

Northwest University

Mothers Standing in the Gap:

An Inclusive Approach to Health and Well-Being in Low Resourced Communities

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Introduction

In sub-Saharan African countries, both patients and doctors suffer physical and emotional adversity due to low access to healthcare resources. During my fieldwork research in Malawi, my observations and interactions led me to question how mothers could fit into the framework of healthcare delivery to alleviate the problems caused by low access to healthcare resources. How could the intrinsic knowledge, compassion, and availability that a mother can offer contribute to the treatment of her child? Further, would the inclusion of mothers in a patient's treatment plan be beneficial to the patient as well as the doctor? These questions led me to academic sources discussing and researching similar matters. Among the research, there is little discussion on the direct inclusion and utilization of mothers' critical resources in a patient treatment plan. By equipping mothers with the medical and emotional capacity necessary to participate in healthcare treatment and utilizing their cultural understanding of health, doctors, patients, and the local community will benefit from the knowledge, availability, and compassion of maternal guardians throughout the course of medical care.

At the Beit CURE Children's Hospital in Blantyre, Malawi, children's orthopedic issues are treated free of charge. A multi-cultural team runs the 58 bed-teaching hospital which serves pediatric patients in the children's ward as well adults in the private ward. It was here that my empathy for patients, guardians, and hospital staff grew as well as my skills as an ethnographic researcher. I watched young patients interact with foreign doctors; I saw cross-cultural doctors attempt to communicate sensitive information with patients and their families. I quietly observed mothers tend to their child in a place far from home, Overall, I witnessed the healthcare gap, which is created by a lack of resources like: overworked physicians, limited time with the doctor, and miscommunication regarding care. It seemed clear that mothers possessed or

could develop the capabilities to fill the gap created by low resources. These moments of observation and empathy sparked inspiration for facilitating medical treatment plan solutions in low resource communities.

After several mornings of rounds with Dr. Kyle James, a UK native, I began to understand his quirks and habits when rounding in the children's ward. As he arrived a few minutes after 8 o'clock, Dr. James asked for the report on Leonard, a patient who had recently undergone orthopedic surgery. While the nurses were updating him on Leonard's recovery, he made his way to Leonard's bed and began to interact with him. He was talking with the young boy with the translation assistance of one of the nurses, because Dr. James did not speak Chichewa. Quickly he asked one of the nurses to find out who this boy's mother was. He noticed that the mechanical adjustments on his leg frame had been executed perfectly, and he wanted to congratulate the mother on doing such a fine job. Leonard's recent surgical procedure was needed to reverse the damages of the developed stages of osteomyelitis, a severe bone infection.

A rare infection in the Global North, osteomyelitis requires surgery to remove the portion of infected bone followed by monitored recovery to ensure proper healing. Surgical recovery requires an orthopedic frame placed on the outside of the leg. The frame ensures the bone sets properly, relieving any need for additional corrective surgeries. In addition to enduring the presence of a large metal frame surrounding the leg, patients must turn multiple nuts on the outside of the frame numerous times per day according to the treatment plan. Turns can be set anywhere from 1/4 of an inch to 3/4 of an inch. For a pediatric patient, these complicated tasks are usually passed to the guardian, most often the patient's mother.

Leonard's mother, a key character in this narrative, was doing an exceptional job following the treatment plan for the osteomyelitis. She was turning the frame correctly according to Dr.

James' orders— something he was struggling to find among other patient's guardians. She shyly accepted his compliment through the translator, not saying much in response. As Dr. James moved on to the next patient he casually asked his team, "Does anyone know if she would be willing to teach other mothers how to turn the frames the way she does." His casual comment during the rush of morning rounds piqued my interest in the capacity of mothers to participate in their own child's treatment. His remark set me on a path to facilitating change in the culture of medical treatment in low resource communities in places like Blantyre, Malawi. At this juncture, the research shifted from a reflective experience to a sharp focus on understanding a healthcare system in which mothers' capabilities are not generally included in achieving patient health and well-being. The narrative of this young boy's mother aiding his recovery process after undergoing intensive surgery illustrates the possible answer to my research question, how could the intrinsic knowledge, compassion, and availability that mothers can offer contribute to the treatment of their child?

The thesis will begin by exploring my personal dedication to understanding this question both in my fieldwork and my theological beliefs. Next, the thesis will provide context of the current climate of health in sub-Saharan Africa. Several organizations, which are working on the community level, will be discussed to better understand how to build capacity within individuals. Then, research will be presented on the hindrances and enablers of capacity building among mothers. In order to fill the gap in knowledge regarding a mother's relevance in a patient's treatment plan, the value of a mother's knowledge, compassion, and availability will be discussed followed by the benefits provided to the patient, doctor, and community. As mothers develop the medical and emotional capacity needed to participate in the healthcare treatment

plan of their child, both patients, doctors, and the community will benefit from the knowledge, availability, and compassion mothers offer.

Fieldwork Reflection

During the Summer of 2016, my husband and I traveled to Blantyre, Malawi, to conduct qualitative research. All my research occurred at Beit CURE International Hospital, a 66-bed pediatric orthopedic teaching hospital ("CURE Malawi"). Upon entering the hospital, it is clear to an observer that this international facility is unlike anything else in Malawi. The administrative staff happily greet visitors, the daily clinic runs on schedule so that all patients can be seen, and someone is always cleaning the hallways, maintaining the ever-present and reassuring disinfectant hospital smell. The unique qualities of the hospital provide visitors with the sense that the facility is run with accountability, efficiency, and integrity.

Throughout my study, I adhered to Henry Wolcott's three-pronged approach to ethnographic research which includes, "experiencing, enquiring, and examining" (48). His approach, outlined in his text, *Ethnography: A Way of Seeing*, helped me experience research through participation and observation. I sat to discuss with people one on one as well as participated in usual hospital activities. I conducted 21 personal interviews with doctors, hospital staff, patients, and guardians. I held one focus group with doctors and nurses from a neighboring government run hospital, Queens Hospital. Additionally, I logged over 90 hours observing and participating in hospital activities like physio-therapy, morning rounds, waiting in the clinic, Bible studies, and more. My data collection methods included several modified practices from Sunstein and Chiseri-Starter's text, *FieldWorking*, like "double-entry notes" (84). All my notes were divided into "facts" and "feelings." This delineation helped me maintain balance and organization in data collection. Also, after each interview, I asked myself these reflective

questions: “What surprised me?” “What intrigued me?” “What disturbed me?” and “Any new questions?” (Sunstein 87). My recorded observations from these questions helped me see themes and patterns emerge from my data.

The themes which emerged in combination with my personal reflections from the field guided me to pursue the question, “How can mothers stand in the gap caused by lack of access to care on behalf of their child?” I observed the knowledge and care that mothers selflessly offered their child in a health care setting. Further, I allowed my subjective position of being the daughter of a successful physician to begin to shape my research. Growing up, my mom shaped my view on so many things including my ideas about medicine and treatment as well as my belief that my fixed position as a female should not limit, hinder, or disrupt the ability to pursue my passions. This unique piece of my story combined with all that I observed in Malawi propelled me forward to further research. In addition to my fieldwork experience and social history, the final piece that forms the foundation of my research, thesis, and proposed solution is deeply rooted in my personal theological viewpoint.

Personal Theological Reflection

As a Christian, my framework for life is founded within the narrative of God shared with humanity in the Biblical text. Author of *Walking with The Poor*, Bryant Myers, asserts that God’s Gospel is “the story into which every human being has been invited by God to be a participant” (82). As I live out my life within the context of His story, I experience continual transformation and renewal, thus informing my professional practice of transformational development. Beginning with creation, I seek to see all people and the Earth we inhabit as made in the image of God. Understanding God’s care for creation gives me a glimpse of what God intended for His people. Secondly, understanding the Biblical fall of man in the Garden of Eden

teaches me about my own sinful nature as well as the sinful nature of others. Acknowledging sin in the world gives voice to “what is working against life in poor communities and why” (Myers 85). Finally, as I understand God’s redemption story, I see how I as a Christian am to enact reconciliation and redemption in my own life and community. God chose to engage with our broken world. He made himself flesh and blood, coming to Earth as Jesus Christ, both fully man and fully God, he made himself nothing, speaking the heart language of his chosen people, directing all who would listen to God the Father. Miroslav Volf illustrates how Christ’s death on the cross serves as a dual example of his “solidarity” with the suffering and “atonement” for the perpetrators (Volf 23). Further, this picture of self-giving love, the love demonstrated within the divine Trinity, exemplifies the type of love which breeds life-altering transformation. My personal theological framework is rooted here, in the self-giving love displayed on the cross; It is the love of the victim, the perpetrator, and the other. As I accept this transforming Gospel in my own life, I am led by Christ to do His transforming work in the world.

