Community Empowerment
with Case Studies from the South-East Asia Region

Community Empowerment Conference Working Document
ACKNOWLEDGMENTS

Background paper written and prepared by:
Dr Glenn Laverack, (Empowerment), TDR, WHO, Geneva.

Case-study paper written and prepared by:
SEWA case-study:
- Dr Davison Munodawafa, WHO Regional Office for South-East Asia, New Delhi, India. E-mail: munodawafad@searo.who.int
- Prof Surinder Aggrawal
- Ms Mirai Chatterjee.

ASHA case-study:
- Dr Thakur, J. S. WHO Country Office, India
- Dr Srivastava, R. K.; Director-General, Health Services, Ministry of Health and Family Welfare, Government of India.

This paper was prepared as a working document for discussion at the 7th Global Conference on Health Promotion, "Promoting Health and Development: Closing the Implementation Gap", Nairobi, Kenya, 26-30 October 2009.

It may not be reviewed, abstracted, quoted, reproduced, transmitted, distributed, translated or adapted, in part or in whole, in any form or by any means. The views presented in this discussion paper do not necessarily represent the decisions, policies or views of WHO or the organizations for which the contributors and reviewers work.
CONTENTS

Part A - Background Paper ................................................................. 3

Introduction .............................................................................................. 3

Community empowerment as a 5 point continuum .................................... 4

1. Empowering individuals for personal action ........................................ 4
2. The development of small interest groups ............................................ 5
3. The development of community organisations ..................................... 7
4. Partnerships .......................................................................................... 8
5. Social and political action .................................................................... 8

Community Empowerment: Lessons Learnt ............................................. 9

Action 1: Addressing Community Concerns ............................................ 9
Action 2: Building Partnerships ............................................................... 10
Action 3: Building Community Capacity ................................................ 10
Action 4: Evaluation to share ideas and visions ....................................... 11

References .............................................................................................. 12

Part B – Community Empowerment Case Studies from Countries of the WHO South-East Asia Region ................................................................. 13

Case Study 1: Women’s empowerment to address social and economic determinants of health: A Self-Employed Women’s Association (SEWA) experience .......................................................... 13

References .............................................................................................. 18

Annex 1 ................................................................................................... 20

Case Study 2: Nepal - Female Community Health Volunteers (FCHV) Programme in Nepal ........ 21

Introduction ............................................................................................ 21
Detailed description .................................................................................. 21
Contributions and achievements ............................................................. 22
Issues and Challenges ............................................................................. 22

Case Study 3 - Community Empowerment through Accredited Social Health Activist (ASHA)
under National Rural Health Mission (NRHM), Government of India ............. 23
INTRODUCTION

The purpose of this paper is to provide background information on community empowerment in the context of the conference theme, ‘closing the implementation gap’, as part of the implementation of health promotion. Community empowerment consists of two concepts: ‘community’ and ‘empowerment’. Communities are groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. Communities may be local, national, international or even global in nature and may have either specific or broad interests (Laverack, 2007). Empowerment in the broadest sense is ‘...the process by which disadvantaged people work together to increase control over events that determine their lives’ (Werner, 1988). Most definitions of empowerment give the term a positive value (improves peoples circumstances) and embody the notion that it must come from within an individual or group and cannot be given to an individual or group.

Community empowerment includes personal (psychological) empowerment, organizational empowerment and broader social and political actions. Community empowerment is therefore both an individual and a group phenomenon. The conceptual roots of community empowerment come primarily from international development work (poor communities needed to become more powerful), the women’s health movement (which challenged the prerogative of others to define women’s health concerns and remedies) and community mental health activists (who stressed that people with mental disease deserved similar rights to others and ought to be treated in ‘empowering’ rather than controlling ways). Community empowerment is most consistently viewed as a process in the literature (something used to accomplish a particular goal or objective), for example, ‘...a social-action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice’ (Wallerstein, 1992). However, it can also be viewed as an outcome (in which empowerment is the goal or objective itself) and is specific to the individual, group or community involved. The outcomes of community empowerment can have a very long time frame, often taking several years to begin to show results. This should be an important consideration for the design of health promotion programmes.

The Ottawa Charter clearly states that ‘health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies’ (WHO, 1986). The Bangkok Charter (WHO, 2005) complements and builds upon the values, principles and action strategies established by the Ottawa Charter including the concept of health promotion as a process of enabling people to increase control over (empowerment) their health and its determinants. Community empowerment is therefore central to the implementation of health promotion both as a process and as an outcome.

There is overlap between community empowerment and other community-based concepts such as community participation, community capacity building and community development. Essentially they all describe a process that increases the assets and attributes that a community is able to draw upon in order to improve their lives (including but not restricted to their health). The concepts are also fundamentally addressing forms of social organization and collective action to redress the inequalities in the distribution of power, decision making authority and resources. This is important for health promoters because a great deal of our
health is determined by the power that we experience and our control over decisions and resources. The key difference between community empowerment and other community-based concepts is the sense of struggle and liberation that is bound in the process of gaining power. Power cannot be given and must be gained or seized by those who want it, often against those in authority. Community empowerment builds from the individual to the group to a wider collective and embodies the intention to bring about social and political change in the favour of the ‘community’ that embarked on the process. In health promotion practice this process can be best considered as a continuum representing progressively more organized and broadly-based forms of social and collective action, and it is this which is discussed next.

**COMMUNITY EMPOWERMENT AS A 5 POINT CONTINUUM**

Community empowerment as a five point continuum is comprised of the following elements: 1. Personal action; 2. The development of small interest groups; 3. Community organisations; 4. Partnerships; and 5. Social and political action (Labonte, 1990). The continuum offers a simple, linear interpretation of what is a dynamic and complex concept and articulates the various levels of empowerment from personal, to organisational through collective (community) action. Each point on the continuum can be viewed as an outcome in itself, as well as a progression onto the next point. If not achieved the outcome is stasis or even a move back to the preceding point on the continuum. The continuum has been used by health promotion practitioners to explain how community empowerment can potentially be maximised to ‘close the implementation gap’ as people progress from individual to collective action.

