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Empowering women health care providers in rural Tibet

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Empowering Women Health Workers in Rural Tibet

Jampa Xiangbalacuo

PIM 75

A Capstone Paper submitted in a partial fulfillment of the
requirements for a Master of Arts in Intercultural Service, Leadership
and Management at SIT Graduate Institute

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Abstract

This paper begins with an overview of the issue of healthcare in Tibet, focusing on how women's access to the quality of healthcare and leadership has been denied due to their lack of political, economic and social rights. Most Tibetan women are dying from preventable causes because they do not have access to basic essential health services. This paper presents an outline of the Pende Clinic, in rural Tibet, including contextual information and preliminary data gathered through interviews and observations. It follows with a proposal to incorporate the process of women's empowerment in the healthcare system. A number of studies of empowerment are analyzed in-depth and further illustrated through the conceptual framework of women's empowerment within three dimensions: resource, agency, and achievement by Naila Kabeer. It argues that these three dimensions of women's empowerment are indivisible in the process of improving healthcare, exemplified by two prominent case studies, in India and Tibet. Based on the findings and analysis, recommendations are provided for the Pende Clinic as a set of guidelines for the standard practices and the implementation of plans for expansion, improvement, and empowerment in providing essential healthcare services in rural communities of Tibet. **Key Words/Concepts:**

Tibet / Healthcare

Resource

Empowerment /Women's Empowerment

Agency

Gender/Gender roles

Achievement

Maternal Mortality

Women Health Practitioners

Introduction

In the summer of 2016, I went home to Tibet to carry out a needs assessment of Tibetan women entrepreneurs. I was aiming to interview 10-15 women to learn about their fundamental needs and how they overcame the challenges they faced. I wanted to learn about the issues from the women's perspectives, what opportunities are available to them, how they arrived at the place they are now, and what expectations they experienced from their families and communities that hinder their lives. I organized the findings into three categories including their personal stories (who they are), their career or vision (what they do or what they aspire to do), and challenges (what prevents them from doing what they want to do or do better).

I talked with a seamstress, who does both tailoring and designs Tibetan robes, has a vision to become the primary source for people who want Tibetan clothes: to preserve tradition and culture, and to train women with the skills so they can become financially independent. A businesswoman/executive director of a small tire repair company has a vision to train men and women in rural Tibet to start their own business and deliver the services in their communities. I also talked to a 24-year-old young mother of two children. After she finished the fifth grade, she attended a training program where she learned how to sew Tibetan clothes. However, she dropped out of the training program and got married. Her vision is to have her own store where she sews Tibetan robes and earns some income so she can send her children to school. Meeting with these women, who have been fearlessly working to bring about changes to their families and communities in

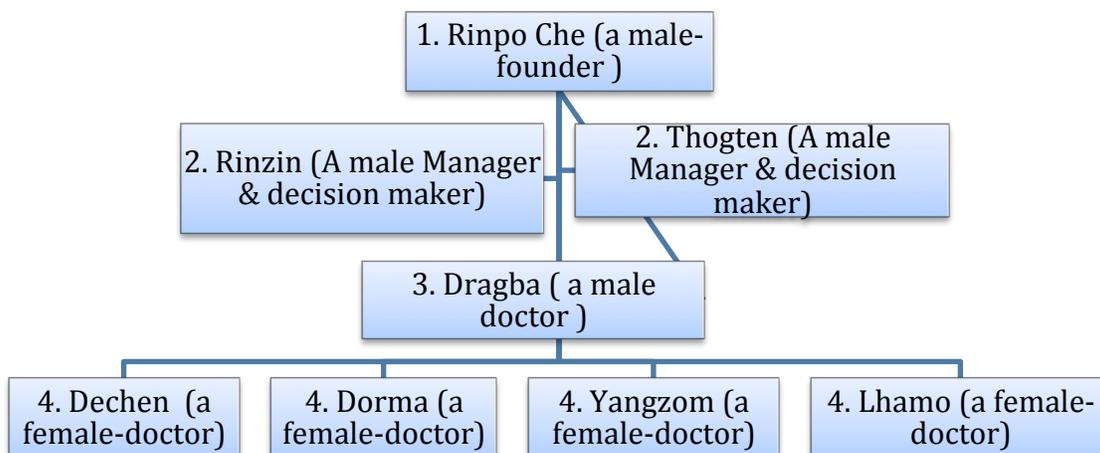
spite of all the barriers in their lives, has inspired me. I realize every one of my interviewees is working towards a grander vision notwithstanding all challenges, expectations, and inequality they face in their everyday life.

My visit to the Pende (Help for Happiness) Clinic, located near my village in rural Tibet, galvanized my passion for women's empowerment and leadership in the medical field. At the Pende Clinic, there are four women doctors, who are working tirelessly to serve their local communities 24 hours a day, seven days a week, with Tibetan traditional herbs and Chinese medicines. Even though the medicines and their work are helping many people, they have very limited resources. There are no exam rooms, no patient beds or even chairs. I observed patients sitting on the cold cement floor outside with their IV drips hanging from the windows. Doctors shared with me they have to boil and reuse syringes because they do not have autoclaves or enough disposable syringes.

My trip to the Pende Clinic has made me realize my most urgent priority is to collaborate with these admirable, dedicated and passionate women doctors to understand their needs such as medical supplies and training in surgery, as well as how to improve their capacity to offer other advanced and life saving procedures. The women doctors are interested in finding practical strategies for long-term expansion of the clinic to construct patient rooms, exam rooms, diagnostic equipment and basic essential medical services. I am interested in exploring the ways to help empower not only women doctors, but also all women in the rural Garze area of Tibet. Doctors ideally should have the capacity to produce high-quality herbal medicines at low cost. At Pende Clinic, the lack of essential

supplies and the leadership structure limits women doctors from meeting their needs and advancing their skills to provide quality services. The current leadership structure is a typical top-down male-dominated hierarchy.

Leadership Structure at the Pende Clinic



The founder and Executive Director of Pende Clinic is Gyalten Rinpoche, who is a well-known reincarnate lama in Garze. Two administrative managers and the financial manager are all males. Even though women doctors are the primary assets at the Pende Clinic and they are the ones who talk to and serve patients on a daily basis, they have no decision-making power. The women doctors demonstrate determination, kindness, and passion for their work, and they have vision, but due to the leadership structure, limited resources and extremely inadequate infrastructure, the doctors are not able to carry out their vision to provide high quality care. The women doctors stated they are not fully

confident in their clinical skills such as basic surgery, resulting in sadness and frustration when they cannot take adequate care of their patients. For example, they are currently not able to help anyone who arrives injured with a severe wound or broken bones because they do not have the training or supplies to do more than the most minor surgical procedures.

