Participatory Communication Unlocks a Powerful Cultural Resource: Grandmother Networks Promote Maternal and Child Health

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Abstract

In virtually all socio-cultural settings in Africa, Asia, Latin America and The Pacific senior women, or grandmothers, are part of family and community systems in which women and children are embedded. [1] And across cultures, in all matters related to the health and development of women and children grandmothers are expected to teach, guide and support these younger members of society. Andreas Fuglesang, Swedish communicologist, (1982) discussed the critical role of the elders in traditional societies as the "information storage and processing unit" of a society (p.47), responsible for storing and retrieving the information resources of the society necessary for their survival. And he referred to grandmothers as a *learning institution* in the community. It is surprising that in spite of the pervasive presence and experience of senior women, or grandmothers, as influential advisors on maternal and child health and nutrition, policies and programs in these areas, and the communication strategies that support them, have rarely seriously taken their role and influence into account.

Aiming to take advantage of this largely untapped cultural resource, i.e. the grandmothers, a methodology for involving and strengthening grandmothers' role as maternal and child health (MCH) advisors in families and communities was developed by The Grandmother Project, an American NGO. The "grandmother-inclusive methodology" works through grandmother networks and leaders, using participatory methods of *communication as dialogue* to acknowledge the important role of grandmothers and to challenge them to combine "traditional" and "modern" knowledge in order to strengthen their contribution to promoting the well-being of women and children. Experiences in Laos, Senegal and Mali using this methodology have demonstrated that the inclusion of grandmothers in MCH programs increases the cultural relevance of those programs, that this leads to greater community support for these initiatives and, in turn, this contributes to greater program effectiveness.

Introduction

Many development programs have had limited impact on the communities they seek to assist. Some communication experts (Balit, 2005; Nair & White, 1994) have argued that insufficient attention to cultural values and traditional

[1] The term "grandmother" is used here to refer to all women who are older and who have experience advising and supervising younger women and their children. This can include mothers-in-law, mothers of younger women and other senior female family members.

communication systems have contributed to these disappointing results. Such arguments have compelled some development organizations to reflect on how their programs can give greater attention to the cultural dimension. For example, UNFPA asserts that "Development paradigms have paid limited attention to cultural variables and approaches" (2004a, p.2). And since 2002 the organization has been actively promoting "culture-sensitive programming" in the reproductive health programs it supports around the world, an approach which involves "working from within complex cultural systems" (2004b, p.2). Along similar lines, in a 1992 World Bank conference on culture and development, Seragaldin (1992) argued for "the need to put 'cultural identify' at the center of the development paradigm" (p.19).

Various benefits are derived from development programs that build on existing cultural values and structures. Culturally-grounded programs are more relevant to communities, and this tends to increase both their involvement in and their sense of ownership of such programs. In addition, culturally-relevant programs increase community confidence in their own resources and in their capacity to grow and develop. Programs that build on existing cultural systems are more likely to influence community norms, and thereby, to have a greater and more sustained impact on community knowledge, survival strategies and well-being.

Over the past fifty years, however, since development assistance programs were launched on a large scale, most community development programs, in different sectors, have given relatively limited attention and importance to local cultural realities and resources. Nevertheless, there have been some efforts to stimulate discussion of this issue, for example, the international conference organized by UNESCO in 2001 on culture and development. A central conclusion of that meeting was that, "there is an urgent need to rethink the role of culture" in development programs. The conference proceedings underline the principle that development programs should work "through the medium of human cultures" (2001, p.1).

Specifically in the field of international health, in the 1980's there was some discussion of the need to give more attention to cultural parameters in programming. Various international public health experts (Mosley, 1984; Nations,1985; Pelto,1987) defended the need to develop programs based on cultural realities. At present, however, it appears that minimal attention is given in international health forums and agencies to the issue of "cultural relevance of program strategies."

Limited attention to cultural parameters

Several key values and assumptions are identified that characterize the majority of health development programs that help explain the limited attention given to cultural parameters. First, in health development programs priority is invariably given to technical [i]priorities, or objectives, to promote "appropriate" and "globally-agreed upon" practices related to nutrition, health , early childhood development etc. Second, culture is generally considered to be a static, unchangeable phenomenon. In this light, it is consistently viewed as an "obstacle" or "barrier" to be overcome, and rarely as a resource to be exploited. Third, in development organizations where culture **is** factored into programming strategies, the predominant view of culture is a reductionist one that focuses on "cultural factors,"

that are equated with discrete "knowledge, attitudes and practices," or KAP, of the community or society. This superficial view of culture blatantly ignores other significant dimensions of culture, of which the social structures and the actors therein are of primordial importance. The combination of these several attitudes and assumptions clearly contribute to the fact that development program planners give limited attention to cultural realities.

These same assumptions that tend to limit the attention given to cultural realities and resources underpin the communication strategies that support community health and nutrition programs. I would argue that the limited effectiveness of many MCH communication strategies can be attributed, to a great extent, to the fact that they are *culturally-insensitive.* This critique is based on two main observations, one related to the approach used to introduce priorities of development agencies into communities, and the second, to the choice of community actors with which programs interact.