**Figure 1: Community Empowerment as a 5 point continuum**

1. **EMPOWERING INDIVIDUALS FOR PERSONAL ACTION**

The process of community empowerment can begin when persons experience a high degree of ‘relative powerlessness’ that triggers an emotional response and a personal action. Then, by participating in small interest groups individual community members are better able to define, analyze and act on issues of concern. In everyday life a personal action and subsequent participation in a small group could be triggered by a road traffic accident and the involvement in a local action group for road safety. In health promotion the basis for personal action and participation is often developed during the planning phase of a programme through an identification of needs. It is important that programmes use approaches to build in a structure as well as a personal way forward toward collective action. If practitioners only focus on the individual they risk making personal the issue and if they only focus on the structural issues they run the risk of neglecting the immediate needs of many people.
2. THE DEVELOPMENT OF SMALL INTEREST GROUPS

The development of small groups by concerned individuals is the start of collective action. This provides an opportunity for the health promoter to assist individuals to gain skills and is a means of developing stronger social support systems and opportunity networks, interpersonal connectedness and social cohesion. An example of the work of a small group to address Female Genital Mutilation in North America, is provided in Box 1 below.

**Box 1: Organizing East African Women on the Issue of Female Genital Mutilation**

Large communities of refugees from East Africa have settled in several European and North American cities. Among some of these refugee communities the practice of Female Genital Mutilation (FGM) is still common. On one hand, opposition to this practice could be seen as a dominant culture imposing its own standards. On the other hand, FGM has also been decried by African women and men on grounds of gender oppression. A mental health worker found herself straddling this political tightrope. She offered one-to-one counselling services through the auspices of an agency dealing with victims of torture. Concerns about FGM arose during some of the counselling sessions. The worker organized support groups for these women that gradually increased in their outward-looking orientation, including advocacy work on the issue of FGM. She also organized an interagency group of health and government organizations that could assist in the lobbying efforts of the women themselves. Direct community organizing around FGM was taken on by a women's health centre with a strong commitment to ethno-racial minorities. As the advocacy and organizing initiatives grew more complex, a multicultural health consultant with the local Council, with more experience in advocacy, became involved. She worked with other organizations to advance arguments to include FGM within the Criminal Code, and to treat its practice as an instance of child abuse (Laverack, 2004, p. 49).

The role of the practitioner at this point of the continuum is to bring people together in small groups around issues which they feel are important to their lives, in a manner that is not too controlling. These include:

- Self-help groups organised around a specific problem such as bereavement support groups and Alcoholics Anonymous. Members usually have a shared knowledge and interest in the problem, are participatory and supportive and often set-up and managed by the participants;

- Community health groups which usually come together to campaign on a specific issue such as environmental pollution or transport needs of socially excluded groups such as the aged. People are motivated to come together either for reactive or proactive reasons usually for short-term periods of time; and

- Community development health projects such as neighbourhood-based projects set up to address issues of local concern such as poor housing, and with government support and a paid community health worker.

It is through the support of small groups that many people find a ‘voice’ and are able to participate in a more formal way to achieve the community empowerment outcomes. However, the membership of small groups is not homogeneous and conflict regarding internal issues does arise, especially during the shift from an inward (self-help) to an outward (social action) orientation. Problem assessment can help to resolve conflict and build capacity when the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community. When these skills do not exist or are weak the role of the
practitioner will be to assist the community to make an assessment of its own problems. Box 2 below provides an example of problem assessment in a school health promotion programme in Scotland. Health promoters must be prepared to listen to what the 'community' wants, they may not necessarily like what they hear, but they must be committed to moving forward and building upon these issues.

Box 2: Problem assessment in a school community in Scotland

Hillhead primary school is in an inner city area in Glasgow, Scotland with 500 children up to the age of 12 years. The Parents and Teachers Association and children had raised the problem of accidents both inside and outside the school environment. The Practitioners wanted to find out from the children about their perspectives of school safety and how they would like to make it a safer environment as part of the design of a public health intervention.

The younger children were encouraged to describe the safe and unsafe areas of the school and on their journey to and from the school by using a drawing. The older children were shown epidemiological data in a visual format using bar charts, pie charts and graphs of school and road accidents in the Glasgow area. These children were asked what they thought this information meant, why did more accidents happen to boys, why they happened at certain times of the day and in certain places? The children provided very thoughtful answers even raising the issue of reporting bias and this provided a different perspective to the Practitioners. The children were asked for their ideas on how to redesign the school playground and on any new rules that they would like to introduce to help make their school a safer place. The children’s’ suggestions included painting the edges of stairs, removing spikes from railings, putting benches in playgrounds where children could rest as a quiet area away from the rough and tumble of the playground and staggering playtimes to allow the younger children to play and to avoid older children. The Practitioner could then use the ideas put forward by the participants as a part of a planning process for community actions, supported by an outside agency (Roberts, 1998).

Once the issues have been identified it is the role of the Practitioner to help the community to develop a strategy to rank them and to begin to analyse the prioritised issues. Box 3 below provides the example of 'story with a gap', a technique that has been successfully used in African health promotion programmes to enable people to analyze important issues shared by their community and then to move toward decision making and action.
Box 3: Analysing community problems: The story with a gap.

The ‘story with a gap’ is used to stimulate discussion about the causes of and the solutions to priority health problems that the community has already identified.

Each group is given two large pictures. One picture shows the before situation of a community priority problem, for example, a community without a drinking supply. The group is asked to develop a story about their community and the problems that they have encountered due to no water in their area. The participants are encouraged to make the story realistic by including the names of places and people.

The second picture shows the after situation, for example, a community well or standpipe. The group is asked to develop a story which explains how this improvement has occurred. The stories that they develop will ‘fill the gap’ between the two pictures. The group members are asked to recount their story and the content is discussed to identify possible pathways to the solutions.

This exercise allows participants to generate ideas about how the community can organise itself to find solutions to problems which they feel have a high priority. The Practitioner facilitates this process of discovery and is part of building specific skills necessary for community capacity (Srinivasan, 1993).

3. THE DEVELOPMENT OF COMMUNITY ORGANISATIONS

While small groups generally focus inwards on the needs of its immediate members, community organisations focus outwards to the broader environment that creates those needs in the first place, or offers the means (resources, opportunities) to resolving them. Community organisation structures include faith and youth groups, community councils, cooperatives and associations. These are the organisational elements in which people come together in order to socialise and to also address their concerns. Community organisations are not only larger than small interest groups but they have a better established structure, more functional leadership and the ability to organise their members to mobilise resources. Community organisations are a crucial step for small groups to be able to make the transition to partnerships and later to social and political action. Importantly, individuals can become more critically aware of the broader issues in community organizations in addition to learning the skills for assessing their immediate problems.

Strategies to develop skills in raising awareness about the broader social and political issues that influence the determinants of health are based on the work of educationalist Paulo Freire. An understanding of the underlying causes of powerlessness is a defining characteristic of empowerment and practical approaches to develop this skill in health promotion include photo-voice (Wang and Pies, 2004).