As an approved Independent Study, supported by Advance Humanity, a certified B Corp that works with humanitarians worldwide, I went to Tibet and interviewed women and gathered my primary data for this study. This research paper begins with background information about the Pende Clinic, its context, and an overview of health care in Tibet within the overarching theme of women's empowerment in healthcare to give a clear picture of the issues in women's healthcare. A definitional and conceptual framework of women's empowerment by Naila Kabeer's, is presented to further illustrate three models: resource, agency, and achievement. This paper explores and further investigates a broad range of literature and discourse of relevance to women's empowerment in healthcare illustrated through two case studies in Tibet and India. Analyzing these cases provides in depth meaning and understanding, looking at different mechanisms, strategies, best practices and examples of how to promote women's empowerment to integrate into broader perspectives and holistic approaches. Based on the findings and analysis, recommendations are provided for the Pende Clinic as a set of guidelines for standard practices and the implementation of plans for expansion, improvement, and

empowerment in providing essential healthcare services in rural communities of Tibet. **I am interested in inquiring what are the elements that improve the confidence of women doctors, what resources they need to help them provide quality services and how can empowering and equipping the women doctors with improved skills, resources and opportunities create a ripple effect in communities at large.**

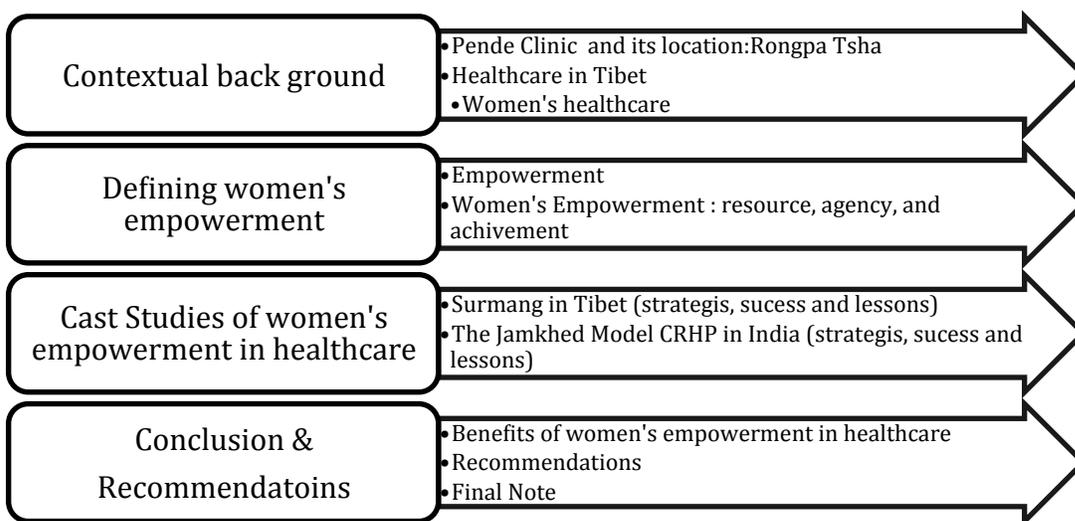
To guide this main research I sought to answer the following sub-questions

Question 1: How does the healthcare system work in Tibet? And what is the context for women's healthcare in rural areas of Tibet?

Question 2): What is empowerment? And what is women's empowerment?

Question 4: What are some of the best examples of women's empowerment in healthcare and what are some strategies and mechanisms that could be effective in Tibet specifically at the Pende Clinic?

Overview of the literature reviews



Background of Pende Clinic and its Services

The Pende Clinic was first established in 2001, in Rongpa Tsha in Ganze County in eastern Tibet Kham, western Sichuan, China, to provide health care to rural Tibetan communities. The Pende Clinic officially opened on July 13, 2003, to treat patients. The doctors stated there are 30 people on average everyday who travel to the Pende Clinic to obtain treatment. The opening of the clinic has been of tremendous benefit to the people in surrounding villages that otherwise would have to travel about 30 to 40 kilometers or more to see doctors in the county town. It has since become the primary health care services facility for the entire Rongpa Tsha area.

The Pende Clinic started with a clear mission to provide the best quality and most affordable health services possible to rural Tibetan communities by improving healthcare standards, providing further training for the women doctors, enhancing public health education, empowering and accelerating women in leadership roles, and building stronger, healthier and happier families and communities.

The ultimate goals of the clinic are:

- * To provide regular weekly or monthly public health and gender-based education in rural communities; raise awareness of the importance of reproductive health and self-care; and to train women to become change agents.
- * To create employment for local people by sustainably producing Tibetan medicines with local resources.
- * To create a pharmacological production center to produce high-quality herbal

medicines at low cost (Independent Studies personal communication, 2016)

In addition to the background information gained through our conversations, the women doctors also shared with me challenges that they face at the clinic as including:

Challenges at the Pende Clinic

1. *Space & Facilities:* The greatest challenge at the Pende Clinic is limited facilities and resources. The Pende Clinic is a one-story building with ten rooms that includes the doctors' residential rooms, a dispensary and a shared kitchen. There is no dedicated space for patients to stay and convalesce. The examination or consultation rooms are the very same rooms in which the doctors live, so it is inconvenient and unsanitary for patients and healthcare providers. In the center of the yard, there is a makeshift canopy with cardboard flooring that serves as the patients' place to stay and get treatment.
2. *Basic Medical Supplies:* The Pende Clinic has a shortage of basic medical equipment and supplies. For example, they do not have enough sterile syringes, surgical tools, medicine bags, scissors, bandages, salves, clamps, chairs, examination tables, and hand sanitizer, hand lotion, soap, etc.
3. *Medicines:* All medicines are imported from other parts of Tibet and China, which is expensive for the Pende Clinic to purchase, so they are unable to sell the medicines to local people at affordable prices.

4. *Training:* The Pende Clinic is unique in that all the doctors are resident Tibetan nuns. The doctors are highly experienced in hands-on training and are trusted by the local community. However, the doctors need further training in specific skills so they can better serve the health needs of their communities.
5. *Technology:* There are no computers and no access to the Internet, which the doctors could utilize to improve their skills and broaden their knowledge. All prescriptions are handwritten and the doctors are quite isolated.
6. *Weather Challenges:* The Pende Clinic has limited access to the power grid and they rely on wood and yak dung to cook and provide warmth in the winter. Without any water heater installation in the building, the cold winter temperatures are a challenge for both doctors and patients when the weather is below zero and the IV fluids freeze (Independent Studies personal communication, 2016)

The Pende Clinic Location: Ronpa Tsha

Ronpa Tsha consists of five townships and approximately 31 villages, with an estimated population of 16,000 with the average altitude of 3,500 meters. There are 18 counties in the Ganze Tibetan Autonomous Prefecture, in Kham, Tibet, and Ganze County is one of the poorest counties with marginal socio-economic conditions and a lack of educational opportunities. The majority of people in the area are farmers or seminomadic. One of the primary income sources is from digging Caterpillar Fungus,

'yartsa gunbu' (ཡུཌ་གུན་བུ་)“summer grass, winter worm” or “worm-grass” or sometimes people call it as “Tibet Gold” (Finkel, 2012). Local Tibetans often climb mountains to seek and dig Caterpillar Fungus to sell to Chinese merchants, who take the fungus back to central China to produce expensive medicine or food. According to an article “China’s prized caterpillar fungus is worth its weight in gold: Fungus known as Himalayan Viagra” (2013), it states, “Millions of Chinese eat caterpillar fungus for supposed medical reasons or because they believe it will enhance male potency.” It is also believed to cure some patients with stomach cancer and breast cancer (2013). For many years, due to socio-economic barriers, many children missed opportunities to obtain an education and a generation of an illiterate population has affected entire communities. The recent influx of Chinese migrants, shifting socioeconomic and environmental conditions, pollution, and a lack of education on proper hygiene and nutrition has caused a current health care crisis across rural Tibet. Rural Tibet is among the poorest areas in China and lacks basic essential healthcare. In the vast and sparsely populated Tibetan regions, there is a high incidence of diseases often caused by malnutrition, as well as a significant lack of medical infrastructure and basic health education (Cao, 2009, p.84). The most obvious concern in the Tibetan health sector has been a lack of investment supporting the development of basic medical facilities, particularly in rural areas like Rongpa Tsha (Healthcare, 2017).

