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COMMUNITY-RELATED ISSUES

A Conceptual Model for Empowerment of the Female Community Health Volunteers in Nepal

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ABSTRACT **Context:** *The existing top-down approach of the training is not appropriate to empower the community health volunteers to produce a sustainable change in their performance.*
Objective: *To propose a conceptual model that relies on Freire's theory of empowerment education and the participatory action research methodology to empower the female community health volunteers (FCHVs) to increase their consciousness, competence and confidence in performing their job responsibilities.*
Method: *The model explains the empowerment phenomenon as a process and outcome. As a process it occurs in the form of repeated reinforcement cycles with alternating activities of action and reflection and includes developing awareness, skills and confidence among FCHVs through small group activities. As an outcome, it results in the change in FCHVs' performance in increasing contraceptive acceptance among the rural women of reproductive age group.*
Conclusion: *It is hoped that empowerment of FCHVs will bring sustainable change in their performance and will consequently produce notable improvement in the health of women and children in particular and in the community in general.*

KEYWORDS *Empowerment, community health volunteer, participatory action research, contraceptive acceptance.*

Context

The use of community health volunteers to provide basic health care to the community has now become a common practice in many countries. In fact, in

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the developing countries where trained health workers are scarce and maternal and child mortality rates are very high, the use of these volunteers to provide the preventive and promotive aspects of health care to the community is the best alternate. The community health volunteers, named differently in different countries, are always the local people who represent the community socio-economically, culturally, experientially and linguistically (Love *et al.*, 1997). Their use in the health care system makes health care more accessible and acceptable to the community. They can be instrumental in providing community members with the necessary support for their emotional and social well being and empowering them to have increased control over their health.

Community health volunteers (CHVs) have, no doubt, existed in some form since the genesis of communities. They did not receive attention as formal participants in public health and health care delivery systems until the early 1970s. They received some legitimacy after the WHO declaration at Alma Ata in 1978 (Zakus, 1998) and with the work by Kark on community oriented primary care (COPC) (Kark, 1981). The result has been the utilization of CHVs in a variety of settings including inner city of New York and rural sub-Saharan Africa.

In the last 40 years, community health volunteers have demonstrated their worth in improving access to health care in a variety of settings. There is also preliminary but incomplete data that CHVs can improve health status outcomes, health behavioural changes, and health knowledge (Swider, 2002). Additional research and evaluative data are needed to assess long-term outcomes of their utilization.

In most countries, the emphasis in CHV programmes has been on their implementation rather than training. CHVs' background and training are as varied as the settings in which they practice. Training has often been site specific and programme focused. This article proposes a theoretical basis for the training of CHVs that is flexible enough to fit any programme, regardless of location or purpose.

To increase access to family planning services and their acceptability by rural people, the Government of Nepal initiated the Female Community Health Volunteer (FCHV) programme in the 1980s. The FCHVs in Nepal are local women from the community who are given training and then are left in the community with the responsibility of providing maternal and child health and family planning services to their respective communities. Their performance in making family planning services available to rural communities has, so far, not been effective. It has been observed that FCHVs were not working fully, their training was inadequate and almost 90% of rural women did not receive any family planning services from them (VRG, 1997; Pradhan *et al.*, 1997).

The existing training programme of FCHVs is of short duration, 2 weeks or less, and the training programme mostly uses a top-down

approach without involving the trainee in the identification of the needs of their communities (VRG, 1997). Such programmes lack relevance to the needs of the volunteers and the community and fail to build a sense of ownership and commitment among the volunteers with the planned services. As a result, the volunteers are not able to fully carry out their job responsibilities.

Control of fertility in the community, through the provision of contraceptive knowledge and services, is one of the main responsibilities of the FCHV (MOH, 1992). The fertility control measures have a great impact on maternal and child health, on the health of the family and the community as a whole. Contraceptives are the basic tools for the control of fertility. However, in over-populated, developing countries like Nepal, the use of contraceptives by women is notably low. Only 30% of Nepalese women in their childbearing years use a contraceptive (Bellamy, 2001).

The common causes for low acceptance of contraceptives among women include lack of knowledge, fear of side effects, perceived low risk of conception, social and familial disapproval, and problems with access to service (Bongaarts & Bruce, 1995; Thapa, 1997; Casterline *et al.*, 1997). So unless the women are empowered by developing their critical consciousness about the problem of high fertility and by developing their ability to control their own reproductive health, any effort toward the government target of fertility will not be effective, and the community at large will not benefit. Empowerment phenomenon, however, is little understood in terms of developing the ability of people to control their own health.