The development of community organisations and strong local leadership are closely connected. The problem of selecting appropriate leadership is discussed by Goodman et al (1998), who argue that a pluralistic approach in the community, one where there is an interplay between the positional leaders, those who have been elected or appointed and the reputational leaders, those who informally serve the community, has a better chance of leading to community capacity.
4. PARTNERSHIPS

To be effective in influencing 'higher level' policy decision-making, community organisations need to link with other groups sharing similar concerns. Community organisations, by forming partnerships, can strengthen social networks, better compete for limited resources and increase participation in the concerns of other member organisations.

The purpose of partnerships is to allow community organisations to grow beyond their own local concerns and to take a stronger position on broader issues through networking and advocacy. The key empowerment issue is to remain focussed on the shared concern that brings the groups together and not on the individual needs or issues of the different groups in the partnership.

Box 4 below is an example of empowerment in women's groups in Samoa through a partnership with the Government.

Box 4: Empowerment for health outcomes in Samoa.

A national programme designed to address women's health needs in Samoa, Polynesia created a community-based self-help network based on neighbourhood support and nursing care that operated through existing Women's Health Committees (WHCs). The WHCs were prestigious organisations and were well attended by all women. The government supported the development of these community organisations through resource allocation, training and regular visits from health workers. The purpose was to develop the skills and competencies of their members in the areas of child care, weaning practices and sanitation, which had been previously identified as the main causes of infant mortality. The WHC put into force village health regulations relating to sanitation to which all families had to conform. The programme not only brought about improvements in women's health but also their authority, an improved ability to organise and mobilise themselves and to raise funds for other projects. The WHCs became the largest and most influential group in the community and were increasingly involved in a range of community concerns. The WHCs were based on an ideology of equality and empowerment partnered with the legitimate use of top-down traditional authority (Thomas, 2001).

5. SOCIAL AND POLITICAL ACTION

Whilst individuals are able to influence the direction and implementation of a programme through their inputs and active participation, this alone does not constitute community empowerment. As discussed, the difference between participatory and empowerment approaches lies in the agenda and purpose of the process. If concerned individuals remained at the small group level, the conditions leading to their powerlessness would not be resolved. If people only engaged in mainstream forms of lobbying through community organisation and partnership development without political action, those with power-over economic and political decisions would have little reason to listen. Individuals progress along the continuum from a position of personal action to a point where they are collectively involved with redressing the deeper underlying causes of their concern through social and political action. Gaining power to influence economic, political, social and ideological change will inevitably involve the community in struggle with those already holding power. Within a programme context the role of the health promoting agency, at the request of the community, is to build capacity, provide resources and help others to empower themselves.
This paper has so far discussed how health promoters can be more successful in building community empowerment. The lessons learnt to achieve empowerment are discussed below and identified as: 1. Addressing community concerns; 2. Building partnerships; 3. Building community capacity; and 4. Evaluation to share ideas and visions between all stakeholders.

**ACTION 1: ADDRESSING COMMUNITY CONCERNS**

A key lesson for empowering people is the preparedness of health promotion practice to identify, and support, those concerns ‘close to the heart’ of communities. There is sufficient evidence to show that if practitioners are not willing to address the concerns of communities then the programmes that they implement are much less likely to succeed. Who identifies the concern to be addressed and how this is taken forward is critical to building empowered communities. A key constraint to achieving this is the use of top-down approaches in health promotion programmes and the tension that this creates by not addressing community concerns.

Health promotion is most often delivered through top-down programmes controlled by government agencies or government-funded NGOs. It is government policy (and resources) that sets the health promotion agenda and the difficulty begins when this does not meet community concerns. The reliance of health promotion on government funding has contributed to the dominance of top-down styles of programming. Health promotion practitioners are employed to design and deliver programmes that improve the health of individuals, groups and communities within the parameters set by government policy. Even when those in the ‘top’ structures agree with those at the community level about the main concerns, the way in which the agenda is designed and implemented can result in the main issues not being addressed. For example, if you ask any reasonably poor person in any inner-city housing area what their leading concern is, ‘drugs’ would probably be among the top contenders. Relatively powerless groups share in common with more powerful groups the necessity to address the reality of this issue. Powerful groups, including politicians and health authorities, define the solution to the drug ‘problem’ in terms of more police, more social marketing programmes, more drug education courses, more drug rehabilitation programmes, and lots of anti-drug posters and pamphlets. Relatively powerless groups, including residents associations and community groups, define the solution in terms of fear of safety, street violence, crime, poor street lighting, unemployment and even poor housing repair. The solution of more police can create tensions because of racial issues, and social marketing and health education do little to address the underlying social and structural causes of drugs. To begin to address community concerns the health promotion practitioner must build a partnership with the community. The purpose is to facilitate the sharing of his/her power in a way that involves the provision of both services and resources, at the request of the community.
ACTION 2: BUILDING PARTNERSHIPS

The role of the practitioner in a health promotion programme is initially concerned with providing leadership, for example, in setting up community groups or to provide the enthusiasm and the resources necessary to move participation forward. However, the expectation of this role can soon change to a position of a more ‘equal’ partnership between the practitioner and the community. Partnerships demonstrate the ability of the community to develop relationships with outside agents based on the recognition of mutual interests and respect. The partnership may involve an exchange of services, the pursuit of a joint venture based on a shared goal or an initiative to take action.

Many practitioners find it difficult to relinquish the control that they have over the design and implementation of a programme. Health professionals may also find it difficult to accept the validity of community knowledge, and they may not know how to share professional expertise in a way that community members can use it to build their own capacities.

Health promotion practitioners do have an important role in providing information (education and awareness activities), resources and technical assistance but this must support the concerns that have been identified by the community as being relevant and important to them. The role of the practitioner in a partnership is to assist people to build a greater sense of control in their lives. The first step towards taking more control can, for example, be through participating in small groups, receiving information that clarifies an issue or gaining new skills. The purpose is to allow individuals to better define, analyse and then to collectively act on issues of mutual concern. Practitioners sometimes consciously do this by advising and educating their clients, by developing skills and connecting individuals to, for example, interest groups. But mostly practitioners are not aware of the importance of the role that they can play in empowerment in their everyday work.

