"Community-Based Impact-Oriented Child Survival in Huehuetenango, Guatemala"

USAID Child Survival and Health Grants Program
October 1, 2011 – September 30, 2015
Cooperative Agreement No: AID-OAA-A-11-00041

OPERATIONAL RESEARCH ON WOMEN'S EMPOWERMENT

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October 2015

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GLOSSARY

Alcalde – Mayor/village leader

ARI- Acute respiratory infection

Auxiliatura – Mayor's office

CAP – Government health clinic (*Centro de asistencia primaria)*

Care Group - Group of mother peer educators (Care Group Volunteers) who meet to learn how to teach their peers about health and nutrition

Casa Materna – Community-owned maternal birthing center

CBIO – Community-Based Impact-Oriented Methodology (project service platform)

CBIO+CG – Combined methodologies of CBIO and Care Groups

Centro de convergencia – Community center (often a health center)

COCODES – Community Development Committee

Comunicadora - Care Group Volunteer

Community Facilitator- Volunteer community health worker who trains *Comunicadoras*

Community Health Committee – Village committee in charge of overseeing community health

Depo-Provera – Injectable contraceptive

Dueña – Owner/proprietor (female)

Dueño – Owner/proprietor (male)

Educadora –Curamericas Guatemala staff Health Educator who supports Care Groups and provides health education and services in the community

Jefe - Chief/boss (male)

OR- Operational Research

Self-Help Group - Group of neighborhood women who meet twice monthly to be taught by a *Comunicadora* about health and nutrition

SRS – Simple random sampling

Suegra - Mother-in-law

OPERATIONAL RESEARCH ON WOMEN'S EMPOWERMENT – PHASE 1 AND END OF PROJECT (PHASE 2) FINDINGS

EXECUTIVE SUMMARY

Bakcground: The social and familial context of the project is a traditional Maya culture characterized by severe male dominance and gender inequity. Experience from previous Curamericas Global projects in Guatemala and Liberia indicates that the combined CBIO and Care Group methodologies can be instrumental in empowering women and that this empowerment can facilitate improvements in community health. Therefore, operational research was undertaken to understand the effectiveness of the CBIO + Care Group methodology in promoting women's empowerment.

Methods: KPC Surveys and focus group discussions were used to explore six indicators of women's empowerment: active participation by women in community meetings; participation of women in the Care Group training cascade; participation of women in decisions regarding location of the woman's last delivery, the practice (or not) of family planning, and the treatment (or not) of a sick child with symptoms of ARI; and control of the money needed to purchase food for the woman's children. The OR plan called for comparing the results in the 89 Phase 1 communities, who received the project services for four years, October 2011 through Sept 2015 with the results for the 91 Phase 2 communities who received services only for two years, October 2013 through September 2015. Quantitative baselines were established for these indicators in the project's Baseline KPC survey in January 2012, which included 300 mothers of children 0-23 months from 30 Phase 1 communities and 300 from 30 Phase 2 communities, all randomly selected using the standard stratified cluster sampling for USAID KPC surveys. The end-of-Phase 1 quantitative research utilized mini-KPC Surveys administered in September 2013 and February 2014 to two sets of 100 mothers of children 0-23 months living in Phase 1 communities in the three municipalities the project is serving, selected with simple random sampling. The project's final KPC survey, conducted in June 2015, included the same questions on the six indicators. The survey included 300 mothers of children 0-23 months from 30 Phase 1 communities and 300 from 30 Phase 2 communities, all randomly selected using the same standard stratified cluster sampling used for the baseline survey.

Findings: At the end of Phase 1, dramatic and statistically significant increases were noted in women's participation in community meetings, and women's involvement in Care Groups/Self-Help Groups. A smaller but significant increase was detected in women's participation in decision-making regarding place of her most recent delivery and care seeking for a child with symptoms of ARI. No significant change was noted in women's participation in decision-making re: or use of family planning or control of money for purchasing food for her children.

At end of project, dramatic and statistically significant increases from baseline were noted in women's participation in community meetings in both Phases (Phase 1- from 10.0% to 24.3%, p=0.00; Phase 2 – from 10.7% to 28.0%, p=0.00) and in participation in the Care Groups/Self-Help Groups. In both Phase 1 and Phase 2 respondents, a dramatic and significant increase was noted from baseline in the percentage of women who reported that they participated in the decision regarding the practice of family planning: Phase 1- 56.5% to 84.3%, p=0.00; Phase 2 – 55.7% to 83.0%, p=0.00. Smaller but significant increases were noted in participation in decisions regarding location of delivery in Phase 1 respondents and treatment of a child with symptoms of ARI in Phase 2 respondents. No change was noted in either Phase in percentage of women stating that they control the money for purchasing food for their children.

The final KPC also showed that actual use of modern contraceptives in both Phases was effectively unchanged from baseline. Also, though 78.3% of the Phase 1 women and 76.0% of the Phase 2 women interviewed for the final KPC stated that they participated in the decision re: place of their last delivery, only 28.7% in Phase 1 and 13.0% in Phase 2 had delivered their most recent child in a health facility. These discrepancies in decision-making autonomy and the resulting decision made indicate that women were opting to not use modern methods of contraception or to deliver in a health facility. This corroborates the qualitative finding (below) that decision-making participation and autonomy does not necessarily correlate with making a decision to practice a given optimal health behavior. There are other factors at work other than disempowerment that will influence the decision that must be identified and addressed.

In January 2014, 17 focus group discussions about these same indicators were conducted with mothers of under-5 children, men/husbands, Community Health Committees, and mothers-in-law from a total of 12 Phase 1

communities drawn from all three municipalities. Most informants noted improvement in women's power to control and direct their own lives, but still in a context of often-severe traditional male domination that represents a stubborn impediment to women's autonomy. This improvement is manifesting in increased education for women; increased practice of key health-related behaviors; greater female participation in community meetings and activities; increased support for these changes from many husbands and other family members; improved self-confidence and self-esteem among the women; improved mobility for women to allow them to leave the home to participate in community meetings and activities; women's (and men's) greater awareness of women's rights; and a greater sense of ownership of and control of their own bodies, such as choosing their own health services.

Discussion: A key finding is that there is no one "magic bullet" facilitator of this empowerment, but rather a constellation of facilitators at work: 1) the health education work of Curamericas Guatemala through the Care Groups; 2) the teachings of the local Catholic Church; 3) greater formal and informal educational opportunities for women; 4) ability to speak Spanish; 5) women producing their own income through employment or artisanal enterprises; 6) women's ability to negotiate their mobility with accommodating husbands; 7) being given explicit opportunities by community leaders to participate without fear in community meetings and projects; 8) the absence of the husband when away working, allowing the woman to represent him in meetings; and 9) the influence of key individuals who include Curamericas Guatemala staff, Care Group Volunteers, supportive husbands and mothers-in-law, progressive community leaders, and female role models.

But the focus groups also revealed that this progress is far from universal and appears to vary widely from community to community, and from family to family within communities. The main arena of women's empowerment, or lack of it, remains the family unit, particularly the woman's relationship with her husband, and, to a lesser extent, her mother-in-law and her parents. This family context remains one of male control, with its traditional sense of male ownership over women, male economic control over the household, male control of female mobility, and extending in its harshest manifestations to the explicit generation of fear through pathological jealousy and intra-familial violence. This repressive domestic environment instills in women the low self-esteem, fear of failure, feelings of timidity and shame, and lack of interest in affairs outside the home that many women cited as impediments to their empowerment. Women also cited their sense that their many domestic chores prevent them from leaving the house to participate in community affairs or Self Help Groups. Male economic dominance was very explicit – the money he earns is "his", not a family resource. Also, community leaders often impede empowerment by keeping women in the dark about community meetings or discouraging their involvement in community affairs.

The focus groups also corroborated the quantitative findings that show the lack of correlation between self-declared decision-making autonomy and the making of what we would consider correct decisions. The women generally asserted that the decision regarding place of delivery or use of family planning was theirs (or made jointly with their spouse) and that the decision made was their preference, but usually the decision was for a home delivery for its tradition, convenience and family support; or to not practice family planning due to unfounded fears and credence in local myths about its dangers. The decision to not take a child ill with ARI to a health facility was often made due to lack of funds or the expectation of poor or no treatment at the facility.

So it would appear that what is needed is to provide the women with the education and resources necessary to make and execute a more informed decision. Decision-making power without knowledge and wisdom nor the material resources to execute the decision is squandered. This means not only the provision of information and behavior change communication, but also accessible services, such as affordable transportation and affordable user-friendly properly-stocked clinics and Casa Maternas.

Limitations: Limitations include potential loss of meaning in the translation of responses from the Maya languages to Spanish to English; lack of certainty as to the extent of the women's participation in decisions made jointly with their spouse; and lack of experience of the focus group leaders and teams.

Conclusion: To achieve its dual goals of improvements in the health of this population and women's empowerment, the project will need to design interventions and find allies and partners to eliminate the specific barriers identified to women's autonomy, as well as reinforce the facilitators that were identified, including the educational and community mobilization and conscious-raising efforts it already is doing. This must include reaching men and husbands; enlisting community leaders; and empowering women economically with sources of their own income.

1. BACKROUND/RATIONALE

The context of the Community-Based Impact-Oriented Child Survival in Huehuetenango Guatemala project is a traditional Mayan culture characterized by severe male dominance and gender inequity. Experience from previous Curamericas Global projects in Guatemala and Liberia that utilized the combined CBIO and Care Group methodologies (CBIO+CG) indicates that the combined methodologies can be instrumental in empowering women and generating community cohesion and social capital, and that this empowerment and social capital facilitate the improvement of community health. Therefore, the evaluative arm of Child Survival Project's Operational Research (OR) included the following objective:

To understand and quantify the social impact of CBIO+CG and the effectiveness of the CBIO+CG methodology in promoting women's and community empowerment.

Two questions the OR asked regarding this objective were:

1. Does the CBIO+CG methodology produce significant increases in women's participation in community health activities compared to a control/comparison area?
2. Does the CBIO+CG methodology produce significant increases in women's health-related decision-making autonomy compared to a control/comparison area?

To answer these questions, the project utilized the following indicators of women's empowerment:

Table 1 – Indicators of women's empowerment

Women's Empowerment
Decision-Making re: ARI Treatment: Percentage of ARI episodes in children 0-23 months in which either the mother or the mother jointly with another person decided the care-seeking and/or treatment
Decision-Making re: Location of Delivery and Birth Attendant: Percentage of households with children 0-23 months in which either the mother or the mother jointly with another person decided the location and birth attendant of her last delivery
Decision-Making re: Contraception: Percentage of households with children 0-23 months in which either the mother or the mother jointly with her husband/partner decided to use contraception or not, and, if so, the method to be used
Control of Money for Purchasing Food for Children: Percentage of mothers of children 0-23 months who indicate that they do not need to ask for the money needed to buy the food necessary to meet the minimum acceptable feeding practices for infants and young children.
Women's Participation in Community Meetings: Percentage of mothers of 0-23 month old children who report that in the past 3 months they both attended and expressed their opinion at a community meeting
Care Group Activity: Percentage of mothers of children 0-23 months old who report that in the past month they have either been a Care Group volunteer, participated in a Care Group meeting, or have been instructed by a Care Group member

The project's operational research design calls for these indicators to be evaluated both quantitatively, via Knowledge Practice and Coverage (KPC) Surveys, and qualitatively, via focus groups discussions. The OR plan called for comparing the results in the 89 Phase 1 communities, who received the project services for four years, October 2011 through Sept 2015, with the results for the 91 Phase 2 communities, who received services only for two years, October 2013 through September 2015. Identical stratified cluster sample KPC Surveys administered to 300 randomly selected mothers of children 0-23 months in 30 Phase 1 and another 300 in 30 Phase 2 communities of all three municipalities in January 2012 yielded quantitative baseline data for these indicators for the beginning of Phase 1. In September 2013 and February 2014, mini-KPC surveys were conducted in Phase 1 communities in all three municipalities that focused specifically on these empowerment indicators. In June 2015, identical 300-stratified cluster sample KPC Surveys administered in 30 Phase 1 and 30 Phase 2 communities of all three municipalities yielded quantitative final end-of-project data for these same indicators for both Phases. In addition, in January 2014, 17 focus group discussions exploring these same indicators were conducted with

mothers, men/husbands, Community Health Committees, and mothers-in-law from a total of 12 communities drawn from all three municipalities. The results of these quantitative and qualitative investigations follow.

2. QUANTITATIVE INVESTIGATION

2.1 Phase 1 Quantitative Investigation

Methodology

In January 2012, identical Baseline KPC Surveys were administered in 30 Phase 1 and 30 Phase 2 communities of the three project municipalities and yielded quantitative baseline data for all project indicators. The Survey included 299 mothers of children 0-23 months from the 30 Phase 1 communities and 300 mothers of children 0-23 months from the 30 Phase 2 communities, with all mothers and clusters randomly selected using standard stratified cluster sampling. This survey included questions on the six empowerment indicators. Details of the implementation, training of interviewers, quality control measures, and analysis are detailed in the report of these findings. Data was entered into Epi Info 7.1 and frequencies, proportions, confidence intervals, and p-values calculated first with Excel, and then confirmed with Epi-Info 7..

In September 2013 and in February 2014, mini-KPC Surveys of mothers of children aged 0-23 months were conducted in Phase 1 communities of all three municipalities. [A mini-KPC is a KPC Survey that focuses on a very limited number of indicators, and so is relatively brief and quick to administer, usually only 3 to 7 questions, plus a few demographic/locator questions]. The questions asked in both surveys were identical to those of the Baseline KPC Survey, and were those that pertained to the empowerment indicators listed above in Table 1. In addition to investigating other indicators, the September 2013 survey looked at 1) women's contact with Care Groups/Care Group Volunteers; and 2) women's participation in community meetings. A copy of the questionnaire is found in Appendix A. The February 2014 survey focused on 1) women's participation in health related decision-making concerning place of their last delivery, practice of family planning, and care seeking for a child with symptoms of pneumonia/ARI; and 2) women's control of the money they needed to purchase food for their children. A copy of the questionnaire is found in Appendix B.

Following its CBIO methodology, the project keeps vital events registers which record new pregnancies, births, and maternal and U-5 deaths. The birth registers identify and locate the mother was well as the child. These birth registers were utilized to achieve simple random sampling (SRS), which permitted a sample size of 100 randomly selected mothers of children 0-23 months of age; this yielded sufficient power to detect statistically significant differences between baseline results and the results of the mini-CPCs.

The interviewers were project Health Educators (*Educadoras)* who were able to integrate their interviewing into their regular visits to the Phase 1 communities (each *Educadora* covers a territory of 5 to 10 communities which she visits at least twice a month to train and oversee Care Groups and to do routine home visitation, such as for growth monitoring of young children). These *Educadoras* had already been trained in the administration of KPC surveys during the Baseline KPC Survey and had already executed the Baseline KPC as well as several previous mini KPC Surveys. Prior the interview, a Declaration of Informed Consent was read to the women and written consent was obtained (signature or thumb-print of the interviewee). The *Educadoras* were all native speakers of the local Mayan language and so the interviews were conducted in that language – Chuj in San Sebastián Coatán, Akateko in San Miguel Acatán, and Q'anjobal in Santa Eulalia – with the *Educadoras* translating the Spanish questions into the local language, using translations already established for the Baseline KPC Survey.

The results were entered into Excel spreadsheets and coverage of the indicators calculated. Margin of error was calculated in Excel utilizing the following formula:

$$ME = z*sqrt[(pq)/(n/de)]$$

where ME=margin of error, p= proportion detected, q= (1-p), z = 1.96, n = sample size, and de = design error (1.0). WinPepi was utilized to verify confidence intervals and calculate p-values for comparisons.

Findings

Because some women could not be located, fewer than 100 women were interviewed during each survey. The September 2013 survey interviewed a total of 94 women, 26 from San Sebastián Coatán, 33 from San Miguel Acatán, and 35 from Santa Eulalia. The February 2014 survey interviewed 99 women, 26 from San Sebastián Coatán, 33 from San Miguel Acatán, and 40 from Santa Eulalia.

A very high level of self-reported decision-making autonomy was noted, with 85.6% reporting involvement in the decision regarding location of delivery; 63.6% reporting involvement in the decision regarding use (or not) of contraceptives; and 90.4% reporting involvement in the decision regarding treatment of a child with symptoms of pneumonia/ARI (Table 2). A very low level of control of money for purchasing food is noted, only 6.1%. Very high participation/contact with Care Groups in the previous month was noted at 95.7%; and around half the women (47.6%) reported attending and actively expressing their opinion in a community meeting in the 3 months prior to the interview.

Table 2 – Results of Mini-KPC Surveys

Indicator	Num.	Denom.	Pctg.	Confidence Interval
Women's Participation in Community Meetings: Percentage of mothers of 0-23 month old children who report that in the past 3 months they both attended and expressed their opinion at a community meeting	45	94	47.9%	37.8%, 58.0%
Care Group Activity: Percentage of mothers of children 0-23 months old who report that in the past month they have either been a Care Group volunteer, participated in a Care Group meeting, or have been instructed by a Care Group member	90	94	95.7%	91.7%, 99.8%
Decision-Making re: Location of Delivery and Birth Attendant: Percentage of households with children 0-23 months in which either the mother or the mother jointly with another person decided the location and birth attendant of her last delivery	85	99	85.9%	79.0%, 92.7%
Decision-Making re: Contraception: Percentage of households with children 0-23 months in which either the mother or the mother jointly with her husband/partner (or another person) decided to use contraception or not, and, if so, the method to be used	63	99	63.6%	52.7%, 74.5%
Decision-Making re: ARI Treatment: Percentage of ARI episodes in 0-23 month old children in which either the mother or the mother jointly with another person decided the care-seeking and/or treatment	66	73	90.4%	84.6%, 96.2%
Control of Money for Purchasing Food for Children: Percentage of mothers of children 0-23 months who indicate that they do not need to ask for the money needed to buy the food necessary to meet the minimum acceptable feeding practices for infants and young children	6	99	6.1%	1.4%, 10.8%

Dramatic and statistically significant improvements from baseline are noted in women's participation in community meetings (10.0% vs. 47.9%, p=0.00) (Table 3). A high level of contact with the Care Group training cascade is also noted (8.4% vs. 95.7%, p=0.00). Smaller but still significant improvement is seen in women's participation in decision-making regarding place of delivery (68.2% vs. 85.9%, p=0.001) and care-seeking for a child with symptoms of pneumonia (72.7% vs. 90.4%, p=0.006). No significant change was noted in women's participation in decision making re: care contraception or control of money for purchasing food for children. It should be noted that baseline indicators for decision-making participation were already rather high (56.5% to 72.7%).

