

Original Article

Women empowerment is a tool to improve the quality of life of a community-case study

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Abstract

A reduction in Quality of life (QoL) is evidenced among disempowered populations in Low Middle-Income Countries (LMIC) like Sri Lanka. Women in marginalized populations were culturally identified as potential persons who have care responsibilities to break the vicious cycle of poverty through capacity building. The aim of the study focuses on framework analysis to develop an implementation strategy with women empowerment to enhance the QoL of the community. A study was conducted for 4 years (2018-2022) in the Family Health Center, Kondavil, Northern Province, Sri Lanka, as a qualitative framework analysis using participatory action research methodology. As a result of the study, the empowered women coordinate several health service delivery programs for their community members and financially support their own families. The study can be concluded that women empowerment is an effective tool to improve the QoL of the community.

Introduction

The World Health Organization defines the quality of life (QoL) as “An individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (1). Reduction of QoL has been observed in Low Middle-Income Countries (LMIC) with ageing, where aggregate levels of wealth are much lower and welfare systems function poorly or may not exist and the financial burden of ageing is more likely to fall on families or the older individuals themselves (2).


Sri Lanka is a LMIC located in the South Asian region and has its ethnic diversity, culture and tradition (2). The health system of Sri Lanka has preventive (as medical officer of health) and curative (primary, secondary and tertiary levels of services) care (3). In addition to health care, community well-being enrolls by Government administrative bodies, community centers of the village, religious organizations, and national and international non-governmental organizations. However, improving

the QoL of the community is found to be challenging due to an inadequately trained workforce as service professionals and evaluation, financial constraints, lack of soft skills in human resources and lack of active community involvement and engagement (4).

Women have showcased important progress in the aspect of community well-being among LMICs in recent decades. Prosperity shared by empowered women not only shines as the spotlight of each woman but also on their families and communities (5). According to The World Bank, Women empowerment is defined as “the process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes” (6). Economic hardship, lack of social support and low education level were reported as common lifestyle factors which influence community well-being in LMIC (7). An analytical review was done on the current trend of enhancing community well-being in LMIC emphasizing the selection of women in rural areas (8).

Sri Lankan women have a high life expectancy (74 years), nearly universal literacy, and access to economic opportunities (9). Qualitative data collection was done by the Government of Sri Lanka among marginalized and disaster-affected communities in 2019 to study the issues that prevent women from entering the labor force. Care responsibilities, traditional expectations of women, lack of flexibility, safe and convenient workplaces, unaffordable transportation and competitiveness (in small-scale enterprises) were identified as the factors that prevented women’s employment (10). In 2016, a survey of 4000 households was conducted for post-conflict development initiatives in the Northern Province, Sri Lanka, and found that 120 (3%) of the households were led by women (11).

The above-published data highlighted that women among the marginalized population are the potential candidates for empowerment to reduce their vulnerability to being in the disempowered group due to poverty, disabilities, and poor household and/or interfamilial links and

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require the systemic transformation of institutions that support patriarchal structures (11).

The community-based peer-to-peer supportive program was designed and successfully adopted with favorable outcomes in terms of reducing loneliness, increasing physical activity and managing chronic disease in South Africa (12). In India, women were used to disseminating health information and seeking to build communities' capabilities for caregiving for their children (13). Mothers2Mothers (M2M) program showed control over HIV transmission in South Africa (14).

Therefore, women empowerment programs are not only a tool for community well-being, but they can break the vicious cycle of being the vulnerable group with low QoL. The unavailability of published implementation research studies at the primary care level paved the way to initiate an implementation study at the Family Health Center, Kondavil (FHC), which is a primary care unit attached to the University of Jaffna.

The Objective was to identify an implementation strategy to use women's empowerment as a tool to improve community wellbeing.

Methodology

The study was conducted as a framework analysis among the women of the FHC Kondavil coverage area for a period of 4 years (2018 to 2022) by following Participatory Action Research (PAR). Kondavil village is located in the Jaffna district, Northern Province of Sri Lanka. It includes five Government administrative Grama Niladharies divisions (J/115 to J/120) with a population size of 10000. A purposeful sampling technique was used to select and approach the research population. Researchers and the research population were considered participants in the study. Women who were older than 18 years were included in the study. Bedridden women were excluded from the study.