In most communication programs, the approach adopted aims to convince community members to "accept" certain health-related practices (Figueroa et al., 2002). The approach used to disseminate the prescribed practices is fundamentally uni-directional and top-down and it attempts to "convince" or "persuade" people to give up "negative" practices and adopt "positive" ones. A second feature of such strategies is that they invariably focus on community *problems, inappropriate practices* and *deficits* rather than on beneficial community *resources, practices* and *assets*. Another important characteristic of the predominant communication model is that it focuses on individual behavior change (ibid.,). Based on the idea that individuals' discrete knowledge, attitudes and practices (KAP) should be changed, communication strategies and MCH programs alike invariably aim to promote individual behavior change. This is based on the western assumption that individuals are able to independently change their attitudes and practices. In *collectivist cultures* where group norms have a strong influence on individual practices, the cultural relevance of this predominant model should be questioned. Most health communication strategies in developing countries are based on this approach for which the name has evolved from Information Education and Communication (IEC) to Behavior Change Communication (BCC) while the underlying conceptual paradigm has remained unchanged. From a community perspective, this paradigm could be considered culturally-insensitive insofar as it proposes pre-defined solutions irregardless of existing and culturally-rooted attitudes and strategies, rather than explicitly promoting the integration of "traditional" and "modern" ideas.

A second major characteristic of the vast majority of MCH communication strategies that reflects their culturally-insensitivity is the fact that they focus almost exclusively on women of reproductive age and their young children. This reductionist approach excludes other key family and community members who play culturally-ascribed roles related to MCH at the household level (Santow, 1995). From a cultural-perspective, it is surprising that very few programs aiming to improve the well-being of children, women and families, give substantive attention to the role and experience of senior women, or grandmothers. In cultures where senior women play an active role in household health-related activities, MCH

programs that do not explicitly involve these women can be considered to be *culturally insensitive.*

Invisibility of grandmothers in development programs

In virtually all socio-cultural settings in Africa, Asia, Latin America and The Pacific senior women, or grandmothers, are part of family and community systems in which women and children are embedded. [ii] And across cultures, grandmothers are expected to teach, guide and support younger women and children. Various social scientists have documented the multi-faceted role of GMs in promoting family well-being, including health, in Africa (Kayongo-Male & Onyango, ibid.), Asia (Gryboski, 1996; Wiley, 2002), Latin America (Finerman, 1989, McKee, 1987) and the Pacific, as well as among Native North American Indian groups (Schweitzer, 1999). A recent review of the literature on the role of grandmothers presents evidence of their involvement and influence in at least 68 non-western cultural settings (Aubel, 2005).

Yet, in spite of the pervasive presence of these experienced and influential MCH advisors, in very few cases have MCH policies and programs in non-western societies seriously taken into account their role and influence. What explanation is there for the fact that in numerous cultures where grandmothers play a central role as advisors and supervisors of young women and children in MCH policies and programs they are virtually invisible.

Two sets of factors are identified which appear to contribute to this inconsistency. First, MCH policies and programs have generally been based on a reductionist approach, with a narrow focus on women of reproductive age, and in which limited attention is given to the wider family, or household, (Kleinman, ibid; Berman et al., 1994) of which grandmothers are a part. Second, there are a series of widely-held negative biases regarding the role of older women which tend to discredit both their experience and their involvement in MCH.

The reductionist focus in MCH programs on women and their children simplifies the parameters which program planners must deal with, but at the same time it gives only a superficial picture of MCH-related dynamics at the household level. Most MCH programs are not based on a comprehensive understanding of the household context and the intrahousehold processes related to health promotion and illness management (Buvinic et al., l987; Mosley, ibid.) in which grandmothers are often intimately involved.

A second factor that militates against the involvement of grandmothers in MCH programs is a series of negative biases toward them that are often articulated both by health sector staff and international donors (Aubel, 2005). First, there is denial that older women do in fact influence MCH practices of younger women and families. Second, there is a widely-held belief that the influence exerted by older women on MCH is generally negative. Older woman frequently are involved with the use of traditional remedies, invariably assumed to be harmful. Third, is the common belief that older women are not capable either of learning new things nor of changing their ways. The combination of these several stereotypes projects a

negative impression of grandmothers' experience and of their potential to promote "modern" MCH practices.

Evidence of grandmothers' role

In the social sciences there is discussion of three facets of non-western cultures that provide insights into the role and influence of elders in general, and specifically of grandmothers, in promoting the health and well-being of women and children. These are *family systems, cultural systems* and *the role of elders in family and community systems.* It is surprising that in the international public health and health communication literatures these three concepts are rarely referred to. All three concepts suggest the need for a more holistic consideration of family and community systems in which women and children are embedded, and of all key actors within those systems, including grandmothers.

