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Mother Support Groups

A Review of Experience in Developing Countries

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BASICS

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Abstract

This report, which reviews the experience with mother support groups, is organized around eight different themes micro-enterprise, breastfeeding, mother' clubs, literacy day care, water and sanitation, forestry cooperative, and social and political groups The report examines the feasibility and effectiveness of using mother support groups to improve the health care seeking behavior of mothers in developing countries, with the intent of using this information to incorporate mother support groups into child survival programs The author reports in-depth interviews with numerous practitioners involved in mother support groups and extensively reviews published and unpublished documents on the subject



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Acronyms

AHLACMA	Asociacion Hondureña de Lactancia Materna
BASICS	Basic Support for Institutionalizing Child Survival
BIG	Breastfeeding Information Group
BRAC	Bangladesh Rural Advancement Committee
CDA	Center for Self-Development
EPB	Expanded Promotion of Breastfeeding
LAM	lactational amenorrhea method
LLLG	La Leche League Guatemala
LLLH	La Leche League Honduras
LLLI	La Leche League International
NGO	nongovernmental organization
OEF	Overseas Education Fund
ORT	oral rehydration therapy
PKK	Family Welfare Movement
PRITECH	Primary Technologies for Health Care
PROWESS	Promotion of the Role of Women in Water and Environmental Sanitation Services
TIBS	The Informative Breastfeeding Service of Trinidad and Tobago
USAID	U S Agency for Information Development
WASH	Water and Sanitation for Health Project
WHO	World Health Organization

Preface

The genesis of this paper was a meeting on health care seeking behavior in November 1997, at the London School of Hygiene and Tropical Medicine that was organized by Jose Martines and Gretal Pelto of the World Health Organization (WHO) and Carl Kendall and Betty Kirkwood of the London School. The purpose of the meeting was to develop plans for prospective studies of improved health care seeking in sites in Ghana, Mexico, and Sri Lanka, under the aegis of WHO and based on the findings of an excellent review paper by Kendall. The country study teams, led by Paul Arthur in Ghana, Homero Martinez in Mexico, and Amarasiri de Silva and Anada Wijekoon in Sri Lanka, wanted to explore various approaches for the improvement of health care seeking, including mother support groups.

Many practical questions were raised about the feasibility and cost-effectiveness of mother support groups as a way to improve health care seeking. Do mother support groups exist that successfully address health care seeking? Can existing groups that focus on other topics successfully add health care seeking to their program? What does it take to start a new mother support group in a community, one that is focused on health care seeking? How long before the group makes an impact? It soon became evident that a systematic review was needed to address these questions.

Cynthia Green undertook this review with funding from BASICS. It proved more difficult than anyone imagined. Mother support groups are organized around many different topics, Green uncovered eight separate clusters of information, with each cluster focused around a different topic. The published and unpublished literature on the subject is sparse and elusive. Much of the relevant information in this review came from interviews, and most of the information is descriptive. As a result, definitive answers are few.

Nevertheless, this paper is rich in information and potential hypotheses. As far as we know, it is the first time that the experiences of a wide variety of mother support groups have been systematically reviewed in one place. I believe this paper constitutes a very useful starting point for efforts that involve mother support groups.

*Barton R. Burkhalter
August 7, 1998*

Executive Summary

This report, *Mother Support Groups: A Review of Experience in Developing Countries*, examines the feasibility and effectiveness of using mother support groups to improve the health care seeking behavior of low-income mothers in developing countries. By reviewing information on a variety of support groups for mothers, and women in general, it was possible to assess the broad range of possible models.

Research and interviews uncovered eight major types of women's support groups with current or potential links to child survival programs:

- *Microenterprise programs* In peer group lending programs, women organize small groups to access credit for supporting small businesses. Some programs combine this approach with education or community activities.
- *Breastfeeding support groups* These groups provide mother-to-mother assistance in initiating and sustaining breastfeeding. Most groups focus on breastfeeding, but some groups have introduced additional child survival topics.
- *Mothers' clubs* In many countries, mothers' clubs are organized for various purposes, including religious study, food distribution, community development, and social activities. Many of the clubs are involved in health and nutrition activities.
- *Literacy classes* Women who attend literacy classes often bond as a group and continue to meet after the classes are finished. Some groups read and discuss materials on health and nutrition.
- *Day care* Programs that provide community day care for children of working mothers in urban slums serve as a source of guidance in care seeking, and they are a catalyst for mothers' interaction.
- *Water and sanitation committees* Many communities establish committees to improve water supplies and sanitary conditions. The committees are often led by women. Some projects have incorporated health education into project activities.
- *Forestry cooperatives* To work collectively and to qualify for government assistance, women who earn their living from forestry have formed cooperatives and self-help groups.
- *Social and political groups* Formal and informal gatherings of women provide opportunities to promote health care seeking behaviors. The *feminist cafes* in Brazil are one example.

Program planners must decide whether to incorporate child survival and health care seeking into the agenda of existing groups in the community or to organize new support groups around these issues. Both approaches have advantages and disadvantages, depending on the local conditions. Existing groups may be receptive to new information and may be energized by taking on new activities, or they may resist any changes. Newly formed groups may be interested in the organizing theme, but it may take time for members to become comfortable with each other.

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In establishing a women's support group, planners must determine the group's purpose, membership, size, meeting place, meeting frequency and duration, ambiance, and the role of group leaders. Programs that rely on volunteers to organize and lead groups need to budget for overall management, field supervision, and training. The high turnover of volunteers increases training costs and can create program instability. Some programs find ways to help low-income volunteers meet their need for income.

Before working in a community, there should be extensive consultations with community leaders and potential members. Programs must involve potential beneficiaries in program planning, and the program must respond to the community's perceived needs.

Group leaders and facilitators must be trained in both group facilitation skills and content areas relevant to the group's goals. One important goal is to encourage volunteers to remain in the program. Women's support groups respond best to participatory, nondidactic approaches that encourage group members to share experiential knowledge.

Women's support groups benefit individuals, families, and communities. More research is needed to determine the effectiveness and cost-effectiveness of women's support groups for promoting health care seeking behaviors. Key issues include—

- Coverage of mothers of young children
- The time required to achieve results
- Costs
- Reliance on volunteers
- Flexibility of program content

When program planners have more information and documentation of women's support groups, they will be able to develop appropriate strategies and programs.

Introduction

Mother support groups may be a workable, efficient way of improving the health care seeking behavior of low-income mothers in developing countries. This paper explains the types of groups that already exist and the advantages and disadvantages of using various groups to educate and encourage mothers to provide preventive and sick care for their children. The information will be used to develop strategies and programs that appropriately incorporate mother support groups in child survival programs.

A recent review of the published literature on mothers' care-seeking behavior (Kendall 1997) identified mother support groups as one of four important face-to-face channels that can be used to improve care seeking. Recognizing that the published literature on mother support groups is sparse, BASICS mounted a systematic effort to collect published and unpublished documents, to interview people with direct experience in organizing and managing support groups, and to work with existing community groups. Few support groups have been systematically evaluated for their effectiveness in influencing behavior change. In general, the structure, format, and activities of support groups in developing countries are poorly documented. Typical reports do not provide adequate detail to judge the extent of group interaction versus passive listening to presentations. Factors, such as frequency and length of meetings, attendance, and topics covered, are often not reported, thus making it difficult to judge how well the meetings fostered conditions likely to lead to behavior change.

This review takes a broad look at both mothers' and women's support groups that are organized around different themes, such as breastfeeding, pregnancy and birthing, literacy, and women's microenterprise. This review did not adhere to a rigid definition of support groups but, instead, sought to reflect the diversity of women's groups and to highlight their accomplishments and potential. It is difficult to draw the boundary between support groups and other types of women's organizations. Often women who come together to achieve a specific goal will continue to meet after reaching their goal. A wide range of formal and informal mechanisms bring women together, sometimes for short periods and sometimes for years. Thus, a small self-generated support group may grow into a multifaceted, large organization offering a variety of services over a large geographic area. The emphasis here is how to link women's support groups to child survival programs.

Rationale for Support Groups

Defining a Support Group

A support group is loosely defined as a group of people who meet to provide mutual assistance. Such groups vary greatly in their organizational structure, content, and membership composition. The term *support group* is used interchangeably with *self-help group* and *mutual aid group*. Researchers in the United States set three criteria for self-help groups: (1) members must share a common situation or problem, (2) assistance is provided mainly through members helping members, and (3) no fees are charged (Meissen and Warren 1994). In developing countries, to maintain the group, support groups may charge dues or small fees. Groups differ in characteristic ways, including group leadership, the involvement of professionals, and methods of adding members. Some groups may be self-generated, while others may be organized by individuals or organizations.

In assessing a support group's effect and viability, the quality of the interaction between group members may be more important than arbitrary indicators, such as regular meetings or good attendance. At a minimum, a support group should allow members to share ideas and feelings. A lecture delivered to a group of passive listeners does not meet the criteria for a support group. However, a small group meeting after the lecture could qualify, assuming that members interact and derive some psychological benefit from their interaction.

Many groups are so informal that the participants would be unlikely to label them as a support group. Informality does not hamper support groups' effectiveness in helping members cope with problems or situations in their lives. In fact, the informality helps create trust and bonding between members.

Support groups for mothers typically cover child-related issues, while general groups for women may deal with economic advancement, literacy, sanitation, or other topics of individual interest. The distinction is not rigid, however, and this review covers the broad range of support groups in which women are involved.

Functions of Support Groups

The proliferation of support groups in the United States in recent decades attest to the need of people to be connected to others and to share their feelings with others who face similar problems and challenges (Katz 1993, Taylor 1996, Wuthnow 1994). Support groups provide a special form of social support that is often lacking in a network of family and friends, because they bring together people who share a common problem or experience. Heany and Israel (1997) define social support as "aid and assistance exchanged through social relationships and interpersonal transactions." They list four types of social support:

- *Emotional* Expressions of empathy, love, trust, and caring
- *Instrumental* Tangible aid and service
- *Informational* Advice, suggestions, and information
- *Appraisal* Information that is useful for self-evaluation

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Thus, support group members receive emotional support, concrete forms of assistance, and helpful information. They also learn how their situation compares with that of others, and they may receive feedback on how others perceive them. Furthermore, the person giving social support derives satisfaction from assisting another person, even if the support does not benefit the recipient as intended. One of the major factors that differentiate social support from other interpersonal exchanges is that the person giving social support intends for the support to be helpful.

People joining a support group may initially be interested in collecting useful information, making contact with others with a similar problem or situation, and obtaining advice on dealing with their problem. As they become more comfortable with the group, participants may share their own knowledge and experiences and thus assist newcomers or provide a new perspective to long-time members.