In the words of Wallerstein and Bernstein (1988), ''Empowerment is a social action process that promotes participation of people, organization and communities in gaining control over their lives in their community and larger society''. This definition considers empowerment as a group activity in gaining power to bring a change. In the group, empowerment occurs as a problem-posing education that unveils reality and attempts to build a sense of consciousness and confidence among people (Ramos, 1998). Participatory action research (PAR) is a preferred research method in developing consciousness and confidence among community groups. PAR relies on local wisdom and knowledge. It uses the principles of group dynamics and is concerned with process training in bringing personal and social change (Schoepf, 1993).

Objective

The objective of this paper is to describe a conceptual model for empowering FCHVs to facilitate the acceptance and use of contraceptives by the currently married women of reproductive age group (CMWRAs).

Theoretical Base

The proposed model for empowerment of FCHVs is based on Paulo Freire's theory of empowerment education that consists of ''listening-dialogue-action cycles'' to help the participating members reveal their values, gain local insights, and develop their leadership abilities (cited in Wallerstein & Bernstein, 1988). The model also uses participatory action research (PAR) methodology that follows the cycle of ''analysis-action-reflection'' (Purdey *et al*., 1994).

High fertility always has a direct impact on the health and well-being of women, and women have a wider range of contraceptives to choose from than men do. It is also true that in terms of gender, women are the disadvantaged group in most societies. So in order to bring them to an equitable level with men in regards to their awareness about contraception and ability to communicate the need for contraception with their husbands, the model focuses on *women beneficiaries*. Further, contraception is considered a personal matter and people do not freely talk about contraception. So, to avoid cultural barriers, the model recommends the use of *women-to-women empowerment approach from FCHVs to CMWRAs to increase the contraceptive acceptance of the later*. FCHVs are the main focus of this model because of two hypotheses. The first hypothesis is that the empowerment of FCHVs will facilitate in the empowerment of CMWRAs. The second hypothesis is that FCHVs will help in controlling fertility through the provision of basic family planning services to rural communities (Figure 1).

The model assumes that by bringing FCHVs together to discuss the problem and to seek a solution, a sense of individual and group empowerment will develop (Wallerstein, 1992). It is also believed that FCHVs know a great deal about their own community and that the group process will enable them to use their existing knowledge and experiences to critically analyse the problem of high fertility in their community. This analysis will enable them to develop critical consciousness regarding the problem and its causes. Through this critical consciousness, which is the core component of empowerment education, FCHVs recognize that the problem of high fertility in their community arises from the lack of power among women and it is necessary to take action to resolve the problem (Stein, 1997). PAR helps FCHVs to increase their consciousness by exchanging information, viewpoints and experiences with the group and to move them from personal to group analysis (Smith *et al*., 1993). PAR also helps FCHVs to develop and enhance their communication skills, participatory planning and decision making. It enables FCHVs to identify and deal with the stakeholders to meet the contraceptive needs of their community. Participants are also likely to develop a feeling of strength and collegiality. The success of PAR, however, also relies on the motivation level of its participants. Their readiness