As a young American, Christian, female desiring to see social change in marginalized communities around the world, I seek to establish my motivations and reasoning for participation in the field of community development, particularly in regards to healthcare. Though my social status and age may identify me as a naive, passionate “twenty something” on a journey to stamp out suffering in the world, I understand that global suffering will not be alleviated by my good works alone. Suffering and injustice call for a much deeper analysis of structural evil, much of which cannot be undone by charity. Author Cynthia Moe-Lobeda illustrates the undoing of structural evil in her text *Resisting Structural Evil*. She argues that structural evil is “composed of power arrangements and other factors that are humanly constructed” (Moe-Lobeda 3). While tragic to acknowledge, there is hope in knowing “what is constructed by human decisions and

actions is subject to human agency,” therefore can be “dismantled by other decisions and actions” (Moe-Lobeda 12). I seek to understand and grapple with suffering, which proves that I am willing to acknowledge the person experiencing the pain. I desire to understand the structural injustice perpetuating suffering, so I may direct my efforts towards dismantling such a structure. It may be easier to devise a solution to ease the symptoms of suffering and push away the thought that the suffering is present, but in this selfish approach, I would also push away the person in front of me experiencing the pain.

Despite my lack of medical credentials, I desire to serve those yearning for both physical and spiritual healing. My position as a non-medical professional presents opportunity that a doctor or nurse may not have. For instance, as a community development practitioner I can serve as a bridge between the medical professional and the patient they are treating. I seek access to all stakeholders as a neutral party. My vocational focus encompasses both the physical and the spiritual side of a patient’s well-being; I seek to address the patient holistically. While serving as a cultural broker in the medical community, I aim to facilitate reconciliation between guardians, patients, doctors, and medical staff in the same way that I see Christ’s work of reconciliation displayed on the cross. In so doing, it is my ultimate ambition that those suffering would undergo transformation and reconciliation to God.

Understanding my personal theological framework is critical in understanding why I care about people having adequate access to healthcare resources. My framework is the foundation for my efforts. Earlier this year in the ICD Leadership course I wrote, “It is important to deliver healthcare, but I believe that it is necessary so that people can become whole again. I want others to experience holistic care in the hopes that their mind, body, and spirit can be reconciled to themselves, their community and to God.” Based on my theological framework, I believe that

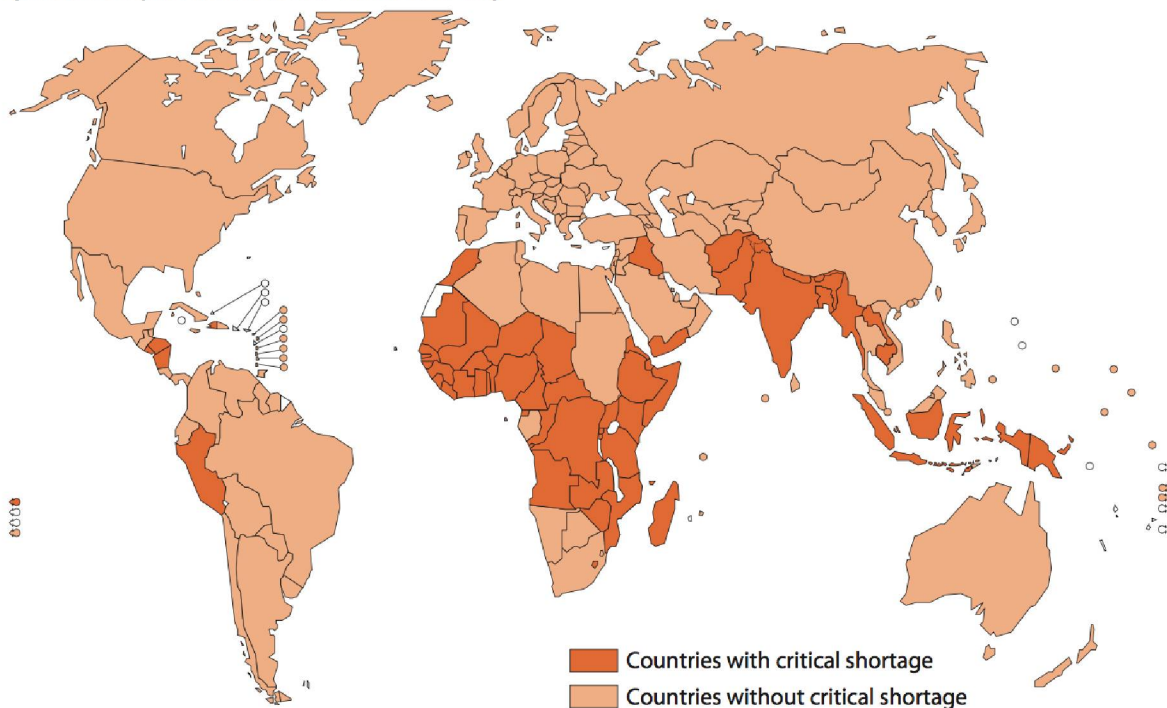
when someone experiences this type of healing, they can step into a dignified perspective of themselves and those around them. Their identity becomes associated with healing, reconciliation, and ability to thrive. Then, they have the chance to contribute to their communities thus helping others reach wholeness. Author Simon Sinek would pinpoint my theological framework as my “why” behind my work. He explains our “why’s” as “your purpose, cause, or belief” (Sinek 39). Therefore, healthcare access is important to me, but my purpose or cause runs deeper. What matters most to me is reconciliation to oneself, to God, and to community; healthcare access is the means to a much greater end.

Health Care Update on Sub-Saharan Africa

Just as understanding my personal connection to this thesis is necessary, so is understanding the health climate of sub-Saharan Africa to properly contextualize the need for improvements. It is important to note that the organizations that provide such data, like the World Health Organization (WHO), are viewing successful health outcomes from a Western perspective. The WHO does not account for community connection or happiness, both contributing factors towards a healthy life. Author Michael Schut addresses this measurement dilemma in his text, *Money and Faith: The Search For Enough*. He discusses tools for reframing the measurement of economies like the Genuine Progress Indicator and the United Nations’ Human Development Index. While these measuring tools are more strictly geared towards economic progress and not health, they illustrate the importance of including more holistic aspects of measurement like life expectancy and education (Schut 80). Because of a lack of insufficient data on countries in sub-Saharan Africa, it is important to note the health update below is an assessment rooted in Western ideologies of good health and human progress.

In 2006, the WHO released a world health update including data reporting on the global healthcare workforce. The WHO identified a minimum threshold to determine whether nations had enough healthcare professionals to meet the health-related Millennium Development Goals (MDGs). Countries were identified as being in “critical shortage” of health workers if they had “fewer than 2.28 doctors, nurses and midwives per 1,000 population and if they failed to reach the target of 80% of deliveries being attended by a “skilled birth attendant” (Wilcox 1). Based on their estimation in 2006, there were “57 countries with critical shortages equivalent to a global deficit of 2.4 million doctors, nurses, and midwives” (WHO). The deficits of medical personnel were proportionally greatest in sub-Saharan Africa. Figure 1 highlights the countries most affected by a shortage of healthcare workers.

Countries with a critical shortage of health service providers (doctors, nurses and midwives)



Data source: World Health Organization. Global Atlas of the Health Workforce (<http://www.who.int/globalatlas/default.asp>).

Figure 1

In 2015, an updated world health report was released still qualifying the sub-Saharan African region as an area with a critical shortage of healthcare workers. The WHO reports only 2.7 physicians per 10,000 population in the sub-Saharan African region, coming in below the identified threshold from 2006 (WHO 122). In comparison, the next lowest number of physicians per population is the South-East Asia region with 5.9 per 10,000 population, more than double the resources available in the African region (WHO 122). The scarcity of physicians, nurses, and midwives in the sub-Saharan African region is critical. In comparison to other world regions, the shortage in sub-Saharan Africa is the most dramatic.

