

Empowerment of women, men, families and communities: true partners for improving maternal and newborn health

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Based on the Health Promotion approach, the Making Pregnancy Safer initiative has proposed a strategic framework for working with individuals, families and communities to improve maternal and newborn health. The aims are to contribute to the empowerment of women, families and communities to increase their influence and control over maternal and newborn health, as well as to increase access to and utilization of quality skilled care. The framework has identified those strategies and interventions that target the factors known to contribute to health inequalities and poor maternal and newborn health. While empowerment is an aim of the framework, it is also considered a means. Emphasis is placed on the processes and the quality of the processes rather than just on the actions themselves. The authors in this paper would like to contribute to ongoing discussions about the 'how' of working with women, men, families and communities for improved maternal and newborn health.

Background

Experience over the past decade has shown that no single intervention is by itself sufficient to improve maternal and newborn health and reduce morbidity and mortality. What is needed is a continuum of care throughout pregnancy, childbirth and the postnatal period¹. To be effective, the continuum should extend from care in the household, to care provided by the skilled attendant³ at the primary care level, including the first-level facility, to care provided at the referral facility. The development of this continuum requires commitment, cooperation and interaction between the different levels of care and between the different care providers. Efforts should focus on building capacities at the individual, family and community level to assure appropriate self-care, prevention and care-seeking behaviour. Concurrently, efforts should focus on building the capacity of health care delivery to define and adapt the needed interventions and services and assure that they are

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available, acceptable and of high quality, particularly for the poor and most vulnerable. Political commitment and inter-sectoral collaboration form part of the context for the effective development of the continuum.

A framework for working with individuals, families and communities

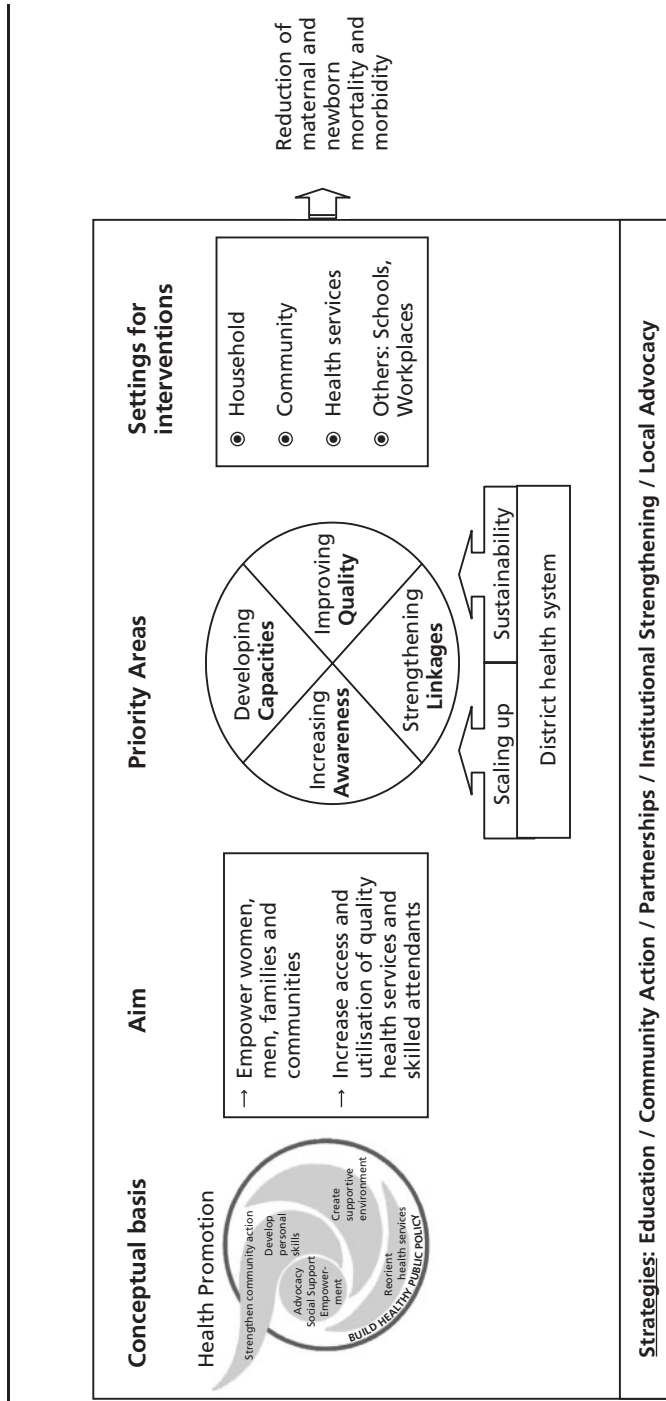
The WHO Making Pregnancy Safer initiative was launched in 2000 to enhance WHO's efforts in Safe Motherhood. The initiative is oriented to assist countries in strengthening their health systems, to develop evidence-based interventions that target the major causes of maternal and newborn mortality and morbidity, with a focus on reaching the poor. Working with individuals, families and communities is considered a critical link in strengthening the recommended continuum of care. Equally, it is recognized that the availability of quality services alone will not produce the desired health outcomes when there is no possibility to be healthy, to make healthy lifestyle decisions and moreover, to be able to act on those decisions. Health gains as well as healthy lives require more than the provision of services. Individual and collective capacities, as well as other determinants of health, cannot be ignored.

