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Barriers and Facilitators of Forming Mother-to-Mother Support Groups as they relate to Infant and Young Child Feeding Practices in Apurimac, Peru

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A thesis submitted to the Faculty of the
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in partial fulfillment of the requirements for the degree of
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Abstract

Barriers and Facilitators of Forming Mother-to-Mother Support Groups as they relate to Infant and Young Child Feeding Practices in Apurimac, Peru
By Adrienne Renee Gilbert

CARE's Window of Opportunity project aims to improve infant and young child feeding (IYCF) and related maternal nutrition (rMN) practices in two regions of Peru. This study conducted formative research in Apurimac, Peru, one region of the Window program. The aim of the study was to determine the barriers and facilitators to implementing mother-to-mother support groups (MtMSGs) in this region. Research indicates that social support groups are successful at improving individual nutritional status among children. Based on this evidence, MtMSGs will aim to increase exclusive breastfeeding (EBF), improve timely and appropriate complementary feeding and promote optimal rMN practices. In-depth interviews were conducted to guide the development of the focus group discussions. Two participatory learning activities, a Social Mapping Activity and a Community Ten Seed Activity, were also conducted to confirm the results of the qualitative data collection. The study was carried out in four rural communities and four peri-urban communities in the region of Apurimac with members of four groups: women of reproductive age with children under two, community health workers, government health care staff and CARE Staff. Data were analyzed using systematic coding and a thematic analysis approach. Findings show that the Peruvian government has already organized many social support groups, through social service programs. Primary barriers to participation in social support groups are lack of time, financial concerns, not being invited by group leadership and negative community perceptions. The primary facilitators of participation in social support groups are material incentives, social diversion or relaxation, a fear of being penalized for not paying dues and a desire to learn new things. Based upon these results, suggestions for the development of MtMSGs are made for CARE's program staff. CARE's collaboration with pre-existing social service programs that have long-standing reputation in the community will be paramount to MtMSG success. To avoid duplicating efforts to conduct educational activities on IYCF practices and rMN, ongoing partnerships in these communities have shown to strengthen activity impact, as observed throughout this study. Collaboration between partnerships could help to engage women and draw upon the collective knowledge of community-based organizations, ultimately strengthening implementation of MtMSGs.

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Chapter One: Introduction

Childhood malnutrition is defined as a pathological state resulting from inadequate nutrition, including both over and undernutrition. Undernutrition occurs when there is a lack of consumption of energy and other nutrients, and insufficient intake of one or more specific nutrients such as vitamins or minerals (Ge & Chang, 2001). Undernutrition is considered to be one of the main underlying causes of about one third of all child mortality in the world. Maternal health and nutrition, especially before and during pregnancy, can have a significant effect on neonatal and prenatal child development (Black, Morris, & Bryce, 2003). Therefore, it is important to focus on maternal and child health and nutrition in the first nine months of pregnancy and during the first two years of life. Not only are exclusive, frequent and on-demand breastfeeding for the first six month of a child's life essential, but timely and optimal complementary feeding at six months of age, with continued breastfeeding to 2 years of age and beyond are important. These behaviors combined with others can be referred to as infant and young child feeding (IYCF) practices (CARE, Window, 2011). It is imperative that women focus on their children's nutrition before they pass the optimal stage of critical physical and psychological development, the first nine months during pregnancy and for the first two years of life.

According to the Department of Health Services in Peru, the rate of exclusive breastfeeding was 65.7 percent in 2008 (1.5 percentage points less than in 2000). This rate of exclusive breastfeeding is relatively high compared to other developing countries. Exclusive breastfeeding in the first month declined from 76 percent o 57 percent by the fifth month, and the median duration of exclusive breastfeeding was 4.6 months in rural areas and 2.7 months in urban areas. The percentage of children who started breastfeeding within 1 hour of birth was 42.2 percent, and the percentage of children who continued to breastfeed at 1 year was 72 percent. Additionally, 41percent of children are bottle-fed. This situation shows that the continuity of breastfeeding is being threatened by the introduction of liquids and other diluted foods with low nutritional content, such as broths,

soups and teas (Window Baseline Data Study, 2010). Our discussion will focus on the importance of exclusive and continued breastfeeding and the importance of complementary infant feeding practices after six months of age.

One IYCF practice that is not practiced widely around the world is early initiation. When a child is born, a mother should give her baby breast milk immediately (Black, Morris, & Bryce 2008; Bhutta, et al. 2008). The first drop(s) of milk that a mother provides to her child are called colostrum, which is a thick-creamy yellowish portion of milk, highly concentrated with proteins, vitamin A and other antibodies. These nutrients help to develop the newborn's digestive tract and help the child to prevent infection. While colosturm is an excellent thing for a newborn to consume, many people are turned off by its consistency and color comparing it to pus. Globally, it is common that many mothers do not practice early initiation of breastfeeding for several reasons. One reason may be that if a mother's milk does not "drop" right away, then she may begin to bottle feed her baby because she believes that she does not have enough milk for her infant. Another reason a woman may not be breastfed immediately is because some cultures believe that colostrum is not healthy for their baby (Dewey & Brown, 2003).

Another IYCF behavior that is practiced less than optimally globally is exclusive breastfeeding. Exclusive breastfeeding is suggested from the day a child is born up to a minimum of six months without the introduction of solid foods, infant formulas or other liquid mixtures. Another IYCF behavior mothers have trouble with is complementary feeding. Similarly with exclusive breastfeeding, preparing the proper mixtures and varieties of foods is challenging is because the process involves a large time-commitment and find themselves divided between among other commitments, such as work (Black et al. 2008; Bhutta, et al. 2008). Starting at six months, soft foods (such as mashed potato, mashed banana or porridge) at the age of 6 months, 2-3 times per day. From the ages of 6 to 8 months, infants should be fed 3 times a day, the same type of foods, but softened, so the infant can easily chew. From 9 to 11 months, an infant should be given food 4 times a day, yet the food should be thickened. Finally, from 12-23 months, and infant should

eat 5 times a day. Likewise, infants should continue to be breastfed up to 24 months in conjunction with these feeding guidelines (CARE, Key and Supporting Messages, 2010; Cable and Rothenberger, 1984; Dewey & Brown, 2003).

There are several purported reasons why some mothers are not able to follow optimal feeding practice guidelines. Among many reasons, mothers may feel that their children might not be full or receiving enough nutrients if they are having difficulty breastfeeding, and therefore introduce a formula or a mixture of semi-solid foods to their infant's diet, prematurely to the optimal guidelines. Some women may feel that their children's developmental behavior might be modified or enhanced by feeding them additional food or product besides breast milk. In cases where some infants are at risk for being fed too much of the wrong nutrients, higher infant weight can be seen as benign, or as a sign of health for some mothers (Heinig, et. al, 2006). In terms of adhering to optimal complementary infant and young child feeding practices, several factors independent factors, such as a child's appetite, caregiver's feeding behaviors, characteristics of the diets themselves (Dewey & Brown, 2003).

These purported reasons why mothers may not be able to follow optimal feeding practice guidelines may lead to the following challenge of stunting. The incidence of stunting is the highest in the first two years of life especially after six months of life when exclusive breastfeeding alone cannot fulfill the energy needs of a rapidly growing child. Complementary feeding for an infant refers to timely introduction of safe and nutritional foods in addition to breast-feeding (BF) i.e. clean and nutritionally rich additional foods introduced at about six months of infant age.

CARE's Window of Opportunity (Window) program is focused on infant and young child feeding and related maternal nutrition. It strives to help families develop optimal nutrition practices with the goal being to improve nutritional status of children under two. In Peru, the program focuses on a range of behaviors including complementary feeding of children 6 to 24 months, active feeding of infants and young children during illness and convalescence and dietary diversity

for children 6 to 24 months and pregnant and lactating women. Additionally, the program focuses on the consumption of Sprinkles by children ages 6 to 24 months, the consumption of iron supplements for pregnant and lactating women, complementary feeding practices, the consumption of safe water for children ages 6 to 24 months and finally, families maintaining healthy and sanitary living environment, while discouraging the use of bottles. Emphasis has been put on this process through individual nutrition counseling, participatory education such as food preparation demonstrations and mother-to-mother support groups (MtMSGs).

The focus of this study is on the barriers and facilitators surrounding the implementation of social support groups related to infant and young child feeding practices in low-resource settings, specifically in Peru. Mother-to-mother support groups have been thought to be a good way to increase optimal infant and young child feeding practices, through sharing stories of personal experience to help support mother peers. They function in part by drawing upon the experiential knowledge of women who had or have children less than two years of age, who can share their experiences with other mothers (Window, 2012).

Friendship and social support are important parts of most people's lives. Both help us to cope with the daily stresses and challenges of life, providing us comfort. Over one hundred years ago, the renowned sociologist, Emile Durkhiem, suggested that social relationships give people a reason for living that transcends their individual lives (Bowling, 1991). Several different disciplines have demonstrated this concept by modeling how social relationships can help in our daily lives.

During the past three decades, social network models have been used and studied in numerous areas of sociology, psychology and anthropology, paving the way for better understanding regarding the aspects of social support that are helpful to individuals during stressful and challenging times in their lives (Thoits, 1986). Relationships with others, especially close interpersonal relationships that involve emotional intimacy, can significantly lower the risk of psychological disturbance

in response to stress exposure. Simply put, friendship and social support help us to recognize, manage and alleviate daily challenges that can help to make our lives more livable by lightening emotional tension and connecting us with resources to help solve problems (Thoits, 1986).

An increasing number of researchers have attempted to link social support to the promotion of health and well-being among people of all ages and with various health conditions (Bowling, 1991). In research specific to health care needs, lack of social support has been associated with increased mortality risk, delayed recovery from disease, poor morale, and poor mental health (Bowling, 1991). Research has found that effective social support groups can provide a secure, warm environment where individuals can feel safe to share their feelings and fears about the problems they are experiencing (Besser 2006). For this reason, social support groups are paramount to people's health because they help them to cope. For example, a social support group in South African for women with HIV called Mothers 2 Mothers demonstrates that social support groups are able to link mothers to existing local networks that provide them with ongoing social support, while simultaneously providing them with connections to community-based, faith-based that are able to provide clinical, psychological and economic support (Besser 2006). Furthermore, some studies have shown that support groups for breastfeeding mothers have increased exclusive breastfeeding and breastfeeding compliance (Albernaz, 1998; Dennis, 2002; Ingram, Rosser & Jackson, 2004). Therefore, this study is important because there is little to no information on the topic and the effectiveness of social support groups in this context.

The health of a newborn baby is directly related to a woman's nutritional behavior in her reproductive and pre-pregnancy years. Maternal nutrition is very important for a healthy pregnancy outcome (Brown et al. 2008). It is essential that pregnant women be properly nourished during the antenatal and the prenatal period in order to guarantee that their bodies contain the essential nutrients to provide her fetus. The essential nutrients that a pregnant woman should consume before and during her pregnancy are a diet, which contains vitamin A, iodine, and zinc (Dewey & Brown, 2003; Black, et al. 2008). Maternal undernutrition, including chronic

energy and micronutrient deficiencies, is a major determining factor of early childhood undernutirton and stunting; the lack of proper nutrient absorption while the fetus is in the uterus has an effect on the initial development of a newborn child (Sawaya et al., 2004). Short term consequences of maternal undernutrition are both maternal and child mortality, morbidity and disability. The long-term consequences are both fetal and maternal body size, intellectual ability, economic performance, reproductive performance and metabolic and cardiovascular disease (Brown et. al, 2008).

In order to understand the current status of social support groups and their effectiveness in this context, background information concerning breastfeeding and early nutrition practices in Peru will be helpful. This study will provide a better understanding of the barriers and facilitators of women's participation in health and social support groups as well as recommendations into the ways in which Window, and other programs focused on IYCF, can implement effective mother-to-mother support groups.

Window in Peru is mainly focused on two activities: (1) individual counseling related to IYCF practices, and (2) food preparation demonstration sessions; however, CARE Peru is now considering implementing mother-to-mother support groups (MtMSGs) as a means of focusing attention on this critical 'window' of time from the prenatal development stage to infancy. Nevertheless, before MtMSGs are implemented within communities in Apurimac, CARE would like run by other NGOs and the government, which exist in their communities.

While examining existing public health and social services groups that are available for our populations of interest in Apurimac, Peru, we will use a theory to guide us through the process of evaluating the social support, which already exists on the ground. A model called the Relationship of Social Networks and Social Support to Health will guide this process (Glanz, 2008). This model will help to delineate one way of thinking about how social relationships give people a reason to commiserate and support one another through challenging life experiences, especially as these relationships relate to public health challenges.

Chapter Two: Literature Review

This literature review provides background information on CARE International and places this discussion in context for exploring young child feeding practices as they relate to CARE's programming. First, the topics of social support and social capital as a means for influencing nutrition interventions are explored. Next, the aspects of support groups that have proven to be successful in public health interventions and reviews the strengths of support groups that might be applicable to the implementation of support for infant and young child feeding practices are covered. A case study is used to demonstrate how social support has been extremely successful for interventions of exclusive breastfeeding. Next, nutrition interventions involving social support groups that have proven to be successful in low resource settings are reviewed. Lastly, the review provides information on existing support groups in Apurimac, Peru and how these groups may inform the implementation of CARE's MtMSGs. Overall, this chapter will provide an understanding for maternal and child nutrition in developing countries and the role that IYCF and rMN programming has on IYCF practices.

Millennium Development Goals

Increasing attention has been given to maternal and child health (MCH) in the past ten years, specifically in developing countries. Since the introduction of the Millennium Development Goals (MDGs) in 2000, urgency has been given to addressing child and maternal health challenges (UN, 2010). The 2010 MDGs 4 and 5 are specifically related to MCH. MDG 4 seeks to reduce child mortality for children less five years of age while MDG 5 seeks to improve maternal health (UN 2010). In response, maternal and child health (MCH) -related studies within the past several years have shown the importance of raising awareness and access to MCH and nutrition programming (Stoltzus, Krebs & Hambidge, 2011; Ehiri & Prowse, Berger 1999). These studies call for programming attention in the areas of iron supplementation for anemia, a full life cycle approach for women's

nutrition, and programs and policies that include heightened access to programming that supports optimal IYCF practices.

Infant and Young Child Feeding, Globally and in Peru

The Millennium Development Goals demonstrate the importance of continued and long-term focus on improving maternal and child health. Globally, women and children are the most vulnerable to the impact of poverty in developing nations (Millennium Development Goals, 2011). The worldwide prevalence of stunting (i.e. short height for age) for children under five years of age in developing nations in 2010 was 29.2 percent (WHO, 2011). Likewise, in all developing nations in 2010, the prevalence of wasting (i.e. low weight for height) for children under five years of age was 9.6 percent and the prevalence for underweight among children under five years of age was 17.9 percent (WHO, 2011). Over one quarter of the children in developing countries are undernourished (MDGs, 2011).

Maternal Nutrition, Globally, and in Peru

Globally, women of reproductive age suffer from anemia, vitamin A deficiency (WHO, 2011). In Peru, the prevalence of anemia in women is approximately 20 percent (WHO, 2011). Due to the fact that Vitamin A is important for fetal growth and maturation and maintenance of the immune system, the WHO recommends, that in areas where Vitamin A deficiency is a major public health concern, that women take Vitamin A supplement to aid this growth process (WHO, 2011). Addressing anemia in women of childbearing age is extremely important because if gone unattended, major fetal developmental problems could take place during gestation and have long-term psychological effects on a child and later on in life as an adult.

Definitions and Causes of Malnutrition and Undernutrition

Often times, the terms malnutrition and undernutrition are used interchangeably, yet are distinctly different and should be clearly defined. Malnutrition can be defined as a deficiency of proper nutrients and minerals in a child's diet or an intake of too much of one type of nutrient or mineral (WHO, 2011). Undernutrition, however, includes malnutrition in its definition and can be described as the outcome of insufficient food intake. It includes being underweight for one's age, too short for one's age (stunted), dangerously thin for one's height (wasted) and deficient in vitamins and minerals (micronutrient malnutrition) (UNICEF, 2011).

There are several social ecological factors that influence poor infant and young child feeding practices and related maternal nutrition practices that point to *why* these challenges exist. The following factors are also relevant to women's participation in mother-to-mother support groups in low-resource settings. On macro-social level, factors that play a role in the persistence of these nutritional challenges are poverty, education, social equality and women's changing roles in contemporary society, and political stability (Ehiri & Prowse, 1999). On a micro-social level, such factors as household sanitary and hygiene conditions and household technology (access to refrigeration and electricity) have an influence on daily food preparation practices and maternal behavior (Ehiri & Prowse, 1999; Reyes, et. al, 2004; Kalita, 2006). Likewise, family characteristics such as family income, household allocation of resources/family organization (a families ability "to combine their knowledge, resources, and patterns of behavior to promote, recover or maintain health status" (Reyes, p.7), family social networks, and child health care resources (Reyes, et. al, 2004). Differences in rural and urban family cultures, unfavorable socioeconomic circumstances, food insecurity, such as difficulties in obtaining food, unemployment, which determines an irregular income for a household, also play a tremendous role in a persistent malnutrition and undernutrition (Reyes, et. al, 2004). On an individual level, maternal child care practices, including child feeding practices, responses that promote a safe and healthy environment for the children, psychosocial interactions and emotional

support, also play an important role in the continuation of malnutrition and undernutrition (Kalita, 2006).

Effects of Malnutrition and Undernutrition

Child malnutrition, partly due to lack of exclusive and continued breastfeeding and access to proper complementary foods during infancy can have immediate, midterm and long term effects on the physical and mental development of a child. Primarily, malnutrition compromises physical and intellectual development during childhood. Undernutrition can lead to poor developmental growth in children under two years of age. Due to the lack of intellectual growth and development during this period, a child's later educational attainment may be affected. Undernutrition in the first years of life can also lead to poorer health in later years. Moreover, studies have shown that childhood malnutrition can affect the overall development of the country. In adulthood, malnutrition contributes to chronic susceptibility to disease and disabilities, and is a cause of long-term poverty (Alderman, Hoddinott, & Kinsey, 2003; Manary & Sandige, 2008; United Nations System Standing Committee on Nutrition, 2004; Victora Adair, Fall, Hallal, Martorell & Richter, 2008, Sawaya & Lydia, 2004).

Maternal and Child Nutrition, as it relates to IYCF Practices in CARE Program areas of Peru

Mothers and babies form an inextricably linked health dyad that cannot be separated. The health of an infant depends upon the health of his or her mother. In the case of Peru, rates of maternal anemia are very high and have had an effect on the health newborn and their health into infancy. Chronic child undernutrition and nutritional anemia in children under the age of five due to the lack of iron in Peru are the most critical nutritional problems in the country (Window of Opportunity Baseline Study 2010). Chronic malnutrition affects about 32.7 percent of children in the two districts (Ayacucho and Apurimac) of Peru where CARE conducts its programming Window of Opportunity Baseline Study). (See Table 1).

Nutritional Statistics of CARE Program areas in Peru

According to the 2008 National Demographic and Health Survey (DHS) and the 2010 Window of Opportunity Baseline Study, as shown in Table 1, stunting affects about 32.7 percent of children ages 18-24 months in Apurimac and Ayacucho (about 44.1 percent in Apurimac). Wasting affects about 8.3 percent of children ages 18-24 months in Apurimac and Ayacucho (about 9.6 percent in Apurimac). About 32.7 percent of children ages 18 to 24 months are affected by chronic malnourishment (44.1 percent in Apurimac).

Table 1. Stunting, Wasting and Chronic Malnourishment in Children in Ayacucho and Apurimac, Peru, ages 18-24 months Years Old (2008 National Demographic and Health Survey and Window of Opportunity, Baseline Study, 2010).

Condition	Percent of Children in Ayacucho and Apurimac Peru ages 18-24 months	Percent of Children in Apurimac ages 18-24 months
Stunted	32.7%	44.1%
Wasted	8.3%	9.6%
Chronic Malnutrition	32.7%	44.1%

Chronic child malnutrition (which includes both undernutrition and over-nutrition) affects about 30.0% percent of children under five in Peru, with large differences between the rural (36 percent) areas and urban (11.8 percent) areas, as shown in Table 2.

Table 2. Distinction of Nutritional Health Challenges in Rural and Urban areas by Percentages (Department of Health Services, 2008).

Condition	Rural	Urban
Chronic Child Malnutrition	36%	11.8%
Low Birth Weight	8.9%	6.4%
Births in Health Service Centers	45%	91%
Anemia in Children, 6-36 months	61%	53.3%
Anemia in Women of Reproductive Age	32%	27%

Differences in percentages of the nutritional health challenges listed in table 2 also exist if we compare regions of the highlands such as Apurimac (34.3 percent) and Ayacucho (37.8 percent) with the capital Lima (9.3 percent). This indicates that the challenges of chronic malnutrition, low birth weight, anemia in children ages 6-36 months and anemia in women of reproductive age are more profound in the highland areas of Apurmiac and Ayacucho, compared to the urban areas of Lima (Window Baseline Data Study, 2010).

Rates of low birth weight stand at 7.2 percent, with smaller differences between urban (6.4 percent) and rural (8.9 percent) areas, although these figures may be underestimated, since only 72 percent of births are attended at the health services, 45 percent in rural areas and 91 percent in urban areas (Window Baseline Data Study, 2010). Nutritional anemia in children from 6 to 36 months reaches 56 percent (DHS, 2007) with differences observed between urban (53.3 percent) and rural areas (61 percent). The rates in Apurimac (64.2 percent) are above the national and rural averages. Amongst women of reproductive age, anemia reaches 29 percent, 32 percent in rural areas and 27 percent in urban areas; amongst pregnant women, anemia affects 34.2 percent, and among breastfeeding women 37 percent (Window Baseline Data Study, 2010).

Table 3. Breastfeeding and IYCF Indicators by percentages in Peru 2010.

Breastfeeding and IYCF Indicators	Percentage
Exclusive breastfeeding, 0-5 months	65.7%
Exclusive breastfeeding in 1st month	76%
Exclusive breastfeeding until 5th month	57%
Average duration of exclusive breastfeeding	Rural, 4.6 months Urban, 2.7 months
Percentage of women breastfeeding within 1st hour of life	42.2%
Percentage of women breastfeeding exclusively at one year	72%
Percentage of women bottle feeding at one year	42.2%

Exclusive breastfeeding was 65.7 percent in 2008 (1.5 percentage points less than in 2000). Table 3 demonstrates that exclusive breastfeeding in the first month declines from 76 percent o 57 percent by the fifth month, and the median duration of exclusive breastfeeding was 4.6 months in rural areas and 2.7 months in urban areas. The percentage of children who started breastfeeding within 1 hour of birth was 42.2 percent, and the percentage of children who continued to breastfeed at 1 year was 72 percent. Additionally, 41percent of children are bottle -fed. This situation shows that the continuity of breastfeeding is being threatened by the introduction of liquids and other diluted foods with low nutritional content, such as broths, soups and teas (Window Baseline Data Study, 2010).

These data call for attention to be focused on optimal infant and young child feeding practices. With regard to complementary feeding, 2004-2006 DHS statistics show that 82 percent of children between 6 and 9 months receive optimal complementary feeding (this is higher than the 76 percent reported by

DHS in 2000; however only 65.2 percent of children received solid and/or semi-solid foods the minimum number of times or more (during the previous day and night), and percentage of children who receive an iron-rich food the previous day was 76.1 percent. In Peru, complementary feeding in children under the age of two years is usually inadequate in amount, quality and frequency (Window Baseline Data Study, 2010). In table 4 below, the anthropometric indicators and key infant and young child feeding indicators are shown for the region of Apurimac by percentage.

Table 4. Anthropometric and infant and young child feeding patterns and practices by percentages in Apurimac 2010.

INDICATORS	Apurimac
Anthropometric Indicators	
Wasting	6.2%
Underweight	9.6%
Stunting	28.6%
Low birth weight	7.4%
IYCF Indicators	
Early initiation of breastfeeding (1 hour)	90.8%
Initiation of breastfeeding (3 days) (with NO other liquids)	91.5%
Exclusive breastfeeding from 0-6 months	82.7%
Continued breastfeeding at 1 year	56.1%
Minimum dietary diversity of breastfed children	89.9%
Minimum dietary diversity of non-breastfed children	90.7%
Minimum meal frequency 6-23.9 months breastfed	95.1%
Minimum meal frequency 6-23.9 NOT breastfed	91.9%
Minimum acceptable diet 6-23.9 months (BF and Non-BF)	94.6%
Consumption of iron-rich or iron-fortified foods	87.7%
Bottle feeding at 12 months	34.8%

The Ministry of Health (MINSA) in Peru acknowledges that attention to IYCF, and other problems related to MCH, require the support from regional and local authorities. In particular, MINSA recognizes the importance of capacity strengthening for health staff, access to quality health services and strengthening

of preventive and promotional health and nutrition interventions. Attention to key programmatic areas will be important in capacity strengthening.

One of the most important aspects of desired programmatic attention is the active participation of the community in health care and maternal and child nutrition activities (Window Baseline Data Study, 2010). This aspect of programmatic attention is particularly important because it has been shown that active involvement of community members builds social capital. Social capital refers to the resources gained from institutional networks (Bordieu, 1985), mutual benefits gained from relationships between and among people (Coleman, 1990), the use of networks, norms and trust to pursue a common interest (Putman, 1996) and a presence that comes from networks with other people that allow them to 'command scarce resources' (Portes, 1995).

Although definitions of social capital remain relatively nascent in current literature, several definitions can help to understand its concept: resources gained from institutional networks (Bordieu, 1985), mutual benefits gained from relationships between and among people (Coleman, 1990), the use of networks, norms and trust to pursue a common interest (Putman, 1996) and finally a presence that comes from networks with other people that allow them to 'command scarce resources' (Portes, 1995).

In order to better address infant and young child nutrition, CARE is currently studying whether strengthening MtMSGs will enhance social capital for women living in these resource poor communities, ultimately reducing infant malnutrition (International Bank for Reconstruction and Development, 2006). It is possible that the development of sustainable, trusting relationships between mothers who have experienced childbirth and are raising young children in the first two years of life, can help women that have yet to give birth. Past research shows that by sharing pertinent and sound advice, the nutritional knowledge and practices of the new mothers improves through gained social support (Bowling 1991; Shea 1992). Eileen Shea, Chairman of the Public Relations Committee and Board of Directors

of La Leche League Canada explains that some women simply like the friendship and support of other breastfeeding women (Shea, 1992).

Furthermore, rural community health workers (CHWs) who are supported by government and/or non-government organizations, such as the Ministry of Health (MINSA) and CARE, strengthen the effectiveness of rural community health networks. The strength, effectiveness and sustainability of such rural community health networks of CHWs can have a profound influence in helping to foster the relationship between young mothers (International Bank for Reconstruction and Development, 2006). Additionally, the strength of a network can foster their personal agency and empowerment to become more intimately involved in building relationships with other women and their community health networks.

Nutritional status for children under two in Apurimac, Peru

According to a baseline survey that the Window of Opportunity project conducted, in the region of Apurimac in 2010, 54 percent of this region is rural with an average of 70 percent of the population living in poverty. About 34 percent of the children in the area are undernourished. The average birth weight of babies in the Apurimac region is about 3 kg (or 6.5 pounds)[1]. Approximately 45 percent of infants aged 18 to 24 months are considered stunted (low height for weight) in growth and considered to be chronically malnourished. (The national average for child stunting is about 30 percent.) About 63 percent of the infants aged 12 to 18 months old are reported to have anemia. Although the previous statistics have demonstrated that infant and young child nutritional status is less than optimal, especially in the highlands of Peru, mothers have shown to be highly compliant with exclusive breastfeeding. About 83 percent of infants are exclusively breastfed between 0 to 6 months of age. Continued breastfeeding was reported at 97 percent between 12 and 18 months of age and at 56 percent between the ages of 20 and 24 months. It is well recognized that the period of 6-24 months of age is one of the most critical time periods in the growth of the

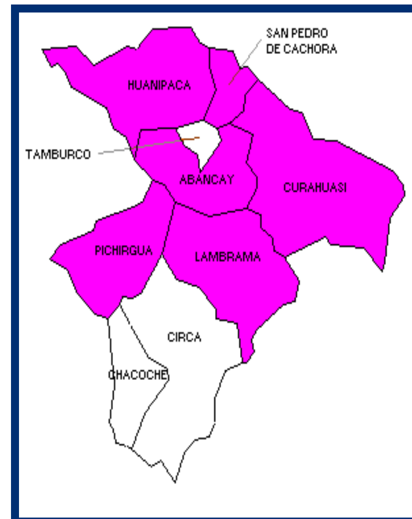
[1] The average weight of a full-term newborn in the developing world is about 3.3 kg, (or 7.3 lbs.) for boys and 3.2 kg, (or 7.0 lbs) for girls (WHO, 2011).