Chen et. al, in their article, ““Human resources for health: overcoming the crisis,” agree that there is a “massive global shortage of health workers,” and the region most affected by the shortage is sub-Saharan Africa (1985). The shortage is so dramatic that in order to ease the crisis and meet global goals, sub-Saharan health systems must add approximately 1 million health workers, tripling the current number of workers. For example, Chen highlights that “sub-Saharan Africa has a tenth the nurses and doctors for its population that Europe has,” and even more specifically, “Ethiopia has a fiftieth of the professionals for its population that Italy does” (1985). Chen et. al assert that skill imbalances, maldistribution and migration, poor work environments, and weak knowledge base for health workers all contribute to a diminished and poorly equipped medical population. Further, the legacy of “underinvestment in human resources” has exacerbated these issues most severely in low-income and politically-unstable countries.

Chen et. al describe the health care workforce consisting of at its base, “family members, relatives, and friends – an invisible workforce consisting mostly of women” (1987). This informal base stretches to a network of traditional healers and community health workers. Beyond these front-line health providers, there are doctors, nurses, and midwives who implement

effective practice. The researchers argue that the workforce, even those participating who may be invisible or technically unqualified, must be engaged in medical training. Even without training, the members of this informal medical network will be administering healthcare therefore they must be included in the training and equipping of the formal sector. The workers who have remained faithful to their positions are “overburdened and overstressed” as they try to compensate for the lack of resources (Chen 1985). They themselves are contracting diseases like HIV/AIDS and or tuberculosis. Some are leaving their community to find a better life in a richer area. The dedicated health workers are beginning to collapse under the pressure of a system defined by low resources and high demand.

The researchers claim that these deficits must be addressed at a national level. Chen et. al call for workforce strategies to be implemented to combat these hindrances to positive performance by the limited number of healthcare workers. All strategies should be focused on ensuring access by every family to a “motivated, skilled, and supported health worker” (1987). National strategies should include “engaging leaders and stakeholders, planning human investments, managing for performance, developing enabling policies, and building capacity while monitoring results” (1987). This type of development demands cross-sector relationships from finance and education to health and NGOs. A coalition like this will take time, dedication, and political will. As diverse sectors, national governments, and existing health workers join forces the development and sustainability of healthcare resources can increase. In the meantime, the “invisible workforce,” made up of mostly women, is an untapped resource waiting to be cultivated and utilized.

Similar to Chen and colleagues, Nkomazana and his research team found there was a perceived shortage of healthcare providers and resources among community members in rural

and urban areas of Botswana, even though the country has more healthcare workers per population than most low and middle-income nations (Nkomazana online). In their article, “Stakeholders’ Perceptions on Shortage of Healthcare Workers in Primary Healthcare in Botswana: Focus Group Discussions,” complex factors like outsourcing training, inequitable distribution, worker migration, and weak management contribute to the perception of a lack of providers and resources. Researchers recommend, “capacity should be built in human resources for health, healthcare management, and systemic monitoring and evaluation. Botswana should also institute strategies to train and retain more healthcare workers” (Nkomazana online). The perception of an under resourced health care system is almost as damaging as an actual under resourced health care system. If community members, especially mothers, perceive the hospital as a place where people go and die, they will not utilize the resources that are available, even if they are limited.

For example, during my field work in Malawi, a group of nurses and doctors explained to me how the negative perception that communities held about the hospital serves as a contributing factor for people visiting the hospital as a last resort for care, once it is too late. (Focus Group 13 July 2016). They said, “Due to miscommunication and misperception, Malawians have an irrational fear of oxygen. They may have seen one critically ill patient being placed on oxygen who died soon after. Now they associate all forms of oxygen with death” (Focus Group 13 July 2016). As a result of this negative perception, some Malawians avoid the hospital in order to avoid death, in turn harming themselves further by avoiding medical care. Therefore, it is almost as important that the public perception of the hospital remains positive as much as the hospital remains equipped to serve patients. Based on these findings, investing in the training of mothers, who are eager to build emotional and medical capacity, and strengthening the perception of

healthcare would be a wise investment for governments who are not yet fully able to establish a stronger framework for training medical professionals. The contribution of trained mothers could diminish the perception of a shortage of healthcare providers.

Just as the public's perception of a lack of healthcare workers tarnishes the reputation of the healthcare system in Botswana, so do missed opportunities in a healthcare treatment plan in South Africa. Even though South Africa may have more access to resources than some other sub-Saharan countries, it still has gaps in the healthcare delivery system, gaps that can be filled by the inclusion of mothers. Despite improvements in healthcare delivery since 1994, South Africa has "failed to reduce the maternal and under-five child mortality rate" (Jonker 2). In fact, it is one of twelve countries who have experienced an increase in mortality (Jonker 2). To counter this trend, researchers in South Africa conducted a qualitative study to understand the experiences and perceptions of mothers utilizing healthcare services for children. In their study titled, "Missed Opportunities in Childcare," researchers interviewed 17 mothers with children under the age of two. Mothers reported "missed opportunities" in their care like nutritional training, immunizations, and disease prevention drugs (Jonker 6). When dealt with singularly, these areas of health are much more preventative than emergent. Still, overtime if not dealt with at all, these areas can cause significant damage to a child's health.

These simple yet integral aspects of care seemed to be overlooked when mothers visited the clinic. For instance, it is required in the South African "Expanded Programme on Immunization" that immunization services be offered at all service delivery points like hospitals, clinics, and community health centers. One mother reported that after two visits her child still had not received immunizations because of staffing issues. There was no one available to immunize her child. Another missed opportunity reported by mothers was the lack of knowledge

provided surrounding the “road to health card” (Jonker 5). This card is required to be provided at the birth of every child and contains useful information on feeding, nutrition, and care. Several mothers reported not receiving the card and others reported receiving the card but were given little to no instruction on the importance and relevance of the card. Finally, mothers reported doctors weighing their child at monthly visits, but offering no further advice regarding the improvement or decline of their child’s weight. Even after mothers revealed incorrect feeding practices, no one gave them instruction on proper feeding techniques. Lack of information regarding feeding and nutrition is a missed opportunity for improved health outcomes. Research participants revealed how most nutritional information came from older women in their lives like grandmothers instead of healthcare providers. Even though the idea of maternal knowledge will be discussed later in the thesis, it is important to highlight here in regard to missed opportunities in healthcare. It is important for healthcare providers to include maternal knowledge as valuable information in a patient treatment plan in order to preserve generational bonds and local culture. Areas like immunizations, nutritional information, and the road to health card paired with the implementation of maternal knowledge are important preventative measures to maintaining strong health in children. Mothers must be informed and equipped to monitor their child’s health outside of a healthcare delivery point.

Even though South Africa has a structure in place to deliver reliable and safe healthcare, the data recording maternal and infant mortality does not show vast improvement. Mothers can be a catalyst for change within the South African health care system if medical professionals spend time empowering them to properly care for their children. The knowledge, availability, and compassion mothers possess will prevent further “missed opportunities” in an over run and under staffed health care system.

While the sub-Saharan African region struggles from a shortage in resources, the children of the region are struggling with diarrhea, respiratory infections, HIV/AIDS, malaria, and other causes of death. In Malawi, where 45% of the population is under the age of fifteen, malaria is reported by the WHO as the highest cause of death for children below the age of five. It accounts for 40% of all hospitalization for children under the age of five and 40% of all hospital deaths ("Malawi - Country Cooperation Strategy."). Further, more than 40% of children in Malawi under the age of five are stunted, a condition which affects physical appearance as well as cognitive development ("Malawi: WHO Statistical Profile").

With one of the highest fertility rates in sub-Saharan Africa, at 5.7 children per mother, the Malawian neonatal mortality rate per 1000 live births is 24, and the maternal mortality ratio per 100,000 live births is 460 ("Malawi - Country Cooperation Strategy"). These neonatal and maternal mortality rates are staggeringly high for several reasons including the low number of physicians, nurses, and midwives. There are only 0.019 physicians per 1000 population and 0.283 nurses and midwives per 1000 population in Malawi ("Malawi - Country Cooperation Strategy."). The complex health issues which impact children like malaria, diarrhea, and HIV/AIDS are compounded by "delays in seeking care, poor referral system, and lack of appropriate drugs, equipment and staff capacity" ("Malawi - Country Cooperation Strategy."). Such healthcare deficits contribute to the vulnerability of women and children in sub-Saharan Africa.