Table 3 – Baseline vs. End of Phase 1 Indicators for Phase 1 Communities

Indicator	Baseline Phase 1	End of Phase 1	p-value
Women's Participation in Community Meetings: Percentage of mothers of 0-23 month old children who report that in the past 3 months they both attended and expressed their opinion at a community meeting	10.0%	47.9%	0.00
Care Group Activity: Percentage of mothers of children 0-23 months old who report that in the past month they have either been a Care Group volunteer, participated in a Care Group meeting, or have been instructed by a Care Group member	8.4%	95.7%	0.00
Decision-Making re: Location of Delivery and Birth Attendant: Percentage of households with children 0-23 months in which either the mother of the mother jointly with another person decided the location and birth attendant of her last delivery	68.2%	85.9%	0.001
Decision-Making re: Contraception: Percentage of households with children 0-23 months in which either the mother or the mother jointly with her husband/partner (or another person) decided if the couple would practice contraception and, if so, the method to be used	56.5%	63.6%	0.240
Decision-Making re: ARI Treatment: Percentage of ARI episodes in 0-23 months old children in which either the mother or the mother jointly with another person decided the care-seeking and/or treatment	72.7%	90.4%	0.006
Control of Money for Purchasing Food for Children: Percentage of mothers of children 0-23 months who indicate that they do not need to ask for the money needed to buy the food necessary to meet the minimum acceptable feeding practices for infants and young children	12.6%	6.1%	0.112

Limitations

The KPC questionnaire was originally written in English, translated to Guatemalan Spanish, and administered orally in the local Mayan language, hence there may have been losses of comprehension in this process. Also, it cannot be clear to what extent the woman participated in a decision she said was made jointly with her spouse.

Discussion

Extremely encouraging is the large and significant increase in the percentage of women who reported that they attended and expressed their opinion at a community meeting in the previous three months. This is the most unequivocal quantitative evidence detected for an increase in women's empowerment at the end of Phase 1. Given the near complete absence of Care Groups at baseline, achieving a large improvement in Care Group/Self-Help Group contact is not surprising. Nevertheless, the 95.7% contact rate detected indicates very high penetration of the methodology into the community. Evidence of improvement in women's decision-making participation was also strong, though starting from an already relatively high baseline.

The improvements noted in empowerment coincide with end of Phase 1 improvements detected via mini KPC Surveys and project M & E data in coverage of key health indicators, such as antenatal care, health facility deliveries, post-partum care, and complementary feeding. The implication is that the combined methodologies appear to improve both health indicators and empowerment indicators. But how the improvement of health and empowerment correlate and the existence of causal chains remained to be understood, as well as confirming that the improvements in empowerment and solidarity can even be attributed to Curamericas Guatemala and CBIO+CG methodology. Also needed was a better understanding of both the facilitators and impediments to the development of women's empowerment, so facilitators could be strengthened and impediments reduced. For these reasons a qualitative analysis was undertaken utilizing focus group discussions to explore the indicators listed in Table 1 and to better understand the intra- and inter-personal dynamics behind women's ability to participate in community affairs and health-related decision-making (see Qualitative Investigation, below).

2.2 End of Project (Phase 2) Quantitative Investigation

Methodology

In June 2015, identical Final KPC Surveys were administered in 30 Phase 1 and 30 Phase 2 communities of the three project municipalities and yielded quantitative final end-of-project data for all project indicators. The Survey included 300 mothers of children 0-23 months from the 30 Phase 1 communities and 300 mothers of children 0-23 months from the 30 Phase 2 communities, with all mothers and clusters randomly selected using the same standard stratified cluster sampling used for the Baseline KPC Survey. Prior to selection of clusters, the Final KPC sampling frame was modified to include the most-current updated population statistics for each community in the sampling frame, secured from the Guatemalan National Institute for Statistics. This final KPC survey, conducted in June 2015, included the same questions on the six empowerment indicators utilized in the Baseline and mini-KPC Surveys. Details of the implementation, training of interviewers, quality control measures, and analysis are detailed in the report of these findings. Data was entered into Epi Info 7.1 and frequencies, proportions, confidence intervals, and p-values calculated with Epi-Info StatCalc.

Findings

Table 4 below summarizes the Final KPC findings for the empowerment indicators for the informants from Phase 1 and Phase 2 communities:

Table 4 – Results from Final KPC Survey- Phase 1

Indicator	Phase 1				Phase 2			
	Num.	Denom.	Pctg.	95% Confidence Interval	Num.	Denom.	Pctg.	95% Confidence Interval
Women's Participation in Community Meetings: Percentage of mothers of 0-23 month old children who report that in the past 3 months they both attended and expressed their opinion at a community meeting	73	300	24.3%	19.5%, 29.1%	84	300	28.0%	22.9%, 33.1%
Care Group Activity: Percentage of mothers of children 0-23 months old who report that in the past month they have either been a Care Group volunteer, participated in a Care Group meeting, or have been instructed by a Care Group member	203	300	67.7%	62.0%, 72.9%	179	300	59.7%	53.9%, 65.2%
Decision-Making re: Location of Delivery and Birth Attendant: Percentage of households with children 0-23 months in which either the mother or the mother jointly with another person decided the location and birth attendant of her last delivery	235	300	78.3%	73.7%, 82.9%	228	300	76.0%	71.2%, 80.8%
Decision-Making re: Contraception: Percentage of households with children 0-23 months in which either the mother or the mother jointly with her husband/partner decided to use contraception or not, and, if so, the method to be used	253	300	84.3%	80.2%, 88.4%	249	300	83.0%	78.7%, 87.3%
Decision-Making re: ARI Treatment: Percentage of ARI episodes in 0-23 month old children in which either the mother or the mother jointly with another person decided the care-seeking and/or treatment	46	62	74.2%	63.3%, 85.1%	52	58	89.7%	81.9%, 97.5%
Control of Money for Purchasing Food for Children: Percentage of mothers of children 0-23 months who indicate that they do not need to ask for the money needed to buy the food necessary to meet the minimum acceptable feeding practices for infants and young children	35	300	11.7%	8.1%, 15.3%	22	300	7.3%	4.4%, 10.2%

A very high level of self-reported decision-making autonomy is noted, with 78.3% in Phase 1 and 76.0% in Phase 2 reporting making unilaterally or jointly the decision regarding location of delivery; 84.3% in Phase 1 and 83.0% in Phase 2 making the decision regarding use (or not) of contraceptives; and 74.2% in Phase 1 and 89.7% in Phase 2 reporting making the decision regarding treatment of a child with symptoms of pneumonia/ARI. A very low level of control of money for purchasing food is noted in both Phases, 11.7% for Phase 1 and 7.3% for Phase 2.

A high level of contact with Care Groups/Care Group Volunteers in the previous month was noted for both Phases, 67.7% for Phase 1 and 59.7% for Phase 2, though for Phase 1 this had dropped notably from 95.7% for the September 2013 mini-KPC; and around a fourth of the women in both Phases – 24.3% for Phase 1 and 28.0% for Phase 2 -reported attending and actively expressing their opinion in a community meeting in the 3 months prior to the interview. This indicator had also declined notably for Phase 1 from 47.6% for the September 2013 mini-KPC.

Table 5 (below) compares baseline vs. final results for the selected indicators for each Phase and whether the difference detected was statistically significant, as well as comparing final results of the two Phases.

Table 5 – Empowerment Indicators: Baseline KPC vs. Final KPC; Final Phase 1 vs. Final Phase 2

Indicator	Baseline Phase 1 (95% CI)	Final Phase 1 (95% CI)	p value Baseline vs. Final KPC	Baseline Phase 2 (95% CI)	Final Phase 2 (95% CI)	p value Baseline vs. Final KPC	P value- Final Phase 1 vs. Phase 2
Decision-Making re: ARI Treatment: Percentage of ARI episodes in 0-23 months old children in the past two weeks in which either the mother or the mother jointly with another person decided the care-seeking and/or treatment	72.7% (60.5, 84.9)	74.2% (63.3, 85.1)	0.500	76.9% (65.4, 88.4)	89.7% (81.9, 97.5)	0.017	0.000
Decision-Making re: Location of Delivery and Birth Attendant: Percentage of households with children 0-23 months in which either the mother of the mother jointly with another person decided the location and birth attendant of her last delivery	68.2% (61.7, 74.7)	78.3% (73.7, 82.9)	0.003	71.3% (65.0, 77.6)	76.0% (71.2, 80.8)	0.114	0.344
Control of Money for Purchasing Food for Children: Percentage of mothers of children 0-23 months who indicate that they do not need to ask for the money needed to buy the food necessary to meet the minimum acceptable feeding practices for infants and young children	12.6% (7.2, 18.0)	11.7% (8.1, 15.3)	0.430	11.4% (6.3, 16.5)	7.3% (4.4, 10.2)	0.072	0.094
Decision-Making re: Contraception: Percentage of households with children 0-23 months in which either the mother or the mother jointly with her husband/partner (or another person) would practice contraception and, if so, the method to be used.	56.5% (49.6, 63.4)	84.3% (80.2, 88.4)	0.000	55.7% (48.8, 62.6)	83.0% (78.7, 87.3)	0.000	0.539
Women's Participation in Community Meetings: Percentage of mothers of 0-23 month old children who report that in the past 3 months they both attended and expressed their opinion at a community meeting.	10.0% (5.8, 14.2)	24.3% (19.5, 29.1)	0.000	10.7% (6.4, 15.0)	28.0% (22.9, 33.1)	0.000	0.157
Care Group Activity: Percentage of mothers of children 0-23 months old who report that in the past month they have either been a Care Group volunteer (CGV), participated in a Care Group meeting, or have been instructed by a CGV).	8.4% (4.6, 12.2)	67.7% (62.0, 72.9)	0.000	10.3% (6.1, 14.5)	59.7% (53.9, 65.2)	0.000	0.05

Dramatic and statistically significant increases from baseline to final were noted in women's participation in community meetings in both Phases (Phase 1- 10.0% to 24.3%, p=0.00; Phase 2- 10.7% to 28.0%, p=0.00); and in contact with the Care Groups/Care Group Volunteers (Phase 1- 8.4% to 67.7%, p=0.00; Phase 2 - 10.3% to 59.7%, p=0.00).

A dramatic and significant increase was noted from baseline to final in the percentage of women who made or participated in the decision regarding the use of contraception (Phase 1- 56.5% to 84.3%, p=0.00; Phase 2 – 55.7% to 83.0%, p=0.00). Smaller but significant increases were noted in making or participating in decisions regarding location of delivery in Phase 1 (68.2% to 78.3%, p=0.003); and in Phase 2 for treatment of a child with symptoms of ARI (76.9% to 89.7%, p=0.017). No significant change was noted in either Phase in percentage of women stating that they control the money for purchasing food for their children.

Comparing final results of the two Phases, we see significantly higher Care Group contact in the previous month for Phase 1 (67.7% vs. 59.7%, p=0.05); and in Phase 2, despite the shorter intervention, a significantly higher percentage of women reporting making or participating in the decision regarding treatment for a child with symptoms of pneumonia/ARI (89.7% vs. 74.2% for Phase 1, p=0.00). These findings are confirmed by a comparison of the percentage changes from baseline to final for these two indicators, with Care Group contact increasing 705.9% in Phase 1 vs. 479.6% in Phase 2 (p=0.00) and mothers participating in the decision re: treatment of pneumonia/ARI increasing only 2.1% in Phase 1 compared to 16.7% in Phase 2 (p=0.00).

Discussion

The significant increase in the percentage of women who reported that they attended and expressed their opinion at a community meeting in the previous three months continued to be the most unequivocal quantitative evidence detected for an increase in women's empowerment. In this severely male-dominated context, this increase in female participation in community affairs is an important project achievement.

Given the near complete absence of Care Groups at baseline, achieving a large improvement in Care Group contact is not surprising. Unfortunately, the final Phase 1 participation rate was substantially less than that detected in the mini-KPC. In addition, the final Care Group contact rates detected for both Phases fall below the 80% coverage threshold considered the minimal goal for practitioners of the Care Group methodology. Clearly there were impediments to participation at work, which the qualitative investigation has identified (see Qualitative Findings, below).

Though starting from a relatively high baseline for all three indicators, evidence in the Final KPC of improvement in women's health-related decision-making participation was also generally strong, particularly regarding use of contraception. But the improvements noted in decision-making participation did not always coincide with improvements detected by the Survey in coverage of the health behaviors that were the subject of the decisions in question. The implication is that while the combined CBIO+CG methodologies appear to improve both health indicators and empowerment indicators, the empowerment indicators cannot always predict desired behavior changes, which implies the presence of barriers to the desired behavior other than disempowerment.

An ideal example is health facility deliveries, where participation in the decision regarding place of delivery increased significantly from baseline to final in Phase 1, corresponding with a significant baseline to final increase in that Phase in health facility deliveries (from 16.4% to 28.7%, p=0.00). Another example is proper treatment of a child with symptoms of pneumonia/ARI, where in Phase 2 this improved significantly from baseline from 20.5% to 46.6%, corresponding with the significant Phase 2 increase in decision-making participation for that behavior noted above. But the caveat is that while we see these correlations, we cannot infer causality.

Also, there are disconnects that must be noted. Correct treatment of pneumonia/ARI increased dramatically and significantly in Phase 1 (26.0% to 51.6%, p=0.001) though decision-making participation of women in that Phase did not change from baseline. Were the women still deciding as previously, but now more often making the right

decision regarding treatment? An even stronger disconnect is exemplified by use of contraception. The final KPC showed that actual use of modern contraceptives in both Phases was effectively unchanged from baseline to final, even though we noted significant increases in decision-making participation re: contraception in both Phases. Also, though 78.3% of the Phase 1 women and 76.0% of the Phase 2 women interviewed for the final KPC stated that they participated in the decision re: place of their last delivery, only 28.7% in Phase 1 and 13.0% in Phase 2 delivered their most recent child in a health facility. Women were thus opting to not use modern methods of contraception or to deliver in a health facility. This corroborates the qualitative finding (below) that decision-making participation and autonomy does not necessarily correlate with deciding to practice a given optimal health behavior. There are other factors at work that will influence the decision that must be identified and addressed.

Limitations

The KPC questionnaire was originally written in English, translated to Guatemalan Spanish, and administered orally in the local Mayan language, hence there may have been losses of comprehension in this process. Also, it cannot be clear to what extent the woman participated in a decision she said was made jointly with her spouse.

Recommendations

Given the disconnects noted between empowerment indicator results and actual resulting health behaviors, the project must apply qualitative investigations – such as Barrier Analysis – to determine the impediments to the practice of the desired health behaviors that persist despite indications of women having greater decision-making autonomy. In addition, given the caveats identified with decision-making autonomy as an indicator, the project should explore defining and utilizing other indicators of women's empowerment.

3. QUALITATIVE INVESTIGATION

Methodology

Focus groups were the chosen methodology due to their time efficiency in the light of limited available resources and their ability to provide safe venues for the expression of women's opinions in the company of other women. The focus group scripts consisted of questions that addressed the six empowerment indicators listed in Table 1. Additional ice-breaking and probing questions asked about the general situation concerning women's empowerment, if there had been a change in women's empowerment, and if and how Curamericas Guatemala had facilitated that change. Copies of the scripts are found in Appendices C-F.

The goal was to conduct in each of the three municipalities served by the project three focus groups with women, one with men, one with a Health Committee, and one with mothers-in-law. Each municipality represents a unique Mayan language and ethnic group. Seventeen (17) focus groups were conducted in 12 communities: 9 with reproductive age women (one group of which consisted of Care Group Volunteers, or *Comunicadoras*); 3 with married men; 3 with Community Health Committees; and 2 with mothers-in-law (*suegras)*. (We were unable to schedule a focus group with mothers-in-law in San Miguel Acatán). The Committees were groups of mixed gender (Chenen, 7 men and 7 women; Ixlahuitz, 10 men and 1 woman; and Temux Chiquito, 3 men and 2 women). While the number of focus groups was determined by available time and resources, the saturation of themes achieved implies that this was a sufficient number. The distribution of the focus groups is presented in Table 6. The communities were chosen randomly. The women were selected randomly from the rosters of Self-Help Groups, except for one group of women (from Yalanculuz) who consisted of the Care Group volunteers from their community; the men and mothers-in-law were selected purposefully both by convenience and by "snowballing", with women and Health Committees suggesting the men and mothers-in-law. Health Committees for the selected communities were interviewed in their entirety. The focus groups consisted of between 4 and 14 participants, with a median and mode of 7 participants, and took between an hour and an hour and fifteen minutes to conduct. They were held in varying locations that afforded sufficient comfort, convenience, and privacy, and included classrooms in elementary schools, the homes of Community Facilitators and *Comunicadoras,* meeting

rooms at mayor's offices (*Auxiliatura)*, and community centers (*centro de convergencia*). The focus groups took place between January 13 and 17, 2014.