Being a member of a support group also affects the individual's self-concept. Usually, the individual develops a stronger sense of self-confidence, but sometimes the comparison with others lowers the individual's self-esteem. Three psychological processes are at work:

- *Status embracement* By becoming involved in a group representing a specific status, members tend to strengthen their identification with this status and make it more a central part of their self-concept.
- *Self-stigmatization* Affiliating with others with the same status could cause people to feel stigmatized by sensitizing them to the ways their group is considered deviant by society. On the other hand, people may feel less stigmatized by learning that others have similar problems.
- *Self-efficacy* Groups may reduce the sense of personal blame for life situations, participants may attribute their problems to outside factors (Kingree and Ruback 1994).

For many women, support groups offer a broader perspective and recognition of many positive qualities that may be unacknowledged in one's everyday social contacts. Women find the experience empowering, giving them the determination and self-confidence to exert control over their lives.

Women's support groups can be a catalyst for women to change their current situation and stop viewing themselves as powerless to change their circumstances, as Benton (1993) describes:

For many marginalized women, joining a women's group has made an unprecedented difference to their everyday lives of hardship and toil. Attending meetings provides a welcome diversion from a life of drudgery and, in many cases, of physical violence. They obtain a feeling of camaraderie from the group membership and have the opportunity to discuss problems and work together.

In the opinion of many of those interviewed, although adequate housing, water supplies, and cash to buy food, clothing and medicines are essential to life and any means of increasing household earnings are worthy of consideration, their greatest need is for education in the full sense of the term. Once literate, an individual cannot be deprived of the ability to read and write and countless opportunities are available. "Popular education" programs help women to recognize ways in which they are oppressed and to challenge the worst aspects of their exploitation, the self-confidence and management skills gained from group organization and leadership have a life-long duration.

Many women in developing countries are socially isolated and constricted by cultural norms. Support groups can help them overcome these constraints.

The psychological benefits of support groups are similar to those of small group therapy. Kath Ryan (1997), a pharmacist and lactation consultant from New Zealand, lists the benefits of support group membership:

- Feeling and sense of affiliation
- Revitalization
- Dissipation of tension and guilt
- Renewal of sense of identity
- Social outlet
- Empowerment of individual and family
- Opportunity to vent pent-up feelings and emotions
- Validation of care-giving experiences
- Affirmation and development of coping abilities
- Exploration of alternative behaviors
- Mutual support
- Reintroduction of feelings of normality into situation

Ryan (1997, 189) states that “Support groups provide a forum for transferring information, discussing difficult situations, and comparing experiences and solutions to encountered problems.”

Support Groups as a Health Intervention

Many studies have found that support groups have helped people prevent disease, recover from a serious illness or major personal crisis, or cope with a debilitating condition (Wuthnow 1994). Being in a support group can help people adopt long-lasting changes in health-related behaviors, including major changes in lifestyle and diet.

People with strong social support networks are more likely to persist in a behavior that is supported by their close contacts. For example, a Canadian study found that mothers who received emotional or instrumental support from influential people—family members, friends, and health care professionals—breastfed their premature infants longer than women who received no social support. Women with no source of support were six times more likely to stop breastfeeding than women with six sources of support. Interestingly, several mothers in the study formed a bond with other mothers visiting the neonatal intensive care unit at the hospital and the women shared their experiences. Few mothers received help from organized groups such as La Leche League (Kaufman and Hall 1989).

Support groups provide multiple benefits to women:

- *Improved psychological well-being* Recent research identifies strong linkages between people’s psychological state and their physical health (Moyers 1993).
- *Increased community participation* Communities are closely involved in program planning and implementation and thus feel ownership of the program.

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- *Greater message comprehension* In a group setting, messages disseminated through the mass media and health workers can be clarified, reinforced, and adapted to local conditions and individual needs
- *Individual assistance* Individuals receive advice and encouragement through the various stages of testing and adopting a new practice. Questions and difficulties are addressed as they arise

As Dr. Dory Storms of The Johns Hopkins University explains (Storms 1998),

Support groups can serve to fine-tune messages and add clarity. For example, the mega-message says that mothers should feed sick children. But a mother finds that her child isn't hungry and won't eat. Other mothers in the group can make suggestions and encourage her to keep trying to feed her child. Thus the group is a way to apply the message in a realistic setting and elaborate it. It has a similar effect to the question-and-answer period after a lecture, which clarifies what was said and amplifies some points.

One of the few studies of the impact of mothers' groups on health behaviors was done in Rohtak, India, where 288 women volunteers in 12 villages were organized into 12 groups. After one week of training in maternal and child health, the groups were encouraged to share the information with 10 to 20 households. The groups carried out various health interventions. All groups chlorinated village well water and distributed print materials. Five groups promoted family planning and five others distributed antimalarials. Each group met at least once weekly. It took one year to organize the groups. After the one year of activities, a cross-sectional survey of village mothers found substantial increases in beneficial health practices. For example, the proportion of mothers who reported that they breastfed on the day of or immediately after delivery increased from 23 percent in 1988 to 60 percent in 1990. Similarly, 14 percent of the mothers gave their children oral rehydration therapy in 1988, compared with 54 percent in 1990. In 1990, 12 percent of the mothers said that they continued to feed their children when the children were ill, compared with 41 percent in 1988 (Lal 1992).

This review did not identify any studies that assessed the cost-effectiveness of support groups relative to other interventions designed to influence health-related behaviors. However, two studies assessing the cost-effectiveness of group meetings relative to individual counseling and home visits suggest that the costs of establishing and sustaining support groups may be comparable to, or even lower than, those of other interventions.

For four to six months, an operations research study in Mexico compared the costs of various combinations of one-on-one counseling, group counseling, and teaching about exclusive breastfeeding. They studied four combinations: (1) community promoters provided one-on-one teaching and counseling, (2) social workers taught groups of mothers, (3) both individual and group teaching and counseling were provided, and (4) no teaching or counseling was provided. In all three treatment groups, the proportion of women breastfeeding exclusively for six months increased significantly, with women counseled in groups having the largest increase. The cost per mother was \$124 for the one-on-one counseling group and for group counseling or a combination of individual and group counseling. If costs are calculated in terms of the number of women participating until six months postpartum, the individual counseling was the least expensive and the combination approach the most expensive. The community promoters were paid less than the social workers, thus reducing the costs of individual counseling (Rodriguez-Garcia et al. 1988). These findings suggest that the costs of group meetings are comparable to those of individual counseling. While the group meetings were lectures more than support groups, the women who attended

the lectures subsequently formed their own informal support groups. The researchers noted that this development was an unexpected outcome of the project (Rodriguez-Garcia, Aumack, and Ramos 1990)

A second study found that the costs of group instruction were much lower than the costs of making home visits. A study in Bangladesh compared the costs of teaching diarrhea control and prevention to mothers individually or in small groups. Sponsored by the Bangladesh Rural Advancement Committee (BRAC), the study compared the costs and efficacy of two approaches: (1) trained female health workers made home visits to teach mothers individually about home preparation of oral rehydration therapy (ORT), and (2) the female health workers asked five mothers to gather in a nearby house and she taught them together. An evaluation study found that the cost of individual instruction was nearly twice that of group instruction, 15.34 and 8.51 taka per mother, respectively (in October 1998, 48.50 takas equaled U.S. \$1.00), while mothers' ORT usage and knowledge, as well as the composition of the solution, were comparable between the two groups (Chowdhury et al. 1988)

Despite many positive features, support groups are not a foolproof health intervention. The variability of mother support groups is too large and the number of available research studies too small to provide reliable information about the functioning of support groups in different settings. In the studies that found negative results, it is not known if the failure was due to poor implementation of a good design, an inappropriate design for that setting, or a setting that will not support any mother support groups.

Organizing Themes

Addressing Basic Needs

In developing countries, women's support groups usually have a utilitarian purpose, especially in the initial stages. Most groups meet one or more of the following needs:

- *Generate income* through credit and training
- *Meet other basic needs*, such as assistance pertaining to domestic violence, day care, water and sanitation, postabortion counseling, and disabilities
- *Impart practical skills*, such as breastfeeding, literacy, cooking, and gardening
- *Teach marketable skills* such as computer skills, entrepreneurial skills, and forestry
- *Provide social and psychological support* through informal networks, such as religious groups, community events, and organized social gatherings

The emphasis on income generation reflects the fact that most women in low-income communities have an extreme, pressing need to ensure their family's day-to-day survival. Women's need for social support to help them cope with physical and psychological stresses is not well recognized, even by the women themselves. With limited time and heavy demands from other family members, women need to receive some tangible benefit to motivate them to make the time to attend meetings and to secure the approval of family members. Income generation programs and literacy courses have been the major catalysts for women in low-income communities to join groups. Through these programs, women not only learn new skills but also open up their minds to new possibilities, including the idea that they can exert some control over their lives.

Over time, women become more self-confident and they are able to pay attention to new messages, such as child health (Andina and Pillsbury 1997, Hashemi, Schuler, and Riley 1996, Howard-Grabman 1994, Vor der Bruegge et al 1995). However, women's support groups should not be seen as a captive audience for lectures on optimal health behaviors. Rather, they present an opportunity for women to learn what they personally can do to protect their children's health, to share experiences, to explore options, to identify sources of assistance in the community, and to test new behaviors. This gradual process, buttressed with social support, is more likely to lead to sustained, widespread behavior change than simply telling women what they ought to do (Howard-Grabman 1994, Steel et al 1991, Vor der Bruegge et al 1995). One of the hallmarks of support groups is the value given to experiential learning, group discussion, and exploration of options, rather than the didactic, directive tone of most health communication campaigns (Israel 1985, Powell 1994, Silverman 1980, Wuthnow 1994).

Major Types of Women's Support Groups

Eight major types of women's support groups have current or potential links to child survival programs

- *Microenterprise programs* In peer group lending programs, women organize themselves into small groups to gain access to credit to support small businesses. Credit with Education programs add an educational component, facilitators (paid credit agents) bring up health and nutrition topics, and through group discussions members arrive at their own solutions. In Credit with Action programs, members commit themselves to performing health-related activities in their communities, health specialists provide the training.
- *Breastfeeding support groups* Many breastfeeding support groups follow the La Leche League model based on the concept of "mother-to-mother" assistance in initiating and sustaining breastfeeding. Group meetings are led by a trained volunteer counselor and concentrate almost entirely on breastfeeding. Members drop in and out of meetings, depending upon their needs. Some groups have introduced additional child survival topics.
- *Mothers' clubs* In many countries, mothers' clubs are organized for various purposes, including religious study, food distribution, community development, and social activities. Not all of these groups qualify as mutual aid groups. Many of them have been involved in health and nutrition activities.
- *Literacy classes* Literacy classes typically provide classroom instruction in reading and writing. While their format is not designed to promote group discussion, many women students, as they learn to read, bond together as a group and continue to meet after the classes are finished. Some groups read and discuss materials on health and nutrition.
- *Day care* Programs that provide community day care for children of working mothers in urban slums serve as a source of guidance in care seeking and a catalyst for mothers' interaction. The mothers pay a local woman to serve as a day care provider for 10 children. The program supplies food supplements for the children. Some day care providers organize meetings of the mothers.
- *Water and sanitation committees* Many communities establish committees, often led by women, to improve water supplies and sanitary conditions. Some projects have incorporated health education into project activities. Most water and sanitation committees disband after they complete their construction project, but, to maintain the new technologies, some groups continue.
- *Forestry cooperatives* Women who earn their living from forestry have formed cooperatives and self-help groups to work collectively and to qualify for government assistance, these groups have large memberships. Some groups become involved in other activities, such as literacy classes.
- *Social and political groups* Formal and informal gatherings of women provide opportunities to promote health care seeking behaviors. The *feminist cafes* in Brazil are one example of such gatherings.

