Empowerment Education: A Case Study of the Resource Sisters/Compañeras Program

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Empowerment education is a social action process that promotes participation of communities in gaining control over their lives and their community. The Resource Sisters/Compañeras Program represents a case study in implementing an empowerment education effort. The program developed skills of women from the community to facilitate peer support groups that brought other women together. The program attempted to foster community development while also providing individual case management services. The program, its challenges, and its successes are described. The difficulties of possibly conflicting goals and objectives are discussed.

INTRODUCTION

As Robertson and Minkler point out, it is "well documented that health is significantly affected by the extent to which one feels control or mastery over one's life, in other words, by the amount of power or powerlessness one feels."[1] Wallerstein and Bernstein[2] identify common themes in community empowerment as both a process and an outcome: "a social action process, people being subjects of their own lives, connectedness to others, critical thinking, personal and social capacity building, and transformed social relations."

Where does one begin an initiative toward developing empowering efforts in health education? Pablo Freire's work on empowerment education, which is the foundation of much of Wallerstein's writings, "involves people in group efforts to identify their problems, to critically assess social and historical roots of problems, to envision a healthier society, and to develop strategies to overcome obstacles in achieving their goals."[3] Friere presents three steps of empowerment education. The first step is actively listening to the issues and concerns of the group, the second step is dialogue about the issues and problem posing, and the third step is action or positive changes.[3]

In the world of services and programs, how can these ideas be translated into a useful and feasible program design? Rappaport identifies the role of those who have power as

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that of providing "the conditions and language and beliefs that make it possible to be taken by those who are need of it [power]."[4] The Resource Sisters/Compañeras Program represents a real-world effort to develop the conditions and a structure (with peer counselors and peer support groups) to foster empowerment health education. This article describes the design of the program; the implementation challenges, limitations, and successes; and their effects on program goals.

METHODS AND PROGRAM DESIGN

The cornerstone of the Resource Sisters/Compañeras Program was peer support groups for pregnant women, which might develop into community empowerment groups over time. The program design was threefold: (1) employ and enhance the natural skills of women from the community (peer counselors) to assist other women and foster collective problem solving, (2) provide outreach and case management through home visits, and (3) develop ongoing peer support groups.

The project was funded by the Robert Wood Johnson Foundation with a local match of Florida's Healthy Start program dollars for maternity case management. The March of Dimes administered the project, while the local health department provided programmatic direction.

While this public and private partnership made the program possible, it also yielded several goals and objectives and many expectations for the program, some overlapping and some perhaps conflicting. The goal of the Florida Healthy Start program was improved pregnancy outcomes (as reflected by lower low-birth-weight and infant-mortality rates), and the principal objective was case management with pregnancy and childbirth education a secondary objective. However, the investigators' goals were community development and empowerment with skill development of the staff hired from the community and through the peer support groups. The state Healthy Start program saw empowerment and community development as useful additions to the goals of the project.

Lofquist describes three primary views of clients.[5] We can perceive clients as objects, as recipients, or as resources. Many public services are provided in such a way as to communicate the views of clients as objects or, at best, as recipients. When clients are viewed as "multiproblem families" or "chaotic families" and not as resources, the clients' and community's own strengths and resources are rendered invisible and are undermined. To develop peer support groups, it was necessary that the resources in the target communities be recognized. It was also necessary that we defined our clients by their strengths (resources) first and foremost.

With the perception of clients as resources, we hired women who were peers, in one way or another, of the women in the neighborhoods the program had targeted. A full discussion of defining a peer is beyond the scope of this article but certainly merits attention.

We attempted to bring women together to talk about whatever they wanted to discuss. We anticipated that the peer support groups (or "mothers' circles") would provide a safe, reaffirming forum for discussing issues that participants feel are important, addressing the long-term problems in their lives, developing applicable solutions, and developing long-term support among women in the community. As a forum for discussion of issues of concern to the women, the groups would take the first of Friere's steps, actively listening to the issues of the group. In the groups, the women would be encouraged to

discuss their problems and to examine the underlying environmental issues (problem posing, the second step) while increasing social cohesion among them.

