

Title: Community Empowerment in Health: An exploratory study in rural community of a district of West Bengal

Abstract:

Background: Community empowerment is the process and outcome where community itself is able to identify, prioritize health problems and address **them**. It has been considered as the key strategy for scalability and sustainability of health services.

Objectives: to explore the status of community empowerment in health in rural areas in West Bengal, India and the interplay of different stakeholders.

Methods: A cross-sectional, qualitative study was conducted in 2017 – 2018 among the people residing in rural areas of Birbhum district in West Bengal, India who utilize the public health system (lay informants), formal and informal leaders of the community, community level health workers and peripheral health staff (key informants). Three community blocks, two sub-centers from each block and one village from each sub-center were selected randomly. In-depth interviews were conducted among 36 lay and 36 key informants using Laverack's nine dimension model of community empowerment. Framework analysis was done to summarize data.

Results: Participation of people was restricted to awareness and utilization of existing health services. Unmet aspiration for greater participation was noted among a small section of the community. They were mostly fitted to the role of beneficiaries. Functioning of village level organization to promote communitization as envisaged in national health programmes was largely deficient. The community health workers acted as the most peripheral appendages of formal health system rather than the health activists to empower community regarding community's health.

Conclusion: Although, every national health programme advocated community empowerment, the current status and the process of empowerment **in** health is in nascent stage.

Introduction:

Community participation was one of the key principles for “health for all” in Alma-Ata Declaration; is a topic of renewed interest considering the poor progress towards millennium development goals in the resource constrained countries.^[1] In that context ‘community participation’ is a concept of concern.^[2] **The failure to address community care and participation effectively within the health programmes is the major reason for the poor sustainability and ineffective scalability of health interventions.**^[3]

Community participation and empowerment are closely related subjects. Participation indicates involvement of the community either passive or active. Whereas, empowerment is the process and outcome of acquiring knowledge, skill, confidence and right to have control over the decision.^[2,4] Community empowerment in health means building capacity and creating enabling environment for identification of problems, decision-making, planning, implementation, resource management, monitoring and evaluation of health care programmes by the community itself in active collaboration with partners in and outside the community.^[4,5] Community empowerment was linked with improved health outcomes and equity of health services.^[6,7]

To measure community empowerment, Laverack and his colleagues identified and interpreted nine domains of community empowerment in a programme context: (1) Participation, (2) local leadership, (3) problem assessment, (4) organizational structure, (5) resource mobilization, (6) links to others, (7) ‘asking why’, (8) programme management, and (9) relation with outside agents.^[4,5]

Despite its significance; due to the vastness and complexity of the concept, only a very handful of research work has been done.^[8-11] In India, every national health programmes and policies advocate for empowering community to achieve and sustain the health goals. However, there are

scarce information regarding the actual nature and current status of community empowerment among the different levels of stakeholders. West Bengal is noted for its deep rooted Panchayati Raj Institution where participation of the community in decision making and implementation of developmental work was significant.^[12] With this background, the present study had been conducted in socio-cultural settings of rural West Bengal to explore the status of community empowerment regarding the health care services among the beneficiaries of the system and to assess the role of different stakeholders in planning, implementation, monitoring and evaluation of health programmes.

Materials & Methods:

Study type & design:

A community-based, descriptive, cross-sectional, qualitative study was conducted during 2017 - 2018 among rural population of Birbhum district (DMS Coordinates of Suri, the District Headquarters is 23°55'0.12" N 87°31'59.88" E) of West Bengal, India.

Study area:

The rural area of Birbhum district spreads over 2242 villages in 19 community development blocks having 3.5 million population. There are 484 health sub-centers in Birbhum to cater the rural population; as per data available in District Census Handbook Birbhum - Census of India, https://censusindia.gov.in/2011census/dchb/DCHB_A/19/1908_PART_A_DCHB_BIRBHUM.pdf, accessed on 23.11.2018.