Cultural systems

Anthropologists refer to the "pervasive influence of cultural meaning systems" on the lives of individuals and societies (Dressler & Oths, 1997) and the fact that "cultural influences permeate all of human thought and behavior" (p.361). Conversely, MCH experts and programs usually give limited attention to the cultural systems into which program interventions are introduced. When cultural factors **are** discussed there is frequently a tendency to equate such factors with *beliefs and practices* (Hill et al., 2004; WHO & UNICEF, 2003). This orientation minimizes the impact of cultural systems on individuals' and families MCH strategies and practices. The work of social psychologist, Pepitone (1981), supports the need for a broader understanding of pervasive cultural systems. He describes two interrelated dimensions of all cultural systems. On the one hand, there are *social structures* and *organizations* in which individuals are embedded related to the family, kinship, roles, hierarchies, and communication nets. For example, all cultures define the roles and responsibilities of different family members required for the survival of the society, as well as intra-familial communication systems that ensure the transmission of necessary cultural knowledge from one generation to the next. On the other hand, there are *normative systems* that include the values and beliefs that affect practices, or behavior. In most MCH programs, much more attention is given to *cultural practices* (corresponding to Pepitone's second category) than to the *structural and organizational dimension* of families and communities. This orientation explains, in part, the fact that the role of grandmothers in family systems has been largely ignored.

Family systems:

There is an intimate relationship between cultural systems and family systems, insofar as families are immersed in cultural systems. Given the importance of the family in all cultures in ensuring the health and development of its women and children, it is surprising that in the international MCH literature *family systems theory* is very rarely referred to at all. Family systems theory was developed in several fields each of which takes a systemic, rather than a reductionist, view of individuals within family settings, namely in anthropology (Bateson, 1994), social work (Turk & Kerns, 1985; Hartman & Laird, l983), nursing (Anderson, 2000) and family therapy (Papero, 1990). Given the influence of the family on MCH,

particularly in non-western societies, it is surprising that only superficial attention has been given to family organization, dynamics and decision-making in international MCH forums and publications (Berman et al., ibid; Mosley, ibid.).

Several key characteristics of family systems are related to the critical role played by grandmothers in MCH within the family, namely; all parts of a family system are interconnected; in order to understand one element of the family system you must consider the whole system; all family systems are composed of sub-systems such as the mother-child dyad, husband-wife dyad, etc.; and there are rules regarding acceptable and unacceptable behaviors within the family system. Hartman and Laird point out another feature of family systems that is directly related to the advisory function of senior women. The authors argue that in order to function effectively all family systems require a *decider* who first, "exercises control" over other components, or actors, in the system and second, who "makes decisions" in relation to a goal and hierarchy of values. The authors maintain that the role of *decider*, or *advisor,* is essential to guarantee internal order and homeostasis in any family system. Logically, the *decider* role is assigned to the person/s who have more experience. In the case of MCH it is generally the senior women in the family who are more experienced than other family members. Family systems theory clearly suggests the inadequacies of a reductionist focus on either the mother-child dyad, or the mother-child-husband triad (ibid.). It supports the need for a systemic perspective on the social environment that includes consideration of all household actors involved in MCH, as well as the interaction and decision-making between them. Unfortunately, MCH programs generally have not adopted a systems perspective and they continue to focus on the dyad, in most cases, and occasionally on the triad, described above.

Other facets of family systems that contribute to maintaining equilibrium within a household, that are also related to expectations of grandmothers, are the fact that the knowledge and roles of various household actors are gender-specific and that there are established patterns of decision-making. In most non-western societies, family systems are very hierarchical, based on status, gender and age. Nigerian sociologist, Makinwa-Adebusoye (2001) argues that in patriarchal and hierarchical African households, the most common type of household structure in Africa, "most women cannot exert much, if any, control over their own lives" (p.12). Both the men and senior women make numerous decisions that dictate what younger women can and cannot do. These statements suggest the cultural dissonance that exists between household structure and roles and the orientation of most MCH programs that focus on younger women and assume that they are independent decision-makers. MCH programs need to be based on an accurate understanding of decision-making and authority patterns within family systems related to the roles of women and to children's care and well-being.

Role of elders in family and community systems

Another critical, culturally-determined aspect of family and community systems in virtually all non-western societies in Africa, Asia, Latin America and The Pacific, is the role of elders as teachers and advisors of younger generations. In the

development literature in general, and specifically that on MCH, the role of elders is almost completely ignored.

There is some discussion of the role of elders in non-western societies in the social science literature. Anthropologist, Margaret Mead (1970), was one of the first to discuss the critical role played by grandparents in the transmission, from one generation to the next, the "model" of how family life should be organized, including how children should be nurtured and taught how to survive in each society. The important role of the elders in more traditional societies was emphasized by communicologist, Fuglesang (1982), who equated their role to the function of the hard drive on a computer. Based on this analysis he argued that elders should be fully involved in efforts to promote change within community systems. Sociologist, Treas (1993), also discusses the influence of elders' views and advice on others in the community. She argues that, "development programs have sometimes not taken the views of elders into consideration, making the programs less likely to be accepted by them" (p.11).

The gender-specificity of roles in non-western societies applies as much to elders as to younger members of the society. In virtually all of these societies, grandmothers and grandfathers play quite distinct, but complementary roles in family and community systems. And, as mentioned above, it is generally the experienced, senior women, or grandmothers who have primary responsibility for advising and dealing with MCH matters at the household level. Elder men, or grandfathers, typically become involved in MCH issues when there are serious problems and/or special resource needs.