The dramatic shortage in access to healthcare resources and poor quality of care are systemic issues that will not be resolved overnight. In fact, the symptoms of this problem may not be fully alleviated through the Western benchmark of "access to care." In addition to time, political will, and nationals dedicated to the health of their nation, a more holistic approach to

well-being must be researched and discussed. While change is being authored from the top, action must take place at the bottom. In areas of low access and resources, mothers could serve as a bridge between their child suffering illness and the nearest healthcare official. She may be able to provide forms of traditional care that a healthcare provider cannot offer. Her cultural knowledge and understanding of her child must not be excluded by Western benchmarks of health. Instead, her knowledge must be honored to avoid the risk of undermining the capacity community members already possess to care for one another, not based on Western standards, but according to local cultural frameworks. Utilizing the intrinsic resources of a mother relieves the burden of an overworked doctor or nurse and creates confidence within the mother to help other women and children in her community. As healthcare capacity is developed within her, she may be more inclined to contribute her knowledge, availability, and compassion that stem from her experience as a mother. Ultimately, healthcare officials can supplement the knowledge she possesses so she may be a vessel of knowledge poured out to her local community.

Understanding the context of health in sub-Saharan Africa is necessary in understanding why capacity should be built and developed within mothers. As the health situation becomes clearer, a context for why this action is necessary unfolds. Because of the high neonatal and maternal mortality rates and the low number of physicians, nurses, and midwives, communities must work together in developing resources to alleviate these health burdens.

Capacity Building in Developing Countries

To understand best practices in building capacity, I discuss three programs that align with my personal desire as a community development practitioner to seek justice and community well-being, a motivation informed by my theological beliefs. Community Health Evangelism

(CHE), Partners in Health (PIH), and Citizen Voice and Action (CVA) have been chosen because of their focus on healthcare development in the Global South.

Community Health Evangelism (CHE) is a Christ-centered community development model that equips communities to identify issues and resources necessary to achieve sustainable change. Indicators of success within a CHE program include “shared vision, leadership, ownership, cooperation, volunteers, dignity, learning, skill and resources, and Christian community” (“Community Health Evangelism Overview”). As these outcomes are achieved, community change is apparent. CHE has thousands of lesson plans on topics across the spectrum including health, education, sanitation, and more which can be facilitated within the community through a trained CHE leader. These training materials are available at no cost for any trained CHE leader. It is up to the community to determine how much or little of the CHE resources they will utilize in their area. The community driven, community led model of CHE is necessary to create lasting change. A model like CHE’s is useful in empowering mothers to build medical and emotional capacity. Through the various lessons like “Preventing Malaria,” “Healthy Eating,” and “Common Health Problems” mothers can grow in knowledge, skill, and confidence (“Community Health Evangelism Overview”). Further, the CHE lessons build community among mothers who experience the training together. They are able to join in solidarity with other mothers to be an advocate for their child’s health.

Currently, CHE is working in 125 countries around the world. In those countries, CHE is involved in over 3,000 local communities where 2,990 leaders and 17,411 volunteers facilitate change (“About the Network”). Because of the uniform training required to become a CHE leader, a global network has formed of leaders from all over the world. The network aims to be collaborative, impact focused, enabling, mutually transforming, and synergistic. It has an open

ideology always welcoming new ideas and innovations. CHE aims to provide a resource that can be utilized for capacity development in any community around the world by providing a culturally flexible tool adaptable to any group of people (“About The Network”). The development of maternal capacity will engender a confidence within mothers to step into a role of power on behalf of their child. The increased confidence will make them more likely to participate in the treatment plan of their child, thus lightening the burden of a low-resource community.

In contrast to CHE, Partners in Health (PIH) provides a larger scale community based, community led framework for healthcare. Backed with funding and government support, PIH offers governments and community health systems a lasting partnership aimed at creating positive health outcomes. Dr. Paul Farmer, co-founder of PIH, began his work in Haiti and has now expanded the influence of PIH to places like Peru, Malawi, Russia, Rwanda, Mexico, Navajo Nation, Sierra Leone, and Liberia. These locations have been specifically chosen because of their low level of resources (“Countries”). PIH zeroes in on a low resourced community and works to offer a preferential option for the poor. At times, this ideology can be considered controversial because of its selective nature, but Farmer believes we must fight selectivity with selectivity. If disease has a preference for the poor, then healthcare should as well. Many studies show that “the poor are sicker than the non-poor” (Lysaught). As a result of the combination of increased exposure to disease and low access to healthcare resources, the poor are starting from a disadvantaged place. PIH works to dismantle and recreate the system in which the poor are disadvantaged, one community at a time.

PIH’s selective yet thorough approach is exemplified through their work in the rural district of Neno, Malawi. PIH began work, in partnership with the ministry of health, in Neno in

2007. At that time, there was no district hospital and the ten health centers in the area were nonfunctioning (“Malawi”). Since their investment and partnership in this community, the health centers have been revitalized and a Neno District Hospital has been constructed. PIH provides comprehensive care to 150,000 people in this small southern district of Malawi (“Malawi”). The clinical services offered by PIH are paired with outreach programs. Village health workers visit community members in their homes to conduct health screenings. These preventative visits help identify disease early and enable patients to be referred to the proper centers for treatment (“Malawi”). The community outreach conducted by PIH builds trusts between community members and medical personnel.

Knowing that poverty is a risk factor for illness and illness a risk factor for poverty, PIH has invested in community members beyond the construction of buildings into their economic and social lives. Community members lead the Program on Social and Economic Rights, which promotes job-skills training and employment programs in areas like “carpentry, tailoring, knitting, cookery, and farming” (“Malawi”). These capacity building activities go beyond the physical health of the patient by giving them options for a higher quality of life and thus increasing the overall well-being of the community. As Dr. Paul Farmer said in an interview with PBS, “Making someone well takes more than medical science” (PBS). Building capacity is a holistic process that should engage multiple aspects of a person’s life connecting them to the inherent resources they hold within themselves. The PIH approach couples high quality medical care with an investment in one’s social and economic life bringing more than just health, but restoring well-being to a community.

Finally, Citizen Voice and Action (CVA) is a third framework for capacity building in developing communities created by World Vision. The community-based ideology promotes

citizen advocacy on the local level. It aims to improve essential services like health and education by enhancing the relationships between local communities and government. CVA creates accountability for governments, requiring them to perform to previously created standards allowing citizens to voice their opinion on what makes a strong school, clinic, or other government service. CVA creates an avenue for government accountability while also encouraging local communities to maintain a higher level of individual and collective responsibility (Cant 2).

CVA is carried out in three phases beginning with “enabling citizen engagement,” followed by “engagement via community gathering,” finalized by “improving services and influencing policy” (“Citizen Voice and Action Field Guide”). The first phase helps citizens to engage in and understand public policy as well as build networks and coalitions. World Vision encourages CVA to always be led by a community leader. It is necessary for these leaders to establish relationships and connections in order to cultivate an environment of trust and mutual understanding. Next, members of the community will gather together for an initial meeting, a monitoring standards session, and finally a community score card session in order to collect opinions regarding services in the community. The scorecard is the chance for individuals who would otherwise not have a voice to share their opinions by providing their own “qualitative performance measures” (Cant 4). After the community completes a scorecard, stakeholders are gathered together for an interface meeting. At this final meeting, citizens, community leaders, and government officials gather to discuss services. It is here that citizen’s voices and opinions can be heard and acted upon. Further, the community can hear about the pressures under which government services operate. This conversation is designed to unite citizens with local government instead of divide. By the conclusion of this meeting the group has developed a

specific, measurable, achievable, realistic, and time-bound (SMART) action plan (“Citizen Voice and Action Field Guide”). Ultimately, all stakeholders are welcomed to celebrate the accomplishment of creating a plan of action, which includes voices from all areas of the community.

As a result of citizens working with governments to hold them accountable to the local law, health services have improved. For example, in Uganda, women are often treated harshly by nursing staff who are most likely over worked and under paid. Each negative experience fosters distrust of the medical system, causing the woman to be less likely to return before, during, or after pregnancy. Because of CVA, patients and providers have had a space to reconcile these negative experiences. World Vision reports a rise in health seeking behaviors as a result of “improved relationship between staff and patients” (Cant 15). Not only have community and government relationships improved so have access to resources. The World Bank reports the collective action of communities lobbying their district governments for a higher number of staff as well as adequate medical supplies has been the “strongest determinant of service delivery in country research in 2011” (Cant 15). The relationships fostered towards collective action are the result of empowering citizens to use their voice in a productive compassionate way. CVA develops within local citizens a knowledge of their basic human rights and gives them tools to hold their government accountable to those rights. Further, the program empowers citizens to use their voice in a collaborative effort *with* their government instead of fighting *against* the power of their government. Once citizens, especially women, are given the tools to develop the capacity within themselves, change is soon to occur.