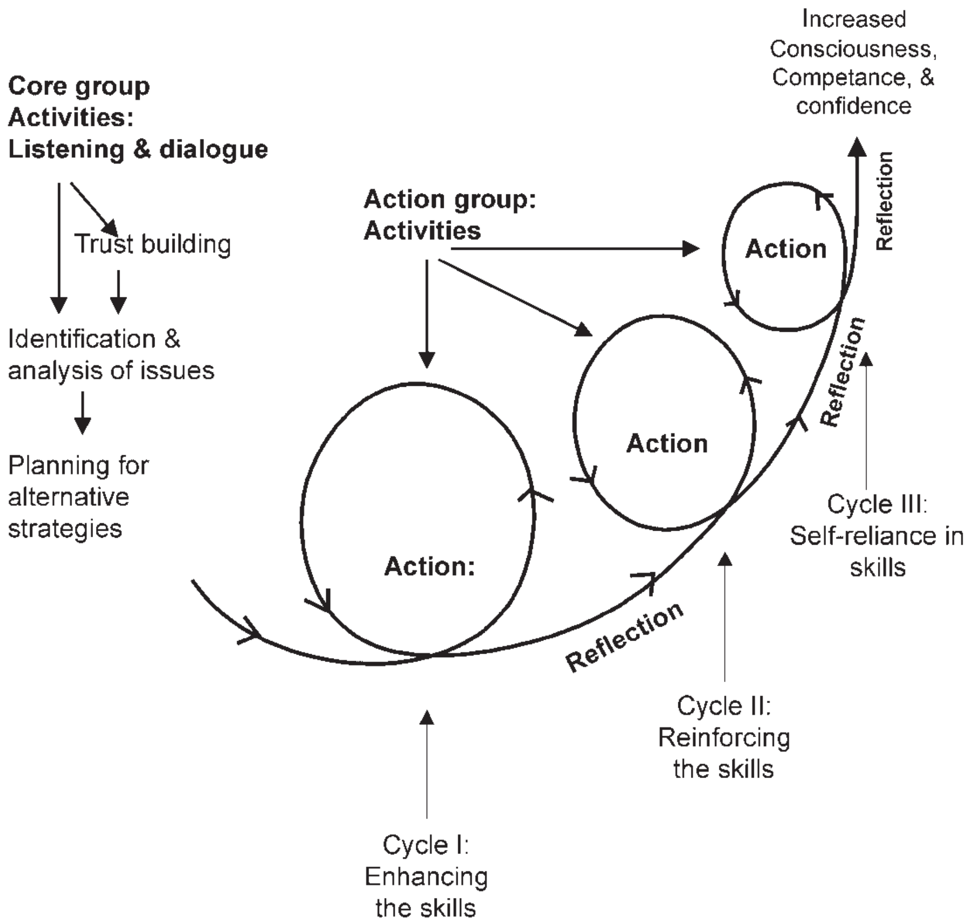

Figure 1. A model for empowerment of FCHVs.

to learn and commitment to work or serve are two pre-requisites to keep them involved in PAR.

The proposed model considers that empowerment occurs both as a process and as an outcome (Israel & Checkoway, 1994; Stein, 1997). As a process, it occurs in the form of repeated cycles with alternating activities of action by the FCHVs and reflection with the colleagues and facilitator through which FCHV gain consciousness, competence and confidence. Empowerment is an outcome when there is a sustainable change in the performance of FCHVs.

The nursing education programme in Nepal uses a similar model in training its students. The assumption is that nursing skills do not develop at once. They develop gradually as a result of repeated supervised practice of skills followed by feedback from the supervisor. In the process of skill development, students practice and demonstrate their skills first in the classroom until they can perform safely. Only then are they allowed to try out their skills with the

patients/clients in the clinical (hospital/community) settings. In the clinical settings, they practice their skills under the guidance of the clinical supervisor a number of times until they can independently perform the skill correctly and confidently.

Process of Empowerment

In the proposed model empowerment as a process, occurs through group activities based on the principle of group dynamics that people learn better and more happily by sharing with one another (Zandon, 1996). The model focuses on two groups of stakeholders: FCHVs as change agents and CMWRAs, as the beneficiaries. The FCHVs facilitate the contraceptive acceptance among the CMWRAs. In order to build the capability among the FCHVs to raise their consciousness, competence and confidence, each FCHV will work at two group levels: (1) core group and (2) action group.

At the *core group level*, FCHVs work as participants with a female health professional facilitator, preferably a Community Health Nurse, to promote their learning from group activities. This group serves as a forum for the participating FCHVs to learn from each other's viewpoints and experiences. The activities at this group level include the analysis of the problem, its causes and consequences, and the planning of the strategies to resolve the problem through dialogue. This will be followed by practice and feedback in a simulated setting using role-playing to implement the strategies. Later on, this group will also be concerned with regularly reviewing the actions implemented at the action group level.

As the literacy rate among rural women is generally low, use of pictorial-aids is suggested for opening up the dialogue among the participants. The use of visual exercises, such as the ''story-telling-with-scenarios'' that uses two scenarios (one showing the problem and the second showing the ideal), is beneficial in relating to real life situations and in stimulating conversation in the group (Rietbergam-McCracken & Narayan, 1998). The facilitator, in order to initiate the dialogue, asks the group to describe what they see and feel about the scenarios and what they visualize as the different levels of the problem(s). Further, they are encouraged to share similar experiences from their communities, to explain why the problem(s) exists and to develop strategies to address the problem(s) (Wallerstein & Bernstein, 1988). Through dialogue, participants in the core group identify the problems related to high fertility. They analyse the underlying causes of non-use of contraception, identify their relationship with the problem, and formulate the possible strategies to resolve the problem.

