libreta electoral*, the identification document which entitles them to vote. The *libreta* costs 30 soles (approximately \$18.00) and must be obtained in the city of Chulucanas, a one and a half to two hour bus ride from Salitral and Bigote. Time and financial costs are prohibitive for women living and working in these rural areas. Thus, despite universal

suffrage which was proclaimed in 1955 (Instituto de la Mujer 1993), rural women have limited voice in politics.³⁸ The consolidation of women's organizations such as the Red de Mujeres, which are entering into consultation, dialogue and negotiation with political decision-makers, provides a way of having women's voice heard and pressuring for change.

4.3 The Centro IDEAS Reproductive Health Project: An Entry Point to Participation and Empowerment

Centro IDEAS is a Peruvian development NGO which has programmed rural development projects in Northern Peru since 1980. In 1990, IDEAS implemented its Agricultural and Community Development Programme in the department of Piura. The programme is funded largely by Dutch and German donor agencies. It comprises four projects: ecological agriculture, irrigation, reproductive health and sanitation³⁹. A male team is in charge of agricultural projects and two obstetricians are responsible for the reproductive health project. While it is neither a feminist nor a women's NGO, the Centro IDEAS focuses on women's health and empowerment through its reproductive health project and has attempted to implement a gender component to all its activities.

³⁸ The fact that there is a cost for the *libreta electoral* clearly brings into question President Fujimori's 'democracy'. It also indicates the sector of society that is capable of voting and that supports the President's regime. I spoke with several people of lower socio-economic status in both Lima and the *campo* and they all voiced frustration and discontent with his neo-liberal policies.

³⁹ It is important to note that donor priorities may have a large impact on the NGO's decision-making regarding programming. Although it is not the focus of this study, the issue will be taken up again in the conclusion.

Centro IDEAS originally initiated the reproductive health project in 1988 in response to the absence of women's health services in the Upper Piura Valley. Luz María Gallo, the present Director of Centro IDEAS, recalls that in 1988, there were no women's health programmes in the area and existing health centres were neither staffed nor equipped to provide care or services for women (other than family planning). Indeed, until 1991, women's health was subsumed under the Ministry of Health (MINSA) Mother and Child Health Programme which addressed family planning, maternal and peri-natal health issues.⁴⁰

IDEAS therefore started providing the human resources and medical equipment necessary for gynecological and obstetric care. The Centro's obstetricians formed a health committee in Serrán through which they trained health promoters and offered health education classes. In their work with the committee, the obstetricians were able to "enter into the lives of women and understand their problems" (Luz María Gallo, Piura, May 4, 1996).

By conducting a diagnostic study and workshop on health education in the area,

⁴⁰ It is important to note that in 1995, the Ministry of Health began its first Reproductive Health and Family Planning five-year plan. In this plan, the MINSA recognizes the need for a broader, more holistic approach to women's health. However, in practice, it focuses heavily on family planning and cervical cancer such that other health problems remain neglected. Equally noteworthy is that since both MINSA and the World Bank are now addressing women's health, the NGO has decided to maintain reproductive health only as gender strategy rather than an institutional line of action (while funding is available). It continues to emphasize institution-building and awareness raising in order to complement existing women's health projects and maintain pressure on the Ministry for gender-sensitive health policies.

the Centro uncovered the incidence of gynecological problems and the level of women's awareness about their health. The study found that 90% of women in the sample had gynecological problems such as vaginal infections, sexually transmitted diseases and prolapsed uterus. These are due in large part to spousal sexual promiscuity and lack of hygiene, high fertility rates, women's preference for traditional birth attendants and home deliveries, women's workload, and an underdeveloped sanitation infrastructure. These problems had hitherto been unreported as women did not seek care either because they failed to recognize their condition as 'unhealthy' or avoided the clinic out of shyness or fear of their husband's reaction. The Director remembers how women in the workshops "thought we had only one orifice through which we urinate and have children. Their lack of knowledge about their body was surprising..." (Luz María Gallo, Piura, May 4, 1996).

The high incidence of reproductive problems, coupled with women's lack of understanding of their bodies and their health, justified the Centro's inclusion of reproductive health in its institutional framework. The main goals of the project were the improvement of rural women's reproductive health and institution building. From 1988 to 1990, the project aimed to increase women's awareness about their health and the lack of health policies and programs relating to rural women's needs. For the 1988-1995 period, the objectives were to strengthen the individual and collective autonomy of women's organizations by promoting their participation in the management, design,

execution, evaluation and follow-up of reproductive health plans, programs and policies. From 1993 to 1995, the NGO aimed to consolidate efforts to improve women's reproductive health through a process of dialogue and consultation with Ministry of Health officials, local health professionals, and other community based organizations. Developing a gender awareness among rural women has underlined all activities throughout the life of the project.

The project's objectives were to be met through:

- 1) research to increase the understanding of women's epidemiological profile and other health issues in the area⁴¹,
- 2) health service delivery (primarily gynecological and obstetrical care via surgical and preventive health campaigns),
- 3) education and capacity-building through workshops on topics such as self-esteem, women's rights, reproductive health and rights, family planning, sexuality, gender, citizenship, and leadership, and
- 4) institutional strengthening of women's organizations, particularly the Red de Mujeres. This entails increasing their negotiation and decision-making power, their ability to formulate and implement proposals, and their capacity to influence public and social policies at both micro and macro levels.

All objectives would be achieved with the participation of the Red de Mujeres (Puente and Campos 1995).

⁴¹ Examples of such research include two studies on gynecological and obstetric problems in the area (Centro IDEAS 1995 and 1996) and a participatory study on women and quality of care in local health centres. The results of the latter were discussed with participants and brought to the attention of Ministry officials at a consultation meeting on quality of care.

IDEAS's gender and empowerment ideology is reflected in the above objectives which go beyond service delivery to emphasize women's self-esteem and their individual and collective autonomy. Of particular interest for this thesis are objectives three and four for their focus on increasing women's awareness and active participation in decision-making. Through workshops, the Centro has aimed to enhance women's knowledge of and attitude towards their health, bodies, and sexual/reproductive rights, and examine the reasons for their subordination and *autopostergación* (the self-denial of one's rights). The NGO also facilitates the active involvement of the Red de Mujeres in local and district level Ministry of Health meetings. In an attempt to incorporate men into the process, the NGO organizes two workshops per year for husbands of leaders and members. However, attendance to date has been low.

The Associate Director of IDEAS is firm in his conviction that the Red's participation in health is a tool to "create a space for women wherein they enhance their self-determination, recognize their own worth and gain the recognition of the community and society as a whole". He further adds that, in their participation, Red members will eventually see that dialogue and bargaining with the NGO and health professionals/officials is not "out of their reach, but rather part of their right as citizens" (*no es parte de otro mundo sino que es parte de su derecho como ciudadano*) (Interview with Víctor Pineda, April 29, 1996).

Thus, IDEAS viewed health as an entry point to working on gender and a means of achieving the democratic participation, empowerment and recognition of rural women. The Red de Mujeres is the vehicle for achieving these goals. The reproductive health project blends health with organizational strengthening objectives, both of which are critical if the goals of women's empowerment, participation in policy making, and improved health are to be achieved. In this sense, the project must be seen as one of the more innovative projects in the area. It combines a holistic vision of health and development with a gender perspective and participatory methodology. IDEAS is one of the only NGOs in Peru working on gender at the community level (personal communication with Edita Herrera, Red Nacional de la Promoción de la Mujer, Piura, March 27, 1996).

However, carving a space for women has not been struggle-free for either the NGO or local women (as will be demonstrated later). Luz María Gallo, who helped conceptualize and implement the Centro's gender approach, remembers the barriers she and the health promotion team encountered within the women's organization, the community and within her own institution. With respect to taking up the issue of reproductive health with local women, Ms. Gallo recalls how surprising it was

to see how they began to know their bodies...They did not know that sex could be pleasurable. Many of them told us that their sexual relations had been rapes or otherwise traumatic experiences...It was quite shocking to hear such things...I understood that by working on reproductive health, we were entering a totally unknown and taboo world, and this was not easy (Piura, May 4, 1996).

Male control over women in all aspects of life and women's attitudes towards sexuality and reproductive rights made it difficult to discuss these issues even amongst women themselves. The underlying feminist tones of what women were learning in workshops also made the male population feel threatened. Early in the project, men from one village retaliated by locking the NGO's local office, essentially 'throwing them out' of the area. However, by concurrently focusing on service delivery rather than solely on empowerment, the IDEAS obstetricians eventually gained the recognition of men and women and acceptance into the community (interviews with Luz María Gallo and obstetricians Lourdes Espinoza and Pilar Puente). This demonstrates how focusing on practical needs can be a means of addressing strategic interests.