Women’s Healthcare in Tibet: It is important to understand the fundamental double standard Tibetan women face in their daily lives regarding basic healthcare across rural

Tibet. Motherhood and childbirth are one of the most sacred and powerful contributions that women are capable of, yet as noted further on, a high percentage of Tibetan women and newborns are dying of preventable causes in childbirth, similar to the situation in many developing countries around the world.

Globally, an estimated 830 women die every day from preventable causes related to pregnancy and childbearing, and 99% of all maternal death occurs in developing countries (World Health Organization, 2016). The maternal mortality ratio (MMR) for rural Tibet was reported to be as high as 400, even 500 per 100,000 and infant mortality within the first 12 months is as high as 20% to 30% in rural Tibet (Lafitte, 2011). Despite the fact many women die in childbirth, most Tibetans consider childbirth to be a normal process; the majority of women give birth at home with the assistance of their mothers or mother-in-laws (who have no training in attending births). In many cases shortly after a delivery, women start doing house chores, or sometimes they leave their one or two-month-old newborn baby at home with a grandmother to go digging Caterpillar Fungus to earn some income. The result of not taking sufficient time to fully recuperate from childbirth is an increased risk for complications such as hemorrhage, postpartum infections and severe anemia, often due to a lack of education, information, and awareness in rural Tibet regarding care during the pregnancy, childbearing and postpartum periods. Culturally, women are considered to be inferior and also responsible for doing all house chores, even during pregnancy and postpartum. Poor nutrition, a lack

of trained health personnel, long travel distances, and limited access to emergency care are the primary barriers for Tibetan women to attain adequate treatment and assistance in childbirth (Cao, 2009, p.85).

China has made significant progress in reducing maternal mortality. In 2010, the official maternal mortality ratio (MMR) was 46.1 per 100,000 live births, decreased from 95 deaths per 100,000 live births in 1990 (Gyaltzen et al., 2015, p.2). However, China's progress in reducing maternal mortality does not reflect the high MMR in distant rural areas such as Tibet. There are large disparities in outcomes between rural and urban populations in equal access to and the quality of health services for rural, poor, migrants and ethnic minority women resulting in a disproportionate burden of mortality (Lafitte, 2011). Many Tibetan women die alone and unattended by trained personnel; hospitals are too far away, and too expensive. Moreover, International Aid agencies including health NGOs have been required to cease working in Tibet, thus preventing potential opportunities to improve care and outcomes. Due to the lack of infrastructure in rural Tibet, many maternal deaths are not reported and therefore are not included in official statistics (Lafitte, 2011).

During my fieldwork in Tibet, doctors at the Pende Clinic stated that the majority of their patients are women and Tibetan women feel more comfortable and safer sharing their personal health issues with Tibetan women doctors rather than Chinese male physicians in the Government hospitals in the county towns. The county towns are far,

inconvenient and expensive, and women face language barriers in communicating with Chinese male doctors (Personal communication with Pende doctors, 2016). All of these are reasons women choose to come to the Pende Clinic in spite of the limited resources and facilities. Despite the seriousness of their illness, many Tibetan women want convenience rather than expending the resources to go to the county town clinics. It is essential to find ways to improve the existing clinics at the local level by training and empowering Tibetan women doctors to provide quality services to rural Tibetan women and their families.

In global health leadership positions, there is a significant lack of women representation and inclusion. For example, only 54 (28%) of the 194 World Health Organization states employ a woman as their top health official (Down et al., 2016). Globally the absence of women global health leaders is another example of inequity in the science, technology, engineering and mathematics (STEM) fields, which undercuts efforts to advance women's health (Down et al., 2016). Tibet is no exception. The majority of physicians are male and the Pende Clinic is unique in that there are four female doctors on staff who are dedicated to providing accessible, quality respectful care to Tibetan women. However, women doctors at the Pende Clinic are not in leadership positions due to cultural norms, gender roles and power dynamics in Tibetan society. Gender roles and power relations have a significant impact on women's health and every aspect of their lives. Researchers have found that female doctors are crucial in delivering

care worldwide, and play a critical role in conducting and advocating for women's health. Studies also show that female patients often prefer female doctors due to cultural, religious or personal reasons (Down et al., 2016). Similarly, the women doctors at the Pende Clinic shared that many of their women patients expressed their feeling of satisfaction, safety and easiness as apposed to their feelings of being censored, fear, shame and anxiety with male doctors, most of whom are Chinese (Independent Studies personal communication, 2016). The Chief Executive of Save the Children International stated, "women community health workers are the heroes (Sheroes) of their communities, and they can share their knowledge, provide vital medicines and care in their villages and they become empowered women in their communities and wise advocates for health" (Weinberg, 2011).

To advance women's health worldwide, some research shows it is necessary to focus on women's health and empowerment to actively seek to integrate health and empowerment sciences and address the causes and consequences of gender and health disparities, as well as aim to empower women globally to advocate for and achieve the highest attainable standard of health (Center of Expertise on Women's Health and Empowerment, 2009). To improve healthcare for rural Tibetan women, this paper focuses next on the concept of women's empowerment to learn ways in which empowering women could be linked with healthcare to promote social change.

Empower/Empowerment: What does the word empower or empowerment mean? In many languages, there is no direction translation. In Tibetan, it says “dbang cha sprod pa” (to give someone a power or authority) or “nus shugs spel ba” (to strengthen someone’s ability to do something) (Tibetan Dictionary 2012-2016). Similarly, in the English dictionary, empower, or empowerment means, “to give someone the authority or power to do something, or process of becoming stronger and more confident, especially in controlling one’s life and claiming one’s rights” (New Oxford American Dictionary, 2005-2016). Concerning the commonality of both definitions, rather than a comprehensive element, both definitions sound patronizing and passive. According to these definitions, there is a disempowered person as a passive receiver of the power that is given by the empowered person, as a giver. I believe that empowerment is about realization or discovering one’s potential, innate talent, being able to claim one’s rights to exercise justice and perform effectively for the betterment of one’s life and others within a supportive system. The definition in the dictionary lacks a multifaceted dimension and perhaps more importantly, lacks the essential all-encompassing element of self-realization of the power within. Empowerment could mean different things to different people. Robert Adams (2008) points out the limitations and danger of a single definition of ‘empowerment.’ Academics or specialists’ definitions may alter the word empowerment and possibly connect it with practices from the very people they are supposed to belong to. Adams defines empowerment as “the capacity of individuals, groups, and communities to take control of their circumstances, exercise power and

achieve their goals and the process by which, individually and collectively, they can help themselves and others to maximize the quality of their lives (p.7). He emphasizes the significance of empowerment in terms of both personal and collective power and that it is an active process of self-realization and self-help to enhance the quality of their lives.

The notion of empowerment is understood as a transformative process that has the potential to challenge societal inequities, such as conditions rooted in culturally constructed beliefs in gender, class, and race. For individuals and groups, “class, caste, ethnicity, and gender determine their access to resources and power. Empowerment begins when individuals not only recognize the systemic forces that oppress them, but also act to change existing power relationships” (VeneKlasen, L., & Miller, V. p. 53). Empowerment is a process that aims to change the nature of systemic gendered power relations and forces that marginalize women and other disadvantaged groups in a given context.

