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Health Women's Way: Learning to Listen

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If women are indeed to benefit from actions to improve their health, we in the health care community must first benefit from women's voices. To do this we must make listening and talking with women a fundamental organizing principle of women's health programs.

This imperative arises on both developmental and pragmatic grounds. From a development perspective, programs that derive from community women's concerns and that work to strengthen women's ability to address those concerns are more likely to be programs that translate into long-term gains for women without disproportionate dependence on donor resources. Such programs can truly improve the quality of life--the goal of development.

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From a pragmatic perspective, women-centered programs are likely to be more effective, because they appropriately address local needs, as well as more cost-effective, because they draw on local resources.

Few people who have worked in or studied development closely would dispute these statements. Yet listening and talking with women is far from a standard activity in program design and implementation. We as health professionals can offer many rationalizations for this. Most of them stem from assumptions we make, implicitly or explicitly, albeit with the best of intentions:

- First, we assume that health can be divorced from the everyday lives of women and acted upon with purely technical solutions. Therefore, we consider that we as international health professionals, because of our worldwide perspective and technical expertise, can best identify the priority problems and points of intervention, almost holding constant the environment in which women live.

- Second, we assume that women who are illiterate, of low socioeconomic status, and with little or no economic or political power are reluctant or unable to analyze their problems and speak about their health and health needs--particularly regarding a sensitive subject such as reproductive health. Therefore, it follows that we should design the programs that we assume women would want.

- Third, we assume that the biomedical model of health, disease and health care is, if not universal, at least universally desirable. At best, we tend to see folk practices as interesting vestiges of

> traditional societies in which we are trying to effect change. At worst, we view such practices as products of ignorance and superstition that should be easily discarded for "rational" health beliefs. Therefore, we proceed to mount programs based on the biomedical model and discourage folk practices.

But if we are to take seriously the imperative of making listening and talking with women an organizing principle of our work, we need to: (1) dispel our assumptions and put a greater value on local knowledge; (2) understand how listening and talking to women as an organizing principle can benefit programs; (3) increase our efforts to work with women collectively; (4) become familiar with the different ways that women's voices can reach policy makers, planners and managers. Many of the papers presented at the 1991 NCIH Conference offer guidance on these points, while underscoring the urgency of embracing the imperative.

Local Knowledge

Unfortunately, too often health services for women that fit well within the biomedical agenda of global intervention priorities are inappropriate at the local level and therefore underutilized, ineffective and unsustainable. Many conference papers underscore the importance of opening our ears and learning to listen and talk with women, of being guided by what the anthropologist Geertz calls local knowledge--seeing broad principles in parochial facts (1983:167). Listening and talking with women offers the best way to find common ground between what we as health professionals think is best and what local women want and will accept.

Health First?

The first assumption--that health can be acted upon alone--is repudiated by a clear message we heard repeatedly at the conference: Health is an integral part of the political-economic and sociocultural milieu in which women live, as Letelier, Matembe and da Silva emphasized in the forum on Voices from the South. In session after session presenters offered testimony on how women's health is strongly conditioned by the political and economic environment in which they live, the society of which they are a part, and the cultural belief system that organizes and gives meaning to their life.

Mataka, for example, spoke of how young women in Zambia may place themselves at risk of HIV infection because of economic need, despite their knowledge of how AIDS is transmitted. Shamima Islam recounted the case of a Bangladeshi woman whose own mother resisted all attempts to seek hospital care for her during a difficult labor because of the loss of prestige the family would suffer with this violation of purdah. Krieger and ElFeraly similarly reported that in Egypt the sex of the doctor affects access to health care because of strong social norms that govern correct behavior between males and females. Patel showed how social and cultural notions of white vaginal discharge affect health-seeking behavior in India. And Bang and Bang reported how in India reproductive tract infections are not just microbiology, but are surrounded by a complex cultural universe. Consequently, health programs that are to be effective must take these non-technical, environmental factors into account.