Because the program was funded, in part, as an alternative model for providing state-mandated case management for at-risk pregnant women, it was necessary to ensure that all women assigned to the program received case management services. A pregnant woman was assigned to the program if she had four or more demographic, psychosocial, or medical risk factors on a state-developed prenatal screen (completed at her first prenatal visit to a public or private provider). The required individual case management was provided through home visits as well as through the support groups. We had anticipated that many of the women's service delivery needs would be addressed in the groups as women came together to compare their strategies for getting services they needed.

IMPLEMENTATION

The program focused on specific zip code areas of Orange County, Florida, which had high rates of low-birth-weight babies, infant mortality, substance-exposed newborns, and poverty. The program was implemented in an inner city area, a rural section of the county, and a quasi-suburban area (part of the urban sprawl, but neither urban nor rural). The inner-city area was predominantly African American. The rural community, dubbed the "indoor foliage capital of the world" for its greenhouses and agricultural base, was approximately one-third African American, one-third white, and one-third first-generation Hispanic.

One of the first challenges for implementing the program was developing a working definition of community that would meet administrative needs, guide us in hiring the peer staff, and foster programmatic development. Although we were administratively charged with serving all high-risk women within a given zip code area, we were programmatically charged with community development.

In our first year of operation, we would find and invite all pregnant women and mothers with young children in the community (e.g., housing complex, trailer camp, neighborhood) to the group meetings. By our second year, the number of women assigned to us from the state high-risk screening program had increased dramatically. Because of the volume, we were unable to seek out women in the community other than those assigned to us.

The original staff participated in an intensive 3-week group training that covered empowerment, resources, needs assessments, case management, women's issues, problem posing, prenatal health, labor and delivery, and group facilitation. In addition to group training, staff had ongoing weekly one-on-one meetings with the training staff, weekly staff meetings, and weekly staff in-service training. As others joined the staff to fill vacancies, training was individualized. Peer counselor staff who were more experienced participated in the training of incoming staff.

We used the outreach and home visiting to invite women to participate in the support groups. We quickly found the home visits to be an integral part of the group development; without continual home visits before group meetings, many of the women did not come. The individual home visits provided opportunities to develop personal relationships with the women and to build on those relationships as a means to encouraging their participation in the support groups. For many women, the establishment of a trusting relationship with the peer counselor over the course of several home visits was needed before they would consider coming to the support group meetings. Among those women who attended the group meetings, it took, on average, three home visits before a woman would come.

As the requirements from the state-funded case management program increased, the home visits also became the avenue for individual needs assessments and many case management functions.

We held the group meetings in clients' neighborhoods. Whenever possible, the group meetings were located in environments familiar to the clients such as community rooms in apartment complexes and housing projects, local Boys and Girls Club facilities, health department sites, and trailer camps. Also, by locating services in the community, we attempted to reduce transportation difficulties. We were able to link with Head Start to provide transportation to two of the groups. We offered bus passes to women in the other groups.

RESULTS

Improved pregnancy outcomes were one goal of the project. Births of women who participated in the project's first year (1993), when the program invited all pregnant women in a neighborhood to the group meetings, were compared to births of nonparticipants in the same zip codes.[6] Nonparticipants were those who we did not identify in the community or who lived in different neighborhoods in the same zip codes. Babies born to program clients (n = 1,117) had a mean birth weight of 3,213 grams and a low-birth-weight rate of 9.6% compared to 3,298 grams and 7.9%, respectively, for those born to nonparticipants (n = 6,975). However, clients had more sociodemographic risk factors identified in the state's screening instrument (mean score of 3.6 vs. 1.9 for nonclients on a scale of 0 to 17). When clients and nonclients with scores of 3 or higher were compared, the difference in low-birth-weight rates was not statistically significant. Birth data for 1994 are forthcoming.