The three interrelated concepts, discussed above, *cultural systems, family systems* and the *role of elders in those systems*, support the following recommendations for MCH program planners, and specifically those responsible for developing communication strategies. First, there is a need to better understand the role and experience of grandmothers in specific cultural contexts as a precursor to strategy development. In order to do this, alternative methodological tools are required, given that in most past assessments data collection tools, focused on "mothers of young children," have tended to camouflage the role of grandmothers. Second, programming approaches should be developed that view and include grandmothers as partners and resource persons rather than as obstacles.

Common features of grandmothers' role across cultures

The 2005 literature review, mentioned above, on grandmothers' role in non-western cultures revealed great variability in their cultural practices related to different facets of MCH and early childhood education (Aubel, 2005.). At the same time, through analysis of the literature from approximately 68 different cultural settings, a series of thirteen features of grandmothers' core experience and role were identified that appear to be similar across cultures. Each of these thirteen parameters are related to grandmothers' responsibility for the transmission of values, knowledge and skills to younger generations and all have implications for MCH programming and for the development of communication strategies for such programs.

- Grandmothers are involved in multiple aspects of the lives of children, women and families at the household level.
- Grandmothers' role related to the development and well-being of children and women are gender-specific
- Grandmothers are responsible for transmitting cultural values
- Grandmothers are confident of their own child-rearing expertise that was acquired over a life time.
- Grandmothers are directly involved in promoting the well-being of children and women as well as indirectly involved (through the advice they give to women and other family members)
- Grandmothers are the primary household health advisors
- Grandmothers advise and influence the decisions made by male family members regarding the well-being of women and children.
- Some of grandmothers' practices are beneficial for the development of women and children whereas others are not.
- Grandmothers have a very strong commitment to promoting the growth and development of their grandchildren.
- Compared to younger women, grandmothers generally have more patience and more time to spend with young children.
- Grandmothers' knowledge comes primarily from older women in their families and from their peers
- Most grandmothers have a collective sense of responsibility for children and women in the community.
- Many grandmothers feel that their status as advisors in child and family development is diminishing.

There is clearly a need to further analyze and document the role of grandmothers in different cultural, geographic and socio-economic contexts. However, the existing body of data supports the conclusion that they are central actors in MCH in numerous socio-cultural contexts and that they constitute potential resource persons for MCH programs in those settings.

Methodology to build on GMs' role in MCH

Though many development practitioners would agree that GMs play an active role and have a great influence on both women and their young children, many also believe that they are both resistant to change and unable to modify their attitudes and practices. The challenge that I undertook, in collaboration with partner NGOs first in Laos, and later in Senegal and Mali, was to develop a culturally-relevant and participatory methodology that would be effective in encouraging grandmothers to integrate "modern" health-related practices with their existing practices. The objective was to develop a generic methodology that could be used to address various health issues or problems.

Systems approach to capacity building

Development of the methodology for community MCH promotion at the community level was influenced by several key concepts and frameworks. The principal concept underpinning the methodology is *community capacity building,* an essential ingredient for sustainable development (Chaskin et al., 2001). Closely related to this central concept are several other key principles. An *assets approach*

(Kretzmann & MacKnight, l993) was adopted, as contrasted with the more frequently used *deficits approach*, wherein the aim is to acknowledge and strengthen existing community resources, especially, but not exclusively, grandmothers. The approach also gives priority to working with *social networks* of grandmothers in order to strengthen those structures while especially increasing the knowledge, skills and confidence of grandmother leaders within such networks (Israel & Rounds, 1987). A *transcultural approach* to health promotion was adopted which involves eliciting dialogue regarding concepts both from the indigenous, or popular health culture and from the bio-medical, or "modern" health culture (Aubel, 1995). The overall approach is grounded in an *ecological approach to health promotion* (Green et al., 1996) which justifies the need for programs to involve multiple community groups including grandmothers, young women, men and community leaders, etc. in community programs. Lastly, the methodology was inspired by a *community empowerment approach* (Wallerstein & Bernstein, l994) wherein community members and health workers are involved in a participatory process of dialogue and negotiation as a means of increasing community commitment and capacity to collectively solve problems.

The grandmother-inclusive methodology

Experimentation at the community level in several countries, evaluation and action-learning, or *praxis* (Freire, 1970), progressively lead to development of the *grandmother-inclusive methodology* (Aubel, 2005). The methodology consists of five key steps: 1) rapid assessment of grandmothers' role and influence in the household and community related to the issue/s of interest through discussions with a variety of family and community members; 2) public recognition of grandmothers' role in promoting the health and development of women, children and their families; 3) participatory communication/education activities that engage members of grandmother networks, along with members of other community groups, in discussion of both "traditional" and "modern" practices and of the possibility of combining them; 4) strengthening the capacity of grandmother leaders to promote improved practices with other grandmothers, in families and in the community-at-large; and 5) ongoing monitoring and documentation for learning.