Table 6 – Number and distribution of the focus groups

Community	Municipality	Language/ Ethnicity	Women	Men	Health Committees	Mothers-in-Law
Yalanculuz	San Sebastian Coatán	Chuj	1 (*Comunicadoras)*			
Chenen			1		1	
Calhuitz			1	1		
Lolbatzam						1
Poj Najap	San Miguel Acatán	Akateko	1			
Yucajo			1			
Canton Santa Cecilia			1			
Mete				1		
Ixlahuitz					1	
Buena Vista	Santa Eulalia	Q'anjobal	1			
Temux Chiquito			1		1	
Pena Flor			1	1		
Sataq Na						1
Total FGDs			9	3	3	2

There were three focus group teams, one for each municipality, each consisting of three Curamericas Guatemala staff *Educadoras* who spoke the local Mayan language as her first language, as well as fluent Spanish. One team member was the leader who led the questioning; the second was the recorder who took notes; and the third was the observer and time-keeper. The teams received two trainings in doing focus groups in which the staff had opportunity to practice extensively and try executing different team functions. During the second training they practiced with the scripts to be used in the actual focus groups. Based on their performance during the trainings, the teams were chosen from those who demonstrated the best ability to either lead, record-keep/take notes, and execute the role of observer/time-keeper.

The focus groups were conducted entirely in the local Mayan idiom, Chuj, Akateko, or Q'anjobal. The script had been prepared in Spanish and was translated by the team into the local idiom. After the reading of a declaration of confidentiality, verbal informed consent was obtained from all participants. For lack of equipment and staff time to listen to and transcribe recordings, the focus groups were not recorded. Recorders listened to the discussion conducted in the Mayan language and took notes in Spanish. It was therefore not always possible to record every statement and sometimes paraphrases rather than direct quotes were recorded. The notes were reviewed by the team shortly after the focus group ended to ensure accuracy and that no important statements were missed. The hand-written notes were then digitized into Word documents by a Curamericas Guatemala staff and then, to facilitate coding and analysis, entered via copying and pasting into an Excel file.

The analysis used both Grounded Theory and codification based on identification of specific facilitators and impediments to women's empowerment. Substantive coding was used to identify themes and concepts, and then axial coding to combine them into macro-concepts/themes and to identify associative and possible causal links between themes and concepts. The resulting themes and macro-themes identified are summarized in the Discussion, Table 7, below.

Findings

1. Women's power to control and direct their lives

The focus groups opened with the general question, "Do you believe that in your community women have the power to control and direct their own lives?" Among the women and *Comunicadoras*, the responses were very mixed by community and within several communities. In Yalanculutz, Yucajo, and Buena Vista, the women nearly unanimously opined "yes." In Yalancalutz, whose participants were all *Comunicadoras* (Care Group

volunteers) the women stated that they now have higher self-esteem and value themselves more, depend less on men, and can make their own decisions.

[The women] value themselves and don't depend so much on men anymore. (Woman, Yalanculuz)

[Women] know how to make decisions for themselves now. (Woman, Yalanculuz)

They cited a greater awareness of their rights, their improved physical and mental health, and the income that many now produce for themselves by selling such things as bread, produce, and domestic animals. In addition, they said that now they can freely leave their homes without control by their husband.

When [women] want to leave the house they only have to let their husbands know, not ask permission. (Woman, Yalanculuz)

In Yucajo they stressed their ability to participate in community meetings and affairs, but qualified this by adding that they still did need approval from their partner to participate in activities outside of their community.

If there is an activity in the community I can freely leave the house, but if it is in another place, yes, I ask permission to avoid problems [with my husband]. (Woman, Yucajo)

In Buena Vista, they cited their right to control their own lives and their ability to express their opinions and participate in any community activity. Some stated that what has helped their status is the education they have received about women's rights.

Now we have rights to control our lives, now we can state our opinions, and participate in any activity. (Woman, Buena Vista)

Through talks [on human rights] we have received we have learned to participate and know our rights. (Woman, Buena Vista)

In Calhuitz, the women who answered "yes" cited that they have a right to go where and when they need to go; that they are now more knowledgeable, and can reach understandings with their husbands that permit their participation (though it often still entailed acquiring permission from him). In this vein, some mentioned the contribution of "good communication" with their spouses and reaching agreements with him. For example, as long as they inform their husband of their activities they feel that they can count on his approval.

Because now [women] have more knowledge and only have to reach an agreement with the husband. (Woman, Calhuitz)
They still have to inform him in order to count on receiving his approval. (Woman, Calhuitz)

In Temux Chiquito, those who answered "yes" said they now had achieved the "maturity" to assume more responsibilities, and cited their right to stand up for themselves and express themselves freely.

…because now we have the maturity to take on any responsibility. (Woman, Temux Chiquito)

..because we have rights and we defend ourselves and our free expression. (Woman, Temux Chiquito)

They mentioned the education they have received and seeing the example of other empowered women. In Pena Flor, those who answered "yes" stated "we are free," and attributed their power to the education they'd received and to God; some mentioned being owners (*dueñas)* of their own lives.

Yes, because we are owners [dueñas] of our lives and no one can obligate us to do anything we don't want to do. (Woman, Pena Flor)

But in all the focus groups. there was also much discussion about the lack of women's control of their lives. In Chenen, Poj Najap and Canton Santa Cecilia, the women almost unanimously did not feel that they could control and direct their lives. Some women stated that others who are responsible for them have to make decisions for them, or cited low self-esteem and a lack of will ('voluntad") on their part to assert themselves. In Chenen, many women explained that their husband was in charge of the family and of making decisions for them. They mentioned their responsibilities for caring for their children, their lack of a salary (i.e., their own money), and their fear of generating problems with their spouse should they assert themselves. One mentioned the jealousy of husbands, parents, and mothers-in-law as impediments to their autonomy. Another woman from Yucajo stated that she doesn't participate in activities because her mother-in-law (*suegra)* won't give her permission.

We have to ask permission to leave the house to avoid problems with our husbands.
(Woman, Canton Santa Cecilia)

I don't participate in activities because my mother-in-law [suegra] won't give me permission.
(Woman, Yucajo)

Someone has to make decisions for us, besides, [the husbands] are the ones in charge and responsible for our lives. *(Woman, Pena Flor)*

The husband doesn't permit or approve of leaving the house because of the obligations [the women have for caring for the children and the household.] (Woman, Calhuitz)

Some expressed the fear of failing to expressing themselves well or executing outside responsibilities well and, therefore, the fear of being ridiculed. They cited "verguenza" (shame) as inhibiting them. Others cited discrimination against women and low self-esteem as inhibiting control of their lives.

We are afraid of not doing things well, or not saying things well and that people will ridicule what we say. *(Woman, Temux Chiquito)*

It's shame that takes control of us. (Woman, Temux Chiquito)

There was one dissenting voice in Chenen, and that was a woman whose husband was away working in the US, and so she was able to freely involve herself in activities outside of the household.

In the men's focus groups, opinions varied widely by community and within the focus groups. The men in Mete and Pena Flor generally felt that women did have the power to control and direct their lives because many were now leaders in women's organizations, and because the women had benefitted from projects that had guided them to advance themselves.

Yes, now they participate and are leaders in various women's organizations. (Man, Mete)

Yes, because they have all the right to control their own lives and there exists equality. (Man, Pena Flor)

But the men in Calhuitz and some in Pena Flor felt the opposite for the following reasons: women had been conditioned since childhood to be taken care of; because women must always consult with their husband when making decisions; because they lack employment and the husband is in charge of both earning and spending.

When she has a husband she can't decide or herself, she has to negotiate with the man, because the woman can't support herself, it's the husband who takes responsibility to take care of the expenses. *(Man, Calhuitz)*

They don't have employment, and if it were the opposite it would be different, but in the community

the women don't have an income and for that reason the man rules. *(Man, Calhuitz)*

A surprising opinion expressed by one man was a critique of his own culture:

Indigenous culture in most of the communities hasn't developed completely as in other cultures; for that reason the woman always depends on the man. *(Man, Calhuitz)*

Others stated that the women themselves are at fault.

They themselves impede their opportunities out of shame and fear that they will be rejected. *(Man, Pena Flor)*

When asked what facilitates women's ability to control their lives, some men mentioned women participating in meetings as mothers; others mentioned the Catholic Church, educational talks and trainings, and education/the schools. When asked what impedes women's ability to control their lives, many men cited the influence of men and women's dependency on men, and the marriage vow which declares that the man must maintain and rule over the woman.

It's the influence that the man has over the woman for decisions and the dependence of the woman on him. *(Man, Calhuitz)*

In marriage there is a vow that the man makes to maintain and rule over the woman. (Man, Calhuitz)

The participants in the focus groups with the Community Health Committees – who were mostly men - had widely varying opinions. A few felt that many men respected their wives autonomy.

Yes,, some men respect the decisions that the women make. *(Committee member, Ixlahuitz)*

Some felt that women could control their lives but that it was conditional: only if there was "good communication" and respect within the family, and for that dialogue is needed. Some stated that to achieve this dialogue and support the women still must ask permission.

If she asks permission it will be given to her, but there has to be a dialogue [with the family]. *(Committee member, Temux Chiquito)*

But generally the committee members verbalized the limitations and impediments to female autonomy, particularly the conditions that must be negotiated within the family, especially with the husbands. Most committee members agreed that women could not control their lives because the family does not allow them to participate, and particularly due to their economic dependency on their husband, who sustains the family, and, before their marriage, their dependency on their parents. Many felt women could not control their lives because men intervene in their decisions and many men do not respect women. Women must ask permission and even if they do, they are told "no" by their husband.

What prevents them from controlling their lives is they depend [economically] a lot on their husband, since it is he who supports the family. (*Committee member, Chenen*)

No, men intervene in their [the women's] decisions. *(Committee member, Ixlahuitz).*

Some stated that also impeding the women's ability to control their lives was their inability to speak Spanish well and the responsibility of caring for their children.

No, because they are tied down by their responsibilities with their children. *(Committee member, Chenen)*

The dominant opinion among the mothers-in-law (*suegras*) was that women still did not control their lives. But while the mothers-in-law from Lolbatzam unanimously did not believe that women in their community had the power to control and direct their lives, some Sataq Na mothers-in-law stated that women did now have more control.

> *Before, the woman had no right to education, they hid her away in the chuj (sweat lodge) or in the fields, and would beat her if she left the house…but now it's different…now there is an equality of rights, and young girls study and have [decent] clothing. (Suegra, Sataq Na)*

However, this acknowledgement of increased autonomy was sometimes from a disapproving perspective, lamenting a loss of control of the parents over their daughters.

> *Beforehand, there was more respect in the family because it was the parents who made the decisions – who their daughters would marry – but in the present day women are those who decide who to marry or how to live their life. (Suegra, Sataq Na)*

Impeding this autonomy was fear:

> *They fear their husband, because he'll think that she's saying inappropriate things. (Suegra, Lolbatzam)*

> *They are afraid of the community leaders, since they have to pass judgment on the decisions the women make to make sure they are correct. (Suegra, Lolbatzam)*

The mothers-in-law also noted the fear of intra-familial violence that husbands use to intimidate their wives.

> *If my daughter-in-law left the house to go to any meeting or take on any [community] responsibility, her husband would beat her. (Suegra, Sataq Na)*

> *The women don't say anything because they don't know what to do or where to go to live [were they to leave their husband], and so they have to endure the blows. (Suegra, Sataq Na)*

Behind this violence lurked suspicion and jealousy. One mother-in-law stated that the men feared "licentiousness" (*libertinaje)* on the part of their wives.

> *Many husbands are jealous and there are always going to be problems if [their wives] go to meetings because they are not permitted to walk around alone. (Sataq Na)*

2. Women's participation in community affairs and meetings

All the women's focus groups indicated that in the last three months there had been community meetings to discuss community problems and/or community projects. These included: disposal of garbage, potable water, the Casa Materna, remodeling the elementary school, fixing the roads, improving access to electric lighting, improving child health, the election of the community health committee, and the selection of a Community Facilitator.

When asked if they attended these meetings, the women's response again was very mixed by community and within communities. In Yalanculutz, Poj Najap, Yucajo, Temux Chiquito and Pena Flor, all of the women stated that they participated in the meetings. The reasons cited were: to benefit the community and environment; that it was important to express their opinion to the community leaders for the benefit of their children, to improve their health and education; to understand what was happening in their community; so that their opinions are taken into account in their communities; and to exercise their rights as women.

Yes, in order to express our opinions and see that they are taken into account. (Woman, Yucajo)

To be taken into account [recognized] and thus we practice our rights as women. (Woman, Yucajo)

In the remaining communities (Chenen, Calhuitz, Santa Cecilia, and Buena Vista), some women attended and some did not. The women who attended in Santa Cecilia and Buena Vista cited their responsibility as mothers of young children since the meetings pertained to potable water and election of the Community Health Committee, respectively. In Chenen and Calhuitz, the women who attended meetings stated that their husband was out of town and so she had to represent him as head of the household, as well as report back to him what occurred at the meeting.

…because their husband isn't home and they have to go in order to be able to tell their husband [about the meeting]. (Woman, Calhuitz)

….because when the husband is out of town she [the wife] is then in charge of the family. (Woman, Chenen)

Of those women who did not attend, many cited that it was the husband's, mother-in-law's, or their father's responsibility to go to meetings and then report back to the family what was decided.

Because the husband is in charge of going to the meetings and later he'll tell his wife about what was discussed in the meeting, meanwhile they [the women] take care of their household chores. (Woman, Chenen)

Others expressed a lack of interest in attending; having recently delivered a baby; and for not being informed of the meeting. Many women cited the conflict between household responsibilities and attending community meetings.

Participating in the meeting means not harvesting the cornfield or beans, not shucking and shelling the corn. (Woman, Poj Najap)

When asked what or who facilitated their attendance and active participation in the meetings, the women cited the importance of the encouragement of village leaders, such as the mayors (*alcaldes*), members of the COCODES (Community Development Committee), the Care Group Volunteers (*Comunicadoras*), and of their husbands. Others cited their will/desire ("voluntad") to express themselves, their concern for their children's education and welfare, and their self-esteem.

Those who help us come are the village leaders. (Woman, Calhuitz)

What facilitates is the liberty my husband gives me and the invitation that the leaders give me. (Woman, Pena Flor)

Our desire to participate and make known to those running the meeting the importance of valuing the lives of our children and giving them a better and good education. (Woman, Pena Flor)

When asked what or who impeded their attendance and active participation, women across all the focus groups cited timidity and fear (of ridicule); shame; low self-esteem; not being permitted, as women, to attend, or if permitted to attend, not being permitted to express themselves; not feeling like their contributions were valued by the community; and being prohibited by their husband and/or mother-in-law.

The women themselves [impede their attendance] due to timidity. (Woman, Yalanculuz)

They fear being ridiculed by the others. (Woman, Calhuitz)

When we don't participate it's because of our mothers-in-law. (Woman, Yucajo)

We don't express our opinions because [the leaders of the meeting] don't permit us.
(Woman, Canton Santa Cecilia)

In the focus groups with the men, in all three communities there had been meetings to discuss community problems and projects, which included potable water, street lights, problems of property damage, and the resolution of a community conflict. The men in Mete reported that women always attended these meetings and that the community actually explicitly invited them to express themselves.

Women always participate in the community meetings. (Man, Mete)

Yes, they participate and we ask them to speak. (Man, Mete)

In Calhuitz, the men stated that while some women did attend and express themselves, many did not, and many who did attend did so because their husbands were away and they therefore had to represent him, since it was the husband's role to participate in these meetings.

Because the man wasn't around in the community and the woman took responsibility to attend and then inform her husband what the meetings were about. (Man, Calhuitz)

In Pena Flor, the men stated that women attended but the majority did not express their opinions for shame and fear of being ridiculed. They added that the women are not disposed to speak up in the presence of men at these meetings.

They attend but the majority of them don't share their opinions out of shame that they will ridiculed. (Man, Pena Flor)

They don't express their opinions because don't have the encouragement to speak, even more so when men attend the meetings. (Man, Pena Flor)

The men stated that what facilitates the women's participation is the absence of their husband; being encouraged to speak by the community leaders; and being supported in her participation by her husband. What impedes her participation is her domestic responsibilities, taking care of house and children; and being actually prohibited from attending by her husband.

What facilitates is that community leaders give them the floor and a chance to speak. (Man, Mete)

On many occasions they prohibit women from participating in meetings. (Man, Mete)

It depends, sometimes they don't attend the meetings because of their household chores that they have to do or because of having to take care of their children. (Man, Pena Flor)

Men from all three groups approved of their wife participating in meetings, but for widely different reasons: to represent the husband when he was gone; wanting all community voices to be heard and in agreement on decisions made; and so their wives would benefit and develop by participating, diminishing their shame and fear.

So that the meeting was transparent and that the entire community was in agreement with the results of the meeting. (Man, Mete)

It makes the husbands proud to see their wives participating, and see the fear and shame that inhabits them diminishing. (Man, Pena Flor)

In contrast, other men disapproved of women's attendance, citing their domestic responsibilities.

> *Because it's the man's job to attend the meetings and the woman has obligations in the home and with her children.* *(Man, Calhuitz)*

Among the Community Health Committees, all three focus group communities had had meetings to discuss community problems and projects, which included school improvements, the Casa Materna, and potable water.

According to the committee members, women's participation varied widely from community to community. In Ixlahuitz, the committee members stated that women were actually a majority of those present at the meetings and many expressed their opinions. In Chenen, the committee members said that only about 15% of the people attending were women. Generally, it is men who attend meetings and then bring the news home to their wives. The Temux Chiquito committee stated that while 30 women attended the community meeting, few actively participated, and the few who did were those who had responsibilities related to the Casa Materna. In all three communities, many or most of the women present at the meetings were representing their absent husbands.

