

Empowerment in Rural Viet Nam: Exploring changes in mothers and health volunteers in the context of an integrated nutrition project*

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Abstract

Empowerment is often cited as a fundamental component of health promotion strategies. Anecdotes suggest that Save the Children's integrated nutrition project empowers local women and health volunteers. The aim of this research was to document the degree to which this is being accomplished. Using qualitative methodologies, we conducted a cross-sectional assessment to compare self-reported changes in identified empowerment domains among 17 program health volunteers and 20 mothers involved in a child nutrition intervention and among five Women's Union leaders and five mothers in a non-intervention comparison commune. Intervention mothers reported increased knowledge, confidence, and information sharing about child-care and feeding, while non-intervention mothers reported minimal changes in these domains. Both intervention health volunteers and non-intervention Women's Union leaders expressed improvements in knowledge, confidence, and relationships with community members. In this study we found that the relative increases in empowerment were greater for mothers than for health volunteers. Intervention mothers reported more sharing of information on child

relationships with community members than Women's Union leaders. The increased information sharing has positive implications for spread of key messages to families that did not directly participate in intensive feeding and the sustainability of the intervention's impact. Future research should focus on developing culturally specific concepts of empowerment to better understand the effects of empowerment efforts. This study's identification of empowerment domains will inform future empowerment studies in Vietnam.

Key words: empowerment, positive deviance, child nutrition, nutrition education, health volunteers, Viet Nam

Introduction

Empowerment is often cited as a fundamental component of strategies to improve the complex and inter-related causes of child malnutrition [1]. Viet Nam has one of the highest rates of child malnutrition in the world** [1–3]. To address this problem, Save the Children Federation/US (SC) uses a positive deviance (PD) approach to *empower* communities to rehabilitate malnourished children through their community empowerment and nutrition program (CENP) [4].

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Mention of the names of firms and commercial products does not imply endorsement by the United Nations University. *care with neighbors. Health volunteers developed closer*

* The ViSION (Viet Nam study to improve outcomes in nutrition) project evaluated the implementation and impact of an integrated nutrition program on the nutritional status, morbidity, diet of, and care for children 5 to 25 months old at baseline in rural Viet Nam, through a partnership among Save the Children/US (Hanoi and Westport, Conn., USA), the USAID-funded LINKAGES Project (Washington, D.C.), Emory University's Rollins School of Public Health (Atlanta, Ga., USA), and the Research and Training Center for Community Development (Hanoi).

** Between 39% and almost 50% of children under-five years old are stunted and underweight, (underweight-weight for age with a less than -2 Z score).

While the term empowerment has become popular in the fields of public health and community development, there is no single accepted definition of its meaning [5]. The World Health Organization (WHO) incorporates the concept within its philosophy of “enabling people to increase control over, and to improve, their health” [6]. Empowerment has been defined as a process by which individuals or communities gain mastery over their lives [7]. The breadth of definitions is an acknowledgement that empowerment is a dynamic and contextually based phenomenon for which a single definition or set of outcomes may not be appropriate [7]. The interconnectedness and synergy between multiple levels of empowerment (e.g., individual and community) adds complexity to the concept and further supports the need for context specific analysis [5, 8].

A single definition of empowerment is elusive, in part because the meaning of the root word, *power*, is difficult to understand outside a social context [9]. In Viet Nam, for example, the concept of power invokes a negative sense of individual decision-making or control at the expense of the group. In this case, a positive notion of empowerment is only understood within the context of the family or community, not as an individual phenomenon alone. To explore empowerment changes within a particular context, several studies have used context-specific empowerment domains as proxies to assess an intervention’s empowerment effect [10–12].

PD can be most simply defined as “success in spite of hardship.” Within the context of SC’s CENP program in Viet Nam, the PD approach was used to identify PD families, resource-poor families who have thriving well-nourished children [13]. Through PD inquiries, community members and program staff interviewed identified PD families to understand how they kept their children well nourished. Locally selected health volunteers (health volunteers) are critical to the success of the program. During 12-day nutrition education and rehabilitation program (NERP) sessions with caregivers of malnourished children, health volunteers promoted the locally identified child-care and feeding practices learned from local PD families. Health volunteers also monitored the growth of commune children, visited caretakers’ homes to encourage them to adopt PD behaviors, and reported program progress to the rest of the community.