Key concepts and methods

Within the five-step methodology, communication and learning activities of several types are carried out, particularly in step three. The approach used in these activities differs considerably from the predominant approach used in most health communication strategies that is based on behaviorist and message-transmission pedagogies. Here, the approach draws on concepts and methods from *adult education, participatory development communication* and *feminist pedagogy*. Key concepts and methods from each of these fields that are essential to understanding the core grandmother-inclusive methodology are summarized below.

All communication and learning activities used in the core methodology are based on transformational, or constructivist, theories of adult learning supported by the work of Freire (1970), Kolb (1984) and Mezirow, 1991). Community members are expected to critically analyze their own experience, along with alternative ideas, and to "construct" their own strategies to deal with everyday MCH-related problems. Especially in steps three and four, this is done through the use of *stories-without-an-ending*, a methodology inspired by Freire's work on *dialogical pedagogy* and the

use of discussion “codes.” “Learners” are not expected to internalize pre-defined knowledge, or messages, as is often the case in health communication activities. Rather, the focus is on collective dialogue and critical thinking regarding both past experiences and new information.

The grandmother-inclusive methodology has also been informed by key concepts from the participatory development communication literature that point to the importance: of *horizontal communication relationships* that promote two-way knowledge-sharing and power-sharing Diaz-Bordenave, 1994; Bessette & Rajasunderam, 1996); mutual *respect, dialogue and reciprocity* in relationships (Thomas, 1994); *dialogical communication* (Servaes et al.,1996.); and of “consciousness-raising through critical reflection” (White et al.,1994, p.48). Another key concept is that of the *catalyst communicator* whose responsibility it is “to catalyze thinking, motivation, interaction, action, reaction and reflection” (White, 1999, p.38) on the part of community members. All of these concepts are embodied in the approach used in the core methodology first, to establish rapport and communication with grandmother groups, second, to elicit dialogue and collective problem-solving by them and third, to empower grandmother leaders to continue to elicit community dialogue on priority MCH topics.

Equally important to development of the participatory communication activities with grandmother networks is the contribution of feminist pedagogy (Belenky et al., 1986; Riaño, 1994). Key elements from this field that are integrated into the methodology include: acknowledgement and validation of GMs’ role, subjective knowledge and experience; challenging the sexist and ageist stereotypes about GMs; and empowerment of GMs in their role in the family and community. This last point is further addressed by Riano’s gender perspective on women's participation in communication and learning activities at the community level. She maintains that in traditional societies in Asia, Africa and Latin America older women play an essential role as "informal communicators” on topics related to their roles and expertise, and that efforts to increase their access to information and communication tools can strengthen their competencies and status as more active and more formal communicators in their communities. Riaño also points out the critical communication function played by women's groups which constitute "informal networks of exchange and collective strategies of survival” (ibid., p.39). This perspective is shared by Balit (ibid.) who insists on the importance of utilizing women’s traditional “social communication networks within communities” to promote dialogue and learning (p. 6).

These ideas directly influenced the decision to work with grandmother networks and their leaders in order to increase their collective communication capacity.

Culturally-adapted communication methods

The communication activities and materials developed for use in the overall methodology were chosen in light of the capacity-building and empowerment frameworks. In this regard, the choice of communication tools was based on the following criteria: they be culturally-adapted; they must stimulate group interaction and learning; they must be inexpensive to reproduce and/or disseminate; and they can be used by grandmothers themselves and other community members. Based

on these criteria songs, stories-without-an-ending and group discussion have been used in the grandmother-inclusive methodology.

Songs play an important role in the work with grandmother groups. Two types of songs have been developed, each with a specific purpose. Certain songs acknowledge the importance of GMs' role in household child health matters. These songs in praise of grandmothers have proved to be particularly important in establishing rapport with them and in increasing their self-confidence in their capacity to participate and to learn. Other songs convey key information related to the MCH topics being addressed. In all cases the songs contain both "traditional" and "modern" information on the MCH issue dealt with.

The specific purpose of the stories is to stimulate critical thinking regarding various MCH topics. In other settings, stories have been used in health communication strategies (Begbie 1985, Hilton 1981), however, in those cases the objective was usually to *instruct* people on what they should do when faced with certain health-related problems. Here, the structure and use of the stories is quite different. The development of the story format was inspired by Freire's work on *problem-posing codes,* Kolb's *experiential learning* model, and on Brookfield's (1991) use of *critical incidents* to stimulate critical reflection and problem solving. In each story, two characters present two different ways of approaching the same problem. One has more "traditional" views on the issue, while the ideas of the second character include more "modern" notions. The juxtaposition of the alternative views serves as a catalyst for discussion of both. Each story is accompanied by a set of questions that are based on Kolb's (ibid.) 4-stage experiential teaming cycle. A facilitator uses the questions to guide and challenge the group to analyse the alternative opinions and to arrive at their own conclusions. In each story the protagonist is a GM, reflecting the leading role they play in health matters in real life. In all cases they are portrayed as competent and respected women, corresponding to an important concept from feminist pedagogy (Belenky et al., ibid.).

These stories are, in fact, a centrepiece of the grandmother-inclusive methodology. They are intended to stimulate discussion of everyday health-related problems, the role of grandmothers and other family actors, and traditional and "modern" MCH concepts and to encourage community members to identify possible strategies for overcoming such problems.