Because local women understand the many factors that affect their quality of life, when given a choice they might not even choose

a health program as a high priority. In Haiti, for example, Maternowski found that village women considered hunger, landlessness, lack of water and fear of political persecution as more important than their lack of access to family planning. And Beaton and Robinson found that women in Nepal put a higher priority on literacy, day care and income-generation than on health as we might narrowly define it. But these "non-health" programs can have health effects. In Bangladesh, women who joined together to form a savings group were more likely, after a period of participation, to accept contraception than women who did not join, according to Amin Islam. And, also in Bangladesh, Gomes reported that as women's incomes increased, so did their demands for health services.

A corollary to this assumption of the separability of health from the environment is the assumption of the separability of actions within health, that is, that certain single actions have catalytic effects in the sense that they can precipitate development almost singlehandedly. Often referred to as the "silver bullet" proponents, those who hold this assumption usually advocate one particular intervention as the spearhead to development. The underlying logic is that resources are not adequate to address all problems so a lead intervention must be identified. Unfortunately, the intervention is typically chosen by health planners, based on what is in vogue or has been successful in other contexts. The type of intervention thus recommended changes over time as development programmers try one "bullet" after another. This results in donor programs that seldom have lasting impact.

Many of the conference papers gave evidence that local women reject silver bullet

approaches to development, favoring synergism over catalysis. In synergism, different types of interventions can work together to produce an effect--development--that none can do alone. As Bang and Bang put it, "women's lives know no such compartments" (1991:11). Thus, in Haiti, Maternowski reported that, in accordance with the wishes of local women, a comprehensive project that considers women's health within a larger developmental standpoint took the place of the original donor-intended family planning program. And, as AmaraSingham pointed out, women should not have to choose between maternal and child health or women in development programs, but should be able to participate in the synergistic approach that was envisioned under Health for All strategies almost 15 years ago.

Another reason to work within a development model that considers the broader socioeconomic context is that as change occurs, it might not always be in the direction that donors expect. Though some observers characterize health development as a type of convergence model, in which non-Western societies adopt more and more of biomedicine as its efficacy for particular ailments becomes evident (e.g., Foster 1978: 252), the opposite can also occur: Krieger and ElFeraly report that the revival of fundamentalist Islamic movements has limited the acceptability of biomedically-based perinatal care among Egyptian women who previously accepted it, because of the predominance of male doctors in service delivery. In such cases, there is little point in assuming a gradual attrition of the environmental factors that affect health.

Who's Listening?

The second assumption--that of women's reluctance or inability to speak--is contradicted by the abundant data in the conference papers that showed that poor, illiterate women do speak eagerly and eloquently about their bodies and health needs--if they are given the chance and their views are respected. The problem may not be so much their inability to speak as our inability to listen. Baker had little difficulty finding Nairobi women willing to discuss abortion experiences. Franco stated that women in Niger had a lot to say about the quality of health services. The women said they had not spoken out earlier because they had not been asked their opinion. Maternowski found that poor women in urban Haiti were very forthcoming about wanting education on the relative merits of the gamut of contraceptive methods, not just a "how-to" booklet on oral contraceptives.

Moreover, we may not be asking women about the problems they wish to discuss. Bang and Bang, Patel and Kanani *et al.* all found many Indian women who would speak at some length about their priority problem of white discharge, a problem that an expatriate expert had dismissed as an "innocuous symptom" (Bang and Bang 1991:4). And Sanchez *et al.* in Bolivia found that usually reserved women spoke freely when involved in a process that allowed them to select and prioritize their problems.

It is also important that women understand why they are being sought out and that they see a possible benefit in making disclosures. Yacoob and Brieger told of prostitutes in the Gambia who fictionalized their life stories until the reasons were explained for all the question being put to them. And Gomes related how in her first attempt to work with

destitute rural women in Bangladesh she was rejected, because they couldn't understand why she was interested in them. But when in a second attempt she entered their world directly, through participant observation, they opened their "hearts and lives" to her (1991:2).