Local people were also reticent to accept IDEAS into their communities because they interpreted their leftist posture as terrorism-related. Their reputation as *terroristas* lives on in the eyes of those most far removed from community organizing. Ironically, IDEAS's contact with popular organizations and its affiliations with the feminist NGO Flora Tristán has made it the target of *Sendero Luminoso* (Shining Path) terrorist activities. As a result, the NGO was forced to close its field office in Serrán. Since the arrest of the Sendero's leader in 1992, IDEAS staff have not faced any direct threats. However, they remain cautious because Serrán is the travel corridor to the rebels' mountain refuge of Huancabamba.

Resistance to the health project also came from within the NGO itself. The incumbent Director was shocked that the obstetricians could actually openly discuss sexuality and women's rights with women and pressured the obstetricians to change the nature of the workshops. This was part of an ongoing series of internal male-female struggles which continue to mar the organization. Resistance to gender-related projects is a constant source of tension between the agricultural workers and the obstetricians. This will be discussed again in chapter six.

4.4 The Red de Mujeres

4.4.1 A description of the organization

Rationale

Since its inception in February 1990, the Red de Mujeres of Salitral and Bigote has been the means of implementing the Centro IDEAS's reproductive health project. As women began to discuss their health needs, IDEAS stimulated the formation of a larger local women's organization which could be the vehicle for awareness and capacity-building workshops and which would ultimately promote health locally and pressure health institutions to provide resources to satisfy these needs.

The Red de Mujeres, a secondary level women's organization, groups together members and leaders of existing local women's base groups such as the *Vaso de Leche*, *Club de Madres*, and *red de promotoras de salud* (health promoters network). The Red

is intended to act as an intermediary between these grassroots groups and authorities, institutions and other community organizations (Puente and Campos 1995; Puente and Castro 1995). As such, this woman-centred organization represents a transition from traditional women's groups dedicated solely to family nutrition and well-being. As an organization which represents members from two districts, the Red is intended to bring women's concerns beyond village borders and into larger arenas, be it at the municipal, district or departmental level. Thus, the Red marks a shift from passive to more active participation models.

Membership

Red membership has reached 1229 in Salitral and 1400 in Bigote. The executive committee, which was elected democratically for the first time in 1995, consists of a president, vice president, treasurer, secretary and speaker, each of whom comes from a different village. There are 120 leaders in the two provinces, each holding the position of executive committee member, health promoter, sector representative or base group leader. As the Red is an umbrella organization for existing base groups, the membership is composed mostly of poorer women with children. This may prove to be one of the organization's weaknesses as it does not attract many professionals or younger single women who tend to be better educated and potentially have more time on their hands.

A member profile indicates that 13.4% of members are illiterate, thirty-three percent have not completed their primary education, and thirty percent have finished grade six. The average fertility rate in the Red is 5.8 live children per woman.⁴¹ With respect to the members' reproductive health, 83% suffer from vaginal inflammations, 14.2% from cervicitis, 4% from prolapsed uterus and 0.6% from cervical cancer (Puente and Campos 1995: 3).

Institutional linkages

As mentioned, the Red is an inter-district organization which encompasses villages in the districts of Salitral and Bigote. This research concentrated on two villages from each district (Salitral and Serrán in Salitral, and Bigote and La Pareja in Bigote). Salitral and La Pareja joined the Red with the 1995 committee elections while Serrán and Bigote are pioneer villages. The relationship between the Red and the health centre is considerably different in each village. In Salitral and Bigote, for instance, Red leaders have established close linkages with the attending doctor and obstetrician respectively. Most notable is the doctor in Salitral who has begun to coordinate a project with the Red to facilitate the acquisition of the *libreta electoral*. In contrast, relationships are just beginning to form in Serrán and La Pareja where doctors have recently been appointed.

⁴¹ This rate is higher than the national average of 3.6 live births per woman but is consistent with the rate in rural areas nation-wide (6.2 live births per woman) (Instituto de la Mujer 1993: 26).

Similarly, differences exist between the Red and the municipal government. The Mayor of the district of Salitral has little interest in social development, particularly women-oriented projects. He has frequently threatened to close down the lower village *Vaso de Leche*. The Red leaders have commented that he manipulates other *Vaso de Leche* committees by supporting them in exchange for their political support. In Bigote, relations between local authorities and the Red have been more positive. The mayor has facilitated certain Red activities by providing funding for food and supplies. He has also asked the President of the Red to act as *fiscalizadora* for the *Vaso de Leche*. She is presently in charge of keeping track of the distribution of food supplies.

The Red's Mandate

The organization's statutes list fifteen objectives, of which the first five are:

- to strengthen the different organizations and institutions in the *caseríos* (villages); attempting to sensitize members and civil society to the *problemática* of women,
- to contribute to research on socio-economic and gender problems,
- to defend the Red's autonomy,
- to contribute to the consolidation of the women's movement, and,
- to generate mechanisms and conditions conducive to the holistic development of women

The case study will demonstrate that the Red leaders are not entirely clear on the organization's objectives as they are listed in the statutes. The implications of this for the NGO's participatory methodology and the Red's internal cohesion will be explored in the concluding chapter.

4.4.2 Participation of the Red de Mujeres: a description of the process.

As the above objectives indicate, the Red's role is not limited to participation in health development. Nonetheless, this has been its focus over the past eight years. Although the Red is beginning to branch into other activities such as the *libreta* project, its main responsibilities to date have been related to the promotion of reproductive health as part of the reproductive health project discussed in section 4.3.

Workshops

A large part of Red activities is attending awareness and capacity-building workshops (*talleres de capacitación* or *charlas*) and meetings organized by the Centro IDEAS or the health centres. The NGO offers yearly workshops to 133 women (leaders and non-leaders). Workshops are held in villages or in other parts of the country. The assumption here is that women will return to their villages and diffuse the information to leaders of base groups who, in turn will transmit this knowledge to their members. In cases where the base group leader is a leader of the Red, she is to diffuse the information directly to members. As will be shown later, information is not necessarily trickling down as effectively as the NGO assumes.

Community level health promotion: awareness-raising and mobilization

At the community level, the leaders are also in charge of registering 'clients' for family planning (including sterilization) and Pap campaigns. This involves informing

members and non-members of the importance of health campaigns (Pap, tubal ligation, and hernia) and demystifying the process by explaining medical procedures and possible side-effects. Once they have signed women up, they provide a list of names to the local health centre. In addition to or, in some cases, instead of door-to-door recruitment, campaigns are announced over the village loudspeaker and on banners outside the health centres.

The Red is also in charge of identifying indigent women who are sick but refuse to seek care and bringing them to the attention of local health professionals. Leaders are also intended to mobilize funds for sick women who cannot afford medication. Leaders from all four villages feel that these promotional activities have contributed to women's increased health awareness and use of health care services, particularly cervical cancer screening and family planning.

District level health promotion

The Red de Mujeres also has a fundamental role in pressuring the Ministry of Health for change. Since 1995, the Centro IDEAS has facilitated the leaders' participation in provincial and inter-district multi-sectoral meetings with the Ministry of Health, NGOs and other local women's associations in order to elaborate reproductive health plans. Prior to these meetings, Red leaders meet on separate occasions with NGO promoters and health professionals in their respective villages to discuss the local

health plan for their district. They then bring these plans to departmental and provincial meetings and voice their demands. They have also participated in a Ministry consultation meeting on Quality of Care.

Participation in the Centro IDEAS project

Explicit in the Centro IDEAS's project objectives is that the Red de Mujeres is intended to participate in all phases of the reproductive health project including needs identification, implementation, management, evaluation and follow-up. The extent to which their participation is 'active' will be discussed in the case study.

4.5 Conclusion

This discussion has set the context for analyzing the participation of the Red de Mujeres in the Centro IDEAS reproductive health project. It has described the goals of the NGO's project and the Red de Mujeres as well as the means by which these goals are to be achieved. In principle, the Red de Mujeres has a large role to play in promoting women's reproductive health both within and beyond the community. Participation in the Red is intended to be a means of empowering women to gain control over their health and increasing their presence in decision-making. The following case study will examine the extent to which these goals are being achieved.

Chapter Five

Case Study

Participation in the Red de Mujeres: An Empowering Health Strategy?

5.1 Introduction

This chapter is the culmination of a four-month field study in Piura, Peru and an in-depth analysis of data collected through interviews, focus groups and personal observations. By articulating the voices of the Red de Mujeres, the Centro IDEAS and health officials/professionals, this case study provides a nuanced analysis of the Red's participation in the reproductive health project and evaluates the extent to which this participation has fostered women's empowerment.

This case study is divided into three sections which explore the personal and organizational levels of empowerment described in chapter two. The first will examine the personal dimensions of empowerment. It will address the following questions: has participation in the Red de Mujeres enhanced women's health awareness and self-esteem? Has it improved their ability to protect and promote their health? And, does it represent a challenge to existing gender ideologies? The second and third sections will assess the extent to which the leaders' empowerment has led to organizational strength both in terms of the Red's ability to influence health programmes and policies and its capacity to empower its members. Although community empowerment is an important element, it was beyond the scope of the fieldwork and will therefore not be discussed in

detail in this thesis.