Although the CENP effort had been found to positively impact child nutrition [14], its effect on empowerment had yet to be studied. This article compares self-reported changes in empowerment domains among health volunteers and mothers participating in the CENP with Women’s Union (WU) leaders and mothers in a non-intervention commune.

Methods

Study site and subjects

This study was conducted in two phases between June and August 2000. Phase I consisted of in-depth interviews with Vietnamese development professionals in Hanoi to identify empowerment domains to be explored in Phase II. These domains included access to resources, knowledge/education, confidence, decision-making, participation in social activities, community support/relationships, community problem-solving and community reaching-out-to-others for help.*

In Phase II, we conducted semi-structured interviews in three communes in northwest Viet Nam—An Dao, Phu Nham, and Phu Khanh. We randomly selected one CENP intervention commune and a comparison non-intervention commune from 12 communes participating in the ViSION project’s evaluation of the CENP [15]; the second intervention commune was chosen based on its demographic similarity and geographic proximity to the “empowerment” study area. The socioeconomic and nutritional characteristics of the CENP communities have been described in detail elsewhere [MISSING REF NUMBER].

Subjects from the CENP intervention communes included 17 health volunteers and 20 mothers of children under three who attended at least one NERP session. In the comparison commune, we interviewed five Women’s Union leaders and five mothers of children under three. Women’s Union leaders in Viet Nam implement government programs at the local level including credit schemes and family planning [16]. Hamlet-level Women’s Union leaders are elected by local union members. More than 50% of Vietnamese women over 18 years of age belong to the union and most of the 11 million members are rural women between the ages of 30 and 50 [17].

We chose Women’s Union leaders as a comparison group because most of the CENP health volunteers were also leaders in the union, and we wanted to measure increases in empowerment due to involvement in the CENP over and above that which may result from being a union leader. Sixteen of the 17 health volunteers in this “empowerment” study also worked as leaders in the Women’s Union. All the health volunteers in the two intervention communes were interviewed except for one who was ill. Two methods were used to select mothers for the study. Either a mother volunteered at a NERP session and was interviewed at the NERP location, or a health volunteer asked a mother to participate and we interviewed her in a health volunteer’s home or

* Description of methods from Phase I in Hendrickson J. Empowerment in Vietnam: Exploring changes in mothers and volunteers—unpublished master’s degree thesis. Emory University, Atlanta, Ga., USA, 2001.

at the community center. Twice, the original mother selected by a health volunteer was not available to be interviewed, and the health volunteer asked a different mother to participate.

Instrument development

The principal investigator developed the data collection instruments with input from individuals experienced in qualitative research in Viet Nam. Senior Vietnamese SC staff also reviewed the question guides and provided valuable feedback on content and cultural appropriateness. The guides were translated into Vietnamese and translated back into English for SC staff to check for accuracy. After pre-testing, we made further modifications to improve comprehension.

Semi-structured field guides were used to inquire about changes in the lives of health volunteers and mothers since the start of the intervention six months earlier. We focused the field guide questions on changes in three of the identified empowerment domains: decision-making, community support (relationships with other community members), and confidence. We selected these key empowerment domains based on discussions with SC staff and other researchers familiar with the CENP. Knowledge, also a key domain, will be assessed in other ViSION project reports. We asked a fixed list of open-ended questions about these domains, followed by probes. To gather information on changes in other areas, we asked health volunteers to explain, "How has your life changed since you became a health volunteer?" and we asked mothers to explain how their lives had changed since attending the NERP, followed by probes. In the comparison commune, we slightly adapted questions to refer to changes in Women's Union leaders' lives since becoming leaders, and we asked mothers about life changes in the last six months. We used six months as a timeframe because at the time of the interviews, the CENP had been active for about this amount of time.

Socio-demographic characteristics included age, years of education, and socioeconomic status. A family's socioeconomic status was determined through self-identification as "hungry," "poor," "enough food," "better off," or "rich" [15].