The eight types of women's support groups models will be discussed in more detail in the following sections

Microenterprise Programs

The tradition of rotating savings and credit associations exists in many developing countries. In this model, women form groups (usually based on a common background) and meet regularly (weekly or monthly) to pool savings. Members take turns collecting the entire group's contribution. The person who receives the savings pool may be chosen by lottery or the group leader may receive the pool first, depending on local customs. In some groups, the winner is expected to provide refreshments to the group, thereby reducing the funds available for business investment. In peer group lending schemes, members receive loans and then make regular repayments, the group provides a mutual guarantee for repayment.

During the 1970s, organizations concerned with socioeconomic development adapted the traditional model of peer group lending programs to the needs of the poorest of the poor in diverse settings. Adaptations included providing management oversight to avoid misappropriation of funds, allowing individual members to determine the timing of their loan, and eliminating the requirement for hospitality. The number of peer group lending programs is growing rapidly throughout the developing world, they have served more than 1 million borrowers in 24 countries (Berenbach and Guzman 1992).

Organizing Principles of Peer Group Lending Programs

Peer group lending programs have three main goals:

- *Serve the poor* Banks usually consider the poor undesirable borrowers because the administrative costs of granting small loans are high. Because the poor lack collateral or loan guarantors, the risk of default is high.
- *Reach financial self-sufficiency* Interest payments and fees can be used to support program costs. Some programs become self-financing within three years of their initiation.
- *Reach large numbers* By reaching large numbers of poor people, programs can have a significant development impact, reduce per-unit costs, and broaden the risk.

Organizing borrowers into groups has several purposes: (1) the group greatly reduces the risk of loan defaults by exerting peer pressure and taking collective responsibility for repayment if a member defaults, (2) administrative costs for loans are reduced, because the costs to extend credit to a group are the same as for an individual, and (3) a larger number of borrowers can be served (Berenbach and Guzman 1992).

According to a review by ACCION International of peer group lending programs in 24 developing countries, a major factor in their success is "a relentless commitment to management efficiency. The successful programs examined have tested, refined, and streamlined their credit delivery methods to obtain maximum results. Sophisticated management information systems have been devised to track client and staff performance" (Berenbach and Guzman 1992, 13–14). A second factor in their success is market responsiveness, they focus on meeting clients' needs. The following list of ten "keys to successful peer group lending programs" is adapted from Berenbach and Guzman (1992, 16).

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- 1 *Client population* The client population must have an ongoing microenterprise or prior experience in its proposed business. Some groups limit membership to women. The activities of group members should include a variety of sectors, primarily manufacturing, services, and trading businesses.
- 2 *Group self-formation* Groups must select their own members and leaders. Group size is kept small, usually three to ten members. The sponsoring program may provide orientation and guidance, but the dynamics of the group is the key component.
- 3 *Decentralized operations* Program extension staff work in communities, reaching borrowers at their workplace. Field delivery is important for reducing the transaction costs for borrowers and overcoming cultural barriers in dealing with banks. Also, the extension agents become more knowledgeable about their clients' business environment.
- 4 *Appropriate loan sizes and terms* The loan amount and terms must be appropriate to borrowers' needs. Initial loans are for small amounts, loan size is increased as businesses and client experience grow. The payback period ranges from quarterly to yearly, depending on local business trends.
- 5 *Simple loan application and rapid review* Loan applications should be limited to basic information. Formal project credit analysis is not needed. Loan applications should be turned around in three to seven days. Group members are involved in approving individual loan requests.
- 6 *Interest rates and service fees* To cover operating costs, borrowers are charged service fees as well as interest. Borrowing costs are higher for peer lending groups than for commercial borrowers because of the small size of the loans. The operating cost of lending to groups ranges from 28 percent to 58 percent of the average portfolio of ACCION programs in Latin America. The Grameen Bank's operating costs are 28.5 percent of loan portfolios.
- 7 *On-time repayment requirements* Group members are responsible for collecting the total loan. No member is eligible for additional credit until the group's loan is repaid. The incentive for paying on time is the prospect of obtaining subsequent loans faster and in larger amounts than the initial loan. Up-to-date information systems alert staff to delinquencies. Most programs report default rates of less than 1 percent of loans.
- 8 *Credit is linked to savings and other financial services* Most groups offer savings for members, and this service is highly valued. Savings can be used as a safety net for repayments and an emergency fund for members if a personal crisis prevents repayment.
- 9 *Cost-effective training and organization building* Training helps members strengthen their existing management skills and administrative techniques. Self-help organizations address members' social and economic needs. The processes of group building and individual empowerment help members gain confidence and the personal qualities that lead to business success.
- 10 *Borrower-lender accountability and mutual respect* Lenders demonstrate their trust in the group by providing credit and by giving responsibility for credit management to the groups. The lender is obligated to provide a service of value to borrowers. In time, lenders and borrowers develop a sense of mutual trust and respect.

As implied from this list, the methodology for designing and implementing peer group lending programs is well-established and has been tested by low-income groups in diverse settings

Solidarity Groups in Latin America

In Latin America, ACCION International has promoted solidarity group programs when three to ten people form a group to receive loans and related services, such as training and organization building, members collectively guarantee loan repayment and loans are scaled to the borrower's needs. More than 120 local organizations are using solidarity group techniques, and they have provided more than \$80 million in small loans (Berenbach and Guzman 1992)

Grameen Bank and Bangladesh Rural Advancement Committee

Two of the best documented microenterprise credit programs are the Grameen Bank and the BRAC, which provide credit to poor rural women in Bangladesh. Founded in the 1970s, Grameen has approximately 2 million female members and BRAC has more than one-half million female members. Grameen has primarily functioned as a bank for poor people. BRAC has emphasized consciousness-raising and informal literacy training. Both programs employ field staff, mostly young men who live in the areas where they work. When a new branch opens, staff visit nearby villages and ask women who are interested in participating to organize into groups of five. Each group has joint responsibility for repaying the loans, so women tend to exclude women who they believe may be unable to repay a loan. Eight groups of five are needed to set up a center, which consists of the groups in one or more contiguous villages. After the groups are formed, membership is closed, except to replace dropouts. Dropout rates are low—about 5 percent (Hashemi and Schuler 1997, Hashemi, Schuler, and Riley 1996)

Training sessions are provided for new groups. Groups meet weekly to deposit savings and repay loans. Most loans are used for paddy processing, poultry, livestock, traditional crafts, and small trade. The Grameen Bank has maintained repayment rates of 95–98 percent over its 20-year existence. Most branches become profitable after four or five years of operation. However, in economically depressed areas destitute families may default on loans, causing bank branches to be unprofitable (Hashemi and Schuler 1997, Hashemi, Schuler, and Riley 1996)

An analysis of these two programs found that they empower women by strengthening their economic roles and increasing their ability to contribute to their family's support. A 1992 survey found that women who had participated in Grameen or BRAC programs scored higher on an index of their social and economic self-sufficiency "empowerment," and the women were more likely to contribute to family support than women who were not members or who lived in communities without the programs. The length of membership was significantly related to women's ability to make small independent purchases, be involved in major family decisions, and participate in political campaigns or public protests (Hashemi et al 1996). The programs also provided women with greater mobility within their communities. Before joining the credit programs, many women had never belonged to a group outside their own family (Schuler, Hashemi, and Riley 1997)

Credit with Education

A variant on the Grameen Bank model is the Credit with Education program supported by Freedom from Hunger. This program provides women with small loans (less than U S \$300) for income generation, as well as education in health, nutrition, and family planning. The goal of Credit with Education programs is to improve family nutritional status and food security by increasing women's economic capacity to purchase food and health care and by motivating them to adopt beneficial behaviors, including

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breastfeeding, weaning, and diarrhea management and prevention. Credit with Education programs are operating in 15 sites in nine developing countries (Bolivia, Burkina Faso, Ghana, Honduras, Mali, Philippines, Thailand, Togo, and Uganda). Some groups, established in 1989 at the start of this initiative, are still going strong (Freedom from Hunger 1997).

An evaluation of the Credit with Education program run by the Lower Pra Rural Bank in Ghana found that the height-for-age scores of 1-year-old children in the program communities increased significantly between the 1993 baseline survey and the 1996 follow-up survey, while infants' nutritional status in the control communities fell. More than 9 in 10 program participants in 1996 said that their incomes had increased or increased greatly since joining the program. Between 1993 and 1996, program participants' average net nonfarm income increased by U S \$36, compared with U S \$18 by nonparticipating women and U S \$17 by women in the control communities.

Program participants showed major improvements in breastfeeding practices, including giving colostrum to newborns, delaying introduction of water and watery foods until at least 120 days after birth, and never using a feeding bottle. In all of these categories, more program participants were doing optimal breastfeeding practices than nonparticipants or women in the control communities. For example, 98 percent of program participants gave colostrum to their newborns, compared with 78 percent of the nonparticipants and 71 percent of the women in control communities. Similarly, program participants introduced water when their infants were 125 days old on average, compared with 63 days for nonparticipants and 51 days for women in control communities. Program participants were much more likely than women in the other categories to help someone with his or her work and to give health or nutrition advice. Of the program participants, 86 percent reported that they had given health or nutrition advice in the last six months, compared with 30 percent of the nonparticipants and 46 percent of the women in control communities (MkNelly 1997).

An evaluation of the Credit with Education program in Mali found that 65 percent of the credit association members knew the proper age for introducing solid foods to an infant, compared with 20 percent of those in control communities. Eighty-five percent of the credit association members thought that the health and nutrition of their preschool children had improved, compared with 40 percent of women in control communities (Freedom from Hunger [undated]). Similar but unpublished findings were reported for Thailand and Honduras (Vor der Bruegge 1995).

To establish programs in rural areas, Freedom from Hunger first identifies a local counterpart agency that can manage the loan and savings accounts and supervise field staff. The most common counterpart agencies include commercial banks, credit unions, and nongovernmental organizations (NGOs). Many banks already have branches in rural areas. The process of establishing systems and organizing village groups takes about 18 months. Usually, start-up time is shortened by using financial institutions because they have already established systems for managing loans. Training community development organizations to manage loans takes more time and effort. The set-up cost depends on the counterpart agency and size of the program. The computer technology and training costs roughly U S \$100,000.

The counterpart agency hires and trains a credit agent, who is responsible for village-level programs. Credit agents usually have a high school education and are able to speak local languages. Facilitation skills and interactive ability are the most important qualifications. Freedom from Hunger has found that schoolteachers do not make good credit agents because they can't resist teaching their groups, instead of serving as facilitators. People applying for positions as agents are hired to conduct community studies on

practices and beliefs. Staff then observe their work and assess their language skills and level of comfort in remote areas.