ACTION 3: BUILDING COMMUNITY CAPACITY

Sometimes communities know what they want but do not know how to achieve it. In other instances, communities do not know what they want and are further constrained in identifying their concerns by internal conflict or a lack of understanding and skills. The practitioner has an important role to play, especially at the early stages of a programme, to provide the necessary support to help communities to identify and/or address their concerns. This is a temporary role and longer term the practitioner should be working toward building the capacity of the community so that its members may take more control of the programme. The programme design should clearly define how it will build the capacity of the community from planning, through implementation, through management and evaluation. Without this focus the community can become dependent on an outside agency to provide support during the lifecycle of the programme. The way in which community capacity is addressed and defined can be overlooked in health promotion programming and includes two key areas of specific skills development:

1. Firstly, for communities to resolve their own concerns, they need specific skills and competencies which can be then applied to a variety of health issues. For example, the organisational skills that are developed in a community in an exercise to prepare for a natural disaster may be used again to address, for example, youth unemployment. Building community capacity therefore has a generic characteristic and is not limited to only one health issue;
2. Secondly, the community should be able to take more control of the health promotion programme itself. Health promotion should itself invest in the development of skills such as financial management, report writing and evaluation.

The provision of resources and technical support serves as a basis for partnerships to develop between the health promoter and the community. New resource inputs will be identified as a strategic plan is developed and should be flexible in the type of resources that are provided. In a programme context resources are often designated to a specific budget category, for example, travel costs, training and equipment. However, the resources requested by the community may not fit neatly into one of these categories. Activities that are difficult to justify as being strictly health promotion but that nonetheless build the social dimension of communities through a sense of inclusiveness include traditional singing and dancing, a sporting event or a community barbeque. These activities create a sense of community, bringing different groups and clans together and bonding them through their own traditional customs and rituals. The flexibility of resource allocation should allow all types of activities so as to build community capacity.

ACTION 4: EVALUATION TO SHARE IDEAS AND VISIONS.

The need for dialogue, the free flow of information and open communication between all stakeholders is essential for empowerment. To avoid misunderstandings, expectations must be clearly defined, documented, shared and discussed. The need for the free and equitable flow of information has been identified as an important element in the process of community empowerment including inter-agency collaboration and effective communication (McCallan and Narayan, 1994) and a dialogue between the community organisation and the individual community members (Speer and Hughey, 1995).

A key turning point in the empowerment of a community is when it stops focusing solely on its immediate needs and begins to address issues that have a broader concern. The process starts with a local problem that has been identified by the community, for example, used syringes being left in a public park. Through the support offered by the programme this local problem develops into an understanding of the underlying causes of lack of control and a discussion about the broader determinants of their lives and health, for example, how the syringes are a symptom of anti-social behaviour. Continued support by the programme leads to capacity building and an increase in knowledge and skills toward broader social and political action, for example, lobbying for better policing and an improved policy on cleaning and monitoring public parks. This has the potential to develop into further community programmes that engage people to address local problems supported by public health agencies. However, this will only happen if ideas and visions are shared between stakeholders and if funding bodies are willing to be creative to scale-up successful local initiatives (Laverack, 2009, p. 124).

In practice, providing people with the information that they need to make informed decisions and to plan strategies can improve their lives and health. However, the sharing of information from one person to others, even when everyone has an equal sense of ownership, can present a challenge and it is crucial that this information is in a format that can be understood by all stakeholders.

As health promotion practitioners we need to recognize that working in empowering ways is a political activity. The structures of power, of bureaucracy and authority remain dominant and part of the role of health promotion is to strive to challenge these circumstances in order to close the implementation gap.
REFERENCES


PART B – COMMUNITY EMPOWERMENT CASE STUDIES FROM COUNTRIES OF THE WHO SOUTH-EAST ASIA REGION

CASE STUDY 1: WOMEN’S EMPOWERMENT TO ADDRESS SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH: A SELF-EMPLOYED WOMEN’S ASSOCIATION (SEWA) EXPERIENCE.

It has been recognized by social scientists, health organizations and other providers of health care that great improvements in health standards of marginalized groups can be realized through improvements in social determinants of health. This paper attempts to document the general and specific contribution of the Self Employed Women’s Association (SEWA) to improving the social determinants of health through women’s empowerment. Intensive reviews of SEWA publications, impact studies of SEWA activities, supplemented by field visits and direct interaction with SEWA members have helped unravel the linkages between women’s empowerment and health improvement of a family or community.

The 1970s saw an increase in social activism and action by nongovernmental agencies in the field of development in India and other parts of the world. SEWA or the Self Employed Women’s Association was founded in Ahmedabad in 1971 by a small group of poor and largely illiterate women, led by Ela Bhattt. SEWA worked to promote the social and economic wellbeing of women through its twin goals of full employment and self-reliance. Its founding members, like Ela Bhattt, turned SEWA into a social movement across various states of India. At present, with nearly one million women members, SEWA is the largest trade union of informal workers in India.

As economic security is crucial to the empowerment of women, SEWA sought to offer full employment to produce income security to its members. As a trade union, it organized its members to demand fairness and justice and fight for the right to seek a livelihood. Members were infused with self confidence to fight against harassment at the hands of the police and municipal authorities. By organizing themselves into trade and service based cooperatives, members increased their ability to bargain with middlemen and contractors. Realizing there was a need for banking services that conventional banks were not able to meet, members started their own cooperative SEWA Bank. The bank now provides microcredit to its members. Loans from the bank are packaged with programmes to train members in skills that enable them to start or expand their businesses. The bank also provides integrated insurance schemes to protect members from property and asset losses resulting from natural calamities and physical illness.

The members’ ability to work was found to be impaired by their own ill health or the poor health of family members. Health care services were found to be lacking and SEWA stepped in to provide and strengthen access to preventive and curative health care. Preventive health care primarily included health education and awareness, immunization and micronutrient supplements to expectant mothers and health insurance. Curative care included improved physical and financial access to health care provided by trained health workers (barefoot doctors and other paramedics) and the sale of low cost western and indigenous medicines. VIMOSEWA, a health insurance cooperative, offered health collective insurance packages to SEWA members and their families at an affordable cost to primarily meet emergency health needs. Likewise, the Mahila Housing Trust offers loans to purchase a house or for expansion and improvement of an existing house. It also partners with other organizations to improve
the quality of life and enhance income generating capacity of slum dwellers through assuring
the provision of drinking water, sanitation and power.

These and several other facilities and services provided by SEWA have played a major role in
empowering women. On the economic front they find more regular employment. Most of
them have experienced an increase in income as a result of being able to devote more time to
work, improved skills, better marketing facility and working conditions. They are also able to
put aside a small amount of money in their bank account on a regular basis. Loans from the
bank have allowed some of them to acquire assets for the first time in their lives. The Housing
Trust has helped them to improve the quality of their housing and many of them have access
to drinking water, toilets and electricity. This has had a positive effect on their work efficiency
as well as on their health outcomes. More children are now able to attend school as their
labour is no longer required to complete domestic chores. The greatest positive impact of
empowerment through membership of SEWA is to be seen in the increased confidence and
self esteem of its members. They take great pride in being members of SEWA and are no
longer afraid of raising their voices against injustice and approach appropriate authorities
with their problems. Most of them also report a greater decision-making role in affairs at
home and confess to being treated with greater respect by their husbands and other members
of their families. Leadership quality promoted among many members helps SEWA in
spreading the benefits of social movement and it empowers the members as well.