5.2 Participation in the Red de Mujeres: Personal Empowerment and Social Transformation

As mentioned in the previous chapter, the Centro IDEAS has made conscientization a central component of its reproductive health project. Interviews with leaders and active members⁴³ clearly illustrate the extent to which their participation in workshops and health promotion activities at the local and provincial level have incited consciousness-raising and self-development. All the women interviewed who had attended workshops and played an active role in the organization attest to an enhancement of their self-esteem, increased knowledge about their health, and an awareness of their rights as citizens.⁴⁴ They have learned to respect and value themselves as women (*respetarme y valorarme como mujer*) rather than only as mothers. Expressions such as 'claim our rights' and 'women deserve respect' filter into

⁴³ A point of clarification is necessary here. The term 'leader' applies to women who form part of the executive committee, that is, the President, Vice President, Treasurer, Spokesperson (*vocal*), and Secretary, or women who are sector representatives. In some instances, leaders of the Red also hold leadership positions in their base groups. Leaders of base groups who are not part of the Red leadership are considered active members, that is, women who participate in meetings, workshops and promotional activities. The participants of this study who are considered 'active' all hold leadership positions in either the Red or a base group with the exception of one woman in Serrán. Therefore, as active members are in fact leaders, I have collapsed the two categories and will refer to them all as 'leaders'. Others will be called 'members'. The fact that women who are actively involved in the Red are also leaders certainly comments on the breadth of participation and the level of member control over the organization's activities. This will be discussed in greater detail later.

⁴⁴ It is clear that these are all interconnected. They feed off of one another and have a cumulative effect. It is therefore difficult to discuss the order in which such transformations occur. However, for reasons of comprehension, I have had to divide them and have chosen to discuss health awareness first.

their testimonies. They have begun to know their rights and have become assertive enough to demand them in the household and within the community. It is important to note that members of the Red have not demonstrated such a sense of personal development. As this reflects weaknesses in the leaders' ability to transmit information and suggests that the organization is not empowering its members, it will be discussed later in the context of organizational empowerment.

5.2.1 Health awareness and self-esteem: enabling women to protect and promote their health

Health workshops have taught women about their sexuality and how to identify and prevent illnesses related to reproductive and child health. When asked about common health problems afflicting women in their community, the leaders identified vaginal infections, prolapsed uterus, and inflammations, and commented on the importance of the pap test to "see what we might have inside us". This is particularly significant considering that, prior to their entrance into the Red, they did not know their anatomy and "walked around thinking the pain was normal". They have also begun to identify underlying causes of their ill-health, notably, their workload, their husband's promiscuity, and poverty.

While this research does not measure improvements in women's health, interviews indicate that combining awareness about health and reproductive rights with self-esteem and gender analysis is a powerful means of enabling women to better

safeguard and promote their health. For instance, they are more inclined to attend pap and family planning campaigns, and, in certain cases they resist their husband's sexual advances to remain free of disease. Either situation clearly involves a direct challenge to male control over women's mobility and sexuality.

For example, women like Gabriela Pineda⁴⁵ now view their health as a right and argue that "even if he doesn't want me to, I have to go [to the health centre] because it is my health" (Salitral Sectoral Representative). The following testimonies further illustrate how women contest their situation.

Now my husband controls himself. If he goes with others, I don't have sex with him. We didn't know our rights before, so we didn't claim them.

- Susana Chavez, active member, Serrán

And,

before, men beat us when we didn't want to have sex with them. But now he [my husband] understands because I give him the pamphlets and we talk about them. He is starting to understand me.

- Flor Córdova, Serrán sector representative

In some cases, men have become more attuned to women's health problems. Leaders from all four villages confirm that their husbands now encourage them to have

⁴⁵ All names revealed in this case study have been changed to protect the participants' identity.

their pap tests. The Serrán Sectoral Representative adds that “husbands never used to worry about women’s health, now they come with us to the health post”. Interviews with men also suggest that those who have been exposed to workshops either directly or indirectly through conversations with their wives have begun to see that women have a right to health.

Not all leaders have succeeded in stimulating such change, however. After one focus group discussion, three women who are leaders of base groups told me that they experienced extremely painful intercourse due to severe inflammations. They continued to say that they had to have relations with their husbands “because they are men and otherwise they will go elsewhere (...) we must be *payasos* (clowns)”.⁴⁶

It is also important to note that, in general, women’s health care seeking behaviour has changed particularly with respect to contraceptive use and preventive measures such as the Pap test (both of which are presently free⁴⁷). This is undoubtedly due to the fact that these are the areas of women’s health which are promoted most intensively by MINSA and the NGO. Interviews and informal discussions indicate that women, including leaders who no longer fear going to the clinic, still neglect their

⁴⁶ Women feel they must always smile and, in the case of painful intercourse, they should ‘grin and bear it’. Such gender ideologies are deeply ingrained in women and are indeed very difficult to change. This underlines the importance of making personal level transformations visible.

⁴⁷ At the time this field work was conducted, the fee for a pap test was dropped from s/3 to free of charge in response to pressure from the NGO and the Red leaders.

health. Many reported living with severe eye infections, leg and back pain, or vaginal inflammations detected by the Pap test because they did not have the money to pay for medical consultations or treatment. This issue will be taken up again in the section on collective empowerment as it brings into question the Red's ability to respond to local needs.

5.2.2 Challenging traditional gender ideologies: implications for today's women

Women's participation in health promotion activities, workshops and meetings has also created a space for women to come together. In a society where women are to keep busy in the confines of the home, "it is an achievement that [they] meet to talk and get to know each other" (leader, Salitral). Realizing that "one cannot be solely in the house" (leader, Bigote), the leaders are challenging traditional roles and social boundaries. The sectoral representative recalls that "women only had their house [and] had to be dedicated only to their children and husband, and could not go out, not even for meetings. But now we know that women must take the time for everything to get ahead. We have understood that we can go forward". Thus, women are becoming conscious that they have a role to play outside the home, and they have begun to act on it.

Men's acceptance of women's participation has also gradually increased through a slow process of negotiation, struggle and even subversion. Most of the leaders in this

study began participating without their husband's permission, slipping out during the men's work hours. Some have gained *permiso* by explaining the content of the workshops to their husbands. A leader in Serrán comments that "men have learned how husbands should treat us. We make them understand that they should not beat us, that women are not only for the house (...) I think that in this respect the Red has served us well".

Many leaders now participate with their husband's permission (if not their full approval). In certain situations, husbands even support and encourage their wives' participation by ensuring they are on time at meetings, or by taking care of the children during workshops, for instance. Some men now understand that "being part of an organization means more than just being organized, that we have to get together to make decisions...one of our major successes is that our husbands have given us a little more freedom to participate" (active member during focus group in Bigote). The Treasurer of Salitral confirms that through their participation in the Red they have "succeeded in breaking down *machismo* a little".

This is a particularly important accomplishment considering the social pressure imposed on men to "control" their women. Interviews with men in Serrán indicate that neighbours and family members criticize them for their lack of control over their wives or, worse yet, for their wives' control over them. They have learned either to ignore

the comments or even to counter them directly by telling others that "women can also participate".⁴⁸ Interestingly, women (members and non-members) have also criticized Red leaders for neglecting their role as mother and caregiver, an issue with which the leaders must contend. A leader of the *Vaso de Leche* in Salitral comments that "even the women here are *machista*".

It is noteworthy that some leaders continue to participate without their husbands' permission in spite of frequent beatings. And, with or without permission, all women must ensure that they finish their chores which may include bringing their husband's lunch to the farm (an hour or two on foot). They must juggle their meetings and daily activities, either passing responsibilities on to their daughters or working excessively long days to ensure everything gets done. In meetings I attended with the leaders, I noticed they were anxious to get home afterwards to make lunch or dinner.⁴⁹ I overheard comments such as "I may end up with a black eye if I don't hurry" and, "if dinner isn't ready, he's going to get angry".

The President of Bigote inevitably feels that she is failing in her maternal and conjugal duties and is wrought with the internal tension which arises from managing the

⁴⁸ While men are increasingly allowing women to participate, few actually understand the value of participation for the family and the community, and even fewer view women's participation as a fundamental right.

⁴⁹ This holds true for their participation in my focus groups as well.

roles of mother, wife and citizen. She feels guilty for leaving her daughter to do the cleaning at home “like a slave” and justifies her husband’s violence by saying,

You arrive home and get scolded by your husband. You suffer threats because it is already 1:30 p.m. But you can understand that the husband is not speaking wrongly because you really neglect the house...you can’t even make a good dinner because you are so late...It is not easy to take on such a responsibility in the *campo* because one neglects her husband, her house and her children.