Representatives of the counterpart agency visit villages to explain the program to community leaders. Then, they organize a series of meetings with village residents. Women are asked to identify four to six friends, members of this group, known as a solidarity group, guarantee each other's loans. Four to five small groups make up a village banking association composed of 30 to 35 members (20 members in small communities). Each group selects one member to be its representative on the management team of the village bank. Within three years, programs usually reach 70–100 percent self-financing. However, in low-income areas with stagnant economies, women have difficulty repaying their loans, thus limiting the growth of some associations.

Groups meet weekly. Initially, meetings last two to three hours, later, the time is reduced to one to one and one-half hours. Credit associations that are 8 to 10 years old cut back to one or two meetings monthly. Groups set their own rules. At least half of the group members have children under age 5.

The credit agent manages the credit program, facilitates group meetings, provides training, and leads discussions on all educational topics. The groups operate on 16-week loan cycles. During each of these cycles, the weekly meetings cover one nutrition or health topic. The discussion evolves week by week, allowing members to spend time considering each issue. Usually, the first topic to be covered is the control and prevention of diarrheal disease, including home remedies and advice on when to seek help. Other topics include breastfeeding, nutritious diets, and family planning. Some programs cover AIDS and malaria. Programs have not covered acute respiratory infection. Whenever possible, programs refer group members to local service providers and immunization services.

The credit agent facilitates problem solving by introducing a new idea, creating a conversation about it, and turning the question back to the group for them to find a solution. Groups discuss how to access services and how to use information. Role plays, case studies, and story telling are used to evoke group participation. The new information spreads beyond the groups because many women talk to others about what they have learned.

Credit agents visit the communities regularly, some reside in the communities where they work. In Africa, credit agents tend to be women, but in Bolivia most agents are men because of the arduous travel involved.

Credit with Action

Another variant on the Grameen Bank model is Helen Keller International's Credit with Action projects. These projects support revolving loan funds managed by women's groups. In addition, members of credit groups agree to visit 20 households in their communities to identify people with trichiasis and suggest ways to reduce flies, which transmit trachoma. The first project of this type, the Kongwa Women's Credit Program, began in 1996. Working in remote rural villages in central Tanzania, the project formed three lending groups of about 30 women each. During 1997, it provided 125 loans totaling \$13,000. At their weekly meetings, all group members were trained to identify trichiasis and were given referral information. In less than a year, the three groups had identified 42 women with trichiasis (Helen Keller International 1997).

Breastfeeding Support Groups

The best-known, most extensive network of women's support groups worldwide is La Leche League International, which has more than 30,000 members in affiliates in 66 countries (Burkhalter 1992, Kyenkya-Isabirye and Magalhaes 1990, Magalhaes 1998) Founded in 1956, La Leche League International has created a system for developing women's support groups

La Leche League groups are based on the concept of experienced mothers helping new mothers At regular meetings (usually monthly), mothers and pregnant women share information and discuss problems Members usually attend meetings sporadically, depending upon their breastfeeding status La Leche League support groups focus on four topics (1) advantages of breastfeeding, (2) preparation for the arrival of the baby, (3) techniques of breastfeeding, and (4) nutrition and weaning (Rosenberg and Joya de Suarez 1996) Some breastfeeding support groups have added other topics of special interest to mothers, such as child development, consumer issues, health, and safety

Support groups are led by volunteer breastfeeding counselors, who are supported by a large structure of volunteer committees at the local, subnational, national, and international levels, as well as by paid headquarters staff To ensure high-quality group leaders, La Leche League first identifies group members with the potential to be group leaders, then gives them the extensive training required to be certified as breastfeeding counselors Newly trained counselors serve an apprenticeship Counselors "do not make decisions for mothers, but instead help them to gain confidence to do what they consider best for themselves and their children" (WHO 1991, 63)

Studies show that breastfeeding support groups are effective in improving the breastfeeding practices of their members (AHLACMA et al 1993, Ridler 1988, Steel 1990, Steel et al 1991, Tompson 1976–1977) One of the few studies to compare breastfeeding practices of support group members and nonmembers found that participation in the group was associated with improved breastfeeding practices A 1976 study in the United States found that mothers who participated in local La Leche League activities were more likely to exclusively breastfeed their children longer than nonparticipants (Steel et al 1991) Women who join a breastfeeding support group are likely to be highly motivated to breastfeed, leading to selection bias that could affect the study's findings A review of La Leche League groups in the United States by Harvard University mental health experts concluded that one of the group's key benefits is to provide opportunities for new parents to learn how to assume their new roles and to reinforce feelings of normalcy (Silverman and Murrow 1976)

La Leche League started out as a predominantly middle-class movement In recent decades it has developed programs for poor and migrant populations in the United States, and it has expanded to many developing countries, including Bolivia, Brazil, Ecuador, Guatemala, Honduras, Mexico, and Zambia In developed countries, La Leche League members can provide donations and volunteer time because their members are highly literate, have access to technical knowledge, and have the ability to interpret and disseminate information (Steel et al 1991) The Mother-to-Mother Support Group in rural Tennessee organizes groups of low-income women to exchange information and support each other in breastfeeding The groups have two types of meetings (1) discussion of breastfeeding techniques and resolving problems and (2) "enrichment" meetings where a resource person speaks to the group on selected topics, such as budgeting, exercises for mothers and babies, and cardiopulmonary resuscitation The enrichment meetings are held in alternate months, some groups decide to meet twice a month (Steel 1990)

Some breastfeeding advocates are concerned that La Leche League's strategies may be less effective in developing countries. Organizers of breastfeeding support groups in developing countries report that they have difficulty recruiting volunteers in low-income communities, because most women give priority to income-generating activities and have heavy family responsibilities (Rivera et al 1993)

Four studies on the impact of breastfeeding support groups in developing countries have been published: two reports from Guatemala (de Maza et al 1997, Stone-Jimenez and de Maza, 1993) and two reports from Honduras (AHLACMA et al 1993, Rivera et al 1993)

Guatemala

La Leche League of Guatemala (LLLG) recruited and trained volunteer breastfeeding advocates in ten peri-urban communities. The advocates formed mother-to-mother support groups based on the La Leche League model and they distributed print materials. In one community, exclusive breastfeeding increased from 16 percent to 22 percent after the groups had been operating for one year (Stone-Jimenez and de Maza 1993). A 1996 study by the BASICS project and La Leche League International assessed the program's status after three years of operating on a greatly reduced budget. The study concluded that "the LLLG peri-urban program has been sustained at nearly the same level of service as before. In the most successful communities, the program is reaching about 25 percent of the women aged 15–49 years" (de Maza et al 1997, 6). Of the women who had contact with a breastfeeding counselor, 65 percent received referrals to health facilities for their children. More than half (51 percent) of the referrals came from home visits, 27 percent from individual counseling, and 21 percent from support groups (de Maza et al 1997)

Honduras

La Leche League of Honduras conducted a study using community volunteers to promote breastfeeding and the use of the lactational amenorrhea method (LAM) of child spacing. In a low-income peri-urban area, La Leche League trained physicians and nurses in breastfeeding and LAM. Twelve percent of mothers of infants had contact with the volunteer breastfeeding counselors, 7 percent attended a support group meeting. Women who had contact with the breastfeeding counselor had improved breastfeeding practices and increased their knowledge of LAM. Mothers of infants under 6 months old who had contact with the breastfeeding counselor breastfed exclusively for 9.6 weeks, compared with 4.3 weeks of the mothers in the control group (Rivera et al 1993). In a second study, La Leche League of Honduras trained volunteer peer counselors in 20 rural communities. The peer counselors organized monthly meetings and visited one or two mothers monthly in their homes. Of the mothers who had contact with the peer counselors, 50 percent were exclusively breastfeeding at two months postpartum and 31 percent at three months postpartum, compared with 20 percent and 9 percent, respectively, for a control group who received routine health education from community health educators (AHLACMA et al 1993)

Mothers' Clubs

Mothers' clubs, founded at the initiative of local Catholic churches, exist in several Latin American countries. Most of the clubs were organized to provide a social outlet and Bible study for young mothers. Sources of information about mothers' clubs consist of church-affiliated groups and organizations concerned with hunger alleviation and health.

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In Bolivia, the mothers' clubs provide support to young mothers and teach them about child care, health, and hygiene. They also take on other tasks, such as raising funds for a fiesta, purchasing school books and equipment, cooking breakfasts for schoolchildren, and collecting donations for needy families (Benton 1993). Since 1955, the Ministry of Health has provided food supplements to mothers' clubs. District health workers oversee the program. Paramedics (auxiliaries) are responsible for training and supervising 5 to 10 community health workers. The paramedics are paid, they visit each community about once a month. In each community, a community health worker registers the mothers and their children and provides the food supplements. These workers are not paid, but they benefit from the training provided and the prestige of participating in a national project (Bender 1984, Bender and Cantlay 1983).

In 1986, building on the network of 1,800 mothers' clubs in Bolivia, the Primary Technologies for Health Care (PRITECH) Project developed an initiative to educate rural mothers about oral rehydration therapy (ORT). The mothers clubs, which have 30 to 40 members each and meet weekly, receive surplus food donations through Caritas Boliviana, the social service agency of the Catholic Bishops of Bolivia. The project attempted to transform women's groups from "passive recipients of surplus food to active agents of health education" (Aguilar, Schaeffer, and Spain 1988, 23). In each diocese, four-person teams of trainers received training. The trainers then conducted a four-day training course for leaders of mothers' clubs on how to control and prevent diarrhea. Leaders also received flipcharts. ORT packets were added to the monthly food allotments. After one year, an evaluation found that the effort increased mothers' awareness of ORT therapy, knowledge of the consequences of ORT use, and availability of ORT supplies. More than 7 in 10 mothers' club members were aware of ORT packets, compared with only about 2 in 10 nonmembers. Club members were four times more likely to have an ORT packet in their home than nonmembers, and "Almost half of the club members knew that ORT cured diarrhea, compared to about a tenth of non-members" (Aguilar, Schaeffer, and Spain 1988, 28). Comparing group members with nonmembers raises the potential of selection bias, which could affect the findings. Nevertheless, this study showed the effectiveness of mothers' clubs for educating mothers about ORT.

The mothers' clubs also served an important outreach function. About half of the members who received ORT instruction reported that they had instructed a nonmember in diarrhea care. Project organizers considered coverage of the target population (mothers of children under age 5) to be good, given the remote rural setting. Two-thirds of the mothers' club members received face-to-face instruction in diarrhea management and one-third of the members gave such instructions to nonmembers (Aguilar, Schaeffer, and Spain 1988).