> *It was a general community meeting [asamblea] in which the women, yes, gave their opinions and their decisions were respected and the majority of the participants were women.* *(Committee member, Ixlahuitz)*

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> *All the women who came have husbands [working] in the US.* *(Committee member, Chenen)*

Facilitating women's participation was having available time; encouragement from community leaders; and particularly the absence of their husband.

> *What helps them participate is availability of time.* *(Committee member, Chenen)*

> *The [community] leaders who take responsibility for informing the community [about the meeting].* *(Committee member, Chenen)*

According to the committee members, impeding the women's attendance were several factors: it was the role of men to attend the meetings and then communicate to their wives what happened; timidity and shame; and lack of education/studies.

> *Because generally it is the men who attend meetings and then tell their wives what happened.* *(Committee member, Chenen)*

> *Those who don't speak, they do it out of embarrassment and fear.* *(Committee member, Ixlahuitz)*

Some stated that they [the Health Committee] gave the women the opportunity to participate but that the women often do not take advantage of this opportunity. Also impeding the attendance of many women was their lack of interest in community affairs.

> *They aren't interested in knowing about projects and problems in the community.* *(Committee member, Chenen)*

Nevertheless, all three committees acknowledged that both attendance and active participation of women in community meetings had noticeably increased. Women have more awareness of their rights and have achieved a higher level of education, and their increased participation is a benefit for both the women and the community. They emphasized the role of education in facilitating this change, helped along by the opening of more education

centers ("*centros educativos*"). Some noted that the Catholic Church has played a key role, giving talks about leadership and gender equality.

> *Women's participation in this last year has been very active, and now they participate more and express their ideas. (Committee member, Ixlahuitz)*

> *Now that women hear more about women's rights, they have heard it and now put it into practice. (Committee member, Ixlahuitz)*

A female member of the Temux Chiquito committee lamented:

> *Before, no one gave me any education, but with education I have improved my life, I learned to read, and I realized the importance of education, but I couldn't continue studying because my husband prevented me. In some cases there is no change because the woman herself does not allow a change in her life.*

Both communities of the mothers-in-law had had meetings to discuss community problems and projects (e.g., the election of the assistant mayor ("alcalde auxiliary").

The mothers-in-law from Lolbatzam stated that generally women did not participate in the meetings. This was because it was for the husband and mother-in-law to attend the meetings, and if the women attended it would generate problems with their husband. The women who did attend usually were representing their husband or father when they were either away or lacked time to participate. Even in such situations the women still had to consult with her husband or her in-laws. When women did attend they were inhibited by fear, did not express their opinions, and when they did, were often ridiculed.

> *When the husband isn't around, the woman goes to the meeting and accepts the responsibility, But first she has to consult with her husband or mother- and father-in-law to avoid problems. (Suegra, Sataq Na)*

> *The husband is the one who goes to the meetings, and when women go they don't express their opinions they only come to take up seats and they are laughed at for what they say, so many don't go for fear of taking on any responsibility; they don't express their ideas or what they think… (Suegra, Sataq Na)*

However, when asked if they'd approve of their daughters-in-law attending community meetings, some mothers-in-law stated that they would approve so the daughter-in-law could become better informed and know what was going on in the community.

3. Participation in Care Groups and Self-Help Groups

When asked if they participated in a Care Group (*Grupo de cuidado*) or Self-Help Group (*Grupo de autocuidado*), nearly all the women across all the women's focus groups responded in the affirmative, indicating at least a monthly participation. When asked who or what facilitated their participation, many cited key individuals: the Curamericas Guatemala *Educadora* and Community Facilitator; and their Care Group Volunteer, the *Comunicadora,* who leads the Self-Help Group. Many women cited their participation in order to learn more and thus become better mothers to their children. Many also cited the approval and encouragement of their husband importance of "good communication" with their husband and mother-in-law to facilitate their participation, especially about reconciling their attendance with the completion of their household chores, which was cited by many as a condition for their attendance. Some women cited the encouragement of their mother-in-law (*suegra*).

What helps is good communication with the mother-in-law and husband. (Woman, Buena Vista)

[Our husbands] approve because they say they want our community to develop and for the wife to receive education on how to care for themselves and for their children. (Woman, Chenen)

When asked who or what impeded their participation, one of the most commonly cited reasons was their family responsibilities and tasks ("oficios"), and the need to have these all completed in order to have permission from either husband, mother-in-law, or, in some cases, from themselves in order to attend. Some cited sheer lack of time to attend due to caring for their children.

[The husbands] don't approve because they say that [the wives] have many things to do in the house and that they already have knowledge about what was going to be taught. (Woman, Chenen)

To facilitate our participation we do our household chores in order to be able to leave the house. (Woman, Canton Santa Cecilia)

[Our husbands] don't prevent us, but the condition is to have completed all of our household chores. (Woman, Temux Chiquito)

Others cited laziness or lack of interest, attending to sick children or when they themselves are ill, or not being informed of the meeting.

In the focus groups with men, most of the men reported that their wives participated monthly or bi-monthly in a Self-Help Group. What facilitated their participation included their [the husband's] approval and encouragement; and the women's interest in the well-being of their children. Some men mentioned their wives were sometimes unable attend due to family responsibilities.

Many men expressed a patronizing paternalism: it is for the husbands to approve of their wives' participation; as such, they saw themselves as facilitators of the women's attendance. Men in all three groups stated that they gave this approval for the benefit of the health of their wife and children as well as for their own health.

The husband is he who approves of the participation and it's he who supports her in attending any group meeting. (Man, Calhuitz)

Yes, I approve of her participation for the benefit of my wife and children. (Man, Mete)

All three Community Health Committees stated that the women in their community participated regularly – at least monthly – in the Self-Help Groups. Facilitating this participation were distinct individuals, who included community leaders, *Educadoras*, husbands, and mothers-in-law. Also facilitating were the women's own volition/determination to participate, and "good communication" with their husbands and mothers-in-law. But the husband's facilitation often required his explicit permission.

We as husbands give permission to our wives so that they learn more about how to improve the nutrition of our children. (Committee member, Ixlahuitz)

We like it when they participate provided that they ask permission so we know where they go. (Committee member, Ixlahuitz)

Committee members related that husbands and mothers-in-law were also impeding attendance, and often prefer that the woman stays at home and takes care of her domestic responsibilities ("oficios").

[What impedes] are the mothers-in-law [las suegras] who want the women to stay in the home doing their household chores. (Committee member, Chenen)

Also impeding was the woman's own lack of interest or willingness to make herself available; poor communication with husband and/or mother-in-law; and cultural beliefs ("creencias culturales").

In both focus groups of mothers-in-law the participants indicated that their daughters-in-law regularly attended a Self-Help Group and that they approved of their attending. Facilitating the participation of the daughters-in-law were the husbands, via "good communication" and dialogue between couples to negotiate the husband's permission to go, as well as the mother-in-law's permission.

> *[The daughters-in-law] also have to consult with us if they want to leave to go somewhere or participate in an activity. (Suegra, Sataq Na)*

Impeding their attendance was "*machismo"*; fear of gossip; lack of interest; and, if attendance was counter to their husband's will, fear of intra-familial violence and abandonment.

> *Some are beaten by their husbands, and so they don't want to go [to the Self Help Group] because they think that this would be disobeying their husband and so he might abandon her, and she can't support herself alone. (Suegra, Sataq Na)*

While the mothers-in-law approved of the Self Help Groups, they did not seem to associate them with women's improved status or educational level. In fact, one *suegra* noted that when women become educated they think they know everything and think that they don't need the Self-Help Groups, and in reality they are the first have sick or malnourished children.

4. Participation in the decision of the place of their most recent childbirth.

Among the women's focus groups, only in Calhuitz (site of a Casa Materna) and Yalanculuz, did the majority of the women indicate that they gave birth in a Casa Materna or other health facility. One woman in Chenen delivered in a Casa Materna; one in Santa Cecilia delivered in the hospital in Huehuetenango due to an obstetric complication, and two women in Buena Vista delivered in the local Ministry of Health Clinic (CAP). Otherwise, the women indicated that they gave birth in their home.

Overwhelmingly, across communities and regardless of the site of the delivery, the women reported that they participated in the decision, generally in the context of a joint decision-making process with their spouse/partner, though some women stated it was their unilateral decision. Some explicitly cited their right ("derecho") to decide, whatever that decision may be, and specifically their right to make decisions regarding their life and their body. Very few cited not participating in making this decision.

> *Yes, because it is my body, my life. (Woman, Temux Chiquito)*

> *Because they have the right to decide the place that is most appropriate to give birth. (Woman, Chenen)*

Most of the women across communities and regardless of site of delivery indicated that the site was their preference and had explicit reasons for their preference. In Yalaculuz and Calhuitz, where most of the women had a health facility delivery (usually in a Casa Materna), they cited the presence of an emergency transport plan, that it was the best place to receive good professional attention, the presence of sufficient medicines and a skilled staff, and that they ran no risk delivering there.

> *In the hospital they have sufficient medicines and medical supplies. (Woman, Yalanculuz)*

> *The staff of the Casa Materna are more skilled and knowledgeable. (Woman, Calhuitz)*

Women cited a variety of reasons for their preference for a home delivery: in the hospital or clinic they do not speak Spanish, treat them well or provide good care; the *Comadrona* provides good care at home; for economic reasons/to avoid medical bills; not liking to leave the familiarity of their home to go elsewhere; the presence of a chuj (sweat lodge) at their home; the comfort of hot home-cooked food; and the overall convenience of giving birth at home.

> *Because we feel comfortable in our house, we eat well, there is nothing to be ashamed of, there aren't so many expenses as going to other places. (Woman, Temux Chiquito)*
>
> *We are more comfortable in our houses and we eat better. (Woman, Pena Flor)*
>
> *The Comadrona gives us good treatment [in the home]. (Woman, Chenen)*
>
> *In the hospital they don't receive good treatment because they can't speak Spanish well. (Woman, Yalanculuz)*

However a few women who delivered at home stated that it was not their preferred location, feeling that they had no other options.

> *We don't have any other place to go…if we go to the CAP it's no use [meaning they receive poor treatment and care] and we don't have options or the money to go to a private [clinic]. (Woman, Buena Vista)*

Among the men's focus groups, in Pena Flor and Mete the men's youngest children were delivered at home. In Calhuitz, a mix of the Casa Materna and home delivery was reported. The men in all three focus groups indicated that the decision of place of delivery was usually a joint decision of husband and wife (or, a "family decision") in which the woman actively participated.

> *The decision was a decision made between the couple. (Man, Pena Flor)*
>
> *It's the family that decides. (Man, Calhuitz)*

Some men stated that the women have the right to make this decision because it was they who experience the risks and the pains of labor and delivery.

> *Because they also have all the right to contribute her opinion because she is the one suffers. (Man, Pena Flor)*

Most of the men felt that the decision, regardless of place of delivery, be it at home or a health facility, was the preference of their wife. Home delivery was preferred because of the presence of the *Comadrona*, the chuj (sweat-lodge), and home cooking, and for how she was treated in her own home. In contrast, Casa Materna delivery was preferred by the women because of the better care and the attention from trained staff.

> *It's their preference [to deliver at home] because they feel more comfortable in their own homes, and also because of their cooking and the attention they receive. (Man, Pena Flor)*
>
> *It [Casa Materna] was her preference because women get better attention there and the staff who take care of them are well trained. (Man, Calhuitz)*

But some men indicated that often the site of delivery was not the woman's preference. Some men indicated that for their wife the Casa Materna delivery was not their preference, since they were accustomed to deliver at home, but they over-ruled their wife and insisted on the Casa Materna delivery. Other men indicated that it was the

home delivery that was not their wife's preference, that they would have preferred the safety of a health facility, but the husband insisted on a home delivery.

> *[Delivering in the Casa Materna] was not her preference because they are accustomed to give birth in the home.* *(Man, Calhuitz)*

> *[Delivering at home] wasn't her preference because the women want to go to a hospital or clinic [centro de salud] for their own safety.* *(Man, Pena Flor)*

Among the Community Health Committee focus groups, opinions varied widely regarding who made the final decision of place of birth. Some stated that the woman herself decided the place of delivery. Some said it is a joint decision with the husband or with the family.

> *Yes, they decide, but sometimes it's decided by the couple or by the family.*
> *(Committee member, Ixlahuitz)*

> *No, the women don't decide alone, because it's a decision that's made together [with the husband].*
> *(Committee member, Temux Chiquito)*

In cases of obstetric emergency, committee members generally agreed it usually becomes a family decision, with the husband or mother-in-law often making the final call for a health facility delivery regardless of the woman's preference to remain at home.

> *The majority of the women make the decision, but in case of an emergency it's the family that makes the decision.* *(Committee member, Temux Chiquito)*

> *The mother-in-law [suegra] and husband decide, if there is a complication they take her to a clinic or hospital.* *(Committee member, Temux Chiquito)*

But many committee members – particularly in Chenen - stated that the women generally did not make the decision of place of delivery; the husband decided since he is responsible for family expenditures and the lives of his wife and children. For unmarried women, their parents made the decision.

> *No, because it is the husband who is responsible for the expenses and the life of his wife and child.*
> *(Committee member, Chenen)*

Regardless of the decision-maker, the health committee members stated that the women generally preferred to give birth at home due to its comforts.

> *They prefer to give birth in their home because they can bathe in the chuj, and they are given hot food with chiles and something to drink.* *(Committee member, Ixlahuitz)*

Among the mothers-in-law, the daughters-in-law of the Lolbatzam mothers-in-law had had their most recent deliveries either in the Calhuitz Casa Materna or in their home; those of the Sataq Na mothers-in-law had delivered in their homes.

The mothers-in-law stated that the decision of place of delivery was generally made by the daughter-in-law, since she knows best where she feels most comfortable at the time of delivery, though sometimes it is a family decision with the couple and mother-in-law involved. However, one mother-in-law noted that sometimes it's the *Comadrona* who decides the place of delivery, be it at home or in the Casa Materna.

> *Because they [the daughters-in-law] know where they feel most comfortable at the hour of*

Birth. *(Suegra, Lolbatzam)*

In general, it's she who decides where to give birth, even though the family might have something else to say, it's she who has the last word. *(Suegra, Sataq Na)*

Regardless of the place of delivery, the mothers-in-law stated that the decision made was generally the woman's preference. For those who delivered at the Casa Materna, it was because of the better health services; for those who delivered at home it was for feeling secure at home amidst family support.

Because in the Casa Materna they give better service and they are well-trained to look after the señoras properly. *(Suegra, Lolbatzam)*

They feel more comfortable in their home, they are treated better, they eat better and are well taken care of and they bathe in the chuj [traditional sweat lodge]. *(Suegra, Sataq Na)*

But one *suegra* stated that women are ashamed of going elsewhere and for that reason deliver at home. Most of the mothers-in-law agreed that there was no need to go elsewhere (except when there were complications), that home delivery was natural, and it was costly to go elsewhere.

5. Participation in the decision regarding family planning/child spacing and the method to use

In the women's focus groups, many women indicated that they were practicing a method of family planning. Only in Poj Najap, Temux Chiquito and Pena Flor did most of the women indicate that they were not practicing a method of family planning. The methods being used include Depo-Provera (by far the most often cited), LAM, IUD, sterilization, birth control pills, and condoms. Many cited the absence of their husbands (away working, usually in the US) as their "method" of family planning (i.e., their lack of need to practice it).

Regardless of whether or not they were practicing family planning, nearly all the women indicated that they participated in the decision and that this was generally a decision made jointly with their spouse. Many indicated that this should be a joint decision on principle. Some women stated they must be involved in this decision as masters of their own bodies ("dueñas de sus proprios cuerpos"). Some women mentioned that family planning is a right.

…it was a decision done as a couple. *(Woman, Canton Santa Cecilia)*

Yes, I participated in the decision because we have to express our opinions. (Woman, Buena Vista)

Many women indicated that they felt compelled to involve their husbands in the decision to avoid marital problems; some specifically cited the risk of physical abuse from their husbands if they made the decision on their own to practice family planning.

If we practice family planning we have to make our husband aware to avoid problems. (Woman, Yucajo)

If we make the decision alone our husbands get angry and sometimes hit us. (Woman, Pena Flor)

Two women who did not participate in this decision cited shame ("verguenza") and lack of good communication with their husbands as the reasons. One woman mentioned not wanting to use birth control but acceding to the advice of a nurse. Some stated that they would like to practice family planning but their husbands won't permit it.

We want to plan but the husband doesn't want to. (Woman, Buena Vista)

Regardless of the decision to practice or not (or kind of contraception to use), most who participated in the decision stated that the decision made was their preference. Those who elected to use family planning cited the

following reasons: to be able to give better care and nutrition to their existing children; to have a good birth interval; to maintain their own health; and because it was their right to control their bodies.

We want a good spacing of our children and because it's a right that we have. (Woman, Calhuitz)

…in order to dedicate more time to my son and give him better care. (Woman, Calhuitz)

Those who elected not to use family planning cited reasons that included: their body won't accept the "medication" or she feels that it weakens her; it's inconvenient; fear of bad consequences to their health; the absence of their husband or their status as a single woman making it unnecessary; or their body naturally spaces their children every three years.

Many of us don't use it because our husbands are outside of Guatemala. (Woman, Yucajo)

No, because my body is this way, every three years I get pregnant. (Woman, Poj Najap)

No, because my body won't accept medications. (Woman, Calhuitz)

The few for whom the decision made was not their preference cited the opposition of their husband; fear of physical spousal abuse if they practiced FP or questioned their husband's opinion; and acceding to the advice of a health professional.