The secret of SEWA’s success lies in its organizational structure and its strategy of networking
and forging partnerships with other like-minded agencies. Its organizational strength comes
not only from its large membership but also from the fact that most of its leadership is derived
from amongst its grassroots members. Its partnership with governmental and
nongovernmental agencies has worked to its own advantage and also to the advantage of its
partners and their beneficiaries. It has also networked successfully with other organizations
working in similar areas to advocate the cause of its members and lobby for favourable
policies and legislation at national and international fora. It has adopted an intersectoral
approach to produce synergy amongst its various wings to benefit the members of its services
in an integrated manner.

The SEWA experience has proved that poor self-employed women are bankable and insurable.
It has also shown that given the right guidance, poor, illiterate and semi-literate women are
perfectly capable of identifying their problems and finding solutions to them. The other lesson
that can be learnt from the SEWA experience is that the poor benefit more from health
services if these are made available at the doorstep and by health providers from their own
community. Large investments in health care infrastructure are not needed, at least for the
poor, as they suffer more from avoidable episodes of water-borne and air-borne diseases.
Regular supply of drinking water, adequate housing and proper sanitation can make a
substantial difference not only in their health status but also in income generation. Despite its
success, there are some challenges that SEWA needs to tackle. While many members have
increased their income earning capacity, they continue to remain below or only marginally
above the poverty line. SEWA must prepare them for trades and occupations where incomes
are substantially higher but where the security net of SEWA may not be available. SEWA
needs to prepare its members for challenges posed by globalization that threaten small
enterprises with import of cheap consumer goods.

SEWA was founded in Ahmedabad, one of the leading industrial cities of India. In the
twentieth century, Ahmedabad emerged as the hub of the textile industry. Its many mills
provided direct and indirect employment to thousands of people. One of the first trade unions
in India, the Textile Labour Association (TLA) was founded here under the guidance of
Mahatma Gandhi and Anasuya Sarabhai. Inspired by the two, Ela Bhatt joined the TLA as a lawyer in 1955. By 1968 she was head of TLA’s women’s wing and had the responsibility of organizing sewing and typing classes for the wives and daughters of textile workers. These women often worked in the informal sector in order to supplement the family income.

Ela Bhatt thus came into contact with women who stitched, embroidered, vended vegetables, rolled bidis and agarbattis and did all sorts of informal work to earn money. They had irregular incomes, no job security, and lower wages than the organized sector and were subject to exploitation by moneylenders, contractors, policemen and municipal authorities. Such issues were not addressed by other trade unions, government legislation and policies. The worst was that their work had no recognition. They were ‘invisible’ workers. Ela Bhatt realized that this was the fate of 94 per cent of all women workers in India.

In 1971 Ela Bhatt and the TLA were approached by a group of head-loaders and cart pullers. These migrant women were living on the footpath and sought help to solve their housing problem. Ela Bhatt soon realized that housing was only one of the many problems these women faced. Being illiterate, they were cheated by merchants and deprived of money due to them. Of the cart pullers, most did not own carts and a substantial part of their daily earnings were retained by the cart owners as rent. Their plight was highlighted by Ela Bhatt in articles written to local newspapers. This initial success inspired several other exploited groups of women from the informal sector to approach the TLA. It was soon apparent that though the nature of their work was different, many of the problems they faced were common. A meeting of women working in the informal sector was convened and their problems discussed. This was followed by the birth of SEWA in December 1971. It could, however, be registered only in April 1972 as Indian labour laws had trouble accommodating a trade union where no formal employer-employee relationship existed.

SEWA organizes the individual and voiceless women through various economic activities. SEWA’s approach to organizing is area specific and demand driven. Initially rural workers were organized for providing the minimum wages; later SEWA shifted its focus on livelihood and employment protection and promotion.

The main objective of SEWA is to organize self employed women for their social and economic empowerment. They work for the deliverance of full employment to its members to help them achieve work security, income security, food security and social security. The other important objective is to organize women for self-reliance at both individual and community levels to empower them both economically and in terms of decision-making abilities. These twin goals of SEWA are achieved through the strategies of struggle and development. The former tries to remove the constraints and limitations due to the poor socioeconomic conditions of the targeted population and the latter tool strengthens the women’s economic status, thereby enhancing and achieving social security, in the form of better maternal and child health care, educational attainments and improved housing conditions. All these subsequently lead to improved health outcomes. Ela Bhatt strongly believed in the dictum that “health is wealth”.

Women, although they constitute half of humanity, are socially, economically and politically marginalized. They are seen primarily as wives, mothers and home-makers rather than as workers, because their reproductive role is given prominence over their productive role. This has kept them away from playing a significant role in the public domain in almost every part of the world. The large amount of work they do in looking after the home and family is unpaid, unnoticed and unrecognized. Not only this, but a large amount of income-generating work that they do in and around the house also goes unnoticed and is not computed in national income statistics. When they do step out of their homes to seek work in public spaces, they are
discriminated against, exploited and become vulnerable to harassment and violence. In some societies, right from her birth till death, the female receives an unfair deal in comparison to her male counterpart. The situation is worse in the less developed world, where poverty, malnutrition and certain social customs worsen her plight.

For the past several decades, national governments, nongovernmental organizations and international agencies have been aware and concerned about the status of women. Efforts have been made by these bodies to improve women's literacy, nutritional and health levels and enhance their income-earning capacity. Various strategies have been adopted to achieve these ends, with varying degrees of success. Initially it was believed that economic growth would automatically lead to improvement in the status of women. When it was realized that such improvement was not forthcoming, women were made the recipients of numerous schemes specially designed for their welfare. Even these schemes failed to bring about substantial change in the position of women as they did nothing to change the economic, political, social and cultural forces that contributed to their marginalization. In the 1980s and 1990s it was realized that improvement in the status of women (and other marginalized groups) could only be achieved through structural changes in power structures which gives them greater control over their own lives and also the world around them. This, in turn, could only be achieved through empowerment.