The Warmi (woman) Project, a three-year (1990–1993) demonstration project to improve maternal and neonatal health, also used the Bolivian mothers' clubs as a way to involve mothers. Implemented by Save the Children/Bolivia, the project used a community-based, participative approach with six major interventions: (1) organizing and strengthening 50 women's groups, (2) "autodiagnosis," a problem identification and prioritization exercise conducted by the 50 women's groups, (3) a "planning together" process implemented in 22 communities, (4) training of 45 community midwives, (5) family planning education and services in seven communities, and (6) development of a health card, manual for community midwives, four booklets, and five radio programs. More than 850 women participated in the 50 women's groups. Although a separate evaluation of the women's group component was not done, the project did lead to improved health status and behaviors: the number of perinatal and neonatal deaths (during pregnancy and the first month of life) declined, while contraceptive use, use of prenatal services, tetanus toxoid immunization among new mothers, deliveries assisted by trained birth attendants, and breastfeeding within the first hour after birth increased (Howard-Grabman 1994).

In Mexico, a 1989–1991 project to promote ORT worked with mothers' groups in 158 communities in the states of Hidalgo and Veracruz. The project trained 221 community health aides and supervisors from 47 maternal and child health units. Other interventions, such as distributing flipcharts, pamphlets, and gourd dolls, holding a lottery, and setting up a stand to dispense ORT in 18 marketplaces, were also implemented. A total of 1,730 mothers in community groups were reached. A comparison of mothers' rates of comprehension of hydration therapy concepts before and after their meetings with community health aides found that mothers' knowledge increased. A test two days after the post-test found that comprehension rates had fallen. Mothers who participated in the mothers' groups had higher rates of comprehension than those who were reached through the marketplace interventions (Ciclope, S C, Consulting Group 1992). The study report did not provide details on the specific educational techniques used, the groups' composition, or the women's length of exposure to the information. It is unclear if the mothers' groups were newly formed or already existing.

In Brazil, the mothers' clubs have become a politically active force. Initially, the women gathered to knit, crochet, and read passages from the Bible. Later the women began to discuss the need for a water supply, sewage system, health centers, and nursery schools. "Through these small battles we began to see things differently and to see through things better," one participant remarked (Caipora Women's Group 1993, 113). In 1972, many mothers' clubs joined forces and organized a campaign against increases in the cost of living, sending a letter to government officials. Three years later, the same group surveyed more than 2,000 households about the cost of living. In 1978, the mothers' clubs obtained 1.3 million signatures on a petition to government officials, but the officials refused to meet with them. They held a public rally in Sao Paulo, attended by 20,000 people, and continued to organize demonstrations and meetings. The mothers' clubs became linked with Rede Mulher, the Women's Network, which led a successful initiative to incorporate women's rights provisions into Brazil's new constitution (Caipora Women's Group 1993, 113).

In the Maldives, the Ministry of Health and Welfare conducted an operations research program to test the feasibility of using mothers' groups to educate mothers of children under age 3 about primary health care. The 1988–1989 study was designed to improve mothers' knowledge of antenatal care, family planning, diarrheal disease, immunization, use of growth cards in growth monitoring, and communicable disease control. In the experimental area, family health workers met weekly for eight weeks with groups of five or six mothers, thus, each worker taught six groups a week, totaling 30 to 36 mothers. Six mothers were recruited as permanent group leaders, and they formed successive sets of six mothers' groups until 180 mothers had been taught. Women in the control area were visited in their homes by the family health workers, who had four months' training. After the intervention, scores of knowledge on the six topics doubled among mothers in the experimental group, while those of mothers in the control group showed little change. For example, the mean score for knowledge of pregnancy risk factors increased from 0.26 to 3.75 among mothers in the experimental group and from 0.40 to 0.47 among those in the control group (Yoosuf 1993). This intervention appears to have covered 15 percent of mothers with children under 3 years of age. Changes in behavior were not measured.

In contrast to these positive findings, some studies found that mothers' clubs have little or no effect on child health status. A study in the Philippines found that the presence of mothers' clubs in the community was not associated with lower rates of infant diarrhea. Based on the 1984 Cebu Longitudinal Infant Health and Nutrition Study, the analysis assessed whether the association between mother's education and infant diarrhea was modified by three factors: household assets, community economic resources, and the availability of mothers' clubs. The study found that maternal education had no protective effect on infant diarrhea in low-income communities. Among women with less than a primary education, the

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presence of mothers' clubs was associated with an increased risk of diarrhea, probably due to the fact that mothers' clubs are created in disadvantaged communities where infant diarrhea is more prevalent. Women with higher educational levels did not benefit from the presence of mothers' clubs (Dargent-Molina et al. 1994). Information on the membership, activities, and participation level of the mothers' clubs was not presented. Due to the lack of behavioral measures among club members, the study did not address the issue of the clubs' effectiveness in promoting child survival.

Literacy Classes

For many low-income women, literacy classes have been the first step in reaching beyond the confines of their everyday world. Many illiterate women are highly motivated to learn to read, and they will take the time to come to class. In class, women learn to overcome their shyness and speak before the group. Class members become acquainted and develop friendships. Even after classes have ended, many groups of women continue to meet. Some literacy classes evolve into reading groups, where the group reads and discusses new materials on a variety of subjects.

Literacy specialists believe that literacy is a prerequisite to educating mothers on child health and nutrition issues. They argue that it is difficult for illiterate women to absorb new information and learning new skills. Once women learn to read, they can take in information more readily. Printed materials can be provided at regular intervals to support the learning process. Literacy may also increase women's receptivity to other information sources, such as radio (Smith 1998).

In Bolivia, the Center for Self-Development (CDA) offers literacy classes to housewives' committees, mothers' clubs, factory workers, market cooperatives, peasant groups, and wives of relocated miners. The power of literacy to lead to community activism is illustrated in a report of two literacy classes in a low-income area of La Paz. While one group of women was learning how to write their names, the more advanced group was debating how to persuade their husbands to move rubbish from the streets and garbage dumps to prevent the spread of infection and disease (Benton 1993).

Day Care

Day care centers do not usually organize regular meetings of mothers, but they are included in this review because they offer a potential structure for bringing mothers together. Some centers have organized informal meetings of mothers that could form the basis for a support group.

Several countries in Latin America, including Chile, Colombia, Costa Rica, Peru, and Venezuela, have developed programs to assist working mothers by providing affordable child care and other services. The structure of child care offers opportunities for women to meet other mothers, to share information and advice, and to provide other forms of assistance, such as loans. Also, the day care providers become knowledgeable about child health, and they can be a source of guidance to mothers on care seeking.

A project in Guatemala, Programa de Hogares Comunitarios de la Primera Dama, provides day care to more than 10,000 children under age 6. The program enables single mothers living in urban slums to work. The women are often isolated from support systems of family and friends who would otherwise be available to care for their young children while they work. The day care center provides them and their

children with much-needed stability, including nutritious meals for the children and greater attention to their health care needs. The meals may be the children's major sustenance, on weekends, at home, they may go hungry. Children enrolled in the program are weighed and measured every three months, if a child appears to be malnourished, day care providers notify the program office. When children are ill, the providers advise mothers to take them to health facilities.

Day care providers are women in the community who agree to care for 10 children in their homes. Most day care providers are 40 to 50 years old and have grown children. Providers attend a two-week training course that covers optimal feeding practices, children's activities, safety, and treating common childhood diseases, such as diarrhea and colds. Parents pay the day care provider for her services, and the program provides supplemental food for the children. Day care centers are open from 6 A.M. to 6 P.M.

Over time, the day care provider becomes knowledgeable about the children's health and nutritional status and can advise mothers on appropriate actions, including care seeking. Through the day care center, the mothers become acquainted informally and help each other out. Some day care providers organize meetings of the mothers (De la Briere 1998).

Water and Sanitation Committees

Water and sanitation projects often work with groups of women because, in many cultures, women are the primary water carriers. Many projects organize groups of women and men in the community to introduce new technologies for improving water supplies and sanitation. To maintain the new technologies, the groups may continue, but their work is usually limited to the immediate task (Donnelly-Roark 1987, Yacoub et al. 1992). By participating in the projects, women gain confidence in themselves and improve their skills in implementing a group project (Kinley 1991, Narayan-Parker 1990).

In Indonesia, the Indonesian Family Welfare Movement (Pembinaan Kesejahteraan Keluarga) implemented a water project in the province of Nusa Tenggara Timur from 1985 to 1987. Male field workers based in provincial offices organized 25 water users' groups in four villages. Each group comprised 10 to 75 households. Although the groups consisted of both men and women, the movement encouraged women to participate, and the groups provided training and organizational support. Women were the leaders of all management teams, both at the provincial and village level.

A 1987 survey found that women were more knowledgeable than men about the water users' groups. Women were generally perceived to have been most active and to have made most decisions, although men gave more credit to other males than women did. After the project was completed, women's self-ratings in terms of intelligence and leadership improved. Women leaders were more widely recognized as leaders by both women and men (Narayan-Parker 1990). Working in the projects users' groups led women to apply their leadership, knowledge, and problem-solving skills. Their accomplishments boosted their self-confidence and their community's recognition of women's contributions.

CARE has been involved in installing simple sanitation systems in Bolivia, these programs incorporate teaching in nutrition and hygiene. CARE requires each community to select a woman to be trained as a health promoter (Benton 1993).

Forestry Cooperatives

In the forestry sector, women have formed cooperatives and self-help groups to work collectively and to qualify for government assistance related to seedlings, training, and receiving advice from extension workers. In Kenya, a study of five women's groups involved in community forestry projects in one district reported that these groups were strongly committed to tree growing as an income-producing and conservation measure. The five groups, with a total of 2,150 members, were also involved in literacy classes, cooking, and home crafts (Hyma and Nyamwange 1993).

Social and Political Groups

Formal and informal gatherings of women provide opportunities to promote health care seeking behaviors. Women may be more likely than men to belong to social clubs. For example, a study in Kenya found that nearly half (48 percent) of the women aged 20 to 54 belonged to a social club, compared with 42 percent of the men in this age group. Women were more likely than men to participate in several clubs: 46 percent belonged to a women's club, 37 percent to religious groups, 12 percent to community organizations, and 10 percent to self-help groups. In contrast, 30 percent of the men belonged to religious groups, 19 percent to sports clubs, 17 percent to community groups, 16 percent to self-help groups, and fewer than 2 percent to men's clubs (Kekovole et al. 1997).

Some women's organizations plan meetings or sponsor social events to promote community discussions of women's issues. In Sao Paulo, Brazil, the Centro de Informação Mulher (Women's Information Center) organizes *feminist cafes*, periodic gatherings of women to discuss women's rights, including work, violence, health, homosexuality, racism, and public policies. Some of the debates have been published (Andina and Pillsbury 1997). Local communities could adapt this idea by sponsoring "mothers' night out" sessions and providing light refreshments.