CHE, PIH, and CVA represent three frameworks of capacity building that focus on individual and community development. Community health and well-being requires an emphasis

on both the individual and the community, which makes aspects of each of these practices valuable. CHE offers an individualized form of capacity development that builds confidence, knowledge, and power through local training and education. PIH combines high quality individualized care with social and economic investment in the community. CVA makes a broad investment in the community supporting advocacy and change at a higher structural level. Incorporating these three approaches to capacity development strengthens the individual as well as the community, ultimately promoting health and well-being.

Hindrances to Capacity Building for Women in Developing Countries

Despite the appealing roadmap to capacity development provided by CHE, PIH, and CVA, there are barriers to overcome to begin the process of capacity building. Identifying the barriers women experience in seeking healthcare, like location, transportation, trust, and more, will help identify barriers women must overcome in capacity building efforts as well.

The Encyclopedia of World Poverty reports, “70 percent of the poor people in the world are women” (Donkor 1173). In most developing nations, women operate within a patriarchal society that limits their access to resources. Men are responsible for defining “values, actions, and expectations and women act within those definitions” (Donkor 1173). Therefore, the choices women have in work, health, and education are the result of a society that values the voice of men over women. Their gender classification limits their voice in major social and economic decisions. Understanding the complexity of the feminization of poverty requires an examination of the structures within the health system that prevent progress and forward movement for women.

The barriers women experience towards receiving medical care will have an impact on the way they choose to medically care for their family, therefore it is important to identify and

understand these barriers to care. In their article, “The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania,” researchers seek to understand the perception and usage rates of prenatal and postnatal care among women in order to make recommendations on how to improve overall maternal health. During the study, researchers conducted in depth interviews for nine months with health care providers, pregnant women, and women with children aged one year or younger. Women reported fears of caesarean sections as a hindrance to giving birth in a hospital or with a skilled birth attendant. In fact, labor in a hospital is highly associated with complications and even death. Most women had no one to refute this fear as a myth. No one within the medical system spoke to these women asking them to unveil these fears or hindrances to seeking medical attention. Additionally, during interviews, women reported a misunderstanding on medications they were given as well as verbal abuse and condescension from medical staff (Mrisho 7). From the perspective of the health care providers, respondents wished for refresher courses to improve their job skills as well as a lighter workload, sufficient supplies, and fair wages (Mrisho 7).

As a result of the study, researchers found that “shortages of staff, equipment and supplies, difficulty accessing health care facilities and lack of clear guidelines of postnatal care” are areas that need to be addressed in order for women to receive the best care available before, during, and after childbirth (Mrisho 9). Further, researchers urge that efforts to improve maternal health care have a focus on “addressing geographical and economic access while striving to make services more culturally sensitive” (Mrisho 1). A woman’s location and social position should be considered when devising ways to build capacity within her. Further, researchers believe, “addressing staff shortages through expanding training opportunities and incentives to health care providers and developing postnatal guidelines are key steps to improving maternal

and newborn health” (Mrisho 1). Building medical capacity within a woman begins outside of herself. The structure or facility in which she is receiving care must be adequately supplied, within a manageable geographical distance from her, and filled with equipped professionals who will offer her compassionate care. Dr. Chokotho of CURE Malawi reiterated the need for adequate resources during our personal interview. She said, “my biggest frustrations stem from being unable to do my job because of a lack of resources” (Chokotho). Once a week she volunteers at Queens Hospital, the government run hospital across the street from CURE. She argues, “the government must examine its budget and be sure there is enough allocated for the health sector” (Chokotho). After witnessing negative health outcomes because of poor resources, Dr. Chokotho is an advocate for increasing government allocations towards health. From this strong foundation of increased healthcare resources, capacity building can begin.

The hindrances identified by researchers for women seeking care can also be identified as possible hindrances to capacity building for women in developing countries. In the article, “Barriers and facilitators to health care seeking behaviors in pregnancy in rural communities of southern Mozambique” researchers, Munguambe et. al, discuss why some women seek care at a medical facility and others do not. Researchers found that some factors contributing to women not seeking necessary maternal care were “unfamiliarity with warning signs...fear of mistreatment from healthcare providers, lack of transport and financial constraints” (Munguambe). Most women have no financial independence therefore are unable to make important decisions like when to go to the doctor. When their partner is unable to provide necessary finances, the women, including their children, may not go to the hospital at all. For instance, 16-year-old Enosi Chikapa was unable to visit CURE for treatment on his neglected club foot because of distance and travel cost. His mother reported, “We have not been able to

treat his legs because we live so far away and cannot pay the transportation fees” (Chikapa).

Most children with club feet began corrective non-surgical treatment weeks after birth, but Enosi was required to undergo several intensive orthopedic surgeries to correct his club foot.

Hindrances to seeking personal medical care, like those experienced by Enosi and his mother, are important to observe and discuss because they may also double as hindrances to capacity building for vulnerable women.

As women grow in mistrust regarding their own personal medical treatment, their mistrust in medical professionals will inevitably increase in regard to treating their child. Constraints like lack of transport and or finances will also affect women’s ability to increase their medical capacity. If they are unable to acquire transportation to the hospital for a pressing need, it will be difficult for them to acquire or pay for a similar form of transport for any type of training or capacity building programs.

When dealing with sensitive issues like health, trust building actions must be implemented and modeled at the onset of a patient-doctor relationship. Ugandan researchers, Jane Namatovu, Fred Ndoboli, Julius Kuule, and Innocent Besigye, observed similar issues of mistrust as recorded by researchers in Southern Mozambique. In Uganda, researchers set out to measure the participation in health services by community members frequenting Namayumba and Bobi health centers in their study, “Community involvement in health services at Namayumba and Bobi health centres: A case study.” After holding focus group discussions and formal interviews, researchers found that “lack of trust of health workers and poor communication” deter community members from being involved in healthcare (1). Research participants reported mistrust in political promises regarding resources and mistrust in the attitudes of health workers. Further, community members do not feel heard by local leaders or

health workers. This poor level of communication leads to decreased community participation in formal healthcare programs. Further, there is miscommunication between the village health teams and the health center staff, which further frustrates the staff causing them to react harshly to community members (4). This lack of trust and poor communication means a lower utilization of health services by community members, leading to poor health outcomes. Women in developing countries are not likely to get involved in capacity building activities in the field of healthcare if they distrust the healthcare workers and do not feel heard or understood by them. It is paramount that trust and communication form the foundation of capacity building for women in developing countries.

During my time conducting qualitative research in Malawi, I saw the themes of miscommunication and mistrust in the lives of the mothers bringing their children to the free clinic each week. Maria, a patient's mother, told me during her personal interview about her inability to speak up regarding the doctor's treatment plan. She said, "at the previous hospital I did not agree with the doctor, but I felt like I couldn't say anything" (Likupe). She chose to visit CURE for a second opinion because of the open and empathetic doctors.

The hindrances women experience in seeking medical care like geographic location, transportation access and cost, mistrust of healthcare providers, and cultural gender norms are also barriers to developing capacity. These barriers can be overcome by increasing communication and building trust.

Enablers of Capacity Building for Women in Developing Countries

While it is necessary to identify the hindrances towards capacity building, it may be more important to identify the assets that facilitate and further capacity building among women.

Community care workers are among the list of assets that help build capacity within women.

Seeing the effectiveness of these workers, the WHO and United Nations Children's Fund created 16 key family practices that could be integrated and taught on the community level.

Unfortunately, researchers Ethelwynn Stellenberg, Marjorie van Zyl, and Johanna Eygelaar published findings that explain how these practices are not being fully integrated and taught at a level high enough to combat child mortality rates. In their article, "Knowledge of community care workers about family practices in rural communities in South Africa," researchers state how a low level of training among community care workers (CCWs) negatively affects the way mothers care for themselves and their children. They suggest that a yearly refresher course be instituted for CCWs to attend because 61% of CCWs surveyed have never attended a refresher course (6). The model of community care workers cannot be effective without properly training and updating workers on changes in health indicators and new solutions in health. Without community care workers who are properly trained and equipped to teach the material created by the WHO and the United Nations Children's Fund, most mothers will be uneducated on the signs and indicators of poor health.