We want to but our husbands don't and will hit us.
(Woman, Pena Flor)

In the men's focus groups, in Calhuitz all the men indicated that they and their wives were practicing a method of family planning. In Mete and Pena Flor the response was mixed. The methods being used include Depo-Provera, condoms, birth control pills, "natural method" (calendar), and the patch ("yandel"). All of the men indicated that the decision to use or not use family planning and of the type of method was a decision made jointly by the couple with the woman's participation. The men in Mete cited the decision made via dialogue with their wife.

According to the men, the decision made, be it to practice family planning or not, was their wife's preference. For those who practiced it, it was so her child would be well-nourished and so she would better care for her existing children.

Because it's difficult to maintain many children. (Man, Pena Flor)

For those that didn't, because they believed contraceptives to be harmful or a sin.

Family planning methods can cause death or illnesses. (Man, Pena Flor)

It is a great sin against God. (Man, Pena Flor)

In all three Community Health Committees, most of the participants indicated that women were involved in the decision regarding family planning. Some expressed the women's right to participate in this decision as masters/owners ("dueñas") of their own body. But most informants stated that the decision is generally made jointly with the husband. As with other joint decisions, it often depends on "good communication" between the couple to avoid conflicts within the family.

When there is good communication between the couple, the two together decide.
(Committee member, Ixlahuitz)

Couples are involved in the decision in order to avoid conflicts in the family to and reach an accord.
(Committee member, Chenen)

But many committee members felt that it was often the husband who made this decision, feeling himself master/owner ("dueño") of his wife.

Sometimes the man is the one who decides because he believes he is the owner of the woman.
(Committee member, Temux Chiquito)

Some committee members noted that women sometimes make the unilateral decision to use contraceptives secretly, without informing their husbands.

Sometimes they use family planning, but secretly, unknown to their husband.
(Committee member, Ixlahuitz)

Regardless of who decides and how the decision is made, the committee members related that many women prefer not to use family planning out of fear or misconceptions, or because they want many children.

They don't use family planning for lack of trust in those who will be injecting them [with Depo-Provera].
(Committee member, Ixlahuitz)

Women don't use family planning in this community because they don't know much about this subject, or because of machismo, or because she wants to have many children.
(Committee member, Ixlahuitz)

Among the mothers-in-law, some stated that their daughters-in-law were practicing family planning, others stated that they were not. Sometimes this was a decision made by their daughter-in-law, but the mother-in-law advised them; sometimes the decision was made jointly with the husband.

[The daughter-in-law] made the decision, because it's she who uses it [contraception] and needs it.
(Suegra, Lolbatzam)

Opinions were mixed about the woman's right to autonomy in this decision. One stated that women had the right to decide and she advised her daughters and daughter-in-law accordingly. But others noted that while women may have the right to decide for themselves, the reality is different – to decide unilaterally would provoke their husbands.

In the end it's our body and we ourselves decide and this advice I say to my daughters and to my daughter-in-law. *(Suegra, Sataq Na)*

No, they alone can't decide and if they do that they will have problems with their husbands.
(Suegra, Sataq Na)

The mothers-in-law generally believed that the decision ultimately made was the woman's preference. For those who opted to use contraception it was so they could space the births of their children. But one *suegra* noted that the preference of some to not use contraceptives was due to lack of correct knowledge.

There is lacking education about this subject [contraception], because they think that the methods cause illnesses. *(Suegra, Sataq Na)*

6. Participation in the decision regarding care seeking and treatment for a child with symptoms of pneumonia or ARI.

Nearly all of the women across all the women's focus groups indicated that they personally made the decision to seek care for a child with symptoms of pneumonia or ARI (cough, rapid breathing). Only in Pena Flor did some women indicate that the decision to seek care was made jointly with their husbands.

The reasons cited for their making this decision included: fulfilling their responsibility as mothers and housewives to watch over their children's health; to make sure their children would be cured and/or would not die; and for the satisfaction of seeing their children get well. Some indicated that often the decision was theirs by default when their husbands decline to decide or don't preoccupy themselves with their children's health or support their care.

> *I am not going to wait around for my children to die. (Woman, Chenen)*

> *I am the one in charge of caring for my child. (Woman, Calhuitz)*

> *Because women are the only ones who maintain the household, because the husband doesn't concern himself with the children's health and sometimes [the husbands] say that money is more important [than the children's health]. (Woman, Temux Chiquito)*

Though the women made the decision to seek treatment, the treatment sought varied considerably, ranging from seeking help from trained health professionals or paraprofessionals at a Casa Materna, CAP/clinic, or, in severe cases, the hospital in Huehuetenango, to consulting comadronas, pharmacists and traditional healers, to providing home herbal remedies (prepared by themselves or by their mother-in-law or other family member). The remedies received by the children consequently ranged from injectable antibiotics to acetaminophen, Alka Seltzer and other over-the-counter pharmaceuticals to traditional medicinal plants and healing rituals. Many expressed reservations about going to clinics; others stated they would use clinics only if traditional medicines failed.

> *We gave him medicines from the pharmacy, for example Tabcin, mineral water, Sal Andrews. (Woman, Pena Flor)*

> *We go to the clinic because we're not about to let him die. (Woman, Pena Flor)*

> *If he doesn't get better [from home remedies] then we'll take him to the health post. (Woman, Temux Chiquito)*

> *Everyone said to take him to the CAP [public clinic] but in the CAP they don't give medication. (Woman, Buena Vista)*

Some women preferred to seek traditional healers and/or use traditional herbal remedies, often for financial reasons, or to trust in God.

> *Many say that natural medicines cure them and that there is no need to go anywhere. (Woman, Buena Vista)*

> *Many say they don't have money to go anywhere [for treatment]. (Buena Vista)*

Though nearly all the women decided to seek treatment, there was less unanimity expressed about the women's participation in the decision regarding the type of treatment/health care provider sought. Some women stated that they don't know what treatment is best and often the woman's mother or mother-in-law or other family member decided the actual treatment.

Regardless of the treatment given, across the groups, the treatment itself was generally the stated preference of the women. Those who opted for a health professional/clinic expressed satisfaction with the treatment received and getting good quick results in their child's recovery. Many who opted for home treatment cited that they as mother knew best; some expressed that natural medicines work well and that there was no need to seek help elsewhere.

But some women indicated that the home treatment provided was <u>not</u> their preference, for lack of money to either bring the child to a health professional or purchase the necessary medicine.

The treatment wasn't my preference, for lack of money. (Woman, Poj Najap)

All the men in all three focus groups indicated that the last time a child of theirs had symptoms of pneumonia or ARI they and their wives sought treatment for the child. In Calhuitz and Mete the children were taken to health professionals/health facilities; in Pena Flor, treatment was sought with health professionals, at pharmacies, and via home treatment with medicinal plants. Motivating all was concern for the well-being of their child.

If [the child] dies on can't have another rapidly, so it's necessary to cure the child. (Man, Mete)

The men in all three focus groups indicated that regardless of the treatment sought, the decision to seek treatment was either their wife's decision or a joint decision made with her participation. Men in all focus groups said that the women had the right to decide in order to watch over (*velar*) the health of their children; and the men in Pena Flor stated that the couple knows best how to act in this situation.

She participated in the decision because she has the right to decide and look out for the health of her children. (Man, Calhuitz)

Both of us decide because both of us know how our situation is. (Man, Pena Flor)

All the men indicated that the decision made, whatever it was, was their wife's preference, all indicating that the treatment sought, regardless of type, she felt would keep her child healthy and not allow him/her to die.

Most Community Health Committee informants believed the care-seeking decision was a joint decision made by the couple, for reasons of both health and family expenditures, and that it required a discussion between the couple, especially since it concerned family expenses.

Because the two of them talk together in order to see where to go and what to do with the sick child. (Committee member, Temux Chiquito)

The decision has to be made by the couple, for health reasons and because of the expenses. (Committee member Ixlahuitz)

But committee members stated that often the woman makes the decision, sometimes because it is her role as mother – especially when the husband was unconcerned with the child's health - and sometimes because in the absence of her husband she has to defer to a higher authority.

The women make the decision because they are closer to the children and know what is best for them. (Committee member, Chenen)

When [the women] alone decide it's because a father hasn't shown love for his child and for that reason [the women] don't take into consideration what we [men] decide. (Committee member, Ixlahuitz)

Sometimes the husband isn't around and they have to ask the mother-in-law… (Committee member, Temux Chiquito)

Some committee member comments clearly indicated that the assessment of the seriousness of the illness and the state of family finances both factored into the decision-making concerning the kind of treatment to be sought.

When the child doesn't seem gravely ill we give him [home] medicines here in the house. When the child is gravely ill we take him to the public clinic [centro de salud] and when we have some money we take them to a private clinic.
(Committee member, Ixlahuitz)

While some mothers-in-law stated that the daughter-in-law made the decision to seek care and treatment, it being her duty and she being the first to know, others emphasized that they themselves are often involved in the decision.

The mother decides because it is she who immediately realizes the child is sick. (Suegra, Lolbatzam)

No, I, as mother-in-law, see what's going on and look for help when my grandchildren get sick because I am there and spend more time with them. (Suegra, Sataq Na)

Other times the decision requires intra-family communication involving the *suegra* when it involved possibly taking the child to a clinic, in order to weigh the family's options. Often when the child is treated at home for lack of money or expectation of poor treatment at the clinic, the home treatment is not the mother's preference.

No, it wasn't her preference, because we have to talk among ourselves to see if there is enough money, and we don't like to go to the health center [public clinic], they treat us poorly, the staff is really irritable and nasty, they only waste time walking around and chatting… (Suegra, Sataq Na)

7. Needing to ask for permission and for money from their husband/partner in order to purchase food for children, medicine or medical services.

Across nearly all the focus groups with the women, most of the participants indicated that they did need to ask their husband for permission and for the necessary money to purchase food for children or medicines and medical care. Across nearly all the focus groups the reason for this was the husband's control of the family finances due the money resulting from his earnings (i.e., he earned it so it was his money); the woman's lack of her own money/income; and the husband's traditional role as head of household, which includes family financial decision-making and maintaining his wife financially.

Because he is the one who is working and brings money home, for that reason he is in charge of the money since we don't have a salary. (Woman, Chenen)

Because the man has the obligation to give money to his family and administer the money.
(Woman, Calhuitz)

However, many women indicated that they did not have to ask permission or for the money. The most common reason cited was the woman's control of money from her own earnings and enterprise.

We don't have to ask for money because we get money selling eggs, home-raised hens, fruit that's available in the community and what we produce. (Woman, Yalanculuz)

When we have our own business and obtain our own money we help with the expenses and In this way buy things we need. (Woman, Yucajo)

Others cited the sale of bread or tortillas; earning income as a Community Facilitator; selling animals and unspecified crops, and earning some income working for others. Some women indicated not having to ask permission or for money from husbands because the husband was absent, they were single, and/or they were being supported by their parents.

The men in the men's focus groups indicated that their wives did have to ask them for the money and the permission to spend it, citing that men are in charge of family finances and financially supporting their children, and because they earn their money it is theirs, not the couple's. Wives had to ask because they did not work or have any of their own money.

> *She has to ask permission because it is the man in charge of handling money and of maintaining economically his children. (Man, Calhuitz)*
>
> *She has to ask me for money because she doesn't have any of her own. (Man, Mete)*

Some men stated that the women had to ask permission because spending decisions concerned the couple and were not unilateral decisions she alone could make. The men related that wives who did not have to ask for money were generally those who had their own business or their own savings. In other cases, it was because of the mutual confidence the couple had in each other or because the woman knew how to handle money well.

> *She doesn't have to ask me for money because she has her own business. (Man, Calhuitz)*
>
> *She doesn't have to ask for money because of the trust that exists between us. (Man, Pena Flor)*
>
> *No, she doesn't ask for permission because she knows how to handle money very well. (Man, Pena Flor)*

All three Community Health Committees related that women generally had to ask their husbands for permission and for money to purchase food for children, medicine, or medical services. This was because the husband was the one who worked and administered the money, and because of his role as the one responsible for the family. Some noted that though women may obtain their own money, when they marry it is the man who does the earning and the women must devote themselves to taking care of the home.

> *They have to ask permission because it's the husband who is in charge and responsible for the family. (Committee member, Chenen)*
>
> *…because it is the husband who works and administers the money. (Committee member, Chenen)*
>
> *Women can obtain their own money, but when they marry the man obtains the money and the women have to take care of the home [rather than work]. (Committee member, Ixlahuitz)*

Some committee members noted that if the woman made the decision unilaterally and things went poorly with the child or the money she decided to spend was not enough, this would cause her husband to castigate her and provoke family problems.

> *If something bad happened to the child or if the money wasn't sufficient the husband would scold her and from this would arise many problems. (Committee member in Temux Chiquito)*

However, some committee members saw the asking for permission more as dialogue between the couple for good family financial management.

> *Yes [they have to ask permission], why? Because if the money is to be well administered there needs to be dialogue. (Committee member in Temux Chiquito)*

The mothers-in-law also said that generally the women did have to ask permission and for money, because it was the man's role as head of family and breadwinner to control the money.

Yes, she has to ask for money because women are meant to be in the home and the man is meant to work so always the woman depends on the man. *(Suegra, Sataq Na)*

Yes, because the man is the father of the children, and therefore has the obligation to cover the costs for them. *(Suegra, Lolbatzam)*

One mother-in-law explained that if the women did not ask, the husband would assume there was no need and the women would then have the responsibility of raising the needed money herself – in other words, either she asks him for the money, or she has to obtain it herself – there is no practice whereby the women are given a certain sum every month for food, medicines, and other household expenses, to spend as they see fit. The money for each purchase must be explicitly requested and doled out by the husband. Some *suegras* noted that often the husband has no money to give, and so the woman must look for other sources, which sometimes means gleaning crops in the community.

8. Has the situation of women and their ability to control their lives changed in any way? And how?

While the first focus group question was a general ice-breaker about women's ability to control their lives, this question sought to understand specific changes that have occurred with respect to women's empowerment.

All the women in the women's focus groups, with the exception of only one woman in Pena Flor, acknowledged that things had changed for the better. Reasons cited included: greater access to education, and specifically to health education; being given more liberty by their husbands; less maltreatment from their husbands; better health and nutritional care (e.g. food and vitamin supplements and antenatal care were mentioned); greater awareness among women of their rights.

Yes, because before the women had no rights, but as a change now we have our rights. *(Woman, Pena Flor)*

Before they didn't give us any education but now women receive education, and moreover, they give us talks about health in order to take better care of our children. *(Woman, Pena Flor)*

Now women aren't so mistreated by their husbands. *(Woman, Yalanculuz)*

Men give more freedom to women and lessen mistreatment towards women. *(Woman, Calhuitz)*

Others cited greater participation in community meetings and activities where they felt freer to express their opinions, and felt their opinions now were valued; women generally feeling more assertive and less timid/fearful; being more knowledgeable about health and therefore better caretakers of children; and acquiring "new points of view."

The opinions of women now are valued more. *(Woman, Calhuitz)*

Now we aren't afraid to express our opinions. *(Woman, Poj Najap)*

Before only men participated in community meetings, now that's not the case. *(Woman, Canton Santa Cecilia)*

The one dissenting voice opined that nothing had changed, and women were still denied education and maltreated.

Nothing has changed, the life of a woman continues being the same, with no one giving her education and treating her badly. *(Woman, Pena Flor)*

Some women acknowledged that despite the positive changes, fear and discrimination persisted.

> *Before, there hadn't been opportunities for women but nowadays all has now changed, although still there exists the fear of being discriminated against. (Woman, Temux Chiquito)*

The men in all three focus groups agreed that the situation of women had changed for the better in terms of their ability to control their own lives: the women having greater knowledge and better health and a higher level of education; women now are participating more in community meetings and in making community decisions, and are less fearful, not being afraid to speak at community meetings; and many women have been trained to put into action their own activities.

> *Women are now participating in making [community] decisions. (Man, Mete)*

> *Now they don't have that fear that they have or have had. (Man, Mete)*

> *Nowadays they are very well trained to execute well their own activities and projects. (Man, Pena Flor)*

> *Women now have much more knowledge. (Man, Calhuitz)*

All three Community Health Committees agreed that the situation of women had changed for the better. More women are now making their own decisions and initiating their own activities. This has been facilitated by the monthly educational talks given to the women (Care Groups and Self-Help Groups); more education provided by various organizations; and improved communication in the families. Some emphasized the Catholic Church's role in facilitating these changes, but noted that the Church was not educating men enough and for this reason the men are preventing change.

> *Yes, because now [women] are making their own decisions thanks to the various programs that are working with them. (Committee member, Ixlahuitz)*

> *The [Catholic] church has initiated great changes, but since they are not educating the husbands that is impeding this change. (Committee member, Temux Chiquito)*

One dissenting committee member voice did not believe the situation had improved because many in the community would not accept these changes.

All the mothers-in-law agreed that the situation of women had changed and women now had more control over their lives. One *suegra* noted, philosophically, "times change, life changes." Now women can make more decisions about their lives and have more rights. Women get better care during pregnancy, childbirth, and post-partum; and are more knowledgeable about healthcare and can participate in Self-Help Groups.

> *They are supported in going to the Self-Help Groups, something that was prohibited to them before. (Suegra, Lolbatzam)*

> *Women can make decisions about their lives, have rights, there is more cleanliness, they have knowledge about feeding and hygiene. (Suegra, Sataq Na)*

Facilitating this change has been education and talks about health and rights; advice from community leaders; and the role modeling of exemplary women.