The framework analysis process was carried out over the period of the study in five steps. Such as familiarization, identifying a thematic framework, indexing, charting and mapping/interpreting. PAR was used to empower the selected women through capacity building with the cork-screw cycles of engagement-involvement and transformation process. Short, intermediate and long-term outcomes were considered to evaluate the success of the developed implementation strategy.

Results and Discussion:

1. Familiarization

This village has a divisional hospital, primary medical care unit and Family Health Center for health service delivery. The medical officer of health for the village is Nallur, which is attached to the Faculty of Medicine, University of Jaffna as a field project area. Kondavil village has four schools with primary and secondary education levels, eight community centres and several religious places including temples and churches. There are public transport facilities available to connect with other villages. People living in the Kondavil village show a spectrum of economic, educational and other socio-demographic characteristics. Women in Kondavil village can be classified as shown in Figure 1.

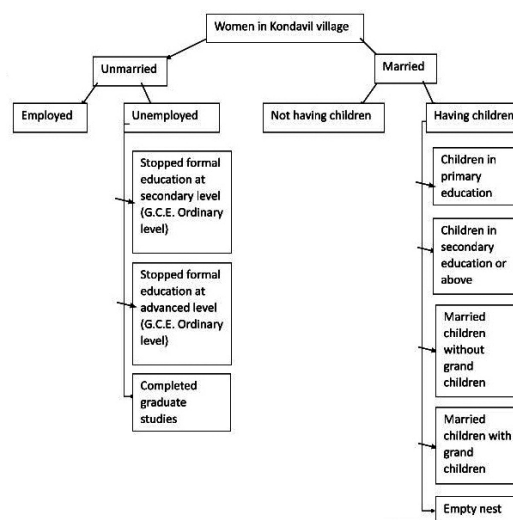


Figure 1: Characteristics of the study population

2. Identifying a thematic framework

Empowering women was considered as the theme. PAR was used to identify and develop the thematic framework. It was designed with suitable intervention for each homogeneous group as an empowerment-iterative model to build their capacity towards livelihood capabilities to link the community wellbeing as follows:

1. Economically active through socially recognized work opportunities
2. Informally educated with on-the-job training by experts in relevant fields
3. Move towards behavioural and cognitive development by providing exposures/ chances/ opportunities
4. Better household well-being and spread it to their community for sustaining in the local context

3. Indexing

The framework was piloted for a homogenous group of unemployed women who had stopped their formal education at G.C.E O/L and were given on-the-job training with socially recognized job opportunities in the health service delivery sector. Faced and overcoming the challenges were indexed as goal setting for plan implementation.

Challenge 1: Recruitment of women

The potential candidates were identified from the clusters through frequent interaction of health service providers with the women during the hospital (FHC) visits, field/home visits, public meetings and recommendations from other service providers or community leaders.

Challenge 2: Development of a thematic framework

A core research team was formed that includes a Consultant Family Physician, Community engagement involvement researchers and multi-disciplinary experts. Triangular analysis was done for the developed thematic framework by the core team during both planning and piloting. It helped to finetune the framework.

Challenge 3: Availability of resources for capacity building programs-

Human resources finance and other resource constraints were overcome through volunteer/incentive scheme participation of trainers, sponsors and beneficiary's support.

Challenge 4: Monitoring and evaluation -

Internal monitoring and evaluation were carried out using feedback from beneficiaries, research participants and coordinators. An external evaluation was done by the experts through periodical socialization programs.

Challenge 5: Sustainability of the built capacity

To pertain to the empowered women, safety and rights, psycho-social well-being, acceptable transport service, economic benefit, social reputation, and opportunity to improve their personal and professional skills were taken into consideration throughout the implementation process. The leading or coordinating role was given to these empowered women for the newcomer's capacity-building programs.

5. Charting

In the service delivery area covered by FHC, Kondavil, it was found that the marginalized population's QoL

was decreasing with age and that they were particularly vulnerable to being in disempowered groups due to poverty and poor household links. This problem was reflected through the study by using women's empowerment as a tool to improve the community's well-being or QoL. The following projects/services were designed for women's capacity building through on-the-job training and community well-being:

Project 1- Shadow teachers in the neurodevelopment clinic

Children who fall on the Autistic spectrum display a variety of social, behavioural and developmental challenges throughout their childhood. For such individuals, self-care, socialization and learning are major hurdles to overcome. Research shows, supporting such children via personalized play activities and shadowing them at schools will have beneficial effects on the child's skill development. It is also considered a culturally responsive management strategy for children.