The relationship created between community care workers and mothers generates trust and communication, two key elements that can enable women in building capacity. Since these workers have a direct way to build trust and communication with mothers, they are one of the primary ways mothers/guardians can undergo capacity building training in the field of health therefore it is crucial that they are properly trained and equipped year after year.

Capacity building does not have to occur through an expert panel intervening in a community or by one group of trained professionals. Authors Daniel C. Taylor and Carl E. Taylor, in their book *Just and Lasting Change: When Communities Own Their Futures*, present the seed-scale model that makes access to community change available to any and every

community. The authors outline a model that encompasses approaches from the bottom-up, the outside-in, and the top-down (14). This three-way partnership for development is designed to include local people, outside ideas and training, and arenas of influential “policies, values, and financing” (14). Instead of working from one angle, this “three-dimensional” approach allows for a greater chance at achieving a more just and lasting future. Similar to previously discussed models, the seed-scale model harnesses partnership, cross-sector integration, and communication as key elements to building capacity among community members. Using just one approach for enabling community development is too narrow. Multiple approaches like community care workers, trust building experiences, and the seed to scale model are necessary in seeing capacity development occur. Various methodologies will incorporate more stakeholders in the community. As more community members are involved, the capacity built will have a greater impact.

Building Capacity Leads to Developing Capacity

Among women in the developing world, we have discussed hindrances to capacity building like mistrust, poor communication, transportation issues, and cost. On the other hand, we recognize there are assets that promote and further capacity building among women in the developing world including community care workers, joint partnerships, and a high level of communication. Researchers Roman Kislov, Heather Waterman, Gill Harvey, and Ruth Boaden define capacity building as the “creation, expansion or upgrading of a stock of desired qualities and features called capabilities that could be continuously drawn upon over time” (2). Their research promotes the importance of capacity building in the healthcare field in developing countries. The article, “Rethinking capacity building for knowledge mobilization: developing multilevel capabilities in healthcare organizations,” states how important it is for capacity

building activities to be committed to long-term outcomes. Their model helps people move from building capacity to developing capacity, resulting in a higher level of engagement and commitment in the activity. As individuals move through this process, they are increasing their freedom to develop and choose thus rising above the poverty created by their lack of resources. Amartya Sen develops this idea in his text, *Development as Freedom*. Because, “human beings are intended to develop not just survive,” the transition from capacity building to capacity development is crucial in acquiring “capabilities” (Myers 30). Sen defines capabilities as “what people are able to do or choose to do” (Myers 30). By developing capacity within mothers, they gain a new sense of freedom which is both the means and the end to their well-being and the well-being of their children.

Researchers in Western Kenya observed the transformative power of capacity building in young mothers through the Mwana Mwende (Treasured Child) project. After observing teen mother’s shyness, lack of confidence, and limited interaction with their children, project leaders became very interested in this population’s link to children’s health. They wanted to start a support and training program for these mothers to build their self-esteem and address child-rearing questions. “Project planners anticipated that empowering young mothers and providing support and skill development would enhance children’s healthy development” (Kabiru 360). As they built capacity within mothers, they hoped to see mothers then begin to develop capacity within their children. At the time, there were no self-help groups for teen mothers. There were no meetings or gatherings for them to share ideas and struggles. The Mwana Mwende project, established in 1999, was the first of its kind.

Because of program growth and popularity, the teen mother group grew to over 300 young women ranging from ages 15 to 26. The mothers experienced training in a participatory

methodology “which engaged them in sharing experiences, dancing, reciting poems, demonstrating cooking techniques, and role playing to help them reflect on their lives, identify their potential, and recognize possibilities and opportunities available in the community and beyond” (Kabiru 361). By gathering together, these women could experience the joys, benefits, and connection of community. The consistent emotional support flowing from other women their age urged them to reflect on their own positive qualities.

The numerous ways capacity was built in their lives gave them a tangible way to begin using a developed skill. Researchers found when “young mothers are empowered and equipped with relevant skills and knowledge, they are more willing to take on new initiatives that can provide them a better income and quality of life” (Sorenson 362). Once these mothers experienced someone believing in their value, skills, and worth, their self-esteem grew to a level high enough for them to take a risk on their new skills. One mother reflected on the program saying, “I found an identity...with other young mothers who had experiences like me...I am now happy as a mother and convinced I have done my best” (Kabiru 361). More than 150 women reported “that their lives had changed as a result of their participation in the Mwana-Mwende-initiated groups and workshops” (Kabiru 361). Some participants pursued further training in “computers, dressmaking, or tie and dye making” (Kabiru 361). Women who felt ashamed and abandoned because of becoming pregnant reported that they no longer felt shy but instead gained a new sense of confidence in themselves. Some women expressed a vision for their future, one they would not have been able to articulate without the support and belief of the women’s group. The women of the Mwana-Mwende project have a “far more engaged and participatory membership in the larger community” (Kabiru 361). Because the Mwana Mwende program built capacity within them in a few small areas, their self-esteem rose to the point where they believed

more was possible for their lives and the lives of their children, and because the program built capacity within the young mothers, they are now able to develop capacity within their families and communities.

In the field of healthcare, first capacity is built then it is developed on both an individual and systemic scale. As individual women are building capacity within themselves, health care systems as a whole can be developing their capacity to serve a wide-ranging patient population. This type of development is seen through the Maternal and Newborn Health in Ethiopia Partnership (MaNHEP).

On the ground in Ethiopia, researchers proved the success of a capacity building campaign aimed at sustaining long term improvements for maternal and neonatal health. In their article, “Building district level capacity for continuous improvement in maternal and newborn health” Stover et al. discover, the positive impact that can be made when healthcare providers and community members join together to improve clinical care and public health concerns. The Maternal and Newborn Health in Ethiopia Partnership (MaNHEP) conducted training, community education, and behavior change communication strategies in several different district level healthcare facilities. In those districts, training summits were conducted to train specific leaders in four areas of improvement for maternal health. These trained leaders would then become regional leaders and enlist various stakeholders in the healthcare hierarchy to implement these newly improved practices. The inclusion of so many stakeholders engendered a sense of comradery and teamwork. Over the course of three years, regional leaders were trained and re-trained in “learning sessions.” These gatherings allowed for follow-up, refresher courses, and a chance to share experiences.

These implementations resulted in a multifaceted approach to building capacity within district facilities that now serve as examples to other facilities initiating the process of capacity building (Stover et al.). Surveys were conducted to measure the impact of this approach, and researchers found that when developing a system of structure and leadership that sustained itself, respondents reported a positive change in leadership culture, an improved commitment to maternal and newborn health, an increase in locally developed and tested solutions to improve healthcare, and a supportive environment where health care providers can continue to grow and improve (Stover et al.) This research conducted in Ethiopia serves as a model for how to build capacity at a larger organizational level so that patients benefit from a more organized and confident healthcare delivery service.

Individual and organizational capacity development are crucial to promoting the health and wellness of a community. As capacity development occurs within mothers, like at the Mwana-Mwende project, they begin to nurture the capability to care for themselves and their child. They develop confidence, desires, and dreams thus teaching their children to do the same. Concurrently, it is important for health organizations to develop capacity in order to increase their quality of care. As organizational leaders develop capacity, the well-being of the community sustains a higher status quo of health and wellness. The benefits to investing in mothers through capacity development will unfold as their intrinsic knowledge, availability, and compassion is discussed next.

Maternal Contribution to Healthcare in Low Resourced Communities

During my fieldwork research in Malawi, I observed an innate knowledge that mothers had regarding their child in the clinic, the ward, and in the home. Secondly, I witnessed numerous mothers' commitment to remain available to their children throughout their treatment

as they waited by the bedside and slept on the floor. Finally, I observed and heard stories of the tender care and compassion mothers offered to their children during their stay in the hospital. Because of these fieldwork observations in Malawi, I was led to research how a mother's knowledge, availability, and compassion would benefit the healthcare system in a low resourced community.

Knowledge

Early in the International Community Development program, I was fascinated by the cultural and traditional knowledge highlighted by Anne Fadiman's study of the Hmong people in her text, *The Spirit Catches You and You Fall Down*. She embeds herself into the journey of, Lia Lee, a young Hmong girl and her parents as they navigate the child's complex medical condition whilst in a foreign culture, the United States. In the case of the Lee family, very few physicians caring for their daughter Lia acknowledged or accepted the cultural knowledge the Lee's could offer. Instead, they Lees were forced to adhere to an American system of treatment thus breeding resentment and distrust in the Lee family towards Western medicine. Ultimately, this distrust and exclusion of their knowledge led to tragedy within the Lee family.