Finally, the type of person who is asking the questions can greatly influence how candidly women speak. Women may say things to other women that they will not say to men, as Krieger and ElFeraly point out. Or they may communicate more freely with someone who is not in their social control network. Mataka spoke of Zambian teenagers who, close-mouthed in health education class, opened up when the teacher left the room and they were able to speak freely with an HIV-positive person from distant Nairobi. And Whitney *et al.* found peer counseling an effective strategy for reaching young women in the Philippines.

Moreover, those doing the listening must be sensitive to how notions are expressed. We need not always accept initial statements on face value but should continue to talk and listen to learn what else is intended. This was brought home in two independent pieces of research done in India by Bang and Bang and by Patel. Both studies reported that women with white discharge may speak of their problem obliquely, in symbolic terms, because of the social stigma attached to the health problem. They may speak of a generalized weakness or backache rather than of the discharge itself. Medical practitioners may take this weakness to mean anemia, when women are really saying something else. In other words, many times it takes a sensitive <u>listener</u> to hear what women are saying.

In summary, reports of women not wishing to speak to health researchers must be measured against the conditions under which the research was done. The success of listening and talking with women is largely conditioned by our willingness to open our ears and our ability to learn how to listen.

Meanings and Contexts

The third assumption--that of the universality of the biomedical model--is vitiated by the many research findings in which women's notions of how bodies work, diseases originate and cures are sought contrast with the dominant paradigm of biomedicine.

Biomedicine, which underlies Western health and health care, divides the human being into the somatic body and the intangible mind. It then deals primarily with diseases that are discernible via empirical symptoms. It seeks organic, proximate causes of disease and treats these proximate causes. This model favors disaggregation, specialization and categorization and so feeds into the previous two assumptions: Just as it divides people into bodies and minds and divides bodies into systems, organs and smaller components, biomedicine has a similar tendency to divide health from the setting that produces it. And just as it emphasizes areas of specialization laden with experts, biomedicine tends to have little confidence in lay or generalized knowledge -- knowledge that is not the domain of an expert.

In many other cultures, however, the biomedical model coexists or is dwarfed by an ethnomedical model of health, disease and health care. This point is critical, because we very often presume that local people, when they do not have the health education knowledge we would like them to have, are

ignorant in the sense of knowing nothing about a topic. Clearly there are times when people are uninformed or misinformed. But more than likely they know very much about the particular topic, albeit in very different terms--their own ethnomedical terms. In the same way that biomedicine is a product of Western culture and is consonant with our faith in positivist science, disaggregation and specialization, other ethnomedical models reflect other cultural values. As Yacoob and Brieger explained in their work on guinea worm in Nigeria, discovering ethnomedical perceptions furnishes the meaning and context necessary to understand the disease in the culture at hand.

Examples abound in the conference papers. In Patel's work in India, the explanations women gave for the causes of their illnesses incorporated elements of a personalistic ethnomedicine, in which a being outside the sufferer can be responsible for the illness. In such a system, unity prevails: not only are mind and body not divided, but the person herself is not completely separable from other persons. In the Bang and Bang and Kanani *et al.* studies, disease causes cited by women reflected belief in a naturalistic, equilibrium model that seeks a balance between hot and cold humors. In the equilibrium model there is again an importance on wholeness, unity and balance, in contrast to biomedicine's propensity to separate. Similarly, in Africa, Yacoob and Brieger found that women suffering from guinea worm see the worm as part of the body--not as a separable outside organism that invades the body, as our biomedical model describes it. And one reason Anderson gave for Indian women's reluctance to eat more during pregnancy is that they consider their stomach and uterus to be one.

Increasing food intake deprives the baby of space.