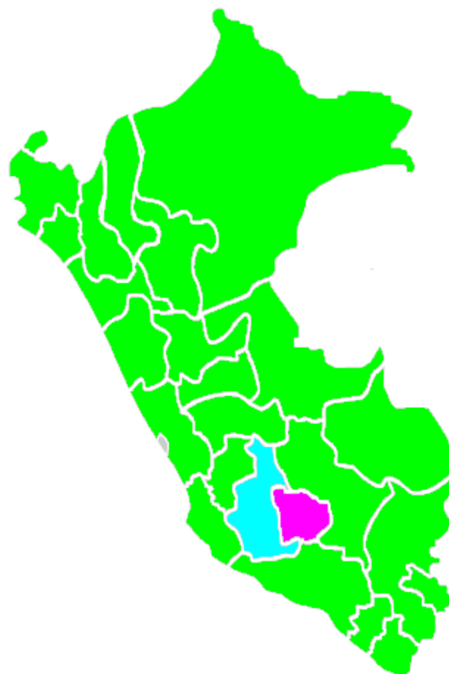
infant. The incidence of stunting is the highest in this period as children have high demand for nutrients and there are limitations in the quality and quantity of available foods, especially after exclusive breastfeeding (Shrimpton, Victora CG, de Onis, Lima, Blossner &, Clugston, 2001). Nutritional anemia in infants 6-36 months is approximately 64 percent, which is above the national rural averages.

The region of Apurimac consists of six districts, made up of several communities. Each of the following names is a district with the number of communities in that district in the parenthesis following: Abancay (8), Pichirhua (10), Curahuasi (45), Huanipaca (25), San Pedro de Cachora (12) and Lambrama (20). Figure 1 displays a map of the project location that highlights the regions of Apurimac and Ayacucho, specifically Apurimac.

Figure 1: Project Location Map

Project Location Map
Peru, Project Region of Apurimac
Regions: Apurimac & Ayachucho





The Window of Opportunity is being implemented in three of these six districts: Abancay, (where CARE's district office is located), Curuhuasi, and San Pedro de Cachora. Table 4 describes the beneficiary population of the Window of Opportunity Program, including both of the regions where the CARE Regional offices are located. Highlighted in red are the region, province and districts where this study has been implemented. The number of communities the Window of Opportunity project serves are highlighted: Abancay has 8 communities, Curahuasi has 45 communities, and San Pedro de Cachora has 12 communities.

Table 4: Number of Communities, Population Totals and Participant Beneficiary Totals of the Ayacucho and Apurimac Project Regions

Region	Province	District	Communities	Total Population	Direct beneficiary population	Pregnant and Breastfeeding	Girls/boys under the age of two
Ayacucho	Huamanga	1. Tambillo	27	5 381	475	255	220
	Huanta	2. Huanta	40	41 842	3 893	2 188	1705
		3. Huamanguilla	29	5 413	471	251	220
Apurimac	**Abancay**	**4. Abancay**	**8**	**11 269**	**1 090**	**674**	**416**
		5. Pichirhua	10	4 536	425	233	192
		6. Curahuasi	**45**	**19 643**	**1 819**	**986**	**833**
		7. Huanipaca	25	5 483	506	273	233
		8. San Pedro de Cachora	**12**	**3 904**	**363**	**197**	**166**
		9. Lambrama	20	3 380	314	170	144
		Total	**216**	**100 851**	**9 356**	**5 227**	**4 129**

The combined total population of these three districts, in the region of the Apurimac, at the time of data collection of the 2010 Baseline Study was about 34,816 people. The combined number of women in these three districts who are direct beneficiaries of the Window program is about 3,272 women. The number of women who were breastfeeding and/or pregnant at the time of the 2010 baseline study was roughly 1857 women. The number of children, both boys and

girls, under the age of two years old at the time of the baseline data collection in these three districts was 1,415 children.

Apurimac is among the three departments (or provinces) with the highest levels of poverty (69.5 percent), child malnutrition (34.3 percent) and illiteracy (21.7 percent), and reduced rates of access to basic services. Access to running water is about 32.3 percent, local sewage plumbing about 18.5 percent and electricity about 56.6 percent. Child mortality rates are about 52 in every 1,000 live births, with rates of nutritional anemia of children under 36 months about 64.2 percent (Window Baseline Data Study).

CARE's Window of Opportunity Program

Background of CARE

Cooperative for Assistance and Relief Everywhere, Inc., known as CARE, is one of the world's largest private international humanitarian organizations, committed to helping families in poor countries improve their lives and achieve lasting triumphs over poverty. Founded in 1945, CARE, originally known as the *Cooperative for American Remittances to Europe,* provided relief to survivors of World War II. The term that many Americans have come to know as a 'care package' was coined after the American Army arranged for Americans to send care packages to their families and friends in Europe, where millions were in danger of starvation. CARE now works in more than 80 developing countries to strengthen communities through programs that address root causes of poverty. Recognizing that women and children suffer from poverty disproportionately, CARE places special emphasis on women and girls to create long-lasting social change. The CARE USA headquarters, located in Atlanta, Georgia, is one of 12 member organizations of CARE International committed to communities in the developing world (CARE, 2011).

Peru was the first country to adopt the International Code of Marketing of Breast-Milk Substitutes in 1990 as part of its national legislation. This was followed by the development of the Baby-friendly Hospital Initiative (BFHI) in 1992, in conjunction with the WHO and UNICEF. From 1993 to 1995 the Peruvian Ministry of Health developed its Action Plan for implementing BFHI, with the technical and financial support from UNICEF, PAHO/WHO and USAID. By 1997, 60 Baby-friendly Hospitals had been accredited in Peru. The programs put in place by the Maternal Breastfeeding Committees in these hospitals showed a significant increase in the percentage of breastfeeding in the first hour after birth from 17.5 percent in 1992 compared to 54 percent in 2000 (Window of Opportunity Baseline Study, 2010).

In 2006 the Peruvian Government modified the National Child Feeding Regulations bringing them in line with WHO definitions and guidelines. This technical document focuses on achieving effective child feeding practices for children ages 0-24 months. Following, the Peruvian government attempted to improve the nutritional status of children by focusing on delivering a considerable amount of its resources to food assistance programs. Unfortunately, these programs were not been highly organized. In 2006 the Ministry of Health shifted its priorities and focused mainly of curative services, children nutrition strategies, such as the promotion of breastfeeding and infant and young child feeding practices. Nevertheless, these interventions have lacked sufficient resources to improve technical capacities and the educational component in order for behavioral change to occur (Window of Opportunity Baseline Study, 2010). Subsequently, chronic malnutrition in children remained unacceptably high during the 1996–2005 period, at 25 percent nationally and 40 percent in rural areas. As a consequence even despite significant government investment, social programs focused on child nutrition have had limited efficiency and effectiveness, despite significant Government investment, chronic malnutrition in children remained unacceptably high during the 1996–2005 period, at 25 percent nationally and 40 percent in rural areas. Social programs were not effectively coordinated with programs from other sectors. There was no clear progress

towards precise objectives, which an absence of a planned intervention model. Programs were not focused effectively on achieving clear and precise objectives. There were an absence of planned and goal-oriented interventions, with little funds and weak monitoring and evaluation systems (Window of Opportunity Baseline Study, 2010).

Given the high prevalence of chronic child malnutrition, CARE Peru in alliance along with other NGOs and donors formed an alliance called the Child Malnutrition Initiative (CMI) in 2006. This initiative focused on national advocacy for the implementation and institutionalization of public policy to fight child malnutrition. From 2006 to 2011, the Peruvian government improved its public policy by improving the organization of state action to improve malnutrition interventions. This included multi-sectoral interventions in coordination with different public and private entities. During this period in 2007, the government created the National CRECER (GROWING) Strategy, which focused on technical assistance to the government concerning implementation strategies. CARE Peru is now an active part of the coordination spaces of CRECER in the Regions of Apurimac, Ayacucho and Huancavelica. The Window of Opportunity Project has been created to work with the community, the health system and national, regional and local authorities in the promotion, protection and support of adequate maternal and child nutrition practices. These initiatives take place within the framework of the National CRECER Strategy and the Baby-friendly Hospital Initiative (Window of Opportunity Baseline Study, 2010).

Current Window of Opportunity Programming and Related Initiatives

The Window of Opportunity project is a five-year funded program, designed to protect, promote, and support breastfeeding and optimal infant and young child feeding (IYCF) practices of children less than two years and related maternal nutrition (rMN) practices for improved nutritional status of women of reproductive age. It is currently being implemented in five countries that include: Bangladesh, Indonesia, Nicaragua and Sierra Leone. Each country was selected

based on nutritional status of infants and children under two and the country office experience with IYCF programming.

In recognition of CARE Peru's experience and preparedness to implement a nutritional programming, it was selected as one of five countries in the Window of Opportunity project. The Window of Opportunity project began in Peru in December of 2008 and will conclude in December of 2012. This project offers an innovative combination of service delivery, capacity strengthening, facilitation and advocacy, which promotes essential nutrient actions, and increases the accessibility of nutritious foods. Past studies conducted by CARE in Peru have shown that child nutrition strategies have lacked sufficient resources to develop interventions that improve technical capacities and educational components to improve behaviour change (Creed-Kanashiro, 2011). In an effort to continue to work alongside government organizations that have a long-standing reputation in the communities, CARE, recognizes the need to partner with the Peruvian Ministry of Health in order to maximize their efforts to improve child malnutrition and related maternal nutrition. The Window project is aligned with the goals and intervention strategies with the Ministry of Health (MINSA) in Peru:

In Peru, Window specifically focuses three project activities:
(1) Organizing national, regional and local authorities advocating to strengthen the National CRECER Strategy[1];
(2) Improving management capacities related to nutritional deficiencies among regional and local authorities, and;
(3) Developing the capacity of the health sector to apply targeted actions to improve maternal and child feeding.
More specifically, under the activities led by regional and local groups, the following activities are being implemented:
(1) Individual counseling to promote Infant and Young Child Feeding Practices (IYCF) on the individual level;

(2) Demonstration sessions about breastfeeding and food preparation for infants of 6 to 23 months, as well as hygiene and sanitation workshops at the community level, and;
(3) Mother-to-mother support groups

In the other Window countries, the MtMSGs have been implemented; however, these groups are new in the Peruvian context. At the time this study was conducted, the support groups had not begun to be implemented. The results of this study will help guide the development and implementation of the MtMSGs.

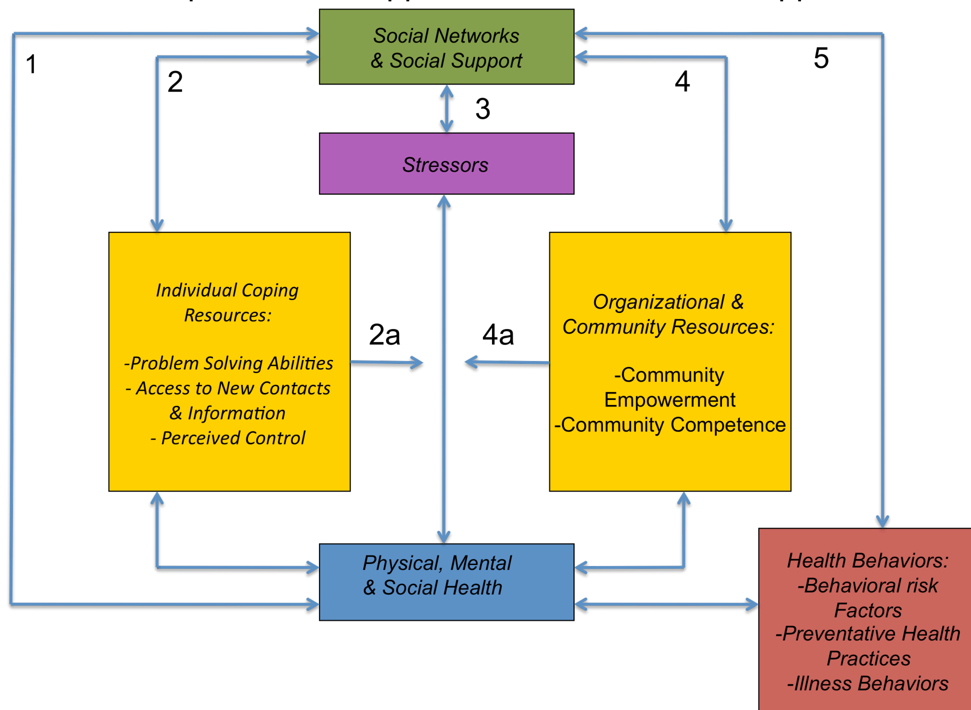
Public Health and Social Services as Social Support Groups

While examining existing public health and social services groups that are available for our populations of interest in Apurimac, Peru it is important delineate certain factors of such 'successful' groups that help to define their function and success. As we have discussed, social relationships give people a reason to commiserate and support one another through challenging life experiences. In other words, connection to a social network, and in turn access to social support, allows individuals to connect to a purpose beyond themselves. Social support can be defined as the interactive process in which the emotional, instrumental, or financial aid is obtained from one's social network (Bowling, 1991; Myers 1975). Other sociologists include the aspects of emotional concern (liking or love among members), instrumental aid (services received), information (about the environment in which they live and work) and appraisal (information for self evaluation) in the definition of social support. It is important that an individual feel that they are members of a network of 'mutual obligations', where similar personal concerns are addressed within that group (Bowling, 1991). Therefore true support exists only if the individuals involved feel that the support they receive leads to certain beliefs they posses or connects to needs they have (Bowling, 1991).

Other sociologists and psychologists, such as, House, Cobb, Kaplan and Thoits, suggest that the greater the number of the *links* (or significant others) in the social network, the greater the health protectiveness of social supports, and the greater

the support *functions* of the links, the more health protective the network (Myers, 1975). Different from social support, social capital is a concept that develops out of the social network that is developed or possessed within a community of neighborhood. Social capital is important to consider when describing social support groups. Social capital can exist within social networks (Berkman & Glass, 2000). Sociologists, Berkman, Cobb, House, Kaplan and Thoits, also suggest several characteristics of networks that appear to be relevant to the strength of social support groups (Bowling, 1991). Those characteristics are: (1) a connection with other people in order to receive social support; (2) the size of the network; (3) frequency of contact between members; (4) geographic location; (5) transportation facilities that influence frequency of the contact; (6) density/integration of the contacts; (7) the strength of the ties (strength of intimacy, aid, reciprocity, availability, emotional intensity); (8) the composition (friend, neighbor, etc) of the group and finally; (9) the quality or member satisfaction with the support (Bowling, 1991). Additionally, the individuals' subjective views of the group, in terms of the meaning of the relationships and the strength of 'affectional' ties are also important to the success of support groups (Durkheim, 1951). Figure 2 below represents one conceptual model of how we might explain the role of social networks and social support in explaining their relationship to health outcomes. This model is called the Relationship of Social Networks and Social Support to Health (Glanz, 2008).

Figure 2. Relationship of Social Networks and Social Support to Health



Various mechanisms through which social networks and social support have positive effects on physical, mental and social health are represented in this model (Glanz, 2008). Pathway 1 represents a hypothesized direct effect of social networks and social support on health and suggests that by meeting basic human needs for intimacy, a sense of belonging and reassurance of one's worth as an individual, health and general well-being will be enhanced regardless of stress levels (Glanz, 2008). Pathways 2 and 4 represent a hypothesized effect of social network support on individual coping and community resources (Glanz, 2008). The pathways suggest that social networks and social support can enhance an individual's ability to access new contacts and information to and support for personal problems (Glanz, 2008). Alternatively, Pathway 3 suggests that social networks and social support may influence the frequency and exposure to stressors (Glanz, 2008). Lastly, Pathway 5 reflects the potential effects of social networks and social support on health behaviors (Glanz, 2008) (such as breastfeeding, infant and young child feeding practices and related maternal nutrition). Glanz (2008) explains that, through the interpersonal exchanges within

a social network, individuals are influenced and supported in their health behavior choices that can have an influence on personal risk factors and preventative health behavior. This pathway makes explicit that social networks and social support have an impact on the incidence of, diagnosis of, and recovery from discovered illnesses or conditions (Glanz, 2008).

Likewise, studies from CARE have demonstrated that health and social service social support groups in rural settings have created a tremendous amount of social capital and helped sustain community development projects (Howes & Bode, 2003). The challenge at hand has been to continue stimulate the social capital that exists within the communities, by helping women utilize the social networks (and social support), which exist in their communities. It is thought that by continuing to help women remain connected to these social networks, it will help them to utilize their resources, both human and material capital in order for them to continue to practice preventative health behaviors.

Case Study: Le Leche League

Taking the concepts mentioned above into consideration, a particular case study surrounding women's social support groups and nutrition helps to demonstrate how support groups can be integrated into a community. A renowned example of a social support group that has proven to be incredibly effective is 'La Leche League', meaning 'The Milk League'. Developed in 1957, La Leche League was formed by a small group of women to give information and encouragement to other women to breastfeed. Today is has members in over 50 countries, and publications in about 35 languages, and has reached more than 6 million breastfeeding women (Shea, 1992). Studies express that one of the reasons that the group has proven to be successful is that women are very responsive to breastfeeding counseling (Shea, 1992; Marrow, 1999). Counseling differs from mother-to-mother support groups in that it is directed by a professional towards a mother, where as support groups are peer led and based on experiential learning. The leaders of La Leche League act as the experts in breastfeeding counseling, supporting women in the technical aspects of breastfeeding as well as guiding

them in the logistical and emotional struggles surrounding the activity. Support can take place before pregnancy, which is the optimal time or after the child is born (Shea, 1992). As for support groups, La Leche League has provided an open and safe space for women with similar experiences to provide positive and supportive feedback for one another (Shea, 1992).

Depending on the context in which La Leche League is working, support and training may take various forms depending upon the specific population. For example, La Leche League provides training on breastfeeding geared towards individuals who will provide support to breastfeeding women via peer support. Training might include lectures and stimulated breastfeeding sessions, role-plays, and practical sessions for hands-on experience. In addition to this training, peer support counselors also visit communities to demonstrate their learned skills at the community level and attend peer led mother-to-mother support groups. These support groups focus on four main areas (1) advantages of breastfeeding, (2) early breast-feeding, including techniques for breastfeeding, (3) breastfeeding difficulties and how to overcome them, and (4) complementary feeding (Nakunda et. al, 2006; Dearden et. al 2002). Research indicates that women's exposure to information shared during Le Leche League mother-to-mother support groups and sessions with peer counselors, either through emotional support or help accessing clinical services, increases their knowledge and breastfeeding behaviors more so than women who were not exposed to the support groups and counseling sessions (Nakunda et. al, 2006; Dearden et. al 2002; Marrow et. al, 1999).

In the case of La Leche League, women are provided a safe space to open-up emotionally about challenges and successes they have had in a comforting environment Based on these experiences many women are drawn to one another to share common, emotionally charged IYCF experiences and this often times heightens the strength of the a groups. Important to note is that the organization has had a profound impact on the perception of breastfeeding, especially in developing countries where open and continued breastfeeding is more culturally acceptable than in Western developed nations (Cable & Rothenberger, 1984).

Social support groups have been associated with improved health outcomes. In these groups, members are able to surround themselves with others who are experiencing similar life events to them, providing an *empathetic understanding* of the particular challenge at hand (Thoits, 1986). Derived from the social comparison theory, it is thought that "…effective support is most likely to come from socially similar others who have faced or are facing the same stressors, and who have done so or are doing so more calmly than the distressed individual" (Thoits, 1986, p. 419). Both socio-cultural and situational similarity enhance the likelihood of the perception and reception of empathic understanding, the condition under which coping assistance should be most effective' (Thoits, Cohen & McKay 1984; Coates & Wortman, 1980). Women have been able to provide support and help to solve personal challenges of breastfeeding and complementary feeding (Shea, 1992). As an aside, women are reported to discuss more topics with their network members, and to report more help from people with whom they communicate their concerns (than are men) when they are provided such a space (Thoits, 1986).

Although La Leche League has had an impact on breastfeeding practices, the organization has not adequately addressed complementary feeding practices. Although not explicitly stated in studies regarding La Leche League or other related breastfeeding studies, it seems as though the focus on the importance of breastfeeding has overshadowed the equally important phase of complementary feeding. Nevertheless, several studies show that the continued development of exclusive breastfeeding programming and focus on complementary feeding practices are needed to support the period of time after six months of exclusive breastfeeding is achieved (Dearden, 2002; Brown & Dewey, 2003; Piwoz, Huffman, & Quinn 2003).

Effective Social Support Groups in Low Resource Settings: Case Studies of Effective Groups

Few interventions have led to sustained changes in nutritional practices (Allen & Gillespie, 2001; Andrien & Beghin, 1993). Nevertheless, many social support

groups have been successful in bringing out effective health improvements in other areas, such as HIV/AIDS, mental health and other related birth outcomes (Besser, 2006; Bowling, 1991; Manandahar et. al, 2004). We will discuss case studies of effective social support groups in low resource settings.

Evidence suggests that in low resource settings, community based interventions may be more effective than clinical health care based interventions due to the lack of access to the health care services themselves (Haines, et.al, 2007). "Improvement in health facilities alone is not sufficient to avert a large proportion of child deaths (in part due to malnutrition) because facility based services often emphasize curative care over prevention and because children from poor families (in low resource areas) are less likely to access health facilities than are wealthier families" (Haines, et. al, 2007). This points to social support groups, community health workers, grandmothers, and mothers themselves as being effective resources within community based interventions. Bhutta suggests that interventions that can be routinely scheduled and delivered, such as immunizations or antenatal care, and are more often utilized in low resource settings than those that rely on availability of clinical services (Bhutta, et. al 2008). It can be suggested that the use of social support groups within these routinely scheduled interventions, can be used to augment the effectiveness of the interventions in general.

Literature shows that women of reproductive age, more so than medical professionals, will seek the advice they need from those within their extended family or community, such as grandmothers and older women who are family friends, who have also had similar experiences (Aubel et.al, 2004). The literature indicates that shifting from a "directive pedagogy", which is used in much of western behavior change communication (BCC) strategy, to a community participatory communication approach, where community members are encouraged to create dialogue amongst themselves, is central to effective social support (Aubel et al, 2004; Allen & Gilespie, 2001). Having the women and female elders be the central components to their own learning discoveries is essential because women capitalize on a trusted source of knowledge.

One study in Senegal, which incorporated the use of senior, grandmother, community members as 'camouflaged household actors' into a generally directive health education program, has demonstrated how to successfully incorporate collective community social values into teachings about infant and young child feeding practices (Aubel et. al, 2004). The study consisted of an action research project that utilized the grandmother's knowledge and experience, advised through storytelling, songs, skits, and group discussions that was implemented into the larger community health program of the Ministry of Health. Unlike traditional models of health directive health education models, this intervention used 'stories-with-out-an-ending' which elicited discussion of problematic nutrition related situations and possible solutions (Aubel, 1995b). The intervention consisted of four parts: (1) an initial qualitative community study on the role of grandmothers in health and nutrition; (2) development of the nutrition education methodology with the NGO, Children's Christian Fund and the Ministry of Health stakeholders; (3) implementation of this strategy into 13 villages; and (4) documentation and evaluation of the strategy (Aubel et. al, 2004). Pre and post-tests were given to mothers of infant children in the intervention communities and the control communities. Twelve months after the implementation of the program 100 women were sampled; 93% of the women in the intervention community were able to report that they introduced the first complementary foods to their infant's diet at 5 to 6 months (as opposed to 35% of the control group). Likewise, of 150 grandmothers sampled in the intervention communities, 97% were able to name two foods rich in iron, as opposed to 57% of the grandmothers in the control communities (Aubel et. al 2004). Overall the data suggests that the combined efforts of the intervention showed evidence of positive changes in community nutrition norms, both for the mothers themselves, and for the grandmothers as rich resources of familial knowledge and social support (Aubel et. al, 2004).

Another nutrition intervention that has shown to be effective in low resource settings is the Hearth Model (See Appendix A), which has been implemented in Haiti, Vietnam, Pakistan, Egypt and Bangledesh (Allen & Gillespie, 2001;

Schooley & Morales, 2007). The model has served as a component of comprehensive programs, which have included growth monitoring, deworming, vitamin A and iron supplementation, and treatment for infectious disease. In this model, volunteer mothers from the community conduct feeding sessions, called 'hearths', in order to provide malnourished children in the community with a nutritious meal. The women who act as models for their peers in this manner are called 'positive deviants' and are encouraged to socialize, disseminate and share the behaviors and practices they use in order for other mother's to replicate their behavior (Schooley & Morales, 2007). The women who prepare meals with and for mothers who have malnourished children posses similar socioeconomic challenges, yet have found ways to overcome the barriers that their families face; they practice positive behaviors in order to help socialize their peers to do the same, without external influence (Schooley & Morales, 2007). The basic model of the intervention used in Haiti, (1) identified 'Positive Deviant' families in order to observe their feeding and care behaviors, (2) taught the behaviors to mother's of malnourished children, and (3) subsequently evaluated the impact on children's nutritional status (Schooley & Morales, 2007; Berrgen & Wray, 2002). The model also includes elements of behavior communication change (BCC) strategy and social learning theories as the basis for the nutrition education component of the model (Allen & Gillespie, 2001). Schooley and Morales explain:

It is an asset-based approach that focuses on what is positive and possible, then draws upon the resources and solutions inherent in a community rather than focusing on problems and needs that can only be addressed with outside intervention. It tends to be more empowering and less dependency-creating than many traditional development approaches, and because practical solutions are found within the community and promoted by the community, behavior change is often more likely to be maintained by the community members (Schooley & Morales, 2007).

The authors speculated that the Hearth Program was most effective at preventing further deterioration of children who were moderately malnourished, because the model was used in conjunction with other program interventions as mentioned

above (Schooley & Morales; Allen & Gillespie, 2001). The model has also been used for behavior change in interventions involving female genital cutting in Egypt and to identify to inform HIV/AIDS prevention interventions in Vietnam. As previously mentioned the underlying need for social support groups is important in the preventative stage of early initiation of infant and child feeding practices. Although the positive deviance hearth model has shown to be successful in these cases, the model has also been widely for being labor intensive and unsustainable. Likewise the disadvantages of solely focusing on growth are that unhealthy practices might be overlooked (i.e. a well-nourished child who has yet to become ill despite bottle-feeding. Replicating positive behaviors may also be evident and easy during brief moments during an observed intervention, or during the critical and immediate newborn period, but perhaps not during longer term learned behaviors throughout infancy (Lapping, et. al, 2002).

A final example of the use of social support is for the prevention of mother to child transmission of HIV/AIDS in South Africa. This example reinforces the idea that social support groups as a preventative intervention are successful when coupled with other programming and used in collaboration with clinical efforts already in place by national and local health organizations. An innovative and powerful HIV/AIDS prevention and treatment support project called, 'Mother 2 Mother (M2M)', has been used to combat the transmission of mother-to-child transmission of HIV, including providing support to mothers who need extra support in feeding their infant children the proper foods during this critical period (Besser, 2006). M2M has been able to link mothers to local networks that provide ongoing social support through mother-to-mother support groups. Through "peer-peer mentoring and support groups, M2M has been able to inspire HIV positive women to take control of many aspects of their lives, including how to feed their infants" (Besser, 2006). It is important to note that the activities of M2M "complement the efforts of and fill the gaps in a clinical model reliant on doctors, nurses and lay counselors already over-burdened fulfilling their clinical responsibilities" (Besser, 2006, p. 122). In this model intervention, the mothers act as 'Mentor Mothers' who are key care providers. A central program manager oversees site coordinators at individual clinics, who manage the Mentor Mothers

within given communities. Over the past five years M2M has "developed and refined a replicable, scalable, sustainable, integrated, cost-effective model of peer-based support… which has fostered female empowerment, leading the staff of M2M to act as leaders and role models in their families and communities" (Besser, 2006, p. 128). This intervention provides evidence for social support groups' effectiveness as they are coupled with clinical and social support efforts already put in place by NGOs and government run programs.

Overall, those interventions that draw upon knowledge and strength from within the community have shown to be the most effective. Community members are more receptive to information and practices, which makes sense to them, socially and culturally. Interventions that draw upon the assets of the community are positive. "It is an asset-based approach that focuses on what is positive and possible, then draws upon the resources and solutions inherent in a community rather than focusing on the problems and needs that can only be addressed with outside intervention" (Schooley & Morales, 2007). Likewise, interventions that are introduced to the community in collaboration with pre-existing social service organizations have proven to be successful.

