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Women's empowerment: A case study on the Female Community Health Volunteer Programme in Balkumari, Nepal

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Abstract

The Female Community Health Volunteer (FCHV) Programme in Nepal is considered the backbone of the national health system. With over 52,000 female volunteers trained across the country, they have gained the ability to provide intimate support to mothers and young children, acting as the interface between community and national health (MoHP, 2014, p. 23). As Nepal is a patriarchal nation, women's and children's health can often be not prioritised or dismissed. Prioritising women's health is linked with women's empowerment and a step towards addressing poverty. This study focuses on one NGO, the FCHV Programme that works towards women's health, and aims at understanding in what areas the programme actively works towards women's empowerment. The FCHV programme operates with female volunteers, whose responsibility is working with women that need health support.

This study is framed within a gender and development context. It utilises a qualitative methodology and an empowerment framework to explore how the FCHV programme operates within a local Nepalese context, and in what ways the programme includes empowerment of women. The primary research method applied were semi-structured interviews throughout the seven-weeks of fieldwork in the village of Balkumari in Bardiya District. This study found that despite a lack of financial remuneration, the female volunteers in Balkumari have had some empowering experiences through the education they received. By sharing their education within the community, other women also benefited. In the process, the women experienced increased self-esteem and social status.

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Acronyms

ANM	Auxiliary Nurse Midwife
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHV	Community Health Volunteers
CHW	Community Health Workers
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
GDI	Gender Development Index
GII	Gender Inequality Index
GNI	Gross National Income
GoN	Government of Nepal
HDI	Human Development Index
LIMICs	Low-and-Middle-Income-Countries
MGH	Mothers Group for Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
PDNA	Post Disaster Needs Assessment
SBA	Skilled Birthing Attendant
SDGs	Sustainable Development Goals
UN	United Nations
UNDP	United Nations Development Programme
VDC	Village Development Committee

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Chapter One: Introduction

1.1. Introduction

The Female Community Health Volunteer (FCHV) programme was established in Nepal in recognition of the marginalisation of women, and the need to prioritise women's empowerment and healthcare. The maternal mortality ratio (MMR) is one of the key indicators of women's status within society, and at 529 per 100,000 live births, Nepal holds one of the highest MMRs in the world (Regmi, et al., 2016, p. 9). Women's empowerment is globally prioritised, although with societal norms built on patriarchal constructs, the healthcare of mothers and babies has historically been less prioritised and was overlooked in Nepal. The Ministry of Health and Population (MoHP) established the FCHV programme in 1988 and began prioritising women's health by involving female volunteers and enhancing their reach out to women in villages (MoHP, 2014, p. 23).

In 2000, when the Millennium Development Goals (MDGs) were established, maternal deaths of women within the reproductive age range in Nepal were estimated to account for 27 percent of all deaths (Hotchkiss, 2001, p. 39). Furthermore, the MoHP estimated that 4,500 women died every year from pregnancy-related complications (Simkhada, van Teijlingen, Porter, & Simkhada, 2006, p. 258). The Ministry has identified that to improve women's health and work towards women's empowerment, women's education needed to be addressed and prioritised. To help address the need for women's education in Nepal, the FCHV programme has facilitated educational training of over 52,000 female volunteers across the country who directly support members of their communities by providing education and health support (MoHP, 2014, p. 23).

Nepal has made strong progress towards women's empowerment and women's health first throughout their pursuit of meeting the MDGs, and currently by targeting towards meeting the Sustainable Development Goals (SDGs). However, significant inequalities remain within Nepal's maternal health provisions. These need to be continually addressed through a drive towards the SDGs. One of the universal principles that drives the SDGs is the intent of 'leaving

no-one behind' (Gardyne & Malecki, 2022). To achieve this principle, inequalities such as gender inequality and poor healthcare reception need to be eliminated, and this requires that women's empowerment is prioritised.

No single definition of empowerment exists. Empowerment is multifaceted and can be considered both an end state and a process (Mahmud et al. 2012, p.611). The need for women's empowerment has been prioritised in Nepal through initiatives, such as the establishment of the FCHV programme, which focus on women's health and education. Nepal's national FCHV programme's goal incorporates the desire to impart knowledge and skills towards empowering women, which will be a focus in this study. This research has been framed within a gender and development context and uses Balkumari village as a case study to explore a local operation of the FCHV programme. The research aim is built on the FCHV's objective to empower women (see DoHS, 2021, in Chapter 3), and seeks to understand in what ways women involved in the FCHV programme are empowered. The more detailed research aim and questions are outlined in the next section.

1.2. Research aim, questions, and objectives

The **Research Aim** is to understand how the FCHV programme in Balkumari operates and in what ways the empowerment of women involved in the programme is prioritised. Two research questions were central to the research process.

Research Question 1:

Does the FCHV programme in Balkumari support women's empowerment?

Objectives: **1.1** – Explore what empowerment means to the FCHV staff.

1.2 – Analyse whether the programme activities promote women's empowerment.

Research Question 2:

What resources support the operation of the FCHV programme in Balkumari?

Objectives: **2.1** – Understand what resources are available.

2.2 – Analyse how the programme's resources support the female volunteers.