Data collection

The principal investigator worked with a research assistant/translator who had previous experience conducting in-depth interviews regarding maternal and child health in Viet Nam. The assistant conducted all interviews in Vietnamese, each lasting approximately one hour. Before each interview, the assistant explained the research goals to the participant and obtained consent for interview participation and audiotaping. We tape-recorded all the interviews and took notes in case

of recording failure. The principal investigator and assistant translated interview notes and checked them against recordings for accuracy and completeness at the end of each day. To further check translation accuracy, a bilingual Vietnamese sociologist in Hanoi transcribed 10 tapes verbatim. We found few differences between these transcripts and the translations conducted by the assistant and the principal investigator in the field.

Data analysis

We entered English translations of interview narratives into Word and Excel (Microsoft Corporation, Redmond, Wash., USA) for analysis. Results were analyzed in two ways. The first involved reading through all the interviews several times and identifying, coding, and compiling key words and phrases by themes. We then reviewed each theme and divided it further into key domains. We entered the results by theme, and by domains within themes, into a Microsoft Word document. The second method involved reviewing narratives and grouping responses from different respondents in an Excel document and analyzing them for common themes. Each method resulted in similar findings. The principal investigator reviewed observations, preliminary findings, and key interpretations with the assistant, a Vietnamese sociologist, to assure cultural accuracy and reach interpretive consensus.

Results

Demographics

Health volunteers were somewhat younger, less educated, and less economically well off than the comparison Women's Union leaders. Intervention mothers were somewhat older than, but of similar educational and socioeconomic background, compared to comparison mothers (tables 1 and 2).

Intervention communes: health volunteers

Changes in four domains emerged from the health volunteer interview narratives: knowledge, confidence, relationships with community members, and a sense of satisfied contribution (table 3). We had specifically asked about two of these domains in the interview guides: relationships with community members and confidence. The other themes emerged when asked, "How has your life changed since you became a health volunteer?" and "What things do you feel more able to do since you became a health volunteer?"

Although the volunteers were not specifically asked about knowledge they gained from the intervention, the domain of increased knowledge was one of the most prominent when describing changes in their lives.

TABLE 1. Socio-demographic s of health volunteers and Women's Union leaders

Variable	Intervention communes Health volunteers <i>n</i> = 17 (%)	Comparison commune Women's Union leaders <i>n</i> = 5 (%)
Age (yr)		
Range	31–54	40–48
Mean	38.2 (6.3)	41.4 (7.2)
Education		
Incomplete junior high school	5 (29)	1 (20)
Complete junior high school	9 (53)	1 (20)
Incomplete senior high school	2 (12)	2 (40)
Complete senior high school	1 (5)	1 (20)
Socioeconomic status		
Poor	2 (12)	0 (0)
Enough food	13 (76)	2 (40)
Well off	2 (12)	3 (60)

Health volunteers are community empowerment and nutrition program health volunteers.
SD in parentheses.

TABLE 2. Socio-demographics for participant mothers

Variable	Intervention communes Mothers ^a <i>n</i> = 20 (%)	Comparison commune Mothers ^b <i>n</i> = 5 (%)
Age (yr)		
Range	22–36	22–33
Mean	27.7 ± 5.4	26.6 ± 5.8
Education		
Complete elementary school	1 (5)	0 (0)
Incomplete junior high school	13 (65)	3 (60)
Complete junior high school	5 (25)	2 (40)
Incomplete senior high school	0 (0)	0 (0)
Complete senior high school	1 (5)	0 (0)
Socioeconomic status		
Poor	7 (35)	2 (40)
Enough food	13 (65)	3 (60)
Well off	0 (0)	0 (0)

a. Mothers of children under three years old who had attended at least one NERP session.

b. Mothers of children under-three years old.

“Knowledge” appeared 89 times in the transcripts of 17 health volunteers. Volunteers described how their new knowledge affected not only their ability to care for children in the NERP sessions, but for their own children as well.

Many volunteers' testimony showed that increased knowledge was related to two other domains, increased confidence and satisfaction from making a contribution to their community. Health volunteers expressed greater confidence in their ability to care for children and teach other mothers how to do so. They indicated these changes came from seeing children in NERP sessions gain weight and mothers learn the PD child-

care and feeding lessons [15]. One health volunteer explained,

Before I didn't know exactly which foods available in our commune were good for children. Now I feel confident when I tell mothers which foods to feed their children. They don't have to be afraid.