Existing Support Groups in the Apurimac Region

When this study began in May of 2011, there were several public health and social service social support groups functioning on the ground in Apurimac. Understanding the background and function of these groups is imperative in understanding the barriers and facilitators that might be in place concerning CARE's development of successful mother-to-mother-support groups. Four groups in particular have the largest presence and reputations within the communities: JUNTOS, or 'Together', Vaso de Leche or 'Glass of Milk', 'Club de Madres' or Mother's Clubs, and 'Wawa Wasis' or (the Quechua name for) Government Run Child Care Centers.

Of seemingly utmost importance to the women in the community was JUNTOS, a governmentally operated organization with a long history in the community. The organization offers a financial incentive of 100 New Soles (Peruvian currency,

about 36.50 USD) to each woman who is formally inscribed in the social service group. The groups are informative in nature and focus on support for feeding children through economic support. In order for women to get the financial incentive they must attend a JUNTOS meeting when they are offered. Women who do not attend the meetings regularly are removed from the program. An overwhelming concern the women have about JUNTOS is avoiding 'sanctions' or a financial penalty for not attending the meetings.

Similarly, the group 'Vaso de Leche' or Glass of Milk, is a group focused on mothers support around nutrition and child care and prevention of malnutrition, family violence and alcoholism. Like JUNTOS, Vaso de Leche offers the women liters of milk or powered milk products as an incentive and nutritional supplement. Along with JUNTOS, 'Vaso de Leche' is one of the most often attended social support groups which women from these communities attend.

More social and self-organized in nature, the third social group that held the attention of the women involved in the study were the community 'Club de Madres' or Mother's Club. These clubs revolve around different kinds of common social and hobby experiences such as cooking, sewing, weaving and gardening. These clubs function as a means for women to congregate as friends and also to benefit from selling their products in order to raise funds to supplement their families' incomes.

Finally, one of the newest social service organizations implemented by the Peruvian government is the 'Wawa Wasi', or (the Quechua name for) Government Run Child Care Centers. These centers are located within the communities and provide childcare support for mothers who work both in rural and urban areas. Due to the fact that the groups mentioned above are relatively new young and understudied, there has not been much research conducted on the competing uses or attendance between groups. Therefore, the results of this research study will help to understand why some of the groups are more utilized than others.

Summary of Literature Review

In summary, social support has been and continues to be a form of healing because it allows us to connect with people who have had similar experiences. Some might argue that this is particularly true for women who are and have been experiencing challenges of child rearing such as breastfeeding and appropriate and timely complementary feeding. Due to the fact that maternal and child health are inextricably linked, it has been shown that concern for child health begin during and even before a women's pregnancy. This is especially true in the case of Peru where maternal anemia has been shown to contribute to the health or lack thereof, of a newborn or growing infant. Breastfeeding and complementary feeding are of equal importance to address. CARE programming in Peru has addressed these issues by working with the Ministry of Health and implementing individual nutrition counseling and food preparation demonstration sessions through the Window of Opportunity. As the literature has shown, social support groups have been successful in improving nutrition practices (Allen & Gillespie, 2001; Besser, 2006; Lapping et. al, 2002; Schooley & Morales). Social support groups are particularly helpful because they allow behavior change to take place from within the women's social and cultural context, which has proven to be more sustainable than directive behavior change education interventions are rooted in outsider's authority.

Significance of Study

The new information this study will provide for maternal and child nutrition programmers are (1) ways in which programming can be better developed to focus on targeting better infant and young child feeding practices; (2) identifying aspects of the social and cultural setting that make it challenging for women to partake in mother-to-mother support groups; (3) reveal aspects of mother's lives that will contribute to their desire and ability to want to participate in mother-to-mother support groups and; (4) provide information about programs within the communities that are already successful in terms of sustained social support and how these groups can act as model for how mother-to-mother support groups can be developed and modeled in other communities. Finally, the findings of this

study will be important to share with health and development organizations that are interested in maternal and child health practices, specifically as they relate to the development, implementation and on-going monitoring and evaluation of the mother-to-mother support groups.

Research Questions

This study will examine the following three research questions:

RQ1: What are the barriers to participation in mother-to-mother support groups (MtMSGs), for women of child bearing age or who have children less than two years of age in Apurimac, Peru?

This question is important to include because in order to improve MtMSGs, a clear understanding of factors that hinder participation will allow CARE and others to potentially address problem areas.

RQ2: What are the facilitators of participation in mother-to-mother support groups (MtMSGs), for women of childbearing age or who have children less than two years of age in Apurimac, Peru?

On the flip-side, this question will offer insight as to what encourages women to participate in programming. This information will help IYCF program implementers develop strong and sustainable MtMSGs.

RQ3: What are the alternative support groups, to mother-to mother support groups, which already exist in Apurimac, Peru, which aim to promote breastfeeding and infant and young child feeding practices and related maternal nutrition?

The significance of the final question is to understand if women already participate in a social support group that addresses IYCF and whether or not CARE is duplicating efforts. Additionally, by identifying networks of support in the communities that already exist, CARE will be able to understand *what is*

already functioning for the women and how CARE might be able to learn from those groups and/or programs. It is crucial to understand what social support groups already exist in the communities and why the mothers are loyal participants of these groups and organizations. The ultimate concern is not to determine whether the groups are in competition with one another, but to learn why particular social support groups are more appealing, to perhaps create a synergy between those groups that can work together. Ultimately we could like to be able to emulate the components that allow the groups to be successful so that CARE might be able fill any gaps with the new mother-to-mother support groups.

Chapter 3: Methods

Study Description

Specifically, this study explores the barriers and facilitators of the women's ability, desire, and willingness to attend pre-existing health and social support groups and what alternatives to support groups, mothers feel might be more relevant and useful. Ultimately, this study will provide operational research for programmatic suggestions to CARE Peru and other new programs that implement community-driven, mother-to-mother support groups in low resource environments. It is hoped the findings from this study will enhance interventions that are currently being implemented in the field office of CARE Peru for the nutritional practices for children less than two years of age and women of childbearing age. Qualitative methods were used for data collection because they facilitate an understanding of why, how and under what circumstances behaviors occur (Ulin, Robinson, & Tolley, 2005). In addition, qualitative inquiry is particularly useful for emerging topics or unexplored areas of research, in order to gain a holistic understanding of the complexities of human behavior (Sterk & Ellifson, 2004). Using interview guides with an open-ended question format allows the researcher to capture the viewpoints of the study participants (Patton, 2002). In regards to this study, the open-ended interview format will demonstrate to be particularly helpful in exploring the women's perspectives as they unfold, about their thoughts, feelings and emotions surrounding their experiences within their communities and beliefs, attitudes and actions surrounding participation in health and social support groups. The Doer/Non-Doer Interviews gave the team a base platform for which to formulate questions for the focus group discussions in order to delve deeper into to the mother's, health personnel and CARE staff's perspectives, based upon the general perspectives of the women. These results helped to shape the Focus Group Discussion Guides and the richer results. The study also utilized focus groups, social mapping activities and community ten seed activites in order to triangulate the data collection.

Participants

The participants included women who have children ages two years or less and mothers of childbearing age in the regions of Apurimac where CARE programming us currently being implemented. Participants were selected from eight different communities in the region of Apurimac where CARE Peru currently has programs implemented, along-side the Ministry of Health (MINSA) in the community. Of the eight communities where participants were recruited, four of the communities were rural and four of the communities were peri-urban. Other participants included in this study were health care professionals that work with the above-mentioned women in locations where CARE programming is currently taking place. Likewise, the CARE Staff members themselves were included in the study as a means to triangulating perspectives of the research questions at hand.

Inclusion criteria for women of childbearing age and women who have children less than two years of age participate in the IDIs were the following: (1) Must be living in one of the eight Window target communities (either rural or peri-urban); (2) Must be of childbearing age or, if they have children, their youngest child must not be older than two years of age; (3) Must proficiently understand more Spanish, (or speak more Spanish than Quechua, the native language of Apurimac), due to the fact that the principal investigator spoke Spanish and not Quechua and; (4) Be a resident from one of the eight targeted communities. We were interested in interviewing an equal number of women from rural and peri-urban areas to gain the perspectives of how their experiences might vary due to their physical locations. Due to the fact that communities in rural areas have shown to have less connectivity to certain resources (due to factors such as transportation, work and economic activity), the CARE team was interested in comparing these differences.

Procedures

Setting and Recruitment of Participants

In order to maximize the time and potential to recruit from these communities, the principal researcher accompanied CARE Peru staff members to food preparation demonstrations (one of Window's current activities) and meetings at the Municipal Clinic of Curuhuasi. The majority of the women who need medical attention, who live in these eight communities, if they are not seeking (minor) medical attention or unscheduled appointments from their community *posta* (health post), have appointments with the doctor, OBGYN, early childhood specialist, and dentist at this Municipal Clinic. Many of CARE's programming activities, accompanied by the staff of the Ministry of Health (MINSA) are also held in this clinic.

The principal researcher recruited women, using non-probability convenience sampling, from the waiting area of the clinic, either before or after CARE program meetings or during high volume scheduled appointment times, usually during the hours of 9 a.m. to 1 p.m. The sampling could also be called quota sampling because a certain number of women from each of the communities were to be sampled. The principal researcher approached women as a representative of CARE and screened them for participation in an interview about the health and social support groups in which they are participants. If the women agreed to take part in the interview, they were asked if they met the inclusion criteria for the study. As this screening took place, the principal researcher asked the participant to indicate the community she lived in. After each community had the number of desired participants accounted for, and the principal researcher could not recruit any more participants from the Municipality in Curuhuasi, she traveled directly each community. She recruited at the *posta* (health post) or asked the community health technician to take her directly to the home of women who have children under two years of age.

If the IDIs were conducted at the Municipality Clinic of Curuhuasi, they usually took place on the porch of the clinic, outside of the waiting area or in an empty office, separated from the other people in the room. In any of the above-mentioned settings, the researcher conducted the interviews as far away from the hearing of the other people in the clinic as possible. The data collection took place during various times of the day. It was also advantageous to conduct interviews about 20-30 minutes before a CARE program activity took place, because the women usually came early to wait before the events started. If the interviews took place in the individual communities, they took place either at the *posta* (health post) or at the women's homes.

Questionnaire Development and Pilot Testing

The IDI guides consisted of one semi-structured interview guide for both women of childbearing age and women who have children less than two years of age. The interview guide was pilot tested with a convenience sample of women from three of the communities in Apurimac. After the interview was pilot tested once, changes were made according to the women's understanding of the questions and then repeated two more times. The interview guide began with four questions to build rapport. This helped to develop familiarity and begin small conversational points with the participant before the interview began. These questions are as follows: (1) What is your full name? (2) What community do you live in? (3) How long have you been living there? and (4) What are the names and ages of your children, if you have children? (Appendix B). The interview guide consisted of twenty questions, which were divided into five content or subject domains: (1) participation; (2) positive and negative consequences; (3) self-efficacy; (4) susceptibility and; (5) social norms. The themes for this guide were adapted from the Designing for Behavior Change Curriculum (BCC) workshop (CORE Group, 2008) at CARE International on May 4th 2011, led by Dr. Lenette Golding, Senior Technical Advisor for the Window of Opportunity. Each question contained follow-up questions or probes where necessary in order to help facilitate conversation. Questions were asked which followed the natural progression of the conversation in order to elicit the appropriate data when necessary. The IDI guide

was developed in order to separate the women, as respondents, who *do* participate and social support groups, named participants or 'doers', from those who *do not* participate, named non-participants or non-doers, in health and social support groups. The purpose of this separation was to organize the focus group questions based on those women who consistently participated and those who did not consistently participate in health and social support groups. The first question of the participation domain determined this distinction, and the non-doers then began answering domain two. Appendix B contains the IDI guide developed for the doers and the non-doers.

The IDIs were built around the *designing framework* which targets one single behavior, in this case participation or non-participation in health and social service groups, in order to understand the beliefs, actions and external influences which drive the behavior. This framework involves five categories which can help the researcher understand a person or people's actions: (1) Identify the *behaviors* from the participants point of view; (2) understand the *priority or influencing group* of this particular behavior; (3) discover the *determinants* of the behavior; (4) address the *key factors* which influence or surround those determinants and; (5) determine which activities can be conducted in order to help shape behavior change surrounding this particular behavior (Designing for BCC Workshop, 4 May, 2011). Table 5 identifies example questions from each of the five domains, and follow-up questions and probes, where they are appropriate:

Table 5. Data collection instruments items

Determinants of Behavior	**Related Main Questions and Follow-Up Probes:**
Group Participation	Do you belong to a social organization right now? If yes, which one(s)? If no, why not?* In the last year, how many times have you participated in the meetings of X (or Y) organization?* In the past year, have you participated in any other meetings of any other organization, other than the one(s) you have mentioned? What things did you like the most about participating in this (these) group(s)?

Positive and Negative Consequences of Group Participation	Do you believe that it is important to attend meetings in the community? Why or why not? What do you gain from participating in the meetings of X (or Y) organization? For example: new information. Or, What are the good things about participating in the meetings? What do you lose from participating in the meetings? For example: your time, or other activities. Do you think that your attendance at the meetings helps you take better care of your family? For example: feeding your children that are less than two years old?
Self-Efficacy in relation To Group Participation	Why can you not attend meetings? For example: you do not have transportation What helps you to assist meetings without problems? For example: when someone is able to care for your children while you attend.
Susceptibility of Influencing Factors on the Behavior	If you cannot attend meetings, could something bad happen to your family? If yes, what? Do you think that you will know less information regarding your infants if you do not attend meetings? Yes, no, and why?
Social Norms Influencing the Behavior	Who does not support or like your participation in the meetings? Why do you think they do not support or no like your participation? Who supports or likes your participation in the meetings? Why do you think they support or like your participation? Is it well regarded in the community to participate in meetings? If yes why? If not, why not?

*Designing for Behavior Change Communication Workshop, 4 May 2011,Golding, CARE

Barrier Analysis:

The Barrier Analysis is a rapid needs assessment tool that utilizes both quantitative and qualitative features. It is a tool used in community health and other community development projects to identify behavioral determinants associated with a particular behavior. These behavioral determinants are identified so that more effective behavior change communication messages, strategies and supporting activities (e.g., creating support groups) can be developed. The Barrier Analysis uses the Doer/Non-Doer Interview as its instrument of choice. It focuses on eight determinants: perceived susceptibility, perceived severity, perceived action efficacy, perceived social acceptability, perceived self-efficacy, cues for action, perception of divine will, and positive and negative attributes of the action (i.e., the behavior).

The Doer/Non-Doer Interviews gave the team a base platform for which to formulate questions for the focus group discussions in order to delve deeper into to the mother's, health personnel and CARE staff's perspectives, based upon the general perspectives of the women. Based upon the eight determinants of behavior mentioned in methodology section, behaviors emerged from the Doer/Non-Doer Barrier Analysis as being significant for barriers and facilitators for both the Doers and the Non-Doers (See Appendix J). These results helped to shape the Focus Group Discussion Guides and the richer results.

Based upon the data collected from the four different data collection tools; the Doer/Non-Doer interviews, four focus group discussions (one focused on the DOERS, one on the NON-DOERS, one with Ministry of Health Staff, and one with the CARE Staff members themselves), and two participatory learning activities; the social mapping technique and the Community Seed Activity, both quasi-statistical/quantitative and qualitative results were collected to form the results of this study.

Informed Consent and Confidentiality

Due to the fact that the study was considered to be non-research with human subjects by Emory University's IRB in March of 2011, informed consent was not required. However, ethically, the researcher felt that it was necessary to show respect and build rapport with the participants and to positively represent CARE International, by asking permission from the participant. Participants were asked permission to be recorded. All of the IDI data collection procedures were conducted in as quiet and as private areas as possible, in order to ensure the utmost participation of the participant as possible.

Audio Recordings

Each interview was recorded digitally to ensure that all of the information that the participants were providing was captured. Before each interview began, the investigator asked the participant if they were willing to be recorded in order that the investigator could better understand and capture the information they provided. The investigator also told the participant that the information would only be heard by the investigator herself and that the information would be used to help listen, another time and more carefully, to the beliefs and ideas or the participant in their native language. The recoded files were saved on the researcher' computer desktop and a USB drive, which was only accessible to her. All of the interviews were transcribed word-for-word into Spanish, but identified with an anonymous participant identification number.

In-depth interviews

Thirty-two in-depth interviews (IDIs) were conducted with women of childbearing age or who have children that are two years old or less in the targeted communities. Based on the number of children who were under two years of age in each community, a proportionate number of interviews were conducted with women from each of these communities. Sixteen interviews were conducted with rural participants from: Ccoc-hua (4), San Luis (5), Bacas (3), and Concacha (4) and sixteen with peri-urban participants from: John F. Kennedy (4),

Micaela (5), San Cristobal (3), San Juan de Dios (4). Little research has been conducted on the facilitators and barriers of participation in support groups which pertain to infant and young child feeding practices. Therefore, IDI Surveys were chosen as the best way to explore the participant's "attitudes, interests, feelings, concerns and values as [they] relate to the research topic" (Salazar et al., 2006, p. 182).

Focus Group Discussions

Participants-Community Member Focus Groups

Based on the division of participants (doers) and non-participants (non-doers) of the preliminary results of the IDIs, two focus group discussions (FGDs) were conducted with women who live in the communities where CARE programs take place. Focus groups discussions were included in this study because discussions among groups of people surrounding a particular topic are able to shed light on the topic as it is discussed through group dynamics (Salazar et al., 2006, p. 186). The researcher understood that it would be important to understand health and social support group participation as it is viewed through the women in the community as whole. The key feature of the focus groups were desired group perspective of the thoughts, feelings, beliefs and actions of the women who are doers and women who are non-doers. After the preliminary analysis of the IDIs was reached, questions were formed for two specific FGDs, based on the responses that the women gave the researcher during the IDIs. Two FGDs were formed, (1) made of mostly of doer women in the rural community of Concacha, who discussed questions about women who consistently participate in health and social support groups (2) and the second made up of mostly non-doer women from urban communities who met in Curuhuasi, who discussed questions about women who do not consistently participate in health and social support groups. Originally, the researcher and CARE team would have liked to organize two focus groups: (1) with women who *only* are doers, and (2) the other with women who are *only* non-doers. However, due to logistical reasons and time

transportation limitations, the FGD guides question were developed to reflect the group's perspective of both doers and non-doers together.

Health Professional Focus Groups

Two additional FGDs were conducted: (1) with the health care staff of the Ministry of Health (MINSA) and (2) the CARE Peru Apurimac team staff. The FGD with MINSA included an OBGYN, male and female nurses, clinic administrators, and health education facilitators. The purpose of this FGD was to gain a group dynamic perspective of the clinical professional who serve this female population concerning most of their clinical health needs. The district clinic where these clinical professionals work is located in Curuhuasi. The fourth and final FGD that was conducted was with the CARE Peru Abancay staff members: the program manager who is a nurse, and two program support members, one of which whom is a nurse and the other a licensed nutritionist. The group dynamic perspective of the CARE staff members themselves is an incredibly important component of this study, due to the fact that the programs that CARE has been implementing for Window has derived directly from the work and expertise of these female staff members who have been working with the women in the program for the past several years. The combination of these different FGDs allowed the researcher the ability to triangulate various perspectives in order to better reach conclusions about the questions this study is asking.

Procedures

Settings & Recruitment of Participants-Community Member FDGs

FGDs took place in two communities that were prearranged by the CARE Peru Abancay staff members who are assigned to those particular communities. The FGD that was conducted in the rural community of Concacha was conducted immediately following a community health event at the community *posta* (health post). This FGD was focused on participants who were doer participants. After

the women were finished participating in the JUNTOS (national government supported nutrition program) meeting, the CARE staff member asked women who had children under the age of two years old if they would like to take part in a FGD inside the health post in a private, vacant examination room. Six women agreed to participate, all of which spoke as much Quechua as they did Spanish. The CARE staff member led the focus group with the investigator acting as a co-facilitator and note-taker. This community was selected for the first FGD due to the fact that recruitment would be advantageous due to the timing of the community event. The second FGD that took place was conducted in the municipality clinic of Curuhuasi in the late afternoon. This FGD was focused on the non-doer 'participants'. The CARE staff member who works in the urban communities prearranged the meeting by calling women she knew who pertained to health and social service groups who she knew would be particularly knowledgeable about the actions, beliefs and attitudes of women who do not participate in health and social support groups. This focus group was conducted in an empty conference room of the clinic. Four women agreed to participate, all who spoke Spanish more fluently than Quechua. The CARE staff member led the focus group with the investigator acting as a co-facilitator and note-taker. This group of women was arranged because they live in peri-urban settings, where more women tend to be non-doers than rural communities. Also, the late afternoon for many women in the peri-urban environment is a good time to meet, due to their ability to leave the home after many chores have been completed. It was also a time that the CARE staff member was available to conduct and translate the FGD.

Health Professionals FDGs

Two separate FGDs were conducted with health professionals. The first included staff from MINSA and the second FGD was conducted with staff from CARE. The program coordinator for the Window of Opportunity project arranged the FGD of the MINSA health care professional team. She has a long history and successful working relationship with many people at the clinic and arranged the time and place that would be the best for these participants to meet. The FGD was

conducted in an empty conference room at the municipal clinic in Curuhuasi on a weekday in the early afternoon. The professionals who were recruited to participate in the FGD represent the various working relationships that the staff has with women in the communities who have children who are two years of age or less. They were chosen because they have an intimate understanding of the health, social and personal challenges that these women face on a daily basis. Likewise, the FGD with the CARE Peru staff in Abancay was arranged due to the understanding that the three staff members have working with current CARE programs in Window target communities. The researcher arranged this FGD with the CARE staff at the CARE office in Abancay at a time of their convenience. The CARE staff FGD was able to produce rich data concerning the perspective of staff who work with the women and the logistical problems the staff faces as they learn, day by day, the daily routines of the women in the Window target communities.

Data Collection Instruments and Administration of the Community Member FGDs

The FGD guides for the community member FDGs in the rural and peri-urban communities of Concacha and in Curuhuasi were developed based on the preliminary results of the IDI Surveys conducted with the 32 women. The guides contained 23 questions. The guides were based on the results of the IDI Survey questions. Both focus groups lasted about 40 minutes. The women were asked to sit in a circle to foster conversational discussion and were given refreshments as the discussion began.

Health Professional FGDs

The FGD guide for the health professional FDGs with MINSA and CARE Peru Abancay Staff were developed based on the preliminary results of the 32 IDIs and community based FGDs. This guide includes 25 questions. Based on the results of the IDI questions and FGDs of the community members, surrounding the main emerging determinants of group participation, the FGD guides were tailored to

reflect how the health professionals might give the researcher insight on the struggles women face as mothers. The focus group lasted about 90 minutes. The group of health professionals was asked to sit in a circle in order to foster conversational discussion and was given refreshments as the discussion began.

The FGD guide for the CARE Peru Abancay staff, likewise was developed and based collectively upon the preliminary results of the 32 IDIs and of all the previous FGDs. This guide consisted of 17 different domains, and included 43-questions. Due to the fact that the CARE staff worked with the investigator on a daily basis, the team was prepared to have an extended FGD concerning the topic. Each of the three team members received a copy of the list of questions and fully participated in the discussion. The investigator led the facilitation of the FGD. Based on the results of the IDI questions and FGDs of the community members, the FGD guide, from the researchers and community development perspectives, the questions were tailored to reflect how different social and contextual/cultural determinants affect the women's group participation.

Audio Recordings

Each FGD was recorded digitally to ensure that all of the information that the participants were providing was captured. All participants agreed to be audio recorded. Before each FGD began the investigator asked if the participants were willing to be recorded and were told the information would only be heard by the investigator herself and those transcribing and translating for the purposed of the study. The recorded files were saved on the researcher' computer desktop and a USB drive. All of the FGDs were transcribed word-for-word into Spanish, but the participant voices were described with descriptions of what they said and where not identified by name.

Social Mapping and Community 10 Seed Activities

Social Mapping

Social Mapping is a participatory learning activity (PLA) which takes place in a group setting. The activity allows individuals to express themselves using a visual representation of where different aspects of their community are located or what aspects of their community are influential to them. In this case, each member of the group draws a map to describe which aspects of the community provide them most with the most social support.

Participants, Recruitment and Setting

In order to maximize the time on traveling to communities and data collection, the researcher organized the social mapping activities to take place with a purposive sample, with the same participants who were included in both of the community member FDGs. One social mapping activity took place in the rural community of Concacha, and included six women. Directly after the women were finished with the social mapping exercise they participated in an FGD. All of the six women were from the rural community of Concacha. These women represented the voices of the doer or participants. The second social mapping activity took place in the Municipal Health Clinic of Curuhuasi with four women who represented the voices of the non-doer, or non-participants. The four women were from the peri-urban communities where CARE programs were currently implemented. This activity took place directly after the FGD.

Procedures

During the social mapping activity, each woman was given a large blank sheet of white paper and a set of markers. The women were given instructions to draw a woman from their village or district in the middle of the page. Then the participants were asked to draw, list and/or label, around the woman, all the places and or people in the community where they get information, go to meetings, or talk about IYCF practices. Then the participants were asked to draw

a circle around, or a line from the woman, to the person, meeting or organization that gives the woman the most social support on these topics. After the women completed their drawings, the facilitator and researcher had a 15-20 minute discussion about the drawing, including questions about why they circled or did not circle the certain people or organizations. An additional explanation for the purpose of the Social Mapping activity, and discussion questions can be found in Appendix F. After the discussion was over, the researcher asked if she could have the drawings from each of the women to be part of the data analysis. (Appendix I)

Audio Recordings

The Social Mapping activity was recorded digitally to ensure that all of the information that the participants were providing was captured. The same procedures as the FGDs were followed for the audio recordings. The audio recordings were not transcribed verbatim, but were reviewed in order to analyze major emerging themes.

Informed Consent and Confidentiality

The same procedures for the FGDs were followed with the Social Mapping Activity.

Community Ten Seed Activity

The Community Ten Seed Activity is a participatory learning activity (PLA) used to gather qualitative information on various topics in a community. It is useful in gathering information related to the perceptions of community members and the way they see their own behaviors and attitudes in relation to others, in an interactive manner. For this activity, ten seeds are used to represent the "breakdown" of community member participation and time spent on certain activities or certain features of the community. The activity helps to explain why certain activities may be more popular than other activities, based on community members' interests and participation (Jayakaran, 2002).

The Community Ten Seed Activity was the third tier of the data collection process. The questions asked during the community ten seed activity were developed from the preliminary results of the focus group discussions as a way to triangulate the data being gathered. These results are considered to be Quasi-Statistics or mixed methods.

Participants, Recruitment and Setting

In order to maximize the time on traveling to communities and data collection, the researcher organized the Ten Seed activities to take place in one of the peri-urban communities, San Luis, and in one of the rural communities, Concacha, and where the health post nurses had concurrent activities arranged, to ensure the women's participation and/or attendance in the activity. The first Ten Seed activity consisted of 15 women in San Luis, all who had children under two years of age and who regularly attend CARE's food preparation demonstrations at the health post. The second Ten Seed activity took place in the early morning at the health post in Concacha where the women were waiting to be seen by the clinic nurse to weigh and measure their babies. The activity consisted of 6 women in Concacha, all who had children under two years of age who participate regularly in health and social service groups in the community.

Procedures

During the Ten Seed activity, each woman was given a seed that she used as a 'response marker'. The women sat in a large circle around a pile of large sheets of colored paper that had written response boxes for each of the questions they were asked. The researcher explained to the women that the purpose of the activity was to understand and learn about their perspectives on attending health and social support meetings in the community. She also explained to the women that they were to think about their own thoughts and feelings about the questions they were asked about health and social support meetings. They were told that their seed would represent their personal response to each question that was asked to the

group on the activity guide (Appendix G). The researcher assured the women that there was no, right or wrong answer, but that it was simply an activity to understand their perspectives. The activity guide was adapted from techniques in 'Use of the Ten Seed Technique', a training manual by Dr. Ravi Jayakaran (2002). There were twelve questions on the activity guide which were placed into the following categories: (1) behavior regarding participation, (2) negative and positive consequences of participation, (3) self-efficacy, (4) factors that facilitate participation, (5) gender roles, and (6) sources for information. These categories were developed based on the preliminary results of the IDIs and the FGDs. The researcher then posed a question to the group of women and gave them a few minutes to think about their answer. The researcher then read aloud, and pointed, the answer options on the sheet of paper. The researcher then asked each woman to place her seed in the appropriate answer box or their choice. For example, Question 1 on the activity guide, was "Do you find it difficult to attend social or support groups in the community?, Response Options: Yes/No/Sometimes" (Appendix G). The researcher also helped and reminded the women of which box corresponded to which answer, if the women were not literate. Based on the number of seeds placed in each both, the researcher facilitated a short discussion with the women on why they thought the majority of women said, for example, "Yes", "No", or "Sometimes." The same procedure was followed with each of the twelve questions on the guide (Appendix G). After the activity was over, the researcher gave each of the women a piece of fruit and or a package or cookies for their participation in the activity.