Nonetheless, the President remains active in the organization so as to further her knowledge and make changes in the community.⁵⁰ The above comment is heavily charged. First, it reveals the new problems which arise from participation. Second, it exemplifies the resistance and negotiation power of women who step out of the home in the face of such adversity. And third, it demonstrates how profoundly gender roles and ideologies are inculcated in both men and women and the challenge this represents for strategies which aim to transform them.

5.2.3 Challenging traditional gender ideologies: implications for future generations

The testimonies of leaders have demonstrated that the critical consciousness and confidence gained by participating in promotional activities has led them to directly question and challenge traditional gender roles and relations. Perhaps the greatest indicator of their conviction to transform the status quo is their transmittal of new ideas

⁵⁰ It is important to note that the President feels that financial compensation for her efforts in the organization would justify her participation to her husband and children.

to their children. One leader mentions that

we are accustomed to raising our children such that the boy is for the *chacra* (farm) and the girl for the house...but these days the girl can wash, iron and cook, and so can the boy. Then, when our kids get married, they can raise their children that way...He [my son] helps me sweep and even washes his own clothes.

The concept of women's participation is also being passed on. Children's presence during meetings and their mothers' conversations exposes them to the process at an early age. I witnessed an interesting scene in Salitral where a young boy and his sister simulated a Red de Mujeres meeting in their home.

Lastly, by speaking more freely about sexuality and health issues with their children, women are helping to create a new generation of more conscious people. One leader explained how her children pretend to organize and attend pap campaigns. Another overheard children talk about the method of contraception used by their mothers.

5.2.4 Participation in health promotion: feeling a sense of personal and collective agency

The sense of personal empowerment described above also manifests itself in the leaders' confidence about their role in promoting women's health in their villages. They feel that women are taking better care of their health because of their recruitment activities in the communities.

The leaders' confidence and experience in meetings have also enabled them to enter into discussion with other community groups, local health professionals, and Ministry officials. They no longer feel "embarrassed to speak in public". They feel capable of "defend[ing] their organization" from authorities (*ya no me dejo manipular*), standing up for their rights, and making change in the community. They have also learned "how to knock on the door of the health centre" to make demands (Sector Representative, Serrán). The extent to which these claims hold true will be explored later. What is important here is that the leaders have a sense of purpose and capability and this contributes to the organization's sense of collective agency.

This section has illustrated the individual changes and personal empowerment felt by leaders as a result of their participation in the Red de Mujeres. It showed that all participants who have had access to capacity-building and health education workshops have noticed positive changes in their personal lives. They have gained an increased awareness of health, self-esteem and knowledge of their rights, all of which have given them the sense of self-worth necessary to take care of their health. What is more, their understanding of their situation in a *machista* society has spawned an active questioning and transformation of gender roles and relations both within the home and in the community. In addition, this personal development and empowerment has given leaders the confidence to articulate their demands in local and departmental arenas. It is clear that even amongst this group of experienced women, the degree of transformation

varies depending on their exposure to meetings and workshops, as well as their personality and family situation. Nonetheless, the process has begun.

While this speaks highly for the level of personal empowerment developed in the leadership, it does not provide insight into the empowerment of the organization as a whole. The following two sections explore the extent to which the leaders' personal empowerment translates into organizational empowerment. The first examines the Red's capacity to influence decision-making regarding women's health. The second assesses the Red's ability to empower its members such that they partake in information acquisition, decision-making and control of activities.

5.3 The Red's Participation in Larger Arenas: From personal to organizational empowerment

As mentioned above, through their participation in the Red, the leaders have lost the fear to speak in public and have begun to articulate their needs and demands in consultation meetings with other community groups and health professionals. Their success in articulating their demands is largely attributable to the NGO's work in the area. IDEAS has not only pressured the MINSA to open up decision making to civil society, but has also trained local health workers in participatory methods.

The NGO has been preparing Red leaders to participate in the MINSA *mesa de*

*concertación*⁵¹ (“consultation table”) for health matters by offering leadership training and facilitating their participation in the development of their reproductive health plan. The Red then uses this plan as a working document and attends local health centre community meetings to incorporate the women’s reproductive health plan into the centre’s yearly health plan. Then, with the help of IDEAS, the Red attends inter-district multi-sectoral meetings with the Ministry of Health, and other NGOs and local women’s associations to finalize the MINSA Reproductive Health and Family Planning Programme.

Thus, the first step in the process is the Red’s participation in developing the Centro IDEAS’s reproductive health plan. Observations during planning meetings reveal that the Red has limited involvement in actually defining priorities. The leaders’ input largely revolved around the timing of health campaigns, workshop topics, and their role in recruiting women. Larger issues such as the types of projects to be implemented seem to be determined by the NGO. This will be discussed again in chapter six.

At the community level, the Red participates in the health centre’s community meetings to develop the local health plan. These are mixed meetings that unite local

⁵¹ The term *concertación* refers to a process by which agreements are made through concerted efforts. It combines the notion of consultation and negotiation and implies that all actors participate in decision-making.

authorities and organizations. Red leaders feel that their invitation to these meetings is in and of itself an achievement as it demonstrates that the community has begun to acknowledge their efforts.

Before when a woman spoke, no one would take her into account. Men would continue to talk. Only when the man spoke would people listen. Now, when a woman speaks, everyone is quiet. It seems they have understood.

- Sectoral Representative, Salitral

A member of the *Comisión de Regantes* in Bigote notes how organized women have become. "Before, you'd see a group of women talking or complaining in the street. Now, they are making demands in an organized manner" (member during focus group with Comisión de Regantes, Bigote, April 18, 1996).

The Red's participation in health promotion has won the organization acceptance in community discussions. However, the Red's input is largely limited to women's health and child welfare, leaving men responsible for other community development decisions. In health centre meetings, the Red participates by informing meeting members of the nature and dates of health campaigns. These health campaigns were already on the health centre's agenda. And, although the topic of domestic violence did arise during the meeting in Salitral, the health centre has still not begun to address the problem.

Moreover, the Sectoral Representative in Salitral notes that in community meetings other than those called by the health centre, her status as Red leader is overshadowed by her role as mother. She feels this undermines her position as a community actor and comments that women will “only be valued when they stop seeing us as *la señora* but rather as someone who should be respected”.

At the level of Ministry of Health discussions, the Red brings the reproductive health plan to the *mesa de concertación* and other meetings held to improve women's health care and services. During my field work I was able to witness the leaders' participation in several meetings.⁵² At the district level meeting on Reproductive Health and Quality of Care, one Red leader read a list of demands which included free pap tests and family planning, a fee reduction for leaders for gynecologic surgery, more private examination rooms, the inclusion of domestic violence as a priority, and more attentive medical staff. These demands stemmed from the results of an IDEAS study on quality of care that were translated into a list of demands in a meeting with the Red.

Although the meeting on Quality of Care did result in free pap tests and family planning, the changes may have been more a reaction to the pressure of the Centro's

⁵² These include the Red-IDEAS health plan development in Bigote and Salitral, the inter-district multi-sectoral meeting on quality of care in reproductive health, and a UNICEF-women's organization meeting in Salitral to discuss the implementation of a child nutrition project.

health promoter than to the Red's involvement. In addition, issues such as domestic violence and better treatment from medical professionals remained peripheral to discussions. The NGO and the Red felt that MINSA had set its agenda before the meeting and was paying lip service to the consultation process (interviews with Pilar Puente, Luz María Gallo and the President of the Red de Bigote). The Red leaders also felt their demands were falling on deaf ears. In fact, the President of the Red stood up to tell the health officials that she resented their attitude. In a discussion with her later, she commented that "they think that simply because we are a women's organization, they don't have to value our work. I have the right to demand to be heard...If we present a work plan and they don't listen, then why am I organized?" (President of the Red de Bigote).

Research is required to gain more insight into the Red's role in the consultation process. The field study I conducted was too short to understand the relationship between the Red and the local health centres and Ministry. Nonetheless, interviews suggest that the Red is not participating broadly in defining health priorities in the Centro IDEAS and MINSA reproductive health projects. Rather, its most active role is coordinating with the doctors to recruit women for campaigns (Interviews with Doctors Littner and Valdiviezo and Obstetrician Jossely Noblejas).⁵³

⁵³ The leaders with the most seniority are beginning to question their participation in the Red. Despite the personal changes, they feel their involvement is an exploitation of their time. The leaders in Serrán and Bigote were particularly adamant about voicing their frustration. They commented that their participation

The treasurer of Salitral noted that "the Red proposes and proposes, but everything stops there". In meetings with the health post, the NGO and the Ministry of Health, the leaders had indeed suggested a number of projects on which they would like to work. These included income generating projects, a shelter for victims of domestic violence, a room in which out-of-town members can live when they come for meetings, a video on domestic violence, and fund-raising activities to purchase medicine for members. However, neither the NGO nor the health centre had begun to discuss implementing these when I left the field. This speaks both for the Red's autonomy and the willingness and/or ability of institutions to respond to new demands arising out of health and empowerment workshops.