The World Bank's 2002 Empowerment Sourcebook identifies empowerment as "the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives." Empowerment is the means by which a relatively powerless individual or a group of individuals attain power. Rappaport defines empowerment as an attempt to "enhance the possibilities for people to control their own lives" (Rappaport, 1981, 15). Vanderslice (1984) includes within the concept of empowerment of individuals, the ability to influence those people and organizations that affect their lives and the lives of those they care about. Empowerment is both a process as well as an outcome. As a process empowerment helps relatively powerless people. They work together to increase control over events that determine their lives. It gives them freedom of choice and action. Power or control is not granted to them by other agencies, rather they themselves must obtain it. The process of redistribution of power is not always smooth but often involves resistance from and conflict with the structures, systems and institutions that are disempowered. External agencies can provide guidance and create conditions conducive to the shift in power relations between different individuals and social groups in favour of those seeking to be empowered. As an outcome, empowerment is the product of redistribution of resources and decision-making authority. It is reflected in the increased sense of self-esteem in the empowered individual or group of individuals.

UNICEF's empowerment framework involves five hierarchical levels. The first level of empowerment is the welfare level. At this level, women are passive recipients of schemes designed to remove gender gaps in material well-being. At the second level, women's access to resources, such as land and credit, is improved. At the third level of conscientization women become aware of discrimination against them and identify and remove obstacles that work against them. This leads to the level of participation when women begin to take part in resource and power allocation. The final stage of control is achieved when women begin to control and direct events that affect their interests. Empowerment can be considered complete only when women gain control over themselves as well as over resources and factors of production and participate in decision-making at home and in the public arena.

Thus empowerment of women leads to better health for women and also for children, families and communities. There are many examples of empowerment strategies initiated by various
agencies. Sometimes the marginalized group itself has taken the initiative while at other times governments, civil society groups and international agencies have played the lead role. Reprosalud works towards the empowerment of economically disadvantaged women in rural and periurban areas in Peru. The project adopts a participatory approach to address the fundamental issues of gender inequity that affect the reproductive health of women. It sees income generation as a factor that would enable women to overcome economic obstacles to improving their health. The Grameen Bank has assisted a large number of poor people in Bangladesh in improving their standard of living by providing them microcredit to start their own small business. Its experience shows that with six to ten successive loans, an utterly destitute person can break free of the shackles of poverty. Poor housing and chronic ill-health are seen as the major deterrents to freedom from poverty. The Bank, therefore, also provides housing loans at low interest, together with low-cost housing technology. It has also started a health programme that includes health insurance. In addition to credit, the Grameen Bank also offers guidance to members with the aim of improving their social and living conditions. Many of these guidelines are related to health. The impact of the programme is evident in better literacy levels (especially among children), better toilets and drinking water facilities and increased use of contraceptives among its members. The Small Farmers’ Development Programme (SFDP) in Indonesia has helped women engaged in agriculture, fishing and home-based industry to improve their level of well-being. This has been done by skill enhancement, leadership training, marketing and business management in addition to provision of microcredit. Women report greater participation in decision-making, lower fertility and improved nutrition (Rosintan, 1999). In India, the Annapurna Mahila Mandal in Mumbai works for the empowerment of women through programmes related to literacy, health and nutrition, mother and childcare, family planning and environmental sanitation. It trains women in decision-making and group leadership. It provides education, training in self employment, microcredit and legal and medical aid. More than 200,000 women have benefited from it so far.

Attempts at empowerment often run into trouble when a clash of interests takes place. Fonjong’s study examines the role of nongovernmental agencies in empowering women in Cameroon (Fonjong, 2001). It was found that while NGOs had reached a large number of women, their impact had been mixed. While they had been fairly successful in meeting the practical gender needs of water, safety, income and health, their success in meeting strategic gender needs (education, self-confidence and decision-making) was relatively unsatisfactory. NGOs had been successful in providing women access to resources but not in real empowerment in terms of reversing discrimination against and subordination of women. This was because strategic gender needs could be met only after fundamental cultural and institutional changes. Such changes were resisted by the state and by men who had vested interest in the subordination of women.

Arti Sawhny’s study of the Women’s Development Programme (WDP) also found a similar clash of interest in the implementation of the programme. In 1984, Rajasthan became the first state in India to initiate a programme for women’s empowerment. Sathins (grassroots level workers) were selected and trained under the WDP. In 1986, a health programme was launched as part of WDP. To begin with, WDP worked very well. Women organized themselves to fight against domestic and sexual violence and also to demand employment, minimum wages and basic needs like water, education and health care. In 1987 a year-long health project, with focus on reproductive health problems of women, was initiated in Ajmer district. The project elicited tremendous response from women. For the first time women found space to discuss openly issues like fertility and sexuality. New-found knowledge gave them a sense of control over their lives. But within six months, the authorities were rattled by the growing sense of power in the women. Rajasthan experienced severe drought in the 1980s
and situation came to a boil when government officials tried to use drought relief to achieve family planning targets by making the adoption of birth control measures as a precondition to receiving relief. The grassroots interest of women and community needs came into open conflict with government policies. Empowerment of women was now perceived as a threat rather than a goal. As the author concludes, "no form of collective strength will be tolerated by the state if existing power relations are challenged." (Sawhney, 1994)

In brief, SEWA has contributed to the empowerment of its members by providing:

- Organizational strength
- Policy action
- Networking
- Partnership
- Leadership
- Intersectoral approach

REFERENCES


School of Planning and World Bank- Water and Sanitation Programme. Undated Wealth and Well-being: Impacts of Slum Upgrading and Improved Service Delivery to the Poor: A Study Of Slum Networking Project: Ahmedabad, India.

Self-Employed Women Association (SEWA) Entities

- **SEWA Union (Swashree Mahila SEWA Sangh):** Recruits and organizes SEWA’s urban and rural membership around issues of concern to its membership.
- **SEWA Bank (Shri Mahila SEWA Sahakari Bank Ltd.):** Provides financial services.
- **SEWA Cooperative Federation (Gujarat Mahila SEWA Cooperative Federation):** Responsible for organizing and supporting women’s cooperatives.
- **SEWA District Associations:** Provide services to SEWA-organized village groups and links SEWA members for other services.
- **SEWA Social Security:** Provides health care, childcare and insurance services.
- **SEWA Academy:** Provides research, training and communication services.
- **SEWA Marketing (Gram Haat and Trade Facilitation Centre):** Helps women producers, through their cooperatives, associations and groups to directly reach local, domestic or international markets.
- **SEWA Housing (Gujarat Mahila Housing SEWA Trust):** Provides housing and infrastructure services.