One implication of the existence of health and medical models other than the biomedical one is that people who are not served by "modern" health programs nevertheless have a health system to which they have recourse. This may include home remedies and care that are part of generalized cultural knowledge diffuse in the community, as well as specialized knowledge and care by such traditional health personnel as healers, diviners and birth attendants. Zigirumugabe found, for example, that in Rwanda births may be attended by any experienced woman or man and that birth attendants, in the sense of someone with specialized knowledge from whom everyone seeks help, don't exist. Birthing babies is generalized knowledge. In speaking with women, Bang and Bang learned of nearly 40 types of indigenous treatments for white discharge--certainly not a limited pharmacopoeia.

Reconciling Agendas

If indeed women know best what they need and have an alternative health system in place, what should be the role of donor-assisted programs in women's health? Clearly biomedicine, with its effective drugs, surgical techniques and hygienic practices, has much to offer, particularly in the realm of life-saving treatment. But women seem to be saying through the conference papers that health programs should not be exported in an unqualified way; they need to be tempered with an interest in and respect for local knowledge of needs, appropriate types of programs and resources, and should be designed, delivered and managed in an acceptable manner. In short, we need to reconcile the agenda of

international health experts with that of the local women international health programs propose to serve.

One case in point is maternal mortality. The high rates of maternal death in many developing countries are unacceptable, and many women around the world live in fear that pregnancy or childbirth may result in that fate for them, as Zigirumugabe cited in her work in Rwanda. There is no undermining the seriousness of that problem. The Safe Motherhood Initiative was launched in 1987 to apply creative thinking and large-scale resources to reduce maternity-related death and certainly deserves a high priority in all countries.

At the same time, it appears equally clear that many Third World women do not consider maternal mortality their only problem, or perhaps even their most important problem. While maternal mortality presents a risk for all women who become pregnant, it is still a relatively infrequent occurrence and one over which some women may think they have little control. Therefore, they may put a higher priority on less dramatic but more chronic and frequent ailments that undermine the quality of their daily lives--illnesses in which both incidence and duration are high, translating into high prevalence.

This appears to be the case in both Patel's and Bang and Bang's research on gynecological morbidity in India, where women chose white discharge as their most serious health problem; the reason they gave for that priority was its painful and chronic nature. Few international health experts would have anticipated this response, perhaps because in Western culture we have such easy access to effective cures that we tend to dismiss these ailments *a priori*. And, Sanchez *et al.*

pointed out that when women in the Altiplano of Bolivia prioritized maternal health problems and needs, they put family planning services first, then problems that relate more directly to maternal death.

Reconciling the two health agendas primarily means making services more appropriate. This requires considering the local ethnomedical system in service design. Zigirumugabe reported that women in Rwanda prefer to give birth at home because of the warm, supportive environment home birth affords. Incorporating this element of the ethnomedical ambiance might make institutional deliveries more appealing in situations like this, which abound in the Third World. Another alternative is to take selected aspects of biomedical delivery to the home or to maternity homes, which is what was proposed after Wedderburn's research in Jamaica indicated that women looked first for social support and secondarily for medical support when describing the ideal delivery situation.

Services and messages must also be socially appropriate. Mataka reported the conflicting messages Zambian adolescents receive when their social upbringing prepares them to be submissive to their husbands in marriage, while AIDS health education programs ask them to be assertive in practicing safe sex. Should they listen to their grandmothers or their teachers? With careful thought, some middle ground can certainly be struck here.

Timing of certain services must also be appropriate. Though childbirth is one of the major times that women come into contact with the biomedical health system, women in the three countries of Verme's research felt strongly that labor was an inappropriate time to discuss family planning.

An Organizing Principle

For listening and talking to women to be an organizing principle in women's health, we must always have our ears and minds open and learn from and build on what we hear. Communication and collaboration with local women is essential--not only in the early stages of project design, but throughout project implementation and evaluation. Only though a continuing dialogue with local women do short-term health projects have the possibility of translating into sustainable, long-term development advances. The conference papers demonstrate the many uses and benefits that listening and talking to women can bring.

Listening and talking to women heightens women's awareness of their health needs and resources for addressing those needs. In Bolivia, Sanchez *et al.* showed how the process of self-diagnosis of health needs made women more conscious of their health. With the aid of local women in Mexico, Salamon developed an education guide on domestic violence that helped women analyze the problem and its possible solutions.