Study population:

Proximate stakeholders of primary health care in the study area were broadly categorized in five groups: a) beneficiaries of the health system, b) formal leaders (members of Panchayat) and c) informal leaders (leaders of self-help groups, respected school teachers, distinguished members of local club/ committee/ NGOs or other key persons) of the community, d) Community Health Workers i.e. Accredited Social Health Activists (ASHA), e) Peripheral health staff e.g. Auxiliary Nurse Midwives (ANM). There might be other stakeholders in health who act through various interrelated and interdependent relation with proximate stakeholders.

The beneficiaries were described as ‘lay informants’; while the other groups of stakeholders were ‘key informants’.

Sampling & sample size:

Multi-stage random sampling was used to identify two community development blocks of the district, three sub-centers in each block and one village in each sub-center. Stratified purposive sampling was used to identify stakeholders from different groups in each village. In each village, two beneficiaries; at least one from other group of stakeholders; were included in the study.

Development of study tools:

Two interview guides; one for beneficiaries and other for key informants like leaders (formal and informal), health care workers and link workers, were framed in local vernacular based on the nine domains developed by Laverack et al.^[4,5] After assessing for content validity by a group of sociologists and public health specialists, this interview guide was pre-tested among the similar

communities in Birbhum. The final interview guide was prepared after necessary modification with emphasis on its comprehensibility, acceptability and spontaneous flow of the questions.

Parameters to be studied:

The framework of ‘nine domains’ for community empowerment, developed by Laverack et al., was followed.^[4] It encompassed the following sub-themes:

1. Stakeholder Participation: Process of awareness, participation of different layers of society, involvement in improving access
2. Programme Management: Awareness, participation, contribution and critical appraisal of planning process, implementation and evaluation of health programmes
3. Organizational structures: Organizational structures in a community, representation from different groups, their participation
4. Leadership: Awareness, contribution and proactive involvement in leadership in health programmes
5. Problem Assessment: Awareness, identification, solutions of problems.
6. Resource Mobilization: The ability to mobilize resources from within and to negotiate resources from outside
7. Stakeholder ability to ‘Asking why’: The ability of the community to critically assess the social, political, economic & other causes of inequalities in health
8. Networking: Links with people and organizations, including partnerships, coalitions between the community and others
9. Relation with outside agents: The equitable relation with an outside agents who stimulate and promote community empowerment

Besides that the brief background information (age, sex, occupation, income, and education) were recorded from each interviewee.

Method of data collection:

The study obtained clearance from the Institutional Ethics Committee of the concerned medical college (Memo No. CMSDH/IEC/44/04-2016; date: 02.04.2016). All concerned were informed beforehand. On the days of surveys in different villages, in-depth interviews of the stakeholders were conducted after taking informed consent by a team of two members. One, who was trained in qualitative research techniques, was responsible for rapport building, taking consent and the actual in depth interview and other acted as note taker. The interviews were recorded in voice-recorder after obtaining permission from the interviewee.

Data analysis:

The recorded interviews were transcribed and translated in English by authors. Two authors independently reviewed and coded six transcripts; one each from lay and key informants of three villages. Open coding was used along with explanatory notes. The codes were then compared and contrasted among the coders and final codes were developed. The final coder was then sorted and indexed along the domains of the pre-defined framework of community empowerment.^[4] During this process, the domains of ‘networking’ and ‘relation with outside agents’ were collated into one, due to similarity of codes. The rest thirty transcripts were analyzed systematically by two investigators and appropriate codes were applied to each meaningful phrase/ word of the texts and entered in a MS excel spreadsheet separately for

individual respondents. Once the coding was completed, the data were summarized in a matrix prepared according the framework.^[4]

The study was approved by the Institutional Ethics Committee of College of Medicine and Sagore Dutta Medical College vide no. CMSDH/IEC/44/04-2016, dated 02.04.2016.

Results:

The total number of respondents was 36; 16 key informants (KI) and 20 lay informants (LA). Among them, four were members of Gram Panachayat, two informal leaders, five Accredited Social Health Activists (ASHAs) and five Auxiliary Nurse Midwives (ANMs). All the leaders were males. Among the lay informants, five were daily laborers, four cultivators, three working in informal sector and two doing small business. Two were teachers of primary/ secondary schools, one was in government service and three were home makers. Except the homemakers, all lay informants were males.