Use of participatory communication methods in three settings:
The grandmother-inclusive participatory communication methods have been used in several settings including Laos in 1996 with WHO and UNICEF, in 2001 in Senegal with Christian Children's Fund (CCF) and in 2003/4 in Mali with Helen Keller International. This section of the paper provides an overview first, of the reaction of grandmothers and other community members to these methods, and second, of the results of the experiences in the three countries based on both quantitative and qualitative data collected at each site.

In all three settings, participatory communication activities (songs, stories-without-an-ending and discussion) were initiated in community gatherings attended by grandmothers, representatives of the traditional, male community leadership structures and community health volunteers. Later similar sessions were organized

with groups of other women and of men. In each case, monthly or bi-monthly sessions with grandmother groups were organized in a place where they felt comfortable going and expressing themselves. In Laos this was in the Buddhist pagodas and in Senegal and Mali it was on mats under a tree, away from the center of the village.

In all three sites in Asia and Africa, the overall reaction on the part of grandmothers, family members and other community members to the participatory learning activities was similar and very positive. And everywhere, an unanticipated effect of the group sessions was that the presentation of the stories, dealing with various maternal and child health topics, served as a catalyst for discussion of those issues in the community-at-large.

When the participatory communication and education activities were initiated in all three settings, an "adaptation period" was required for the grandmothers before they felt entirely comfortable participating in group learning activities. At the outset, some grandmothers were skeptical about attending the sessions. One of the Senegalese grandmother leaders later said, "At first we were afraid. We had never before been invited to attend such sessions in the community. And we wondered if we would be able to understand what was being said and if our ideas would be accepted." Initially many grandmothers listened and observed the group activities but did not express themselves. Gradually, in all sites, their comfort level and confidence increased when they heard the songs praising them for their role in family health, listened to the stories about their own lives, were asked to share their experiences and found that their ideas were respected. By the end of the first or second session, in all three countries, almost all of the grandmothers were demonstrating overwhelming enthusiasm for and interest in being involved in the participatory learning activities.

In most communities where the participatory communication/learning activities were carried out the number of grandmother participants increased over time. And on numerous occasions, they brought along their "girl friends" from neighboring villages, a demonstration of their interest in sharing the experience with their peers. At the end of most of the community sessions, quite spontaneously the grandmothers danced and sang. The facilitators interpreted this reaction as a sign of their deep sense of satisfaction with the sessions that acknowledged both their experience and their opinions about how to solve the problems presented in the open-ended stories.

In all three settings, the very positive response to the grandmother-inclusive communication activities came not only from grandmothers, but also from members of the larger community and from health and development workers. In all cases, male community leaders and men, in general, were very supportive of the fact that the approach contributed to reinforcing not only the knowledge of their mothers and wives (i.e. the grandmothers) but also their status in the community. In all three sites there was a strong consensus among health and development workers that it was very beneficial to involve the previously "invisible" grandmothers in efforts to address maternal and child health problems.

While the overall reaction to the grandmother-inclusive communication activities was very positive, in all three sites constraints were encountered conducting the participatory learning activities due to inadequate group facilitation skills of some health and development workers. In other cases, community sessions were not held regularly due to scheduling or logistical constraints.

Results of the grandmother-inclusive communication activities

In Laos, Senegal and Mali, use of the participatory and culturally-adapted communication activities yielded very positive results, some anticipated and others quite unexpected. On the one hand, quantitative evaluation results in all three sites revealed positive changes in grandmothers' own practices, in their advice to young mothers and in younger women's practices. On the other hand, qualitative data from the three sites revealed various unanticipated but beneficial effects of the grandmother-inclusive methodology (discussed below). Examples of both the quantitative and qualitative results, presented below, provide evidence of the positive results observed in the three sites.

In the first experience using the methodology in Laos in 1996, the objective of the strategy was to improve grandmothers' advice and practices related to the care of sick children (Aubel & Sihalathavong, 2001). Evaluation results showed that on all eleven indicators measured in baseline and endline interviews, grandmothers' knowledge of "modern" practices regarding home treatment of sick children increased and their advice to other family members improved over the course of the one-year intervention. For example, at baseline, only 30% of all grandmothers were giving "lots of fluids" to children with diarrhea whereas in the endline study 74% of grandmothers were giving this beneficial advice. Similarly, the proportion of grandmothers who advised mothers with young children to continue breast-feeding during diarrhea increased from 73% at baseline to 90% at endline.

In Senegal, in a nutrition education project supported by CCF, there were improvements in all indicators related to grandmothers' advice to younger women and to their own practices with young children (Aubel et al., 2004). For example, evaluation data showed that before grandmother-focused activities began, only 57% of grandmothers were advising younger women to give colostrum to their infants. By the end of the intervention almost all grandmothers (97%) were giving this advice to their daughters and daughters-in-law. Similarly, at the outset only 59% of all grandmothers were advising young mothers to give enriched porridge to their offspring as a first complementary food, whereas the final evaluation revealed that 97% were preparing and giving an enriched porridge. In addition, the final project evaluation showed that changes in younger women's practices were greater in communities where nutrition education activities were carried out with grandmothers as compared to places where only younger women participated in these activities.