Based on the Health Promotion approach as outlined in the Ottawa Charter², the Making Pregnancy Safer initiative has proposed a strategic framework for working with individuals, families and communities to improve maternal and newborn health³. The aims are to contribute to the empowerment of women, families and communities^b to increase their influence and control of maternal and newborn health, as well as to increase access and utilization of quality skilled care^c by women and their families. The framework (Fig. 1) has identified those strategies and interventions that target the factors known to contribute to health inequalities and poor maternal and newborn health.

Priority interventions

A set of promising interventions (Table 1) to achieve the aims mentioned above, identified both in the literature and from experience, have been organized into four priority areas:

- 1 Developing capacities of women, families and communities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies
- 2 Increasing awareness of women, families and communities of their sexual and reproductive rights, and of the needs and potential problems related to maternal and newborn health



Source: Indonesia Health Promotion concept, Healthy Indonesia (July 2002)

Fig. 1 Strategic framework for the development of individual, family and community (IFC) interventions.

Table 1 Overview of interventions in the priority areas

Priority areas of intervention	Developing CAPACITIES to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	Increasing AWARENESS of the rights, needs and potential problems related to maternal and newborn health	Strengthening LINKAGES for social support between women, families and communities and with the health delivery system	Improving QUALITY of care, health services and interactions with women and communities
Intervention topics	Self-care Care-seeking behaviour Birth and emergency preparedness	Human rights The role of men and other influentials Community epidemiological surveillance and maternal-perinatal death audits	Community financial and transport schemes Maternity waiting homes Roles of traditional birth attendants within the health system	Community involvement in quality care Social support during childbirth Interpersonal and intercultural competence of health care providers

- 3 Strengthening linkages for social support between women, men, families and communities and with the health care delivery system
- 4 Improving quality of care, health services and health provider interactions with women, men, families and communities

Local context and resources will ultimately decide the interventions to be implemented. Initial assessments will assist in determining priorities. However, a comprehensive strategy, with interventions from each one of the four priority areas, is recommended. Increased capacities and awareness of women, families and communities need to be developed while strengthening linkages in the communities and between the communities and health services. Also, the development of interventions at the household and community level will not achieve its full effect if maternal and newborn health services are not available or responsive to the culture and needs. In sum, an integrated approach is needed that maximizes the benefits of a range of activities, planned and implemented internally within the health sector with other sexual and reproductive health programmes, and externally with other sectors.

Empowerment approaches

While empowerment is an aim of the framework, it is also considered a means, developed at two levels that interact and affect each other⁴:

- 1 At an individual level, efforts are aimed at increasing resources like knowledge, cognitive capacities, health competencies and the capacity and confidence to make healthy lifestyle choices
- 2 At a collective or community level, efforts are aimed at applying skills and resources collectively to meet the collective needs, including structural changes to the environment to improve access to social, economic and political resources

In sum, empowerment is an ongoing process of enabling individuals and groups to improve capacities, to critically analyse situations and to take actions to improve those situations⁵.

The emphasis is placed on the processes and the quality of the processes rather than just on the actions themselves. Thus, as we look to strengthen the body of information and evidence related to the strategies and priority interventions in the proposed framework, we are also looking to improve understanding of the underlying processes that lead to the desired outcomes.