In a few cases, the CENP health volunteers also expressed greater confidence in other areas of their lives, including taking care of their own families and participating in community activities. For example, one volunteer said,

Because I have a chance to have training in the program and talk to many people I'm sure about my knowledge. Now, I feel more confident when I attend any commune activity.

All of the health volunteers interviewed reported that relationships were "closer" between the volunteers and community members, especially the mothers of young children attending NERP sessions. One participant who had been a Women's Union leader for many years explained,

...everyone is friendlier to me. When I go out in the commune, people ask me if the children have gained weight. The relationship is closer. I know that they care about me and care about the program.

Three of the 17 participants also mentioned how becoming closer to other women through the program influenced their work in other community activities. One explained,

I think when I became a health volunteer it made my work in the Women's Union easier because now I am closer to the other women.

A fourth domain that emerged from the volunteers' narratives was the sense of satisfaction and happiness women expressed in connection with the program. This satisfaction was most often expressed in terms of contributing to improving the lives of the mothers and children in their community, as well as in their own family. One volunteer offered,

We are happy because we're healthier than before. My children are well and can eat much more than before. We are healthier and stronger, and I know how to make my life better.

Another volunteer spoke about the importance she felt in contributing to the future of her community. She said,

I think of the children's future. When they grow up, they can become good members of society, so I have to try to do it.

Only one participant indicated any change in community or household decision-making.

Comparison commune: Women's Union leaders

Results from interviews with Women's Union leaders were similar to those of the CENP health volunteers. The union leaders described changes in knowledge,

confidence, a sense of satisfied contribution, and community relationships (table 4). However, unlike the health volunteers, the union leaders also mentioned changes in household decision-making since becoming a Women's Union leader.

Four of five Women's Union leaders mentioned increased knowledge as a result of their participation as a leader. Increased knowledge in these narratives focused on how to improve a family's economic condition, a major concern of most study participants. When asked how her life had changed since becoming a union leader, one participant explained,

[There are] many changes in my family. For example, because I have more knowledge on how to raise pigs or chickens, my economic condition has improved.

The Women's Union leaders also expressed gaining confidence through their roles as leaders. One said,

I feel more confident when I do some things now. When I want to do some 'big' things I feel surer. When I want to buy or decide something in the family with my husband, I feel more confident.

Like the health volunteers, the Women's Union leaders expressed satisfaction from making a contribution to their community. All of the union leaders interviewed discussed their interest in wanting to help other women in their commune and their happiness that they were able to improve the economic condition of other families, as well as their own. Changes in community relationships differed between health volunteers and Women's Union leaders. The CENP volunteers mentioned "closer" relationships with mothers due to frequent contact with them. The Women's Union leaders stated that they felt more trusted and respected in the commune now that they were leaders. Changes in decision-making also differed between health volunteers and Women's Union leaders. While only one health volunteer mentioned any change, four of the five union leaders said they now made more decisions in their households.

Intervention communes: mothers of children under three

Changes in three domains emerged from the mothers' interviews: knowledge, confidence, and information sharing (table 3). Mothers were specifically asked about two of these areas, changes in information sharing and confidence.

While mothers were asked about decision-making, none expressed any change. Changes in knowledge emerged from questions, such as, "How has your life changed since attending the NERP?" "What do you feel more able to do now than you did six months ago?" and "How did your child become healthier?" Mothers

TABLE 3. Changes in empowerment domains self-reported in field interviews

Domains identified by Vietnamese key informants in Hanoi (Phase I)	Domains from interviews with health volunteers	Domains from interviews with comparison commune Women's Union leaders	Domains from interviews with intervention mothers	Domains from interviews with comparison commune mothers
Access to resources	NA	Increased economic status	NA	NA
Knowledge/education	Increased	Increased	Increased	Increased for one
Confidence	Increased	Increased	Increased	Increased for one
Decision-making	Increased for one	Increased	No change	No change
Participation in social activities	Increased for three	No change	No change	No change
Community support	Closer relations with community members	Increased respect	NA	NA
Community solves their own problems	NA	NA	NA	NA
Community reaches out to others for help	NA	NA	NA	NA
Other	Increased sense of contribution and satisfaction	NA	Increased sharing advice	NA

NA, not applicable; no mention of concept.

were asked about changes in sharing information as an indicator of changes in knowledge and confidence.

