CHAPTER III

EMPOWERMENT MODEL

The purpose of this dissertation is to develop and test an empowerment model for the Female Community Health Volunteers (FCHVs) so as to enhance the contraceptive acceptance in the Currently Married Women of Reproductive Age Group (CMWRAs). This chapter describes a conceptual model for the empowerment of FCHVs by increasing their awareness, competence and confidence in the provision of contraceptive services.

3.1 Conceptual Model

A conceptual model is a symbolic representation of the interrelationships of the abstract concepts of the phenomenon under study (Polit and Hungler, 1995). It builds on logical and theoretical interrelationships of the concepts, which form the theoretical system. Since the concept of empowerment is still in a phase of development and its components are difficult to quantify, this study intended to determine the process of empowering FCHVs as change agents and its outcome as the resulting change in the performance of the individual FCHVs being empowered. The process reveals a state of changing i.e. the change occurring in the group during the process of empowerment. Effect of this group activity on individuals is the outcomes i.e. increase in skills and abilities among the participants.

3.2 Phases in the Development of the Model

The development of model involves three distinct phases namely (1) conceptualization, (2) model formulation and (3) validating or testing the model for appropriateness (Gibson, 1995). The first phase, i.e. conceptualization, begins with defining the variable i.e. empowerment in terms of the desired outcome and identifying the primary stakeholders. The focus of the model is determined accordingly. In the second phase, i.e. model formulation, the empowerment model is constructed through

literature search. The steps of empowerment as well as the measurement of empowerment are determined through literature search. The theories applicable to the model are identified. In the third phase, the validation of the model is carried out by testing the model in the field to see how well it works. Based on the field-testing the model might need to be revised to add to the validity of the model.

3.2.1 Concept of Empowerment

Empowerment is a multi-dimensional concept occurring at different domains e.g. personal, group and community. In the words of Wallerstein and Bernstein (1988) "empowerment is a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their communities and larger society." This definition emphasizes empowerment as a group process. Isreal and Chackoway (1994) theorize empowerment to occur both as process and outcome activities occurring at three different levels namely personal, family and community. Staples (1990) also considers empowerment as a process and an outcome and describes empowerment as a spiral phenomenon i.e. individuals, through their participation in the group activities, gain knowledge and skills that lead to personal development. It is cyclical or spiral with alternating activities of action and reflection that is based on non-hierarchical small group participation. Used as an outcome, empowerment refers to the resulting change in the performance of the individuals being empowered. Process includes a group activity whereas outcome includes the resulting increase in power and control among the participants that they can use in changing their situation.

The term empowerment is concerned with bringing equity. It is a strategy used in relation to oppression among powerless or disadvantaged group of people whose basic needs are unmet. Women in a patriarchal society and rural women can be considered as the disadvantaged group in the society. Empowerment is also understood as a "reflexive verb" revealing that individuals can only empower themselves (Purdey, Adhikari, Robinson and Cox, 1994). In the process of empowerment, the professionals can only facilitate the participants through a problem-posing education to unveil reality and to build a sense of consciousness and confidence among the participants (Ramos, 1998). Thus, in empowering the participants, the facilitator would need to take various

roles such as "teaching/advising and providing support, promoting participants in decision making and assisting in identification of solutions" (Stewart, 1994).

3.2.1.1 Components of Empowerment

Because of the complexity of the concept of empowerment, there is little consensus regarding its levels and components for measurement. Although, it can occur at various levels: individual, group and political level, most studies have focussed on the personal level of empowerment. Within the personal level, different authors have identified different components of empowerment. For instance, Gutiérrez (1990) with a psychological orientation has described empowerment as consisting of simultaneous and synergistic changes in the four main psychological constructs in the individual namely "increasing self-efficacy, developing group consciousness, reducing self-blame and assuming personal responsibility for change".