The authors of this study would like to contribute to ongoing discussions about the 'how' of working with women, men, families and communities for improved maternal and newborn health. Examples of interventions and strategies from the above-mentioned framework are presented applying an empowerment approach (with a focus on pregnancy as an intervention period). Each of the scenarios is grounded in a vision of the health care delivery system and health care providers entering into a reciprocal relationship with women, families and communities where the exchange of information, identification of problems and development of solutions is an ongoing process. Thus, the discussion will ultimately lead us to a reflection on roles and responsibilities. Many will also argue, and rightly so, that in this reflection, empowerment of health care providers must also be considered.

Shared decision-making for maternal and newborn health

The principles of informed decision-making are not new in the field of sexual and reproductive health. These principles have been fundamental tenets of quality family planning services for decades⁶. One of the stated criteria of Women-Friendly Health Services⁷ focuses on empowerment of users and respect for their rights, including the right to choice. Yet, it is difficult to find an emphasis on decision-making or problem-solving processes or direct references to this terminology within evaluations of maternal and newborn health programmes in lower-resource settings. Furthermore, although informed decision-making has been embraced as a central focus of modern maternity care in Western and developed countries, evaluations have shown that this has not necessarily been translated into practice⁸.

Frequently, maternal and newborn health programmes include components to develop health care providers' inter-personal communication skills. Yet, many programmes in implementation continue to put emphasis on the modality of information giving. The word 'counselling'—which is to provide support for decision-making and problem-solving—is often used interchangeably with providing advice and recommendations. An emphasis is currently given to a good client–provider interaction, highlighting the importance of a dynamic two-way interaction and the woman's active participation⁹. However, a truly empowering encounter would assure that the woman (and her family) would not only receive appropriate information and interact with the health service provider. She would also have the opportunity to analyse the information in relation to her individual situation and life experiences, plan what to do next and explore solutions to the different health issues^{d,10–12}.

The principle of informed decision-making could be usefully applied in an intervention to increase birth and emergency preparedness^e, identified as a key component of antenatal care¹³. The key elements of a plan to prepare for birth or the eventuality of an obstetric complication (see Table 2) require that, at a minimum, the health care provider works with the pregnant woman to explore the different possibilities, so she can begin to identify the most feasible solutions. For example, the health provider may consider that it is best that the woman give birth in a facility, based on her health status or on an identified obstetric condition. One way for this to become a reality is if the woman was supported in thinking out all of the related issues pertinent to her and her family: does she prefer the care in the recommended facility, how could she get there, who would take care of her home and children, what are the related expenses, how could they meet these expenses, *etc.*

Table 2 Some key elements of a birth and emergency (obstetric and neonatal) plan

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- Selecting a birth location (home, health centre or hospital)
 - Identifying the location of the closest appropriate care facility, in case of emergency
 - Identifying a skilled attendant
 - Identifying a companion for the delivery and for emergency
 - Identifying support for care of the home and children during delivery and emergency
 - Planning for funds for birth-related and emergency expenses
 - Arranging transport for facility-based birth and in case of emergency
 - Having adequate supplies for the delivery (depending if at home, in a health centre or hospital): a clean delivery kit, clean cloths, clean water (and a way to heat that water), clothes for mother and baby, soap, food and water for the mother and the companion
 - Identifying a compatible blood donor in case of haemorrhage
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Adapted from: WHO¹⁴ and Moore¹³.

Further, given household decision-making processes, the woman more than likely will need support to discuss the plan with her partner and/or other key decision-makers in the household^f. This may imply inviting the partner or a family member to the next antenatal care session, or having a card that outlines the issues to be resolved. A feasible final plan could only be developed after this interaction at the household level. Providing support to plan for birth and to be prepared for emergencies may not always lead to the recommendation initially envisioned by the health provider. However, birth and emergency preparedness efforts can lead to a decrease in the delays in decision-making for reaching care when needed and an increase in the use of services. And as an empowerment process, based on informed decision-making, the process will also provide the woman and her family with additional capacities to influence and improve health.