1.3. Context of Nepal's FCHV programme and the role of community health volunteers

This section gives an overview of the national programme structure from the policy established by MoHP to the localised community intervention of individual volunteers. Subsequently, as this research report seeks to understand lived experiences of women involved with the FCHV programme, this section broadly explains the role of community health volunteers (CHVs) and how their roles can have empowering effects for women they work with.

1.3.1. Nepal's national health structure

The policy for the national FCHV programme is produced by MoHP and supports a community based operating model. Health volunteers within communities have autonomy to educate and support their community on what they deem necessary, and report their work to the person in charge of their local health facility (referred to as a health post). Within Nepal, health posts report to a Municipality Office, then the District Health Office, subsequently the Provincial Health Office, and finally the MoHP. Figure 1.1 (below) depicts the structure of Nepal's health system, and visually represents how the FCHV programme spans from the guidance of the MoHP down to individual volunteers operating in communities.

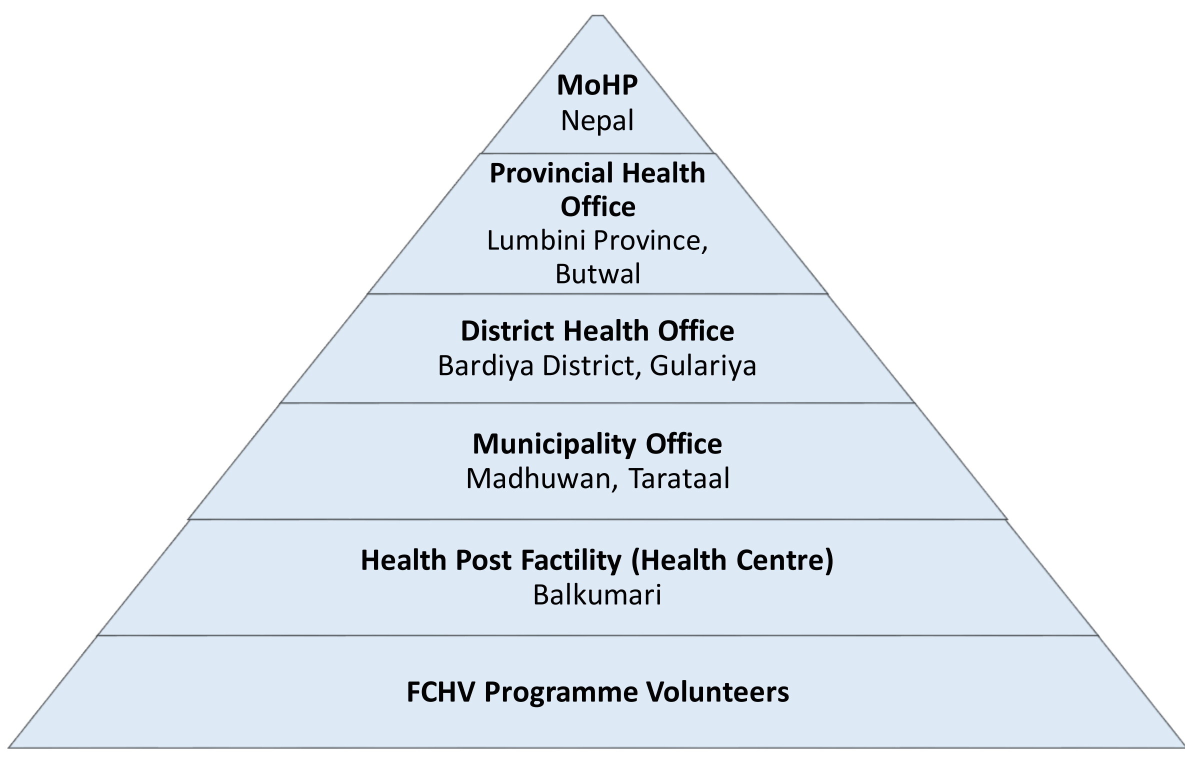


Figure 1.1: *Nepal's health structure (from MoHP to Balkumari Village)*

Maru et al. (2018) discuss that over 52,000 female volunteers work within the national FCHV programme, and the programme is considered to successfully navigate the health barriers throughout the country. The authors have described the programme to bridge a gap between poor healthcare provisions and communities. Despite the common issues of volunteer programmes across the globe being plagued with high attrition rates, the FCHV programme in Nepal has recorded a loss of less than five percent of their volunteers annually (Glenton et al., 2010). Annotated in the latest FCHV national survey report by the MoHP (2014), the contributions of the programme have included "increasing the rural population's use of modern health services; reducing infant, child, and maternal mortality; and ensuring the prevention and treatment of key diseases" (p.23). Nepal's national improvements in health, and in particular MMR and the under-five mortality rate, are attributed to successful community outreach of their FCHV programme (Schwarz et al., 2020). These improvements have been made possible by the large pool of highly motivated volunteers creating a ripple effect towards improving the nation's healthcare through education and health support within their local communities (Schwarz et al., 2020).