> *From the advice the leaders give them, and from the life experiences of women who are examples. (Suegra, Sataq Na)*

9. Has Curamericas Guatemala facilitated this change?

The women's focus groups unanimously agreed that the work of Curamericas Guatemala had facilitated this change for the better in the situation of women. Reasons cited included: the health education provided by the *Educadoras*, Community Facilitators, and Care Group Volunteers (*Comunicadoras*); the opportunity afforded the women in such meetings to speak and express their opinions; the improvement in the health of their children; a lessening of their timidity and fear of participating in meetings, now feeling that their opinions were taken into consideration; and a greater awareness of their rights.

> *They give us the opportunity to speak and participate and express our opinions. (Woman, Poj Najap)*
>
> *All now know their rights and obligations. (Woman, Buena Vista)*
>
> *Yes, if we go to the trainings where we receive education on health and nutrition and this has helped us because we practice and see the change because our children don't get sick and at least we wash our hands, which wasn't so important, but now we try to change our behavior. (Woman, Pena Flor)*
>
> .

The men's focus groups also all agreed that Curamericas Guatemala had facilitated this change through the Casa Materna; the education and health services provided to the women; by bringing women together and encouraging them to speak and participate; and the general community development the organization provides.

> *Curamericas has helped this change through the education that it provides to women. (Man, Calhuitz)*
>
> *[Curamericas helped facilitate the change] through the Casa Materna. (Man, Calhuitz)*
>
> *Yes, because before [the women] didn't have the knowledge of how to take care of their children, but nowadays they are well trained and now they participate [in community affairs]. (Man, Pena Flor)*

All three Community Health Committees concurred that Curamericas Guatemala had facilitated these changes, by means of the educative talks, home visits, the advice provided by the Casa Materna staff, by teaching about the very sensitive subject of family planning (which many men oppose as "killing children"), and in general for its unconditional support. They noted improved health practices at the family level, greater participation of women, whose voices were now heard, and more women in positions of leadership due to Curamericas Guatemala's efforts.

> *Yes, because now there are women presidents [of committees] and Community Facilitators. (Committee member, Ixlahuitz)*
>
> *Yes, in most part because the women participate more and now make their voice heard. (Committee member, Ixlahuitz)*

Both focus groups of mothers-in-law agreed that Curamericas Guatemala had facilitated this change by providing staff who come to educate women about how to care for themselves and their children; providing counsel about exclusive breastfeeding; providing medicines; improving practices of nutrition, hygiene, and care seeking for sick children; and raising community consciousness about the importance of healthcare.

Discussion

The general pattern revealed across all classes of informants and all participating communities is notable improvement in women's power to control and direct their own lives, but still in a context of often-severe traditional male domination that represents a stubborn impediment to women's empowerment. This improvement correlates well with the quantitative evidence of the KPC surveys. The informants state that this improvement is manifesting in increased education for women, increased knowledge and practice of key health-related behaviors,

greater female participation in community meetings and activities, increased support for these changes from husbands and other family members, improved self-confidence and self-esteem, women's (and men's) greater awareness of their rights, and women having a greater sense of ownership of and control of their own bodies.

Across the focus groups, multiple themes emerge about what facilitates and what impedes women's empowerment, presented below in Table 7.

Table 7: Facilitators and Impediments to Women's Empowerment

Facilitating Empowerment	Impeding Empowerment
Self-Esteem and Confidence	
High self-esteem and self-confidence. Little or no fear of expressing oneself in the presence of men or of assuming community responsibilities.	Low self-esteem. Timidity and fear: of speaking in presence of men, of ridicule, of failure, of assuming community responsibilities. Too inhibited by fear to take advantage of opportunities to participate in community meetings.
Education/Spanish Fluency	
Education (both formal and informal). Fluency in Spanish .	Lack of education. Little fluency in Spanish.
Consciousness of Rights and Self-Ownership	
Awareness of her civil and human rights	Lack of awareness of her civil and human rights
Sense of being owner ("dueña) of her own body	No sense of being owner ("dueña") of her body- husband is owner ("dueño) of woman and family
Supportive Relationship with Husband/Family	
General support from husband (and to lesser extent, mother-in-law and/or woman's parents)	Domination by husband (and to lesser extent, mother-in-law and/or woman's parents)
Trust of husband – that woman will comport herself well, remain faithful, handle money and responsibilities well, make sound decisions	Lack of trust of husband – fear that woman will behave irresponsibly, be unfaithful, waste money, make poor decisions
"Good communication" with the husband, ability to negotiate mobility or participation in decisions	Poor or no communication with husband; inability to negotiate mobility and/or decisions
Mobility – ability to leave the household, especially alone, to participate in meetings and community activities, with or without husband's permission	Lack of mobility/ability to leave home – forbidden or requires husband's explicit permission and surveillance, and being accompanied by others
Permission of husband to participate is not needed or easily granted – often only as a formality or just to know the woman's whereabouts.	Permission of husband to participate is not given or given grudgingly or conditionally (e.g., when household chores are done).
No of fear of husband's anger or of intra-familial violence.	Living in fear of angering husband/provoking "problems" or domestic violence.
Ability to participate (at least nominally) in most decisions regarding place of delivery, family planning, and care seeking for sick children. Recognition by family that "mother knows best" regarding care seeking and treatment for sick children or place of delivery	Being ignored or over-ruled by husband and/or mother-in-law in health-related decision-making.
Absence of husband – out of town or away working as migrant labor.	Presence of [unsupportive] husband living in household
Managing Household Responsibilities	
Ability to balance role as participant in community meetings/ activities with traditional role as housewife/mother. Ability to not let household responsibilities impede participation in meetings/activities.	Feeling too burdened by household and childcare responsibilities to leave the home to participate. Acceding to the traditional housekeeping/childcare role that keeps women isolated in the home.
Economic Autonomy	
Producing own income to acquire her own money that she controls.	Economic dependence on husband (and before him, parents). Traditional role of husband as breadwinner; the money he earns is "his" – no sense of joint ownership. Not producing her own income/money that is "hers".

Facilitating Empowerment	Impeding Empowerment
Support of Community Leadership	
Being informed/aware of meetings and community activities. Being invited to attend and given openings to participate and speak freely in community meetings. Being given opportunities to take on responsibilities for community activities.	Not being aware or informed of community activities and meetings. Not being given opportunities to speak up in meetings or take on community responsibilities.
Encouragement of key individuals/institutions: *Educadoras,* Community Facilitators, *Comunicadoras,* supportive husbands and mothers-in-law, community leaders, exemplary women; Curamericas Guatemala, Catholic Church	Opposition of key individuals: husbands, mothers-in-law, parents, repressive community leaders [note: no institutions cited as impediments].

A key finding is that there is no one "magic bullet" facilitator of this empowerment, but rather a constellation of factors at work: 1) the health education work of Curamericas Guatemala through the Care Groups; 2) the teachings of the local Catholic Church; 3) greater educational opportunities for women; 4) ability to speak Spanish; 5) women producing their own income through employment or artisanal enterprises; 6) women's ability to negotiate their rights and mobility with accommodating husbands; 7) being given explicit opportunities by community leaders to participate without fear in community meetings and projects; 8) the absence of the husband when away working, allowing the woman to represent him in meetings; 9) women's ability to juggle their household responsibilities; and 10) the influence of key individuals who include Curamericas Guatemala staff, Care Group Volunteers, supportive husbands and mothers-in-law, progressive community leaders, and female role models.

But the focus group responses also indicate that this progress is far from universal and appears to vary widely from community to community, and from family to family within communities. The responses also indicate clearly that the main arena of women's empowerment, or lack of it, remains the family unit, particularly the woman's relationship with her husband, and, to a lesser extent, her mother-in-law and her parents. This family context remains one of male control, with its traditional sense of male ownership over women, and extending in its harshest manifestations to pathological jealousy and domestic violence. This repressive environment instills in women the low self-esteem, fears of change and failure, feelings of timidity and shame, and lack of interest in affairs outside the home that informants cited as impediments to their empowerment.

Looking at the locus of the family, it is clear that women's empowerment must accompany a change in the man's traditional role of *jefe* ("chief"/"boss") and *dueño* ("owner/manager") of his spouse, and an increasing sense on her part that she is *dueña* of her own body with the accompanying rights and responsibilities. According to all classes of focus group informants, the man/husband himself is the gatekeeper, the key facilitator or impediment to female empowerment. In most cases a woman's freedom to participate fully in community affairs is not something instrincally hers, but rather something granted by those controlling her life, generally her husband.

The focus groups indicate the existence of a gradient of male domination which in turn suggests ways to move the needed change along:

1) Total machistic male familial and economic dominance maintained by fear, jealousy, anger or outright violence, absence of female earnings, and prohibition of female mobility (often accompanied by suspicion and jealousy) to the point where even the asking of male permission may not even tolerated.

2) A "kindler/gentler" paternalistic male dominance in which the woman is permitted mobility and, hence, participation in community meetings/affairs that is conditional on explicit male permission and completion of her

chores, often accompanied by better male understanding of and approval of health and other female-directed education (such as Self-Help Groups) that will benefit his children and family. This may include the "good communication" cited by many participants, which allows the woman to negotiate her mobility/participation in community activities, engage in income generation, and her participation in family decision-making.

3) Men fully understand the value of female education and participation, and so male permission for mobility/participation is not required, or expected only a formality and/or only to know of the woman's whereabouts, and there is "good communication" between the couple equal to equal and complete female participation in health-related decision-making. This unconditional mobility enables the women to a) participate more freely in community meetings/activities and b) engage in her own economic activities which allow her to generate her "own" money - and the further empowerment that these activities may bring in a virtuous cycle of reinforcement.

Clearly any efforts to move from condition #1 to condition #3 must involve the family unit, especially the men/husbands. It is important to note that women whose husbands were away from home (working in US or elsewhere) are freer to participate in community meetings and affairs, often by representing him, and to make independent decisions – the absence of the man seems to by default help empower these women. Note, however, that even in these situations, there still may be a degree of control exerted by the mother-in-law and/or the woman's parents.

The family exists in the social context of the community, and so community actors must also be taken into account. This would include the Community Health Committee and other community leadership who can explicitly inform and invite women to participate in community meetings and help create an atmosphere that diminishes the women's isolation in the home as well as lessens her timidity and fear of failure, ridicule, and speaking her mind in the presence of men. Ideally, the community leadership would include women as well as open-minded men who see the value in facilitating the mobility and participation needed to allow women to help advance the community's social, economic, and health agendas. An institution whose involvement on the community level could be intensified obviously includes Curamericas Guatemala, whose work was consistently cited as facilitating women's empowerment. However, Curamericas' players are almost invariably women, and given the state of male dominance/*machismo* and its disrespect for the opinions and abilities of women, it will likely require men speaking to other men to effect change. Also cited were the talks and teachings of the representatives of Catholic Church, which fostered women's awareness of their rights and the importance of gender equity and respect for women. A more coordinated alliance with the Church may greatly facilitate the needed changes, lending critical spiritual as well as practical support.

The self-expressed empowerment of the *Comunicadoras* in the Yalanculuz women's focus group indicates that women's participation in Care Groups facilitates empowerment. These provide "safe" all-female venues where women can learn that they are capable of executing responsibilities without feeling threatened by the presence of men. This suggests the possibility of "women's committees" as adjuncts to Health Committees and COCODES in which women can feel safe working with other women while demonstrating to the community that women can indeed be trusted to execute community responsibilities. This can then be leveraged into full integration with men. A necessary corollary to this would be providing the women training and support so these women would not be set up for failure.

Control of the money needed to buy food for children and/or medical services still lies emphatically with the husband – he is the breadwinner and it is "his" money to spend as part of his role of both "*jefe*" and "*dueño*" of the family. But when women engage in money-producing enterprises – such as raising and selling produce or animals – this gives them their own money which they can control, obviating the need to ask their husband for money and the permission to spend it. The *Comunicadoras* from Yalanculuz exemplified this economic empowerment, citing their various ways of earning income, though it remains to be determined if being a *Comunicadora* encouraged their enterprise or if they were already economically empowered and therefore disposed to be a *Comunicadora.* Nevertheless, this clearly suggests that fostering female income production not only gives them control of money destined for health and nutritional purposes, but could also foster the skill-building, self-confidence and independence that are hallmarks of empowerment.

On the surface, the area in which the women appear to be most consistently empowered is with respect to health-related decision-making, at least regarding place of delivery, family planning, and care seeking for a sick child. The informants stated that women generally participate actively in these decisions, either unilaterally or in consultation with their partner and/or other family members. Place of birth was generally either the woman's decision or made in concert with husband and family; use of family planning was usually a joint decision made with the spouse; and care seeking for sick children seems generally the woman's decision, since she is closest to the child and "a mother knows best." Few informants cited women being over-ruled by husbands or mothers-in-law. Given that "joint" decisions may or may not involve true collaborative decision-making, the informants were also asked if the decision made was the woman's preference, and generally that also seems to be the case.

When does the woman appear to be over-ruled, or when is the decision made is not her preference? In cases of obstetric emergency, the husband and family or *Comadrona* may insist she go to a Casa Materna or other health facility. Only once in the focus groups did an informant indicate that a woman wanting a health facility delivery might be overruled. The women themselves appear to be an impediment to health facility births with their strong preference for home delivery with its traditional conveniences and family support. Conversely, women desiring to practice family planning are prohibited, sometimes with threats of violence, by their husbands (who may see it as "child killing') and some may even resort to practicing it secretly. This seems to be a clearer case of male domination inhibiting empowered decision-making. In the case of care-seeking for sick children, while some informants preferred to take the child to a health facility, they did not because of the poor care and/or rude treatment expected. Others did not take the child to the preferred private clinic for financial reasons. So these decisions made for home treatment were not their preference. Sometimes mothers-in-law intercede in care seeking decisions to assert their presumed better judgment. Still, despite these examples, decisions concerning place of delivery, family planning, and care seeking for sick children that were not the stated preference of the woman appear to be the exception, not the rule.

That said, we also see that while the woman participated in or made unilaterally the decision, and the decision was generally her preference, it was not always the decision we as public health professionals would want her to make. This is especially true of the decision to have a home delivery, which the women seem to prefer for convenience, tradition, and the presence of home cooking, the chuj, and family support. But note that those who elected unilaterally or jointly with their spouse to deliver at a Casa Materna or other health facility were also satisfied with this decision for the safety and skilled birth attendants available. Many women expressed unfounded fears of the health consequences of contraception and so were satisfied with their decision – made unilaterally or jointly with the husband – to not practice family planning despite the health and financial risks of having too many children. Others were quite satisfied with the decision to practice FP, generally for the sound reasons we advocate. Care seeking for sick children seems to often involve the "right" decision to seek help with a health professional, but just as often women were satisfied with the decision to provide home remedies or consult a traditional healer according to their assessment of the severity of the case weighed against the potential cost in rude treatment and money of using a clinic.

So it would appear that what is needed is to provide the women with the education and resources necessary to make and execute a more informed decision. Decision-making power without knowledge and wisdom nor the material resources to execute the decision is squandered. This means not only the provision of information and behavior change communication, but also accessible services, such as affordable transportation and affordable user-friendly properly-stocked clinics and Casa Maternas.

How family decisions are made and who truly makes them can be very difficult to analyze. A deeper investigation of the decision-making process and its complex dynamics is needed to confirm if this apparent decision-making empowerment is genuine.

Limitations

The informants may not be representative of the population and their class of informants. Because there were six empowerment indicators to inquire about, there were more than the usual number of focus group questions and hence less time than ideal to discuss each question, posing the risk that valuable input was not obtained. As such, the focus groups had elements of a group/structured interview rather than a true focus group that permits more probing questions and more time to elicit other facets of the question. The focus group teams had recently been trained and for many this was their first real attempt at facilitating a focus group. They may not have had the skills to elicit the possible responses or ensure that all participants had their say. For technical and logistical reasons the focus groups were not tape-recorded and so note-takers fluent in the Mayan language being spoken listened in that language but took notes in Spanish, raising the risk of mis-translation or loss of subtleties of meaning. The interview questions explicitly asked what or who either facilitated or impeded specific behavioral indicators of empowerment. Thus, the questions structured the responses and, therefore, directly influenced the coding, which may have inhibited freer discussion among the participants and therefore opportunities for other themes to emerge not explicitly related to facilitators or impediments to the indicators. Finally, "joint" decision-making with the spouse may or may not be truly a decision-making partnership.

Recommendations

- Explore consciousness-raising and educational activities targeting men, utilizing male equivalents of *Educadoras,* Community Facilitators, *and Comunicadoras.*
- Identify and recruit male "positive deviants"/"early adopters" who support women's empowerment and can represent role models and popular opinion leaders.
- Work with Community Health Committees, Micro-regional Committees, COCODES, and other community leaders to see that all women are informed of meetings and make the meetings more open to women's attendance and full participation.
- Provide safe venues for women's leadership skill development – such as committees or sub-committees/work-groups of women to execute tasks and projects - and provide necessary training and skills to facilitate their success.
- Facilitate income-generating activities for women, perhaps through micro-loan programs.
- Develop and strengthen partnerships with the Catholic Church, which appears to be helping disseminate messages facilitating women's rights and empowerment.
- Identify and develop partnerships with organizations with expertise in decreasing domestic partner violence, community conflict resolution, combating machismo, and the development of leadership skills (particularly in women).
- Conduct a follow-up qualitative investigate utilizing focus groups and/or interviews to explore more in depth the subtleties of the family decision-making process.