**Experiences....**

“For SEWA, women's empowerment is full employment and self-reliance. When there is an increase in her income, security of work and assets in her name, she starts feeling economically strong, independent and autonomous. Without economic strength they will never be able to exercise their political rights in the local government. A woman has to have more work on her hands, such work that ensures her income as well as food, and social security that ensures at least health care, childcare, insurance and shelter...”

Ela Bhatt, Founder of SEWA

*Keynote address at the 1st meeting of South Asian Association for Women’s Studies, Nepal (2002)*
CASE STUDY 2: NEPAL - FEMALE COMMUNITY HEALTH VOLUNTEERS (FCHV) PROGRAMME IN NEPAL

INTRODUCTION

Recognizing the importance of women's participation in promoting the health of people, the Government of Nepal initiated the Female Community Health Volunteer (FCHV) Program in 1988/89 in 27 districts, and expanded to all 75 districts of the country in a phased manner. Initially, the approach was to select one FCHV per ward regardless of the population size. Later in 1993 a population based approach was introduced in selected (28) districts. At present there are 48,514 reported FCHVs actively working all over the country.

DETAILED DESCRIPTION

The major role of the FCHV is to promote health and healthy behaviour of mothers and community members for the promotion of safe motherhood, child health, family planning, and other basic health services, with the support of health personnel from the Sub-Health Posts, Health Posts, and Primary Health Care Centres. Besides motivation and education, the FCHVs re-supply pills and distribute condoms, oral re-hydration supplement packets and vitamin A capsules. In IMCI programme districts, they also treat pneumonia cases and refer more complicated cases to health facilities. Similarly, they also distribute iron tablets to pregnant women in Iron Intensification districts.

FCHVs are selected by Mothers’ Group Members with the help of local health personnel. They are provided with 18 (9+9) days basic training on selected primary health care components. After the completion of this basic training, FCHVs are provided with a certificate and medicine kit box free of cost, consisting of necessary drugs and supplies. The FCHVs are also provided with manuals, flip chart, ward register, IEC materials, FCHV bag, signboard and identity card. For family planning services, pills and condoms are distributed free of cost by FCHVs and are to be re-supplied by the concerned Health Institutions.

External development partners like USAID, UNICEF, UNFPA and many nongovernmental organizations support the FCHV program. Various policy, strategy and guidelines have been developed to strengthen the program. Numerous factors have influenced the program including national health sector reform, decentralization and handover of local health facilities to Village Development Committees, as well as the depth and breadth of experience gained from program implementation at the community level, and the recognition that community-based health programs are the key to reducing mortality and fertility in Nepal.

The national FCHV program strategy document provides strategic directions and critical approaches to ensure a strengthened national program and consistent, continuous support of every FCHV.
CONTRIBUTIONS AND ACHIEVEMENTS

Through their voluntary services, Female Community Health Volunteers (FCHVs) contribute extensively to the health and well being of their communities, in particular to the women and children in rural areas of Nepal. FCHVs are present in over 97% of rural wards in Nepal. Their median age is 38 years and 62% of them literate; 53% of FCHVs have been working for more than 10 years and the annual turnover is only about 4%. On average, the FCHVs were found to work for 5.1 work hours per week and 76% of them willing to increase the amount of time they spend working as FCHV in the future. The role of the FCHVs has been outlined as below;

- To act as voluntary health educators and promoters, community mobilisers, referral agents and community-based service providers in areas of health as per the training received.
- To promote the utilization of available health services and the adoption of preventive health practices among community members.
- To play a supportive role in linking the community with available PHC services and to continue to play an important role related to family planning, maternal/neonatal health, child health and select infectious diseases at the community level.

ISSUES AND CHALLENGES

It is important to further promote this community volunteer scheme as it is one of the most successful programmes in the health system of Nepal. Strengthening it would ensure that the FCHVs will be able to support the health staff at peripheral level to provide good quality health care. Therefore following areas are suggested;

- Strengthen support by all concerned for effective implementation of the strategic directions and critical approaches of the national program as per revised FCHV programme strategy, 2003.
- Ensure strong health system support through health promotion and an effective referral system and institutional establishment for orientation, training and retraining for the volunteer health workers.
- Population–based programme supported by key stakeholders to ensure effectiveness of work of the FCHVs. Most evidence suggests that programme coverage decreases rapidly with increased catchment population per FCHV. However, this effect is lessened when the programmes are of high profile (like the Vitamin A distribution).
- Support the distant learning program for FCHVs through mass media and by radio in particular.
- Utilise FCHVs to increase service coverage or underserved groups, supported also by programs designed with this end in mind.
- FCHVs have substantially better knowledge of HIV/AIDS than rural women, and somewhat better than rural men so they can be better utilized in HIV/AIDS prevention at village level.
- Innovative incentive programs designed / supported to sustain the motivation of the volunteers.
Recognizing the importance of health in the process of economic and social development and improving the quality of life of citizens, the National Rural Health Mission (NRHM) was launched by the Honourable Prime Minister of India on 12th April 2005, to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions. The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, having weak public health indicators and/or weak infrastructure, which are: Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water, social and gender equality and is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It also aims to mainstream the Indian systems of medicine to facilitate health care. The thrust of the Mission is on establishing a fully functional, community owned, decentralized health delivery system with intersectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalising community health centres into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – ‘ASHA’ or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA acts as an interface between the community and the public health system. Currently Anganwadi Workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organizing supplementary nutrition programmes and other supportive activities. The very nature of her job responsibilities (with emphasis on supplementary feeding and pre school education) does not allow her to take up the responsibility of a change agent for health in a village. Thus a new band of community based functionaries, named as Accredited Social Health Activist (ASHA) was proposed to fill this void. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

The selection of ASHAs is done very carefully. The District Health Society, envisaged under NRHM, oversees the process and designates a District Nodal Officer, preferably a senior health person, who ensures full involvement of health department. S/he acts as a link with the NGOs and with other departments. The Society designates Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process, organizing training for Trainers and ASHA as per the guidelines of the scheme. The Block Nodal Officer identifies 10 or more Facilitators in each Block so that one facilitator covers about 10 villages. The facilitators preferably are women from local NGOs; Community based groups, Mahila Samakhyas, Anganwadis or Civil
Society Institutions. In case none of these is available in the area, the officers of other Departments at the block or village level/local school teachers are taken as facilitators. These facilitators are oriented about the scheme in a 2-day workshop which is held at the district level under supervision of the District Nodal Officer. During this meeting, the Block Nodal Officers are also present. The District Nodal Officer briefs the facilitators and Block Nodal Officers on the selection criteria and importance of proper selection in effective achievement of the objectives of the same and also the role of facilitators and Block Nodal Officers as required to be played in ensuring the quality of the selection process. The facilitators are required to interact with community by conducting Focused Group Discussions (FGDs)/workshops with the local self help groups etc. This exercise leads to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. The interaction also results in the short listing of at least three names from each village. Subsequently a meeting of the Gram Sabha is convened to select one out of the three short listed names. The minutes of the approval process in Gram Sabha are recorded. Further, the Village Health Committee enters into an agreement with the ASHA as in the case of the Village Education Committee and Sahayogini in Sarva Shiksha Abhiyan. The names are forwarded by the Gram Panchayat to the District Nodal Officer for record. State Governments may modify these guidelines except that no change may be done in the basic criteria of ASHA being a woman volunteer with minimum education up to VIII class and that she would be a resident of the village. In case any of the selection criteria or guidelines are modified, these should be widely disseminated in local languages. The general norm is ‘One ASHA per 1000 population’. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc. This may be relaxed only if no suitable person with this qualification is available. Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