New knowledge was the most often mentioned domain in the mothers' narratives, and many explained that their children were healthier in part because of this. One mother explained,

Before I felt that my child was malnourished, but I didn't know how to help him. Around me was a lot of food like shrimp and crab, but I didn't know it was good for my child. The health volunteer showed me how to cook [these foods].... Now when I catch a crab or snail, I can cook this for my child. My child is healthier due to the knowledge [I gained].

CENP mothers interviewed also reported gaining confidence in what to feed their children after attending the NERP. One mother said,

I learned from the program which foods are good for my child. Now I know how to put a lot of different foods together at each meal. I feel more confident because I understand better.

According to the mothers' reports, acquiring new knowledge also led to increased sharing of information on child feeding with other community members. The majority of mothers said that before the intervention they did not give advice on child feeding. One mother explained,

When I was working in the field, someone asked me about how to take care of children. But I said I wasn't sure about how to make the child gain weight.

When asked if they gave any advice recently, more than half of the women responded that they could now give advice. Knowledge and confidence led to information sharing. One mother claimed,

Now it's changed very much. When I take care of my child at the program, everyone sees that my child is stronger and they ask me how I cook and take care of my child. I tell them everything I learned in the program.

Two mothers also explained that their knowledge from the program had also helped them change the opinions of their husband and parents-in-law. One described it this way,

Before this program, I couldn't change the opinion of my parents, because the elders always thought crab and snails were not nutritious. So when I attend this program, I learn about nutritious food and can explain it to my parents.

Comparison commune: mothers of children under three

Mothers in the comparison commune reported few changes. In terms of changes in knowledge or confidence, only one mother, a 33 year-old member of the Women's Union, reported feeling more confident to feed her child because of knowledge on child nutrition she had gained from Women's Union meetings. When asked how they learned what foods to feed

their children and how to care for their children, most comparison mothers reported that they “learned by themselves” or received information from the Women’s Union or health center. None of the mothers reported that they had given advice on child-care or feeding to other mothers.

Discussion

This study used in-depth qualitative methods to identify key domains of empowerment in Viet Nam and to document changes in domains among the CENP health volunteers and mothers. While both participant mothers and volunteers involved in the CENP reported increases in certain empowerment domains, the relative increases were greater for mothers than for health volunteers.

Findings from health volunteers

This study suggests that health volunteers’ participation in the CENP resulted in changes in their knowledge, confidence, relationships with community members, and sense of satisfied contribution. While the reported changes in knowledge and confidence mostly related to child-care and feeding, several health volunteers also said they felt more confident participating in other community activities.

Although the key informants in Phase I did not specifically identify sense of contribution as a domain of empowerment, underlying all identified domains was the notion that individual empowerment in Viet Nam is “good” only when pursued for the benefit of the individual in addition to the family and community. In Vietnamese culture, emphasis is often placed on the well-being of the family and community above the individual [18], and empowerment outside of that context invokes a sense of individual decision-making at the expense of the group. Thus, the empowerment in a Vietnamese context is generally regarded as positive only when it benefits the family and community, along with the individual.

Women’s Union leaders in the comparison commune reported changes in knowledge, confidence, and a sense of contribution similar to the CENP health volunteers. Both groups also reported changes in their relations with community members. These similarities suggest that it is the act of becoming and participating as a community leader, either as a health volunteer in the CENP or a leader in the Women’s Union that results in “empowering” changes. Other studies have similarly found that participation in community activities can empower participants by providing the opportunity to develop self-efficacy or self-esteem [5, 6, 10, 12, 19], learn and practice new skills [10, 11, 20], gain information, help others, and increase one’s social support network [21].

However, changes in decision-making varied between health volunteers and the comparison Women’s Union leaders. Only one of 17 health volunteers reported any change in household decision-making, but four of five Women’s Union leaders reported increased participation in household decision-making since becoming a leader. This difference may be that Women’s Union leaders learn from the union not only how to mobilize and teach women to feed and care for children, but also how to improve their family’s economic condition. The former is the accepted role of women in Viet Nam [22], but the latter may have more impact on decision-making with husbands and family elders. Recent studies in Viet Nam found a shift toward more equitable household decision-making in the families of women who participate in development credit interventions [22].