Kak and Narasimhan (1992) used the individual level psychosocial changes to describe the process of empowerment. They advocated three categories namely "self-enhancement, family relations and community relations". Self-enhancement can be measured by the individual's economic status, knowledge and skills, autonomy (self-reliance), independence, self-esteem and feeling of wellbeing (i.e. general confidence, happiness and decreased depression and frustration). Family relations can be measured in terms of the individual's relationships with family members like husband and parent-in-laws and increased decision-making regarding children's need, health care, and household expenses. Community relations can be measured in terms of the individual's mobility, relations with neighbors, respect from community and attitude towards FP.

Wedeen and Weiss (1993) used a different approach. They described the personal components of empowerment process as "the ways of feeling (in terms of self-esteem, self-confidence, sense of freedom, aspiration and identification), the ways of thinking (in terms of control over life activities, knowledge of environment, critical consciousness and problem solving) and the ways of behaving (as autonomy, assertiveness and joint action)".

Gibson (1995) used a stepwise approach and described the process of empowerment as consisting of four psychological changes developing in a phase-wise manner. The first phase is discovering reality and realizing the existence of a problem. The second phase involves critical reflection, evaluating oneself and examining the situation critically and developing confidence in one's knowledge and abilities to carry out the activities needed. The third phase is taking charge of the situation through activities such as learning to interact effectively with the health care system and establishing a partnership with other significant persons such as the facilitator and peers. The fourth phase is maintaining one's own sense of power in making efforts to attain the desirable outcome. Thus, when a group is empowered, it results in participatory competence and increases self-confidence. Common to all of the above literature is the development of critical consciousness, enhancement of a feeling of self-confidence and increased level of competence as the core of empowerment.

It is possible to study empowerment at a group level but only a few published studies have done so. The Ford Foundation (1992) has proposed a set of group indicators for the measurement of empowerment at group level. These include the ability of the group to identify the problems, to determine the actions for the resolution of the problems, to obtain the resources needed and to form linkages with other concerned groups.

3.2.1.2 Measurement of Empowerment

The psychological transformation, as a result of empowerment is not easy to quantify. Similarly, the measurement in terms of increase in ability of the individual is hard to quantify. Staples (1990) suggests that individual level perceptions are easier to quantify through a series of attitude type questions. Along with these, other measurements that can be used to assess the outcome of empowerment are "the degree of responsibility that they have assumed, reports and fliers produced, meetings attended and contacts with the professionals made" (Stein, 1997).

A number of studies have used the community empowerment strategies. These strategies have been found to be effective in implementing sustainable community

development projects in Rural Nepal (Purdey, Adhikari, Robinson and Cox 1994) in improving the birth outcomes in homeless pregnant women in San Francisco (Ovrebo, Ryan, Jackson and Hutchinson, 1994), and in enhancing the individual and community self esteem, power and economy through a mother to mother support program among high risk Hispanic women (McFarlane and Fehir, 1994). Purdey, Adhikari, Robinson and Cox (1994) identified the outcome of the empowerment process in terms of overcoming the physical, bureaucratic and interpersonal difficulties and change of attitude from that of dependency to independence in water project, whereas in the chulo (fire stove) project they used the quantitative and qualitative measures in terms of health outcome and capacity of women to influence other women. Ovrebo, Ryan, Jackson and Hutchinson (1994) measured the outcome in terms of quantitative and qualitative data i.e. birth outcome and transformation of the lives of women from that of hopelessness to developing hope. McFarlane and Fehir (1994) measured the outcome of empowerment program in terms of enhancement of individual and community's self-esteem and power.

In this study, the focus of empowerment is at the group level. Empowerment is measured in terms of the FCHVs' ability to identify the problems related to high fertility, to determine the activities that lead to resolution of the problems and to identify the resources needed. Individual level of empowerment of FCHVs is organized into psychological and social empowerment. The individual level of psychological empowerment of FCHVs is described in the form of their perceived consciousness, competence and confidence in facilitating the CMWRAs to control their fertility. Consciousness is measured in terms of awareness of FCHVs about the causes of the problem and about its consequences and cues to action that result through group analysis. Competence is considered as the ability of FCHVs to use the techniques of facilitating and enabling CMWRAs to increase their awareness and use contraceptives. Confidence is taken as the FCHVs' self-feeling of their ability to carry out the activities without the assistance from others. The individual level of social empowerment is considered in terms of increased participation, mobility and ability to establish relationship with the concerned health personnel and the community.