Therefore, young girls who had stopped their formal education at the secondary level were selected from the village with the help of the patient forum, FHC. On-the-job training was given for 6 months by relevant field experts. These girls were trained to do child-centric play activities to develop gross motor, fine motor, creative, life and pre-learning skills. It started with 6 girls in 2018, and now there are 10 women in the group. In addition, 20 registered children and their families became beneficiaries. Two of the empowered girls are leading and coordinating the program in 2022.

Project 2- Community health assistant in home and community-based geriatric care

Home-based geriatric care is one of the services provided by the FHC to patients who are unable to visit the hospital for various reasons, such as elderly or bedridden conditions. Young women who were introduced by the patient forum of FHC were trained to register selected geriatric people for home care, locate the houses, book the visit dates monthly, provide drug delivery dates, and maintain the home-visit bag and equipment in a calibrated manner.

These community health assistants facilitate the patients and care-taker to do self-care and management until the next visit. They are also available over the phone to connect with the patient's parties. This home-based geriatric care started to cover only five Grama Niladhari divisions, but in 2022, it expanded further up to the Nallur MOH area.

Two of the empowered girls organize a screening for NCDs in the community centres twice a week. They assist identified people in approaching the FHC for further registration for routine clinic follow-ups. These girls work as data collection assistants for household-level surveys conducted by FHC.

Project 3- Health assistant for non-communicable disease clinic

As a part of community members' involvement in routine clinical activities in FHC, these women were trained as health assistants for non-communicable disease clinics. They maintain the patient's medical records, provide appointment dates, arrange clinical set-ups, use equipment such as ECG, blood pressure monitor, and glucometer, as well as do routine clinical data entry, draw blood and be involved in the bio-samples analysis.

These women can educate patients about self-care for diabetic foot, basic level of breathing exercises, basic level physiotherapy for stroke patients, proper use of spacer, inhalers and insulin injection. The FHC currently has two health assistants on staff.

Young girls who were empowered became social motivators for other subgroups. As a result, women with children who require economical support to run their families, as well as women with empty nests, became beneficiaries of the women empowerment clinic.

Project 4- Community-based nutrition program

These empowered women are increasing the availability, accessibility and affordability of nutritious foods in the village. They hygienically prepare the food and pack it in biodegradable paper bags or tissues. They also have food delivery services. Food menu preparation has traditional and modified meals, snacks and beverages with the guidance of a registered Nutritionist. Two active women are covering 25 beneficiaries' daily morning and evening snacks a day.

Project 5 – Skill development, social gathering, cultural activities, home and institution gardening

Only a few of the women in the group are interested in encouraging skill development in others by sharing their content with the other women in the group. A retired English teacher who is a registered patient at the FHC's NCD clinic led spoken English classes with outstanding results. Two of the empowered girls shared their practical ICT skills with their peers.

Some women utilize their leisure time for earning money. They do crafts using waste materials with minimum investment and make gift items and envelopes. They are also capable to make teaching and learning materials for slow learners.

Every month, one of the female members of the group organizes an event for the entire group's enjoyment. These events help them to develop self-confidence, encourage them to work independently as well as in a team, develop mutual understanding and begin caring about others.

Few of them are involved in home and institutional vegetable gardening on a small scale. Green leaves, brinjal, ladies' finger, chilly, beans, long beans, bitter gourd and banana were cultivated and shared with other women in their group.

6. *Mapping and interpreting*

Identifying the significant number of potential candidates, designing appropriate projects for women-linked community wellbeing, formulating the progress way of women's involvement and engagement (for women's wellbeing as regular attendants to the work, monthly earning, saving, improve their soft and hard skills and contribute to identifying the solution for the day-to-day problem) were gained as immediate outcomes of the aforementioned projects. The main outcomes of the entire project can be divided into three:

1. Short-term outcome-
 - Improve the quality of life of empowered women.
2. Intermediate outcome-
 - Improve the quality of life of the beneficiaries and women's families of the project.
3. Long-term outcomes-
 - Activities initiated by the empowered women on community wellbeing.
 - Improve the quality of life of the population in the coverage area of service delivery.

Conclusion:

According to the findings, the study concludes that 'women empowerment' is a successful tool for improving the QoL of program participants, their families, and their community.

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