Attitudes towards community relationships also varied. Women’s Union leaders reported noting greater respect from community members, but not the increased closeness reported by the health volunteers. One health volunteer, who was also a Women’s Union leader, explained that this difference was due to the greater amount of time health volunteers spent with mothers compared to typical union leaders’ activities. These results suggest that health volunteers were able to build closer relationships with community members through their CENP activities than through their Women Union activities or compared to their Women’s Union leader counterparts. The significance of close relationships with community members is reflected in the importance of sense of community and community support found in empowerment studies [7, 10–12, 23].

Findings from mothers

Mothers who had participated in NERP sessions were more likely to report increased knowledge and confidence in child feeding and care practices and increased sharing of advice with others as compared to comparison mothers. While increased sharing of advice was not originally identified as an empowerment domain, it illustrates the mothers’ increased confidence and knowledge about child-care and feeding, as well as community support. These results are relevant not only in terms of the CENP’s empowerment impact, but also in terms of sustainability. As mothers gain knowledge and confidence, they may pass their knowledge along to other community members not directly targeted by the intervention.

In addition to sharing information with neighbors, two CENP mothers explained that their increased knowledge from the program helped them change the opinions of their in-laws who objected to feeding children crabs and snails, two locally identified “good” foods. This represents a significant step for a mother

who may not regularly participate in household decision-making about food.

In contrast, comparison mothers reported almost no changes associated with any empowerment domains. None reported giving advice to women in their hamlet on child feeding or care, and only one reported greater knowledge and confidence about child care than she had six months earlier. This lack of reported change among women in the comparison commune suggests that increases in the empowerment domains in the intervention mothers were due to participation in CENP activities rather than societal influences associated with economic reforms, mass media campaigns, and the like.

The changes reported by CENP mothers appear consistent with empowerment at the individual level. Narrowly defined, individual empowerment is similar to the development of self-efficacy [5, 6, 10, 12, 19]. CENP mothers did not report greater confidence or ability to address other obstacles that they had identified as relevant to child health, such as poverty and lack of time. However, most reported greater knowledge and confidence to address immediate causes of child malnutrition, such as inadequate dietary intake [1].

The multiple levels of empowerment in terms of a continuum from personal change through community action to social/political action have been discussed elsewhere [24]. In the case of the CENP, a mother's success in rehabilitating her child through her knowledge and actions is likely an individual level empowering experience, which in turn led to increased personal confidence and information sharing with others.

This study had a number of limitations. It is possible that the 20 mothers interviewed differed from other CENP mothers. However, there were no apparent differences in responses between mothers whom we selected ($n = 6$) and those selected by the health volunteers ($n = 14$). The relationship between participation and empowerment could be confounded by age, marital status, or other factors correlated with being a health volunteer or a Women's Union leader. For example, the somewhat better education and economic status of Women's Union leaders versus health volunteers may have limited the empowerment possibilities for the health volunteers. However, past research found that the relationship between participation and empowerment remained after age and socioeconomic status were controlled [20]. Incomplete or biased recall might have influenced responses about events that

had occurred six months or several years prior to the interview. In some respects, the study is biased against detecting change among the health volunteers. In addition to the differences in socioeconomic status between health volunteers and Women's Union leaders noted above, the comparison union leaders reported changes occurring over several years while health volunteers reported on changes only in the previous six months. Finally, many health volunteers were already Women's Union leaders so detecting incremental changes may have been difficult. Overall, this limitation makes the health volunteer findings all the more robust.

In summary, this study found that participation of mothers and health volunteers in the CENP resulted in changes in several empowerment domains. While there is little doubt that empowering community health workers and participants will lead to better outcomes, few programmers know if their empowerment efforts actually work. Specific to the ViSION study, we were most encouraged to find that participant mothers commonly share information with neighbors and are more confident to implement new child feeding and care strategies. This may well be an important mechanism through which PD-informed interventions lead to better and sustainable health outcomes. Future research should focus on developing culturally specific understanding and measurement approaches of how and to what degree empowerment can be achieved in a given program. Such tools will ultimately lead to more efficient use of resources and more effective interventions.

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