Audio Recordings

The Ten Seed activities were recorded digitally to ensure that all of the information that the participants were providing was captured. The same procedures as the FGDs were followed for the audio recordings. The audio recordings were not transcribed verbatim, but were reviewed in order to analyze major emerging themes.

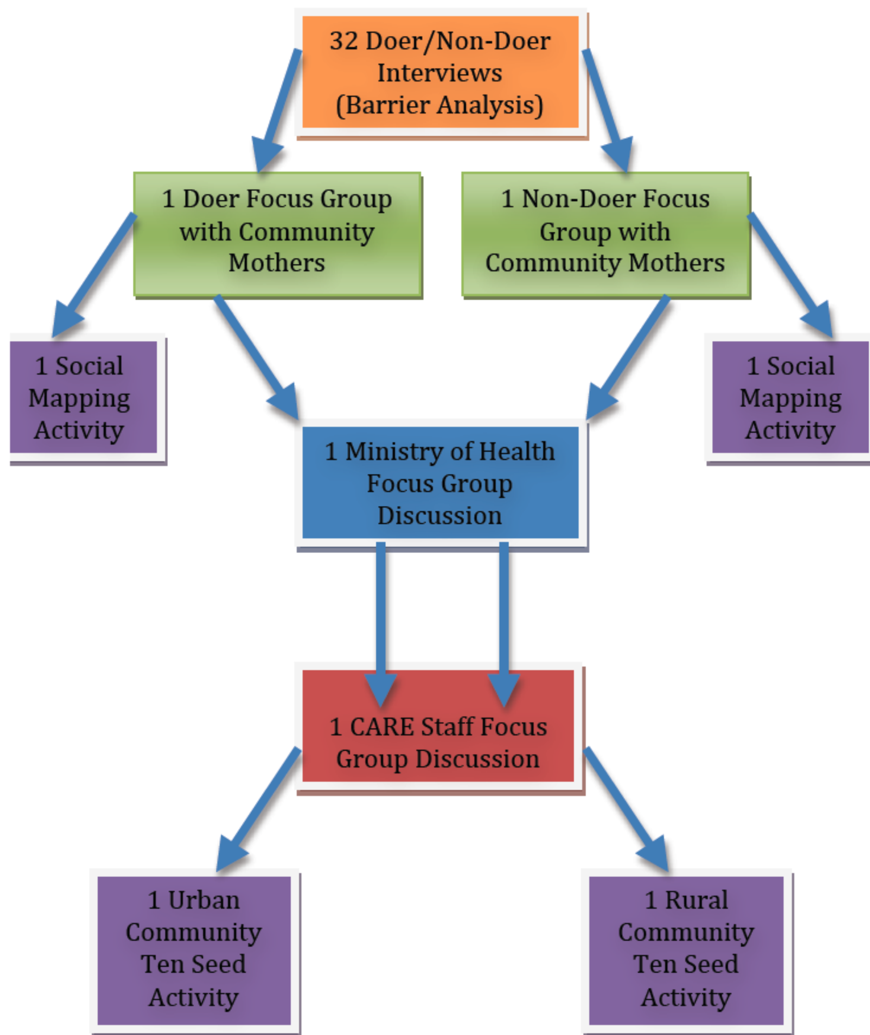
Informed Consent and Confidentiality

The same procedures for the FGDs were followed for the Ten Seed activity.

Data Analysis

A tiered data collection process helped the principal investigator to arrive at preliminary data results in each phase of the data collection to help inform the final analysis process. The in-depth interview (IDIs) guides and results were used in order to generate themes that could be used to guide the development of the focus groups discussion guides. A research framework for this process can be seen in Figure 3 below.

Figure 3: Research Data Collection Framework



The doer and non-doer interviews served as the first tier of the data collection process. The principal investigator used thematic analysis to generate the most common themes in the first several IDIs. This 'quick' analysis served as the first tier of the process. The second tier of the data collection process was the doer and non-doer FGDs. The social mapping activities were conducted along side each of the doer and non-doer focus group discussions and incorporated into the final analysis. The results of the doer and on-doer focus group discussions (FGDs) were used to guide to the development of the MINSA FGD protocol. Likewise, during the second tier of preliminary of analysis with the FDGs, thematic analysis was also used to analyze the themes by comparing and contrasting new themes that arose after the FGDs had been conducted. The third tier of the data collection

was the MINSA Focus group discussion. The results from the MINSA FDG were then utilized to develop the protocol questions for the CARE FGD. The community ten seed activities were conducted in the same rural and urban communities where the focus group discussions took place and were shaped by the results of the CARE Focus Group discussions. The community ten seed activities were conducted to validate the CARE focus group discussion results. The community ten seed activities were analyzed by generating the frequencies of the responses elicited from both of the activities. Counting the number of responses that were recorded on paper during the activities gave us the frequencies. Although each tier of data collection was used to develop the following tier, each data set was thoroughly analyzed on its own. MAXQDA qualitative data analysis software was used to analyze the most common themes for both the IDIs and the FGDs. The principal investigator used a combination of grounded theory and thematic analysis to generate the most common themes in both the IDIs and the FDGs. The data sets from the Social Mapping activity and the Ten Seed activity were used in conjunction with the results in order to triangulate the final results.

Chapter 4: Results

This section will consist of five major components. The first section will provide an overview of the existing and most utilized social support groups in the study context. Following, an explanation of the participants 'doer' and non-'doer' interview results will be provided. The third section will consist of an explanation of the perspectives of the mothers who participated in this study, from the results of the Community Ten Seed Activity. Additionally, the barriers of participation and second the facilitators of participation will also de discussed. The fourth section will cover the perspectives of the Ministry of Health staff, including some of their ideas for program recommendations. The final section will consist of the perspectives of the CARE Staff and what they see as the barriers of participation, what is currently bringing women to the groups, and their recommendations for program implementation. (A table of the Community Ten Seed Activity can be found in Appendix K).

Overview of Existing and Most Utilized Social Support Groups

In this section the principal investigator will describe the characteristics of and identify the spaces in the community where the mother and child under two years old come together with other mothers and to share experiences about caring for their child. By applying the Barrier Analysis method, groups of mothers who were considered "doers" were mothers that participated in one of the following social support groups at least once in the past six months. Mothers that had not actively participated in one of the following support groups: JUNTOS, Vaso de Leche, Club de Madres, Asembleas Comunales and Wawa Wasis, in the last six months where considered, "non-doers", or non-participants. Although some of the "non-doers" had participated in the social support groups in the past, they were not considered active members for the purposes of this study. The researcher strived to recruit an equal number of doers and non-doers for the activity. There were about an equal amount of women were "doers" (18/32) as "non-doers" (14/32).

The information collected from the doer/non-doer interviews enabled the team to understand the dynamics of the areas or groups within the community where

mothers are involved to see the opportunities that could have an impact on the implementation of the mother-to-mother support groups in the communities. The research team found that in theory mothers who gather together to express themselves and talk about topics of their interest form these groups. Nevertheless, the team found that in groups where monetary and material 'hand-outs' were involved women were more interested in the material goods which were offered to them, rather than focus on the content of the educational meeting, brief presentation or intended health message exchange. Furthermore, the exchange of material goods also played a role in creating an ill-perceived social division between mothers who were considered to be formal members of the government run groups, and those who were not. Women who were not formal members of the groups, for reason that will be further explained, tended to seem or feel badly for not being 'invited' to participate, which created a sense of exclusion. Additionally the doer/non-doer interviews indicated that although women are given time to socialize with the health personnel or group leaders before the formal presentations (during the food 'hand-out session the group's leader simply provided the mothers with information on the future meetings. The women socialize with one another, which is encouraged, but the focus of the meetings are not on the educational content, but on the details of the upcoming meetings, the details of the food hand-out and political logistics of the groups. The CARE staff had hoped that these sessions would be found to be more informative; however, they lacked educational based content or skill building activities or practice sessions.

Before an in-depth discussion of the results, a brief summary of the existing and most utilized social support groups will provide a foundation for further discussion of the results. Based upon the results of the doer/non-doer interviews the most utilized groups are the following and a brief summary of each: (1) JUNTOS, 'Together', (2) Vaso de Leche, 'Glass of Milk', (3) Club de Madres, 'Mother's Club', (4) Comedor Popular, 'Popular Dining Room' or 'Common Eating Place', and recently introduced and becoming more popular, (5) Wawa Wasi, Quechua, "House of Baby".

(1) *JUNTOS, 'Together'*, is a government program operated through the Ministry of Health, which began in 2005 as a Condition Cash Transfer (CCT) program, that provides economic assistance of 100 Nuevo Soles (about 37 USD) a month to families who qualify for assistance. Women of economically disadvantaged families must provide the group leaders with their children's birth certificates, their personal identification numbers, and proof of their income to be formal members of the group (JUNTOS, 2012). JUNTOS attracts families that have children, but who are older, yet under the age of about 14 years old. Where as the original intent of the program was said to have been more educational, from the perspective of the CARE Staff, the program often times, simply functions as a CCT program.

(2) Likewise, *Vaso de Leche, 'Glass of Milk'*, is a governmentally operated program through the Ministry of Health, which began in the early 1980's, which provides either fresh milk or canned milk to families who qualify and are officially members of the group. Similarly to JUNTOS, both groups are formally run and official members pay a fine of 5 to 10 Nuevo Soles if they do not attend the monthly meetings. Women who consistently do not attend the meetings might be considered to be removed from the groups if they repeatedly offend. In order to avoid being sanctioned, or taken out of the group, women attend meetings are regularly as possible. As with JUNTOS, this program was hoped to have been more educational, from the CARE Staff, we well, but remains to be, in many cases, a kind of 'hand-out' social service.

(3) Whereas JUNTOS and Vaso de Leche are government operated, aimed to be informative in nature, where money or food products are exchanged the *Club de Madres,* or *'Mother's Clubs'* are independent community organized meetings where women come together to share a space where they can cook, partake in sharing crafts such as weaving, embroidering, or work in their plant/horticulture gardens in order to sell products at the markets to raise money as income. Mothers believe that the meetings should be used to converse about nutrition and childcare, to discuss malnutrition prevention in children, and to talk about domestic violence and alcoholism. For these groups, women do not have to be formal members, and attend the meetings organized by other mothers in their

communities, as they are able to attend.

(4) *Asembleas Comunales, 'Community Assemblies'*, like the Club de Madres are independent community organized meetings which are organized by leaders of the community who feel that it is important to come together to discuss the specific needs unique to the particular community, such as 'community cleans', repairing the roads, and other general community-wide concerns. These meetings more so than the previous three mentioned groups, involve men as the main organizers and do not involve an educational focus, rather a community work- type group to come together and solve tasks or problems in the community.

(5) The fifth most commonly mentioned and discussed support group or organization was the *Wawa Wasi,* or in Quechua, the indigenous Peruvian dialect, the *"House of the Baby"*. The Wawa Wasi is a government run day care group/center that started in the early 1990's that is paid for through a partnership of government's Ministry of Education and funding form UNICEF. Each community that has a Wawa Wasi has a centrally located space, with a day care provider paid for from the government. The women in the community who work on the farms or in other various day time jobs are able to drop their children off at the Wawa Wasi, free of charge, in order for their children to be cared for while they are working. The 'mother-in-charge' is a caregiver who is trained in health care, early child stimulation, and basic nutrition. The meals that are given to the children by the caretakers are supplemented from Vaso de Leche (UNICEF, 2011).

Mothers' Perspectives on the Barriers of Participation in Social Support Groups

This section will consist of an overview of emerging themes for the barriers to participation, results from the Community Ten Seed Activity, and a thorough explanation of the barriers of participation in the social support groups from the perspective of the mothers.

Overview of Emerging Themes for Barriers

Several factors became evident as barriers to the mother's participation in support

groups. The following were the main theme categories for barriers. Sub-categories will be discussed in further detail: (1) *Lack of Time:* the fact that women had to work, either inside or outside of the home (2) *Feelings of Inferiority* as they relate to social and community norms (3) *Financial Concerns* relating to the formal group participation requirements, (4) *Gender Norms of the women in relation to their husbands, both inside and outside of the home, and (5) Community Perceptions* relating to their relationships with their husbands/partners.

Mothers' Perspectives of the Barriers of Participation in Social Support Groups

Theme (1) Lack of Time:

During the Community Ten Seed Activity, of the women who responded to the question, "Is the main reason why you, or other women, do not participate, is because you don't have time", a majority of the women said yes (13/21). In response to this question, when asked why, they stated that both work and activity time is hard to manage at the same time. Overall, one of the most challenging aspects of the women's daily lives that prevented them from being able to attend social support meetings was the lack of time they had in their schedules. Even though the meetings generally met once a month ('Together' and 'Glass of Milk') or ever two weeks (Mother's Clubs and Community Assemblies) and some more involved groups on a weekly basis, the mothers still found it challenging to set aside the time to leave their homes. Many of the women take of cultivating land, 'la chacra' that is near their homes and/or care for their animals and house gardens. In the case the women were bound to their homes because they were mainly homemakers they had to take care of house chores as well as take care of their children. During the Community Ten Seed Activities, when asked if it is "easy to attend meetings" a majority (11/21) of the women said, no, and their common response was "we have children and animals to take care of". For those women and families who cultivated vegetables for part of their household income, selling food at the markets on the weekend took away from the time they were able to attend social support groups, which in some cases, took place on the weekends during market hours. Although many of the women who regularly participated in the social support groups *were* considered "doers," lack of time

was generally their largest complaint.

Results from the Interview Survey with a Non-Doer:

"I have no time, I sell food at the market for my children, if I go to the meetings, I lose time because I cannot sell for them, and do not see the money ... for a liter of milk I am not going to go there.... They don't give more than a liter of milk ... I have resigned from being a member of 'Vaso de Leche', because there always were for meetings and gatherings always had to clean the cemetery ... " (Non-Doer #16, p 46-47).

Doer Focus Group Discussion:

Even though the meetings may be once a month, whether or not they know about the meeting ahead of time, they have not arranged for their home responsibilities to be taken care of, and cannot attend the meeting.

Investigator: "But, you only congregate, get together, only one time a month, no more? And for that one time a there are difficulties only that one time?" Participant Two: "Yes, they have a difficult time". Participant One: "We sometimes have meetings every fifteen days, every fifteen days already, but the women have their fifteen days all planned out and they cannot come, it's like this, working daily in the field". Investigator: "So the bad things about attending the meetings? You loose your time and your work." Participant One: "Yes, we loose time and work, attending the meetings" (Doers Focus Group Discussion, p 202-203).

Theme (2) Feelings of Inferiority:

Another common theme that was discussed in the interviews and the focus group discussions with the mothers were feelings of inferiority among the women who were not regular attendees of the social support groups. This idea pertained more so to the government run organizations, JUNTOS and Vaso de Leche and was associated with a few variables. Another barrier to participation in the groups is the manner in which the women become part of the group or who invites them to take part in the activity. During the Community Ten Seed Activity, when the women were asked, "If you were invited by the leaders, or more informed within

the community, would you participate more frequently or more easily?", almost all (20/21) of the women said yes. Their common response was, "we would like to be invited or better informed." In order to be formal members of the groups, families have to meet economic income criteria for being eligible to participate in the groups and have to be 'invited' by the leaders who are in charge of the groups. Families have to provide their children's birth certificates and the parent's personal identification cards. When women move from one community to another, for different work or family related reasons, they are less familiar with families and the community networks.

As I have recently arrived to the community, I haven't become part of the group yet. Maybe next month. I don't know. The people preferred it to be their families, its like that, no? Maybe someone will invite me to go there, maybe they will accept me, 'Vaso de Leche or JUNTOS…They almost never invite me, as I am one to stay in the house, I often do not participate, I'm not invited, its between them, among family they get together…I see what they are doing, I look from afar, but nothing more. (Non-Doer, #24, p36-38).

Several of the women asked during the interview why they did not attend the groups said that they were not invited to be a part of the group, which created a feelings, warranted or not, of inferiority on the part of the women who were not able to participate. Coupled with this challenge were also feelings of inferiority due to the lack of writing ability (if the women were asked to produce something in writing during the meetings), or the lack of Spanish language skills. Many of the women in the communities spoke primarily in Quechua, where many of the meetings take place in Spanish. Therefore the inability of the women to participate as fully as they might be able to, if they could speak similarly to their Spanish-speaking counterparts, we were told, left the women feeling 'ignored' or unable to participate as fully as they would have liked to.

During the focus group discussions, the participants explain this challenge to the investigator:

Investigator: "And these mothers that don't go that much [to the meetings] they feel inferior to the mothers that always go?" Participant One: "Yes, because there are mothers that don't know how to write correctly…". Participant Two: "…in Spanish". Participant One: "They don't express themselves well in Castilian [Spanish] and only speak Quechua. Mainly, it is because of the writing,

because they can't write… they write, but slow, because when you're in those educational courses, you have to be able to get together some notes fast, you have to write". Investigator: "Ok! So the mothers feel a little inhibited when they don't write well, to participate in the trainings and think that the other women that participate are…". Participant One: "…Better than they are. Yes. Always." Investigator: "The mothers, you are saying, the mothers that, are very… they feel very limited because they cannot demonstrate the language very well…" Participant One: "Yes, and that makes them more shy." (Non-Doer Focus Group Discussion, p 118-126).

It seems as though the lack of language capabilities for some of the women is a challenged that spirals into a lack of confidence to fully participate. The lesser-exposed women, therefore, have been generally quieter and less driven to participate because of the way it allows them to feel when they are participating. The women explain that there are some meetings were some of the women are very talkative and they listen and project well when the leaders talks and ask questions of them but it is always the same women who tend to participate, and leave little room the shyer women to develop the capacity to give their opinions (Non-Doer Focus Group Discussion 133-142).

There is kind of ownership over membership in the groups. If they are paying members, they feel a part of the group. If they are not paying members and they show up to the groups, the other women might look at them judgmentally if they receive hand-outs from the group leaders and they are not officially 'inscribed' in the group.

Investigator: "When you went to the Vaso de Leche meetings, how did you feel when you were participating?" Participant: "The women looked at me poorly. When you go, they say 'why do you give her milk is she doesn't come, why are you going to give it to her if she doesn't come [regularly], she doesn't come to the meetings? 'Don't give it to her', they say". Investigator: "But it wasn't because you didn't want to go to the meetings. Right? It was because of the other women?" Participant: "Uh huh. They look at you poorly. They say, 'oh they aren't going to stay in Vaso de Leche' because they doesn't go to anything else". Investigator: "And how did you feel?". Participant: "Bad" (Non-Doer Participant #16, p 58-63).

Theme (3) Financial Concerns

Another prominent theme that emerged from the interviews and focus groups with the mothers was the theme of financial concerns. Some of the 'Non-Doer' mothers seemed to feel that those who participated in the social support groups lacked economic status or income. Although this in part true, many of those same 'Non-Doers' were said to have unfairly marked those who participated as 'women who do not want to work' because they can receive support from the groups.

When asked why she had never gone to a social support group, one of the Non-Doer participants responded:

"Because the social organizations are for the women that don't have work, this is how things work, Vaso de Leche, they say, is for everyone, but no, there are mothers that just don't want to earn, right?... JUNTOS is for mothers that have low incomes, you have you count your [income], how should I say it, you have to be at a certain social economic level, to participate in this…." (Non-Doer Participant #29, p 45-47).

On the other hand, there are some women who were misinformed about the social/professional status of people the social support groups, which also seemed to cause the women to feel distanced from the groups. This misinformation may stem from community gossip that goes unresolved. Some of the women seemed to think that in order to be a part of the group you had to be of professional status.

During the Non-Doer Focus Group Discussion, two of the participants discuss this perception:

Participant One: "…You have to be a teacher to receive from JUNTOS…" Participant Two: "Yes…They are of an economic level that is higher than ours. They are the ones that have [money]". Participant One: "Yes, they have [money]. They are not content with what they have". Participant Two: "They want more." (Non-Doer Focus Group Discussion, p 21-28).

Another concern for the women, yet not mentioned as prominently as the previous concerns was the amount of money they might spend on activities that took place during the social support groups. This might have been the case for JUNTOS and

Vaso de Leche, but perhaps, as we well for Club de Madres, where mother's bought and traded materials to be used in weaving and embroidering products. Although these activities are part of what the women like to do for diversion, not being able to partake in trading materials, due to the lack of ability to buy the materials, was a barrier to their participation.

A participant in the Non-Doer Focus Group explains her perspective:

"What we lack here in Curuhuasi [the town where the main clinic for the region is located] is that there are many people who critique JUNTOS, but are the people who receive things from program. They are lazy. Also, these same mothers, the same Mayor who participates, she should help the mothers in the JUNTOS program if she wants that they make good use of their 100 Nuevo Soles that they are given. They should receive a training course, a produce project… but they are receiving to critique. Me either, in my neighborhood, we haven't made a solution for what we need to do, with the guys at school in the department of nutrition. We have made corn cream, and anis [a prominent seed that is used in the area] cream, and I look at the group of women that I have, there are many of them that have the desire to learn, and there are other mothers that do not, they don't"… Participant Two: "But none of that is important when they say it costs a lot of money… they won't [come out to the meeting]" (Non-Doer Focus Group Discussion 95-96).

Theme (4) Gender Norms

One of the major determinants that factored into whether a woman was a "Doer" or a "Non-Doer" was whether or not, for the women we communicated with, her husband tended to make the decisions about how the wife spent her 'free' time. Many of the women who claimed to be regular participants of the social support groups mentioned that they were the person that made their own decisions about attending the meetings. On the other hand, one of the main barriers for some of the women who did not attend the meetings regularly was her husband's attitude towards his wife's participation in the meetings. Many women stated that although their husbands might like the fact that the women attend meetings to learn new information regarding how to better take care of the home and the children, they said that their husbands often became jealous of spending social time outside of the house.

The women also explain that they are afraid and jealous of the freedom their wives spend outside of the house learning about new topics, such as general health, nutrition, and family planning. They explain that their husbands think if they are learning about certain birth control methods, or condom use, that their wives will gain the freedom to go outside of the home to 'be free' and be with other men.

When reflecting on the women's desire and ability to participate in the meetings, many of the responses the women gave us, was that their willingness and personal capability to participate depended on whether or not their husbands might react in the way as described above. This idea relates further to questions asked later on, in both the interviews and the focus group discussions about if 'anyone disapproves of your attendance to the meetings'. During the Non-Doer Focus Group Discussion, participant two explains the challenge probes this topic:

Participant Two: "…The problem is, miss, is that the husbands are jealous. They say, if you take care of yourself [protect yourself using contraception] even to the point that you go with other [men], he [your husband] will never get you pregnant. Besides this problem, there is the problem they the women are scared, it's that their husbands don't like that they know more new things [that the clinic is teaching them at the meetings]… the husbands think that if the women protect themselves, 'they are going to get horns'…". Investigator: "Who are the women afraid of?". Participant One: "They are afraid of 'machismo', the men prohibit the women from protecting themselves [from using contraception] because they use contraception to protect themselves, because if you take care of yourself, they the men say that you can 'go out' with another [man], and another, and another… When the husband isn't looking" (Non-Doer Focus Group Discussion p35-38).

Theme (5) Community Perceptions

Trust

The women explain, that it is for this reason that some of the women are prevented from going to the social support groups, and more ultimately, prevented from fully expressing themselves while with the other women. They have the fear that if they fully express what is happening in their households, that the other women might publically discuss their situations and shame them. They seem to

not fully trust what is considered to be an open, shared space for communication. During this discussion, it was evident that the women are afraid to express that they have somehow 'failed' at something in their homes, have done something wrong, but that they are challenged to tell other women in public, although they are encouraged to do so. Participant One, who is particularly verbose and strong said *"…'This is bad' [referring to the particular home life situation] I hear in the meetings, 'If you all think something bad about me, tell me now and now, tell it to my face' but they never say it".* The Investigator goes on to affirm what the participant is explaining and said, *"So, the women fear of how the other women are going to represent how things really are in the home [with her relationship with her husband]*." Participant One said, *"Exactly."* (Non-Doer Focus Group Discussion 197- 209).

Stigma and Shame

Another community perception that deferred the women from participating in the social support groups, more so than JUNTOS and Vaso de Leche and Club de Madres, was the perception that the 'Non-Doers' had of the women who participated in the social support groups as being lazy, not proactive or idle. When the women in the focus groups were asked what some of the 'Non-Doer' women in the community think about the women who participate in JUNTOS and Vaso de Leche, one participant responded *"… hmm, of the women in JUNTOS, the mothers…. the mother that aren't in the program say that, 'oh look, these women are lazy".* The other participants in the discussion agree and the same participant concurs, "…the women in the program JUNTOS are lazy, they don't need to work, that's how it is…" (Non-Doer Focus Group Discussion p-10-19).

Additional Emerging Themes

A few additional barriers emerged from the interviews and focus group discussions, although not as prominent as the formerly explained barriers. The additional emerging themes are: lack of group leadership, children's age, and fear of illnesses. These topics emerged at least once in the interviews and the focus group discussions.

Lack of Group Leadership

A few of the women stated that there was a lack of group leadership in the groups they had attended in the past. This is not to say that *all* of the women mentioned that they had experienced a lack of leadership, but a few mentioned they had felt that the group presidents and health personnel could have been better at managing the groups and presenting the material at hand.

Children's Age

Another barrier worthy of mentioning was that many women in the community did not attend JUNTOS and Vaso de Leche if they had children that were much older than the age of six. They felt that the meetings were for women who had much younger children that they had. Although the focus of this study was on women who had infants aged 0 to 2 years old, this barrier is an important perspective to take into account.

Fear of Illnesses:

A final barrier that is worthy of mentioning was a fear of knowing or being aware of illnesses. Although many women recognized the importance of learning about their families' health and helping their families, a few women mentioned that they would just rather not know about illnesses or health matters because in the end, the situation may be out of the woman's control. This desire to remain unaware of concerns that are of importance to the women may be due to the lack of resources the women have to properly mitigate the challenges.

Overview of Emerging Themes for Facilitators of Participation in Social Support Groups

Of utmost importance to the women in terms of attending the groups were: (1) *Material and Economic Incentives* given by the group leadership, (2) *Stress Relief, Diversion and Social Cohesion,* (3) the *Fear of Removal for Not Paying Dues* and being financially penalized by group leaders for women formally 'inscribed' in the groups (4) *Recognition/Marked Attendance/Obligation* to participate in the groups, (5) *Social Influences,* including family influence and husband encouragement and (6) a *Desire to Learn New Things*, whether it be their children's health or other topics of interest.

The Facilitators of Participation in Social Support Groups According to Mothers

During the Community Ten Seed Activity, of the women who responded to 'what are the main reasons you participate in the social support groups?' the women gave the following responses: money (6/21), not to get fined (3/21), to see friends or build relationships (3/21) and to learn (1/21).

Theme (1) Material and Economic Incentives given by the group leadership

The material and economic incentives that the group leaders 'handed-out' at the sessions emerged as a very important theme in this study in particular to discussions around JUNTOS, and Vaso de Leche. As mentioned in the social support group summaries, JUNTOS provides its officially 'inscribed' members with 100 Nuevo Soles (about USD 37) a month to those women who regularly attend the meetings (about once a month). Likewise, in Vaso de Leche, the women are given milk, either in liquid or powder form when they come to the meetings. In addition to the milk that is offered, if the staff has the products available at the time, the women can also receive cooking oil, cans of tuna, and 'papilla', which is a type of infant porridge. The women were usually quick to respond when they were asked about the benefits of the social support groups.

The focus group discussions also brought to life the women's focus on receiving the financial and material incentives. The women spoke excitedly and

specifically about the food products they are given by Vaso de Leche.

Investigator: " In the case of JUNTOS and Vaso de Leche, where in JUTNOS you receive 100 Nuevo Soles every month… is that not also true and in Vaso de Leche… what is it that you 'get handed'?". Participant Two: "Ah yes, they give us milk. Each month, three times and Saturdays". Participant One: "Yes, they are giving us fresh milk for the children, at the least they give us one liter and a fourth".