The story of Lia Lee and her family has remained with me throughout the ICD program. If those involved in her medical situation would have just asked a few more questions, listened longer, and engaged her parents a bit further, would things have turned out differently for Lia? If the Lee's cultural knowledge regarding their daughter's condition was recognized and incorporated into her care would her outcome have been different? As healthcare decisions arise, the intrinsic knowledge a mother can offer regarding her child must be acknowledged and included into the treatment plan of her child. Researchers across Africa seek to discover the importance and relevance of mother's knowledge regarding the health of their child.

The pluralistic nature of healthcare in Africa caused researchers Alexandra Towns, Sandra Mengue Eyi, and Tinde van Andel to question how women decide to treat their children's ailments. Do they rely on traditional practices and healers, do they use medicinal resources like plants, or do they take their child to the doctor? The researchers sought to uncover which pediatric illnesses mothers chose to treat with traditional practices and which illnesses caused mothers to seek biomedical care. Researchers found that mothers rely upon and work well within the pluralistic healthcare system. Their cultural and traditional knowledge of plants does not diminish their trust in biomedical care. In fact, the more a mother knows about plant based treatment, the more likely she is to interact with biomedical care, because her increased healthcare knowledge of one area of treatment informs and contextualizes another area of treatment (Towns 2). Knowledgeable mothers are eager to take advantage of all that a pluralistic system offers. They serve as an example of incorporating diverse approaches to care into one child's treatment plan.

As the mother parents her child, she becomes the adult figure who spends the most time with him or her, developing an understanding and knowledge of the child's health. Towns et. al report, "African mothers' knowledge of health is directly associated with children's well-being, as women are largely responsible for childcare" (2). It is important that her knowledge is incorporated into the treatment plan of the child because she, more than any other adult figure, has spent the most time with the patient. Towns et. al discovered that mothers were most knowledgeable on plants used to treat "respiratory illnesses, malaria, diarrhea, and intestinal ailments" (1). More than 95% of mothers interviewed in Bénin and more than 84% of mothers in Gabon reported knowing a recipe to treat one of those ailments (Towns 4). Most mothers felt comfortable treating their children with medicinal herbs or cultural traditions for non-urgent

health issues. When things became more serious, mothers sought biomedical care. One mother is recorded saying, “Use traditional medicine if modern medicine doesn’t work, or if it’s not serious” (Townes 7). Most women were not exclusive in their choice of medical treatment, but instead viewed the pluralistic system as complementary.

Unfortunately, the three sectors of treatment do not always work in partnership despite mothers’ use of all three. Only segments of the pluralistic system incorporate maternal knowledge into treatment solutions. For the best interest of the patient, all segments of the pluralistic health system, traditional, medicinal, and biomedical should seek to incorporate maternal knowledge regarding the health of a patient. By incorporating maternal knowledge, communities with a low level of healthcare resources can utilize the assets offered by mothers to create a more flourishing community.

Researchers in Tanzania also concluded that a mother’s intrinsic knowledge cannot be overlooked when developing a medical treatment plan for a child. In their article, “Quality of Neonatal Healthcare in Kilimanjaro Region, Northeast Tanzania: Learning from Mothers’ Experiences,” researchers found that mothers play an important role in detecting a child’s illness and their subsequent medical care. To perform the study, researchers interviewed mothers from two health facilities, ten district hospitals, one regional hospital and one referral center in the Kilimanjaro region. In total, 112 mothers participated in the study (Mbwele 3). Researchers found that most women reported noticing a problem with their baby before the doctor. In the periphery facilities (all but the referral center), 73.8% of mothers “noticed their baby had a medical problem after their request for further medical investigations” and “13.8% noticed the baby’s diagnosis themselves without any assistance” (Mbwele 3). Only 3.7% of mothers were told of the child’s problem by the doctor (Mbwele 3). Mothers reported from all health facilities

themes of dissatisfaction regarding the time the doctor spent with their baby as well as limited opportunities to ask health workers questions about their baby. More than half of the research participants wished for more frequent visits from the health provider. In stressful situations such as an ill baby, the mothers were looking for information, support, and encouragement, but instead were met with overworked and under resourced health care providers.

About 13% of mothers expressed concern over the lack of information shared with them regarding their child's illness. A few mothers reported the difficulty in understanding how to personally care for their child once they left the hospital. One twenty-year-old mother said, "They did not explain my baby's problem, and I was not taught how to take care of my baby at home" (Mbwele 7). These motherly concerns come from a place of love for their child. When asked for suggestions on improvement, these mothers showed willingness to offer feedback. Now, that feedback must be presented to stakeholders who possess the power and resources to enact change.

Mothers from all regions of the world possess an intrinsic knowledge that can be developed for the sake of their child's health. Dr. Mbwele, the principal author of the research and a Tanzanian physician, recommends a "special medical training programme for mothers" to be offered in primary care facilities so that mothers can use their intrinsic knowledge to participate in community interventions both for their own children and others. Training mothers to increase their medical knowledge regarding the health of their child will create better health outcomes, less stress on the physician, and happier mothers who feel informed and empowered to care for their child.

Availability

Researchers Alta Kritzinger and Elise van Rooyen studied the effects of neonatal training on South African mothers' knowledge and communication with high-risk infants. In their article, "The Effect of Formal, Neonatal Communication Intervention Training on Mothers in Kangaroo Care" the researchers seek to understand if training mothers and increasing their knowledge on Kangaroo Mother Care (KMC) affected the health outcome of the infants. First, researchers divided the participants into three groups of ten. The first group of mothers received training on KMC and practiced it with their infants in a KMC unit. Group two was not trained, but encouraged to practice KMC in the same unit. Finally, group three was not trained was sporadically encouraged to practice KMC.

After observing the mothers and interviewing them after their training, researchers found that mothers in group one had the best knowledge and descriptions regarding the condition of their infant. After two weeks of KMC training, mothers from group one were the most confident in describing their infant's behavior, their listening and visual abilities, and their stress signals. Also, these mothers "showed a high prevalence of communication-facilitating behaviors whilst interacting with their infants" (Kritzinger). The training on kangaroo care and mother to infant communication instilled confidence in mothers to interact with their baby. On the other hand, mothers in group three were hardly able to describe their infant's behaviors and stressors and did not demonstrate an increased level of interaction with their infant (Kritzinger). The difference in mother to infant interaction from group one to three was statistically significant, highlighting the positive impact of training mothers.

Though the sample size was small, researchers concluded that trained mothers were empowered to care for their children in a more informed way. Mothers, like those highlighted in the study, are eager to care for their children in a higher quality way, they just need training like

the mothers in the study. The eagerness and availability of mothers should be considered as an asset when seeking healthcare solutions in low resourced communities. Mothers offer a direct relationship with their child and availability to care for that child. No one else in the healthcare community shares the same connection or availability to the child like their mother does. Her availability to be trained and properly care for her child must be included in planning ways to overcome the barriers presented in a low resource community.

Compassion

When seeking solutions to barriers to healthcare in a low resourced community, it is important to utilize the maternal knowledge and availability offered by local mothers. The knowledge they have about traditional practices as well as their own child are key in developing a treatment plan. Further, the availability and connection they can offer their child is incomparable to healthcare providers therefore must be leveraged for the good of the patient. Above all, mothers offer a deep sense of compassion towards their own child that is matched by none other. Theologian Frances Young reflects on her personal journey in caring for her son in her book, *Arthur's Call*. As a mother, and a Christian, she discovers the depths of compassion, struggle, and confusion through the journey of raising her son Arthur, a child born with severe cognitive and physical disabilities.

Young recounts her journey of mothering Arthur as something that “marked me, and changed me, and [has] given me things I wouldn’t have otherwise had” (45). As she shifted from accepting Arthur’s limitations to rejoicing in them, she discovered a sense of vocation in being Arthur’s mother. Her son Arthur afforded her to live out a deep quality of compassion that may not have otherwise emerged. Without her son and his disabilities, her compassionate nature may have not been so deeply developed. As Arthur’s condition changed over time her compassionate

care grew to new heights. In the same way, mothers in the developing world possess the same motherly compassion for their children, but also possess the capacity for their compassion to be expanded through suffering and sickness. Young's story of her compassion deepening to new levels is a story that transcends cultural differences. Her story is that of motherhood, a compassionate calling in every culture. As we honor mothers with knowledge, training, respect, and inclusion their well of compassion will grow deeper still.