A question may arise as to the viability of implementing informed decision-making principles in the busy antenatal care setting. Lack of time is often cited as an impediment. But the time dedicated to an effective antenatal intervention may in the long run decrease time required at another moment in the progression of the chain of maternal care. Research^{9,15,16} (extracted from areas other than maternal and newborn health, such as family planning, general practice, hormone replacement therapy, cancer treatment, *etc.*) shows that the time invested in this type of approach could in fact lead to greater satisfaction of the woman with the quality of services, increased understanding of the health situation and increased compliance/continuance/adherence^g. Increased research is needed to study the details of the applications of this approach within maternal and newborn health, and specifically for birth and emergency preparedness, as well as measurement of the desired outcomes of empowerment and increased use of skilled care.

Another question that may arise relates to the development of health provider skills to engage in an informed decision-making process. We also need to consider health care providers' attitudes and beliefs related to entering into this type of encounter with the woman and her family. Pilot studies and research continue for the development of models to support the development of health care providers' skills and attitudes^{10,11,17-19}. Research and other experiences are also being developed looking at the processes and skills of the woman or the client in empowering interactions^{19,20}. Efforts should be made to gather and systematize this information, and assure its widespread distribution for increased discussion and application of the lessons learned.

Ultimately, birth and emergency preparedness as an intervention must be considered within a package of interventions^h. In order to involve other decision-makers in the community and reach women who do not receive antenatal care, some programmes have developed birth preparedness

for health workers at the community levelⁱ. A complementary process of dialogue and building partnership with the community, based on the principles of a reciprocal relationship, may be useful in certain contexts in order to discuss maternal and newborn health needs and the importance of skilled care for births and obstetric complications, postnatal care of the mother and newborn and neonatal complications²¹. The community can also be approached to discuss solutions to obstacles to seeking this needed care, including identification of danger signs, transport schemes, financing schemes, *etc.*

Finally, many of the other recommendations provided to women in antenatal care (postnatal care and care of the newborn as well) could also benefit from the application of the principles of informed decision-making, which despite the result, respects her final choice. This would include those recommendations related to self-care in the household, including increased nutrition, reduced workload activities, iron supplementation compliance and others. All will also require efforts to increase family and community support, but the main concern should be to make sure that programmes advance with the central objective of supporting the woman to take better care of herself and her baby.

Health education approaches

Most community health programmes, as well as the education and communication approaches applied, focus on convincing specified groups to adopt a desired behaviour^{5,22}. Many of these models are based on behavioural and social cognitive theories and on a premise that development problems, including poor health, are primarily rooted in a lack of knowledge²³.

Thus, efforts have concentrated on increasing knowledge and changing behaviour for the recommended practices for maternal and newborn health. During pregnancy alone, there are a range of desired behaviours ranging from self-care in the household to preventive measures to care-seeking behaviour for childbirth and emergencies. Yet different evaluations of these efforts often show an increase in knowledge, without the corresponding changes in practice. One possible explanation for this gap is that the input is not sufficiently related to the existing knowledge of people. As a result, neither true appropriation of knowledge nor long-term behaviour change nor local ownership of the processes occurs. Thus, it is inherent that these approaches do not lead to empowerment.

Therefore, a different approach to health education is proposed for discussion to reduce the knowledge-behaviour gap and for empowerment to occur. In this approach, priority is placed on appropriation of knowledge and development of cognitive capacities, rather than a simple increase in knowledge. The approach is based on socio-interactionist theory, which has

become the theoretical and experimental basis of current approaches used in formal education, with children and adults, in settings of higher and lower resourced countries.

The socio-interactionist theory emphasizes that the central element in intellectual and psychological development and the learning process is the 'zone of proximal development'. This zone is defined as the distance between the level of current development and the more advanced level of potential development that comes into existence in interactions between more and less capable participants²⁴. A key principle for the design of health education processes lies in the effective use of the zone of proximal development, and the identification of existing knowledge and capacities. It recognizes that cognitive development is more efficient in a situation of social interaction.

Another key element of the theory relates to the fact that knowledge, thoughts and the associated practices are socially, historically, institutionally and culturally situated, defined and shared. Thus, external inputs or new knowledge, introduced as untied and unarticulated pieces whose production and coherence are situated outside of the group or community receiving them, cannot be effectively integrated. Individuals receiving this external knowledge do not have the social, linguistic and cultural background to interpret and correctly decode this input.