Conceptualizing Women’s Empowerment: Kabeer’s Three Dimensional Model

The concept of women’s empowerment has been widely supported, and it’s emerging as a significant topic of discussion in many international development communities. According the United Nations Development Program (UNDP) (2012), there are eight Millennium Development Goals (MDGs), achieving gender equality and women’s empowerment, which is particularly relevant to this study. Furthermore, the number four of MDGs is reduction of child mortality and the number five is improving

maternal health outcomes (UNDP). The Millennium declaration reflects a worldwide acknowledgment that women's empowerment and achievement of gender equality are matters of human rights and social justice. Although Millennium Development Goals do not embody the full vision of gender equity, equality and women's empowerment through structural revolution and poverty eradication around the world, having a gender equality agenda on global policy is considered as one of the great successes in our time. There is a growing body of literature on empowerment and discourse on women's empowerment and gender relations. Kabeer (2011) states women's empowerment is "the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them" (p.437).

Kabeer (1999) points out that empowerment entails a process of change that gives power to the disempowered people and increases their ability to make strategic choices. She also argues that people who have the power to exercise choices in their lives may be very powerful, but they are not necessarily empowered because they were never disempowered. When talking about empowerment, we are also talking about disempowerment. When talking about poverty, we talk about the rich as well. Nevertheless, it's not about binary or juxtapositions of these notions in our lives. We should recognize choices open to women are almost always limited compared to men in the same community due to gender inequality. Women may internalize these choices as having less power and status. Kabeer states that "one-way of thinking about power is in terms of the ability to make choices: to be disempowered, therefore, implies to be denied

choice” (p.437). Concerning the complexity of empowerment, questions of what it means to be empowered and what choices we are looking for through the process of empowerment are critical. When we observe power in empowerment, we may automatically assume that if one has the power to make choices in life, one is empowered. When we talk about women’s empowerment, some may assume this is a women’s strategic plan to replace or take over a man’s power. It’s crucial to understand that “women’s empowerment does not imply women are taking over control of authority previously held by men, but rather the need to transform the nature of the power relation” (Aklar, 2010, p. 28).

Kabeer (2005) plots a pathway to empowerment through three interrelated dimensions: “resources, agency, and achievement,” and lays out resources as pre-conditions, agency as process and achievements as outcomes (p. 13). Even though each of these defines a different point of empowerment, they are inseparable in the overall process.

Figure 1. Nalia Kabeer’s Conceptual Framework of Women’s Empowerment



First, resources (pre-conditions) are the basic conditions of people's lives that enable individuals to make choices for their livelihood. In a conventional economic sense, it is understood that resources mean material wealth, but the various human and social resources impact people's ability to exercise choices (Kabeer, 2005). Regarding empowerment, changes in women's resources can translate into changes in the choices they can depend on, in part, or on other aspects of the conditions in which they are making their life choices. When people have the power to make choices, the choices could increase possibilities of alternatives. However, Kabeer asserts that not all choices are equally relevant to the definition of power; some choices may have greater significance and impact than other choices in relation to the outcomes in people's lives (Kabeer, 2005). Therefore, it is vital to distinguish between the order of first and second choice orders. First choices are the essential part of strategic life choices that determine how people want to live (choice of livelihood) whether to marry or have children. First choices can help frame second choices, if not directly, the results of which could be about the quality of one's life without limitations (Kabeer, 2005).

The second dimension is agency, the ability to define one's goals and act upon them. Agency is also understood through 'power within' which encompasses the sense of motivation and purpose individuals bring to their actions in addition to decision-making and observation (Kabeer, 2005). The 'power to' refers to people's ability to make and act on their own life choices even in the face of challenges and opposition (Kabeer, 2005). There is also a negative sense –the 'power over' means the capacity to abuse power or

authority and use other forms of coercion to obtain what they need and make choices that harm others (Kabeer, 2005). Agency in relation to empowerment, is not only exercising choices but also to some extent challenging the power, norms and rules that could constraint their decision making power (Kabeer, 2005).

The third dimension is achievement, a combination of resources and agency that build up people's capabilities: to extend the possibility for the full potential to be unleashed and to lead the lives people aspire to. Regarding empowerment, achievement, outcomes must reflect those things women value as well as their life principles. These values may vary in regards to cultural and historical context, but also from individual to individual according to family backgrounds, socioeconomic status and personal preference (Kabeer, 2005). This three-dimensional model shows the interconnectedness in every step of the process towards women's empowerment.

Three of Kabeer's dimension of women's empowerment overlap with the United Nation's Guidelines on Women's Empowerment (2001) definition through "five components: women's sense of self-worth; their right to have and determine choices; their right to have access to opportunities and resources; their right to have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally" (p. 4).

As women's empowerment has become a central discussion within international development organizations, development practitioners or actors may not necessarily

always use the term correctly or measure it precisely (Arnoff, 2011). The Pathways of Women's Empowerment Research found empowerment "has multiple meanings, relating power, participation, capability, autonomy, choice and freedom and the presence and significance of these definitions varied greatly among different actors and contexts" (Eyben, 2011, p.3). It further states women's empowerment happens when "individuals and organized groups can imagine their world differently and to realize that vision by changing the relations of power that have kept them in poverty, restricted their voice and deprived them of their autonomy" (Eyben, 2011, p.2). All these definitions of women's empowerment interchangeably use the terms power, choices, self-worth, rights, opportunities, participation, and autonomy, which ultimately aim to enhance the quality of life. It also implies the magnitude of the volume of interdependence and collective efforts required to genuinely practice and promote principles of women's empowerment in every level of socially conscious work, particularly in the healthcare sector. No matter how empowered an individual can be, it almost always takes an entire village, community, society to nurture that person to be who he or she is. These fundamental notions of empowerment and growing awareness at the global level, has resulted in increased literature on the conceptualization of women's empowerment. The following case studies shed light on the practical aspects of integrating women's empowerment in the healthcare system and promoting women's empowerment and leadership to achieve better health care for women and their families. I am drawing information, statistics and examples from their official websites focusing on women's empowerment and health

care. These case studies are weaving my analysis and successful practices, and strategies that are significant to this study.

Case study 1:

Background of the Surmang Foundation:

The Surmang Foundation is a US non-profit corporation from the State of Colorado and tax-exempt under IRS 501(c) 3 and an independent charity. Since 1992, Surmang Foundation has operated the Surmang Clinic, located in Surmang Township, Yushu prefecture, Amdo, in western rural Tibet. It is remote, 97 percent ethnic Tibetan, and a mountainous region with little access to basic health care services. At the beginning, foreign health care providers staffed the clinic and provided basic free medical care working out of improvised clinics in yak tents to nomadic people living in areas that were difficult to reach depending on the time of year. In 1996, a freestanding clinic facility was completed and in 2000, the Surmang Foundation hired and provided formal training for two local physicians to provide year-round free primary care services (Surmang.org) with the core value of free medical care. In 2004, the Surmang Foundation conducted a public health survey among nomad women that revealed a huge gap in care for women and children, “the danger of a pregnant mother is over 3 times that of a US soldier in Afghanistan” (Surmang.org). As a result, the Foundation designed and implemented a Community Health Worker (CHW) program, which now has 39 women from 10 villages who have been trained as birth attendants and healthcare educators

Strategy: specific aspect of women's empowerment

- Recognize the maternal and child health care needs of area women, understand the contextual environment in which women's conditions for their access to material wealth, education, healthcare and other resources would affect the choices they make in life. As Kabeer would say that "access to such resources or preconditions will reflect the rules, norms which govern distribution and exchange in different institutional areas" (p. 437).
 1. The Surmang Clinic is equipped to diagnose and treat minor medical problems, give access to customized services to the Surmang community
 2. Initiating a community-based model supporting the maternal and child health care needs of area women
 3. Distributing clean birth kits that contain basic supplies for birth, such as umbilical ties, a single razor, gauze for cord care, towels etc
- Voice & Agency: **Empower** and **train** local women on safe antenatal care and attendance at birth and motivate them to take leadership roles. Women come together to share challenges and reflect on their roles as women, discuss issues that affect them and their families. In fact, Kabeer (2005) states that merely having access to resources is insufficient when we talk about empowerment, women must also have ability to identify and utilize those resources. Moreover, women have come together collectively as women, both to acquire a shared understanding of the nature of inequality, and constructed gender roles that are imposed upon them in

order to collectively tackle these injustices and challenges (Kabeer, 2005 & 1999).