Listening and talking can allow women to realize that some problems of high prevalence need not be accepted as normal or as women's fate, but are amenable to treatment. Kanani *et al.* cited an Indian woman: "What to tell you, after marriage and childbearing it is natural for women to have weakness. All women around here have these problems in some degree or other" (1991:10). And Bang and Bang also cited: "Like every tree has flowers, every woman has white discharge, only thing is, it's not soothing like flowers" (1991:2).

Communication with women is essential to identifying and prioritizing health needs as women perceive them, as discussed above. Maternowski, Beaton and Robinson, and others stated women's preference for programs that take a broader view of health than do most experts. Yacoob and Brieger did some interesting impact case studies, in which the toll of guinea worm disease was not measured in such macro indicators as days lost to agricultural production or school days missed, but in micro, women-centered indicators, such as inability to perform household chores and to care for themselves, as well as negative effects on nutrition and prenatal care. This type of analysis can point to some different intervention points for the disease.

Local women can be effective in advocating policy that favors their health development. Bang and Bang asserted that by rejecting contraception, poor women of the Third World are sending signals to policy makers in the capitals of international donor assistance that no contraception is acceptable without gynecological care. In Nigeria, Okafor reported using seminars as a forum for policy input by community-based women's groups to city-based groups who controlled outside resources. And in both Uganda and Tanzania, according to Kasolo and Kamba, women's organizations are advocating appropriate policies for national Safe Motherhood Initiatives to government.

Services are likely to be more appropriate if community women help plan interventions. Based on discussions with community women, Krieger and ElFeraly gave the example of deploying mobile units of female doctors and nurses to address the problem of underutilization of care in Egypt.

Collaboration in planning by women in Nepal

and Haiti, among other sites, resulted in more broad-based health programs. Wedderburn showed how women's opinions can be used to design birthing facilities that are an alternative to hospitals.

Where women themselves implement programs, those programs are more likely to benefit women's long-term development and to be sustainable in the absence of large donor inputs. The women's agents in Haiti were poor women native to the communities in which they worked; their training and development feeds into the development of the whole community. And the model in Uganda and Tanzania of implementing Safe Motherhood programs through women's organizations allows those groups to be strengthened at the same time that the limited resources of government are not overly taxed.

By collaborating in measuring improvements in health, community women see tangible benefits to health actions, further strengthening their belief in the value of health programs. Gomes described how women in Bangladesh collected data during the day and analyzed them at night to decide in which directions they should next move. And Maynard-Tucker provided an example of training local women in the mystery client method to get a true picture of what is happening in health services.

Strengthening Women Collectively

The experiences documented in the conference papers support the notion that the most effective way to help improve the health of individual women in an ongoing way is to work with women collectively. This process means:

- Strengthening women's networks. Most women have networks of kin and friends, diffuse

contacts they maintain to seek and give advice or aid. These networks can be further strengthened to coalesce into formal groups able to act more concertedly for women's development. Beaton and Robinson spoke of "creation of organization" with women in Nepal, in which the formation of interest groups led to viable community organization that now brings pressure "from below" to bring about change. And Amin Islam described the main thrust of Save the Children women's programs in Bangladesh as organizing women in groups.

• Heightening awareness of shared feelings and reducing isolation and shame. Gomes described how a group of women of which she was a member traveled to villages in Bangladesh to listen to other women's tales of poverty and exploitation. During these gatherings, the visiting women told their own stories of suffering and explained how their lives had changed since banding together. Whitney *et al.* provided the example of peer counselling in the Philippines, in which teenagers felt less shame in approaching other teens for advice. Participants in the Bolivian's women's groups described by Sanchez *et al.* spoke openly about very intimate things so they could grow to know each other and realize that their problems were shared by others. The confidence of these women increased to the point that they were able to talk to women they didn't know about maternal health problems.