Commenting on the decision-making process with the health centre, the Sectoral Representative for Serrán indicated that "we give our opinion. They read everything out loud and, if we agree, no modifications are made. If not, they make us understand how things are and then we begin to work on the project." As the Doctor in La Pareja suggested, "coordinating is one thing, making decisions is another...ultimately decisions are made by professionals". This comment speaks for the willingness of health professionals to facilitate the active participation of the community in decision-making, an issue which will be discussed further in the concluding chapter.

is a "struggle", a "sacrifice", and even a waste of time. They are beginning to request financial compensation because "no worker works for free all of the time" (President of the Red de Bigote).

5.4 Participation in the Red de Mujeres: Empowerment for whom?

The discussion has thus far focused on the leaders of the Red de Mujeres, their personal empowerment and their involvement in the Reproductive Health Project. The exclusion of the members from this discussion is by no means accidental. Rather, it reflects the division which exists between members and leaders with regards to their participation in the Red and their level of empowerment.

Unlike the leaders, the members of the Red de Mujeres do not take part in the Centro IDEAS capacity-building and awareness-raising workshops or meetings held to discuss future plans with IDEAS and the health centres. This is considered the work of leaders who are responsible for both transmitting their members' needs in larger forums and diffusing to the bases information related directly to health as well as to self-esteem, women's rights and Red activities in general. Thus, information is intended to flow up from the bases and back down again, and members are intended to have a voice in their organization's decision-making process. This section will examine the extent to which the Red is an empowering organization. That is, it will assess whether members are involved in the acquisition of information and whether they participate in needs identification, decision-making, and control of activities.

5.4.1 Awareness and Knowledge: How far do they really trickle down?

Health awareness

Leaders are confident in the Red's ability to diffuse health information and *captar pacientes* (sign patients up). In their recruitment rounds they tell women about the importance of going to the clinic for their pap test or family planning. The speaker (*vocal*) of Bigote notes that she no longer has to recruit women because they register at the clinic on their own or visit her for family planning information.⁵⁴ The leaders find this tendency particularly noteworthy considering they "used to have to beg the women to go to the campaigns" (active member, Serrán). Local health professionals and NGO health promoters also speak highly of the Red's capacity to mobilize women and promote health. They value the Red's pre-campaign outreach work and comment on the importance of having women from within the community act as intermediaries between the client and the health worker.⁵⁵

⁵⁴ The fact that some women go to Red leaders for advice or information demonstrates their recognition of the organization's role in health promotion. All active and several non-active members and non-members acknowledged that the Red has played a part in 'coordinating' with the Ministry of Health and the NGO to implement campaigns locally at low cost to women. This awareness stems from the Red's recruitment efforts and from loudspeaker announcements and health post banners which indicate that the campaigns are organized by the Ministry of Health, the health post, the Centro Ideas and the Red de Mujeres. Thus, even though local people are uncertain of the capacity in which the Red has participated, many of them have come to associate the campaigns with the women's organization. As a result, the Red has gained credibility in the community.

⁵⁵ Although I do not question the integrity of the health workers or the importance of the Red's community level health promotion, it is important to note that the obstetricians and the doctors at the health centres alluded to the fact that the women are now doing a job the health staff used to do. This voluntary work reduces the burden of professionals and can be seen as a way of shifting state responsibilities onto local women. As mentioned earlier, the leaders with the longest history of participation are beginning to feel exploited.

Yet interviews and observations suggest that many participants in the study have not received effective information from the Red's campaign recruitment rounds. Some members exhibited little understanding of their health, commenting that everyone is healthy or that they have never 'fallen ill'. Others stated that all women suffer from pain but nobody knows the cause. And yet others recognize specific problems but will not seek care (or cannot afford care) unless they 'fall ill' (that is, to the point where they are bed-ridden). Many members also mentioned that they would rather wait until they had the money to go to the city for their pap tests and other treatments. It is important to note that some of the research participants (including non-members) were aware of the Pap test and did get it done regularly. However, of these women, only one mentioned her decision was influenced by the Red de Mujeres. Others had learned from their doctor or relatives.⁵⁶

When asked why members had not sought health care (in general), the main reasons were related to poverty, perceived inadequacy of equipment and personnel in the *campo*, client preference for seeing a doctor with whom they do not have daily contact, the embarrassment of being called over the village loud speaker when results are ready, preference for traditional medicine, and the fact that they had never 'fallen

⁵⁶ The fact that women are increasingly attending pap and family planning campaigns (interviews with Doctor Littner, Salitral and Jossely Noblejas, obstetrician, Bigote) may result as much from other factors as from the Red's work. Certainly local health centre workshops which are open to all women, the implementation of campaigns locally, television and radio programming, and/or communication with urban relatives or doctors have influenced matters considerably.

ill'. While the question of money and doctor-patient relations was raised in both leader-NGO meetings and my focus group discussions, the other issues mentioned above were unknown to me until my interviews with members. This suggests that leaders are either unaware of them or do not view them as a priority.

Although Red leaders sign women up and announce campaign dates, they may not be addressing the factors which affect health seeking behaviour and may be weak in diffusing 'empowering' knowledge which would enable members to take control over their health. Moreover, where this type of diffusion is occurring, it may be limited to friends and family. The fact that many women who sign up for an examination or surgical procedure fail to attend, and that the 1995 pap campaigns covered only thirty percent of their target objective further indicates a weak link in the Red's promotional activities (Director of the MINSA Reproductive Health and Family Planning Programme; Dr. Littner, Salitral).

Identity building and self-esteem

The difference in self-esteem between the leaders and members is palpable. During interviews, members were more timid and unsure of themselves than leaders. The members' discourse is also substantially different from that of the leaders. They speak neither of 'defending one's rights' nor of valuing themselves as women. In further contrast to the leaders, the members did not identify any changes in their lives

from being members. The sense of personal development, self-esteem and gender awareness so evident in the leaders did not come through in the members' testimonies or demeanour. I decided to ask all research participants whether they noticed a difference between a leader and a member. All, including the NGO members and health professionals, responded in the same vein. They noticed that a leader is confident, values her health, and can speak in public, while a member is shy, lacks knowledge, and is passive. Surprisingly, the NGO did not stop to question the discrepancy.

Information on the Red de Mujeres

Red members also have limited awareness about the role of their organization and the activities it undertakes. When asked what the Red's role is, few members could answer. Instead, they either told me they did not know, or they returned the question to me: "perhaps you could tell me, señorita" and "I was going to ask you the same thing. What do they do?". Other members did know about the Red's role in the pap campaigns and promotion of women's health, yet spoke of the Red in the third person saying "*they* go to meetings" and "*they* attend workshops, but we don't know what they are about". Again, the NGO members and Red leaders are fully aware of this. When I asked the NGO obstetricians and Red leaders to suggest participants for my study, they originally only gave me the names of leaders because the others "don't know anything". Their lack of knowledge is precisely what I found very revealing.

Although the empowerment experienced by the leaders is laudable, many women are left at the margins of the process. The limited awareness of members regarding their health, their gender identity and their organization has had a great effect on the internal cohesion and collective empowerment of the Red de Mujeres. It suggests that leaders are not sharing knowledge or facilitating the participation of members in the acquisition of information. Some of the leaders acknowledge that trickle-down or 'cascading' of information to the bases is deficient. The president of Bigote, for instance, confirmed that she "has capacity, has knowledge, but the members don't get the capacity-building and don't have the knowledge".

The leaders themselves recognize their responsibility in this matter and have resolved that they must diffuse information more effectively. Leaders who have conducted meetings with base groups are concerned that members are not "catching" (*captar*) much information. This is further confirmed by my contacts with members who asked me to explain *machismo* and *discriminación* as they had learned about them in a meeting and were uncertain of their meaning. When asked why this may be occurring, one leader from Bigote confessed that,

Sometimes the members don't understand what we say. But, also, the leaders don't transmit the information well. We go to *talleres* [Centro IDEAS workshops] and don't write in our notebooks and we don't catch all that is explained. It would be good for us if, after each meeting, we could write up a summary and circulate it to all leaders so they know how to explain things to the members.

- leader, Bigote

This illustrates that the responsibility for effective diffusion of information does not lie solely with the leaders. Rather, the Centro IDEAS clearly has a role to play in ensuring that the content of workshops is understood and that leaders are able to transmit what they learn. The deficiencies of the Centro's methodology will be discussed in the following chapter.