3.2.1.3 Theoretical Considerations

The theory of empowerment also known as theory of freeing (TF) values culture as inseparable part of human life and believes that education must be influenced by culture and education in turn must also influence the culture. This theory is heavily based on group process. The philosophy behind group process is that it promotes social learning through social facilitation. Social facilitation means enhancing the effect on the behavior of individuals through the presence of others either as participants or as an observer. Social learning is the learning that takes place through observation of the behavior of others e.g. through modeling or imitation. Social studies have revealed that the presence of other people, however, does not always enhance the performance of the person rather it can inhibit the performance through a process of social loafing. Social loafing is the tendency for individual effort to diminish in group-task situations that occurs mainly when the individual perceives the task as unimportant (Argyle and Colman, 1995). However, when the task, which is of value to them, is used, the output is rather enhanced.

The size of the group is also important because even though it is a structural component it influences the nature of interaction. The smaller the size, the more is the opportunity for the group members to learn about each other and to establish close relationships. However, the size should be at least 5 or more so as to promote adequate group conversation but as the group size increases it becomes less manageable and also the establishment of mutual conversation becomes less possible. When the group becomes larger the tendency of group polarization increases in group decision-making. Group polarization is the tendency of a group to take decision as per the direction of the opinion of a predominant group member rather than from the consensus of the individual opinions of the group members (Argyle and Colman, 1995). Polarization can, however, be minimized by use of a facilitator to direct the group.

The Social Cognitive Theory (SCT) considers reinforcement or the process of feedback to be one of the important components in learning a behavior. SCT believes that reinforcement can be accomplished through three approaches namely; (1) direct reinforcement through verbal feedback from the facilitator, (2) vicarious reinforcement

through social modeling and (3) self-reinforcement based on self-evaluation of the performance (McKenzie and Smeltzer, 1997). All these approaches are used in facilitating learning among FCHVs. In addition to reinforcement, the other constructs like behavioral capability (i.e. developing skills for translating knowledge into practice) also plays an important role in the performance of the behavior. So, if a person is to perform the behavior well, he or she must know what behavior to be performed and how to perform the behavior (McKenzie and Smeltzer, 1997).

Empowerment of group members occurs along a continuum from the minimum to the maximum level depending upon the degree of their participation. Participation means involving people in sharing their views, experiences, in making decisions about, in planning for and implementing activities, and in evaluating the outcome of the action. When people participate constructively in activities of social value to their self and to others they become empowered.

Participatory Action Research (PAR) is the method that empowers people because it values experiential learning and uses process training to bring personal and social change (Schoepf, 1993; Whyte, Greenwood and Lazes, 1991) PAR enables FCHVs to realize the importance of contraception and empowers them to deal with the hindering factors. In PAR the research cycle begins with building consensus about the issue and investigation of the issue in terms of causes and consequences through dialogue. Experiential learning is used as a source of information, which is supplemented by new knowledge if needed. Action cycle begins with planning action for the issue followed by initiating action and evaluating the outcome and reflecting on the action implemented.

PAR is people-centered and focused on practical problems of importance to the people. It is characterized by group-activity aimed at undertaking action through participation of people with the facilitator. So, in PAR, people with different power, influence and language facility come together to work in a common problem (McTagyart, 1991). This enables sharing of information (theoretical and experiential)

relevant to the issue producing mutual benefit to the facilitator and participants. PAR believes in local talents, and empowers and activates local people to develop their potential (Rains and Ray, 1995; Chesler, 1991). People's participation is essential to empower them. Stromquist (1985) asserts that "a social study that looks for the improvement of a particular group cannot impose change from above or outside, so, the group itself should become conscious of its situation and potentialities for change" (Cited by Sanchez and Almeida, 1992). Involvement of community members in the resolution of the community health problems is important because it fosters motivation among people to bring change (Weisberg, and Greenberg, 1998). Additionally, for any change "felt need" is essential. When the recipients of change themselves have participated in identifying the need for the change, a felt need for change is most likely to occur. Consequently PAR will lead to self-imposed action which is more likely to be acceptable and followed up than the actions imposed by other methods (Israel and Checkoway, 1994). Since empowerment does not occur all of a sudden, the participants will need assistance to implement the newly learned skill until they are ready to try themselves and feel confident to repeat the cycle of action and reflection individually to affect change.