• Helping channel demands collectively. In many instances, aspects of community social organization may thwart women's attempts to effect changes in their lives. For example, Amin Islam reported opposition among Bangladeshi villagers who feared loss of family status if their kinswomen participated in activities outside the home. But if women

organize into strong groups, they can bring greater pressure to bear by voicing their demands collectively. Beaton and Robinson presented examples of pressure "from below": videos made by illiterate women to document their areas of concern; visits by group representatives to government officials to press demands and to other villages to strengthen solidarity; and greater female participation in village meetings.

• Encouraging non-hierarchical relations. In programs where local women's skills are increased through participant-based activities, such as the Haitian project's women agents and the groups in Bolivia, women's strengthened expertise often confers greater status and acceptance and hence self-confidence and self-esteem. As women gain strength through their collectivity, they bring new confidence to their relations with other women and with other groups. Noorani describes how, through work in a women's group, "active" women were able to help more "passive" women and give them confidence and motivation to, for example, go to the health center. Okafor told of a program in Nigeria that sought to promote a good working relationship between traditional birth attendants and trained community midwives. Lack of confidence between the two groups of women health workers stemmed from disparagement of the traditional attendants' role. By analyzing their needs and problems together, women can understand more completely their social relations with men, the medical community and other segments of society. Indeed, Danforth and Karefa-Smart, and Brabec caution that men need to be a target audience of women's health programs in instances where they are decision-makers regarding health (the case in Brabec's work in Papua New Guinea) or participate in women's health care (the case in birthing in Bolivia, per Sanchez *et al.*,

and Rwanda, per Zigirumugabe).

• Strengthening women's resource base. Working with women's groups facilitates pooling of resources at the same time that it adds to the collective resource base for the benefit of all. These additions may be in the form of knowledge, new linkages, materials, technical expertise or financial support. In Gomes' work in Bangladesh, different women in the group trained in different areas, increasing the resources of all. One area included legal aid because of the many problems women had with domestic violence and marriage status. Many other papers cited how loan funds have increased women's financial resources and provided seed money for income-generation; as Amin Islam pointed out, this in turn has had its effects on child survival, nutrition and acceptance of family planning.

• Making sustainable change more likely because it is effected at the group, rather than individual, level. When women work for their health development in groups, the success of their efforts is not dependent on any one person. Further, because of the additional resources number confer, the content of the development can be wider. Gomes spoke of how women's groups in Bangladesh have evolved from an initial focus on savings for income-generation to encompass education, legal aid, health education, growth monitoring, collective kitchens, community sanitation, community health assessments and other areas. Similar broadening was reported by Maternowski, Beaton and Robinson, and Amin Islam.

Methods for Listening and Talking with Women

To hear women truly, we must come to them without fixed agendas and as free of cultural bias as possible. This means the methods we use and the information we obtain must principally be qualitative in nature. When research is of a quantitative nature, the questions and the categories for possible responses are a given. This research is appropriate once we have allowed women to define some of the question and response categories. However, at this stage in the development of women's health programs, so little is known and so much of the subject matter sensitive that survey instruments will not allow us to hear what women really want to say.

Whether the information was gathered in an informal way through women's groups or under a structured qualitative research protocol, the data presented in conference papers all showed the importance of taking time early in a project planning phase to allow women to talk, prioritize needs and work on solutions. While the methodologies are not always fully described in the papers, they cover the range of available qualitative methods. In addition, some useful techniques for assisting women in their analysis and prioritization of problems have been used as part of these methods.

The methods represented in the conference papers range from time-intensive observation, to structured in-depth interviews, to focussed group discussions conducted by skilled professionals and, in other cases, by trained local workers, to group interviews and less formal group discussions. The choice of methods depended on the purpose of information gathering and type of information required, and on whether the research was done as part of an ongoing development program with established women's groups.