Also when presenting new knowledge, the strong relationship between thought and language should be taken into account. Socio-interactionist research has demonstrated that one provides resource to the other; language being essential in forming thoughts and in determining personality features²⁵.

In health education processes, we often simply translate information or 'messages' into the local or popular language, without considering that the structure of language itself and concepts are particular to each society and culture²⁶. More attention must be given to this and to finding common words to truly assure that the new concepts are understandable. When a direct translation may not be possible, common words must be identified to form the conceptual basis. A glossary should be created to form a true understanding.

A process of critical debate must occur where existing knowledge confronts new knowledge^j. New knowledge must be examined according to its pertinence in relation to the socio-cultural context. Phases of deconstruction, decontextualization and subsequent construction and contextualization must occur in the process^{27,28}. What is proposed is in fact not the introduction of knowledge but the creation of knowledge (see Table 3).

By understanding and using the socio-interactionist approach, the learning process can be more efficient than with those methodologies that focus on providing information, repetition of messages or imitation of behaviours. This approach also permits the development of superior

Table 3 Key principles of a socio-interactionist approach

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- The educational process should start from the participants' knowledge (texts and representations) in order to strengthen or weaken it, present and analyse new external knowledge and create a new knowledge derived from the confrontation of both sets of knowledge.
 - The educational process should enable a conceptual attainment of knowledge as well as abilities to further acquire knowledge, in order to permit an autonomous intellectual capacity to continue one's own education. This can be summarized as learning to learn.
 - Knowledge expressed and learned has to be linked to social, historical and cultural realities.
 - The educational process should be a learning experience that allows the participant to be responsible for his/her own development, in order to reinforce the capacity for critical analysis of his/her own formation and the formation of the other participants.
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capacities such as autonomy, critical reflection, social values, establishing a dialectical dynamic between psychological capacities, language and socio-historic-cultural influences.

It is in fact central to the socio-interactionist approach that the learning process allows for not only the development of knowledge but also the development of cognitive capacities used in the integration, the search and the construction of new knowledge, useful for the current process and for future learning processes. By doing so, the approach can contribute to empowerment.

Different approaches and models have been developed based on principles of socio-interactionism. For example, the 'Pedagogy of the Text' (PdT)^k is an educational approach based on these principles, including the most up-to-date knowledge and relevant research from a number of sciences, including linguistics (textual linguistics), psychology (social inter-activity), pedagogy and didactics. PdT is currently being applied and tested in several countries of Latin America, the Middle East and Africa¹. The Swiss NGO *Enfants du Monde* has begun discussing the application of the PdT in maternal and newborn health programmes with national authorities and local and international NGOs in Haiti and Guatemala.

There are different moments in health education components of maternal and newborn health programmes when such an approach can be applied. Some examples include: (a) information and 'message' development—an approach to create knowledge which is socially and culturally situated could serve as a basis for the development of information to be included in educational materials, mass media campaigns and training materials; (b) raising community awareness—the approach can serve as a basis for discussions with communities on maternal and newborn health problems and developing solutions; (c) training of health care providers—such an approach can also be used for the development of curricula content and the learning process for developing their knowledge, capacities and skills.

Other experiences exist which apply concepts similar to those outlined above; some examples include participatory research, community-driven quality approaches and community-action cycles²⁹. Community dialogue (between the community and the health programme) is an innovative methodology that can serve to improve mutual understanding and increase awareness of the reality, perspective and conditions of the other party. It recognizes the importance of current knowledge as a starting point, of introducing information on maternal and newborn health needs for discussion and debate, and of the central role of communities in decisions and actions that influence their health and well-being³⁰⁻³³. Bolivia has developed different experiences utilizing approaches based on community dialogue, participation and problem-solving. Programmes would benefit from learning more about these experiences, both through a more rigorous evaluation of the methodologies and outcomes and through documentation and discussion of the processes developed.