- Mobilizing local community and raise awareness through *Surmang Community Health Festival*, which gathers community health workers and other members to celebrate their achievement through their traditional music, dance and singing
 1. It became a safe space for women to share their experiences, challenges and discuss ways to improve village life and continue to support the well being of their families and neighbors.
 2. Women felt connected with their culture and values of community, and they expressed that they felt motivated by each other and work together for a visionary planning for the future (Surmang.org)

As presented earlier, Kabeer (2005) noted that achievement (outcomes) is combined with resources and agency, which strengthen people's capabilities in making choices in life, being able to live desired lives and thrive as individually and collectively.

Overall solution oriented strategy for the future:

- By making health care available to people who otherwise don't have it
- By training and increasing the visibility of 40 Community Health Workers (all women) and over 50 Village Health Workers

The chair of the Sumang Foundation affirmed that once women are the health care providers, local people automatically respect them, acknowledge their expertise and women themselves initiate caring, raising awareness, gain self-confidence and they

are likely to bargain power and control over resources (the Surmang Foundation).

- By putting quality care within greater reach of Tibetan nomads and farmers through well trained Village and Community Health Workers
- By connecting village and township providers in one coherent system (collaboration, emphasis on shared goal of communities)
- Creating a model of rural public health in partnership with the Yushu Public Health Bureau, means fixing a problem that is broken due to remoteness, poverty, and lack of infrastructure
- Raising awareness and consistently emphasizing on idea of “saving a culture we need to save a mother” which mobilize local communities and empower women and train women community health workers

Lessons Learned: Program sustainability can be a challenge for NGOs when they enter into community partnerships without adequate strategic planning and local support; therefore Surmang learned that the involvement of the clinic doctors and village Community Health Workers (WHWs) in the development of the health care system is essential because it gives a platform for continued *sustainability* through a sense of shared *ownership* between the the Surmang Foundation and communities. The Surmang Foundation demonstrates the importance of community involvement in program design and execution, as well as the potential for empowerment that can occur when community members are drawn into improving health outcomes (Surmang Foundation).

Case 2: The Jamkhed Model-Comprehensive Rural Health Project

The Jamkhed Comprehensive Rural Health Project (CRHP) was founded by Dr. Rajanikant and his late wife Dr. Mabelle Arole in 1970 in the village of Jamkhed, India. It has been working among the rural poor and marginalized for over 47 years. CRHP is a widely acknowledged and recognized organization that has successfully facilitated the transformation of local women from poor villages into agents of community change. CRHP developed a comprehensive, Community-Based Primary Healthcare approach (also known as the Jamkhed Model), which has led an expansion throughout the world today (Jamkhed.org). The aim of the Jamkhed Model or Community-Based Primary Healthcare approach to health work is to enable and empower Village Health Workers (VHWs) and community people (with the principles of equity, integration, and empowerment) to take health into their own hands and have sense of understanding of basic causes of their problems. It also brings shared values of concern for dignity, equity and justice, thereby building respect and trust, and raising awareness (The Jamkhed Model).

Strategies includes:

- Emphasis on the needs of the poorest of the poor
- Full community participation and involvement

- Integration of promotive, preventive, curative and rehabilitation health services using of appropriate technology
- A multi-sectoral coordination approach to address all issues affecting health

Strategies: as aspect of women empowerment (The Jamkhed Model)

- Build a community care center with diagnostic facilities
- Working at the grassroots with village health workers (VHWs) and community groups leads to the process of empowerment of women particularly and communities in general

Once women have knowledge, skills and are able to make informed decisions, they have power they can use in constructive ways to transform their communities (The Jamkhed Model).

- Status of women: Women Village Health Workers (VHWs) became animators, change agents, health educators, organizers, mobilizers, role models, sources of information, motivators for better health practices, providers of basic health care
- Improving the health of women; knowledge of pregnancy, frequent prenatal care by VHWs; and increasing women's knowledge of safe delivery (Maternal healthcare)
- Incorporate local culture and respect when it comes to physical check ups
- Self-help approach: Women Village Health Workers teach other women how to do self-examination, how to treat their minor health issues with local herbs

Solution Oriented strategies:

It is important to get to know the community, listen to and learn from the people

about what they know, what they do and why, and to build rapport in order to develop a relationship of partnership. In addition, it allows people to share in the assessment of health care and identify their problems, analyze their causes, decide what problem to work on and develop appropriate solutions that will work in their community. I believe giving ownership, and acknowledging community knowledge and agency to make a difference is essential to the process of empowerment. The focus is on helping the community to “health,” to gain control of their own well being. “The villagers themselves are the ones who can best explain the process and motivate other villages to engage in the process” of the movement (The Jamkhed Model). Hence, it is important to organize community groups, men and women, from different villages and motivate them to get involved and become active. Soon, these groups serve as an avenue to share health knowledge and skills with other village people to enable them to appreciate their crucial role in improving the health of their village. It is not only uniting communities, but also encouraging both men and women to work towards a shared goal, which is to improve their health, no one is left behind. In fact, women village health workers are the backbone of the program; they share their knowledge and skills with the community groups and address health and development issues for each village.

Success and lessons

The big success of CRHP “is a radical approach that goes beyond medicine and its central theme is equity that aims to achieve *Health for All*” (Johnson, 2013). Villagers are progressively getting healthier, wealthier, and happier, while the centuries-old traditions

of caste and gender discrimination were all but disappearing (Johnson, 2013). Most importantly, villagers are making progress with their inputs, and the collaboration of the community as a whole. With CRHP's strict emphasis on the sense of community, or the importance of stakeholder participation and mobilization (which created a shared vision among members of the community), the villagers are running emergent self-help community groups, and different clubs such as a farmer's club, women's club and door-to-door health services. The Jamkhed model is centered on the idea of equity, working towards making people emotionally, spiritually, and economically healthy, no matter where they live or who they are. However, CRHP does not merely achieve equity by providing people what is needed, but focuses on people's capacity building by teaching them what they need to know to help them as well as take ownership (The Jamkhed Model).