The investigator clarifies the extent to which the hand-outs are received, in order to gauge how loyal the women might be in regards to the amount that is offered to them:

Investigator: "Each month, or each week?" Participant One: "Each week and weekend, on Saturdays they give to us, in the neighborhood where they work, they give a liter to every child." Investigator: " One liter to every child? Four liters a month?". Participant Two: "Yes, sometimes they give each child two liters, a liter and a half, not an exact amount" (Non-Doer Focus Group Discussion, p 29-35).

The investigator goes on to probe the relationship between the material incentive and the women's motivation for attending the social group meetings or, in this case, showing loyalty to their organization:

Investigator: "… [the leaders of] JUNTOS give you 100 Nuevo Soles…. Vaso de Leche, as well, they give you milk… is this the reason…. Is this why the people, the mothers, come to the meetings?" [All participants say yes]. Investigator: "Why do the women continue to come to the meetings, JUNTOS and Vaso de Leche?" Participant Two: "…Because we recieve [things]… Because we recieve money and we share and everything…". Investigator: "Okay… and in Vaso de Leche? What benefits are there?". Participant Two: "Milk." (Doer Focus Group Discussion, p 258-259).

In several cases, the social cohesion and the desire to learn new things, related to families in general or infant and young child feeding practices, seem like more of an aferthought.

Theme (2) Stress Relief, Diversion and Social Cohesion

One of the second most mentioned reasons for the mothers to want to continue attending the social support groups was to 'let loose', relieve stress and have fun. The women expressed that they found the groups to be a time and a place that they could ease the stress from their daily lives in their jobs and homes, and

communicate and share personal experiences with the other women. Even though the meetings of the social support groups happen weekly or even once a month, the women agreed that they looked forward to the social outlet.

Investigator: "…Okay, what are the advantages of the women attending the meetings? You women, what do you lose when you meet this one day, this one time a month, what do you lose that you have to do, for example, in your houses?" Participant Two: "Because we already know what will be doing in the meeting, we make it just for us. We leave this meeting, perhaps we have left something behind [like house work]. We have denied [the house], but we are conversing, we are ready, you [we, the women] forget about everything".

The women perceived their time spent away from the home, in exchange for conversing with the other women, to be worth it to them.

Investigator: "So, in place of losing something [at the house], it's that you all gain a place that you can relax and leave the house?" Participant One: "Yes, yes…". Participant Three: "We share." Investigator: "… And this is good for all [the women]? If you suddenly need a place to go to distress and all this?" [All of the women say yes]. (Non-Doer Focus Group Discussion p 177-182).

Both in the individual interviews and in the focus groups, the women expressed that the social support groups were a way to come together with their friends, their neighbors and even members of their family to share things together as a group. The women feel happy in these spaces because they are sharing.

Investigator: "...Do the women really like to spend time with the other women?...". [All of the women say yes]. Participant Two: "...Because like this, to converse, it is to make ourselves happy." Facilitator: "It's because they like to get together because it makes them happy". Participant One: "Yes, this more than anything". The women almost celebrate this sacred space they have, away from their partners, husbands, and (sometimes) children to share with one another. *Participant Three: "Yes… mothers, nobody but mothers. That is what we do" (Doer Focus Group Discussion, p 200-201).*

One activity that seemed to be an authentic source of social cohesion, more so than the women gathering together to 'receive' what was given to them by the group's leader of JUNTOS and Vaso de Leche, was the arts and crafts that the women gushed over in their conversations and poured over during the 'educational talks' during the government run programs. The women brought their weaving and embroidering yarn with them everything, and often sought out occasions to share and trade products, in order to augment their supplies without

having to purchase them. The same was true about their discussions about cooking together:

Investigator: "What things do you like about these organizations?" Participant One: We like them because they teach us how to weave, we do activities, we cook. We get together as well, but the ladies come more to discuss things, to make noise [together]... we make weavings, we do cooking every session, every Wednesday it's set [for Comedor Popular], after that we do the community cleanings, and also, for example, it's our turn to do gardening plots, gardens, we will work there [in the gardens]" (Doers #20, p 20-24).

Club de Madres appear to be spaces where the mothers are personally motivated rather than driven by an external impetus. During the Club de Madres the women congregate and share their love for weaving and embroidery, among other activities such as cooking and planting house gardens.

Investigator: "...How do you [women] feel when you are in the meetings?" Participant One: "...More at ease than when we are in the house. Happy. We get together, only the women are there, there we do our work. Quietly, at ease. [At the meetings] we aren't denied, like when we are in our houses" (Doer #20, p 36-38).

Whereas JUNTOS and Vaso de Leche are seen as important to go to in order to gain government handouts. Additionally members of these two groups are not always seen as having socially desirable characteristics.

Theme (3) the Fear of Removal for Not Paying Dues and being financially penalized by group leaders for women formally 'inscribed' in the groups

For those groups in which the women must be formal members in order to 'receive' material incentives such as milk,, a majority of the women stated that one of the main motivating factors for continuing to return to the groups was the fear of penalized for not paying the group 'dues'. Also, if women who were not formal members of the group, attended the meetings casually, formal groups members describe how they might be viewed by the other women, which could have acted as a motivator for attending the groups as formal members and not as casual members:

Participant: "…Yes, if you are not a member, like this, for Vaso de Leche, they look at you with an ugly face, so that you are shamed for having attended, so that you are even ashamed of yourself for going." Investigator: "...but in the case that you were a formal member…?" Participant: "Oh yes, of course then, I would go" (Non-Doer Interview Participant #24).

Nevertheless, being a formal member of the groups, came with its challenges, but acted as a motivating factor that kept the members loyal to attending the groups.

Principal Investigator: "Yes… you are referring to the dues that the women pay to the government… when you don't get together, or rather, for example, when there is a meeting, suppose that there is a JUNTOS meeting and Lydia [one of the group members] can't participate for [whatever] reason, right? How do the others feel or what would the other say that have attended the meeting?" Participant Two: "There is…how can I tell you, here in Curuhusi [the city where the main clinic is located], there isn't any punctuality, there isn't any responsibility, those who come late, or not at all, will be fined, you understand?...So, for those who don't come, it bothers the others." Principal Investigator: "And how much is the fine?". Participant Two: Fifty cents." (Non-Doer Focus Group Discussion p51-54).

Principal Investigator: "Ohh, okay. So if they lose out on the groups [in terms of the information lost], it's like they don't miss out on anything? Participant One: "…They only justify [their behavior], if they haven't come, they can't [or don't] ask you about the topics that have been talked about, about what has been covered, who has come, who has come to the meeting. It's not important to them… only that their [attendance is marked]… Investigator: "… or rather, when they don't come, they don't lose anything… only that they have to pay the fine?" Participant One: "Yes." Participant Two: "And it bothers them, they don't want to pay anything. Participant Two: Three Nuevo Soles… and in the afternoon, 50 cents." (Non-Doer Focus Group Discussion p 77-83).

Yet, there seems to be a difference between the interest in some types of the social support groups. Whereas in some groups, women seem to be less interested in the content of the meetings themselves, as mentioned above, when women are not able to attend other types of social support groups, sometimes they feel the need to follow-up on missed information:

Principal Investigator: "Great, so there are different versions of the social programs… the social programs, the mothers that neglect to go to a meeting and their only preoccupation is that they are going to get fined, but they don't ask what the meeting is all about. But there are meetings in the community [Community Assemblies], if there is an interest, and they don't participate, they ask the leaders of the group what happened, to what places the conversations went". Principal Investigator: "So, now, if a mother in the JUNTOS program, for example, is unable to attend many times, is she taken out of the program?"

Participant One: "No, if she is taking care of the responsibilities that she has…" Principal Investigator: "…then they don't take her out. In the neighborhoods, when a woman has not participated in several meetings, is there a repercussion, apart from the fact that she is fined?" Participant Two: "Only fines". (Non-Doer Focus Group Discussion p-97-105).

Theme (4) Marked Attendance or Obligation to Participate in the Groups

Another emerging theme that seems to be closely linked to the theme of not being financially penalized, is women's desire to be recognized as having had attended the group meetings. It was important to those women who consistently attended the meetings to have their attendance 'marked' by the group leadership, in order for them not to be financially penalized as a result, but also to feel as though their obligation or duty was fulfilled. Therefore, it seemed almost natural that the women participate in the social groups, if they were official members. Many women confidently and quickly said, 'it's obligatory'.

Participant Two: "…To them it's not important what they receive, they aren't aware of what they would receive. They do it because it's obligatory… we [the leadership] stay until three in the afternoon, they go only to get credit [to meet their obligation…" (Non-Doer Focus Group p 145-146).

Theme (5) Social Connectedness

There is a general concensus that the women enjoy being together at the meetings; they have fun, they share, they expain that this is good for them and they view it as a social and personal benefit. One of the participants in the focus group discussion says, *"its like this because we converse, it's to make ourselves happy and feel connected" (Doer Focus Group Discussion, p 200-201).*

The women feel like their voices, their perspectives are a valuable part of the meetings, if they are able to open up and share with the other women. They feel like what they say becomes valuable for the other women, due to the fact that it is a safe space. Likewise, due to the fact that the women are from small communities their relationships have been pre-established before they spend more time within the social support groups. One of the women in the focus group discussion says, *"yes, we are 'good'[with and for one another], this is how we*

are"; the women are all neighbors, who spend time together as it is, or at least see each other and interact on a daily basis. (Doer Focus Group Discussion, p 226). *Participant Two: "We are friends, we converse. We get together well, we are comfortable". (p 229).*

Theme (6) Husband Encouragement

Additionally, some of the women stated that their husbands encourage and approve of their participation in the social groups because it brings them closer together as a couple, creating more 'confianza' or confidence between them. *Participant Two says, "We become closer, we trust each other more" (Doer Focus Group Discussion, p 229).* Those women whose partners were supportive of their wife's participation in the meetings were very encouraging.

Theme (7) Community Perceptions

During the Community Ten Seed Activity, a majority (11/21) of the women said that they made their own decisions about their attendance to the meetings, not their husbands. When asked if family members, neighbors and the community influence the way that women make decision about going to the social support group meetings the women say that their families most times, think highly of their participation:

Participant Three: "Yes [they influence us… for example, if I want to go to a meeting and my neighbor says, 'why are you going to go to this meeting?', I say, its because I like to go to these meetings. So, I tell her what I think and I go to the meetings. This is to influence, if you are paying attention to what she has said and putting into consideration what she says to you… or not, you simply do what you think, you simply do what you think in the end.. or if the neighbor suddenly says, 'I think that it is very good if you are a part of these meetings', and then you say [or think to yourself] she or the community says its good, so I go." [Everyone else says yes, and agrees]. (Doer Focus Group Discussion, p 184-191).

The women's attendance at the social support groups could also have been reaffirmed by their communities' general positive perception of attending social support groups. When the women were asked if their attendance at the social support groups was well perceived by their communities, the majority of the

women said that the community encouraged their attendance because they were able to support one another in their effort to better their families and learn new things.

Participant: "Yes [it is well viewed in the community to participate in the meetings]…because they talk and talk, about good things, sometimes about bad things, sometimes fighting over the money [issues], but about whatever thing, they participate, they organize themselves…" (Doer, #17, p 129-130).

Another participant, although a Non-Doer, describes the way in which the community views participation in the meetings:

Participant: *"Yes [it is well viewed in the community to participate in the meetings]… because when we get together, we talk about everything. Where you should go, what you should do, what we should plan to buy, or make [receive] fresh milk or how we should mix [the milk] with some other thing" (Non-Doer #16).*

Theme (8) a Desire to Learn New Things, (Children's Health or Other Topics of Interest).

The final aspect of attending the social support groups that the women mentioned frequently was their desire to learn new things. From the Community Ten Seed Activity, of the 21 women who participated in both of the activities 13 women stated that even though the social support meetings are difficult to attend due to time constraints, they continue to go because they "want to learn more." When asked if the women attend the social support groups to learn new information and skills 19 out of 21 women said 'yes, because it's important to learn what we don't know". The skills and desired behaviors that will be targeted in the mother-to-mother-support groups are knowledge and skills surrounding infant and young child feeding practices, and therefore our effort to understand the extent to which these skills and behaviors might have been taught or learned was paramount to our discussions. Yet, more so than not, the responses the women gave us concerning the desire to 'learn new things' was very general. During the Community Ten Seed Activity, when the women were asked "Do you like to participate in the support groups even though in some cases you don't receive money or food?" a majority (12/21) of the women said yes. When asked why, the common response was, " it is important that we listen and learn things that we do

not already know". Fourteen of the 21 women felt that they 'lost information' if they did not attend the social support groups. When asked if the women learned specific skill sets related to proper infant and young child feeding practices, more so than not, they listed very general topics, such as what foods are good foods, nutrition, or to get good advice. A majority (16/21) of the women stated that they like to get most of their information about nutrition and infant feeding from their rural health post, more than any other place. The following participant response demonstrates how the women are drawn to continue to learn, although it is very general:

Participant: "If you participate they leave you with good advice, if you don't participate, on the other hand, well, there is the time [you lose], but there are things you must leave for a good lesson. We must try a little to change ourselves." (Non-Doer #25).

One of the women, who was considered to be a Non-Doer, expressed to the Focus Group facilitator, who was a staff member of CARE, who leads the food preparation demonstrations, what she felt she wanted to learn if where were to be part of the social support groups. *Participant Two says, "I would like, I would like to see for my [infant] daughter, to have more of the topics of nutrition and everything like this for pregnant women (Non-Doer Focus Group Discussion, p 119-120).*

One participant in the group explains that the need for the social support groups is there, and what the women do not learn in JUNTOS and Vaso de Leche and the meetings of the Club de Madres, where the infant and young child feedings practices and skills are not actualized:

Participant Two: [The social support groups are good] because no one is teaching us about this, for example, no one tells me, 'this is the way you should do it', no one… like this, how you should, do it." (Non-Doer Focus Group Discussion p 197-199).

The women are very interested in learning new things that will help them augment their income. One of the women recalls an organization that conducted a workshop in the past where the arts and crafts were central. The women appreciated this:

Participant Two: "There were weavings, things to do with your hands, we, everyone that was a part of the JUNTOS group, were brought to different agricultural fairs, everything that we made we could bring, all of our work, selling it there…" The first participant in this focus group augments the theme. She says, " *You could sell out projects, we were able to develop these capabilities, because one time I came, to sell with fondo of employees from Lima and like Cojio [a well known artist] from Curuhuasi, and to some people it wasn't important to learn…" Facilitator: "…they lost the opportunity to learn things". Participant One: "…but my mother, my aunts and uncles, my sister, they learned these things*" (Non-Doer Focus Group Discussion p172-178).

On a general note, more related to the social support groups that help with the wider concerns of the community, the women are interested in learning about things and participating in activities that improve the quality of life of their families and their fellow community members.

Investigator: "What do you learn?". Participant Two: "In the JUTNOS meetings and Vaso de Leche, what do you learn?" Participant Three: " To weave, to embroider, things you do with your hands, everything, this [is what we learn]…" (Non-Doer Focus Group Discussion).

In summary, the women do articulate, what technical skills they learn about nutrition from the meetings themselves. They tell us that they learn what they observe the other women doing while they are at the meeting, but not the content of the education itself, or whatever it is that is happening at the meeting. They sit in groups and share knitting ideas, and different color strings.

Ministry of Health Professionals' and CARE Staff's Perspectives: Barriers and Facilitators of Participation in Social Support Groups

The perspectives of the Ministry of Health Professionals and the CARE Staff will be presented together. Due to the fact that these results serve to integrate the mother's perspectives into an 'outsiders' perspective, they will help to later formulate the investigator's recommendations for CARE's programmatic planning and further research. The MINSA staff perspective will be discussed first.

Ministry of Health Professionals, Focus Group Discussion

Theme (1) Compensation

The Ministry of Health (MINSA) staff believes that the implementation of the mother-to-mother support groups is very important, but, that the question of time and resources are very important to consider. One of the staff members mentions having worked with female health promoters in the past, who were of a/the community, who did an excellent job of traveling house-to-house in the community to teach the women about nutrition and hygiene, who were very motivated. After time, they had to stop working, because there was no material incentive to continue to work as hard as they did without compensation.

Participant One: "… I think the lady [facilitator] that went from house to house, I don't know how her work is functioning now, but there was a time when she was very active, but like everyone says, it's the incentive, because the mothers have to leave their children in the home and dedicate themselves to this [kind of work] and at minimum have to have a secondary [high school] education to be able to in any way that will help and better focus the families in order for the groups to function. I think that what might function better than just incentives, a basket of money or something at the end of every month is to incentivize the women or it could be the president, sometimes the group has to be named, but sometimes they don't commit and it doesn't function" (MINSA Focus Group Discussion).

MINSA staff suggests, that although larger material incentives cannot always be given, such as financial compensation, milk or large quantities of food, that smaller incentives will help the women to be motivated to return to the groups because they feel that they are being recognized by their communities or doing something good for their communities.

Participant Two: "Sometimes they need some type of recognition, at the least have them [the MINSA Staff or the CARE Staff] accompany them at a meeting in the community in order to thelp them strengthen their style becuase then they will feel better about that they are doing, that they are doing something good for the community like leaders. The problem is that now, it lacking a monitoring system, we train the women and we leave then, and we don't realize how they perform or conduct [themselves as leaders] and we lack that [monitoring].

Theme (2) Leadership Skills

Another perspective of the MINSA staff interviewed, is that if there are to be MtMSG leaders, the mother would have to be someone who has had a child that has overcome certain challenges of being malnourished, so that the can speak to the experience of having overcome the difficulties.

Participant Three: "I think that it would be positive if there is some type of work, but always having in consideration with each mother who is the leader, that they have been through some kind of experiece, or have had a child that was below the apporpriate weight, that had had diarrea and now doesn't have any prevalent illnesses, a child under five years old. I think that this woman would have more impact on the women as a strong leader… then women like her could work, but this leader would be trained before older women [who are more removed from the issues themselves] and work with the promoters and be focused on nutrition, from breastfeeding. A mother who has had success with breastfeeding who gives advice to other mothers, the other mothers would listen to her more, because she will talk in a more direct way [from experience] in her own language and with confidence and credibility. I am not sure how we will arrive at this point, but I think that it would be effective, but also it would be very hard work for the staff that would train these women"

Theme (3) Support from MINSA

The MINSA staff suggest that they should be in charge of helping to formulate the MtMSGs and also play a role in monitoring the groups. The staff will not necessarily be a part of how the groups function on a daily or weekly basis, but be in charge or initially teaching and training the women how to properly prepare and mix the foods that are complementary for infants. This would allow the MINSA staff to have more time to travel to the communities where mothers are more in need of training, where children are in more need of help, which would reduce the amount of overall time they have to dedicate to this endeavor. The staff suggests that the training for this type of capacity building has already begun to take place during the individual counseling sessions that the staff has with women from the community. They say it is essential to find mothers who have the capability to lead, someone who is professional who has demonstrated she has a good work ethic, who follows through with their committments, who wants to share their personal experiences, who has had a positive experience in nourshing their child properly. And, someone who is highly recognized by their

communities.

Participant: "Yes, yes, a leader. Suppose it is someone who has the capacity and the power to convene, who has leadership skills with the people… with a child, or a pregnant woman, wtih a baby who is healthy who can have an impact, because sometimes when you have these abilities, but there is not time, sometimes everyone will say, why doesn't this take place with everyone, but the experiences that we have had with all the participants [in groups like this in the past] is that the men speak…. It should be a redistribution on our part [the change this] but what should be the way to go about it…[Something]that will help them to realize why is it so important to seek this support".

Theme (4) The Best Way to Incorporate MtMSGs into Existing Support Groups

From the perspective of the MINSA staff, more women with infant children work with Vaso de Leche, as opposed to JUNTOS, which are both government operated programs. They say that JUNTOS does not work with the MINSA staff, that they are more interested in maintaining their own funds and functioning as an independent group. The main motivating factor for why they would like to remain a part of the groups is to recieve their milk, form Vaso de Leche and their financial incentrive of 100 soles from JUNTOS. The women who are associated with these groups can also work with the Wawa Wasi and leave their children at the day care on the week days.

Therefore, the MINSA staff suggests that it will be important to associate the mother-to-mother support groups that social support groups already exist; *"We propose that a group should be associated with one of the well recognized social programs, in order not to generate and entirely different group" (Paragraph 96, MINSA FGD).* Another member of the discussion goes on to suggest that there are already many groups that make is challenging to attend just one, and that developing a new group might complicate that decision. She suggests that CARE try to combine or try to strengthen what already exists by have the member of the MtMSGs be combined with the beneficiaries of the Wawa Wasi or *"for the infants for who you will be havings these meetings, have them meet every weekend or every two weeks [at the Wawa Wasi] in order to impart knowledge on how to raise [them] how to provide [mental] 'stimulation', and how to better nourish the babies" (MINSA Focus Group Discussion, p 97).*

Theme (5) Incentives as Barriers and Opportunities

The MINSA staff explains that Vaso de Leche is represented by the Government Municiplaity. Every community and sector has a Municipality representative and that these women organize the social support groups in the individual communities for Vaso de Leche. Yet, they explain, that they do not come together to hear a presentation about a particular health topic, but to recieve their allotment of milk. *"Bascially, they come together to recieve their 'benefits' and they don't really take advantage of the space for anything else" (Participant One, MINSA FGD, p 107).*

Few of the meetings actually meet for the purpose of training on health or nutrition, let alone, infant and young child feedings practice skills and behaviors. They use the meetings to distribute products and then approach other topics.

The women in the community are conditioned to know that showing up for the groups is voluntary, or else they won't recieve their products. One of the MINSA staff suggests: "*…in the past if a group of mothers came together and conversed… even if it was for a small bit of time, they got together for a small education session, we would have been able to teach them something, but not everything has changed, when the products arrive sometimes the mother are not even interested… they want that you just give them the 'bocadillas' [snacks]. (MINSA Focus Group Discussion, p 133).* In reality, the staff members explain that, in the end, the products that are given out at the meetings determine what 'activities' that the people show up to participate in.

Theme (6) Group Dynamics

There are different political factors that influence the formation and organization of the social support groups. The MINSA staff suggests having elections or nominations within JUNTOS and VASO de Leche to look for mothers who can facilitate the MtMSGs. They suggest putting conditions on what the parameters of

the group would be, and working with the mothers to figure this out:

Participant One: "We have various political and social factors… the municipal government is a principal actor, here, if we want to unite these programs the best way we can and communicate with the municipality and [team up] with Vaso de Leche, JUNTOS and the Wawa Wasi." (MINSA Focus Group Discussion, p 156-157).

The group explains there must be strategy and planning involved in the next steps moving forward, that representatives from the organizations must come and have a dialouge on the best way to develop steps and who will be responsible for what is happeneing and in what order. It is important to the staff to strategize how they will reach the communities that are far away. They suggest that beginning pilot groups will be the best approach and if they are successful, that they will form a few more small groups. They will need money and human resources to buy products to prepare. They will need to know exactly how each session will go, so that they can evaluate as they go. It has been suggested to combine the activity with the community growth monitoring.

Without a doubt, the MINSA Staff percieve the largest motivating factor of the women's participation in social support groups to be the materials goods they will recieve from the meetings. Second, they mention, the women's self esteem and how they will be perceived in the community. One of the participants says: *" There are mothers that, the recognition can help their self esteeem to a certain level in the community…it can improve their self-esteem…" (MINSA Focus Group Discussion, p 235).*

Theme (7) Shame and Trust

There are times when the MINSA staff feel that the dynamics of the group may encourage or discourage the women's participation, if the women have a good feeling amongst them, they may feel motivated to attend. If there is not a good feeling, or is the women are ashamed of a condition their children have, they may be detered from attending.

Another participant stated that sometimes the women *"have a phobia of us… that*

they are going to say 'oh my gosh, I gave my child diarrea, now I won't go [to the meeting] because the women will get mad and they will say to me, she did this and that' and then they feel disvalued in a certain respect" (MINSA Focus Group Discussion, p 238).

Theme (8) Topics of Discussions at Meetings

At times the women might feel like they do not want to talk about the condition of their children, out of fear and they may want to discuss another topic or participate in a fun activity. Other activities motiavte the women to come because they may be tired of listenting to people tell them that their children have certain condition. The staff points out that the women might be motivated to come listen to topics that aren't no specifically about the children.

Theme (9) Social Support Groups Provide Women with Autonomy and Skills

MINSA staff indicate that a majority of the women say they attend meetings because it is a place to go that is outside of the house that is different where they can relax, laugh and have a good time. They say that it gives them liberty to do things that are outside of the house. The MINSA Staff mention, that, in theory, the women are learning practices and techniques about food preparation that are helping them at home, in the home, with their children.

One participant says, *"theoretically, yes, its like when theoretically we learn how to manage a team, but its not like this, or for me… its a question of skills, I think"* (MINSA Focus Group Discussion, p 297). One of the main advantages that the MINSA Staff percieves to be as a motivating factor for the women is what they can potentially learn to improve their children's health. Second, among the benefits is the space they get to share with other women to interchange ideas and experiences about that has happened in their lives and experiences with their children. One participant says: *"this will be the advantage for the women, that they will learn now to better combine the nutrients to improve the nutritional status of their children because they will learn this [through the groups]"*.

Another participant suggests that the groups are an interchange of ideas and, " *this interchange of experiences, I think, that yes, it is going to strengthen [women's knowledge]…" (P 318-322).*

Theme (10) Radio

MINSA Staff state that the radio is helpful in transmitting information. For the well established organizations like JUNTOS and Vaso de Leche, there are networks of communication to advise one another about when the meetings are held. The leadership of the organizations communicate. The use of the radio is helpful as well because every family is more likely to have a radio, than a television. The CARE staff point out that, "*yes, the radios is used to send messages"* especially in the rural areas, where less families have televisions" *(CARE Staff FGD p 142).*

Theme (11) Ideas on How to Engage Women in Support Groups

One of the staff members suggests choosing one woman from a community, asking her to come prepared to talk about a few topics she is interested in, such as self-esteem or nutrition, and each week a different woman can take their turn to speak. The staff suggests that often times, some of the women they work with have a lot of their mind, a lot to say, but they do not have a comfortable environment to share their ideas or experiences, so they hold the ideas in. The staff suggests that by allowing the women to have a space to speak, that it will give them a chance to develop their leadrship skills and become more comfortable in speaking their minds.

Additionally, MINSA staff mention that it would be helpful to form the social support groups in conjunction with literacy classes, early stimulacion or nutritional counseling. For instance, "*everyone in the family…. Will see the importance of [early stimulation] like nutrition because nothing else is useful, if you aren't nourished. That you should be well nourished!...both things go hand-in-hand"* (MINSA FGD, p 325). The staff also mention that this would help with

the sustainability of the groups because organizational efforts would not be duplicated. Finally, MINSA suggests that each staff member should be assigned one to three sections of the community, that the groups be held two times a months during part of an afternoon and that the mothers have motivation the desure to start the pilot projects in their communities.

CARE Staff Perspectives from Focus Group Discussion

The CARE staff have a tremendous amount of experience working with the rural andurban communities in Peru. One of the Project Coordinators states, *"…this permits us to be able to have a handle on the culture and different forms that our works takes… It has allowed us to know a little bit more the dynamics of the people".* It allows them to be able to know the capabilities of the women they are working with, in order to know how effective the mother-to-mother-support groups would and could be, based on the personal relationships they have with the Ministry of Health staff and the women's themselves. (*CARE Staff FGD, p 289).*

Perceived Barriers from the CARE Staff Perspective

Theme (1) Stigma and Fear

The CARE staff agrees with the women's perspectives; when the women become scared that they will be fined if they do not go to social group meetings, it is no longer a space for the women to relax and share their thoughts and feelings. They no longer feel open to wanting to release stress.

Theme (2) Time

The CARE staff also recognizes that if meetings last too long, and take up too much time because '*they becomes distracted by things they have to do, the children begin to cry, until they, themselves becomes hungry and begin to get bored… therefore we would like to have some kind of meeting that will make it short for them, or with only the most essential information and very dynamic*"

(CARE Staff Focus Group, p118). The women's time is very valuable and the CARE staff point this out.

Theme (3) Women's Decision Making Ability

There are many women who are in charge in the homes; however, there are many women who look to their husbands for approval when making decisions. Husbands may be the only members of the family that are likely to discourage the women from attending the meetings. When the women are asked if their husbands allow them to attend support groups, they will say yes. Yet, when the time comes, their husbands are worried that they are abandoning their house work, and may become jealous of their free time away from the home, and the women learning new liberating information, as mentioned from the women's perspectives.