At the *action group level*, individual FCHVs return to their respective communities to implement the strategies that they have planned in the core group. The action group will consist of an individual FCHV, as the facilitator,

and CMWRAs, as participants. The action group will plan and implement actions to reduce or eliminate the barriers in using fertility control measures for the CMWRAs. Periodically the group also reviews the actions implemented by the CMWRAs.

The repeated cycles of action and reflection at the *action group level* will enable FCHVs to develop their competence and confidence in facilitating CMWRAs in controlling their fertility as described in Figure 1. Use of participatory approach will increase CMWRAs' awareness of the problem of high fertility and enable them to act upon the cause of the problem. The increased competence as well as confidence of FCHVs will help them to gain trust and respect from the CMWRAs, and this will serve as an intrinsic reward or incentive for FCHVs to continually engage in the action group activities. Furthermore, the group approach is culturally suitable to rural settings where people are emotionally and socially bound more closely than in the urban settings.

Since empowerment takes a gradual course, FCHVs will need continual support and feedback before they are ready to use the newly learned skills with full confidence with the CMWRAs (Simons-Morton & Crump, 1996). Based on this premise, this empowerment model describes *three distinct PAR cycles* in developing competence and confidence among the FCHVs.

The first cycle of the model is concerned with *the enhancement of the skills* of individual FCHVs in implementing the strategies planned for increasing contraceptive acceptance among the CMWRAs. During the first cycle, the individual FCHVs receives support and feedback from her peers and from the facilitator of the core group. The second cycle, the *reinforcement cycle is concerned with developing confidence of FCHVs in implementing the strategies planned for increasing contraceptive acceptance among the CMWRAs*. During this cycle, the performance of the individual FCHV is observed and reviewed by her peers of the core group. This cycle is repeated until the FCHV feels confident enough to implement the strategies herself without the support and assistance from the peers. She is then ready for *the third cycle*: *the self-reliance cycle,* which is carried out by FCHVs individually with the CMWRAs in their respective communities.

Outcome of Empowerment

Empowerment as an outcome reveals change in the performance of the person following the process of empowerment. The outcome of empowerment of FCHVs can be measured at the personal and community level (Israel & Checkoway, 1994). The outcome measure at the personal level is the self-reported change in the awareness, confidence and competence of FCHVs in the provision of contraceptive services to the community. The outcome measure at the community level is whether FCHVs have helped CMWRAs in gaining control over their fertility. These can be assessed in terms of family planning

activities carried out by the individual FCHVs such as the number of contraceptive awareness-raising sessions conducted, individual consultations provided, and contraceptive devices distributed.

The impact of empowerment of FCHVs can be measured in terms of the change in the CMWRAs' awareness of contraception and use of a contraceptive method (www.who.hrp, 1997). It is also hypothesized that increased awareness about contraception will enable CMWRAs to communicate with their husbands about contraception and to make a decision to use a contraceptive method. With increased awareness CMWRAs are also likely to be satisfied with the use of the contraceptive method and thus will be willing to continue using it (Ravindran, 1994).

Constraints of the Model

In the empowerment of women, the role of men also needs to be considered. They would need to be prepared to accept and share power with women. In comparison to the existing top-down model, the proposed empowerment model is likely to be more time consuming for the trainer as she/he would need to spend more time with individual FCHVs in their actual work setting. So, this model is likely to add the cost of training. However, the model will have a much more rewarding outcome in terms of effectiveness and sustainability, as it will lead to a self-reliant, motivated and efficient worker.

Conclusion

The process and outcome of empowerment of FCHVs has been conceptualized using an empirical model to increase contraceptive acceptance among the CMWRAs in rural Nepal. The applicability of the model has to be confirmed through scientific studies. It is believed that the empowerment of these grass-root health volunteers, by increasing their consciousness about the problem of high fertility and its causes and by enhancing their competence and confidence in the provision of contraceptive services, will bring a sustainable change in their job performance related to promotion of contraceptive usage in the community. It is also believed that clarification of the process and outcome of empowerment will assist in better understanding of the concept of empowerment and in providing direction to future empowerment strategies.

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