1.3.2. The role of community health volunteers

Community health volunteers (CHVs) are "role models within societies who can have long term effects on people's understanding, attitudes, and beliefs towards health" (Vizeshfar et al., 2021, p. 2). CHVs do not usually receive any formal medical training, or receive official remuneration for their services provided to the community (Singh et al., 2016). The key difference between people referred to as Community Health Workers (CHWs) and CHVs is their remuneration. CHWs often have high attrition rates associated with their lack of remuneration, whilst the retention rate of CHVs commonly sits higher than 90 percent due to common empowering aspects of their roles (Singh et al., 2016, p. 166). Key empowering aspects of the voluntary roles are often associated with: education, mobility, self-actualisation, and decision-making authority. Closser et al. (2019) explained that CHVs gain knowledge and become an integral part of their societies, whilst Omelchenko et al. (2018) described how gaining knowledge commonly leads to self-efficacy for the CHVs through their ability to deliver peer-led education and have positive contributions within their local communities. This study will go on to explore the ways in which the volunteers in Balkumari are empowered through their roles within the local FCHV programme.

1.4. The research approach

This research utilises a qualitative methodology and draws upon the Rao and Kelleher empowerment framework for the basis of analysis to understand how the FCHV programme operates and prioritises the empowerment of women. As will be further explained in Chapter Four, using a qualitative methodology supports meaningful research, and the ability to delve into social complexities and lived experiences. As the literature on the FCHV programme fosters a positive narrative on the ripple effect towards health in Nepal, this research has sought to conduct a case study specifically exploring one local operation of the programme in Balkumari. Despite recent COVID-19 travel restrictions, fieldwork was possible and was conducted within the local community of Balkumari for seven weeks.

The primary research method was semi-structured interviews with people involved in the local FCHV programme who have an intimate understanding of the CHV roles. Seven semi-structured interviews were conducted with people in both executive positions and health volunteer roles within the local programme to invoke a deeper and broader understanding of lived experiences. Four interviews were with leadership or executive personnel, whilst three interviews were with female volunteers in Balkumari.

1.5. Research report outline

Chapter One has outlined the context and presented the research aim and questions. This chapter has also briefly introduced the FCHV programme and concept of community health volunteers. **Chapter Two** frames the research conceptually and will explain ways in which women's empowerment is prioritised in development. **Chapter Three** gives a contextual overview with focus on Nepal, and Balkumari. It will also be explained how the FCHV programme broadly operates throughout the nation. **Chapter Four** explains the qualitative methodology and methods used for this research, the ethical considerations, and processes of fieldwork and data collection. It will also explain the limitations of this research. **Chapter Five** presents the analysis of findings and identifies the key themes that have emerged. Lastly, **Chapter Six** discusses the findings and concludes this research report.

Chapter Two: Conceptualising women's empowerment within development

2.1. Introduction

Women across the globe experience subordination, discrimination, and overall multifaceted disempowerment. Consequently, women's empowerment has been continually prioritised throughout development agendas and conventions. This chapter will explain how women's empowerment has been prioritised in development through the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the MDGs and SDGs. This chapter will then explore empowerment by deconstructing the concept of power and will present two empowerment frameworks that will aid the understanding of empowerment.

2.2. Women's empowerment within development

Women have faced a long history of inequality throughout the development discourse. The 1970s have proven to be pertinent in women's development history, as women started standing up for their rights across the globe. Towards the end of the 1970s, the concept of women's empowerment had started to become prevalent. This section firstly analyses the rise of CEDAW in 1981, subsequently the role of the Millennium Development Goals (MDGs) in achieving women's empowerment during the early 2000s, and will then look at how the Sustainable Development Goals (SDGs) promote women's empowerment since 2015.

2.2.1. Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

In 1981 the United Nations General Assembly adopted CEDAW a UN rights declaration, which became paramount to redefining women's position in development. CEDAW has been described as the "most important binding international treaty for women", and holds the primary output to promote women's rights, and eliminate discrimination against women as a matter of human rights (Vijeyarasa, 2021, p. 37). The pursuit to eliminate discrimination

against women has increased women's rights in decision making and has enhanced their opportunities to build a better life for themselves, which included assuming their rights to access healthcare (Vijeyarasa, 2021). CEDAW still remains the only international human rights treaty with the principal goal of protecting and promoting women's rights.

The advancement of the protection of human rights through CEDAW was described by Martha Nussbaum as a key milestone and success of women's movements in development (Nussbaum, 2016). Nussbaum explained that despite human rights legislation lagging behind women's informal and self-generated movements, as formalised legislation CEDAW plays a key role in enabling women to grow and prosper (2016, p. 589). Contemporary authors reflect on how CEDAW did not create notable change to most women's political and economic rights, but rather it enhanced their social rights (Cho, 2014; Cusack & Pusey, 2013; Raday, 2012). Raday (2012, p. 513) referred to CEDAW as a "harbinger for transformative equality", since the intersectionality of women and their ethnicities was not fully considered, and women have been represented as a homogenous group who all want and need the same emancipation. Despite such claims, CEDAW remains one of the leading human rights conventions for gender equality and has enhanced women's rights and opportunities across the globe (Cusack & Pusey, 2013, p. 55). Like CEDAW, the MDGs, adopted in 2000, were another milestone for women's movements in development and are presented next.