With respect to the diffusion of the Red's goals and activities, it appears that the Red leaders have difficulty expressing their mandate. Members have asked for leaders to explain the Red's statutes and work plan in a general assembly. However, there is confusion as to who can and should organize the meeting. The leaders in La Pareja and Serrán are waiting for the presidents to act. And, the presidents are in turn relying on the Centro IDEAS for assistance in calling the meeting and explaining their statutes and work plan. When I asked the leaders about the statutes and their work plan, they were unable to answer. Some looked in their notebooks or pulled out their statutes for answers. Others mentioned that they were unaware of the work plan because it was kept in the president's house or at the Centro IDEAS offices. Not only does the leaders' limited understanding affect member awareness levels, it also raises serious questions about the Red's involvement in the elaboration of such documents.

Even where leaders have the ability to communicate their knowledge, they may not implement the mechanisms through which to do so on a large scale. Diffusion

meetings are few and far apart.⁵⁷ The leaders did not organize a general assembly or local meetings with members after the elections to discuss the Red's activities. Nor did they call an assembly prior to (or after) the NGO-Red work plan meeting. Ultimately, information is transmitted informally, on the way to the field or while doing laundry at the rivers. Although these are important means of communication for women in the *campo*, they limit diffusion to selected friends or relatives.

5.4.2 How Collective is Collective Action?

Creating a space for member participation

As mentioned above, the communication problem in the Red is such that the flow of information and awareness to members is limited. The leaders' failure to hold meetings with members to discuss work plans and activities also suggests that information is not flowing up from the bases. That is, leaders have not carved a space for democratic decision-making and needs identification within the organization.

Interviews indicate that the decision-making process is indeed vertical in the sense that the president and vice president participate in meetings where decisions are

⁵⁷ It was difficult to gain a clear understanding of the number of meetings organized in the communities, attendance rates, topics discussed, etc. I received very diverse information in this regard: some leaders called meetings but participation rates were low, some had not yet held meetings, and others called meetings which attracted a considerable number of people (approximately 30 women). It was equally difficult to distinguish between meetings the women had organized and led themselves and those held by the NGO. Exact information on the frequency, attendance, and content of meetings is therefore unavailable. Nonetheless, discussions with leaders and members and personal observations reveal the nature of the Red's internal dynamics.

made and then pass the information on to members. Comments such as “they have their meetings and then they call us, and we listen to their opinions” (member, Bigote), and, “we, the most active members make decisions, then we let the members know what will be done, and then we do it” (Secretary, La Pareja) illustrate the process. The speaker of Bigote confirms that the work plan is elaborated by the leaders. “Imagine trying to get all the members together (...) The central committee invites all the base group leaders, and then they tell the bases” (Speaker, Bigote).

Although the treasurer in Salitral demonstrated a more horizontal approach in her meetings where “members make proposals and we elaborate the plan to see what can be done”, she went on to say that when members disagree, “we make them see what is right”. One is left wondering how democratic the internal decision-making process is. The fact that members demonstrated very limited awareness of the Red’s activities and mandate certainly indicates that they have generally had little say in defining the organization’s objectives and work plans. The situation within the Red is not unlike the relationship between the Red leaders and the Centro IDEAS, MINSA and the health centre. One might speculate that the leaders are replicating the environment created by the institutions. The leaders’ inability to foster an open, horizontal decision-making process also suggests that they themselves may be lacking the skills and know-how to do so.

Member ability and willingness to participate

This research indicates that the leaders have been unable to create a space for members to articulate their needs and participate in the internal life of the organization. However, the complexity of the participation process is such that even leaders who have attempted to stimulate member involvement by holding meetings and asking for input have encountered problems.

We call a meeting and only six or eight come. And, they don't participate. The leaders talk and talk and the rest simply listen. They should support us by contributing their ideas, but they want the leaders to do everything.

- Treasurer, Salitral

There are several reasons behind this limited attendance and passive participation. Part of the problem lies in the members' lack of control over their own mobility. And, where they are allowed to participate, they may be too busy with household chores and agricultural work to do so. However, contrary to the leaders' assumptions, *machismo* is not the only barrier to women's participation. Members have also commented on problems such as child-care responsibilities, inopportune scheduling, and the dislike of the fighting and arguing which goes on at meetings. Clearly, leaders must address these issues if they wish to facilitate member

participation.⁵⁸

There are two other major reasons for women's minimal attendance at and contribution to meetings. First, their involvement depends on how they define participation, and this is largely based on their past experiences with collective action. The fact that the Red is composed of members and leaders of the *Vaso de Leche* and *club de madres* is significant here. Women have come to associate 'participation' with providing occasional labour and a stick of firewood in exchange for food handouts for their children. Many members told me they would participate if only there were something in which to do so, such as a food-for-work project. They have become accustomed to traditional forms of participation where 'participants' are beneficiaries rather than active agents and ultimately rely on their president to solicit projects. The notion that they may contribute to their organization by making decisions has not crossed their mind.⁵⁹

Second, a problem which has great implications for the involvement of members and the Red's organizational empowerment is the fact that the members do not feel the leaders are meeting their needs. Consequently, they do not feel part of the organization.

⁵⁸ It must be noted here that the leaders have often commented on the women's lack of freedom to attend meetings. However, they did not mention the other problems listed above.

⁵⁹ This illustrates why women may view voting in the committee elections, signing forms, and going to the clinic as 'active' involvement. It also explains the difficulty I encountered by relying on the terms 'active' and 'non-active' to locate study participants.

There is a gap between the expectations of members and the Red's present activities. Members expect and desire projects that will address their immediate survival needs. And, the leaders in fact promised "help for the poor" or "help if a family member falls ill" during the committee election day campaign and sign up rounds which, for many was the first and last formal contact with their organization. Since the Red has not yet implemented a project which responds to the members' felt needs, members have become dissatisfied with the organization. For instance, one member mentions that her daughter attended a meeting, "but they didn't speak of any help" (interview with member, Salitral). She feels the leaders have

duped us (*nos engañan*) into thinking that help would come for the poor, but until now, we haven't seen anything. It isn't like before when we used to get help and food (...). No, we haven't seen anything yet.

- non-active member, Salitral

The following comments further illustrate the extent to which members feel marginalized from the organization's activities: "maybe the leaders gain something from their meetings, but we don't gain anything" (member, Salitral). And, "one doesn't gain anything from the Red. It is only for receiving *charlas*⁶⁰. But, there isn't benefit" (member, Bigote).

These testimonies clearly indicate that members feel their leaders do not work

⁶⁰ A *charla* is a talk on a particular topic given by the health centre or IDEAS.

for them.⁶¹ Members have not kept their discontent a secret. One leader commented that “they say you don’t get anything from the Red. But, I know that you don’t get economic or food benefit, but you get orientation”. The President of Bigote further states that “they are benefiting [with increased access to care] and it still isn’t enough, they criticize us (...) there go the lazy ones, they say (*ahi se van las osiocias*)”. In addition to highlighting member dissatisfaction, these comments illustrate the formation of a leadership elite in the Red and a clear ‘us and them’ attitude on the part of leaders as well as members.⁶²

Even members who acknowledged the Red’s role in the health campaigns and the increased availability of women’s health services responded that they had yet to see a benefit from their “participation”. It would appear that members do not view reproductive health as a priority. When asked what they wanted out of the Red, all members mentioned income generating projects, cheaper medicine, and women and child welfare schemes. With income, food security, and child welfare rating highest on their list, they clearly have difficulty relating to the organization’s activities.

Interestingly, Red leaders have voiced similar needs as the members. Although

⁶¹ This line of thinking also applies to non-members who do not see any reason to join. Other reasons for not joining included the following: “I am not sick”; “I don’t have children”; “I don’t like going to meetings”; “my husband won’t let me”; and, “what can we learn from them, they don’t have any education”.

⁶² The comment about leader laziness may also reflect a degree of jealousy on the part of the members who are not invited to workshops.

these needs arise more out of a shared socio-economic position between leaders and members than out of a participatory needs identification process, the critical point is that the felt needs of members and leaders do in fact coincide in many respects. The central committee has commented on its desire to provide funding for women and children who need medical assistance, and to implement income generating and child education projects. However, it has not undertaken the steps necessary to implement such projects. This problem stems both from leadership weaknesses and deficiencies in the NGO's methodology.

Given the relationship between empowerment, awareness and women's health, it is not surprising that women who have not received *capacitaciones* (capacity/awareness building sessions) tend not to view reproductive health services as relevant to their lives. How can members perceive reproductive health as a benefit (or a need) if they are excluded from the awareness-raising process which enables them to view it as such? How can the members value their organization when they gain neither orientation, personal empowerment nor tangible benefits? And, why should they participate if indeed they see no benefits? If Red members do not define their health as a need, one might question that reproductive health is the most effective and powerful force for empowering women in this particular context.

5.5 Conclusion

This case study has demonstrated that mobilization around health has been an entry point for the participation and empowerment of women of the Red de Mujeres. The testimonies of leaders and members have illuminated the heterogeneity of the process. For the leaders, participation has meant becoming involved in capacity-building workshops, NGO meetings, and the Ministry of Health consultation process. Members, however, have had a more peripheral involvement which has resembled traditional forms of participation: they passively await welfare-style projects to satisfy their immediate basic needs. For the majority of members, participation has meant voting for new leaders in the committee elections and receiving medical benefits such as free pap tests.