Structure and Organization of Women's Support Groups

In establishing a women's support group, decisions should be made regarding the following parameters

- *Purpose of the group* Some groups are formed with a specific purpose, such as providing access to credit or helping mothers to breastfeed, while others have diverse goals that reflect the needs and interests of group members
- *Membership* Groups must decide at the outset what qualifications members should have (for example, age, marital status, and ethnic, religious or racial background, educational level, first-time versus experienced mothers), how members will be recruited, and how new members will be integrated into the group Some groups are formed by individuals selecting people they know to join the group Others are organized by a group leader or are created when several people become acquainted and decide to continue meeting Some groups restrict membership to a certain number of participants, while others remain open to newcomers
- *Group size* Groups vary in size, typically from 4 to 20 people Experts in small group work say that 10 to 12 people is the best number for encouraging lively group discussions (Wuthnow 1994)
- *Meeting place* Most groups meet in a home, church, community center, clinic, or work site The meeting place should be easily accessible to group members It should be a place where members feel comfortable bringing their children To encourage group participation, there should be adequate space for members to sit in a circle
- *Meeting frequency and duration* The group should decide on the frequency of meetings and the length of meeting sessions Most support groups meet weekly, biweekly, or monthly for one and one-half or two hours The timing of the meeting should not interfere with members' daily activities or conflict with major community events
- *Ambiance* Group leaders and members should make a special effort to make everyone feel comfortable in the group and should promote positive feelings A support group should provide a "safe atmosphere, sense of respect, sharing of information, availability of practical help, sharing of responsibility, acceptance, mutual learning, and emotional connection" (Liga de la Lactancia Materna de Honduras 1996, 1–2) If resources permit, groups should provide refreshments at meetings
- *Role of group leaders* Leadership roles vary considerably, ranging from those in which the group leader directs the discussion and provides information, to other groups in which the leader is a facilitator and remains in the background Some support groups avoid designating a leader Group members may share the tasks and responsibilities usually allocated to leaders If the leader is too intrusive and directive, the group ceases to function as a support group

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The parameters can change over time, but they should form a basic structure, which is needed to maintain continuity (Gottlieb 1988, Katz 1993, Rosenberg and Lee 1992, Wuthnow 1994)

Every support group must have basic agreement on how members will behave so that members feel safe (Rosenberg and Joya de Suarez 1996, Rosenberg and Lee 1992) On the basis of the experiences of breastfeeding support groups in six Latin American countries and the United States, Judith Rosenberg (Support Group Training Project, U S A) and Maria Joya de Suarez (La Liga de la Lactancia Materna de Honduras) list some typical agreements for a breastfeeding support group (Rosenberg and Joya de Suarez 1996, 8–16)

- No one may criticize or attack another member,
- Each mother decides what kind of support or information she wants and needs,
- No one may offer advice to any member without the member's permission,
- Listening is a sign of respect and caring No one may talk when someone else is speaking, and
- Group discussions should be cooperative, everyone has experiences and ideas to share

Group members must agree to maintain confidentiality regarding personal information shared with the group Members need to feel safe to confide in the group Meetings should encourage informal, spontaneous comments and exchanges (Rosenberg and Joya de Suarez 1996)

The format of group meetings should have some structure to organize group tasks, but it should also be flexible enough to allow members to air their thoughts “The support group is a place to share information and practical hints, happy times and celebrations, as well as questions and problems” (Rosenberg and Joya de Suarez 1996, 8-2) An example of the agenda followed by breastfeeding support groups include the following (Rosenberg and Joya de Suarez 1996)

- Members make announcements to share community news and information of general interest
- Each member talks about her personal needs
- Mothers can ask for a turn to speak or do a group activity
- The meeting discusses a specific topic
- The leader provides information and discusses it with group members
- Experienced members take turns helping new members

Costs and Sources of Support

Few programs provide information on the costs of setting up and maintaining women's support groups. One of the most detailed reports describes how La Leche League Guatemala (LLLG) reduced its program costs after the U.S. Agency for International Development (USAID) funding ended. LLLG had a budget of \$50,000 annually to operate breastfeeding support groups in 10 communities. These costs included the oversight of 141 volunteer breastfeeding counselors, seven headquarters staff, with each devoting half their time to the project, field visits, monthly meetings, mini-workshops, and a reporting and information system. When the USAID grant expired, LLLG reduced its budget to about \$20,000 annually. For this amount, it was able to continue working in seven communities. The breastfeeding counselors were supported by six or seven coordinators and three to five subcoordinators. Three headquarters staff, each working 40 percent of their time, continued to maintain the reporting and information system, and to organize monthly mini-workshops for coordinators and subcoordinators and an annual workshop for all breastfeeding counselors. Based on the LLLG budget of \$20,000, the peri-urban project costs U.S. \$13.40 to U.S. \$18.60 annually for each woman covered. Because the budget covered other activities and the number of women covered did not include those counseled by support group members, the actual cost per woman covered was probably lower (de Maza et al. 1997).

This example points out one of the most vulnerable aspects of women's support groups: they operate through volunteers. Most volunteers have limited incomes and need to be reimbursed for expenses, such as transportation to meetings and child care. Community organizations have addressed their volunteers' need for income in three ways: (1) organizing job cooperatives, (2) setting up a communal bank to provide credit for home-based businesses, and (3) giving stipends to counselors who make public presentations, participate in training meetings, and work as liaisons to health agencies. On the basis of input from breastfeeding support groups in six Latin American countries, Rosenberg and Joya de Suarez (1996) advised agencies to be careful not to set up competition between volunteers or to attract counselors who are more interested in the compensation than in their mission. LLLG's national office raised funds to pay the expenses of volunteer counselors to attend training sessions (de Maza et al. 1997).

Programs serving low-income communities often have difficulty recruiting sufficient numbers of volunteers. Some projects find that they must pay outreach staff or provide special incentives, such as per diem allowances or transportation expenses. For example, as its project expanded, La Leche League of Honduras (LLLH) had difficulty recruiting highly motivated volunteers from the community. Recognizing the value of its existing well-trained volunteers, LLLH decided to pay the existing volunteers to conduct an additional support group meeting, although the volunteers continued to lead their original group without pay (Rivera et al. 1993). Similarly, a breastfeeding promotion project in Tennessee paid peer counselors \$50 weekly for 10 hours of work. This sum made a significant difference to these low-income women (Steel 1990).

In low-income communities, many volunteers may drop out in order to take paid employment or spend more time on income-producing activities. Nevertheless, some volunteers thought to be inactive may continue to provide support within their communities. For example, LLLG found that many low-income counselors who had stopped reporting their activities to the national office were still active but at a lower intensity. They continued to provide individual counseling, home visits, and referrals, but they worked fewer hours per month than the counselors who continued to report their activities (de Maza et al. 1997).

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Many of the active volunteers in breastfeeding support groups tend to be middle- and upper-income women who also have the time to volunteer and are able to contribute financially. According to a WHO-funded study by four internationally recognized breastfeeding experts, the groups include La Leche League, The Informative Breastfeeding Service of Trinidad and Tobago (TIBS), and Breastfeeding Information Group (BIG) in Kenya (Steel et al 1991)

The use of volunteers may reduce program costs but it does not eliminate them. As with paid staff, volunteers require training, continuing support and supervision, overall management services, and information systems. Programs usually employ a small paid staff to perform these functions. Because of high attrition rates among volunteers, extra volunteers need to be recruited and trained, thus increasing costs. The rapid turnover of volunteer leaders is another hidden cost that can affect a project's stability (Steel 1990)

Many feminists are critical of development programs that rely on women volunteers for community outreach. They point out that the paid program administrators and supervisors are often male while the unpaid volunteers are women. Feminists view this approach as another example of the way that women's work is undervalued and unappreciated.

Many of the larger development programs that work with women's support groups in low-income areas receive funding from international donors or local governments. Some donors provide seed money to start microenterprise credit programs, with the expectation that such programs will become self-supporting within a few years. NGOs have active fund-raising programs. Their major sources of support are donations, in-kind contributions from local companies, sales of literature and promotional materials, sales of products (for example, breastfeeding aids), membership subscriptions, and fees for services. Funds from external donors can greatly augment their budget and enable them to extend their coverage to needy populations.

Starting Women's Support Groups

Linking with a Sponsoring Organization

Development agencies working with low-income groups often collaborate with existing community service organizations that are known and respected by local community leaders, according to Adwoa Steel and colleagues (1991). The collaborating agency's leaders and staff must be committed to child health and willing to incorporate child health activities into their other activities. In agencies that lack this commitment, staff turnover can be high, requiring continual retraining.

In its Credit with Education program, Freedom from Hunger identifies local entities that can work with community groups. Banks with branches near the community work well; they already have the mechanisms and expertise to manage credit programs. Nonprofit organizations can develop the infrastructure and skills to manage credit programs, but they generally require more technical assistance and equipment (for example, computers) to take on this role.

Many women's support groups have minimal contact with government agencies. In some countries, government health workers and agricultural extension agents give lectures and demonstrations to women's groups. Some women receive donated foods.

Indonesia is one model of potential collaboration between the government and voluntary organizations. The Family Welfare Movement (PKK), an organization of 1.5 million village women volunteers, operates in every village. Sponsored by the Ministry of Home Affairs, PKK runs the village health posts (*posyandus*), which are staffed by PKK volunteers. It also holds a monthly mothers' meeting in each village; children under age 3 are weighed at the meeting, with the weight entered in the child's growth chart. In many villages, mothers have begun neighborhood nutrition clubs that meet periodically to cook meals and discuss good nutrition. In 1990, the PKK began organizing households in groups of 10; each group chooses a chairman, usually a woman, to remind mothers to visit the health post (Hoedoyo 1990).

Beginning Work in a Community

Some programs that involve women's groups start with a series of visits to explain the program to community leaders and potential members. After the project infrastructure is well established, microenterprise projects approach communities located near local bank branches or offices. In breastfeeding promotion projects, community organizers visit the community to determine whether an existing NGO or other community-based health or service organization would be able to collaborate in breastfeeding promotion. If no appropriate organization is found, the organizers contact local officials and other formal leaders to gain their support. After several community members supportive of breastfeeding have been identified, the community organizers assist them in making outreach presentations to community groups, NGOs, mothers clubs, neighborhood health committees, churches, and schools (Rosenberg and Joya de Suarez 1996).

Health education specialists Catherine Heaney and Barbara Israel (1997) recommend that to design appropriate social support mechanisms, program planners must first assess social networks in the

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community. They should determine what networks exist and if the networks are meeting the needs of the target population. The target population should play a central role in project planning to ensure that the most appropriate helpers are identified and that the helpers adopt behaviors that are perceived as supportive by the recipients. Community involvement will help to instill a sense of community ownership and responsibility (Heaney and Israel 1997).

Responding to the community's perceived needs is important. In low-income communities, residents may identify sheer survival, rather than child health, as their highest priority. Ignoring these larger concerns could limit community participation in health interventions (de Maza et al. 1997).

Liaison with Local Health Care Providers

Organizers of women's support groups to promote improved health should determine if local health care services are accessible and of adequate quality before referring women to them, according to Steel and colleagues (1991). Group organizers and members can help women overcome barriers, such as cost, travel distance, long clinic waits, substandard medical care, lack of necessary drugs, and unkind treatment by clinic staff. Also, it is important that the information given by health services is consistent with the topics discussed in support groups (Steel et al. 1991).