This analysis focuses on the goal of empowerment and collective action. Project impact was reflected in group participation in numbers as well as in content and intensity. Participants' perceptions of the project provided another measure of the impact. Social cohesion, social activism, and collective problem solving also reflect empowerment of group participants. Changes in the personal lives of the peer counselor staff provide other indications of the project's effectiveness.

In 1994, we had contact with 1,403 women. Of these women, 19% came to at least one group. Of those who came to group once, 45% came for at least four groups. Initial participation seemed to be a challenge, but those who came were more likely to return several times.

Participation rates by race and ethnicity and by geographic area are shown in Table 1. Among Black women, 20% came to groups; of those who came, 40% returned several times. Among Hispanic women, 24% came to at least one group; of those who came, 63% returned three or more times after that. The lowest participation rates were among white women (15%), although 44% of those who came to the group meetings returned repeatedly.

As shown in Table 1, initial participation was greater in the rural community than it was in the inner city (31% vs. 18%, $p < 0.01$), as were the return rates (51% vs. 40%).

Another measure of the project's effectiveness was the flavor and content of the group sessions. In keeping with the group meetings' purpose of being a place for women to define their health issues, the topics addressed in the self-help groups were drawn from the expressed needs and interests of the participants. In the group discussions, personal violence, stress, relationships, parenting, physiological and emotional changes during pregnancy, and basic survival issues (food, housing, etc.) were common concerns. These

Table 1. Group Participation, 1994, by Geographic Area and by Race and Ethnicity

	Rural	Urban	Black	White	Hispanic	Total
Number of clients	434	481	683	576	144	1,403
Number of women who came to at least one group meeting	134 (31)	87 (18)	139 (20)	86 (15)	35 (24)	260 (19)
Number of group attendees who attended four or more groups	69 (51)	35 (40)	56 (40)	38 (44)	22 (63)	116 (45)

NOTE: Percentages are in parentheses.

issues were explored in the group within a context of individual choices, decision making, and self-care.

Another measure of project impact can be seen in participants' activities. Relationships in the groups carried over beyond the group. At times, when a group member was hospitalized or needed to be on bed rest due to pregnancy complications, other group members would visit in the hospital or home. Other demonstrations of social cohesion include attending one another's labors and passing on maternity and baby clothes to group members. Some group members demonstrated a strong sense of ownership of the group meetings, taking over leadership and assigning group tasks among themselves.

Participants were asked to describe the project. Among their responses were five recurring themes: seeing the project as (1) a source of education, (2) a source of information and a place where one can be linked with resources, (3) a support group in which one can share problems and feelings with others, (4) a social support group in which one can make friends, and (5) a program to realize personal benefits (such as help getting a high school diploma, a job, or an apartment).[6]

The group meetings also involved collective problem solving. Participants often discussed concerns of how they were treated by various service providers such as physicians; clinic staff; Women, Infants, and Children Supplemental Food Program staff; and Medicaid health maintenance organizations (which were developing at a rapid rate during the course of the project). The director of one of the clinics came to some group meetings, at the request of the participants, to hear their concerns. Additionally, when the farmworker association held community meetings about care at the clinic, group participants discussed the farmworker association's meetings and voiced their own concerns, and some group participants represented their views at the community meetings.

The program trained, to varying extents due to staff turnover, 14 women from target communities. While some staff stayed with the program for only a few months and others for a year or more, all participated in some training. The peer counselors appear to have grown tremendously from the experience. One peer counselor began the program afraid to use the telephone to call public agencies. By the end of her first year with the program, she not only was able to use the telephone but also served as a strong advocate for services for other women who had not yet found their voices. Peer counselors describe an increased sense of empowerment and options since working with the program. Some have stated that the program provides a bridge from low-skilled, dead-end employment to further education and career options. Although no staff enrolled in school during the first 2 years

of the project, peer counselors talked about a wider range of options than they had in the past. The peer counselor who had been with the program since its inception planned to register for a college course for the upcoming semester.

CONCLUSIONS

For those who participated, their descriptions of the program as well as their activities, actions, and repeated participation suggest that the groups played a significant role in their lives and increased social cohesion. The groups did develop a sense of community among participants, encouraging mutual support and problem solving.