Theme (4) Trust in the Source of Information

From the CARE Staff's perspective, the women trust the leaders of JUNTOS (CARE Staff FGD p 51-59). They trust the general advice that they are given during the JUNTOS meetings, about the home, about what they should go in any given situation with their infant children, because the leadership of JUNTOS, although the overall support comes from the State, is decided on through a vote from the mothers in the communities. The leaderships then, are not necesarily nutritionists, or women who can speak speficially to infant and young child feeding practices, but teachers, and women of various professions who generally give advice to the women based on shared experiences. These women then become the promoters for the group JUNTOS and can ask for advice and support from the health establishments of the State.

Theme (5) Differences between JUNTOS and Vaso de Leche

The CARE staff points out that JUNTOS gives more educational information than Vaso de Leche. Vaso de Leche is more important for simply recieving milk. More

spefically, the staff says that JUNTOS does not necessarily give '*talleres'* or workshops on specific skills, but '*orientaciones*' or guidlines, which have a tendency to be didatic and not very interactive.

Theme (6) Coordination

One participant explains that a guideline session, "…*more than anything is a good coordination between the health posts [in the communities] where you can find these groups of promoters [during the montly meetings] having, 'groups'* (CARE Staff FGD). The same participant goes on to explain that the CARE staff coordinates with the health post staff to complete the food demonstration sessions, which influce the educational component and the skill based component. She explains, "… the demontration sessions, in which our scope is where we promote, in conjunction with the JUNTOS Staff, but also with populations who don't have access to JUNTOS necessarily…" (CARE Staff FGS).

The discussion continues in this same direction. The staff explains that if the MtMSGs were developed soley by themselves, it would be a waste of time for the mothers, so CARE must strategize and build the social support group efforts onto a pre-existing program. The CARE staff believes that JUNTOS and Vaso de Leche, more so than just the women in the communities, themselves, that these programs help to teach the leaders of the communities about nutricion practices. Beyond that they feel that these groups and leaders must further transmit the knowledge into or within the communities themselves because the leaders of these groups are the women that are 'within' the communities and can truely transmit the information.

"So…we have to consider the best way we are to look for a way to make the groups be the most accessible. We are thinking that they have a nexus with some of the other social programs. Maybe we could combine them with the theme of the Wawa Wasi or with one strategy that we are developing with theme unit of community surviellence [height and weigth monitoring]… So one of the way or another would be linking these two mechanism to ensure that the women have [all that they need]" (CARE Staff FGD, p 87-89).

Theme (7) Topics of Relevance and Interest

The CARE staff has made it clear that the women sometimes tire of hearing about their children being at high risk for malnutrition. They claim they they already hear the information from the other groups that they are a part of and the topics becomes repatative, although important. A group that will function, the staff member says, is "not only [a group] associated with themes or topics about nutrition, about running a high risk, sometimes of the themes to which the mothers don't [always] respond", but also that the groups include other topics of interest to the women. Participant One drives this point home when she says:

One staff commented, "*Lets see, I think that we are aware that the mechanisms [that are in place now], they are not the most apporpiate, so, what we have intended to do, is not only to improve the coverage [of learning and information] in terms of what we intend to deliver… is the alliance between the JUNTOS and Vaso de Leche, but that we can help the infromation reach the population where the information is the most pertiennt and appropriate with an adjusted message, [along with the groups in place] that offer quality information in order to train the health staff, who will train a series of women in the community, which is our objective, but knowing that these relations will have a certain limit"* She says that this must happen in order to establish pratices in the communities and by "*generating a communications campaign over business radios".*She explains that CARE's goal must be then to help with the coverage of these infant and young child feeding practice skills, which will be done by gaining more quality contacts with the women they are targeting *(CARE Staff FGD, p 101-103,).*

Theme (8) Intentions to Behave

From the perspective of the CARE Staff, there seems to be a question of whether or not the mothers actually listen at the meetings of JUNTOS and Vaso de Leche; whether they are actually learning the information they are receiving. The CARE staff seems to think that they women listen and intend to apply what they have learned, but that it may not always be the case.

Theme (9) Cultural Considerations

The leader of the CARE staff team says, what one of the biggest considerations, is that women here, in Peru, in Latin America, are already close to their families,

and when they are faced with a challenge, they seek out their social support, but in a non-organized, non-formal manner. Therefore, when it comes to formalizing what the women already do, in the form of an official 'mother-to-mother support group', the women might find the concept challening. Therefore, when we ask the women what kind social support group they might want, topic arises, that are outside of what they normally receive advice on, especially in the rural areas. Perhaps in the more urban areas, they might need formal groups, such as alcoholics anonymous, for drug addicts or for women who are addicted to lusting after men, because family members are as closely knit as they are in rural areas. They also suggest that it is difficult to say collectively the reason that women continue to use support groups because everyone's reasonsing is different.

They explain that the women would like an activity that is "*more active and more dynamic"* and less of an activity that becomes emotional. She explains, we have to understand the Andean Culture; "*you have to see the form of our culture…we relate [to one another] and if we have 'X' problem… we look to the family closest to us…in the family environment we look for the support for our difficult problems… it seems difficult to say, that if one woman tells you she has a problem, that I should find my group of mothers… Maybe there [in America] mothers find their solutions outside of their families… but here, we go to groups to socialize, relax, to recieve a nutrient [or food]… but [in the rural areas we are like this] and maybe more in the urban areas we might generate support groups, I don't know, maybe for alcoholics anonymous, drug addicts, or women who have love [addictions] or something like that" (CARE Staff Focus Group, p 121).* Therefore, it is important to know that the women who live in the more rural areas, depend on their families more as their support systems and mainly look to the social support groups as a way to socialize, recieve material good, and to relax, away from their home. Over all, the mothers value the social support groups because they feel that it is a *'small bit of help*' that is able to alleviate some of the need for nutrients for their children. They believe that it is help for their children, and help to the mothers. Likewise, it is part of the community culture to attend these types of social functions (CARE Staff FGD p 154).

The CARE staff mentions, that if women in the community are able to have a meeting where they simply talk about their problems, that this is not viewed as a form of support. They mention that it is just not part of their culture. *Over all, there is more social cohesion among the familiy and outside of the families… [viceversa] it just not our culture…" (CARE Staff FGD, 185*). The CARE Staff is sugguesting, that it goes against the culture to devleop social support groups that do not emerge naturally out of family connections.

The peri-urban support groups, where women's families may be more spread out, in other places, could be used for more urgent issues of crisis, such as urgent support for an alcoholic family member, a family member suffering with a terminal chronic illness or a situation of immediate help with a domestic violence case.

Theme (10) Knowledge and Skills formed During Support Groups or Missed Opportunities

When asked if the women really value the information they learn at the social support groups, the CARE Staff commented that unfortunaley, the majority of women who come to the meetings are mostly focused on the food delivery and that JUNTOS and Vaso de Leche usually do not have additional educational sessions associated with them during the delivery session. Participant One says, *"…they aren't learning… we see, out of the 12 meetings that the groups have… one meeting… they might have learned something, I am not sure"(CARE Staff FGD, p 166-168).* If the health personnel allows the mother's time to actually comprehend the informaiton they are receiving, it would be ideal, but the reality of the meetings is that there is not a lot of time and the information does arrive to the mothers.

Theme (11) Leadership

It is evident that a good facilitator is required to help make the groups function and be sustained. It is important to locate naturally strong mothers, who are good leaders to facilitate the groups, or organize them; *"it has to be a person who has the knowledge, this is it why its always the leadership of JUNTOS that is always*

*training [other people]… they had been in the process of training the leaders [in the community] so that they would have the certain type of authority of their group" (CARE Staff FGD, p 269).*The MtMSGs will be the most helpful for mothers, when the groups have strong leadership.

Theme (12) Organization

The groups must also be aligned with another preexisting groups that has recognition in the community, such as JUNTOS or Vaso de Leche. Essentially, CARE Staff members expain that they are trying to formalize what is informal about social support groups. If women are to congregate on the porch and talk and relax, this is a social support group. If the CARE staff are to piggy-back the social support group into a Wawa Wasi environment, the women will already be there. Yet if they are to formalize it and make it duty, they them will be less likley to attend.

If the health promoters or MINSA staff are very clear about what they are saying, there is no reason why the women won't be able to understand what is happening during social support groups. The women will complain if there is not a clear, intentful purpose for the meetings becuase they have left their houses and their work to participate. Therefore, it must be conducted at a convenient time. Some women like to organize the meetings very early in the morning before the light of day, in order to be able to return to their houses to work. The time of the meeting is very important. The location, the duration of the meeting, the quality of the facilitator and the type of incentive or offering are also a determinents of their attendence.

Theme (13) Additional Topics to Include in Social Support Groups

The women want to learn knowledge and information, but they also mention their desire to be able to learn skills that will improve their home living situation. More so than the malnourishment of their children, they mention learning skills to develop house gardens, or skills that will allow them to create more income for the household such as selling crafts at markets or selling produce at the market (*CARE Staff FGD p 271-271).*

Theme (14) Non-Material Incentives

The CARE Staff mention that there is a challenge with the idea of instant gradification. The women want to come to the groups to learn things that will help them immediately and not ideals or lessons that will take a year or more to see the helpful outcomes. Participant Three "… *they don't [necessarily] value aquiring new knowledge… they look to see if things function instantly…but do not think about the process".* In contrast the facilitator offers, " *Americans [more like the urban women] are always planning for the future, its very different*". The Participant follows up, " *Its that the women live in the present. They live…day to day*" (*CARE Staff FGD, p 274-280).*

It seems as though the staff realize that there is the need to think about the future and about providing the women with training so that they can better take care of their children, yet the women, in some way, need a concrete benefit to attending the social support groups that can give them more immediate incentive for attending meetings.

The CARE Staff members believe that the most important and effective aspect of the social support groups will be the positive and rewarding expereinces that mothers have had feeding their children. This will serve as a model for mothers whose children are experiencing malnourishment. This is similar to the idea of the mothers as positive deviants in the Hearth Model. One participant suggest that the mother should "… share successful experiences that a mother has achieved in the care of her child… and share that with the other mothers" (CARE Staff FGD).

Theme (15) Suggestions of How to Ensure the Groups' Success based on Cultural Knowldege

An essential aspect of mother-to-mother-support groups in allowing them to function is the nature of the group leader or her personality. The mothers must have character, they must be well respected amongst their peers, they must be able to generate '*functionality*', because "*if some of the women begin to argue*

amongst themselves for 'x' motives' they must be able to manage the groups (CARE Staff FGD).

The CARE Staff makes it clear, that there will always be somone in charge, someone directing a group. In the model of mother-to-mother-support groups, we as like to think of things naturally coming together by common desire in the more democratic environment, they point out, that someone has to be 'directing'; there must be 'leadership' (p 344). The CARE Staff thinks that it will be challenging for MINSA staff to collaborate in order to train mother to be facilitators. Building trust between MINSA staff members and mothers in the community is key *(p 352).* The desire to want to form and maintain an MtMSG is present in the community with out a formal 'facilitator' because many mothers have seen how this type of trainings works and have the leadership capability to do it.

The CARE Staff response to whether or not the mothers will attend mother-to-mother-support groups without material incentives therefore it is imperative that the groups be developed in combination with the other support services that already exist: " [with the] Wawa Wasi, JUNTOS, community monitoring, and the others… but it will be in relations to a group that has a preestablished incentive. We are not going to generate additional incentives but we will value [the incentives] that already exist as [part of the groups]" (Project Coordinator, CARE Staff FGD).

Summary of Results

From the mothers' perspectives the following were the main theme categories for barriers to participation. (1) lack of time: the fact that women had to work, either inside or outside of the home (2) feelings of inferiority as they relate to social and community norms (3) financial concerns relating to the formal group participation requirements, (4) gender norms of the women in relation to their husbands, both inside and outside of the home, and (5) community perceptions relating to their relationships with their husbands/partners. On the other hand, the facilitators of the women's participation in the social support groups were (1) material and economic incentives given by the group leadership, (2) stress relief, diversion and social cohesion, (3) the fear of removal for not paying dues and being financially penalized by group leaders for women formally 'inscribed' in the groups (4)

marked attendance or obligation to participate in the groups, (5) social influences, including family influence and husband encouragement and (6) a desire to learn new things, whether it be their children's health or other topics of interest.

The themes discussed from the MINSA perspectives were: (1) compensation, (2) leadership skills, (3) support from MINSA, (4) the best way to incorporate MtMSGs into existing support groups, (5) incentives as barriers and opportunities, (6) group dynamics, (7) shame and trust, (8) topics of discussions at meetings (9) social support groups provide women with autonomy and skills (10) the radio, (11) ideas on how to engage women in social support groups. Finally, the important themes that emerged from the results of the CARE Staff perspectives were: (1) stigma and fear, (2) time, (3) women's decision making abilities, (4) trusting the source of information, (5) differences between JUNTOS and Vaso de Leche, (6) coordination (7) topics of relevance and interest (8) intentions to behave, (9) cultural considerations (10) knowledge and skills formed during support groups or missed opportunities (11) leadership, (12) organization (13) additional topics to include in social support groups (14) non-material incentives and finally, (15) suggestions of how to ensure the groups' success based on cultural knowldege.

Chapter 5: Discussion

Summary of Findings

Increasing attention has been given to maternal and child health (MCH) in the past ten years, specifically in developing countries. Since the introduction of the Millennium Development Goals (MDGs) in 2000, urgency has been given to addressing child and maternal health challenges (UN, 2010). Although Peru has a high rate of breastfeeding, there are still challenges around complementary feeding. Worldwide, there has been a lack of attention by programmers to complementary feeding practices. In response, CARE has developed and is implementing its *Window of Opportunity Program* (WOP) to protect, promote and support optimal infant and young child feeding (IYCF) and related maternal nutrition (rMN) practices. Among Window of Opportunity program activities in Peru are: (1) individual nutritional counseling; (2) food preparation demonstration sessions and recently implemented, (3) mother-to-mother support groups. This study aimed to understand the facilitators and barriers of mother's participation in the pre-existing social support groups, as a means to provide recommendations for the development of WOP's mother-to-mother support groups. The following research questions were addressed through qualitative research:

RQ1: What are the barriers to participation in mother-to-mother support groups (MtMSGs), for women who are of child bearing age or who have children less than two years of age in Apurimac, Peru?

RQ2: What are the facilitators of participation in mother-to-mother support groups (MtMSGs), for women who are of childbearing age or who have children less than two years of age in Apurimac, Peru?

RQ3: What are the alternative support groups to mother-to mother support groups which already exist in Apurimac, Peru, which aim to promote

breastfeeding and infant and young child feeding practices and related maternal nutrition?

Findings for RQ1

Several factors became evident as barriers to the mothers' participation in support groups. By conducting the in-depth interview interviews with the mothers, followed by the focus group discussions with the Ministry of Health and the CARE Staff themselves, we were able to gain a layered understanding of the mother's behavior. From the perspectives of the mothers, their lack of time, due to their work, either inside or outside of the home, was a primary barrier. Some of the mothers felt inferior to the women who participated in groups if they were not properly informed of the meetings, or were not invited to participate in the groups; whether they were active members, or not, community social norms, therefore played a role in their attendance. Another large factor prohibiting the women from attending were the costs to participate in the meetings if the women were formal members. For those women whose husbands were more protective of how they used their 'free time', gender norms prevented the women from freely participating in the groups; women were thought to be restricted to the homes to take care of the children, complete house work or work with the animals and house gardens near to the home. Another very important reason the women were apprehensive about their participation in the groups was the trust amongst the women *within the groups*: if they felt they had a personal issue they were not yet prepared to share, they feared they might be ashamed or shamed by the other women. Likewise, women who did not participate in the groups were afraid of being stigmatized as women who were lazy, idle, or who wanted a 'hand-out' from the government. Ministry of Health (MINSA) staff responded that mothers would be less likely to attend if they did not receive some type of material incentive (such as money from JUNTOS, or milk or food product from Vaso de Leche). The MINSA staff also believed that if additional groups were introduced to the women's repertoire, that women would have too many options to choose from. The staff proposed that the women might remain loyal to the groups that have a long-standing history and are familiar within the community. They also

proposed that the women's time would be spread too thin, which might also prevent them from participating. To add to these aforementioned barriers, the CARE Staff recognized that if the technical advisors who teach the mother facilitators are not aware of the day-to-day cultures of the women's lives, the groups might not function because the women might not trust those who did not fully understand their life perspectives. Finally, if the women perceive the groups to be culturally challenging, they may be less likely to attend. In Peruvian Andean culture women receive social support from the family that live in close proximity, so they might perceive it to be out of place to venture further away from the home to form a group to communicate about these issues if it does not occur naturally near the home.

Findings for RQ2

Of utmost importance to the women in terms of attending the groups were the material and economic incentives given by the group leadership of JUNTOS and Vaso de Leche. The women also were very clear about the social support groups as open venues for stress relief, diversion and a place in which they felt connected to other women with whom they do not normally interact for social cohesion. For those women who were formal members of the groups, they were motivated to attend the meetings for the fear of being removed from the groups if they did not pay their membership dues. The women also often mentioned that one of the main reasons they continued to attend the group sessions was because it was obligatory and to be had recognized as having attended. For those women who did participate in the group, social influences, such as their husband's encouragement and affirmations from their mothers, mothers-in-law and neighbors, greatly influenced their desire to return to the groups. Finally, from the perspective of the mothers, they were very eager to learn new things, whether it be their children's health or other topics of interest.

The Ministry of Health (MINSA) staff felt that having mothers who were well trained, have had experience facilitating in the past, and who have had significant success with raising well-nourished children or have triumphed over malnourished challenges would encourage other mothers to maintain interest in

the groups. The MINSA suggests that if the MtMSGs are developed in conjunction with reputable groups (JUNTOS, Vaso de Leche or Club de Madres) or combined with other CARE or MINSA initiatives, such as growth monitoring, early stimulation, or common day care time at the Wawa Wasis, that women would be better encouraged to attend because topics would not be redundant and would make better use of their time. Likewise, the government run groups have political impact in the communities, whether this be good or bad, and have an influence on the women's attention. The MINSA staff also feels that encouraging positive group dynamics *within the groups* will influence the mothers' attendance, if they feel good about their interactions with the other women, despite their economic, social or political status. Finally, the CARE Staff believed that having technical staff who train the mother facilitators and, who are extremely familiar with the women's culture, will be essential in encouraging the mothers to participate and sustain their own groups. The CARE staff also believes that the women must trust the leadership of the combined groups, JUNTOS, Vaso de Leche, and the new potential facilitators of the MtMSGs in order for the groups to continue to operate. Of equal importance to women's participation and to the maintenance of the MtMSGs, would be to include new topics of interest, outside of nutrition, which should be taught and discussed in order for the women not to lose interest.

Findings for RQ3

As part of the data collection process, women were asked what social support groups they participated in, which had long standing reputations in the community. The women, the MINSA Staff and the CARE Staff were also asked what they perceived to be an 'ideal or perfect social support group' or which topics would be of most interest to them, if they were to attend a new social support group. Gathering this information was important because it might help lead the CARE Staff to better support the interests of the women, from the health staff perspective, and also from their own understanding of the women's realities. This idea leads us into the discussion of the findings of alternative social support groups that were found to be popular and also were also suggested by women and

staff in regards to research question three. As previously discussed, the most popular and utilized support groups are (1) JUNTOS, (2) Vaso de Leche, (3) Club de Madres (Mother's Clubs), (4) Asembleas Comunales (Community Assemblies) and (5) Wawa Wasis. JUNTOS and Vaso de Leche are the social support groups that have seemed to have the most influence in the lives of the women due to their long-standing reputation and presence in the communities, as well as their ability provide the women with material and economic incentives. The mother's clubs and the community assemblies seem to continue to be utilized because they draw community members because of personal motivation to be involved in projects that improve family's lives, by selling products to augment household income or to improve the overall well-being of the community. The Wawa Wasi, which is run by the government and established more recently that the other groups, seems to have a very new, yet positive reputation, which is a resource that women, the MINSA Staff and CARE staff believe to be a prime entity for collaboration. The Wawa Wasi is an environment which combines early childhood development, in the form of what the women know as "early stimulation", and childcare by a trained community trained child care provider who informed on infant and young child feedings practices. Most people in the communities are familiar with the Wawa Wasi and this new idea of collaboration has seemed to be peculating in the minds of the MINSA Staff and CARE Staff, but has yet to be actualized.

When the women were asked which topics might be good to combine with the teachings of the new mother-to-mother support groups in conjunction with infant and young child feeding practices, the women mentioned the following topics: early stimulation, family planning, domestic violence, training the trainer, women's and human rights, and produce and economic development projects. They felt that these topics might be taught well during CARE's food demonstration sessions, during MINSA's growth monitoring sessions, or in conjunction with women's time spent at the Wawa Wasis. The women were not necessarily quick to mention that they would only attend the meetings if they were given a financial incentive or food product, but were excited by the idea of

being provided with a snack for their children, something small to eat for themselves and some kind of activity that would keep them engaged in the learning session.

Synthesis of Findings

Despite the mothers' lack of time, where urban women tend to have more paid work outside the homes, and rural mothers are occupied with their children and on the farm, they truly recognize the importance of being involved in social support groups, whose intentions are to inform and educate. The mothers look to the groups as a form of social diversion, relaxation and fun. Mothers recognize the importance of having a social space to discuss their family problems, beyond the educational objectives the social support groups seems to have in place. Although the majority of the mothers say they would attend MtMSGs if material incentives were not involved in the process, it is challenging to know whether or not the disadvantage of not receiving money or food product would ultimately change their decision. The MtMSGs are intended to be designed so that women attend and facilitate the groups voluntarily which might reduce the sense of exterior pressure and negative perception that is created by those who are, or are not, involved in government-run organizations, for whatever reason. Whereas mothers felt that they had to be invited or inscribed to participate in the government run programs, JUNTOS and Vaso de Leche, it is supposed that the mothers might feel more apt to be a part of MtMSGs where there were no need to feel inferior or threatened by those who were or not able to attend, due to lack of time or desire not to be financially fined. It is evident, though, when the mothers are personally motivated to participate in such social support groups, as the Club de Madres, their loyalty and desire to join seems much more genuine. Whereas the women seemed to be more motivated to attend sessions with JUNTOS and Vaso de Leche to receive money and food product, the lack of material incentive involved in the MtMSGs may demonstrate the women's true intentions or desire to support and learn about infant and young child feeding practices. The decisions

on the participation of women in different spaces depend not only on the mothers, but also on the extended family. There is a significant influence of the spouses in this decision.

Healthcare workers at the Ministry of Health (MINSA), despite the burden of care, have a favorable view of the implementation of the MtMSGs, which they recognize as an alternative strategy for changing practices of the mothers, concerning childcare. The MINSA staff believe that the MtMSGs will be very effective, but only if the time and energy is properly given to the training and facilitation of the groups. They seem very exited about the idea, but exhausted at the thought of having to be the sole organizers and facilitators of the project, due to the amount of time they already give of themselves in their clinical work. Likewise, they see the benefit of partnering with CARE staff and other government run groups to maximize potential and minimize duplicated efforts to form the MtMSGs. The MINSA Staff also realizes that the MtMSG facilitators need to be highly motivated, experienced at organizing or facilitating and must have had nutritional experiences with their infant, which were outstandingly positive (in order to lead by example) or particularly challenging, which they have learned from. As the mothers have suggested the MINSA staff believes that it is essential to piggy-back this program on top of another program that is highly reputable or has shown to be successful at maintaining the women's attendance, such as JUNTOS or Vaso de Leche meetings, congenial meeting time at the Wawa Wasi, or with Early Stimulation Sessions at the clinic or CARE staff's nutritional counseling or food demonstration sessions.

From the perspective of the CARE Staff, one of the most important findings of the study is the notion that the women do not perceive the government run meetings to have as much educational value as the CARE Staff had hoped or perceived. The motivation on behalf of the CARE staff to help to implement MtMSGs that give women a sense of engaged and valuable learning is, therefore, paramount in their minds. Another important finding from the perspective of the CARE staff is that often times, women tire of listening to lectures and information sessions on what their children lack nutritionally because its repetitive and the women begin to lose interest in rote lectures. The idea of a social support group to

talk about infant and young child feeding practices, or breastfeeding, which are thought to be emotionally charged topics that will maintain the interest of the women is a foreign concept in Andean Peruvian culture, according to the CARE staff. Whereas women who already live close to their families, use their family network as a means of support, it might seems a bit counter intuitive to travel to a common place to meet with other women who may or may not be family members, but women who live on opposite ends of the community or not so familiar neighbors. There must be some kind of leadership. Staff supposed that the MtMSGs are opportunities for reflection for the mothers that are not subject to the dynamics of the health care staff or facility, if they are properly facilitated.

The mothers of the peri-urban (or urban) areas have access to paid work outside of the home, which permits them to have an income (which is often more robust and regular than women who live in the rural communities). This reduces the time available to these mothers and hinders their participation in the activities, which are promoted by the Window of Opportunity. To address this problem, alliances have been made and should continue to be sought with social program such as JUNTOS and Vaso de Leche, whose actions resemble those developed by the WOP in order to enhance nutritional support. Likewise, the mothers have indicated that the work of the Wasa Wasi is an ideal opportunity to blend similar efforts to help stimulate their children growth, both physically and psychologically. The mothers, Ministry of Health staff and CARE staff also suggest that efforts could be made in conjunction with the community weight monitoring of the children, which is an intervention that permits real and concrete involvement with the community members. This effort is very different from meetings, whose 'educational' content may or may not be received by the target population.

Results in Light of Theory on Social Support

As we have discussed, social relationships give people a reason to identify with and support one another through challenging life experiences. A connection to a social network, and in turn access to social support, allows individuals to connect to a purpose beyond themselves. As Bowling suggests, it is important that

individuals feel that they are members of a network of 'mutual obligations', where similar personal concerns are addressed within that group (Bowling, 1991). In the case of this study, it is evident that the women mainly depend upon the social support to connect to economic resources. They seem to seek and receive emotional social support within their families. In this sense, the social support provided from the groups already in place may serve the purpose of economic support because the individuals involved feel that the support they receive connects them to certain financial and material resources they have (Bowling, 1991). On the other hand, the development of the MtMSGs may serve as an informational support to those women who show interest their topics and the manner in which they are organized.

Results in Light of the Literature Review

In relation to the literature review conducted for this study, there were several similarities between the case studies that were reviewed and the results of the current study. One major similarity to the case study that was reviewed on the Mother 2 Mothers support groups in South Africa is that social support groups were founds to provide a secure, warm environment where women have felt safe to share their feelings and fears about personal problems (Besser, 2006). One of the major findings of this study was that having a sense of diversion, social cohesion and a place to relieve stress was a facilitator for the mother's participation in the exsiting social support groups. Although in the current study, some women felt insecure about not being invited to participate in the groups, the majority of the women stated that they felt comfortable with the other women and looked forward to the social support groups as an outlet for relaxation and recreation.

Another very important similarity found between the literature reviewed and these results was in the Senegalese grandmother study (Aubel, 2004). This study pointed to the importance of collaboration with existing organizations, whether they be government operated, non-government organizations or non-profit organizations already working in the area. This case study points out that success

comes from collaboration with previously established initiatives, ideas and efforts. Likewise, this is a major finding of the current study. One of the major concerns of the Ministry of Health Staff was that the mother-to-mother support groups be established in conjunction with the efforts of their own staff and the CARE staff in order to avoid duplicating such laborious efforts. The women in the study also alluded to the fact that women are drawn to participating in social support groups with organizations who have a positive and long-standing reputation in the community.

Lastly, another very important similarity found in the literature reviewed was the importance of social capital and social networks for improving health and access to health services. Supported by Glanz's Relationship of Social Support and Social Network to Health Model, it is evident that personal interactions and relationships and community resources can improve individuals' ability to cope with the stress of mental, social and physical health challenges (Glanz, 2006). Likewise, the idea described by one sociologist, the greater number of links a woman has in a social network, the greater the amount of health protectiveness she has, supports the current study (Myers, 1975). The women in this study who have in lived in their communities for long periods of time expressed a strong relationship and loyalty to JUNTOS, Vaso de Leche, their mother's clubs and the more recently established Wawa Wasis. The friends, neighbors and family members these women have strong relationships with have shown to connect them to information and resources that are able to help them meet their health and social needs. The women who were new members to their communities, lacked this connectedness and therefore the 'protectiveness' that these links could provide them. This was demonstrated through the insecurities they described of not being formal members of the groups and the lack of benefits that came with that membership.