2.2.2. The Millennium Development Goals (MDGs)

The MDGs were established in 2000 and consisted of eight goals, 21 targets and 60 indicators (Halisçelik & Soytas, 2019, p. 545). They were derived from the United Nations Millennium Declaration, and were adopted by the United Nations Member States to strive to achieve by 2015 (Painter, 2005). Across the eight goals, the MDGs galvanised unprecedented efforts to meet the needs of the world's poorest and most discriminated, whilst recognising that gender-based discrimination was one of the most prevalent issues (Sandler, 2009). The MDGs put particular focus on combating women's inequality, and women's health (Lombe et al., 2014), and had two standalone goals that solely focused on women. Firstly, MDG 3 aimed at promoting gender equality and empowering women, and secondly, MDG 5 focused on improving maternal health. Recognising the multifaceted nature of women's empowerment,

other goals included specific targets allocated to improving metrics of women's empowerment, for example decent work for women, and female education. In 2003 the World Bank (2003) released a statement reinforcing the importance of women's empowerment, "gender issues are highly relevant to achieving all the MDGs, be it protecting the environment, achieving sustainable development or enabling universal access to healthcare" (p. 3). The MDGs raised global awareness of gender inequities and their cross-cutting nature, and the global commitment to them was inherently powerful in messaging that all goals and targets needed to be addressed as an integrated framework for gender inequities to be defied.

A point of difference from CEDAW was that the MDGs addressed women as stakeholders, rather than rights-holders. This approach of identifying women as stakeholders was criticised by Barton since it was seen to leave women of the Global South at the mercy of top-down development approaches of the Global North (Barton, 2005, p. 6). In agreeance with Barton, and in attempt to address this approach, Painter called women's human rights activists to action to strive for gender equality as rights holders (Painter, 2005). Painter (2005) acknowledged the political will of the MDGs to invigorate and obligate nations' action and commitment, although felt that they would have had more impact framed as human rights obligations like CEDAW. Similarly, Gabizon noted that the MDGs enhanced women's livelihoods and social positions, although they had limited impact on women's rights (Gabizon, 2016, p. 100).

As with CEDAW, the MDGs heavily contributed to progressing women's empowerment in development, and Barton acknowledged that their adoption had created the first time-bound targets and indicators to measure progress for women in the development discourse (2005, p. 102). The MDGs kick-started the focus on women's health and created large improvements in some nations' MMRs (Xie, 2015, p. 67). The MDGs also resulted in improved education for women and girls, and greater female representation in politics. Over time these improvements have led to subsequent investment in areas that focus on equal opportunities for marginalised groups (Xie, 2015, p. 67). Women's empowerment was raised in the MDGs, although it was the adoption of the SDGs in 2015 that was seen as pivotal in bringing women's empowerment to the forefront of the discussion in development.

2.2.3. The Sustainable Development Goals (SDGs)

The SDGs were constructed within the UN Agenda 2030 for Sustainable Development, striving for global achievement. The SDGs were ratified and signed in September 2015 with the resolve to build a better future for all. Comparatively to the MDGs, the 17 SDGs are a lot broader, and were initially adopted with 169 targets, and two years later included 244 global indicators (Halisçelik & Soytas, 2019, p. 545). Rather than solely focusing and targeting the Global South, the SDGs are refocused towards an all-encompassing approach to development. The SDGs promote empowerment and grassroots initiatives within nations rather than submitting to top-down direction from the Global North (Dhar, 2018, p. 53).

The SDGs have reinvigorated a focus on individuals and have brought a measurable focus back into discourse of women's empowerment as a matter of equal human rights. The focus on women is reflected in the overarching principles that drive the SDGs and their intent to leave no-one behind, eliminate inequalities and gender discrimination, and link the goals back to RBAs (Gardyne & Malecki, 2022, p. 251). The importance of gender equality was emphasised by 11 out of the 17 goals, with targets specifically relating to gender-equality and women's empowerment (Gardyne & Malecki, 2022, p. 259). By mainstreaming gender equality throughout the SDGs, these global goals recognise intersectionality and attempt to give all women a voice. Cecilia (2020) saw the SDGs as a means of promoting women's empowerment and gender equality to pursue a sustainable future for all. Deshpande and Bhat (2019, p. 30) explained, that the goals were the first formal acknowledgement of the synergies between health, education, and gender equality, and therefore have paved the way for women to be at the forefront of sustainable development planning. This brings particular focus to SDG 3, good health and wellbeing, SDG 4, quality education, and SDG 5, gender equality. Deshpande and Bhat (2019, p. 31) explained that the overt recognition of existing inequalities serves as a reminder for the continued need of promotion of the importance of women's health and their access to healthcare. The authors' suggestions align with targets 3.7 and 5.6, identifying the need for education and access to reproductive health and healthcare services (SDGs, 2023). The SDGs with their accompanying universal principles recognise the nexus and synergetic effect across education, poverty eradication and gender equality.

In summary, CEDAW, the MDGs, and SDGs are three key development interventions that each have contributed in their own manner to supporting the priority of women's empowerment. It is acknowledged that the pursuit of gender equality requires both empowerment and rights-based approaches, and all development initiatives require international commitment to these global agendas and additionally national interventions to be established. The 2030 Agenda has invigorated global commitment and requires governments and local institutions to uphold these commitments and keep enhancing women's empowerment through contextual understanding and interventions. The next section moves to specifically explore women's empowerment in the development literature.