Conclusions & Recommendations for the Pende Clinic

Visiting the Pende Clinic in 2016 prompted me to think deeply about the relationship between gender, healthcare, women's empowerment and social change in rural Tibet. After talking with women entrepreneurs and health practitioners in Tibet, I realized the interconnectedness of health, education, empowerment and social change. I used to think I wanted to empower women in my community through education; however, I learned that we couldn't fail to talk about women's health when we talk about women's education, we cannot fail to talk about women's leadership when we talk about social change and the betterment of families and society. At the Pende Clinic, I met incredibly

passionate and talented women doctors. I observed their daily practices with limited resources as primary barriers to achieving their excellence and providing quality services to the communities. I also learned that the rigid leadership structure at the Pende Clinic is an obstacle for its success and performance (See at p. 7). Because I was born and grew up in a community where girls are told to be kind, gentle, nice and polite; I understand we have been told to live others' expectations and please everyone in our life. I was not surprised to find the women doctors at the Pende Clinic do not have a say when it comes to decision-making. Looking at the acute issue of gender inequality in Tibet, the Pende Clinic is typical of a male-dominated institution. However, there is something unique about the Pende Clinic, where the women doctors are visionaries, they understand what they lack, what they desire to achieve once they are equipped with a better facility and the skills they need to provide essential quality basic health services. The mission of the Pende Clinic is to provide the most affordable quality services to local communities. These women doctors fully embody and live its mission through the principles of their daily practices. They treat each patient with kindness, compassion, and generosity and make themselves available to all patients at any time. Their services reach many communities, which do not have proper healthcare services. In spite of all challenges, the women doctors are working tirelessly and holding the collective vision to bring about positive changes. Other strong women in the community I talked with are equally inspiring. These women are forging their path to change and to bring about positive transformation in the communities. For example, a seamstress owned her business, not

only becomes financially independent, but also she supports her family. Her vision is to train other women and empower them. Another business woman who opens the first female owned tire repairing business, and she wants to train men and women on skills and bring jobs and create developments in rural places. A young 24-year-old mother of two children wants to open a store to sell clothes so that she can send her children to schools and hopes that they bring some positive changes in the community for the future.

This study presented a broad insight towards the areas and manner of empowering women in healthcare with the conceptual framework of women's empowerment from Naila Kabeer, in which she lists three dimensions as resource, agency, and achievement (See at p. 17-18). In general, empowerment means a transformative process of change, to challenge power, recognize one's own potentials and expand one's ability to make choices aligned with one's values. The notion of women's empowerment has been defined and used in a variety of ways, from personal to a community and from particular to very general. It also occurs in different ways depending on individuals in different contexts.

Concerning health care, in general, the health care system in Tibet is a disaster when it comes to women's healthcare. Tibetan women are dying of preventable causes. For example, the maternal mortality in Tibet is one of the highest in the world, significantly unreported, and unknown to the world (Gyaltsen et al., 2015). Therefore, this study looked at Kabeer's three dimensions: resource, agency, and achievement, as a holistic approach to healthcare at the Pende Clinic. In order to tackle gender issues, we have to

develop and implement strategic ways to ensure women have access to essential health services and be able to utilize these services to meet their needs. Kabeer sees three dimensions on a more individual level, for having resources, as a precondition, that translates into changes in choices women make; agency as not only exercising the ability to make choices, but also to challenge norms, rules and power; finally to unleash the full potential to achieve outcomes that reflect their values and principles. This study looks at these dimensions as the institutional process of women's empowerment that also helps individuals become empowered. Each of the three indicators has the potential to bring about immediate changes with longer-term outcomes. Understanding the complexity of the political situation in Tibet, China-Tibet relations, and the culturally constructed beliefs and instructed gender roles within the Tibet culture, women face a tremendous double standard and challenges to meet their healthcare needs. In these uncertain times, it requires imagination to envision new possibilities and a resolve to make the choices necessary to realize healthy, strong and sustainable empowered communities across rural Tibet. Two case studies exemplified the terms of women's empowerment in healthcare clinics in rural India and Tibet. Both case studies illustrate successful approaches which are strengthening capacity within the communities, empowering women to be the change agents by developing resources through opportunities, training, information, education and renewing hope and trust in the potential collective effort. Learning the strategies, and lessons from these studies, I would like to conclude with recommendations for the Pende Clinic for its future strategic planning and implementation along with some potential

funding resources and future collaborators.

Recommendations: Internal and external strategic plan development

Internal Strengths & Weaknesses

- To analyze and understand the Pende Clinic's current situation from three perspectives: identifying internal strengths, weakness in relation to their leadership, performance, and services
- Review the limitations and challenges of its resources and expand in new directions to increase resources, tools and entrepreneurial strategies
- Look into the education, experience and overall competence of doctors to discover competitive advantages, and to learn how to enhance and strengthen the capacity, and skills through further training opportunities, workshops as well as other learning opportunities
- Learn clear impediments of the Pende Clinic for the growth, expansion and improved performance by looking at its leadership structure and limited resources including medical supplies, infrastructure and other barriers
- Clear objective /goals
- In collaboration with the Pende Clinic, the staff expressed their specific internal goals in the three categories below:

1. Immediate needs

- To buy basic medical supplies & equipment including:
 1. Bandages (Gauze/ First Aid dressings)

2. 5 beds and 6 chairs for the doctors and chairs for patients
3. 2 Examination tables
4. 5 Standing exam lights
5. 3 Blood Pressure Monitors
6. 10 boxes of cotton swabs, 12 scissors
7. 50 Boxes of gloves for medical exams,
8. 2 Weighing Scales
9. 2,400 disposable syringes & needles
10. 6 thermometers
11. 100 Tubes for drainage
12. 10 wash basins
13. Hand sanitizer & soap
14. Urine collection cups & urine dipsticks
15. Medicine boxes/containers /zip lock bags /cases & cabinets
16. Adhesive tapes
17. Hanging files & folders
18. 10 IV stands
19. Arm slings
20. Trash bags
21. Gowns for doctors

2. Mid term needs:

Technology

- Computer system
- Copy machine
- Printer/scanner
- Laptops for the doctors

- Intensive training (specifically on surgical operation skills, the production of medicines) whether to go to other institutions or invite experts to the Pende Clinic)
- Build consultation /exam rooms
- Building for a Pharmacy

Women's Health

- Ultrasound Machine
- Birthing kits
- Birthing rooms, beds and tables
- Gowns
- Wheel chairs

3. Long term needs

- Upgrade the infrastructure
- Build laboratory and all supplies needed for the laboratory
- X-ray machine
- Produce medicines
- Create jobs for local people
- Train local midwives

External Opportunities and Threats

- Look at similar clinics throughout Tibet and China like the Surmang Clinic and build upon networks, cooperatives, and collaborations for sharing resources
- Create partnerships with the local government and hospitals with shared goals
- Build rapport with communities, focus on their needs and have their voices heard by listening to their felt needs: both Surmang and the Jamkhed Model emphasize community participation and involvement

- Promote women’s health, knowledge of pregnancy by holding workshops in villages, identifying and investing in other village women as peer, community leaders and health practitioners who share the responsibility and part of the movement
- Incorporate local culture, customs in maternal healthcare along with advanced care and technical assistance, thus creating relevance to cultural roots and making it easier to capture people’s attention
- Understand the changing current political landscape and be strategic about its operations for the Chinese government can shut down the clinic at any moment
- Look for existing organizations or foundations for potential fundraising for healthcare in Tibet

Strong potential funding resources and collaborations for the Pende Clinic

More in-depth descriptions are available on their websites, provided at the end of each organization’s introduction

Tibetan Healing Fund (THF)

Tibetan Healing Fund (THF) is a not-for-profit humanitarian organization based in Seattle, Washington, USA. It was established to improve primary healthcare and education for rural Tibetan women and children in the Tibetan regions of P.R. China. THF was created in response to the needs expressed by Tibetan communities in P.R. China and the vision of Dr. Kunchok Gyaltzen, a Tibetan medical doctor and Buddhist Monk. It has different programs in Western Tibet including Tibetan Natural Birth & Health Training Center “Birth Center, Community Midwife Training, Yushu

Earthquake Disaster Relief, Community Health Education and Outreach, Scholarships for Postgraduate and Medical School, Tibetan Maternal and Child Health System Resource Textbooks, Training of Trainers (TOT) and Community Health Assessment.