Gomes and Salamon both used participant observation techniques to bring them closer to the reality of the women with whom they were working. Salamon lived with the family of one of the female bankers in the project. For Gomes, participant observation meant actually taking up the life of the women she hoped to help. These time-intensive experiences yielded tremendous insights and, in the case of Gomes, a life's work. Patel described the use of direct observation in her research. This is less time-intensive but yields some of the richness of participant observation because the researcher pauses during interviewing or discussion and actually watches--an important corollary activity to listening.

Open-ended in-depth interviewing was a commonly used method of gathering information on women's perceptions of problems and needs, and perceptions of solutions. The Indian researchers (Bang and Bang, Patel and Kanani) used this method with community women, key informants such as traditional birth attendants and community leaders, and health professionals. Through these interviews, the researchers were able to understand the range of health problems women experience, the priority they give these problems and the treatments they pursue. Kattab described the usefulness of in-depth interviews in highlighting the differences in women's and health workers' perceptions of problems. She went on to use the interview results to develop a screening tool for gynecological infections. Baker described her in-depth interviews on abortion with volunteers in Nairobi, and Yacoob and Brieger's interviews illustrated the importance of understanding the etiology of disease from the perspective of the sufferers in order to understand their behavior and pinpoint intervention.

Two other specific types of interviewing were mentioned in the papers. The first, verbal autopsy, was used in Inquisivi, Bolivia, by Sanchez *et al*. Here the family of any woman who died during pregnancy, delivery or immediately postpartum was interviewed to ascertain what happened, what the family/woman did and why they believe she died. The other type of interviewing is mystery client interviewing. This method was used by Maynard-Tucker in Haiti to evaluate health services. Here, local women were trained to be observer-clients at selected health services. After visiting, they evaluated the service based on their level of satisfaction, the competence and attitudes of the health care providers, and the physical environment.

Finally, other common methods involved group interviews or discussions. These were of three types: The first, focussed group discussions (in which specially-recruited groups of people are asked their views on specific talking points) were used for a variety of purposes: Kanani and Yacoob and Brieger used them for initial exploration of topics to be probed further via in-depth interviews. Krieger and ElFeraly, Zigirumugabe, Franco and Wedderburn all used focussed group discussions as their main research method. The work of Krieger and Elferaly in Egypt explored gender issues in health service utilization. Zigirumugabe in Rwanda used focussed group discussions to learn more about women's felt needs relative to starting a family planning program. In Niger, focussed group discussions helped to learn more about women's attitudes toward utilization of health services. Wedderburn used focussed group discussions in Jamaica to inform policy makers on the design of appropriate out-of-hospital birthing

facilities.

The second type of research in a group setting was group interviews, conducted by Noorani and Bang and Bang. These differ from focussed group discussions in that the questioning is more directed, the group is not specially recruited ahead of time, and the group may be much larger than the 6-10 participants recommended for a focussed group discussion. Bang and Bang used the group utterances to prioritize health problems suggested by women. In Noorani's work in Bangladesh, they were used to learn about coping strategies of "active" and "passive" women.

The third type of group work was an informal, semi-structured discussion held among women in organized community groups. The Save the Children projects in both Bolivia (Sanchez *et al.*) and Bangladesh (Amin Islam) used this method, as did Beaton and Robinson in Nepal. These group discussions were called a self-diagnosis by the Bolivia team because women explored their own, collective attitudes toward pregnancy and maternal health problems, they discovered what they know and do about the problems, and they prioritized the problems for the group. These discussions are distinct from focussed group discussions because, again, the participants are not recruited, the group is often larger than that recommended for the focussed group discussions and there is a pre-existing and continuing relationship with the group, *i.e.*, the discussion functions to assist the group's development.

As part of the above-described methods, a number of techniques were used to help order or structure the information gathering:

- Picture analysis: Sanchez *et al.* and Wedderburn used this projective technique

in which women are asked to describe what they see in a picture or what they believe happens to the woman in the picture. This allows women to project their feelings and thoughts to someone else, often making it easier to discuss sensitive subject matter. Both researchers caution that the pictures should be pretested carefully.