The groups demonstrated the power of bringing women together in an atmosphere that encourages active listening, peer support, and empowerment. The effort involved in fostering group participation was substantial, since 81 percent of those contacted did not participate in the groups.

We had hoped that more women would have participated in the group meetings. Although geographic location eliminated transportation problems for some, many of the women with whom we worked were scattered over several miles. Another difficulty with group participation appeared to be that several women were hesitant to try the unknown. Often, women have had negative experiences with other programs and services, and those experiences made them more skeptical about participation. Also, loneliness, isolation, and low self-esteem may have accentuated the fear of the unknown. Additionally, the very idea of coming to a group meeting and "sharing your stuff" was threatening to many women. Transportation remains a barrier. It might have been beneficial to have the groups, as a routine part of prenatal care, incorporated into the comprehensive care package with full support of the prenatal care staff, from receptionist to clinic nurse to midwife.

The higher participation rates in the rural community may have been the result of great social cohesion in that area. It may also be that women in the rural areas had better access to their own transportation than did those in the city. Perceived safety concerns may have played a role in the urban area, although groups in the urban area were held during the daytime. Different relationships within the communities and different perceptions of collective activity held by potential participants might have fostered or discouraged participation in the groups. Another possibility is that other programs targeted at the urban community had disappointed participants and raised the suspicions of women in that area, while first-generation Hispanics in the rural area had had minimal previous contact with social service agencies and community-based programs and so may have been more receptive. Clear explanations are lacking for the lower participation rates by whites.

Another possible explanation for the differences in group participation may have been the skills of the individual peer counselors. The peer counselors facilitated the groups, although some found it very difficult. Some were uncomfortable with group members' sadness or posed problems and tended to respond by glossing over the problem and, in effect, often stifling the group problem solving. Other peer counselors found it difficult to openly disagree with their peers and stated that they felt presenting an unpopular view would be "acting phony."

The program was an externally imposed process, not a grassroots development. Alinsky's approach of community organizing advocates setting up structures and interactions to bring people together in a community.[7] An alternative approach stresses the importance of building on efforts that originate in the community.

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Can a program foster community development and empowerment? Can empowerment education occur in the context of a program and a circumscribed funding source? What basic ingredients are needed? Jackson, Mitchell, and Wright describe an empowerment continuum spanning personal empowerment through community organization to political action.[8] The Resource Sisters/Compañeras Program appears to have had some success in "capacity building . . . nurturing . . . and building upon the strengths, resources and problem solving abilities already present in individuals.[1]

The groups discussed issues and concerns of the participants and struggled with envisioning change. The discussions often did not move beyond the immediate needs of the participants, and explorations of how the immediate situation was linked to social environmental factors often were not developed. However, the group meetings created the structure of active listening and gave participants the forum for defining their own issues, representing the personal end of the empowerment continuum.

Robertson and Minkler point out that "empowerment occurs in a climate that first of all fosters it ideologically."[1] This case study demonstrates how the commitment to empowerment must occur on all levels. Empowerment efforts are likely to be most successful when the commitment to empowerment and community development is consistent, held closely by funding sources and staff, and reflected in organizational structure and activities.

Several factors confined the program's success in terms of empowerment. The circumscribed nature of the local funding, the individual approach of the local funding's program, the fact that the program was externally imposed on a community, the focus on pregnancy, the community environments, and the lack of empowerment education skills among all levels of staff appear to have been factors that mitigated against full development of empowerment education.

It is extremely difficult to use money from one prescribed purpose to do a new approach. The local funding, from the state Healthy Start case management program, played a very strong role in the day-to-day functioning of the program. The number of pregnant women requiring state-prescribed case management in the communities we targeted were more than twice what was originally expected. The requirements of well-documented individual assessments and case management ultimately drove the program, overshadowing the focus on groups and community development. The pressure to ensure that individual case management occurred left little time or energy to focus on community building.