PAR promotes sustainable development. Through continuous analysis of the problem, the participants develop collective understanding of the problem and gain knowledge and confidence to solve problems. A feeling of ownership and commitment develops among the participants resulting in a long-term continuation of the action (Travers, 1997; Rains and Ray, 1995).

Critical consciousness (the awareness of the root causes of the problem that results from group-analysis and that enables people to enact change) is the core component of TF that enables the person to address and alter his/her attitude, beliefs and perception (Stein, 1997). TF believes that critical consciousness develops through dialogue with people rather than through the traditional method of teaching. Critical consciousness or self-awareness enables the person to address and alter his/her attitudes, beliefs and perceptions more effectively than by someone telling what he/she should do (Bergdall, 1993). Equality and mutual respect between the facilitator and

participants characterize Freire's problem posing education (Ramos, 1998). This process promotes free sharing of experiences and learning in a non-threatening and non-hierarchical environment.

3.2.2 Model for Empowerment of FCHVs

The proposed model for empowerment of FCHVs (Fig. 3.1) is based on Paulo Freire's theory of empowerment education consisting of "listening-dialogue-action cycles". These cycles help the participating members to reveal their values, gain local insights, and develop their leadership abilities (Wallerstein and Bernstein, 1988). The model uses PAR methodology that follows the cycles of "analysis-action-reflection" (Purdey, Adhikari, Robinson and Cox, 1994).

Based on the fact that high fertility 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, the proposed model uses *women beneficiaries*. Further, to avoid gender barriers (as it is considered inappropriate to discuss the issues related to sexuality and contraception with the person of opposite sex) the model uses *the women to women empowerment approach (*Katz, West, Dumbia and Kané, 1998; Kamal and Sloggett, 1996; Bongaarts and Bruce, 1995). *FCHVs are the main focus* of this model because of two assumptions. First, is that the empowerment of FCHVs would facilitate in the empowerment of the CMWRAs. Second is that FCHVs would help in increasing contraceptive acceptance among CMWRAs through the provision of basic family planning services to rural communities.