The knowledge, availability, and compassion I observed in mothers while conducting qualitative research in Malawi are qualities that should be honored as valuable by both community members and physician leaders. These maternal qualities can prove beneficial to stakeholders of the healthcare community.

Inclusion of Mothers/Guardians in Treatment Plan

While researching in Malawi, I conducted personal interviews with physicians, hospital staff, guardians, and patients. Each of these interviewee groups offered data regarding the benefit of including mothers in a patient treatment plan. Some participants were direct about the benefits mothers could offer while others were not as definitive. Data collected from these interviews and personal reflection led me to research further how the inclusion of mothers could benefit physicians, patients, and the community at large.

Physician Benefit

During my time conducting qualitative research in Malawi, Dr. Lubega, a Ugandan orthopedic surgeon, reminded me that Malawian people are shy. They do not ask questions because they can be perceived as rude, and they certainly do not question doctors. As I was trying to better understand the power dynamic involved in the doctor-patient interaction, Dr. Lubega explained, "people say yes even if they don't understand" (Lubega). Patients and

guardians defer to the doctor based on his authority and social position. From Dr. Lubega's perspective, he is actively seeking their participation in decision making with little to no result of participation. He gave the example, "maybe you have a child with two or three treatment options, but the guardians still say, "you're the doctor, you choose. We want them to be involved in the decision-making process, but time and time again we are left to choose. It makes you feel more responsible" (Lubega). After observing Dr. Lubega, I could see the emotional weight he bore from seeing so many patients with life altering conditions and being left to decide their fate. He was choosing whether they should undergo surgery, amputate a limb, subject themselves to months of recovery, and many more decisions that affect one's quality of life. Without the support of guardians in this decision-making process, Dr. Lubega shouldered an immense responsibility for the outcome of these patients, which in turn affected his performance and health.

Physicians like Dr. Lubega, with limited access to healthcare and resources are dealing with numerous patients per day who all require a high level of care. In fact, some patients are receiving care that may ultimately change their life. Physicians, in turn, are interacting with people enduring a traumatic piece of their story multiple times per day. For doctors in these situations, the emotional toll is high and can lead to compassion fatigue. The term compassion fatigue (CF) originated from studies regarding post-traumatic stress disorder. CF manifests similarly to how post-traumatic stress disorder does when it affects "individuals who know about a traumatic event that impacted someone else close to them" (Sorenson 457). This type of mental fatigue seems to occur more quickly than burnout. Due to the nature of being exposed to someone else's trauma, CF can have a faster onset time than burnout. CF can result in mental, physical, and psychological exhaustion as well as avoidance of same or similar situations

(Sorenson 457). Researchers Sorenson et al. uncovered relevant literature regarding CF in their recent article, "Understanding Compassion Fatigue in Healthcare Providers: A Review of Current Literature." Self-reported effects of CF included the physical effects of "headache, gastrointestinal issues, and sleep disturbances," as well as emotional effects of "mood swings, irritability, depression, poor concentration, judgement," and the work-related effects of "avoidance of particular situations or patients, decreased ability to feel empathy, and lack of meaning in work" (Sorenson 462). Such effects hindered physicians from performing their job to the best of their ability. After encountering so many traumas in other's lives, the effects began to surface. The research records physicians likening their work to a "Mount Everest expedition" claiming the need for "teamwork to overcome challenges to prevent or delay the onset of CF through open communication, mutual trust, interdependence, and strong team support" (Sorenson 458). Compassion Fatigue can be eased with an intentional framework of delegation, teamwork, and shared responsibility.

Patient Benefit

As responsibility is delegated among health care providers, the stress or burden of care is lightened. The burden of care can be lightened further as mothers or guardians are included in the treatment plan. The inclusion of mothers in health care delivery can alleviate a physician's level of physical and emotional exhaustion. For physicians, the knowledge of having another individual invested in the outcome of the patient who is beyond their medical team may decrease the likeliness of compassion fatigue. Mothers serve as a pillar of trust, dedication, and hope not only to the patient, their child, but also the physician. In the short term, this type of shared emotional responsibility may not seem that mutually beneficial, but the hope is that the long-term effects would cause a significant decrease in compassion fatigue for physicians. Over time,

as mothers share the physical and emotional toll of caring for a patient, physicians will have more capacity to continue the physically and emotionally taxing work of treating patients in low resourced settings.

Including mothers in the treatment plan of a patient, most likely their own child, may be one way to ensure a positive health outcome. Further, inclusion of mothers will benefit the patient in ways beyond their immediate medical needs. In the article, “Community Participation: Lessons for Maternal, Newborn, and Child Health,” researchers Rosato et al. argue that maternal empowerment is a key health indicator for children. For example, researchers found that in Ethiopia, mobilizing women’s groups to “effectively recognize and treat malaria at home led to a 40% reduction in under-5 mortality” (Rosato 964). Similar decreases in child mortality rates were found in programs in India, Pakistan, and Nepal which all included a theme of empowering mothers with the necessary knowledge and skill to participate in their child’s healthcare (Rosato 964). When mothers are included in their child’s treatment plan, mortality rates decrease in turn positively altering the course of their child’s life.

Further, the inclusion of a mother in a child’s treatment plan brings a level of emotional support that the physician is unable to provide. No one knows a child better than their mother. When a mother can share her voice, her compassion, and her care as a form of support, a child is enveloped in an environment of safety and care. In this safe place, a mother can help facilitate a child’s recovery from surgery, fever, or disease confidently and efficiently.

Community Benefit

The positive effects of including mothers in a child’s treatment plan ripple beyond the physician and the patient into the local community. For instance, the shared responsibility between a mother and a physician goes against the gendered norms of developing countries.

Authors Rebecca Holmes and Nicola Jones write about the gendered social and economic patterning that occurs among the most vulnerable including women and children in their text, *Gender and Social Protection in the Developing World: Beyond Mothers and Safety Nets*. Holmes and Jones believe, “greater equity between women and men can support economic growth and development outcomes, including well-being and resilience with regard to future poverty” (Holmes and Jones 22). As gender norms are broken down by a mother working in conjunction with a male doctor, other women in the community are emboldened to use their voice. When the female voice, both maternal and civic, is strengthened, the community will benefit from her engagement and contribution.

Researchers Kabiru et al. claim, “[When] young mothers are valued as critical resources, they can change their attitudes and behavior and influence others, thereby contributing to the well-being of the entire community” (Kabiru 363). When powerful community figures like doctors seek the inclusion and contribution of mothers in a patient’s treatment plan, mothers feel valued. The inclusion in a patient treatment plan qualifies them as a “critical resource.” As a result, the value earned from this social exchange propels mothers to leverage their talents and resources to positively influence others in their community.

Conclusion

The mothers of my life illustrate women who have leveraged their talents to make a deep and a wide impact in the lives of their children and their community. My mother, Elizabeth, my late mother-in-law, Janet, as well as my strong and resilient grandmothers, Anne and Duane, have molded me into the woman I am today. Because of the investment they made in strengthening their own capabilities as competent, educated, and compassionate women, I have been given an example to follow. Their dreams accomplished have served as a bridge to new

spaces I thought I may never reach. They have become my stepping stone to climb to greater heights.

Just as these mothers have shaped my academic, emotional, and spiritual journey, I believe mothers in the developing world have the capacity to do the same for their children and their community. As we look across the globe to women in the developing world, the roof over our head and the color of our skin may appear different, but deep down our desires and dreams are nearly the same. Women in the Global North and the Global South desire to see their children flourish in health and happiness and leave an impact on their community.

In Malawi, I witnessed mothers standing in the gap caused by the lack of healthcare resources on behalf of their child. They assumed the role of the nurse, the caretaker, the provider when the healthcare official was stretched too thin. I questioned, “If mothers were trained and equipped to meet the healthcare needs of their child, would they alleviate the burden on the healthcare system as a whole? Would the inclusion of mothers in a child’s treatment plan benefit their overall outcome?” The thesis aims to prove the answer to this question is yes. Mothers should be viewed as a valuable asset to the health outcome of a child. Their knowledge, availability, and compassion can leave a lasting positive impact on the physician, patient, and community. May this thesis inspire health practitioners to think outside of the traditional model of healthcare to be more inclusive of cultural knowledge and outside voices. Further, may this thesis inspire mothers to invest in their own capabilities for the sake of their children and communities. For others, may this thesis inspire you to think beyond what is right in front of you to a more open, compassionate, and just way of living.

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