Future directions

There are several implications of embracing the approaches and principles outlined above that challenge how health programmes generally work with communities. First is to consider how to develop an open attitude in health programmes and service providers, as stated earlier in this document, to accepting a reciprocal relationship with women, families and communities where the exchange of information, identification of problems and development of solutions is an ongoing process. An empowerment approach questions the approaches which most health care providers are trained to apply. New knowledge and information needs to be presented for discussion and debate with women and communities. Decision-making/problem-solving must be a shared responsibility. These are proposed if appropriation of knowledge and the development of capacities are to occur. For some health care professionals, it may be difficult to appreciate the expertise and abilities brought by women and communities into this reciprocal relationship. Different skills, time pressures, existing attitudes, lack of motivation, programme structures and a biomedical culture which dictates a more authoritative relation with 'clients' are some of the factors that can limit broader application of empowering approaches.

Second, these approaches also imply a new role for health care providers and programmes that engage in health education and interaction with the community. The emphasis within an empowerment approach would now lie on facilitation and dialogue and creating knowledge rather than providing the messages and the solutions. Thus, programmes may seek to build health professionals' capacities in these areas as well as strengthen

partnerships with other agencies and sectors with more experience in applying these skills.

Finally, there is a need for increased research to study the applications of empowerment approaches within maternal and newborn health programmes. As mentioned above, research should support a better understanding of the processes as well as the outcomes of such interventions (with individuals, families and communities) on knowledge, practices, use of skilled care and empowerment at the individual and collective levels. An evidence-based approach is called upon for effective policy and programming for safe motherhood³⁴. This would apply to all levels of the continuum of care. At the individual, family and community level, there are lessons learned about what does not work or what limits programmes from achieving their full potential. Let us now work to build the evidence based on the promising interventions and strategies for building the longer-term capacities.

Bringing together women, families and communities with health care providers is not an easy process. However, sufficient evidence exists to demonstrate that, unless they begin to work more closely together, the goals for maternal and newborn health, including the reduction in morbidity and mortality, cannot be achieved.

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Notes

- a Skilled attendants are ‘people with midwifery skills, such as midwives and doctors and nurses who have been trained to proficiency in the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and to identify, manage or refer complications in the woman and newborn.’ Source: WHO/ICM/FIGO Joint Statement on Skilled Attendant—Way Forward, forthcoming publication.
- b Given the low status of women, special emphasis is put on empowerment of women. The importance of the role of men as partners and fathers is recognized, but for purposes of this document, their role is considered as influential within household and community decision-making.
- c Skilled care is health care provided by a skilled attendant, backed up by the necessary systems and support required to enable them to function effectively and includes access to an effective referral system for emergency care for women and newborns with complications. See www.safemotherhood.org/resources/publications.html

- d The additional benefits of a process of interaction (rather than being a passive recipient of information) and of taking external information and applying it within her own social and cultural context is further explained in the section on health education approaches. See also Santarelli²⁷, Young and Flower¹¹ and Sanders and Fitch¹².
- e Also called birth planning, birth preparedness and complication readiness. It is noted that interventions developed in higher resource countries have focused on the psychological and physical comfort of women. Herein, the authors refer to interventions as they have generally been developed in lower-resource countries, focusing on measures to prepare for action in the event of obstetric emergencies and plan for the use of skilled care for birth.
- f Moore¹³ proposed the design, production and distribution of a 'birth preparedness card' to improve birth preparedness. The main objective of the card would be to improve household dialogue and compliance. Cards have been used in different programmes including CARE Bangladesh, Family Care International Skilled Care Initiative in Kenya and MotherCare Healthy Mother/Healthy Child Project in Egypt.
- g It is noted that research on decision-making processes indicates that it may not be acceptable to project findings from studies in other health areas, as the setting may affect the decision-making process and, consequently, the outcomes¹⁶.
- h The JHPIEGO Maternal and Newborn Health (MNH) programme has developed a Birth Preparedness and Complication Readiness matrix which identifies the roles of the different stakeholders involved, including facilities and communities, policymakers, health care providers, families, and women. See <http://www.mnh.jhpiego.org>
- i See JHPIEGO Maternal and Newborn Health (MNH) experience in Guatemala: <http://www.mnh.jhpiego.org>
- j The process of creating knowledge is described in detail in Santarelli²⁷.
- k The theoretical and implementation frameworks for this approach have been developed by IDEA—Institute for Development and Education of Adults. See Faundez²⁸ for more information on the PdT.
- l Specific countries are: Brazil, Benin, Burkina Faso, Cape Verde, Colombia, Congo, El Salvador, Guatemala, Haiti, Jordan, Lebanon and Niger.

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