APPENDIX A

CURAMERICAS GUATEMALA
PROYECTO SUPERVIVENCIA INFANTIL
Huehuetenango, Guatemala
CUESTIONARIO

Encuesta Familiar Dirigida a Madres con Hijos 0 a 23 Meses
Conocimientos, Prácticas y Coberturas sobre el Cuidado de los Niños Entre 0 y 23 Meses

CONSENTIMIENTO

Explicar a la madre: Mi nombre es ___________ y trabajo con Curamericas y el Ministerio de Salud Pública. Estamos realizando una encuesta de salud de niños en el municipio. Su participación de más o menos 45 minutos puede ayudarnos y a su comunidad, y todo lo usted me diga será confidencial. Tiene el derecho para no participar en la encuesta. ¿Puede usted participar en la encuesta?

SI DICE QUE SI → Firma abajo, y seguir con la entrevista
SI DICE QUE NO→ Ir a la próxima casa

Firma (o huella digital) de la madre o encuestada: ____

Fecha:________/________/______________

Datos de la vivienda: ____________ ____________ ________________________
Sector No. vivienda Barrio Cantón ó caserío

IDENTIFICACIÓN	
1. NÚMERO DE FASE (01 o 02)	----------- ------------
2. NÚMERO DE AGRUPAMIENTO (COMUNIDAD) (01 hasta 30)	----------- ------------
3. NÚMERO DE ENTREVISTA (01 hasta 10)	----------- ------------

4.	Fecha de la Entrevista	_____/_____/_____ dd mm aaaa
5.	Nombre del Encuestador	____________________________
6.	Nombre del Supervisor	____________________________
7.	Nombre de la Comunidad	____________________________
8.	Iniciales de la madre	____ ____ ____ ____
9.		___________años

	¿Cuantos años ha cumplido usted?	
10.	Nombre del niño seleccionado para la entrevista **(SI TIENE MÁS DE UN NIÑO EN ESTE GRUPO DE EDAD, ESCOGER AL AZAR UN NIÑO)**	______________________________
11.	Sexo de este niño	☐ Masculino ☐ Femenino
12.	Fecha de nacimiento de este niño	____/____/________ dd mm aaaa
13.	Edad en meses de este niño **(Use 0 si el niño no ha cumplido un mes. Si la madre no recuerda la fecha de nacimiento, use <u>el calendario de eventos</u> para determinar la edad en meses)**	________meses

(Nota a encuestador: Hablaremos solamente de este niño/a durante toda la entrevista.)

(Diga:) Como le mencioné, esta entrevista tiene que ver con su salud y la salud de (NOMBRE DEL NIÑO). Por favor, saque todo documento (tarjetas/carnets/hojas/fichas de salud) que tenga de (NOMBRE DEL NIÑO) -- vacunación, control de citas, crecimiento/peso, entrega de alimentos — y las que corresponden a usted y su embarazo con (NOMBRE DEL NINO). Esto nos ayudará a contestar algunas preguntas.

PARTICIPACIÓN COMUNITARIA

No.	Preguntas	Codificación	Saltos
01.	Durante el mes previo, ¿tuvo usted algún contacto con el Grupo de Cuidado de su comunidad? Si dice "sí," ¿cómo? **No leer las opciones**.	**Marque todas la respuesta que ella menciona:** **A.** No hay Grupo de Cuidado en la comunidad **B.** Hay Grupo de Cuidado, pero no tuvo ningún contacto **C.** La madre es voluntaria del Grupo de Cuidado **D**. La madre es líder del Grupo de Cuidado **E.** Asistió a una reunión del Grupo de Cuidado **F.** Recibió información y/o consejo de una voluntaria del Grupo de Cuidado **X.** No sabe/no recuerda	
02.	Durante los últimos tres meses ¿tuvo la comunidad una reunión que se trató de un problema o proyecto comunitario?	**A.** Si **B.** No--→ **X.** No sabe/no recuerda--------------------→	 **#05** **#05**

03.	¿Asistieron algunas mujeres a la reunión? Y si asistieron, ¿expresaron sus opiniones en la reunión?	**A.** Las mujeres asistieron **y** expresaron sus opiniones **B.** Las mujeres asistieron pero no expresaron sus opiniones **C.** Ninguna mujer asistió-----------------→ **X.** No sabe/no recuerda---------------------------→	**#05** **#05**
04.	¿Asistió usted a la reunión? Y si asistió, ¿expresó sus opiniones en la reunión?	**A.** Asistió **y** expresó sus opiniones **B.** Asistió pero no expresó sus opiniones **C.** No asistió **X.** No sabe/no recuerda	
05.	Durante los últimos tres meses, ¿la comunidad logró algún éxito trabajando juntos?	**A.** Si---→ **B.** No--→ **X.** No sabe/no recuerda-------------------------→	**#06** **#07** **#07**

No.	Preguntas	**Codificación**	Saltos
06.	Si dice, "sí", ¿Qué fue el proyecto o la actividad?	**Marque todas que menciona:** **A.** Instalar y/o reparar la electricidad **B.** Instalar y/o reparar una fuente de agua potable (pozo, tubería de agua Potable, etc.) **C.** Instalar o reparar las letrinas o alcantarilla/drenaje **D.** Mejorar las cosechas **E.** Aumentar los ingresos de dinero **F.** Mejorar la educación y/o el bienestar de los niños **G.** Construir o reparar casas o edificios comunitarios (escuela, clínica, Casa Materna, centro comunitario, etc.) **H.** Construir o mejorar calles, senderos, Caminos, puentes, etc. **I.** Otro____________________________ **X.** No sabe/no recuerda	
07.	En su opinión, ¿cuáles son las necesidades de salud, de la comunidad, más urgentes? (¿Cuáles problemas de salud son los más serios?) **NO LEA LAS OPCIONES - MANTENGA LA PREGUNTA ABIERTA.**	**A.** Neumonía/infecciones respiratorias/tos **B.** Diarrea **C.** Desnutrición/escasez de comida **D.** Partos - falta de atención y no seguros **E.** Falta de atención prenatal y/o postnatal **F.** Emergencias obstétricas **G.** Sarampión **H.** Accidentes **I.** Diabetes	

	Escriba cualquiera respuesta→ que mencionó que no se encuentra en las opciones	**J.** Infartos **K.** Ataques cerebral **L.** Falta de planificación familiar **M.** Falta general de atención médica **N.** Falta de transporte a las entidades de salud **O.** Personal de salud que no, nos respetan **P.** Otro_______________________ Otro_______________________ Otro_______________________ **X.** No sabe	

REVISAR EL CUESTIONARIO

¡Agradezca la colaboración!

Comentarios:____

APPENDIX B

CURAMERICAS GUATEMALA
Huehuetenango, Guatemala
CUESTIONARIO

Encuesta Familiar Dirigida a Madres con Hijos 0 a 23 Meses
Conocimientos, Prácticas y Coberturas sobre el Cuidado de los Niños Entre 0 y 23 Meses

CONSENTIMIENTO

Explicar a la madre: Mi nombre es ___________ y trabajo con Curamericas Guatemala. Estamos realizando una encuesta de salud en el municipio. Su participación de más o menos 45 minutos puede ayudarnos y a su comunidad, y todo lo usted me diga será confidencial. Tiene el derecho para no participar en la encuesta. ¿Puede usted participar en la encuesta?
SI DICE QUE SI → Firma abajo, y seguir con la entrevista
SI DICE QUE NO→ Ir a la próxima casa

Firma (o huella digital) de la madre o encuestada: ____

Fecha:________/________/______________

Datos de la vivienda: ___________ ___________ _____________________
Sector No. vivienda Barrio Cantón ó caserío

IDENTIFICACIÓN	
1. NÚMERO DE FASE (01 o 02)	----------- ------------
2. NÚMERO DE AGRUPAMIENTO (COMUNIDAD) (01 hasta 30)	----------- ------------
3. NÚMERO DE ENTREVISTA (01 hasta 10)	----------- ------------

4.	Fecha de la Entrevista	_____/_____/_____ dd mm aaaa
5.	Nombre del Encuestador	___________________________
6.	Nombre del Supervisor	___________________________
7.	Nombre de la Comunidad	___________________________
8.	Iniciales de la madre	____ ____ ____ ____

9.	¿Cuantos años ha cumplido usted?	___________años
10.	Nombre del niño seleccionado para la entrevista	__________________________

	(SI TIENE MÁS DE UN NIÑO EN ESTE GRUPO DE EDAD, ESCOGER AL AZAR UN NIÑO)	
11.	Sexo de este niño	☐ Masculino ☐ Femenino
12.	Fecha de nacimiento de este niño	____/____/_______ dd mm aaaa
13.	Edad en meses de este niño **(Use 0 si el niño no ha cumplido un mes. Si la madre no recuerda la fecha de nacimiento, use <u>el calendario de eventos</u> para determinar la edad en meses)**	_______meses

(Nota a encuestador: Hablaremos solamente de este niño/a durante toda la entrevista.)

(Diga:) Como le mencioné, esta entrevista tiene que ver con su salud y la salud de (NOMBRE DEL NIÑO). Por favor, saque todo documento (tarjetas/carnets/hojas/fichas de salud) que tenga de (NOMBRE DEL NIÑO) -- vacunación, control de citas, crecimiento/peso, entrega de alimentos — y las que corresponden a usted y su embarazo con (NOMBRE DEL NINO). Esto nos ayudará a contestar algunas preguntas.

No.	Preguntas	Codificación
13.	La último vez que [**NOMBRE DEL NIÑO**] tuvo una enfermedad con tos y/o la respiración dificultosa o rápida, ¿A quién acudió para consejos y tratamiento para [**NOMBRE DEL NIÑO**]?	**Puede marcar varias opciones** **a.** Doctor **b.** Enfermera **c.** Auxiliar de enfermería **d.** Comadrona **e.** F.C./Promotor de salud **g**. Otro _________________ **x.** Nadie -------------------------→**Pregunta #16** **y**. Nunca se enfermó con tos y/o la respiración dificultosa o rápida----------→ **Pregunta #17** **z.** No recuerda-------------------→**Pregunta #17**
14.	¿A los cuántos días de la aparición de la tos con respiración rápida/dificultosa buscó ayuda?	**Marcar una sola opción** **A**. El mismo día **B.** El día siguiente **C**. Dos días siguientes **D**. Tres o más días después **X**. No sabe/no recuerda
15.	¿Cuales remedios/medicinas le dio a **[NOMBRE DEL NIÑO]?** (preguntar si tiene el frasco y si lo tiene, marcar la opción corecta)	**(Puede marcar varias opciones)** **a.** Ningún remedio **b.** Aspirina **c.** Panadol **d.** Antibiótico **x.** Otro___________________________ **z.** No sabe

16.	Cuándo [NOMBRE DEL NIÑO] estuvo con tos y la respiración dificultosa o rápida, ¿quién tomó la decisión final de buscar ayuda o su tratamiento [o de no lo buscar]?	**Marcar una sola opción** **A. La madre** **B. La madre con su marido/pareja** **C. La madre con otra persona** **D. El marido/pareja** **E. Otra persona**
17.	Cuando se nació [**NOMBRE DEL NIÑO**],¿Quién tomó la decisión final del lugar del parto y de quién le atendió?	**Marcar una sola opción** **A. La madre** **B. La madre con su marido/pareja** **C. La madre con otra persona** **D. El marido/pareja** **E. Otra persona** **X. No sabe/no recuerda**
18.	Actualmente, ¿usa usted un método para espaciar sus embarazos (no quedar embarazada)?	**(Marcar una opción solamente)** **a.** Si **b.** No **x.** No se/No hay respuesta
19.	¿Quién tomó la decisión final de usar o no usar un método para prevenir el embarazo, y de cual método usar?	**Marcar una sola opción** **A. La madre** **B. La madre con su marido/pareja** **C. La madre con otra persona** **D. El marido/pareja** **E. Otra persona** **X. No sabe/no recuerda**
20.	Cuándo necesita comprar comida para [**NOMBRE DEL NIÑO**], ¿usted tiene que pedir le dinero a su marido/pareja?	**Marcar una sola opción** **A. Sí** **B. No** **X. No sabe**

¡Agradezca la colaboración!

REVISAR EL CUESTIONARIO

Comentarios:____

____

____

____

Revisado por (Nombre del supervisor):____

Firma del supervisor:____

APPENDIX C

Protocolo – Grupo Focal sobre el Empoderamiento de las Mujeres

Versión #1 – Para las mujeres/madres

Declaración de consentimiento informado

Gracias por participar en este grupo focal. Un grupo focal es una discusión entre personas sobre ciertos temas importantes, para que podamos entender sus opiniones, creencias, desafíos y deseos. El tema de este grupo focal es el empoderamiento de las mujeres – o sea, su poder de controlar o dirigir sus propias vidas, de tomar decisiones acerca de su salud o la salud de sus niños, y de controlar el dinero familiar para la salud y la nutrición. Deseamos entender sus pensamientos y sentimientos acerca de este tema para mejorar nuestro programa de salud comunitaria. Por eso, lo que ustedes nos dicen es muy importante.

Vamos a plantear algunas preguntas sobre este tema, y les pedimos que nos respondan honestamente. No hay respuestas equivocadas; no busquemos algunas respuestas. Lo que importa es su honestidad. Usted puede contestar la pregunta directamente, y también usted puede responder a la respuesta de una otra participante en el grupo.

Hay que enfatizar que todo que ustedes dicen es confidencial, no lo compartiremos con ninguna persona afuera de Curamericas Guatemala sin su consentimiento. Vamos a escribir lo que ustedes dicen, pero no vamos a identificarles por su nombre y el informe del grupo focal estará guardado en un lugar seguro, accesible solamente al equipo de Curamericas Guatemala para el propósito de estudiar y entender sus respuestas para mejorar nuestro trabajo.

Usted tiene la libertad de negarse a responder a cualquiera pregunta. También, usted tiene la libertad de negarse a participar en el grupo focal o salir del grupo focal sin ninguna consecuencia negativa. Nadie va a privarle de ningún servicio si usted decide de no participar.

El grupo focal va a llevar no más de una hora.

¿Entiende usted lo que es este grupo focal y su propósito? ¿Tenemos su consentimiento informado verbal para participar en el grupo focal? Gracias.

Reglas del grupo

Antes de comenzar, vamos a consentir en algunas reglas para el grupo focal:

- Que nos respetemos y nos tratemos con cortesía y dignidad
- Que una sola persona hable a la vez
- Que no nos interrumpamos
- Que levemos la mano para indicar que uno/una quiere tener la palabra
- Que mantengamos la confidencialidad y que no compartamos con nadie lo que se dice en el grupo focal.

[Nota: el líder puede pedir al grupo si tienen otras reglas a agregar]

Preguntas

Vamos a comenzar con algunas preguntas generales sobre el tema del empoderamiento de las mujeres.

1. ¿Cree usted que en su comunidad que las mujeres tienen el poder de controlar o dirigir sus propias vidas? ¿Porque sí, o no?

¿Qué impide su poder de controlar o dirigir su vida?
¿Qué facilita su poder de controlar o dirigir su vida?

Gracias por sus respuestas. Ahora vamos a discutir temas más específicos acerca del tema general del empoderamiento de las mujeres. El primer es la participación de las mujeres en las reuniones comunitarias.

2. ¿La comunidad ha tenido reuniones durante los últimos 3 meses para discutir los problemas de la comunidad o proyectos comunitarios?

¿De qué se trataron las reuniones?

3. ¿Asistió usted a las reuniones? ¿Por qué sí o no?

Si asistió, ¿usted expresó una opinión? ¿Por qué sí o no?
¿Qué o quién le facilitó o aprobó su participación?
¿Qué o quién le impidió o desaprobó su participación?

Gracias por sus respuestas. Ahora vamos a discutir la participación de las mujeres en los grupos de autocuidado.

4. ¿Participa usted en un grupo de autocuidado?

¿Con qué frecuencia?
Si sí, ¿qué o quién facilita su participación?
Si no, o cuando usted no asiste, ¿qué o quién impide su participación?
¿Alguien aprueba o desaprueba su participación?
¿Porque aprueban o desaprueban?
¿Hacen algo para facilitar o impedir su asistencia?

Gracias por sus repuestas. Ahora vamos a discutir la participación de las mujeres en las decisiones familiares sobre la salud.

5. ¿Dónde fue su último parto?

¿Quién decidió el lugar del parto?
¿Usted participó en la decisión? ¿Porque sí o no?
El lugar del parto -¿fue su preferencia o no? ¿Porque?

6. ¿Usted está usando algún método de planificación familiar? ¿Cuál método?

¿Quién decidió usar o no usar la planificación familiar, y si usted está practicándola, cual método usar?
¿Usted participó en la decisión? ¿Porque sí o no?
La decisión - ¿fue su preferencia o no? ¿Porque?

7. La última vez que su niño pequeño se enfermó con neumonía o tos y respiración rápida, ¿buscó tratamiento?

¿Qué tratamiento?
¿Quién decidió el tratamiento (o de no tratar)?
¿Usted participó en la decisión? ¿Porque sí o no?
La decisión - ¿fue su preferencia o no? Si sí, ¿porque? Si no, ¿porque?

Gracias por sus respuestas. Ahora el tema es el control del dinero familiar para conseguir la medicina y los servicios de salud o para comprar la comida para sus niños.

8. Cuando se necesita comprar comida para sus niños, o comprar medicina o servicios de salud, ¿usted tiene que pedir a su marido/pareja permiso y el dinero?
¿Porque sí, o no?

9. La situación de las mujeres, y su capacidad de controlar sus propias vidas, ¿se ha cambiado en alguna manera?
Si hubo un cambio, cuéntame del cambio.
El programa de Curamericas Guatemala - ¿facilitó o provocó este cambio? ¿De qué manera?

10. Para terminar, ¿tiene usted algún otro comentario u opinión a expresar?

¡Gracias por su participación!