ASHA as a health activist in the community has varied roles to play in improving the health of the community, like creating awareness about health and its social determinants, mobilising the community towards local health planning, increased utilization and accountability of the existing health services, promoting good health practices, and providing a minimum package of curative care as appropriate and feasible for that level and make timely referrals. She would take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygiene practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services. She would also counsel women on birth preparedness, the importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child. ASHA would mobilize the community and facilitate them in accessing health and health related services available at the village/sub-centre/primary health centres, such as Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government. She works with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan and arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC/FRU). ASHA would provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries and would be a provider of Directly Observed Treatment Short-course (DOTS) under the Revised National Tuberculosis Control Programme. She shall also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit is provided
to each ASHA, the contents of which would be based on the recommendations of the expert/technical advisory group set up by the Government of India. Her role as a provider can be enhanced subsequently. She would inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre and promote construction of household toilets under Total Sanitation Campaign. Fulfilment of all these roles by ASHA is envisaged through continuous training and upgrading of her skills, spread over two years or more.

ASHA has her work organized in a flexible way in which she works at AWC, home and in community. She has a flexible work schedule and her work load is limited to putting in only about two-three hours per day, on about four days per week, except during some mobilization events and training programmes. ASHA works under the guidance of Anganwadi Worker (AWW) and Auxiliary Nurse Midwife (ANM). She attends the AWC on the day when Immunization/ANC sessions are being organized. At least once or twice a week, she organizes health days for health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation. She is available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or RCH camp. ASHA also organizes/attends meetings of village women/health committees and other group meetings and attends Panchayat health committees. She would counsel and provide services to the families as per her defined role and responsibility.

ASHA is essentially an honorary volunteer who does not receive any salary or honorarium. Her work is so tailored that it does not interfere with her normal livelihood. However ASHA is compensated for her time while on her training both in terms of TA and DA at the venue of training. Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks are assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position. The Untied Fund of Rs.10,000/- at the Sub-centre level (to be jointly operated by the ANM and the Sarpanch) could be used as monetary compensation to ASHA for achieving key processes. Group recognition/ awards are also considered.

The Gram Panchayat is involved in supporting ASHAs in her work. All ASHAs are involved in the Village Health and Sanitation Committee of the Panchayat either as members or as special invitees (depending on the practice adopted by the State) ASHAs may coordinate with Gram Panchayats in developing the village health plan. The untied funds placed with the Sub-Centre or the Panchayat may be used for this purpose. At the village level, it is recognized that ASHA cannot function without support. The SHGs, Woman’s Health Committees’, Village Health and Sanitation Committees’ of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

From the start of the NRHM till recently, 6.96 lakhs ASHAs have been selected, 5.79 lakh trained and 4.59 lakh provided with drug kits in their respective villages. Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village. ASHA is likely to be more. As can be seen from the above paragraphs, the community and local governance is involved right from planning, selection of ASHA and further supporting her in performing her duties, which translates into the fact that ASHA is one of the community member who is aware about the problems of the local community and would help the people in creating awareness and seeking health care. As the local governance is involved in the
selection process, they in turn become accountable in some way, which leads to ASHA functioning in a better way, thereby empowering community. The success of NRHM to a great extent depends on the proper functioning of ASHA in various states and particularly the weaker states in India. To ensure an enabling environment to keep up motivation levels requires a number of things: 1) adherence to eligibility criteria for selection; 2) clear performance criteria; 3) quality training for enhancement of knowledge and skills; 4) feedback on performance; 5) supportive supervision and mentoring; 6) regular and adequate supply of medical and non-medical commodities; and 7) rewards for good performance, which could make ASHA work more for the community and thus bring a change in the way people perceive health. There is also a need to strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific training material, well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments also needs to be strengthened and its base widened by allowing a larger number of activities to be incentivized.

ASHA programme has created a groundswell for NRHM and ASHA’a are the visible and audible presence among community which is leading more and more people amongst the community to seek health care and making Janani Suraksha Yojana popular. During the 4 years of NRHM, ASHA program is in place and the ASHAs are almost without exception, enthusiastic and functional. They are being seen as the representative of the local community which has helped in keeping their community links strong and acceptable at large. For any society to be healthy, they need to be aware regarding creation of a healthy environment through hygiene maintenance, safe drinking water, sanitation and being motivated to seek preventive and curative health. ASHA is playing that crucial role of generating the much desired awareness and acting as a link between the rural communities and the health infrastructure thus empowering people to have the biggest asset “health” in their stride, which ultimately would be helpful in community empowerment at large and bring revolutionary change at the local level and also helping socio-economic development in the rural areas of the country. Depending upon the needs arising out of health indicators, poor sanitation and water supply, prevalent malnutrition and communicable and non communicable disease burden and adverse female sex ratio, the role for ASHA intervention could be further identified and prioritized from time to time. It is also equally important for the rural community to trust and support ASHA, “their own representative” for the betterment of their health.

Health and family welfare is one sector that requires simultaneous action on many fronts. The institutional platform of Village Health and Sanitation Committees, the Rogi Kalyan Samitis and Panchayati Raj Institution committees at various levels is providing a rare opportunity for convergent action on all determinants of health. An army of locally resident Accredited Social Health Activists (ASHA) with strong referral links with the strengthened health system will put even greater pressure on the public sector health system to deliver quality services. Along with need based and transparent partnerships with non-governmental providers for public health goals, the strengthened system will have positive consequences for all interventions, whether they are for family welfare, disease surveillance, National Health Programmes, etc. It needs to be seen how best Accredited Social Health Activists could be utilized in the present and future for being the true health representatives of the rural population and help them remain healthy.