Participation: The majority of formal and informal leaders reported lack of awareness and passivity from the people and the Panchayati Raj Institutions (PRI) to muster the health issues as priority. However, health consciousness of the community and keenness to receive health services were also reported. Front-line health workers (both ANMs and ASHAs) felt that people were aware of the services at health sub-center and they ask clarification if services were not available. Information was communicated through house visits by ASHAs and whenever villagers visited sub-centers. The role of ANMs, Anganwadi workers (AWWs) and members of self-help groups in disseminating health information was also iterated. One people's representative (Key Informant) expressed – *“It would have been good if all of us had taken part in making people aware; but no such initiative exists”* (KI-5). One front-line health worker commented – *“...participation (of people) is restricted to acceptance of the services and that too*

depends on the enthusiasm of both providers and beneficiaries” (KI-14). Health workers observed that majority of the villagers preferred sub-divisional/ district hospitals, qualified private providers even quacks; and not sub-centers or primary health centers; for curative services.

Lay informants (LI) reported they became aware of health activities when ASHAs and/ or AWWs visited their houses. The widespread perception was that they are supposed to receive the services available free-of-cost from government if not confronted with any other competing priority. The majority of them were not aware of the packages of services that they are supposed to avail. One (LI-13) commented – *“All the things are not known – would have been better if it otherwise”*. Information regarding specific services like that of vaccination, care of pregnant women, contraception was shared by health workers with the villagers. That is when the health workers considered villagers as beneficiaries. If a particular known service like vaccine, iron tablets, contraceptive pill etc. was not available for certain period, people sometimes asked about the reason and the expected time when it would be available. However, posing demand as a part of their right was never represented – *“It’s our experience that nobody will come forward if asked for, though they would vouch otherwise”*. People from wealthier section rarely used the services except vaccination, but had their name registered with government system. Majority of lay informants commented that the health activities were conducted as government wished having very little scope of community participation – *“We are not taken into confidence; everything depends on the decision of them”* (LI-20). However, willingness of them (LI-11) to participate was also expressed – *“I can transmit the information to my neighbors only if I know it myself; but that happens only rarely”*.

Programme implementation: Implementation activities are done mainly by front-line health and nutrition workers. Gram Panchayat members and informal leaders are involved in solving deterring issues. Although front-line health workers felt that involvement of Panchayat was both inadequate and conditional.

Lay informants **unanimously** accepted that programmes were implemented in the way health workers felt those fit and they were recipient only. Their aspiration was reflected in the statement (LI-14) – *“We might have been interested in taking a more useful part in the programme; had they really wanted us to; we never enjoy their confidence”*. The formal and informal leaders are passive onlookers and **self-help groups mobilize people only if wanted by health workers**. Even, presence of village elites was considered as having added glamour quotient to that health activity. Their frustration about their role was expressed – *“We would have liked to have someone of us having say over the functioning of health department”*.

Organizational Structure: Though created for prioritizing health issues in village level; very few were aware of existence of VHSNC. Just one reported to have occasional meeting of the committee; though un-confirmed by everyone else. The distribution of SHGs was unequal and people of marginalized section couldn't have their aspiration represented in health committees and programmes. An ANM commented – *“..... women of lower caste don't have any SHG and can't give any input on health problems or programmes”* (KI-15). The motivation and effectiveness of SHGs was also questioned – *“The SHGs were formed for the sake of employment only and are hardly interested in health issues”* (LI-9).