In summary, it will be helpful to model mother-to-mother support groups based on the aspects of functioning social support groups that have shown to be particularly successful. In the case of the Senegalese grandmother study, it is important to incorporate the generational community knowledge and values of the

elder communitiy mothers and grandmothers into the support groups in a creative manner. According to the Hearth Model, it is helpful to utilize the experiences of mothers who have had success in overcoming nutritional challenges with their own children and who have proven to be strong leaders. Likewise, in the case of La Leche, it is important to build relationships that involve counseling within social support groups that capitalize on the mothers' strengths and most urgent and emotionally charged issues and needs. From the mother's perspectives, these are the most important to address. Finally, in the case of the Mother 2 Mother support groups in South Africa for HIV positve mothers, it is important to pay attention to issues that are most urgent to the mothers because they will respond accordingly to the needs they need met. This study also shows the importance of collaborating with other community organizations, whether they are non-profit, independent or government operated.

In terms of the social support groups that are functioning on the ground in the Apurimac region, it is important the aspects of these groups should be considered when implementing mother-to-mother support groups. Recognizing long-standing reputations and relationships in the community is important. This can be seen in the cases of JUNTOS and Vaso de Leche who are well recognized and well respected. Although it might be hard to emulate these long-standing reputations, it will be important to take them into consideration. The mother's clubs demonstrate a support group model that incorporates the women's hobbies and personal interests into consideration. And finally, the Wawa Wasi should be closely examined for its creative way of developing a sort of internal cash conditional program that involves the government who pays the child care staff, while freeing-up the mother's time and simultanesouly providing infants with early stimulation sessions, nourishment, and social interaction

Updates from the Field

Implementation of the pilot program on the mother-to-mother support groups (MtMSGs) at the community level was undertaken in 16 communities in Apurimac. The implementation began with the identification of the mother-facilitators and concluded with a training by the Window of Opportunity technical

team. The training was aimed at developing the mother's facilitation skills for the MtMSGs. Twelve MtMSGs were developed in September after the training, where the WOP staff provided advice at beginning of the sessions. In October, four MtMSGs remained active, and in November and December, two MtMSGs remained active. The CARE staff has indicated that this was due to a "weak power of convocation of the mother-facilitators and the lack of motivation of the participant's mothers" (Final WOP Report, Peru 2012).

Limitations

Certain limitations of this study must be considered when considering the findings from the data collection and the effect that the study may have on the development and sustainability of the mother-to-mother support groups on the ground in Apurimac. Firstly due to the nature of qualitative research as a lengthy and iterative process, as well as the principal investigator's time constraints, time was limited. The data collection period was also relatively short and collection may not have been as reached thorough saturation.

Another limitation of the study was the principal investigator's limited Quechua language skills. Although one of the CARE Staff members was proficient in the Quechua language acted as a translator in many of the data collection sessions, it would have been helpful for the principal investigator to have fully understood the women who participated in the study who were Quechua speakers. This understanding would have allowed for more accurate translation of the women's responses, and therefore, a better understanding of their perspectives. Likewise, although the principal investigator is a fluent Spanish speaker, she is not a native Peruvian, and therefore the nuances of the Peruvian culture, as represented through Peruvian Spanish, might have been lost in translation. Further research should take this language barrier into consideration as an opportunity to include a full time Quechua translation as an investigator on the research team.

The doer/non-doer interviews were originally supposed to be conducted as surveys, but were conducted as in-depth interviews. During the data collection process, there was a misunderstanding between the Principal Investigator and her

thesis advisor on this topic. After the in-depth-interviews were conducted, the Principal Investigator used the results to fill out a survey (which she created) for each of the women who completed an in-depth-interview. The principal investigator made a survey that had questions that reflected each question in the in-depth-interview, but had a specific set of response options (as the doer/non-doer survey) in order to create the doer/non-doer results table (as seen in Appendix L). After the interviews were complete, she then read each interview response and filled out the response to the corresponding survey question. Due to the fact that not every question in the in-depth-interview was answered uniformly, it was challenging to provide uniform answers in the corresponding surveys, and the answers therefore forced into categories or were sometimes left blank. The response rate in the translated surveys was therefore low for some questions. In sum, the doer/non-doer results (as seen in Appendix L) may be skewed. We may be able to understand this limitation in terms of Joseph Maxwell's explanation of validity (Maxwell, 1996). He explains that the validity of your results is not guaranteed by following a prescribed procedure and that a personal interpretation of results may cause the results to be invalid. In this case, interpreting the interview results into survey results may have caused some of the results to be invalid (Maxwell, 1996).

Finally, there was a lack of consistent use of methods across the regions of Ayacucho and Apurimac during this study. Although the data were not compared across regions for this specific study, when developing program recommendations for the overall country program and CARE USA for the Window of Opportunity program, different recommendations might need to be made based on the methods used. Therefore, the study might have strong validity concerning the recommendations it makes for the Window Project in Peru, but less validity especially when comparing the results with the other Window country programs. The abiliy to generalize the reccomendations of the study to other Window programs might be difficult due to the fact that the reccomendations are contextually based. Although this is true, 'generalizability' is not usually a goal in qualitative research.

Strengths

Although the limitations made the study more challenging, the strengths of this study are something to be proud of and commended. As a student principal investigator, I was able to help lead the research team in Abancay to collect the data in this study. Many students are often given secondary data by which they develop findings and analyses. This process can often be frustrating because they may be less familiar with the data collection process and therefore feel removed from the data analysis process. The data are primary data and therefore the quality of the data is much more rich in terms of the ability of the principal investigator of interpreting results in combination with direct observations. In terms of understanding this strength in relation to Maxwell's definition of validity, we can look to his definition of *descriptive validity.* He explains that if one's description of what she is observing, or of the interviews and focus groups, etc. which are conducted are valid, then interpretations or conclusion which she draws from these observations and descriptions are more compelling or legitimate (Maxwell, 1996). As the principal investigator in the field, I was able to record direct observations from the field during data collection, while removing my personal judgement from the descriptions of the observations themselves. Often times, those who are in the field may place judgement on the subjects or environments which they observe, it was important to remove this bias from the observation and data interpretation process. By removing my personal judgement or bias from process, according to Maxwell, my conclusions can be considered more valid. This also speaks to Maxwell's idea of interpretive validity. Interpetive validity can be described as the accuracy with which accounts are grounded in the language of the people studied, and rely as much as possible, on their own words and concepts. In this case, it was easier for the principal investigator to directly interpret the findings because she was in the field with the people who are part CARE programming (Maxwell, 1996). The principal investigator's loyalty to the entire research process increased the interpretive validity.

Another strength of this study is the relative novelty of the research topic and therefore the importance it has for maternal and child health, specifically social

support groups and their relation to infant and young child feeding practices. Very little research has been conducted on the use of social support groups as a means to help mitigate the challenges of malnutrition, more specifically infant and young child feeding practices. This study is one of the first to investigate this intervention as useful tool for increasing infant and young child feeding practices.

The recommendations of this study will be useful, not only specifically for the CARE Peru Staff of Abancay, but also for other development organizations who have an interest in utilizing social support groups as a means to mitigate undernutrition and malnutrition. Likewise, although the research team in Apurimac, Peru developed preliminary results from this data set, this follow-up thesis is acting as additional operational research that confirms what we, as CARE Staff have realized about our programming.

Implications for Public Health

Recommendations:

(1) Coordinate mother-to-mother support groups to coincide with other existing Social Support Groups: JUNTOS, Vaso de Leche, Club de Madres and Wawa Wasi.

An important point to mention about the existing social support groups in the Apurimac region is that they tend to compete for the mothers' time, because there are several existing groups. There is a certain sense of competition among the groups. This is not to say that the social support groups encourage competition between groups, but the groups vie for the women's time, commitment and energy, due to the fact that they have so little to spare for multiple group meetings throughout the week and months. This fact has a bearing on how best the Ministry of Health, CARE and other such organizations should think about collaborating as to not duplicate health prevention strategies and efforts. By coordinating efforts with other social support groups to develop the mother-to-mother support groups, knowledge and facilitation efforts, use of materials, community time, and organizational efforts will be optimized. This will be true, both in terms of public and private partnerships, government and non-government organizations, not to reinvent the wheel.

(2) Involve trusted mothers as leaders of the MtMSGs, who must be well trained, have competent skill sets, be motivated and be well-respected in the community.

As seen by field updates from Apurimac, it is paramount that mothers who are motivated and experienced as facilitators must be involved as leaders of the MtMSGs. Although in theory, the model social support group might be an entity that is formed organically with equal contribution and participation from its members, in the case of this study, it is evident that strong leadership is needed in order to facilitate and sustain the group. Mothers who stand out as leaders in the communities among their peers should be considered as group facilitators. Therefore it might also be essential to pilot test the development of a couple MtMSGs where strong leaders can be appointed, and later use this as a model for other communities, if it proves to be successful. We must not set the MtMSGs groups to fail.

(3) Consider the Community Context while Developing Curriculum for MtMSGs

It is challenging to create an intervention that can be generalized for all communities. It is extremely important to consider the community context before organizing MtMSG structure and developing and implementing curriculum. All community contexts must be considered; rural vs. urban, smaller versus larger, more prescriptive gender norms verses less prescriptive gender norms. It is important to observe community member's behavior in order to identify women who can act as social support group leaders, in the case of the "Positive Deviants" (Schooley & Morales, 2007). When the strength of the social support is generated from within the community, the sustainability and effectiveness become more effective. This is also important for pilot testing. It is vital to involve as many local volunteer personnel specific to the particular community (e.g. midwives, community facilitators, and health workers) as possible to help bridge the divide between a proven methodology such as the Positive Deviance Hearth and unique and complex set of cultural values, perspectives, attitudes, and behaviors as work within a particular community (Schooley & Morales, 2007). Considering the community context will only work to ensure the effectiveness of the group and also its sustainability.

(4) Develop Curriculum that Responds to the Needs of the Community, including topics outside of IYCF that will Maintain Mothers Interest and Motivation

As mentioned by the CARE Staff, although the topics of infant and young child feeding practices are essential to the long term development and care of their children, often times mothers tire of listening to the same topics during social support groups meetings. When they are faced with listening to the same obstacles they are challenged with, repetitively, sometimes they loose interest in the delivery of the content. Therefore, it has been suggested to combine essential topics with topics of interest and activities that will entice and further engage the women. The women in this study have mentioned incorporating such topics as early stimulation, family planning, domestic violence, human and women's right and economic development activities into the MtMSGs. The women have also suggested 'piggy-backing' these topics into or onto the CARE's pre-existing food preparation demonstrations or individual nutritional counseling. We also suggest that the topics be included in growth monitoring sessions run by the Ministry of Health of incorporated into the educational sessions of the Wawa Wasi.

(5) Consider topics of interest that are the most urgent to the particular community at hand.

Similarly to recommendation #4, perhaps one reason that many of the MtMSGs stopped meeting, is that the mothers might not have recognized an urgent enough need to come together with other women. Although as researchers and program developers, we understand the urgency of this topic for the long-term development of infants in these communities, it has been mentioned that many mothers may not see the immediate need. Although mothers seem to commiserate about emotional topics, including breastfeeding, IYCF practices and their children, the topics might just not be urgent *enough.* Historically, support groups have seemed to function well when people are in crisis situations, such as dealing with a severely alcoholic family member, seeking support for domestic violence abuse, and finding emotional support while coping with illnesses such as HIV and AIDS or cancer (Albernaz, 1998; Besser, 2006; Dennis, 2002; Ingram, Rosser & Jackson, 2004). It is hard to suggest IYCF is not an urgent issue because

taking care of one's children's nutrition is a very important issue. Yet many of the women do not see it as a pressing challenge because its positive long-term effects are not readily visible.

Future Research

There is much opportunity for further research to explore social support in relation to IYCF practices in developing settings. For instance, developing a study to explore alternatives to the use of material incentives for successful participation in social support groups would help programmers gain insight on how to maintain women's interest and loyalty to social support groups. Additionally, another research study that would be useful to conduct is one that addresses the leadership characteristics of women in these kinds of communities, including pertinent qualities of individuals, as well as strengths and weaknesses of community appointed mother facilitators. This could include some follow-up research with mothers who are considered 'positive deviants' according to the Hearth Model, to understand what the women are 'doing right' in the successful pilot programs in order to model successful mother-to-mother support groups in a similar fashion. This study would help to address the challenge of mothers' lack of motivation to continue to lead the mother-to-mother support groups. It is also recommended that future researchers address how to include infant and young child feeding techniques and practices into existing social support groups, mentioned in this study, as well as in other community contexts.

Conclusion

Social support groups in the rural and peri-urban communities of Apurimac, Peru are highly complex and challenging. Findings from this study provide insight into the barriers and facilitators of attendance to social support groups, specifically concerning infant and young child feeding practices. The results of this study have provided useful recommendations on how CARE staff in Peru might be able to draw upon the strength of existing social support groups in order to better

address the important nutritional needs of mothers with children ages 0 to 2 years of age. It is essential to consider the community context when understanding the barriers in participation to social support groups, which is evident from this study. Establishing collaboration between existing social support groups, on behalf of CARE Peru, the Ministry of Health and other non-governmental organizations, will be essential in maximizing mother's participation in social support groups as well as ensuring their sustainability. There remains a great amount of work to be achieved towards the targets set by the Millennium Development Goals in the areas of Maternal and Child Health, but this research is a starting point for future research and program interventions concerning infant and young child feeding practices and related maternal nutrition.

Acknowledgements
Academic Thesis Advisor, Hannah Cooper, PhD
Peer Thesis Team, Venita Embry and Jennifer Munley

Professional/Career ‘Support-a-visor’, Lenette Golding, PhD, MPH
Advisor and Co-Worker, Carlos Rojas

CARE Peru Staff, Walter Vilchez
CARE Abancay Field Staff Team, Rocio Vargas, Marisol Borda,
Angelica Sanchez, Erika Collado, Zuider Zamalloa

CARE’s Window of Opportunity Program Staff
including program Interns, Molly Pilloton, Bill MacWright and Alina Shaw

Former CARE Intern, Allison Ingalls
Peers at Rollins School of Public Health
Family and Friends

Appendix A

The Hearth Model

The Hearth Model is currently being implemented in countries such as Haiti, Vietnam and Bangladesh. It is intended to function as part of a comprehensive programme that includes growth monitoring, deworming, vitamin A and iron supplementation, and treatment for infectious diseases. In this approach, volunteer mothers from the community are trained to conduct feeding sessions (called 'hearths') in their homes, to provide malnourished children with one nutritious meal per day in addition to their normal diet. Mothers attend with their malnourished children each day during the two-week rehabilitation period, to learn how to prepare nutritious foods and observe the improvement in appetite, activity and overall health of their children. The meals fed during the sessions are usually developed using a positive deviance-approach, by determining which foods are fed by low income mothers in the same community whose children are well nourished. This ensures that local, affordable foods are chosen and, through the process of discovery, convinces participants that a solution exists that is within their means. Social learning theories are the basis for the nutrition education component of the model.

The impact of the Hearth model has been formally evaluated in Haiti[a] and Vietnam[b] by collecting data on child weight (though not height). In Haiti, a quasi-experimental longitudinal design was used to compare 192 participants and 185 comparison children from nonprogramme communities who were similar in initial weight-for-age Z-score (approximately -2.7). In multivariate analysis, there was a significant difference between groups in change in Z-scores during a 12-month period, in favour of the hearth programme. The effect was greater among children with higher initial weight-for-age (WA), which was unexpected.

The authors speculated that the Hearth Programme was most effective at preventing further deterioration among moderately malnourished children, but for those who were severely malnourished the local growth monitoring programme may have been more effective because such children were more likely to be referred for medical care. In Vietnam, the Hearth Programme is called the Nutritional Education and Rehabilitation Programme (NERP), and is part of a larger strategy (formerly called Poverty Alleviation and Nutrition Programme and now called Community Empowerment and Nutrition Programme) implemented by Save the Children/US that involves multiple components, including a programme to promote health of mothers and infants, pre- and postnatally. Data collected before and after implementation of the programme in 52 hamlets indicated that within two years, the prevalence of severe underweight (< -3 WAZ) decreased from 23% to 6%, a trend not observed in other parts of the country. Improvements in child weight appeared to be maintained even after NERP sessions were discontinued (which occurred when the number of eligible malnourished children was too low to warrant the sessions), suggesting long term improvement in child feeding and caregiving practices. The scope of the programme in Vietnam (i.e., both pre- and postnatal interventions) makes it difficult to attribute the changes in child weight solely to complementary feeding, but the sustained effectiveness of the overall approach is encouraging ■

Appendix B

Proyecto Ventana de Oportunidad- Apurimac
Investigación Formativa-Grupos de Apoyo a la Madre- GAM
Encuesta- Hacedor y No Hacedor

*Preguntas preeliminarías para **desarrollar familiaridad**:*

1. ¿Cómo usted se llama?
2. ¿ De que comunidad es?
3. ¿Cuánto tiempo usted tiene viviendo acá?
4. ¿Cuáles son los edades y los nombres de sus hijo(as)?

*Dominio A: Cuestiones relacionadas con el **comportamiento**:*

1. ¿Usted pertenece a una organización social ahora mismo?
   Por ejemplo:
   - JUNTOS
   -Vaso de Leche
   - Asambleas Comunales

   Si ____ ¿ Cual organización social?_____________________________
   No ____ ¿Por qué no? _____________________________________ (Pasa a pregunta #2)

   (a) ¿Cuántas veces en el último año ha asistido las reuniones de ………?

   (b) En el último año, ¿Usted ha asistido a una organización diferente que…….?
   Si____ ¿cuál?
   ¿cuantas veces en el ultimo ano?
   ____
   No ___ ¿ Por que no?
   (c) ¿Cuál cosas le gustaban mas sobre las reuniones?

   (d) ¿Cómo usted participan en las reuniones de las organizaciones en su comunidades, como
   líder __________? participante _________?

	Hacedor	NON-Hacedor
Repuesta 1		

2. ¿ Ha participado en reuniones de una organización en el pasado?
   Si ____ ¿Cuál organización? ______________________
   ¿Cuando?________________________________
   No ____ ¿Por qué no ha participado?
   Nunca ____ ¿Por qué nunca?
3. ¿Cuántos veces se reúnen las reuniones de los otros grupos en su comunidad?

   (a) ¿Qué tipo de reuniones son, de los de que no va? Describirlos.

4. ¿Usted siente que es importante asistir reuniones en su comunidad?

(a) ¿Por qué si?
(b) ¿Por qué no?

*Dominio B: Cuestiones relacionadas con **las consecuencias positivas y negativas**:*

5. ¿Qué usted ganaría de participar en las reuniones? Por ejemplo: Aprende información nuevo? o ¿Cuáles son las cosas buenas de participar en los reuniones?

6. ¿Qué usted perdería si participar en las reuniones? Por ejemplo: Su tiempo, o otros actividades

7. ¿Cree usted que su asistencia en las reuniones le ayudara mejorar el cuidado de su familia?
Por ejemplo: la practica de alimentación de sus hijos menor de dos años

(a) ¿Cómo estas cosas les ayudaran en sus vidas? Por ejemplo: en la casa

*Dominio C: Pregunta relacionados con **la auto-eficacia**:*

8. ¿Por qué no puede asistir reuniones? Por ejemplo: No tiene transportación

9. ¿Que le ayuda participar en las reuniones sin problemas? Por ejemplo: Cuando alguien le ayuda con los niños

10. ¿Cómo se siente cuando participa en las reuniones?

11. ¿Cómo se sentiría si no existieran las reuniones?

12. ¿Cómo afectaría, al niños(as) si no existieran reuniones así?

Por ejemplo: ¿Su niño enfermaría mas?

*Dominio D: Pregunta relacionados con la **susceptibilidad**:*
13. Si usted no participaría en una reunión ¿Puede pasar algo malo en su familia?
(a) Si ________ ¿Qué cosa pasaría? __________________________
(b) No ________
14. ¿Cree usted que contaría con menos información o cosas a cuidar a sus niños?
Si _____ No_____
*Dominio E: Preguntas acerca de las **normas sociales**:*

15. ¿Quién no le apoya o no le gustaría su participación en las reuniones?

(a) ¿Por qué cree que no les gustan que participa en las reuniones?

16. ¿ Quién apoya o le gustaría su participación en las reuniones?
(a) ¿Por qué?

17. ¿Es bien visto a participar en las reuniones?

(a) ¿Por qué si o por qué no?

18. ¿ Como participa los promotores de salud (o por ejemplo, lideres de MINSA) en la mejora de las practicas de alimentacion materna infantil?

(a) ¿ Que hacen los promotores de salud el la comunidad?

19. Si existaria una reunion o grupo perfecto ¿Cómo seria el grupo para usted?

(a) ¿Qué cosas sobre el grupo le gustaria mejor?

20. ¿Usted le gustaria tener reuniones de apoyo de madres (entre las madres nuevas) para compartir informacion importante sobre el nutrition y alimentacion de sus ninos?

(a) ¿Asistiria, si el reuinion seria para conversar y compartir, nada mas? Por ejemplo: no recibir aciete, papilla, atun o arroz

Appendix C

La Programa La Ventana de Oportunidad

Grupo Focal- Mujeres
Hacedores: Preguntas Enfocado en las Razones Por Que ***SI****, las Madres se Van a Reuniones Sociales*

(1) ¿Qué son las cosas buenas de asistir a los reuniones de JUNTOS, Vaso de Leche y los asambleas de la comunidad?

(2) ¿Si las madres se van a reuniones, la comunidad dice cosas buenas sobre ellas? ¿De qué manera?

(3) En el caso de JUNTOS y Vaso de Leche, cuando les dan plata y comida, esto es la única razón las madres se van a los reuniones ¿Cómo es este dinero y comida relacionado con su asistencia a los grupos?

(4) ¿Las mujeres, realmente, les gusta pasar tiempo con las otras madres? Si es así, ¿por qué?

(5) ¿Las madres sienten que han hecho algo bueno cuando han asistidos los reuniones? Si es así, ¿por qué?

(6) ¿Las madres sienten que aprenden practicas (de alimentación) cuando asistiendo a las reuniónes? ¿Qué tipo de practicas?

(7) ¿Las madres se sienten seguridad a contar con el dinero o alimentos brindados que les dan en los reuniones?

(8) ¿Las madres se sienten mas seguridad o tranquilidad emocional o social cuando se van a los reuniones? Si es así, ¿cómo? Si no, ¿por qué no?

(9) ¿ La mujeres consideran que si una mujer es mejor del otra si participas en una reunión? Si es así, porque?

(10) ¿Cómo influye, en la vida con sus esposos, su participación en los reuniones?

(11) ¿Cómo influye, en la vida su familia, amigas o vecinos, su participación en los reuniones?

(12) ¿Cómo que le gustarían que la presidente de los reuniones hagan la reunión para que les siente mejor ?

(13) ¿ Que provecho sacan de los reuniones de que asistan?

(14) ¿Cuáles son los desventajas de asistir a los reuniones?

(15) ¿Ustedes creen que aprenden cosas nuevas en los reuniones, o solamente irse para escuchar cosas que ya saben?

(16) ¿En qué momento es mas difícil participar en los reuniones?

(17) ¿Qué cosa debe pasar para que las mamas, ya no quieren ir a los reuniones?

(18) ¿Cuándo ustedes participan en los reuniones, sus opiniones son recibidas con las otras madres?

(19) ¿ Fuera del espacio de los reuniones, ustedes conversan sobre las temas de las reuniones?

(20) ¿ En quién las mujeres confianza mas, con sus preocupaciones?

(21) ¿Qué actividades son divertidas para ustedes? ¿Qué son utiles?

(22) ¿Por qué las mujeres siguen participando en estos reuniones o grupos?

(23) ¿Sobre que temas o que actividades les gustarían hacer en los regiones?

APPENDIX D

La Programa La Ventana de Oportunidad

Grupo Focal- Mujeres
Non- Hacedores: Preguntas Enfocado en las Razones Por Que ***NO****, las Madres* ***NO*** *Van a Reuniones Sociales*

(1) ¿Para las mujeres que no van a los reuniones, que pierden de no asistir?

(2) ¿Piensen que la comunidad piensan mal en las mujeres que no van a los reuniones? Si es así, porque es así? ¿De qué manera?

(3) En el caso de JUNTOS y Vaso de Leche ….
¿Cómo es este dinero y comida relacionado a las madres que no van a estés reuniones?
¿Ellas no necesitan o no quieren el dinero o la comida?

(4) ¿Las mujeres quien no se van a los reuniones, piensan que es una pierda de tiempo a pasar tiempo con otros mujeres o con las presidentas de los reuniones? Si es así, ¿por qué?

(5) ¿Las madres sienten que no han hecho algo bueno cuando no asisten a los reuniones? Si es así, ¿por qué?

(6) ¿Las madres sienten que han perdidos algunos practicas cuando no se van a los reuniones?

(7) ¿Las madres se sienten que han perdido algún seguridad de dinero o alimentos que son brindados en los reuniones, cuando no se van a los reuniones?

(8) ¿Las madres se sienten menos seguridad, tranquilidad emocional o social cuando no se van a los reuniones? Si es así, como? Si no ¿Por qué no?

(9) ¿Las mujeres quien no se van a los reuniones, piensan que las madres que van a los reuniones son mejores de ellas, en alguna forma? Si es así ¿por qué?

(10) ¿Las madres se sienten que tienen menos influencia en lo demás, si no asisten a los reuniones? Si es así, ¿por qué? Si no, ¿por qué no?

(11) ¿Como influye, en la vida con sus esposos, cuando no asisten a los reuniones?

(12) ¿Cómo que le gustarían que la presidente de los reuniones hagan la reunión mejor para que las mujeres asisten los reuniones ?

(13) ¿Qué provecho, no sacan de los reuniones, cuando no se van las mujeres?

(14) ¿Cuáles son los desventajas de asistir a los reuniones?

(15) Si las mujeres no van a los reuniones para aprender de salud ¿donde aprenden prácticas o reciben información de salud de comer?

(16) ¿En qué momento es muy difícil participar en los reuniones?

(17) ¿Usted cree que las mujeres piensan que sus opiniones no son recibidas con las otras madres?

(18) ¿ En quién las mujeres confianza mas, con sus preocupaciones, so no van a los reuniones?

(19) ¿Las mujeres quien no se van a los reuniones piensan que los actividades son divertidos? ¿O, qué no son útiles?

(20) Para las madres quien no van a los reuniones…….
¿Qué cosa debe pasar que las mamas, ya no quieres a los reuniones?

(21) ¿Sobre que temas o que actividades les gustarían hacer en los regiones?

APPENDIX E

Grupo Focal con el facilitadores de MINSA:

(1) Sus percepciones sobre sus mismo habilidades como facilitadores, y el apoyo de CARE
(2) Sus percepciones sobre, si funcionaria los grupos de GAM, o no, para las madres en los comunidades de Curahuasi

PARTE Uno:

Tecnicas de Facilitación:

(1) ¿Cuál es su papel como el facilitador del grupo de apoyo/social?

(2) ¿Qué ustedes piensan son los cosas tan efectivo para ser un facilitador para grupos de mujeres?

(3) ¿Cuáles son las habilidades más valiosas que puede ofrecer como un facilitador?

Sentido de Pertenencia:

(4) ¿De qué manera cree que su experiencia como facilitador ayudará a apoyar a las mujeres en los grupos sociales y / o apoyo?

(5) ¿Usted cree que sus contribuciones como facilitador son valiosos para la discusión en los grupos sociales y / o apoyo?

(6) ¿Qué parte de los debates de los grupos sociales creen que ayudar a las mujeres a cuidar mejor de sus hijos?

Tiempo:

(7) ¿Está satisfecho con la cantidad de tiempo reservado para el grupo de apoyo?

(8) ¿Cuánto tiempo le puede dedicar a ser un facilitador de grupo de apoyo? Y ¿con qué frecuencia?

(9) Fuera del grupo de apoyo, ¿cuánto tiempo le dedican a las actividades relacionadas a la seguridad social y / o grupos de apoyo?

Alternitativas:

(10) ¿Puede dar un ejemplo de un grupo de apoyo social que actualmente existe en la comunidad que trabaja que esta funcionando bien?

(11) ¿Por qué las mujeres siguen para ir a estos grupos?

(12) ¿ Si discubrimos que los grupos de GAM funcionaran, como los empleos de CARE puede asistir les en el trabaja de MINSA a fortalecer los esfuerzos juntos?

Frecuencia de la acción y la equidad en la participación:

(13) Hable sobre los tipos de actividades que les gusta hacer en grupos.
- o ¿Qué actividades son divertidas/son utiles para ellos?