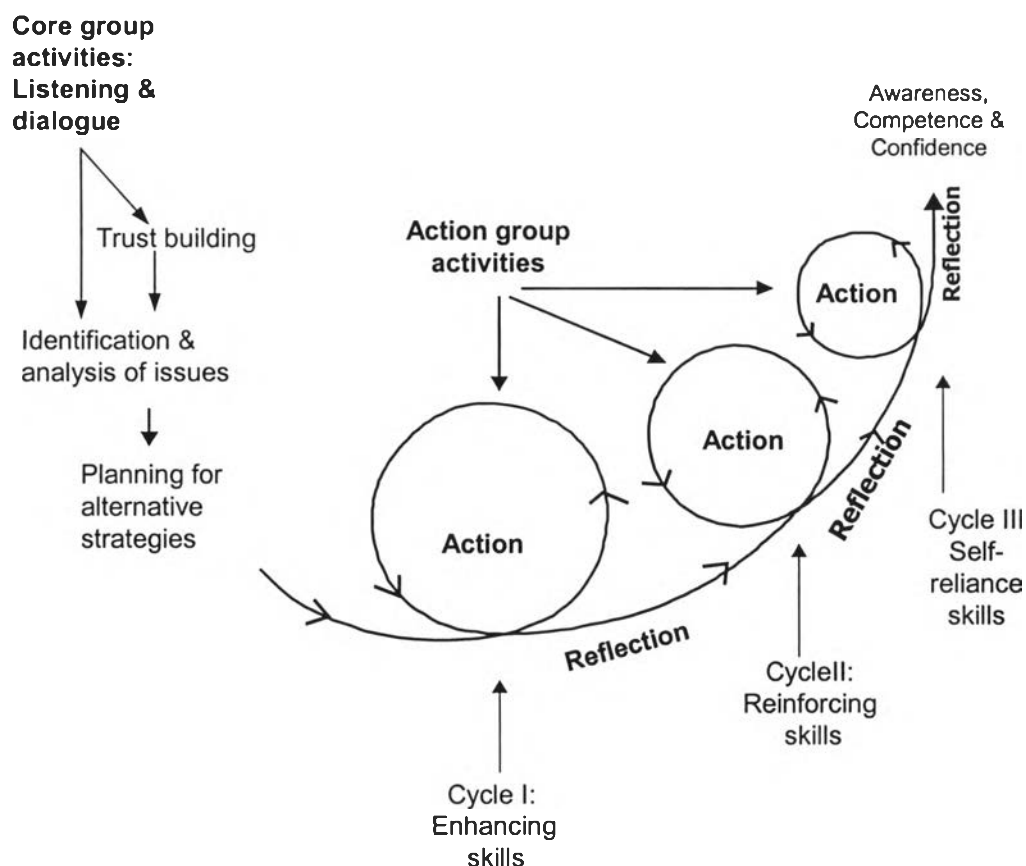

Figure 3.1: A Model for Empowerment of FCHVs

The model assumes that bringing FCHVs together to discuss the problem and to seek solution would develop a sense of individual and group empowerment (Wallerstein, 1992). It is also believed that FCHVs already know a great deal about their own community and that the group process would build upon their existing knowledge to critically analyze the problem of high fertility in the community and develop their critical consciousness regarding the problem and its causes. Through this critical consciousness, which is the core component of empowerment education, FCHVs would recognize the problem of high fertility in their community as arising from the lack of power among women and would realize a need to take action to resolve the problem (Stein, 1997). The use of PAR would help FCHVs to increase their consciousness by exchange of information, viewpoints and experiences within the

group and to move from personal to group analysis and then to the action level (Smith, Pyrch and Lizardi. 1993). Through the use of PAR, FCHVs would also develop and enhance the skills needed for effective communication, participatory planning and decision-making. The success of PAR, however, would rely on the motivation level of the FCHVs. Their readiness to learn and commitment to work or serve would be two pre-requisites to keep them involved in PAR.

The model considered empowerment to occur both as a process and as an outcome. As a process, it would occur in the form of repeated cycles with alternating activities of action and reflection of FCHVs through which they gain consciousness, competence and confidence. First the FCHVs work with a health professional or facilitator and gains knowledge and skills from group activities where their empowerment is emerged. Then the FCHVs are divided into smaller groups of 3-4 FCHVs to go to community to facilitate CMWRAs to increase their knowledge and skills in using contraceptive. The initial facilitation activities of the FCHVs will be observed by the researcher and peers. This would be followed by the joint reflection on the facilitation for further improvement. This would lead to further strengthening of the empowerment of the facilitating FCHVs. The change in the performance of the individual FCHVs would be the outcome of empowerment.

3.2.2.1 Process of Empowerment

Empowerment as a process would be carried out through group activities based on the principle of group dynamics that people learn better and more happily through sharing with one another (Zandon, 1996). The model would use two groups of stakeholders: FCHVs as change agents and CMWRAs as the beneficiaries, to facilitate the contraceptive acceptance in the latter group. In order to build the capability among the FCHVs in terms of raising their awareness, competence and confidence, each FCHV would work at two group levels: 1) core group and 2) action group.

At the *core group level,* FCHVs would work as participants with a health professional, preferably a community health worker, as the facilitator to promote their learning from group activities. This group would serve as a forum for the participating

FCHVs to learn from each other's experiences. The activities at this group level would include the analysis of the problem including its causes and consequences, and the planning of the strategies to resolve the problem through dialogue. This would be followed by practice and feedback in a simulated setting through role-playing on the implementation of the strategies. Later on, this group would also be concerned with regularly reviewing the actions implemented at the action group level.