Leadership: It was agreed that leadership was bestowed with the health department. In some situations when there were hitches, some formal or informal leaders were either requested to assume the leadership role or they assumed it of their own. One front-line health worker

commented – *“It would have been better had all stakeholders participated in planning and implementation”* (KI-1). Leadership was not an issue that were considered one (LI-7) commented *“We fight shy of giving leadership and not aware of its benefit too”*. Some get involved in the planning if they had any close relation with health or ICDS workers of PRI members – *“Some individual occasionally get involved if somebody from their family is a PRI member or health or ICDS workers”*. (LI-5)

Assessing Problem: ASHAs primarily identified the health problems **in** the community. *“It was very occasional when an individual come to us (local self-government) with any health problem of the area”* - commented one key informants (KI-3). It was also iterated that information collected by ASHAs were discussed in Gram Panchayat (GP) meeting with health personnel, AWWs and a priority list was prepared. *“The problems we found are discussed in **Saturday** meeting with health and ICDS workers in Panchayat”* – reported a key informant (KI-10). A section of the formal and informal leaders were completely unaware of any such activity. While the lay informants expressed that finding health problems and prioritizing those were responsibility of government only;; it was perceived that common people lacked knowledge and skill for it.

Asking why? People were regarded as passive recipient of health services **not just merely** by health providers; but they themselves perceived in the same way. The faith on ability of people regarding their critical awareness on health was severely lacking among front-line health worker – *“Had Panchayat bring some information; we would have to verify those – adding to our workload only”*(KI-1).

Lay informants, while expressing the lack of confidence on government health services and preferences for private sector, questioned the accessibility and quality of the government

services– *“We feel the services provided are poor in standard and not available round the clock; so, we prefer private sector”*.

Resource mobilization: Only on rare occasions, PRI arranged some funds for health activities. Sometimes, local club or individuals volunteered themselves in health activities, especially in mobilizing the community members to utilize existing services.

Majority of the lay informants were unsure about the purpose and process of resource mobilization for health – (LI-1) *“..... we are unsure how can we contribute; but in general, people refrain (from doing it)”*. It was only Government to do everything and what they could do best was demanding for more allocation – *“We can press for money as united; but we lack leadership in this regard”* (LI-20).

Networking and relation to an outside agents: Officials at higher positions like Block Development Officer (BDO), Child Development Project Officer (CDPO) and Block Medical Officer of Health (BMOH) occasionally visited the villages during any special programmes. One key informant commented – *“Pulse polio (referring to Intensified Pulse Polio Immunization Programme, a WHO backed national initiative for eradication of Poliomyelitis) is an exception, when we see big officers in big vehicles”* (KI-10). Although it was reported that front-line health and nutrition (AWWs) workers were involved in health programmes in tandem. It was perceived that there was no involvement of higher officials in any health issues of the village. One of them commented – *“Higher Officers are not interested in local affairs”* (KI-2). Even, when higher officials did visit the villages, they usually talked to the concerned government functionaries or elites. They **rued the lack** of communication – *“Even when the higher health officer comes; they keep themselves busy with their departmental staff, aloof from us”*.

Discussion:

Bhore Committee (The first Health Committee set up in 1945 by the Union Govt. of India) observed that no permanent improvement of public health can be achieved without the active participation of the people in local health program.^[15] Community empowerment does not mean the wholehearted acceptance of health services or the generation of demand for health services, but the ability and authority of the community to take appropriate decision on their health.^[16] Although, these were included as a key strategies in every health programmes, there are miles to go before we accomplish community empowerment in health.^[16] In analyzing the barriers in achieving community participation, the factors elaborated by Rifkin are the dominance of bio-medical paradigm, lack of in-depth analysis of community perception regarding community health workers (CHW) and scarce information regarding what works in community participation, why and how.^[17]

In the present study, “participation of the community”, as observed by the lay participants, health staff, community health workers as well as the formal and informal leaders, was restricted to acceptance of health services. Although, some community members were interested, in planning and implementation, there was little opportunity. It was widely accepted that the health programmes were conducted by the government as per their own guidelines. It was observed in several other contexts that the philosophy of ‘I plan, you participate’ may lead to failure of participation of the community in health.^[18,19] There was very little scope of local leadership for the community; rather it was bestowed upon the government health functionaries. Formal and informal leaders of the community were involved on request of the health functionaries only

when situation so demanded. Efforts and capacity to assess health problems was largely absent in the community. The critical awareness of people on relation of environment, social factors and human behaviors with health was absent. Reluctance from the health system as well as community health workers was observed in capacity building of the community to enable them to assess their problem and critically analyze their health situation. Whereas, Madan (1987) observed that the motivation for community participation are 'made, not born' through continuous efforts and the strategies are needed to be reviewed time to time to engage all sections of the community. ^[20]