2.3. Conceptualising women's empowerment

Often women and girls are amongst the poorest and most excluded in societies, which has been recognised by CEDAW, the MDGs, and SDGs. Since empowerment is multidimensional, it has to be contextual, thus holds inherent complexities. Recognising these complexities and the multidimensional nature of empowerment, this section will explore the processes involved with women's empowerment and deconstruct the concept of power.

2.3.1. The processes of women's empowerment

During the 1980s and '90s development practitioners, such as Rowlands (1995), Batliwala and Kabeer (1999), primarily discussed empowerment as the process of transforming power relations in favour of women's rights and gender equality. More recent literature and development practitioners, such as Stromquist (2015) and Mahmud et al. (2012), placed consideration into empowerment being both a desired end state and a process. Mahmud et al. (2012, p.611) explained that no single comprehensive definition of empowerment in development exists, and that the concept is a 'latent phenomenon'.

Mahmud et al. (2012) discussed three important factors for empowerment as a process; it is not directly observable, it is multi-dimensional, and context is crucial (p. 611). These three factors are in agreeance with most contemporary and historic development practitioners and

theorists. For example, Caroline Moser's book (1993) *Gender Planning and Development* discussed how ignorance, rather than contextual understanding, is a critical failure of gender planning in achieving equality and empowerment. In contrast, Cornwall has raised concerns about the overuse of the term 'empowerment', and how it is used as a buzzword without specific contextual understanding to confront grassroots struggles, oppression and social injustices (Cornwall, 2016, p. 344). All authors who have conceptualised empowerment have identify it as multidimensional and acknowledge the complexities associated with achieving it (Cornwall, 2016; Mahmud et al., 2012; Stromquist, 2015). It is the need to apply contextual understanding and individual approaches to empowerment that compels consideration of intersectional aspects.

Intersectionality is a concept that promotes an understanding of how human beings experience the interactions of the various social constructs that they hold (Hunting & Hankivsky, 2020). It is the intersectionality of the women and girls facing poverty and discrimination that compels contextual understanding. It is paramount to understand overlapping identities and marginalisation of people which may render them subject to a range of social injustices and human rights issues (Gardyne & Malecki, 2022). As Hunting and Hankivsky (2020, p. 431) explained, intersectionality should not be an add-on nor an afterthought; it is by applying an intersectional lens that a deeper understanding of someone's individual realities can be discovered, and consequently they can be empowered. Gardyne and Malecki (2022) argued that only once intersectional analysis has been done, and an individual's situation is specifically and contextually understood, can women's empowerment be addressed and their strategic and practical needs be met.

The multiplicity and complexities of empowerment are pronounced in all definitions. However, there are also many commonalities identified, such as how education can strongly contribute towards women's empowerment. Cox et al. (2013) outlined the empowerment process to encompass self-reliance, consciousness-raising and fulfilling, all of which are supported through education. Adams (2003) presented the empowerment process as gaining power to access resources and subsequently control individuals' development outcomes, which without education would not support positive outcomes. Similarly, Kabeer (2005), uses three interrelated components: resources, agency and achievements. Agency represents the

processes by which choices are made and put into effect, resources are the medium through which agency is exercised, and achievements refer to the outcomes of agency (Kabeer, 2005, p. 14). All three have the ability to be enhanced by education to gain the full potential of achievements. Van Kempen (2009, p. 466) described the empowerment process as "the expansion of a person's ability to make strategic life choices in a context where it was previously denied to them". Kabeer's earlier definition is similar to Van Kempen's, as she described empowerment as "a process of change during which those who have been denied the ability to make strategic life choices acquire such an ability" (1999, p. 437). All these definitions of empowerment underpin the idea of overcoming disempowerment and developing a sense of self-worth. For empowerment to be achieved effectively, it is important to address the need for education and transformation of power dynamics. The next section deconstructs the concept of power to aid the understanding how a transformation of power dynamics supports women's empowerment.

2.3.2. Deconstructing the concept of power

Jo Rowlands (1997) attributed the various forms of power as the cause for the multiplicity of empowerment definitions, and was one of the first to theorise that empowerment requires a redistribution of power. The idea that empowerment requires the redistribution of power has been continued by contemporary theorists such as Gengler (2012) and Gardyne and Malecki (2022). Gardyne and Malecki (2022) stated that to achieve gender equality, and women's empowerment in the process, power dynamics and the social structures that promote inequities must be transformed. Gengler (2012) identified that power imbalances run the risk of coercive relationships forming, whereby one group dictates how empowerment should look for another more marginalised group. Therefore, an understanding of the construct of power is needed to truly understand empowerment. Historically there has been a struggle in power dynamics between men and women, whereby men hold power over women, and consequently there is inaccurate fear that if women gain power and agency it will be at the loss of men. To counter this fear, Rowlands (1997) discussed how empowerment should be conceptualised as a non-zero-sum power game, and nobody should be fearful of losing power whilst others wield power.