More information: http://www.tibetanhealingfund.org/Home_Page.html

Nomadic Survival

Nomadic Survival is a Scottish based charity, raising funds to support and work with nomadic and semi-nomadic communities in the Himalayas. It has a particular interest in the well being of mothers and babies. Nomadic Survival is keen to build relationships with each community through mutual trust and respect and it responds to the needs and choices of the communities. It provides support, information and training in including:

- Mother and Child Health
- Reproductive Health
- Prevention of TB/HIV/AIDS/Hepatitis B
- General Health and Hygiene
- Diet and Nutrition

More information: <http://nomadicsurvival.org/about/>

The Jinpa Project

The Jinpa Project is a local grass roots organization in Yushu Tibetan Autonomous Prefecture, Western Tibet and was founded in 1996. It was registered as a charitable organization under the Prefecture Civil Affairs Bureau. It focuses on rural community education, remote community midwife training, health education, promoting awareness

of gender equality, building rural community bridges for access during seasonal migration, providing water and sanitation, and environmental hygiene and supporting impoverished vulnerable children, elderly and single parents. It implemented a three-year midwife training program and it has 300 graduates out of 75% plus have become important members of their own communities, providing basic health education and care in communities, schools, and providing maternity healthcare, and leading community women's associations. More information: <http://www.jinpa.org.cn/Home.html>

ROKPA

ROKPA (means "Help" and "friend" in Tibetan) is an international organization based in Zurich, Switzerland. It is principally active in Tibetan areas of China and in Nepal in the fields of education, medicine, nourishment and culture. ROKPA is actively supporting doctors' practices in Tibet.

Maintaining the knowledge of Traditional Tibetan Medicine (TTM) is an important mission for ROKPA. More information: <https://www.rokpa.org/en/home.html>

Dining for Women (DFW)

DFW is a global giving circle that funds grassroots projects with \$35,000-\$50,000 working in developing countries to fight gender inequality. It is a collective-giving model that provides small contributions, aggregated together which can make a big difference. DFW funds grassroots projects in education, healthcare, economic and environmental sustainability, safety and security, leadership and agriculture. It emphasized that all these projects need to aim at improving the living situation for women and their families by

providing tools and skills they need to make changes in their lives, communities and in their children's futures.

More on the process for a grant application: <http://diningforwomen.org/learn/grants/>

Final Note

All the information that I learned from the Pende Clinic from many hours' conversations with women doctors and interviews with them on the specific area of challenges and their vision as part of my primary data, was based on a previously approved Internal Review Board (IRD) Independent Study. That led me to further investigate literature and specifically looking at Kabeer's three dimensions on women's empowerment, studying other clinics with different strategies and best practices, and looking for funding resources and potential partnerships for the Pende Clinic.

After much of my writing has done, in March 2017, I attended UN Commission on the Status of Women (CSW61) event titled "Empowerment of Female Health Workers," hosted by UNICEF and Jhpiego, an international, non-profit health organization affiliated with The Johns Hopkins University, in New York City. Speakers included Maternal Health Technical Advisors, Education & Training Advisors, Doctors, Experts, Professors, and Directors of Organizations. They all talked about the importance of building the capacity of female health workers for they are the "backbones of caregivers and primary providers." They discussed that empowering women, particularly at the community level is significant to lowering both maternal and infant mortality. However, the gender inequality in many societies often limits women from making a decision within the

household and making choices on their own health care. Dr. Anju Malhotra, Principal Advisor of Gender and Development at UNICEF, presented a number of community health worker programs that train primarily women have successfully prevented gender-based barriers to utilization of health services (Notes taken at CSW 61, 2017). I was further inspired and convinced how important this research study is. Investing in women health workers is absolutely urgent. All this information, facts, statistics, and examples helped me to conclude with recommendations for the Pende Clinic and I hope it helps to empower women health workers and improve healthcare in rural Tibet, and this could be, as well, a source of references and recommendations for any other women's empowerment model initiatives and clinics elsewhere around the world.

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Appendix A: Interview Questions & plans

Need Assessment through digital storytelling in rural Tibet, specifically in Kham, Ganzi, Tibet.

1. Write a clear summary paragraph regarding your project proposal as an expedited HSR case.

For this project, I am aiming to interview 10 women, age between 22—50, both high school drop out and illiterate women who are running small business, such as local handcraft, opening a sewing shop, starting a restaurant etc, to help and sustain their families.

The purpose of this project is to assess women's fundamental needs, to see what challenges they face, what supports they may need to overcome those challenges. As a further matter, this is to learn issues from women's perspective, what opportunities available to explore and what are some possible ways to connect them with resources and dignify their work. They not vulnerable groups, but they are women who are ambitious social entrepreneurs, visionary and

2. Address who, what, when, where, and particularly why and how making this a safe project.

They will be Tibetan women in rural Tibet, Ganzi, East part of Tibet. I will be talking to women who own or have start up business to support their families and find out their fundamental needs, their challenges and their vision. Their involvement is entirely up to them, if they do not want to talk about their life and their visions, they have full rights to make their choices. Moreover, this project will not cause any risks or harm to individuals who participate, it is nothing political. It is more about their lives, their goals for the future and find out way in which we can work together in the future.

Questions (for about 90mins) that the researcher will be asking, divided into three categories, including Personal story (who they are), career or vision (what they do or what they wish to do), challenges (what prevent them doing what they want to do or doing better for what they have been doing)

Personal Story:

1. How many people are there in your family and who are they? (some of women I know, so this question is not necessary)
2. What is your role in your family? What do you like about your role?

3. Can you tell me what are you most proud of yourself?
4. What is one thing you are very passionate about?
5. What do you hope for yourself and your family?
6. What makes you happy and why?
7. What do you do for fun?
8. What do people say / think about you?
9. What does your ideal day look like?
10. How would you describe yourself to someone you meet for the first time?

Career / Vision:

1. What do you do for living?
2. Why do you do what you do?
3. What skills or talent you think you have?
4. If there is a moment you wish you would be doing something else, what would that be?
5. What core values you carry with your life and your work?
6. How often do you plan for your work? How does that work for you?
7. What do you think you need?
8. If you could own a business and money was not an issue, what would you want to own and why?
9. What is the purpose of your life?
10. What qualities people who inspire you have?

Challenges / Issues:

1. What difficulties you face while you are doing your work?
2. What are some challenges you face in doing your business?
3. How do you deal with difficulties or issues?
4. What prevents you from doing what you want to do?
5. What you wish you have to support and help you overcome these issues?
6. Who do you think can support you and who can stop you from doing your dream work, why?
7. What are some disappointments / failure you have?
8. If there could be a moment in the future when you can have everything you wished, what would it look like?
9. What does success mean to you? How do you think you can get there?
10. Where do you see yourself in 5 years?