In Mali, the methodology was used in the two-year neonatal health project implemented by HKI. The final evaluation identified major weaknesses in the implementation of the activities with grandmothers. Nevertheless, the final evaluation revealed improvements in all sixteen indicators related to grandmothers' advice to younger women regarding maternal and infant health (of which thirteen were statistically significant) (INFO-STAT, 2004). Between the baseline and

endline surveys the proportion of grandmothers advising pregnant women to attend pre-natal consultations increased from 34% to 61% and those advising young mothers to give colostrum to their newborns increased from 46% to 63%. Positive changes were also observed in some of women's practices related both to decreased work and to improved diet during pregnancy as well as to improved breastfeeding practices with newborns.

Based on qualitative data collected in the three sites, unanticipated and beneficial effects of the grandmother-inclusive methodology were documented related: to grandmothers; to community leaders; to other family members; and to health and development workers.

Effects on grandmothers: Through the involvement of grandmothers in the participatory learning activities; they acquired new knowledge which, in turn, increased their sense of self-confidence and of empowerment in their role as MCH advisors; their sense of solidarity with other senior women increased; grandmother leaders emerged in all of the groups; and these leaders, in turn, encouraged other grandmothers to consider the new ideas being presented.

We love the songs that praise us for what we do. If someone is working in his field and you pass by and tell him that he is doing a good job he is encouraged to keep on working.

Senegalese grandmother

We feel much stronger now because not only do we have our traditional knowledge but, in addition, we have acquired the knowledge of the doctors.

Senegalese grandmother leader

Usually grandmothers only sit quietly and speak softly with the Buddhist monks. Now they can sing, clap their hands and share their ideas in public places.

Laotian grandmother leader

We have tried out some of the new ideas, they have given good results and our families now have more confidence in us.

Laotian grandmother

The grandmother strategy is like a needle that has sewn us together. Each one of us must play a role to ensure the health of the women and child in our community.

Malian grandmother leader

Effects on community leaders: Many of the traditional community leaders, like other community members, have internalized the attitudes of many development workers who minimize the "traditional" knowledge of grandmothers and marginalize them from development activities. Leaders in all sites were surprised, at first, that grandmothers were expected to play a central role in the MCH activities. But as they observed the grandmothers' enthusiasm and capacity to learn, their respect for grandmothers' updated advice increased. They increased their public recognition of grandmothers' contribution to family well-being and committed themselves to involving grandmothers in their future community activities.

The grandmothers have vast expertise. But this approach is fantastic because it allows them to become even more effective advisors to younger women by combining their traditional ideas with modern ones.

Senegalese community leader

We think that you made a good decision in involving the grandmothers as the health of our children and women depends entirely on them.

Malian community leader

According to our traditions, the elders must be involved in community development activities if they are to succeed. We are very delighted that the grandmothers are involved in these nutrition activities given their role in teaching young women everything they need to know.

Senegalese community leader

Effects on family members: In all three sites, family members reported beneficial effects of the grandmother strategy related to: increased support to pregnant and breast-feeding women from grandmothers; positive changes in their advice to younger women and men; increased confidence of other household members in their advice; and improved communication between mothers-in-law and daughters-in-law.

The grandmothers have learned new things and they feel more confident about caring for our children. And now other family members have even more respect for their advice than before.

Laotian mother

Now when you are pregnant they tell you to work less and to eat more. Before each woman had to do her own work. Now when a woman is pregnant the mothers-in-law ask the other women in the family to help out, or they take on some of your work themselves.

Senegalese women with a two-month old baby

Husbands are more attentive to our special needs when we are pregnant because their mothers have told them what they learned in the grandmother sessions.

Malian women one month before giving birth

Effects on attitudes of health/development workers: Community health and development workers in the three sites progressively increased their appreciation of grandmothers' experience, of their openness to new ideas and of their potential contribution to community MCH activities.

Since I was young, I was always told that older people cannot learn, like our proverb says, "You cannot bend an old piece of bamboo." But we have seen that the proverb is incorrect, that they can learn. I think we should extend such activities with grandmothers to all of the provinces.

Laotian public health doctor

I have worked in these communities for twenty years. The grandmothers have been there but I never really saw them, I never involved them in my activities. I

have seen how important it is to them and for the success of our nutrition activities that they be involved.

Senegalese health/development worker

The quantitative and qualitative data collected in the community MCH programs in Laos, Senegal and Mali, provide complementary evidence of the beneficial effects of the grandmother-inclusive methodology. The qualitative data collected throughout project implementation using *process documentation* was particularly useful in providing insights into the factors that contributed both to anticipated and unanticipated outcomes.

Biases against grandmothers disproved

In all three experiences, the several biases against grandmothers (discussed above) were disproved. First, as regards their harmful influence on women and children, in all sites it was found that while indeed some of their MCH practices are harmful, overall their experience, motivation and commitment to caring for women and children are very positive. These elements support the conclusion that it is both culturally and strategically important to include rather than exclude them from MCH programs. Second, related to the belief that grandmothers are too old to learn and to change, in all three settings it was found that the majority of grandmothers, almost all of whom are illiterate, were capable of learning new things when a communication and learning approach based on respect and dialogue was used. In this regard, in all settings the majority of the grandmothers were very open to combining "new" practices with "old" ones, even when this meant abandoning some of their traditions.