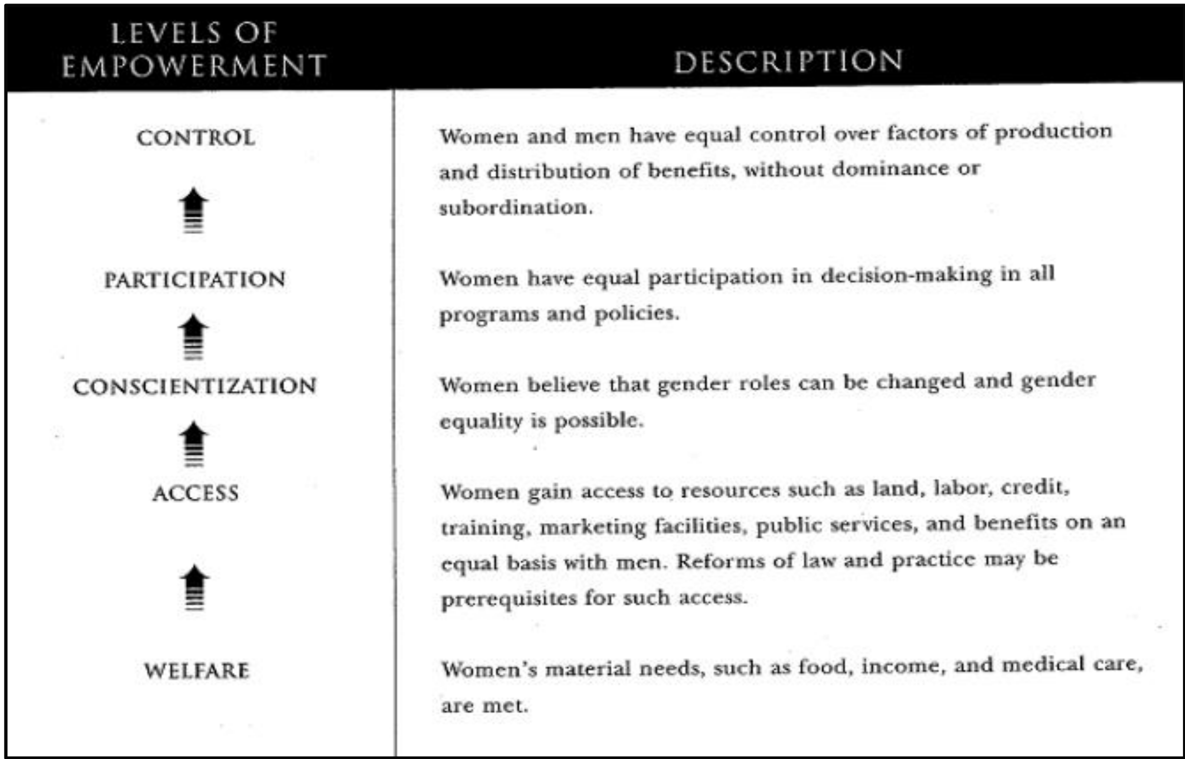
Rowlands (1997) identified four forms of power: *power over, power to, power with*, and *power from within*. When considering a feminist approach to empowerment, Rowlands emphasised how women are empowered by experiencing *power to and power from within*. 'Power to' is achieved through knowledge and agency with a resistance of subordination (power over), whilst 'power from within' is the internal discovery of abilities and potential (Rowlands, 1995). Looking specifically at 'power to and power from within' has more of a focus on the informal sector of empowerment, "giving scope to the full range of human abilities and potential" (Rowlands, 1997, p. 12). 'Power with' creates generative empowerment through collective action, or what Kabeer (2005) refers to as agency. 'Power over' holds a negative connotation with regards to empowerment, whereby someone holds power over someone else. Similar to requiring different aspects of power to be transformed, Kabeer (2005) identified multiple levels of empowerment that need to be transformed and addressed; *deep, intermediate,* and *immediate levels* of empowerment. Kabeer (2005) explained the 'deeper' level of empowerment as structural relations, such as the interactions between gender, class and caste. The 'intermediate' level as awareness of institutional rules and resources, and the 'immediate level' as individual resources, agency, and achievements (Kabeer, 2005). To enhance the understanding of levels of empowerment, the next section presents two empowerment frameworks that focus on different levels empowerment.

2.4. Women's empowerment frameworks

Women experience discrimination across a multitude of domains, such as caste, class, religion, disabilities or native language (Nahar & Mengo, 2022). Consequently, Grabe (2012) recognised that women's empowerment needed to be addressed both individually and structurally. This section presents two empowerment frameworks to aid in understanding both individual and holistic empowerment. Firstly, Longwe's (1994) empowerment framework will be presented as this outlines the individual levels of empowerment. Secondly, Rao and Kelleher's empowerment framework (Rao et al., 2016) will be presented as it seeks to address empowerment in a holistic and all-encompassing manner.

2.4.1. Longwe's empowerment framework

Three decades ago, Longwe (1994) presented the five-point 'women's development criteria' seen below in Figure 2.1. This analytical framework continues to be utilised to assess how individual women's empowerment and transformational change is experienced.