Working with Existing Groups

Health and development specialists have decidedly mixed views regarding the advisability of adding child survival or other health-related behaviors to the agenda of existing community groups. People who work in the income generation and literacy programs believe that women must first master the skills or implement the activities that they originally planned when they joined the group. This accomplishment increases their sense of empowerment and self-efficacy, and they are then able to identify other areas of their lives in which they can begin to make improvements. Therefore, programs should wait to introduce health topics until groups can incorporate new information into their agenda.

Support group expert Judith Rosenberg believes that a broader range of topics will increase women's interest and keep them attending meetings longer than if a single topic is covered. Topics should be based on members' self-identified needs (Rosenberg 1998). On the other hand, breastfeeding advocates attribute their success to their steadfast focus on a limited number of topics. Members can come to meetings knowing that these topics will be covered. Some breastfeeding support groups are involved in child survival issues. For example, LLLG has trained breastfeeding counselors to refer mothers to health centers for prenatal care, family planning, vaccinations, and treatment of chronic diarrhea (Storms 1992). Needless to say, the ultimate determination of topics to be covered rests with the consensus of the group.

In deciding whether to work with existing groups or organize new ones, program planners developing health interventions need to look carefully at the way existing groups function. The advantages of using existing groups include the following:

- *Avoidance of delays in start-up* Extra time is not needed to organize new groups and give members time to become acquainted.

- *Group cohesion* In existing groups the group dynamics have already been worked out. The group is usually stable and cohesive and can turn its attention to new topics.
- *Trust* Over the course of many discussions, group members develop a common bond and learn to trust each other. This trusting relationship enables them to have a more open discussion about the realities of their lives.
- *Altruism* Group members have demonstrated their interest in giving support to others. On the other hand, trying to build on existing community groups is not always successful.

Factors that may lead to problems include the following:

- *Inflexibility* Groups may not be open to adding new topics or different formats, such as having an outside speaker.
- *Dependency on incentives* Groups that were formed to receive some tangible benefit, such as food supplements, may not be motivated to attend group meetings when concrete incentives are not provided.
- *Dysfunctional formats* Some groups may be structured in ways that discourage the active participation of all group members and that restrain members from divulging personal information.

With these factors in mind, the feasibility and usefulness of adding child health topics to the agenda of an existing group must be explored thoroughly.

Another caveat is that women who are current members of groups may be more effective than nonmembers in relating to others. Thus, nonmembers may be more in need of assistance because they lack the social networks that group members can command. In a United States study of support groups for low-income mothers in Detroit, the researchers found that women's involvement in the groups was related to their verbal participation in early meetings. Women who did not talk much were more likely to drop out of the group than those who readily adapted to the group process. The researchers concluded that some women needed to improve their relationship skills before they could benefit from group discussions. The researchers, therefore, recommended that program planners consider two perspectives in programs to encourage women to form relationships with their peers: (1) alter the environment by giving women an opportunity to socialize with their peers, and (2) focus on the person by enhancing a woman's skills in eliciting support from others (Powell 1988).

Forming New Support Groups

Strategies to identify and recruit participants include the following:

- *Self-selection* Ask women to form themselves into small groups, based on their personal preferences. For instance, the Child Health Institute in Haiti set up women's groups by asking one mother to choose one friend, the two women then chose a third, the three women chose a fourth, etc. (Storms 1998). Women who know and trust each other may be more comfortable participating in group

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discussions and more willing to provide assistance to other members. On the other hand, cliques can develop and some community members may feel excluded and rejected.

- *Common characteristics* Recommend group participation to women receiving prenatal care at a health center. Organizing pregnant women into groups provides them with much-needed social support during delivery and infancy. Having children of the same age group could facilitate education regarding the nutritional needs of children of various ages. Mothers with children of the same age may serve as an important reference group as mothers adapt to children's different developmental stages.
- *Recruitment by volunteer leaders* Identify group leaders and ask them to form groups. Volunteer leaders can inspire people to join their groups. These groups are likely to be based in a small geographic area. A study in Honduras found that most volunteer breastfeeding advocates had contact with women who lived within a three-mile radius of their home (Rivera et al. 1993).
- *Nominations by community leaders* Ask community leaders to suggest candidates for group membership. This approach may be subject to favoritism and thus not assist women most in need of support groups.
- *Public promotion* Hold a public event and recruit group members from among the attendees. This strategy opens up group membership to a diverse audience. Finding common ground may be more difficult in such a diverse group.

As indicated, each of these strategies has its advantages and disadvantages.

Group composition is especially important to group dynamics and cohesion. An analysis of women's forestry groups in Kenya found that the heterogeneous groups, in terms of factors such as age, education, income, social status, and motivation, had more difficulties than groups that were relatively homogenous. Group differences led to disunity and confusion (Hyma and Nyamwange 1993).

According to child health specialist Lisa Howard-Grabman (1998), women with one or more of the following characteristics are more likely to join women's groups:

- Familiarity and a positive past experience with the institution that is organizing the group
- Supportive husbands
- Previous leadership positions in community groups
- Adequate funds to afford the risk of joining a peer lending group
- Friends in the group

The following factors discourage women from joining groups (Howard-Grabman 1998):

- Social or geographic isolation (for example, single mothers, landless women, women without husbands)

- Mistaken assumptions that they do not fit the criteria for membership
- Lack of time to attend meetings
- Unsupportive husbands or families
- An inability to recognize the potential benefits of joining a group (partly due to low self-esteem and fatalism)

Some women may not join a support group because they do not like to admit that they need help. Informal gatherings and brief encounters with other women may be more rewarding for them than prearranged meetings with people of uncertain empathy and expertise (Howard-Grabman 1998)

Recruitment of Volunteer Group Leaders

Selection of volunteer group leaders is critical. To establish rapport with group members, group leaders should be socially similar to the target population, it is helpful if they have experienced similar problems or situations. They also need to have empathy for others' problems, and they must be committed to health promotion and respected in their communities (Steel et al. 1991). The most effective group leaders are usually those who are considered *natural helpers*—people in the community that others naturally turn to for advice, support, and other types of assistance. Natural helpers not only provide support directly, but they are also important in linking members to each other and to resources outside the group. Generally, health professionals are not considered to be a useful source of social support due to power differentials and a lack of empathic understanding (Heaney and Israel, 1997).

In the traditional La Leche League model, “women emerge as leaders after being socialized into support group culture” (Rivera et al. 1993, 9). Members of support groups who are identified as potential leaders are taught through an apprenticeship before leading a group on their own. Selection criteria for La Leche League breastfeeding counselors include successful breastfeeding for at least one year's duration, respected in the community, a belief in breastfeeding and desire to share this conviction with others, and a strong desire to help others. Criteria in some of the low-income projects may vary somewhat. For example, in the Honduras project counselors were also required to be 18 years or older. Prospective counselors who meet these criteria are invited to attend a training workshop.

In developing countries, community organizers for breastfeeding programs identify the informal community leaders who are known to provide advice and help, such as lay midwives, traditional healers, grandmothers of large families, and women who run a community kitchen or corner store. The community organizers then spend time with the informal leaders and ask them if they would be willing to promote breastfeeding in their community (Rosenberg and Joya de Suarez 1996).

To establish new support groups, La Leche League of Honduras (La Liga de Lactancia Materna de Honduras) invited prospective group leaders to attend pretraining meetings. During these meetings, staff identified promising candidates—those who seemed active, inquisitive, self-confident, enthusiastic, and friendly, and had previous experience in community work or counseling. About half the women attending a pretraining were invited to attend the training course for counselors (Rosenberg and Joya de Suarez 1996). Of the 125 women who participated in pretraining sessions, 68 women were invited to attend the

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training course, and 41 women actually attended the course and became certified as lactation counselors. After the project had been operating for about six months, new leaders began to emerge from the support groups. This method of recruitment was more efficient: 79 percent of the women recruited from breastfeeding support groups were certified, compared with 15 percent of those entering from a pretraining meeting or community group (Rivera et al. 1993). This example shows that recruiting volunteer leaders from within the organization can be generally more effective than community-wide recruitment efforts.

Training Group Leaders/Facilitators

According to support group experts Judith Rosenberg and Maria Joya de Suarez (1996), group leaders and facilitators need training in two major areas: (1) group facilitation skills and (2) content areas relevant to the group's goals.

Trainers of support group leaders see their task as helping trainees "bring their knowledge to the surface, by treating the participants respectfully and helping them to feel safe enough to talk openly about their own experiences" (Rosenberg and Joya de Suarez 1996, 3-2). They recommend that training include participatory discussions, practical demonstrations, and on-the-job supervision. Written materials should be written in simple language. Visual aids and videotaping of practice sessions are helpful.

Before conducting training courses, trainers should assess the knowledge and experience of trainees (Rosenberg and Joya de Suarez, 1996, Steel et al. 1991). The Breastfeeding Advocates Project in Honduras and Guatemala determines the training needs of counselors by giving them a pretest. Results of the pretest are used to adapt the training curriculum (Steel et al. 1991).

Breastfeeding organizations honor trainees at a special ceremony or community event upon completion of the training workshop. Each trainee receives a diploma that can be laminated and hung outside her house to advertise her expertise.

Program Management Issues

Coverage

The major unanswered question regarding mother support groups as an intervention for health care seeking is this—Can enough groups be formed to effect widespread behavior change at the community level? Because of the small size of groups, large numbers of groups would need to be formed to reach a critical mass of mothers of at-risk children, depending upon the extent to which group members advise and assist nongroup members in the community

A study from Honduras illustrates this problem. La Leche League of Honduras recruited 49 volunteers to serve as breastfeeding counselors. During a one-year period (1991), the counselors formed 12 support groups, with a total of 1,067 participants. The volunteers also provided informal, individual counseling to more than 6,000 women during the same period. Thus, each volunteer counseled an average of 19 mothers per month. Each volunteer made an average of 1.9 referrals monthly to health providers. 32 percent of the referrals were for prenatal care, 26 percent for family planning, 15 percent for immunization, and 12 percent for diarrheal treatment. Only 12 percent of the mothers of children under 1 year of age had any contact with the volunteer breastfeeding counselors and only 7 percent attended a support group meeting (Rivera et al. 1993). From this example, it is clear that additional resources are needed to expand coverage by training more volunteers or providing payments or other incentives to encourage breastfeeding counselors to spend more time organizing groups and counseling mothers.

Coverage rates were higher in the communities served by La Leche League Guatemala. The 1996 community survey, conducted three years after the externally funded project had ended, found that 26 percent of the women who were pregnant or had a child under 6 months old had been in contact with a volunteer breastfeeding counselor and 8 percent had attended a support group meeting. Among mothers with a child aged 6–23 months, 28 percent had been in contact with a volunteer breastfeeding counselor and 8 percent had attended a support group meeting. The study estimates that this coverage was achieved with a ratio of one counselor to every 45 women of child-bearing age (de Maza et al. 1997).