APPENDIX D

Protocolo – Grupo Focal sobre el Empoderamiento de las Mujeres

Versión #2 – Para los hombres

Declaración de consentimiento informado

Gracias por participar en este grupo focal. Un grupo focal es una discusión entre personas sobre ciertos temas importantes, para que podamos entender sus opiniones, creencias, desafíos y deseos. El tema de este grupo focal es el empoderamiento de las mujeres – o sea, su poder de controlar o dirigir sus propias vidas, de tomar decisiones acerca de su salud o la salud de sus niños, y de controlar el dinero familiar para la salud y la nutrición. Deseamos entender sus pensamientos y sentimientos acerca de este tema para mejorar nuestro programa de salud comunitaria. Por eso, lo que ustedes nos dicen es muy importante.

Vamos a plantear algunas preguntas sobre este tema, y les pedimos que nos respondan honestamente. No hay respuestas equivocadas; no busquemos algunas respuestas. Lo que importa es su honestidad. Usted puede contestar la pregunta directamente, y también usted puede responder a la respuesta de una otra participante en el grupo.

Hay que enfatizar que todo que ustedes dicen es confidencial, no lo compartiremos con ninguna persona afuera de Curamericas Guatemala sin su consentimiento. Vamos a escribir lo que ustedes dicen, pero no vamos a identificarles por su nombre y el informe del grupo focal estará guardado en un lugar seguro, accesible solamente al equipo de Curamericas Guatemala para el propósito de estudiar y entender sus respuestas para mejorar nuestro trabajo.

Usted tiene la libertad de negarse a responder a cualquiera pregunta. También, usted tiene la libertad de negarse a participar en el grupo focal o salir del grupo focal sin ninguna consecuencia negativa. Nadie va a privarle de ningún servicio si usted decide de no participar.

El grupo focal va a llevar aproximadamente una hora y media.

¿Entiende usted lo que es este grupo focal y su propósito? ¿Tenemos su consentimiento informado verbal para participar en el grupo focal? Gracias.

Reglas del grupo

Antes de comenzar, vamos a consentir en algunas reglas para el grupo focal:

- Que nos respetemos y nos tratemos con cortesía y dignidad
- Que una sola persona hable a la vez
- Que no nos interrumpamos
- Que levemos la mano para indicar que uno/una quiere tener la palabra
- Que mantengamos la confidencialidad y que no compartamos con nadie lo que se dice en el grupo focal

[Nota: el líder puede pedir al grupo si tienen otras reglas a agregar]

Preguntas

Vamos a comenzar con algunas preguntas generales sobre el tema del empoderamiento de las mujeres.

10. ¿Cree usted que en su comunidad que las mujeres tienen el poder de controlar o dirigir sus propias vidas?
¿Porque sí, o no?
¿Qué impide su poder de controlar o dirigir sus vidas?
¿Qué facilita su poder de controlar o dirigir sus vidas?

Gracias por sus respuestas. Ahora vamos a discutir temas más específicos acerca del tema general del empoderamiento de las mujeres. El primer es la participación de las mujeres en reuniones comunitarias.

11. ¿La comunidad ha tenido reuniones durante los últimos 3 meses para discutir los problemas de la comunidad o proyectos comunitarios? ¿De qué se trataron las reuniones?

12. ¿Su esposa/pareja asistió en una reunión y expresó su opinión?

¿Porque sí o no?
¿Qué o quién facilitó que ella asistiera y expresara sus opiniones?
¿Qué o quién impidió que ella asistiera y expresara sus opiniones?
¿Usted aprueba de que su esposa/pareja participe en las reuniones comunitarias?
¿Porque sí o no?

Gracias por sus respuestas. Ahora vamos a discutir la participación de las mujeres en los grupos de autocuidado.

13. ¿Participa su esposa/pareja en un grupo de autocuidado?
¿Con que frecuencia?
Si sí, ¿qué o quién facilita su participación?
Si no, o cuando ella no asiste, ¿qué o quién impide su participación?
¿Alguien aprueba o desaprueba su participación?
¿Usted aprueba su participación?
¿Porque aprueba o desaprueba?

Gracias por sus repuestas. Ahora vamos a discutir la participación de las mujeres en las decisiones familiares sobre la salud.

14. ¿Dónde fue el lugar del nacimiento de su hijo más joven/chiquito?
¿Quién decidió el lugar del parto?
¿Su esposa/pareja participó en la decisión?
¿Porque sí o no?
El lugar del parto -¿fue la preferencia de su esposa/pareja o no?
Si sí, ¿porque? Si no, ¿porque?

15. ¿Su esposa/pareja y usted - están usando ustedes algún método de planificación familiar?
¿Cuál método?
¿Quién decidió usar o no usar la planificación familiar, y decidió cual método?
¿Su esposa/pareja participó en la decisión?

¿Porque sí o no?
La decisión - ¿fue la preferencia de su esposa/pareja?
Si sí, ¿porque? Si no, ¿porque?

16. La última vez que su niño pequeño se enfermó con neumonía o tos y respiración rápida, ustedes buscaron tratamiento?
¿Qué tratamiento?
¿Quién decidió el tratamiento (o de no tratar)?
¿Su esposa/pareja participó en la decisión?
¿Porque sí o no?
La decisión - ¿fue la preferencia de su esposa/pareja o no?
Si sí, ¿porque? Si no, ¿porque?

Gracias por sus respuestas. Ahora el tema es el control del dinero familiar para conseguir la medicina y los servicios de salud o para comprar la comida para sus niños.

17. Cuando se necesita comprar comida para sus niños, or medicina o servicios de salud, ¿su esposa/pareja tiene que pedirle permiso y el dinero?
¿Porque sí, o no?

18. La situación de las mujeres en su comunidad, ¿Ha cambiado en algunamanera?
Si hubo un cambio, cuéntame del cambio.
El programa de Curamericas Guatemala - ¿facilitó o provocó este cambio?
¿De qué manera?

10. Para terminar, ¿tiene usted algún otro comentario u opinión a expresar?

¡Gracias por su participación!

APPENDIX E

Protocolo – Grupo Focal sobre el Empoderamiento de las Mujeres

Versión #3 – Para las comisiones de salud

Declaración de consentimiento informado

Gracias por participar en este grupo focal. Un grupo focal es una discusión entre personas sobre ciertos temas importantes, para que podamos entender sus opiniones, creencias, desafíos y deseos. El tema de este grupo focal es el empoderamiento de las mujeres – o sea, su poder de controlar o dirigir sus propias vidas, de tomar decisiones acerca de su salud o la salud de sus niños, y de controlar el dinero familiar para la salud y la nutrición. Deseamos entender sus pensamientos y sentimientos acerca de este tema para mejorar nuestro programa de salud comunitaria. Por eso, lo que ustedes nos dicen es muy importante.

Vamos a plantear algunas preguntas sobre este tema, y les pedimos que nos respondan honestamente. No hay respuestas equivocadas; no busquemos algunas respuestas. Lo que importa es su honestidad. Usted puede contestar la pregunta directamente, y también usted puede responder a la respuesta de una otra participante en el grupo.

Hay que enfatizar que todo que ustedes dicen es confidencial, no lo compartiremos con ninguna persona afuera de Curamericas Guatemala sin su consentimiento. Vamos a escribir lo que ustedes dicen, pero no vamos a identificarles por su nombre y el informe del grupo focal estará guardado en un lugar seguro, accesible solamente al equipo de Curamericas Guatemala para el propósito de estudiar y entender sus respuestas para mejorar nuestro trabajo.

Usted tiene la libertad de negarse a responder a cualquiera pregunta. También, usted tiene la libertad de negarse a participar en el grupo focal o salir del grupo focal sin ninguna consecuencia negativa. Nadie va a privarle de ningún servicio si usted decide de no participar.

El grupo focal va a llevar aproximadamente una hora y media.

¿Entiende usted lo que es este grupo focal y su propósito? ¿Tenemos su consentimiento informado verbal para participar en el grupo focal? Gracias.

Reglas del grupo

Antes de comenzar, vamos a consentir en algunas reglas para el grupo focal:

- Que nos respetemos y nos tratemos con cortesía y dignidad
- Que una sola persona hable a la vez
- Que no nos interrumpamos
- Que levemos la mano para indicar que uno/una quiere tener la palabra
- Que mantengamos la confidencialidad y que no compartamos con nadie lo que se dice en el grupo focal

[Nota: el líder puede pedir al grupo si tienen otras reglas a agregar]

Preguntas

Vamos a comenzar con algunas preguntas generales sobre el tema del empoderamiento de las mujeres.

19. ¿Cree usted que en su comunidad que las mujeres tienen el poder de controlar o dirigir sus propias vidas?
 ¿Porque sí, o no?
 ¿Qué impide su poder de controlar o dirigir su vida? ¿Qué facilita su poder de controlar o dirigir su vida?

Gracias por sus respuestas. Ahora vamos a discutir temas más específicos acerca del tema general del empoderamiento de las mujeres. El primer es la participación de las mujeres en reuniones comunitarias.

20. ¿La comunidad ha tenido reuniones durante los últimos 3 meses para discutir los problemas de la comunidad o proyectos comunitarios? ¿De qué se trataron las reuniones?

21. ¿Algunas de las mujeres de la comunidad asistieron a estas reuniones y expresaron sus opiniones?
 ¿Cuántas?
 Si ninguna o pocas mujeres participaron, ¿porque ninguna o tan poca?
 ¿Qué o quién impidió su participación?
 Si varias participaron –¿Qué o quién facilitó su asistencia?

22. ¿Cree usted que en comparación con el pasado (hace dos o tres años), que hoy día en su comunidad más mujeres participan en las reuniones comunitarias, y expresaron más sus opiniones?
 ¿Porque sí, o no?
 Si sí, ¿qué facilitó o provocó este cambio?

Gracias por sus respuestas. Ahora vamos a discutir la participación de las mujeres en los grupos de autocuidado.

23. ¿Participan las mujeres de la comunidad en grupos de autocuidado?
 ¿Con que frecuencia?
 Si sí, ¿qué o quién facilita su participación?
 Si no, o cuando ellas no asisten, ¿qué o quién impide su participación?
 ¿Quién aprueba o desaprueba su participación?

Gracias por sus repuestas. Ahora vamos a discutir la participación de las mujeres en las decisiones familiares sobre la salud.

24. En su comunidad, ¿son las mujeres que generalmente deciden el lugar de su parto?
 ¿Porque sí o no?
 Si ellas no deciden, ¿quién decide?
 ¿Porque?

25. En su comunidad, ¿son las mujeres que generalmente deciden si van a usar o no la planificación familiar y su método anticonceptivo?
 ¿Porque sí o no?

Si ellas no deciden, ¿quién decide?
¿Por qué?

26. En su comunidad, cuando se enfermaron los niños, ¿son las mujeres que generalmente decideen el tratamiento para sus niños?
¿Porque sí o no?
Si ellas no deciden, ¿quién decide?
¿Porque?

Gracias por sus respuestas. Ahora el tema es el control del dinero familiar para conseguir los servicios de salud o comprar la comida para los niños.

27. Generalmente, en su comunidad, ¿las mujeres tienen que pedir a sus maridos/parejas permiso y el dinero para comprar la comida para sus niños o para comprar la medicina o los servicios de salud?
¿Porque si, o no?

28. La situación de las mujeres acerca de su capacidad de controlar su propias vidas – se ha cambiado?
    ¿Cómo?
    El programa de Curamericas Guatemala - ¿facilitó o provocó este cambio?
    ¿De qué manera?

11. Para terminar, ¿tiene usted algún otro comentario u opinión a expresar?

¡Gracias por su participación!

APPENDIX F

Protocolo – Grupo Focal sobre el Empoderamiento de las Mujeres

Versión #4 – Para las suegras

Declaración de consentimiento informado

Gracias por participar en este grupo focal. Un grupo focal es una discusión entre personas sobre ciertos temas importantes, para que podamos entender sus opiniones, creencias, desafíos y deseos. El tema de este grupo focal es el empoderamiento de las mujeres – o sea, su poder de controlar o dirigir sus propias vidas, de tomar decisiones acerca de su salud o la salud de sus niños, y de controlar el dinero familiar para la salud y la nutrición. Deseamos entender sus pensamientos y sentimientos acerca de este tema para mejorar nuestro programa de salud comunitaria. Por eso, lo que ustedes nos dicen es muy importante.

Vamos a plantear algunas preguntas sobre este tema, y les pedimos que nos respondan honestamente. No hay respuestas equivocadas; no busquemos algunas respuestas. Lo que importa es su honestidad. Usted puede contestar la pregunta directamente, y también usted puede responder a la respuesta de una otra participante en el grupo.

Hay que enfatizar que todo que ustedes dicen es confidencial, no lo compartiremos con ninguna persona afuera de Curamericas Guatemala sin su consentimiento. Vamos a escribir lo que ustedes dicen, pero no vamos a identificarles por su nombre y el informe del grupo focal estará guardado en un lugar seguro, accesible solamente al equipo de Curamericas Guatemala para el propósito de estudiar y entender sus respuestas para mejorar nuestro trabajo.

Usted tiene la libertad de negarse a responder a cualquiera pregunta. También, usted tiene la libertad de negarse a participar en el grupo focal o salir del grupo focal sin ninguna consecuencia negativa. Nadie va a privarle de ningún servicio si usted decide de no participar.

El grupo focal va a llevar aproximadamente una hora y media.

¿Entiende usted lo que es este grupo focal y su propósito? ¿Tenemos su consentimiento informado verbal para participar en el grupo focal? Gracias.

Reglas del grupo

Antes de comenzar, vamos a consentir en algunas reglas para el grupo focal:

- Que nos respetemos y nos tratemos con cortesía y dignidad
- Que una sola persona hable a la vez
- Que no nos interrumpamos
- Que levemos la mano para indicar que uno/una quiere tener la palabra
- Que mantengamos la confidencialidad y que no compartamos con nadie lo que se dice en el grupo focal

[Nota: el líder puede pedir al grupo si tienen otras reglas a agregar]

Preguntas

Vamos a comenzar con algunas preguntas generales sobre el tema del empoderamiento de las mujeres.

29. ¿Cree usted que en su comunidad las mujeres tienen el poder de controlar o dirigir sus propias vidas?
 Si sí, ¿Por qué? Si no, ¿Por qué?
¿Qué impide a las mujeres tener el poder de controlar o dirigir sus vidas?
¿Qué facilita a las mujeres tener el poder de controlar o dirigir sus vidas?

Gracias por sus respuestas. Ahora vamos a discutir temas más específicos acerca del tema general del empoderamiento de las mujeres. El primer tema es la participación de las mujeres en reuniones comunitarias.

30. ¿Su comunidad ha tenido reuniones durante los últimos 3 meses para discutir los problemas de la comunidad o proyectos comunitarios?

31. ¿Sabe usted si sus nueras asistieron a estas reuniónes y expresaron sus opiniónes/ideas?

Si sí, ¿Por qué? Si no, ¿Por qué?
¿Qué o quién facilitó que ellas asistieran y expresaran sus opiniones?
¿Qué o quién impidió que ellas asistieran y expresaran sus opiniones?
¿Usted aprueba que sus nueras participen en las reuniones comunitarias?
Si sí, ¿Por qué? Si no, ¿Por qué?

Gracias por sus respuestas. Ahora vamos a discutir la participación de las mujeres en los grupos de autocuidado. {Clarifique lo que es un grupo de autocuidad].

32. ¿Participan sus nueras en un grupo de autocuidado?
Si sí, ¿sabe usted qué o quién facilita su participación?
Si no, o cuando ellas no asisten, ¿sabe usted qué o quién impide su participación?
¿Usted aprueba su participación?
¿Porque aprueba o desaprueba?

Gracias por sus repuestas. Ahora vamos a discutir la participación de las mujeres en las decisiones familiares sobre la salud.

33. ¿Dónde fue el lugar del nacimiento de su nieto/nieta más joven/chiquito?
¿Sabe usted quién decidió el lugar del parto?
¿Sabe usted si su nuera participó en esta decisión del lugar del parto?
¿Si sí, Por qué? Sí no, ¿Por qué?
El lugar del parto -¿sabe usted si fue la preferencia de su nuera o no?
Si sí, ¿Por qué? Si no, ¿Por qué?

34. ¿Sabe usted si sus nueras están usando algún método de planificación familiar?
¿Sabe usted quién en las familias decidió que ellas usaran o no usaran la planificación familiar, y como se decidió cual método?
¿Sabe usted si sus nueras participaron en esta decisión?
Si si, ¿Por qué? Sí no, ¿Por qué?

La decisión - ¿sabe usted si fue la preferencia de sus nueras?
Si sí, ¿Por qué? Si no, ¿por qué?

35. La última vez que unos de sus nietos pequeños se enfermó con neumonía o tos y respiración rápida, ¿sus padres buscaron tratamiento?
¿Qué tratamiento?
¿Sabe usted quién en la familia decidió el tratamiento (o de no tratar)?
¿Sabe usted si su nuera participó en la decisión?
Si sí, ¿por qué? Si no, ¿por qué?
La decisión - ¿sabe usted si la decisión fue la preferencia de su nuera o no?
Si sí, ¿porque? Si no, ¿porque?

Gracias por sus respuestas. Ahora el tema es el control del dinero familiar para conseguir la medicina y los servicios de salud o para comprar la comida para sus niños.

36. Cuando se necesita comprar comida para sus niños, o medicina o servicios de salud, ¿sabe usted si sus nueras tienen que pedir a su marido permiso y el dinero?
Si sí, ¿por qué? Si no, ¿por qué?

37. La situación de las mujeres en su comunidad, ¿ha cambiado en alguna manera?
Si hubo un cambio, cuéntame del cambio.
El programa de Curamericas Guatemala - ¿facilitó o provocó este cambio?
¿De qué manera?

10. Para terminar, ¿tiene usted algún otro comentario u opinión a expresar?

¡Gracias por su participación!