Conclusions

In most community level MCH programs insufficient attention is given to cultural realities and to the critical interface between those realities and technical development priorities. Often cultural factors are considered in only a superficial way and they are frequently viewed as obstacles to be overcome. Among MCH researchers, program planners, policy makers and field workers limited consideration is generally given to the *cultural systems*, in which all families and individuals are embedded, and which are the foundation for the culturally-defined roles, strategies and resources that communities use to promote the well-being of their women and children.

From a sustainable development perspective, it is essential that programming approaches be found that strengthen existing community and socio-cultural systems. In the international health field, a major challenge is to develop program strategies that build on cultural realities and resources while at the same time contribute to measurable improvements in health-related outcomes. The grandmother-inclusive methodology reported on here is an example of a culturally-relevant approach that contributes to positive health-related results.

From all three sites in Laos, Mali and Senegal where the grandmother-inclusive methodology was used both the quantitative and qualitative evidence support the conclusion that the community mobilization and learning approach contributes positively to strengthening family and community MCH strategies. I believe that these positive results can be attributed to two main facets of the methodology: first,

the fact that it builds on the culturally-defined role of grandmothers in MCH; and second, the participatory, capacity-building approach that strengthens the ability of community members and groups to decide themselves how to best address various problematic aspects of women and children's health and well-being. Both of these facets are further discussed below.

In most cases development programs in non-western societies overlook the significance of the socio-culturally grounded role of elders as advisors and supervisors of younger generations. Numerous programs assume that the best way to introduce new information and change into a cultural context is to focus on younger members of society. In this predominant approach in MCH programs around the world the focus is on younger women, and occasionally on their husbands. In contrast, in the grandmother-inclusive methodology a central role is accorded to senior women, or grandmothers, to mirror their role as key household advisors on MCH matters. As gauged by the very positive feedback on the approach received from grandmothers, family members, community leaders and health and development agency staff it seems that its cultural relevance is a major factor in eliciting community interest, ownership and learning. As one community leader in Mali stated, "The strategy recognized the experience of the grandmothers and gave them a central role to play which reflects our African reality. This is the way programs should be organized." Another benefit of the inclusion of this previously untapped cultural resource was that it strengthened grandmothers' intrinsic commitment to promoting the well-being of younger generations.

The second critical facet of the grandmother-inclusive methodology that appears to explain communities' receptivity and learning is the participatory and capacity-building approach. Essential characteristics of this approach include: public acknowledgement of grandmothers' knowledge and experience through various means including songs of praise; establishing horizontal communication relationships between development workers, grandmothers and other community members and eliciting dialogue and sharing related to key MCH issues; strengthening the skills of development workers to respect and involve grandmothers as partners; using culturally-adapted communication tools, namely stories, songs, dance and group discussion; using problem-posing tools, notably stories-without-an-ending, to elicit collective discussion of both past experiences and of new MCH information; challenging community members to decide if and how traditional and modern practices can be combined; increasing the knowledge and confidence of grandmothers through participatory communication activities with grandmother networks; and reinforcing and expanding the role of grandmother networks and leaders as MCH promoters at the community level.

The cultural-relevance of the grandmother-inclusive methodology is based, on the one hand, on the fact that the grandmothers, who are culturally-designated MCH advisors, play a leading role, and on the other hand, to the overall capacity-building and empowerment approach that acknowledges and builds on community values, opinions, traditional modes of communication, social organization and leadership. The experiences in Laos, Senegal and Mali using this methodology support the conclusion that the cultural relevance of the approach leads to greater community interest, involvement in and ownership of the process and that this, in turn, contributes to greater program effectiveness.

In the several different cultural settings where the grandmother-inclusive methodology has been used to address specific MCH issues, the response of grandmothers has been overwhelmingly positive, their participation has been active and they have been open to considering new MCH-related practices. Given the similarities in the core roles played by grandmothers in families and communities across non-western societies and the cross-cultural appeal of the participatory communication tools used in these experiences, I believe that the generic methodology could be effectively used in many other cultural contexts across the developing world.

In the experiences reported on here the grandmother-inclusive methodology was used to address various MCH issues. I believe that the generic methodology could be used equally effectively to address a variety of other issues/problems to include female genital mutilation, early childhood development, school attendance of girl children, early marriage, HIV/AIDS prevention and care and the broad issue of child rights.

One of the unresolved challenges in community health and development programs around the world is how to sustain the motivation of community resource persons to promote optimal community health practices. In communities where an *untapped cultural resource*, grandmothers, have been actively involved in participatory learning and capacity building activities, their interest and ability to learn and to integrate “modern” practices into their MCH repertoire has been documented and their increased sense of confidence in their advisory role observed. Coupled with their intrinsic commitment to promoting the well-being of the younger generations this evidence suggests that they constitute a very promising and potentially sustainable resource for MCH promotion in communities across cultures.

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