Consequently, empowerment levels within the organization are equally diverse. Women who have played a more direct role in the organization (generally the leaders) demonstrate and self-identify elements of empowerment. Notably, they exhibit a sense of personal development, the acquisition of knowledge and a sense of agency and power to make changes, which together have enabled them to take control over their lives and their health. Indeed, they are challenging and altering existing definitions of womanhood and transforming gender relations at household and community levels. However, this sense of personal empowerment is the privilege of a select few, namely the leaders of the organization and leaders of base groups (or, active members).

The more passive participation of members has not provided them with the opportunity or tools to enter into the process, and, as a result, they have remained its voiceless beneficiaries. Their status, however, is due to a combination of factors. First, they are unwilling to participate more actively in an organization which does not provide tangible benefits to meet their survival needs. Second, they are unable to participate more actively due to their responsibilities at home, their husbands' control, and their history of 'passive' involvement in past projects. And third, neither the Red leaders nor the NGO have implemented mechanisms to facilitate their participation.

The case study has also illustrated that despite the personal empowerment of leaders, organizational empowerment is weak. This manifests itself in several ways. First, with respect to the organization's ability to influence health policies and programmes, it would appear that despite the leaders' confidence to speak in public and participate in larger arenas, their bargaining power and effective access to decision-making within IDEAS and the MINSA *mesa de concertación* are limited. Second, the Red has been unable to empower its members. The leadership has formed an elite and members are marginalized from the participation and empowerment process. Moreover, the leaders have not been meeting the felt needs of the members. Consequently, solidarity and internal cohesion is lacking: members do not perceive any benefits from the organization and therefore they do not support it.

The following chapter will discuss the factors which have impeded the strengthening of the Red de Mujeres and will conclude with general prescriptions for empowerment strategies.

Chapter Six

Personal and Organizational Empowerment: Making Linkages

This chapter will explore the factors which have impeded empowerment in the case of the Red de Mujeres de Salitral y Bigote and will draw conclusions regarding empowerment strategies in general.

6.1 Leadership weaknesses

The leaders list several weaknesses which have impeded the empowerment of their organization. First, Red leaders feel incapable of moving from proposal to action because they lack the education and the administrative, managerial and organizational skills necessary to carry out their responsibilities. More specifically, they require more training for drafting letters, writing proposals and implementing and managing projects. This has been a source of frustration for the leaders, except the President of Bigote who is relatively more confident in her abilities. Others have voiced the need for more training: "We have the theory, now we need the practice. We need something to make us understand that we can do more than *just* listen at workshops. Something to help us develop professionally [...]" (my emphasis)⁶³ (Treasurer, Salitral). She, along with the leaders in the other villages, feels incapable or unsure of her abilities to organize

⁶³ I have italicized the word 'just' here to emphasize that the leader feels she does exactly that: 'just' listen at meetings. This connotes a certain degree of passivity in meetings and sheds light on the nature of the Red's participation with the Centro IDEAS and the health post.

meetings, activities and small projects. As a result, they are both unable to respond to the needs of their members and implement mechanisms for member participation.

The leaders also feel they lack the know-how to mobilize resources. The members' dissatisfaction with the organization is such that they do not contribute their monthly dues. And, the leaders have not secured funds by other means. This makes the organization unable to assist sick members in buying medicine or to address other felt needs. Although the leaders discussed fund-raising activities on numerous occasions, they did not begin to organize anything while I was in the field.⁶⁴ They often commented that they did not know where to begin. In addition to precluding the implementation of projects, the lack of financial resources also affects the organization's internal communication. Although the central committee is supposed to meet on its own once a month, it has not done so without the stimulus, assistance, and financial support of the NGO. The treasurer of Salitral feels "impotent" and asks "how can we have meetings and training sessions if we can't even pay for transportation to get together?".

The committee elections and change of leaders compound the problem. Many of

⁶⁴ One exception is the Red in La Pareja which helped organize a raffle with the doctor to purchase medicine for the health post. Approximately eight Red members and leaders were involved in the sale of raffle tickets. This was a local initiative in which IDEAS did not participate. The Red would like to have another raffle to start a low-cost 'medicine cabinet' for Red members.

the older, more experienced leaders have not only stepped down but have stopped participating all together⁶⁵. As they are no longer invited to IDEAS workshops, they feel both 'snubbed' by the organization and abandoned by the NGO health promoters. This is most dramatically felt in Serrán, where ex-leaders were founding members of the Red and supported IDEAS despite their 'terrorist' reputation. In Bigote, two of the founding members are presently part of the central committee and have not had the same reaction. Nonetheless, the fact that the Red does not draw on local resources, experience and skills certainly contributes to the weakness of the organization.

The leaders' skill level and inability to mobilize resources have made the organization highly dependent on the Centro IDEAS for transportation, funding, and stimulus. This reliance has precluded the development of an autonomous mechanism for decision-making and action. As a result, the Red has been virtually stagnant with respect to internally organized activities.⁶⁶ Only two leaders in Bigote voiced confidence in their capacity to continue: "we are no longer as we were, when we didn't meet or do anything unless IDEAS was here. We are no longer 'stuck' to them. Now we are working" (President). Indeed, they have been coordinating with the town

⁶⁵ One has also left her husband and moved to the city.

⁶⁶ One must note that the Red is also marred by internal factionalism. The fact that the sectoral representatives are members of the committee that lost the elections has contributed to the problem. Serrán has succumbed to this '*divisionismo*' to the point where the vice president and the sectoral representative refuse to speak to each other. This has led to a very pronounced rivalry between the upper and lower villages. While all villages exhibit some degree of factionalism and allegiance to one particular leader, other leaders have managed to put their differences aside and cooperate with one another in the name of the Red.

council and health centre and are the only ones who organized an event for International Women's Day (for which they received funding from the municipal hall). The other leaders and members in Salitral, Serrán and La Pareja are convinced that without IDEAS, the Red would weaken, if not dismantle all together.

6.2 Limitations of the Centro IDEAS Methodology

The leadership weaknesses mentioned above and the large gap in empowerment and participation levels are intrinsically linked to the Centro IDEAS' methodology.

6.2.1 Nurturing Self-reliance or Perpetuating Dependency Ties?

A factor which has limited the empowerment of the Red is the extent to which the NGO's methodology has nurtured self-reliance within the organization. As mentioned above, the Red's autonomy is limited. Leaders depend on the NGO for funding, meetings, and project implementation. The NGO is attempting to redress the situation by having the Red leaders communicate and coordinate with other institutions in the community and district. However, without continual leadership training or skill development, this may only shift the dependency to other institutions. While the NGO has emphasized that the Red must work in a more autonomous manner, it is not clear that it has given the women the tools to do so.

6.2.2 The NGO's Participatory Model

The Red's empowerment level is also linked to the ability of the Centro IDEAS to foster broad and active participation in the Reproductive Health Project. Despite the NGO's explicit statements regarding its intentions to facilitate the Red's involvement in the health project, participation levels are low. The NGO's assumption that leaders will transmit information and implement mechanisms for open and democratic decision-making with members is problematic. By relying on the leaders to "go to the bases" without taking measures to ensure the information actually reaches members effectively, the NGO has contributed to the marginalization of a large number of women from the participation process. As was demonstrated, the assumption that women will necessarily want to participate is also problematic.

Moreover, the leaders' limited understanding of their statutes, their inability to articulate their work plan, and their dependence on IDEAS all point to a top down approach which contradicts the objectives and goals of the NGO. Despite the NGO's rhetoric, leaders and members have very limited input in needs identification as well as in the design and management of the Reproductive Health Project. Furthermore, the NGO has not demonstrated a willingness to respond to the needs raised at workshops, even though many of these needs are related to improvements in women's health. The Director of IDEAS states that "if we listened to what they wanted, we would still be doing the garden and chicken raising project. And that didn't work". She goes on to

say that the NGO recognizes the need for income generation projects but is ill-equipped to implement one. And, with respect to requests for violence sensitization workshops, the NGO obstetrician notes that "violence is not a large part of our mandate"⁶⁷.

The Centro IDEAS's unwillingness or inability to respond to such needs speaks for their capacity to implement a holistic and participatory approach to health development. The NGO's capacity to address locally defined needs is in part related to the priorities of its funding agencies. The donors are presently funding women's reproductive health and this has dictated the direction of the Centro IDEAS's programming and decision-making regarding institutional priorities. Further research is needed to understand the relationship between the Centro and its donors: how programming decisions are made, whether local women's voices reach the donors, and whether the funding agencies are listening.