WEEKLY PLAN

Jun 5-14th Traveling & Settling (US--Tibet)

Date	Activity /how	Location	Time
Jun 5 th	Leaving for Tibet from New York city	US—Tibet	Around 21hours
Jun 6 th	Arrived in Chengdu, China	Chengdu—Ganzi	16hours
Jun 7 th	Arrived home		
Jun 8 th	Take some rest and adjust with time	Ganzi	
Jun 9 th	Take some rest and adjust with time	Ganzi	
Jun10th—15 th	Prepare for interviews, look at all questions, check camera and audio	Ganzi	4hours

Week 1 (Jun 15th—19th)

Date	Activity / how	Goal/how	Where	Time
Jun 15 th	Talk about the purpose of this project, Get consent + conduct the Interview,	ONE WOMAN +story sharing get to know her, understand her life Through photo/ video/ audio -take notes	Ganzi	2 hours

Jun 16 th -17 th	Transcribe/ write the story		At home (Ganzi)	14 hours
Jun 18 th -19 th	Continue to write the story and ask the woman if there is any clarification questions		Ganzi	1 hour + any time to fix

Week 2 (June 20th – Jun 26th)

Date	Activity/how	Goal/how	Where	Time
Jun 20 th	Get consent + conduct the Interview	ONE WOMAN +story sharing get to know her, understand her life (Through photo/video/audio/notes)	Ganzi	2 hours
Jun 21 st – 22 nd	Look at the notes & write up the story		Ganzi	14 hours
Jun 23 rd	Continue writing up the story		Ganzi	14 hours
Jun 24 th	Selecting the pictures (taken earlier) and editing the story		Ganzi	1 hour + 5 hours at home
Jun 25-26 th	Finish up writing		Ganzi	10 hours

Week 3 (June 27th - 30th)

Date	Activity	Goal/ How	Where	Time
Jun 27 th	Reflection for deep learning, re-evaluate about questions asked and answered received	By reviewing the story and my original questions and revisit the purpose, evaluating	Ganzi	14 hours
Jun 28 th	Think of all questions, concerns and progress	Write down	Ganzi	4 hours

Jun 29 th	Skype call with supervisor	Talk about all questions, concerns and see if we need any adjustment for the questions	Tibet (Ganzi) - US (virtual connection)	2 hour
Jun 30 th	Re-adjust (if necessary) + Prepare for the next interview	Logistics, transportation	Ganzi to Tshara village	4 hours

Week 4 July 1st - 7th

Date	Activity	Goal /How	Where	Time
July 1 st	Travel to Tshara village	Get the place by local bus	Tshara	1hour
July 1 st	Randomly talk to 10 women and see whom I should interview and get deeper level of story	Visiting to households	Tshara	8 hours
July 2 nd	Continue talking to women	Different households	Tshara village	8 hours
Jun 3 rd	Get consent + conduct the interview	TWO WOMEN By telling the purpose of this project and how their story will be used. Through photo/ video/ audio -take notes	Tshara village	4 hours
Jun 4 th	Review the notes	By collecting words or phrases and quotes	Tshara village	5hours
Jun 5 th	Start drafting the story	See if any clarification questions	Tshara village	10hours
Jun 6 th	Continue writing the story	In narrative version	Tshara village	5hours
Jun 7 th	Finish the story	Revisit the interviewees and	Tshara village	2 hours

		re-confirm by sharing what and how I have written their stories		
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Week 5 July 8th—14th

Date	Activity	How	Where	Time
July 8 th	Travel to Rida	Ask my cousin brother to get me	Rida village	1 hour
July 8 th	Randomly talk to women and create comfortable space and get to know each other	Visiting their places and house	Rida	8 hours
July 9 th	Continue talking to women	Getting to know who they are and what they do	Rida	8 hours
July 10 th	Get consent conduct the interview	TWO WOMEN By telling them the purpose of the project <i>How to choose</i> interviewee: by looking at their existing small business or visions Take pictures (audio, video)	Rida	2hours
July 11 th	Review the notes and journals	Listening the audio and looking the pictures	Rida	8hours
July 12 th	Start drafting the story	Ask questions for clarification if there is any	Rida	8hours
July 13 th	Continue putting all information in narrative	Documenting, photo captioning so on	Ganzi-Home	6hours
July 14 th	Write a report of everything Or questions and concerns or	By reviewing all stories, interactions and results or answers that I receive	Ganzi-Home	2 hours

	suggestions that I would want to get from supervisor			
July 14 th	Send it to Supervisor Skype Call with Supervisor	Email	Internet Café	1hour

Week 6 July 15th -21st (Any time between 15th—18th, expect to hear back from Supervisor)

Date	Activity	How	Where	Time
July 15 th	Plan to travel to Seda—around 50kms away from home	Find local bus, have all questions, camera, audio ready to go	Ganzi—Seda	1hours
July 16 th	Travel to Seda + ask my friend for women's situation there, find a way to get to talk to women	Talk to my friend to stay with	Seda	3hours
July 17 th	Talk to women + take notes and keep journal	Visiting their places, shops	Seda	8hours
July 18 th —19 th	Get consent and interview 2-3women	TWO-THREE WOMEN Take their pictures or record their stories + keep notes and daily interaction experiences	Seda	3 hours 7 hours journal keeping
July 20-21 st	Review the notes and write journals +start drafting their stories	Selecting pictures, listening to audio record	Seda	10 hours

Week 7 July 22nd—24th

- Travel back to home, Ganzi from Seda
- Put all information in secure (word document)

- Compare and contrast and see what changes in terms of how much stories I am getting and how much of them are connected, look for some patterns
- Keep journals
- Review the notes

Week 8 July 25-31st

Date	Activity	How	Where	Time
July 25 th	Plan for the next trip, Evaluate questions, prepare for the logistics	Asking family and friends for more information of particular villages (I want to explore)	From home	5 hours
July 26 th	Travel to RongpaTsha (this may change)	Local bus	GanziRongpaTsha	1 hour
July 26 th	Talking to women in shops or restaurants	Drinking some tea, getting to know some of women and make some connections	RongpaTsha	10 hours
July 27 th	Get consent, conduct interview,	TWO WOMEN To find out what they do, their interests and issues they face Take pictures, or record their voice	RongpaTsha	2 hours + 5 hours
July 28-29 th	+ Review all the notes, journals, selecting pictures Travel back home	Clarifying any questions + drafting the story	RongpaTsha—Ganzi	10+2 hours
July 30 th	Look through all information, see if any changes needed in terms of questions or approaches	Review notes, documented stories so far	Home	5 hours
July 31 st	+ Skype Call Update with Supervisor	Supervisor		1 hour

Week 9 Aug 1st -4th

Date	Activity	How	Where	Time
Aug 1 st	Have all documents in one place	Pictures, audio records and all	Home	4 hours
Aug 2 nd -- 3 rd	Plan for the return Logistics		Home	2 hours
Aug 4 th	Leave for Chengdu, China	Bus	Ganzi-Chengdu	16 hours
Aug 5-6 th	Arrive in Chengdu	Bus	Chengdu	4 hours
Aug 7 th	Leave from Chengdu—US	Flight	Chengdu--US	21 hours

Week 10 Aug 8th -14th

Date	Activity	How	Where	Time
Aug 8 th	Arrived in US			3hours
Aug 9 th —10 th	Travel to MA and adjust the time	Taking some time	MA	
Aug 11	Start polishing stories, editing	One story	MA	8 hours
Aug 12-13 th	Meet with Supervisor	Story with picture to get some feedback	MA	3 hours

Week 11 Aug 15th -21st

From this time, I would be working on stories and polishing them, at the same time, I would be interested in talking about different ideas for creating a website. See how can we put the best quality of stories and pictures of women in rural Tibet on website if we are able to create one. With help of my supervisor, I will be brainstorming different ideas.

Start sharing the stories with friends for comments and feedback if it is possible.

Week 12 Aug 22nd-28th

- Work on 1st reflective practicum paper
- Brainstorm
- Drafting
- Writing
- Proofread
- Submit