LEVELS OF EMPOWERMENT	DESCRIPTION
CONTROL	Women and men have equal control over factors of production and distribution of benefits, without dominance or subordination.
PARTICIPATION	Women have equal participation in decision-making in all programs and policies.
CONSCIENTIZATION	Women believe that gender roles can be changed and gender equality is possible.
ACCESS	Women gain access to resources such as land, labor, credit, training, marketing facilities, public services, and benefits on an equal basis with men. Reforms of law and practice may be prerequisites for such access.
WELFARE	Women's material needs, such as food, income, and medical care, are met.

Figure 2.1: *Women's empowerment framework by Longwe (Longwe, 1994, p.292)*

Figure 2.1 shows five hierarchical levels of equality that are regarded as measurements in the empowerment process: *welfare, access, conscientisation, participation* and *control* (Longwe, 1994). The five levels are utilised as indicators to increase individual women's empowerment, whilst taking into account their social constructs or intersectionality (Longwe, 1994).

Welfare, as the lowest level of empowerment, does not increase empowerment. Instead, it sets the foundations by ensuring that the basic needs of food, clothing, and medical care are met (Ramilo & Cinco, 2005). The first step to empowerment, *access*, refers to women's access to resources relative to men, such as; education and training, land, economic resources, and state benefits (Ramilo & Cinco, 2005). To expand on the importance of resources, Grabe (2012) considered these as a means to empowerment rather than the end result required.

For example, education is a resource that supports the process rather than providing an end state of empowerment.

Thirdly, *conscientisation*, is to dismantle social constructs that subordinate women. Conscientisation empowers women through the awareness of their subordination within their cultural and social belief systems. In the context of Nepal - patriarchal norms give men power over women's decision-making and impacts on their ability or freedom of mobility outside of their homes to pursue healthcare. The level of *participation*, as a fourth step, generates empowerment through collective action where women come together at the grassroots level, identifying issues, and creating their own solutions and pathways to overcome them.

The final empowerment level is related to women having *control* over their own decision-making processes. At the control level, empowered women would have equal access to basic needs and to resources, and are aware of their situation and able to mobilise change (should they so choose to) without waiting on any authority or prerequisite requirements (Longwe, 1994). This framework outlines the requirements for individual empowerment, and the section below will outline how an organisational approach to empowerment could be applied to achieve individual and systematic transformative change.

2.4.2. Rao and Kelleher's empowerment framework

For transformational empowerment to be achieved, Rao and Kelleher presented the idea that change needs to occur at all levels in society and developed their empowerment framework, seen in Figure 2.2 (Rao et al., 2016). Their framework is utilised at an organisational level, as opposed to Longwe's framework that looked at an individual level.