(14) ¿Qué impide que vuelvan a los grupos de apoyo?

PARTE DOS:

(1) ¿Cómo se sienten las madres que se beneficien de asistir a los grupos de apoyo? "Lo que es realmente en él para ellos?"

(2) ¿Alguien en el grupo de proporcionarles una compensación económica? ¿Quién? ¿Y cómo es este dinero relacionado con su asistencia a los grupos?

(3) ¿Cómo las relaciones de las mujeres con sus maridos (tambien, las parejas, vecinos o familia) influyen en su capacidad para asistir a los grupos sociales y / o apoyo?

(4) ¿Se sienten que reciben reconocimiento de la comunidad? ¿De qué manera?

(5) ¿Las mujeres realmente les gusta pasar tiempo con las otras madres? Si es así, ¿por qué?

(6) ¿Las mujeres se sienten como si tuvieran la libertad de ser social, en las afueras de la casa cuando asisten a los grupos de apoyo? Si es así, de qué se trata los grupos de apoyo que les da esa libertad que es diferente de otros tipos de grupos de apoyo o social?

(7). ¿Las madres sienten que han hecho algún tipo de éxito al asistir a la social y / o grupos de apoyo? Si es así, ¿por qué?

(8) ¿Las madres sienten que han adquirido las habilidades asistiendo a la reunión? ¿Qué tipo de habilidades?

(9) . ¿Las madres se sienten algún tipo de seguridad por haber asistido al grupo social? ¿Qué tipo de seguridad? Financiera? tranquilidad emocional o social?

(10). ¿Las mujeres se sientan a gusto después de haber asistido a un bien social y / o grupo de apoyo? Si es así, ¿por qué?

(11). ¿Las mujeres sienten que los demás puedan pensar mejor de ellos si asisten social y / o grupos de apoyo? Si es así ¿por qué? ¿Por qué no?

(12) . ¿Las madres creen que la comunidad socialmente los aceptará si asisten social y / o grupos de apoyo? ¿Cómo es eso? O por qué no?

(13). ¿Las madres se sienten confortados por asistir a los grupos sociales y / o apoyo? Si es así, ¿cómo? Si no, ¿por qué no?

(14) Las madres sienten que ganar estatus en la comunidad si asisten social y / o grupos de apoyo? Si es así, ¿por qué? Si no, ¿por qué no?

(15) ¿Cuáles crees que son los beneficios y desventajas de la asistencia social y / o grupos de apoyo para las mujeres?

(16) ¿Cómo se sienten las mujeres que los beneficios de la asistencia social y / o apoyo
los grupos son mayores que los sacrificios que hacen para asistir a los grupos?

(17) ¿Cómo puede el personal de CARE ayudar a otros grupos de personas para apoyar las prácticas alimentación de la misma manera a estos grupos de gente?

(18) ¿Cuáles son las cualidades (personalidad) de las mujeres que participan/ y no participan en la vida social y / o grupos de apoyo?

(19) ¿En qué circunstancias cree usted que un grupo de apoyo es útil/no util para las mujeres que trabajan?

(20) ¿Cuáles son las creencias culturales en cuanto al apoyo? Las creencias religiosas?

(21) ¿Existen aspectos del desarrollo social y / o grupos de apoyo que son difíciles para las mujeres de entender? O hacer que las mujeres no está seguro de su participación?

(22) ¿Cómo son las relaciones sociales de las mujeres estan apoyo sostenido? O ¿Hasta qué punto mantienen estas relaciones fuera del grupo social?

(24) ¿Qué les ayuda a mantener estas relaciones? Y ¿Qué hace que sea difícil para ellos mantener estas relaciones?

(25) ¿A quién más confianza con sus preocupaciones, las madres? O ¿En Quien confiar mas?

APPENDIX F

Grupo Focal, Trabajadores de CARE

1. Barreras:

Desde la perspectiva de una facilitadora de CARE:
¿Qué creen que afecta la asistencia de las madres a los grupos de apoyo social?

-Responsabilidades con sus hijos?
-tareas de la casa?
-El incentivo económico que se les ofrece?
-Temporada de siembra / el tiempo?

2. Roles de Género:

-¿Cómo las relaciones de las mujeres con sus maridos influyen en su capacidad para asistir a grupos de apoyo social?
-¿Cómo los roles de las madres, en relación del hogar, afectan su capacidad para asistir a grupos de apoyo social?

3. Toma de Decisiones:

-¿Ustedes piensan que las madres tienen la capacidad de tomar decisiones sobre la salud de su bebé, independientemente de sus parejos o miembros de la familia?
-En caso afirmativo, que lo contribuye a estas mujeres, la capacidad de tomar decisiones?
-Si no, que lo inhibe la capacidad de la mujer a tomar decisiones independientes?

4. Dinámicas de Poder:

- Aparte de sus familias y trabajadores de la salud de los puestos, por ejemplo, ¿ Las madres sienten que pueden confiar en otros personas con su información de salud?
    -En caso afirmativo, ¿quién?
    -Si no, ¿por qué?

5. La auto-eficacia:

-¿Por qué es difícil para ellas a asistir reuniones sociales?
-¿Cuáles son maneras de hacer que grupos de apoyo social más accesible para ellas?
-¿Cuáles son maneras de hacer que la información sobre la nutrición infantil accesible para ellas?

6. Normas Sociales:

-¿Cómo JUNTOS y Vaso de Leche, ayudar a las mujeres aprender acerca de las prácticas de alimentación y nutrición para los niños?
-¿Cómo puede el personal de CARE ayudar a otros grupos de personas apoyar nutrición infantil en las comunidades donde trabajan?
-¿Qué se espera de las madres, en términos de nutrición y niños alimentación para los niños?

7. Consecuencias positivas y negativas:

-¿Qué son los beneficios y desventajas de asistir a reuniones para las mujeres?
-¿Qué son los beneficios y desventajas de estar en un grupo de apoyo social, en general?

8. Acción de la Eficacia:

-¿Creen que si las mujeres aplicar lo que aprenden en el Vaso de Leche y JUNTOS, que pueden, realmente mantener a sus hijos sanos?

9. Claves para la Acción, el Conocimiento Práctico:

-¿Qué lo hace las madres decidan participar y no participar activamente en grupos de apoyo social?

-¿Cómo crees que las madres recuerdan a asistir a los grupos?

10. Valores

-¿Qué valor tienen los grupos en la vida de las mujeres? En la comunidad?

-¿Crees que las mujeres están de acuerdo con lo que están aprendiendo en los grupos?

11. Creencias:

-¿En qué circunstancias creen que un grupo de apoyo es útil y no es útil para las madres?

-¿Cómo la cultura de las madres afecta su asistencia a los grupos de apoyo social?

12. Factibilidad percibida / Aceptación:

-¿Es aceptable que las mujeres a asistir grupos sociales? Si no, ¿por qué?

-¿En qué momento es muy difícil para ellas participar?

-Al final, lo que haría que ellas decidan no regresar a los grupos?

-¿Existen aspectos de los grupos de apoyo social que son difíciles para las mujeres a comprender? O hacer que la madre no está seguro de su participación?

-¿Qué parte de un grupo de apoyo social que hacen las madres más probabilidades de asistir?

-la ubicación?
-la hora del día se lleva a cabo el grupo?
-el tema del grupo?
-si o no asistir a tus amigos?
-si su familia asiste?
-el tipo de incentivo, o provechos el grupo ofrece?
-si el facilitador del grupo es bueno?
-Otros ____________?

13. Sentido de Pertenencia

-¿De qué manera cree que su experiencia como facilitador ayudará a apoyar a las madres en grupos de apoyo social?

-¿Qué parte de las discusiones de grupos de apoyo social crees que ayudar a las mujeres a cuidar mejor de sus hijos?

14. El Apoyo Social Real

-¿Cómo son las relaciones de la madres de los grupos sostenido?

-¿Hasta qué punto se mantienen estas relaciones sociales fuera de los grupos?

-¿Qué les ayuda a mantener estas relaciones?

-¿En quién las madres confían más?

15. Frecuencia de la Acción y la Equidad en la Participación

-Discuta los tipos de actividades que hacen en los grupos:
- -¿Qué actividades son divertidas para ellas?
- -¿Que actividades son útiles para ellas?

-¿Qué impide que regresen a un grupo de apoyo?
-¿Qué les disuade de volver a los grupos de apoyo?

16. Técnicas de Facilitación:

-¿Cuál sería el papel de ser el facilitador del grupo de apoyo de madre-a-madre?
-¿Hasta qué punto cree usted que las mujeres confiarían en que el facilitador?
-Si usted fuera el facilitador, ¿cómo facilitar un grupo de apoyo de madre-a-madre?
-¿Cuál es la información más valiosa que un facilitador podría proporcionar a las madres?

17. Tiempo y las Alternativas

-¿Cuánto tiempo podría apoyar a los facilitadores a los grupos de apoyo de madre-a-madre?
-Fuera del grupo de apoyo, ¿cuánto tiempo podría dedicar a los facilitadores de las actividades relacionadas con el grupo de apoyo social?
-¿Por qué JUNTOS y Vaso de Leche seguir para mantener el interés de las madres en asistir a los grupos de apoyo social?
-¿Cómo crees que un grupo de apoyo de madres-a-madres podrían ser desarrollados, sin el uso de incentivos materiales, para mantener el interés de las madres en la asistencia a las reuniones?
-¿Cree usted que una madre dentro de la comunidad sería capaz de mantener y facilitar un grupo de apoyo madre-a-madre, sin un facilitador/a?

APPENDIX G

PROYECTO VENTANA DE OPORTUNIDAD
MAPEO SOCIAL

El Mapeo Social en esta investigación será utilizado para recolectar información sobre los espacios de relacionamiento periódico que tiene la madre con otras madres en su comunidad, Entender la importancia que la madre le asigna a estos espacios o momento de relacionamiento y establecer si estos espacios con otras mujeres le ofrecen ayuda práctica en temas nutricionales u otros temas, respaldo emocional, información. Y explorar los beneficios que ellas perciben de agruparse y relacionarse entre mujeres de la comunidad.

En la aplicación se Pedirá a las participantes que dibujen a una mujer de su poblado/distrito en el centro de la página. Y dibujen al rededor los espacios de mujeres a los que ellas pertenecen dentro y fuera de la comunidad. Luego se les pedirá a los participantes que dibujen un círculo alrededor de los espacios de mujeres que consideran influyen sobre su comportamiento o que ofrecen a las mujeres el mayor apoyo social para que practiquen optimas prácticas de alimentación y nutrición.

Las preguntas que se tomaran en cuenta son:

1. ¿A qué grupos pertenece usted?,
2. ¿Qué grupo al que pertenece tiene influencia sobre su quehacer y sobre las prácticas de alimentación y nutrición?
3. ¿A qué grupo siente usted que no debería dejar de ir?

Additional Method 1: Social Mapping

Steps to follow:

Before social mapping:

1. Decide what field staff will act as the facilitator and which staff will act as note-takers.
Facilitators are responsible for leading the activity. Note takers will take notes during the activity.

2. Decide on the meeting particulars.
Specifically: What day? What place? What time? How long? What participants? Field Program Managers will work closely with a CARE International Backstop to develop the specific questions to be focused on during this exercise.

An example of social maps could include:

Example: Who influences a women’s decision to practice optimal rMN and IYCF and who offers support to women to practice optimal rMN and IYCF? In some

cases this person will be one and the same; however, it is possible for a woman to be influenced for example NOT to breastfeed by one source and offered support to breastfeed by another.

Directions for Example:

1. Divide participants into small groups. About 5 people per group.
2. Distribute markers and paper to all participants.
3. Give instructions to the participants. For instance, for the map in Example A you would:

a) Ask the participants to draw a woman from their village/district in the middle of the page.

b) Ask the participants to put all the sources of influence regarding IYCF and rMN on the map in squares. Participants may wish to include organizations they have relationships with, as well as people on the map.

c) Ask the participants to draw a circle around the sources of influence that offer women the most social support to practice optimal IYCF and rMN.

4. Then ask the participants to share why they made the map they way they did. Why did they circle the people/organizations they did? Why did they not circle the other people or organizations?

5. The note-taker is expected to take brief notes during the social mapping session. Be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the note-taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

**** The note-taker should be recording the discussions that take place during the social mapping exercise.** The note-taker should expand their notes at the end of the session.

6. Ask all the participants to come together in one large group and ask for volunteers to share their maps with the entire group.

7. Collect the map.

8. Analyze maps (see directions on page 39) **and notes and write a summary.**

Analysis: How to analyze community maps
Based on the specific maps the participants made and the notes taken during the mapping exercises, answer all the questions that are applicable and write-up a brief summary.

(1) Who in the community offers women support and information?

(2) What sources have the most influence on a woman's behavior?
(3) What sources of information do women trust the most? Why?
(4) What is the relationship between the sources? For example, do these relationships
provide practical help, emotional support, or information to one another?
(5) How do people communicate within a community, and how is information shared (or not shared)?
(6) How are different people (or groups) involved in decision-making?
(7) What are the benefits and risks of different relationships?
(8) What are the divisions in power within a community?
(9) Are there women that are isolated or who have very few relationships?
(10) Are there differences in relationships between older and younger mothers?

APPENDIX H

"Semillas De La Comunidad''

1. Esta técnica es más adecuada para un grupo de personas. El tamaño del grupo de 8-10 es lo ideal.

2. Explique que el propósito de este ejercicio es entender y aprender de las madres acerca de sus perspectivas sobre los temas que se debatirán en este ejercicio. Dar el grupo de diez semillas, y pedirles que se consideran sus propias perspectivas, como a toda la población en estudio. No necesitan para representar a la comunidad en general.

3. Plantear una pregunta al grupo. Pídales que se mueven alrededor de las semillas en los grupos que representan el tema en discusión. Una vez que el grupo ha llegado a un consenso sobre la disposición de las semillas, pida a los participantes para describir el acuerdo, y por qué se los clasificó de la manera que lo hicieron.

4. Si un tema que puede ser clasificada, pida al grupo que continúan dividiendo a las semillas en consecuencia.

5. Una vez que lo visual es completa, dibujar la imagen en una hoja de papel para continuar el debate.

6. Repita el procedimiento para más preguntas.

En esta actividad hay 15 preguntas:

A. *Comportamiento/Obstáculos a la participación:*

1. ¿Es difícil asistir reuniones sociales, como JUNTOS o Vaso de Leche? (Sí/No/ a veces)

-Una vez que las semillas se han organizado, iniciar una discusión sobre las fuentes de dificultad.
-Vota en los razones mas mencionada
-Pida a los participantes para clasificar porque decidieron en estos razones
-Pregunte a los participantes para dividir aún más las semillas entre las fuentes de dificultad.
(Repita estos pasos con cada pregunta)

2. ¿Les gustarían participar en una reunión de madres aunque en esta reunión no recibirían plata o comida? (Si/No/Quizás)

B. Las consecuencias Negativas y Positivas

1. ¿Cuál son las razones mas grandes que usted participan en los reuniones?
 -A recibir plata
 -A recibir comida
 - para no ser castigada por las presidentas

- para mantener buenas relaciones con las presidentas

2. ¿Realmente, ustedes se van a los reuniones solamente a recibir plata y comida? (Si/No)
3. ¿Realmente, ustedes se van a los reuniones a aprender información o practicas nuevos? (Si/No)
4. ¿Piensan que pierdan información o practicas si no van a las reuniones de JUNTOS o Vaso de Leche?
(Si/No)

C. Auto- Eficacia

1. La razón principal porque no pueden participar en los reuniones es porque no hay tiempo: (Si/No)
2. La razón principal porque no pueden participar en los reuniones es porque tienen que trabajar: (Si/No)

D. Los facilitadores de la participación:

1. ¿Es fácil asistir reuniones? (Sí/No/ a veces)
2. ¿Si ustedes estaban acensado con mas facilidad, participarían con mas frecuencia o facilidad? (Si/No)
3. ¿Si ustedes estaban invitados de los lideres o mas informada en la comunidad, participarían con mas frecuencia
o facilidad? (Si/No/Quizás)

E. Roles de género:

1. ¿Que principalmente toma las decisiones sobre su asistencia en los reuniones en su casa? Y Porque?
   - Usted
   - Su esposo
   - Su suegra
   - Su suegro
   - Su Mama
   - Su Papa

2. ¿Quién decide cuándo tomar el bebé o niño a la clínica? Y Porque?
   - Usted
   - Su esposo
   - Su suegra
   - Su suegro
   - Su Mama
   - Su Papa

F. Fuentes de información:

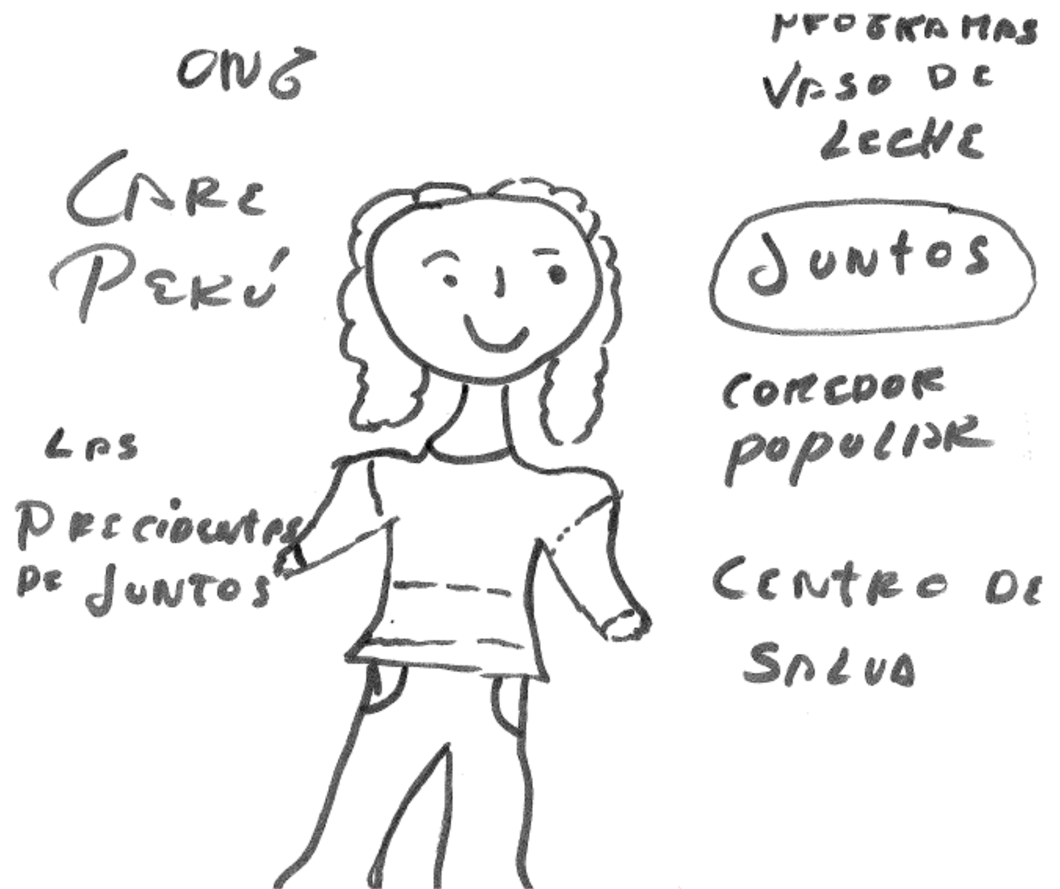
1. ¿A quién prefieren para obtener información de alimentación y nutrición? Y Porque?
   - promotores de salud
   - la enfermera/medico en la posta
   - las facilitadores de MINSA
   - la trabajadores de CARE
   - su madre

- su vecina
- su suegra
- su esposo
- JUNTOS
- Vaso de Leche

2. ¿Con que frecuencia busca sus surgencias?

APPENDIX I

Social Mapping Example



Social Mapping Example

Social Mapping Example

- Vaso de leche
- club de Madres
- comedores
- Centro de salud
- Juntos
- El esposo

APPENDIX J

Question:	Yes	No	Some Times	M	$	Food	No Pun.	Social	To Learn	Myself/ Wife	Partner	Health Prom.	Health Post	MINSA Staff	Child Sick	Weigh	Chi We
1. Is it difficult to attend social support groups?	13	4	1														
2. Do you like to participate in social support groups, even if in some cases you don't receive money or food?	12	2															
3. What are the main reason you participate in social support groups?					6	0	3	3	1								
4. Is the main reason you participate in social support group to receive money or food?	1	18															
5. Do you attend social support groups to learn new information and skills?	19	1															
6. Do you think that you loose information if you do to the meetings?	14	1															
7. Is the main reason that you, or other women do not participate in the meetings is because you do not have time?	13																
8. Is the main reason that you or other women do not participate, is because you have to work?	5																
9. Is it easy to attend meetings?	5	11	5														
10. If it were easier to become members of a group, would you be able to participate more easily?	9	10															
11. If you were invited by leaders/in the community participate more easily?	20																
12. Who primarily makes the decisions about your attendance in social support groups and why?										11	7						
13. In your family, who decides to take the child or the clinic?										20							
14. Who do you like to rece information from about nut and infant feeding and why												7	16	5			
15. How often do you seek from them?															1st	2nd	3rd

APPENDIX K

Community Ten Seed Analysis/Write Up

Two Community Ten Seed Activities were conducted.
Group A consisted of 15 women and Group B consisted of 6 women, Total 21: Women

Questions:

(1) Is it difficult to attend social support group meetings like JUNTOs of Vaso de Leche?
Group A- (9/15) YES, (4/15) NO, (1/15) SOMETIMES
Group B (4/6) YES
Total (13/21) YES, (4/21) NO, (1/21) SOMETIMES
Common Responses for why:
YES but we learn more,
NO we don't go, time conflict
SOMETIMES there are conflicts, but its important to learn things

(2) Do you like to participate in the support groups even though in some cases you don't receive money or food?
Group A- (7/15) YES, (2/15) NO, (5/15) Maybe
Group B- (5/6) YES
Total: (12/21) YES, (2/21) No
Common Responses for Why:
YES- It is important that we listen//Its important to know things we don't already know
NO-
MAYBE- There isn't time

(3) What are the main reasons you participate in the social support groups?
MONEY- (6/21)
FOOD- (0/21)
NOT TO GET PUNISHED: (3/21)
RELATIONSHIPS: (3/21)
LEARN: (1/21)

(4) In reality, is the main reason why you attend social support groups to receive money or food?
Group A- (1/15) YES, (14/15) NO,
Group B- (4/6) No
Total: (1/21) YES, (18/21) No
Common Responses for Why:
NO- Not every meeting has good food.

(5) In reality, do you go to the social support groups to learn new information and skills?
Group A- (14/15) YES, (1/15) NO
Group B- (5/6) YES
Total: (19/21) YES, (1/21) NO
Common Responses for Why:
YES- It is important to learn what we don't know

(6) In reality, do you think that you loose information if you do not go to the meetings?
Group A- (14/15) YES, (1/15) NO
Group B-
Total: (14/21) YES, (1/21) NO

(7) Is the main reason why you, or other women cannot participate is because you do not have time?
Group A- (8/15) YES, (0/15) NO
Group B- (5/6) YES
Total: (13/21) YES

(8) Is the main reason why you, or other women cannot participate is because you have to work?
Group A- (0/15) YES, (0/15) NO
Group B- (5/6) YES
Total: (5/21) YES
Common Response: Both things are difficult to manage

(9) Is it easy to attend meetings?
Group A- (5/15) YES, (10/15) NO
Group B- (5/6) SOMETIMES , NO (1/6)
Total: (5/21) YES, (11/21) NO, (5/6) SOMETIMES
Common Response:
NO- We have animals and children to take care of
SOMETIMES- due to the time we can

(10) If it were easier to become members of a group, would you be able to participate more easily?
Group A- (4/15) YES, (10/15) NO
Group B- (5/6) YES
Total: (9/21) YES, (10/21) NO
Common Response:
NO- because most of us are already members

(11) If you were invited by the leaders, or more informed within the community, would you participate more frequently or more easily?
Group A- (15/15) YES
Group B- (5/6) YES
Total: (20/21) YES
Common Response:
YES- If we were invited// Yes, if we were more informed

(12) Who primarily makes the decisions about your attendance to the social support groups and why?
Group A- (8/15) Myself (5/15) Husband
Group B- (3/6) Myself, (2/6) Husband
Total: (11/21) Myself, (7/21) Husband
Common Response:
Husband- If my husband is the formal member of the group, then I have to go to the meeting
Myself- Because I am the formal member of the group

(13) In your family, who decides when to take the child or baby to the clinic?
Group A- (15/15) Me/Wife
Group B- (5/6) Me/Wife
Total: (20/21) Me/Wife
Common Response:
Me/Wife- Because we are always with our babies

(14) Who do you like to get information from, about nutrition and infant feeding and why?
Group A- (2/15) Health Promoters, (11/15) Rural Health Post
Group B- (5/6) Health Promoters, (5/6) Rural Health Post, (5/6) MINSA Staff
Total: (7/21) Health Promoters, (16/21) Rural Health Post, (5/21) MINSA Staff

(15) Following that question, how often or when do you seek advice from them?

1st When my child is feeling bad, or to check their height or weight

2nd To get my child weighed

3rd To know that my children are doing well.

Appendix L:

Research Findings	Doers %	Non-Doers %	Implications	Focus		
				High	Medium	Low
Attend Social Support Groups	56%	44%				
Vaso de Leche	89%	0%				
JUNTOS	83%	0%				
Asembleas Comunales	28%	0%				
Club de Madres	22%	0%				
Wawa Wasi						
Participation in Past						
Yes	44%	25%	Difference		X	
No	44%	36%				
Never	0%	14%	Difference			X
Is Participation is Important						
Yes	100%	64%	Difference	X		
Learn New Things	57%	7%	Difference	X		
To be informed/to teach others	33%	28%				
Material Incentives/Hand-Outs	33%	7%	Difference	X		
Learn IYCF	22%	7%	Difference		X	
Do you Gain Something?						
Learn What Things We Should Do	17%	0%	Difference		X	
Learn New Information	39%	36%				
To Get Suggestions/Be Informed	39%	14%	Difference		X	
To Be with Other Women	11%	21%				
To Learn About Nutrition	5%	21%	Difference		X	
Do you Loose Something?						
The other work/activities I do	28%	14%				
Time	44%	36%				
Nothing	11%	0%				
Time at Home Taking Care of Kids	11%	0%				
Attendance/Help to Take Care						
Yes	83%	64%				
No	11%	7%				
Prepare Food for Kids	33%	7%				
Take Care of Children	28%	0%				
We Receive Food	17%	7%				
Difficulty Attending Meetings?						
Yes	17%	21%				
No	6%	0%				
Sometimes	61%	28%	Difference		X	
Problems faced when attending						
Other things to to	44%	7%				
Have to work on farm/work	28%	7%				
Husband Helps with Children	17%	0%				
Mother Helps with Children	11%	14%				
Take Kids to Wawa Wasi	6%	7%				
Feel Good About Attending Meetings?						
Yes	89%	36%	Difference	X		
No	0%	0%				

Okay (Good and Bad)	0%	29%	Difference	X		
Good	17%	7%				
Happy/Joyful/Laughing	28%	7%				
Destressed/Relaxed	17%	0%	Difference	X		
Conversing	11%	7%				
Listening/Learning	28%	14%				
Calm When Not Discussing Money	6%	0%				
Forget Problems	6%	0%				
Respobsible	0%	14%	Difference	X		
Sometimes Ignored	0%	14%	Difference	X		
Feel Bad if Groups Didn't Exist?						
Yes	39%	29%				
No	11%	21%				
Something Bad Happen to Family?						
Yes	44%	7%	Difference	X		
No	39%	71%	Difference	X		
We wouldn't know anything	17%	0%	Difference		X	
Miss Out on Information?						
Yes	83%	88%				
Who Does Not Like Participation?						
Husband	11%	29%				
No	56%	36%	Difference		X	
Who Likes your Participation?						
Yes	44%	36%				
Groups Leaders/Governeing Board	28%	0%	Difference	X		
Husband/Partner	33%	43%				
Community Likes Particiapation?						
Yes	83%	76%				
Because its important to participate in	22%	29%				
Health Promoters/IYCF						
Yes	56%	57%				
Teach how to cook/prepare food for baby	22%	7%	Difference	X		
Meetings	11%	29%				
No	33%	14%	Difference	X		
Interest in MtMSG?						
Yes	83%	71%				
Attend without Material Incentives?						
Yes	89%	50%				
No	6%	21%	Difference	X		
Not sure if other women would	0%	21%	Difference	X		

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