As the literacy rate among FCHVs is generally low, use of pictorial-aids is suggested for opening up the dialogue among the participants. PRA (participatory rural appraisal) and SARAR (self-esteem, associative strength, resourcefulness, action planning and responsibility) techniques help to stimulate reflective thinking among participants (Reitbergen-McCracken and Narayan, 1998). PRA tools are concerned with revealing visual overview of rural communities and their ways of living. These tools make use of diagrams/pictures that are drawn by the participants themselves such as community mapping and seasonal calendar. The SARAR tool derived from human development approaches such as the story-telling-with-scenarios is concerned with raising awareness of the participants. Like PRA, SARAR tool also makes use of visual aids to stimulate discussion and facilitate decision making by people. However, in SARAR, drawings are prepared in advance rather than by the participants during the training program (Rietbergam-McCracken and Narayan, 1998).

The use of these tools such as the "story-telling-with-scenarios" that uses two scenarios (one showing the problem and the second showing the ideal) would be beneficial in relating to real life situations and in stimulating dialogue in the group. The facilitator, in order to initiate the dialogue would ask 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 would be encouraged to share similar experiences from their communities, to explain why the problem(s) existed and to develop strategies to address the problem (Wallerstein and Bernstein, 1988). Through dialogue, participants in the core group would visualize the problems related to high fertility. They would analyze 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 would return to their respective communities to implement the strategies that they had planned in the core group. The action group would consist of individual FCHVs, as the facilitators and CMWRAs, as the participants. The action group would plan and implement actions to reduce or eliminate the barriers to the CMWRAs in using fertility control measures. This group would also review the actions implemented.

The repeated cycles of action and reflection at the *action group level* would enable FCHVs to develop their awareness, competence and confidence in facilitating CMWRAs in controlling their fertility as described in Figure 3.1. Use of participatory approach would also increase CMWRAs' awareness of the problems of high fertility and enable them to act upon the causes of these problems. The increased competence as well as confidence of FCHVs would also help them to gain trust and respect from the CMWRAs and this would serve as an intrinsic reward or incentive for FCHVs to regularly engage in the action group. Furthermore, the group approach is culturally suitable to rural settings where people are bound closer, both emotionally and socially, than the people in the urban settings.

Since empowerment takes a gradual course, FCHVs would need continual support before they are ready to apply the newly learned skills with full confidence with the CMWRAs (Simons-Morton and Crump, 1996). Based on this premise, this empowerment model describes *three distinct action-reflection 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 receive 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 the contraceptive acceptance among the CMWRAs.* During this cycle, the performance of the individual FCHVs is observed and reviewed by her peers of the core group. This cycle is repeated

until the FCHV feels confident enough to implement the planned strategies without the support and assistance from the peers. She is then ready for t*he third cycle*: *the self-reliance cycle,* which is carried out by individual FCHVs with the CMWRAs in their respective communities without assistance from either the facilitator or from the peers.

3.2.2.2 Outcome of Empowerment

Focusing on empowerment as an outcome provides a measure of the success of the process. The outcome of empowerment of FCHVs is measured at the personal and community level (Israel and Checkoway, 1994). The outcome measure at the personal level is the 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 will reveal whether FCHVs have helped CMWRAs gain control over their fertility. These are assessed in terms of family planning activities carried out by FCHVs such as the number of contraceptive awareness-raising sessions conducted, of individual consultations provided, and of contraceptives distributed.

The impact of empowerment of FCHVs can be measured in terms of the awareness of CMWRAs' about contraception and use of a contraceptive method (www.who.hrp, 1997). It is also hypothesized that with their increased awareness about the proper use of contraceptive methods and their ability to choose a method, the empowered CMWRAs will derive satisfaction from the use of the contraceptive method and will be willing to continue using it (Ravindran, 1994).

3.2.3 Testing of the model

The model is tested by implementing the model and by assessing its outcome and impact on FCHVs and CMWRAs respectively. These are described in subsequent chapters IV and V.