The local Healthy Start funding was based on a medical model of individual services for clients defined by their deficits, as determined by a screening score. This approach also weighed heavily against community development efforts based on tapping the resources in the community.

The focus of the program on pregnant women, due to the funding source, also limited the program. Empowerment education is a developmental process. The maternity period is short and usually is a period of intense inner focusing. As a group works through pregnancy and early infancy, with many other changes occurring in participants' lives, it may not hold enough opportunities to build the ongoing process of realizing one's own power and collective action. This speaks to the need for a comprehensive approach that allows the opportunity for developing long-term relationships.

Although our program goal was empowerment education, staff were trained with one-on-one counseling skills. While we could discuss the concepts, they were not fully

internalized among the staff training the community workers and/or staff did not have the skills needed for fostering empowerment. Additionally, as discussed earlier, the demands of training staff to do individual case management detracted from the development of empowerment education skills. All community worker staff felt that it was much harder to facilitate the groups than to do one-on-one home visiting and case management.

We found that the administrative and training staff needed to develop skills in working with peer counselors. To foster empowerment of clients, we needed to foster empowerment of the peer staff. We had to learn to step away from the hierarchical approaches we have seen in the past. We had to learn to recognize our own need to have people depend on us. We had to work hard to develop a participatory approach with the peer staff, letting them make more decisions and have a full say in program operation.

Ultimately, the lack of societal action by program participants was not a failure of the implementation of the project; rather, it was the result of an overambitious assessment of what any targeted intervention might achieve, given these restraints. For empowerment education to succeed, it must be fully supported as the heart of the program by those funding the program as well as by those implementing it. It cannot happen as an "extra" superimposed on a one-on-one intervention approach that focuses on deficits. The best promise for success lies in efforts that hold empowerment and community development as core functions, with full support of funders and staff.

SUMMARY

Through the peer counselors and peer support groups, the Resource Sisters/Compañeras Program created conditions and environments conducive to empowerment. The group meetings succeeded in fostering collective problem solving and social cohesion among some of the participants. Empowerment occurs along a continuum, and the program created opportunities to move individuals, groups, and, to some extent, communities along that continuum. However, the program's success was limited, in part, by the conflicting mandates of its funding and the limits of staff skills. Community empowerment cannot be a side dish to a medical model of services.

EPILOGUE

At the time of this writing, project staff decided to separate the two funding sources and two program foci (individual case management and community development components). The local health department will continue the individual case management. A community organization controlled by its own constituency, Farmworkers Association of Florida, will continue the community development and peer support group aspects of the project. The peer support groups should mesh well with the association's mission of community organizing and its grassroots foundation.

As the project enters this next chapter, the peer counselors will direct the project collectively. The peer counselors know what clients need and have the commitment to help them, the vision to carry on the project, and, now, the skills to make it work. The peer counselors have asked a nurse who had worked with the project to continue as their consultant. Empowerment means control over your life, and empowering programs are more meaningful and appropriate when the decision makers are the people served.

References

1. Robertson A, Minkler M: New health promotion movement: A critical examination. *Health Educ Q* 21:295-312, 1994.
2. Wallerstein N, Bernstein E: Empowerment education: Friere's ideas adapted to health education. *Health Educ Q* 15:379-394, 1988.
3. Wallerstein N, Bernstein E: Introduction to community empowerment, participatory education, and health. *Health Educ Q* 21:141-148, 1994.
4. Rappaport J: The power of empowerment language. *Social Policy* 16:15-21, 1985.
5. Lofquist W: *Technology of Prevention.* Tucson, AZ, AYD Publications, 1989.
6. Gulitz E, Coulter M, Bellamy H, Newman C, Maragos J: *Evaluation of the Sisters/Compañeras Project, October 1992-June 1994*. University of South Florida, Tampa, 1994.
7. Alinsky S: *The Professional Radical: Conversations with Saul Alinsky*. New York, Harper & Row, 1970.
8. Jackson T, Mitchell S, Wright M: The community development continuum. *Community Health Studies* 13:66-73, 1989.