In Bolivia, a 1986 project that used existing mothers' clubs to teach rural mothers about oral rehydration therapy achieved high levels of coverage: two-thirds of the mothers' club members received face-to-face instruction in diarrhea management and one-third of the members gave the same instructions to nonmembers. About half of the members who received ORT instruction reported that they had instructed a nonmember in a diarrhea care (Aguilar, Schaeffer, and Spain 1988).

These three studies were the only ones to report coverage rates linked to mothers support groups. They leave several important questions remain unanswered:

- Do mothers in the support groups spread information to other mothers in the community who are not “covered” by the counselors (the so-called *ripple effect*)?
- Will the addition of more counselors or members substantially increase coverage? Beyond the issue of coverage, do mother support groups generate other beneficial effects, such as changes in government or hospital practices and policies?

Sustainability

Many features of women's support groups promote programmatic and financial sustainability: they are community-based, have low recurrent costs, rely largely on volunteer labor, meet the expressed needs of beneficiaries, and motivate members to maintain a high level of involvement. Once established, many support groups can function with minimal external inputs. In Guatemala, the structure of the La Leche League mutual support system is given credit for being a key factor in the sustainability of the program (de Maza et al. 1997). However, breastfeeding expert Judy Canahuati (1998) believes that the members themselves hold the key to long-term viability: "Sustainability comes from the group experience itself."

The more complicated issue is this—What external resources are needed to engage women's support groups as active partners in health and other development programs? To date, little information is available on the costs and impact of support groups on behaviors related to child survival. The relative costs of volunteer-led interventions and those organized by paid staff have not been examined. Accordingly, it is difficult to know whether women's support groups offer a low-cost, self-sustaining way to reach mothers, or whether additional tasks promulgated by external sources threaten the allegiance of volunteer leaders and members.

Retaining Volunteers

The major challenge to support group leaders is to maintain the active participation of volunteer leaders and members. In low-income populations, the turnover of volunteers and members is especially high because of the demands of paid employment, time constraints, and residential mobility. The high turnover makes it difficult to maintain program continuity. La Leche League of Honduras reported that nine months after training, between 30 and 40 percent of the certified breastfeeding counselors were still holding group meetings. The proportion of counselors who are still providing individual counseling is higher, between 35 and 50 percent after nine months (Rivera et al. 1993). Faced with the loss of half of the new trainees within a year and unable to recruit replacements, La Leche League of Honduras offered its existing volunteers a small payment (about U.S. \$4) per meeting to organize additional groups, as long as they continued to meet with their original group as a volunteer (Rivera et al. 1993).

Providing volunteers with positive reinforcement through praise and recognition can help keep them motivated. An assessment of La Leche League Guatemala pointed out that breastfeeding counselors need "ongoing nurturing through positive feedback, demonstrated interest, support, guidance, and incentives" (de Maza et al. 1997, 32). The League provides monthly mini-workshops, community-level refresher courses, and an annual workshop for the counselors, thus updating the volunteers' knowledge about breastfeeding, promoting cohesion, and generating enthusiasm.

Another way to prevent volunteer burn-out may be to rotate volunteers or have two or more volunteers share responsibility so that the burden on any individual is lessened (Galloway, 1998).

Participatory Methodologies

Working with women's support groups requires a major change in the way that health communication programs disseminate messages and interact with intended beneficiaries. Most health programs rely

largely on didactic methods to transmit information, whether by mass media, health workers, formal classes, or other modes. The assumption is that once people know about optimal health-related behaviors they will make an effort to adopt them. Little effort has been made to understand psychological, social, and cultural barriers to action. These barriers may be especially salient to low-income women, who often lead narrowly circumscribed lives.

Didactic approaches are not well-suited to the self-empowering, problem-solving orientation of many women's groups nor to the free-wheeling discussions characteristic of support groups. Suzanne Kindervatter, a women's education specialist, gives the rationale for using participatory methods for women (Kindervatter 1990, 9)

In many cultures, traditional roles and responsibilities isolate women, giving them an inaccurately limited view of their potential and self-worth. Participatory methods, which catalyze dialogue within groups of women and involve them in "learning by doing," provide a means for women to gain a different perspective of themselves, their relationships with one another, and their options for taking action to improve their circumstances. In the OEF's [Overseas Education Fund] experience, this sense of personal efficacy and group support is the foundation on which new knowledge and skills can be built. When women are provided the opportunity to appreciate their strengths and to realize they share common problems with other women, they are more likely to participate in development activities.

Simply telling women what to do reinforces the cultural view of women as passive and powerless. Similarly, support groups are organized around the premise that people arrive at a decision to change their behavior after a lengthy consultation process with their peers and other members of their social network. Thus, the emphasis on a support group is on sharing experiences and discussing alternative solutions to problems. Support groups convey knowledge based on experience rather than facts conveyed by professionals.

Researchers who have studied support groups in the United States differentiate between experiential knowledge (information and wisdom gained from lived experience), lay knowledge learned from everyday sources, and professional knowledge (Schubert and Borkman, 1994, 228). Experiential knowledge is a major facet of the support group experience. A study of a parents' self-help group in a suburban area of Virginia found that the parents with gifted or learning disabled children valued experiential knowledge just as much as knowledge of professionals, such as psychiatrists and experts in learning disabilities. When asked whom they would turn to for assistance with a problematic situation, group members chose experienced parents in 42 percent of the hypothetical situations, professionals in 41 percent of the situations, and generalists, such as school personnel, friends, and family, in 18 percent of the situations.

Group members distrusted professionals and did not allow them to have a leadership role in the group. They invited professionals to give presentations at the group's monthly meetings and then questioned them closely and discussed intensively the information presented. Most of the group's experiential knowledge was transmitted as personal stories or narratives. To the outsider, these exchanges may resemble everyday conversation, but to group members they provided useful information and much-needed emotional support. Gaining the experiential knowledge helped some members of the group to relate effectively with professionals and take a more active role in decisions regarding educational placements (Schubert and Borkman, 1994).

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Robert Wuthnow (1994, 3) describes the evolution of the experiential learning approach in the development of support groups in the United States

The new groups often drew explicitly on ideas from the 1960s about group dynamics and group process, and they paid special attention to mutual interaction rather than following the earlier didactic models. They often borrowed heavily from the emerging literature on expressiveness, thus taking as an end in itself the goal of giving members a chance to express themselves and discover new insights through group discussions. Medical and therapeutic models increasingly influenced the thinking of group leaders and members and encouraged them to believe that greater self-awareness, healing, and the realization of deeper life goals could be nurtured by talking about themselves. There was thus a new epistemology: knowledge was not something that already existed, needing to be transmitted to an audience of learners by someone in authority, it was something to be generated by the group itself through discussing the personal views of its individual members.

An interesting facet of the nondirective approach is that it may provide more positive rewards for support providers and hence aid in volunteer retention. One United States study found that people providing information and advice had more negative reactions when recipients did not heed their advice than those who provided "supportive listening and expressions of empathy and caring" (Heaney and Israel 1997, 189)

Mastering participatory approaches will require major changes in training programs for personnel at all levels. Instead of training staff and volunteers to dispense information and tell people what to do, health agencies need to give more attention to group facilitation skills in pre-service and in-service training. Trainees need to learn skills, such as promoting group decision making, by listening closely and helping people review their options, arrive at a consensus or decision for action, and then develop a practical plan for proceeding (Rosenberg and Joya de Suarez 1996, Vor der Bruegge et al 1995)

Areas for Further Research

The sparseness and limitations of existing studies on women's support groups in developing countries reflect the need for careful research and documentation. Steel adapted the following list of research topics, based on the findings of this review (Steel et al. 1991)

- *Cost-effectiveness analysis* More studies need to assess the relative impact of various interpersonal interventions designed to change behavior. Besides support groups, these interventions include individual counseling, group lectures, and home visits.
- *Message delivery* The use of didactic methods versus group discussion of experiences should be assessed in carefully controlled studies to determine their effectiveness among various audiences and in diverse settings.
- *Cost/benefit studies of volunteers* The relative costs and benefits of programs that rely heavily on volunteers need to be assessed in view of the high turnover of volunteers and the costs associated with training large numbers of volunteers. Would paid staff be more effective?
- *Program expansion* The tradeoffs involved in adding additional topics and activities to a group's mandate merit careful study. What is the maximum number of topics that support groups can handle? What are the most promising venues for child survival initiatives?
- *Evaluation methodologies* Researchers need to develop simple methods for monitoring and evaluating support groups. Indicators, such as meeting attendance, are inadequate measures of program impact. Studies are needed, based on pre- and post-tests in both control and experimental groups.

To undertake such detailed analyses will require much better record keeping and documentation of programs sponsoring support groups and much closer observation of the life course of individual groups.

This review has identified several knowledge gaps that limit the assessment of the effectiveness of women's support groups.

- *Coverage and exposure* More information is needed on the number of support group members, as well as an estimate of their participation in group meetings and activities.
- *Involvement of target audiences* Most support group programs aim to reach underserved populations, but no data are available on whether priority target audiences (for example, mothers of young children) are active members of support groups.
- *Information transfer* Factors, such as knowledge gain, information retention, and the ability to apply general information to a specific situation, are linked to behavioral change.
- *Discussion/sharing* The way that group members discuss an issue and develop strategies to solve a problem could lead to more effective communication interventions.

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- *Behavior change* The ultimate test of the effectiveness of women's support groups is the extent to which members try out new behaviors, adopt them in a sustained manner, and take other supportive actions, such as assisting other women
- *Situational factors* Factors, such as the accessibility and quality of local health services, transportation costs, and opportunity costs, need to be taken into account

Reports on support groups and related programs need to provide adequate details to assess the magnitude and quality of the intervention. Without this information, it is difficult to judge whether the program met its original goals and addressed the needs of the intended beneficiaries.

Conclusions

Unquestionably women's support groups benefit individuals, families, and communities. Whether they can make a measurable impact on child health remains to be seen.

This review found that women's support groups—

- are changing women's perceptions about themselves and motivating them to improve their lives,
- lend social support to the adoption of new behaviors and information-seeking,
- can be adapted to meet the needs of low-income women in remote rural areas and urban slums, and
- are already being used to support child survival programs.

The major uncertainties regarding the efficacy and cost-effectiveness of women's support groups to promote health care seeking behaviors are—

- *Coverage* How many mothers of young children can be reached through support groups or contacts with support group members? Are these mothers reached more efficiently or directly by other channels?
- *Time frame for results* How long does it take to organize support groups and reach a point of readiness to discuss child survival and care seeking? Will donors and implementing agencies allow adequate time for groups to coalesce?
- *Costs* What external inputs are needed? How much do support group programs cost per mother reached or per child receiving health care?
- *Reliance on volunteers* Can programs that rely heavily on volunteers be successful and sustainable in low-income areas?
- *Flexibility of program content* Will support group sponsors, leaders, and members be interested in adding child survival and health care seeking behaviors to their group's mandate?

Given the rapid growth of women's support groups throughout the developing world, many opportunities exist for testing various approaches.

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