There may be debates on role of government in community empowerment. Cavaye (1999) proposed to expand the role of government beyond service delivery to building capacity of the community, from directly alleviating the problems of the community to support community to identify and address their problems.^[21] Sung also advocated for proactive role of government through creating platform and agencies for 'communitization' process, capacity building and mobilization of resources. ^[22] In their policy document on Community Health Care management Initiative (CHCMI), Government of West Bengal, India envisaged the goal of promoting community involvement in improving people's health.^[23] A number of strategies like creating community level institution, capacity building of functionaries, involvement of community level health and nutrition workers were adopted for planning, implementation and monitoring of health programmes at grass-root level. ^[23]

Community Health Workers (CHWs), according to Rifkin, was a term to refer to a person who lives and works closely with the community on health related issues like health education, providing health care etc. such as ASHAs in India. ^[24] Across the countries, CHW programmes were able to generate community participation and thereby put health in the priority issues of the

community. In contrast to the role of social activists, as envisaged in National Rural Health Mission, ASHAs were restricted to dissemination of information and provision of community level curative care for formal health system.^[25] Their crucial role in the process of communitization as change agent for capacity building of the community and activating community level institutions like VHSNC were neglected. Joshi and George explained that due to performance-based incentive system, ASHAs, who are mostly from poor socio-economic background, were specifically interested in activities that carry incentive.^[26] They even shared the perception of considering people as passive recipient of health services. It was observed that CHWs are frequently explicitly mandated or implicitly expected to embody the accountability of the health sector in the expense of their accountability to the community.^[26] Both lay informants and health system were happy with the present arrangement where ASHAs assess the health problems of the community and discuss it with health functionaries to prioritize it with occasional involvement of PRI members. However, it was observed in the present study that there was no specific mechanism to understand the felt need of the community.^[26] Along with the community, ASHAs also believed that resource allocation is the sole responsibility of the government although they recognized clubs and PRIs as alternate sources. ASHAs usually work under directives of health functionaries and are positioned at the bottom of the hierarchy of the health system.^[27] Therefore, there is very little authority or opportunity for them to voice for the community or to act as local leader in health. It was observed that ASHAs as well as other stakeholders at village level might not be skilled enough to identify and address health problems that resulted from interrelation of multiple factors at multiple levels.^[27] It was, therefore, questioned by the researchers whether CHWs be expected to empower others when they are not empowered.^[27]

As observed in the present study, organizational structures like VHSNC were mostly defunct.^[25]

There are “Self-help groups” available in the community which are created for income generation by providing micro-finance to the needy population. Although they were involved in health activities, they lacked both capacity and interest to meaningfully influence health status of the community. Furthermore, the representation of weak and deprived section was mostly absent.

It was observed by Srivastava et al. that the members of VHSNC were mostly unaware about their roles, responsibilities and authority.^[28] In the study area, meaningful relation with any outside agents was not reported. As only elites of the society or the Government functionaries had access to the Government officials whenever they visited the community; their involvement in health programmes was minimal. Researchers from Manipur also underscored the need of capacity building of members of VHSNC.^[29]

Conclusion:

Although, it is agreed that community empowerment is the key strategy for sustainable development in health, still the community in rural areas in West Bengal act and is considered by the public health system as beneficiaries. Participation is restricted to demand generation and utilization of existing health services. Unmet aspiration for greater participation was noted among a small section of the community. The organizational structure for decentralized action at village level, as envisaged in NRHM, were deficient and lagged in fulfilling their role in ‘communitization’ process in health. ASHAs are mainly involved in dissemination health information, mobilizing people for service utilization, collecting information on health problems and proving health services. However, their role, as ‘change agent’ in capacity building of community through institutions like VHSNCs to achieve the goal of ‘community empowerment’ was seriously missing.

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