- Free listing: This was done by the Indian researchers Kanani, Patel, Bang and Bang, and by Sanchez *et al*. Here women are asked to list, for example, all health problems they experience, all the symptoms associated with a disease, or all its cures. This process allows the parameters of the discussion to be defined by the participants.

- Pile sorting: Again, this was used by the Indian researchers Patel and Kanani. Once women have discussed major health problems, each problem is depicted on a card. The women in the group then sort the problems by prevalence and severity. This allows them to prioritize problems.

- Illness narrative: Here women and others are asked to describe fully what they did during a specific illness or event; this technique was used by Yacoob and Brieger and by Kanani to better understand particular behaviors and decision making.

- Hypothetical scenarios: Kanani used made-up situations ("What would you do if...") in her interviews with health professionals to determine their level of competence and empathy with their patients.

While other techniques may have been used but not described by the researchers, it is clear that the repertoire is limited. It is in the development of techniques to help women

discuss their feelings (often referred to as projective techniques), rank or prioritize problems and solve problems that more creative work is especially needed. Ways to explore women's self-confidence and esteem have barely been touched upon, but are mentioned constantly by researchers and programmers as an important factor in improving the health of women.

As well as showing the variety of ways to explore attitudes, perceptions and practices with women, what is abundantly clear from the papers and from the discussions that took place with several authors is that the methods and techniques require additional creative work to allow more depth and scope to be achieved. It will only be when the lifestyle context for women's health programs is truly appreciated that real advances for women will be made. This means women's hopes, fears, inner-most ideas, perceptions of esteem and self-confidence need to be articulated and translated by women into workable solutions and brought out for policy makers, program planners, implementors, and other community members to hear and believe. For this, more time, patience and creativity is required.

Recommendations for Policy, Programs and Research

The conference data on listening and talking with women argue convincingly for a bottom-up approach to development that takes full account of the milieu in which women live. Yet, in contrast, much of the effort in development programming at the international donor level has been devoted to the identification of successful model programs which are then blueprinted and replicated around the globe, often in a top-down manner that tends to hold the local environment

constant.

At the international donor level the top-down approach has a certain logic because it represents theoretical cost-effectiveness: Once a successful program is hammered out, subsequent programs do not have to begin the process all over again. The "goods" can be delivered, whether they be food supplements, prenatal contacts or tetanus toxoid immunizations. But this thinking in turn assumes that the important part of the development process is the product, the "goods" we deliver. What many of the papers here suggest is that the process of encouraging women to articulate and act on their own needs may be more helpful to development than meeting quantifiable targets of goods delivered. Further, the blueprint approach assumes that successful programs can be extracted from the environment in which they were successful, when indeed it may have been precisely their close fit with environmental factors that made them successful.

The realities of international assistance, however, temper the feasibility of purely bottom-up programming. Nor is it desirable to ignore the many "lessons learned" that so abound in the development literature -- especially when probably the major lesson learned is that development programs cannot be cut out like cookies. Clearly there has to be a balance between the sui generis grassroots approach and the culture of donor organizations. That culture calls on the front end for policy formulation based on current scientific knowledge, epidemiological priorities and field implementation experiences, while requiring accountability on the back end for resources expended, via measurable entities such as improvements in nutrition status, maternal lives saved and

births averted. Pure process will never be a satisfactory indicator. To content ourselves with process indicators would be political suicide for donor-financed health programs that must compete with other types of programs for limited development dollars.

But what we can strive to do is to tailor standard packages to the local setting exactly by making listening and talking with women an organizing principle for actions in women's health--by valuing local knowledge. This means that before project implementation begins, formative research should be conducted. This research should guide the tailoring of standard packages to highlight project components most suited to local needs, desires and resources. It also means that during project implementation, local women should collaborate in an ongoing way, with latitude for mid-course alterations in project design. Local women should be in both management and service delivery positions and should be strengthened in their ability to carry out the programs, both through personal development and through expansion of the resource base available to them.

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