The NGO's exclusion of women's voices in needs assessments and decision-making also lies in the organization's lack of experience and sensitivity to participatory development. The Director of IDEAS commented that staff members "speak of participation, but, when it comes to implementing it we are very vertical. There are two or three of us who developed a horizontal methodology. The rest only know the discourse" (interview with Luz María Gallo, Piura, May 4, 1996).

⁶⁷ I was recently informed that the Centro began a domestic violence project in the summer of 1997.

6.2.3 A Gender Approach or a Women's Approach?

Until now, the Centro IDEAS's Reproductive Health Project has focused solely on women's health and women's participation. The NGO has learned that implementing a women-only project has had costs. For instance, by offering women workshops on issues such as women's rights, sexuality, and sexually transmitted diseases, the NGO has created a highly aware group of women. The result is an imbalance in levels of conscientization between women and men in the community. This has caused conflict within the household and has made men more resistant to the project. As a result, many women are unable to participate in Red activities.

Moreover, the focus on women has put the responsibility of family planning and proper hygiene in the hands of women and has done little to alter the division of labour within the home.⁶⁸ While there are cases where men have begun to share the responsibility, this is due more to the women's negotiations than to the NGO's activities. The NGO promoters recognize the need to incorporate men in gender strategies and to work with them on issues including reproductive health (their own, and women's). The health promoters have attempted to raise awareness amongst men by inviting them to workshops, but participation rates have been low.

⁶⁸ The health posts contribute to the problem by equally targeting women and by neglecting to call in the husband when a woman has symptoms of sexually transmitted disease.

The male team could play a significant role by reaching men through their agricultural work and by including more women in production projects. However, they have been unwilling to adopt the institution's gender approach. Their resistance continues to mar relations within the NGO and impede the operationalization of the institution's gender approach. Luz María Gallo asserts that, even as Director of IDEAS, she has been incapable of getting the men to adopt a gender approach. She comments that "it does not even enter into their ethics or frame of mind; they think other people should take care of it" (Piura, May 4 1996).

6.3 Responsiveness of the Ministry of Health

The case study indicated that the Red has limited power with regards to influencing decision-making in health. This is due in part to a weakness in the bargaining skills of leaders and their dependence on the NGO to attend and participate in consultation meetings. The Red's ability to influence health planning and programming is also largely dependent on the responsiveness and openness of the Ministry of Health to participatory models. Without this, the Red's participation will continue to revolve largely around mobilizing women for the pap and family planning campaigns, attending workshops and going to meetings. That is, leaders will continue to 'coordinate' rather than have a voice in decision-making. Dr. León of MINSA is concerned about the absence of participatory mechanisms particularly at the ministerial level. As it stands, the relationship between authorities and civil society is quite tenuous

and depends on whether Ministry officials are sensitized to citizen participation and willing to facilitate the process. Thus, although the 1995-2000 Reproductive Health and Family Planning Programme explicitly states the importance of consultation with grassroots organizations (Ministerio de Salud 1995), only time will tell whether the Ministry is merely paying lip service to the process.

6.4 Final Reflections

This thesis has provided insight into the participation and empowerment process in the context of women's health development. As the analysis is based on the case of the Red de Mujeres in Piura, Peru, it is difficult to make generalizations regarding how the process unfolds in other areas of the world. It is nonetheless useful to reflect on the lessons learned from the case study and draw a list of elements which may stimulate empowerment.

6.4.1 Making Collective Action Collective

The cyclical and mutually reinforcing nature of empowerment and participation is such that participation in decision making and collective action enhances individual empowerment which, in turn, improves one's ability to participate in organizational life (Wallerstein 1992). The nature of this process risks creating a privileged minority, or a leadership elite, as in the Red de Mujeres. As planners increasingly emphasize supporting existing organizations as a means of implementing participatory strategies,

great care must be taken to include as many people as possible in the 'new form of participation'. The case study demonstrated that the use of existing organizations does not necessarily mean members will participate effectively. On the contrary, they may have difficulty understanding their role in participatory development activities.

In order to foster the most active participation possible, NGOs should include both members and leaders in every step of the process by implementing communication mechanisms which respond to the needs and situation of the grassroots organization. Leaders must also be willing to share their knowledge and facilitate the inclusion of members in decision-making and in the planning and execution of activities. Only then will members have access to new information, knowledge, and training. In the event that meetings are held, the NGO and the leaders must ensure that they are appropriately scheduled. However, it is equally important to consider that formal meetings may not be the best solution in some cases. For instance, in Salitral and Bigote, where women are unable or unwilling to attend, other spaces for diffusion are required. The leaders of the Red have suggested the local radio as a means of making information more available.

In order to include members in decision-making and information diffusion, the leaders must understand and address the barriers to participation. In the case of the Red, these included spousal control over mobility, household responsibilities, and lack

of perceived role for themselves in the organization. The leaders of the organization and the NGO must be attuned to these barriers and attempt to address them. More research is needed to determine how best to integrate women into this process.

Lastly, in order to increase and maintain participation rates, the NGO must combine empowerment strategies with projects which address felt needs. If leaders and members do not perceive benefits, they will lose interest in the organization and eventually stop participating. The Red leaders oscillated between speaking of defending women's rights, a perhaps overly abstract notion (and a strategic interest which evolved out of NGO workshops), and wishing to have a fund for sick women and children or purchasing school supplies in bulk for poor families. It is important to maintain a balance between these in order for women to see a value in their organization. This requires efforts on the NGO's part to facilitate a participatory needs assessment process.

6.4.2 Fostering self-reliance

A second critical element required to enhance organizational empowerment is the ability of the NGO to foster self-reliance. NGOs must take responsibility for ensuring that the grassroots organization receives support to design and conduct their own activities and develop autonomous initiatives. Capacity building workshops as isolated events are not sufficient. Rather, the training received must be reinforced and

put into practice. If leaders were to participate actively in all decision-making regarding their project, including defining priorities, determining budget allocations, and developing documents, they may acquire the tools “to develop professionally”.

Moreover, NGOs could use the meetings with women’s organizations as a space for applying and developing skills such as public speaking, workshop facilitation, and information diffusion. To do so, they could have both leaders and members participate actively rather than “just listen”. For instance, women could be assigned a responsibility such as chairing a meeting, taking notes, or summarizing points made. By doing this, the NGO would create the space for women to practice those types of skills, and would also gain a better understanding of the women’s level of comprehension and ability to diffuse information. In addition, NGOs could have more formal capacity-building sessions of the “train the trainer” type where they would focus specifically on training methods leaders could use in their own meetings.

6.4.3 Hearing and Heeding Needs

As mentioned above, the extent to which the organization is empowered to make change also depends largely on the openness of other institutions to participatory development models. More research is required to understand participatory mechanisms such as the MINSA *mesa de concertación*. Insight into factors which impede or stimulate the adoption and effective implementation of participatory development

models would be useful.

6.4.4 Working on Gender: What about the men?

As mentioned above, it is important to incorporate men in participatory health strategies. This may help to foster change in men's attitudes towards women's participation and towards reproductive health issues. First, the participation of men in health projects may increase their awareness regarding the causes of reproductive health problems and may stimulate a sharing of responsibilities of reproductive health issues such as STDs, birth control, etc. Second, their participation may also lead to a greater understanding and acceptance of women's protagonist role in community decision-making. Research is needed to understand men's attitudes towards women's participation and reproductive health. It must uncover the beliefs and attitudes which inhibit men from breaking out of oppressive patterns. Inquiry into factors which inhibit male participation in non-production projects would also be useful as it may help to stimulate the participation of men in workshops.

6.4.5 The Empowerment-Health Link

Proponents of participatory health strategies suggest that empowerment approaches may be health-enhancing. However, the case study suggests that improvements in women's health require more than health awareness and personal development. Strategies must also increase women's capacity to pay for medicine by

either stimulating change in household expenditure patterns, devising health insurance schemes, increasing access to income-generating activities and fostering attitudes in women to ensure that the new income will be used for their health. It is understood that factors such as education, awareness, income, and self-esteem all act together to affect women's control over their health. What is needed now is an understanding of how best to implement strategies which address a combination of these factors. The Centro IDEAS's inability to respond to women's request for income generating activities suggests the need for concerted efforts between sectors and amongst NGOs themselves.

In chapter five the question of whether reproductive health was the most effective entry point for women's empowerment in the case of the Red de Mujeres. As mentioned, the majority of women were not identifying it as a priority and were ultimately many were not supportive of their organization. A more effective means of stimulating empowerment and fostering women's participation on a broad scale would be to ask women what their needs are before imposing a particular intervention. However, despite their ideological commitment to participatory development, NGOs may be unable to incorporate local voices into project planning. Therefore, the responsibility for genuine participation lies not only with NGOs which interact at the level of civil society but also with donor agencies who must be willing to be more flexible in their funding conditions and incorporate new voices into planning.

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IMAGE EVALUATION TEST TARGET (QA-3)

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