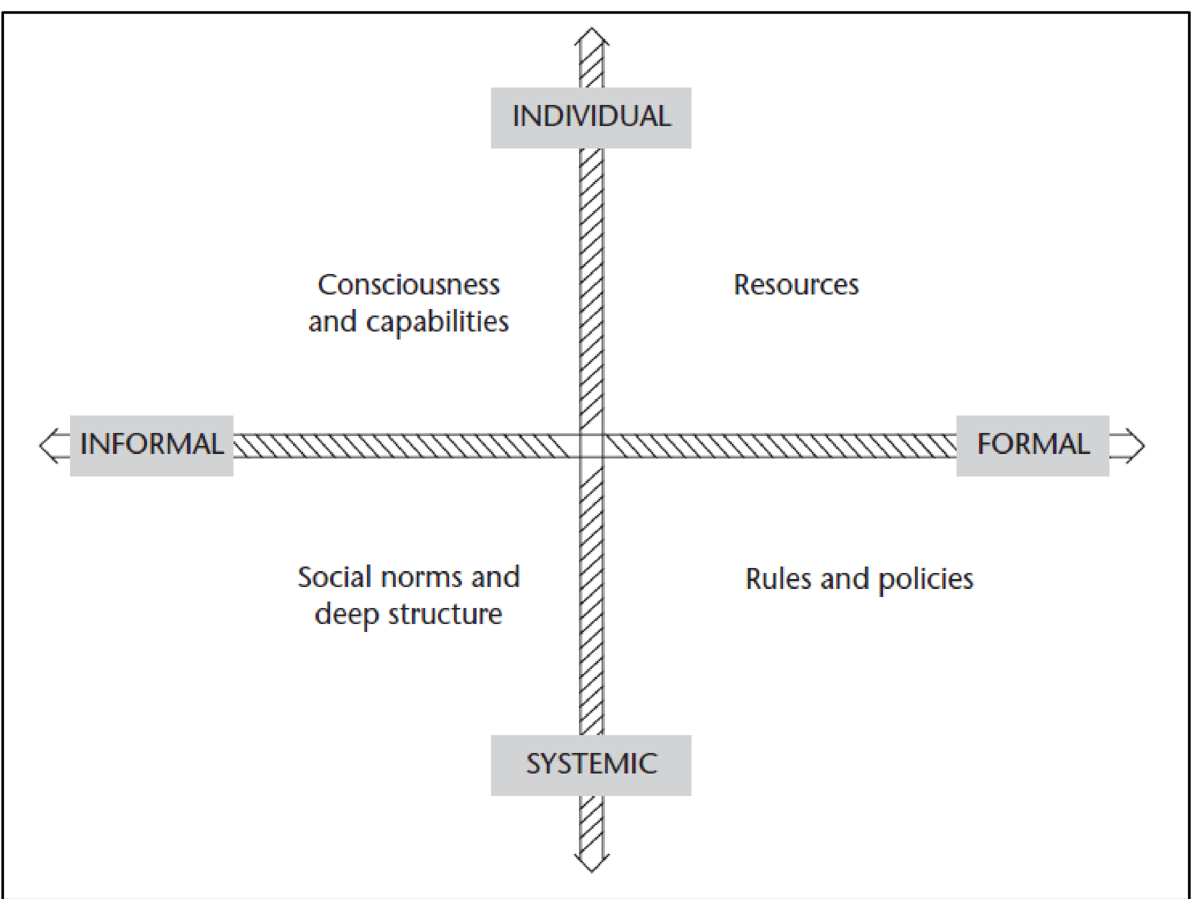


Figure 2.2: *Rao and Kelleher's empowerment framework* (Rao et al., *2016, p. 26)*

The framework presented in Figure 2.2 promotes an all-encompassing approach to empowerment that requires improvements and efforts to be placed into each of the quadrants of the framework, which will now be explained.

Individual consciousness and capabilities refers to an individual's understanding of the power relations around them and taking action to transform these as conscious rights holders (Rao et al., 2016). It can be likened to Rowlands' (1997) breakdown of power, relating to having 'power to' and 'power within'.

Individual's access to resources both physical and conceptual relates to Longwe's 'welfare and access' levels of empowerment. Access to resources is often the strongest focus by development agencies since it holds tangible outputs and increased resources look positive for them when delivered (Rao et al., 2016). For example, women may or may not have good access to healthcare, water, or micro-credits.

Formal rules and policies relate to legislation and organisational policies (Rao et al., 2016). This can have reference to human rights in terms of outlining the responsibility of duty bearers to enable empowerment and give agency to rights holders. Success within this quadrant can often be overinflated, since without social change to support the rights holders to experience the success of the implementation of formal rules and policies, empowerment will not result. Rao noted that changing rules or policies needs to be a key stage in an organisation's change process to create agency or 'power to and power with' (Rao et al., 2016).

Social norms and deep structures often need to change to overcome subordinating power relations, whereby someone holds 'power over' someone else. This can be achieved by generating collective action or what Rowlands (1997) defined as 'power with'. Rao and Kelleher (2016) explained that social norms and structures can often be the hardest but most valuable factors to influence change due to the invisibility of deeply entrenched and socially accepted norms.

The Rao and Kelleher empowerment framework is often utilised as an analytical tool to assess the holistic nature of women's empowerment associated with organisations and will be referred to throughout the discussion of this study. To achieve holistic change for women's empowerment, there needs to be an all-encompassing approach that puts focus both into individual and systemic empowerment.

2.5. Chapter conclusion

This chapter has explained concepts associated with women's empowerment and has explored how women's empowerment has been addressed in various development agendas. This chapter has highlighted how inequalities faced by women are recognised in the development literature and within international organisations. Women's empowerment requires contextual understanding and consideration of intersectionality to be achieved effectively. This chapter presented how a focus on empowerment aids in transforming power relations. Longwe's empowerment framework and Rao and Kelleher's empowerment framework, were analysed towards individual and systematic requirements for empowerment. These two frameworks will be referred to again in Chapter Six when discussing the research findings. The next chapter will provide a contextual understanding of the FCHV programme and where this case study has been conducted in Balkumari, Nepal.

Chapter Three: Contextualising the FCHV programme

3.1. Introduction

This chapter will provide the context for this study. First, the chapter seeks to provide the understanding of Nepal with regards to the geography, political and cultural history, and the development situation. This chapter will explain the social positioning of women and women's health in Nepal, and will present an overview of the national FCHV programme. Lastly, the role and selection process of the female volunteers will be explained.

3.2. Contextual understanding of Nepal

With a population of approximately 23 million, Nepal has a highly diverse culture, is multi-ethnic and multi-lingual, and has over 60 different castes or ethnic groups officially recognised (Khanal & Bracarense, 2021). This section explains the geography, political, cultural and development situations within Nepal. This research was approached as a case study conducted at a village level. The geographical context will be explained by first focusing on the national, then district and village levels. The health facilities will also be explained.

3.2.1. Geographical context

Nepal is a mountainous and landlocked country, engulfed by two countries with extremely fast-growing economies. At the northern boundary is China, and to the south, east and west, Nepal is bordered by India as can be seen below in Figure 3.1.

Figure 3.1: *Nepal's Geographic Location* ("*Nepal country review*," 2022).
Note Bardiya District's approximate location is circled in red, in the west.

Classified as a low-income country, Nepal relies heavily on trade and the economies of its neighbouring countries. Due to Nepal's rugged and mountainous terrain, "only 43 percent of Nepalis have access to paved roads" (World Food Programme, 2018, p. 3), which creates consequences that affect women with regards to accessing markets and social services. Furthermore, terrain limitations exacerbate food insecurities, resulting in a national average of 50 percent of households being food-insecure, and 60 percent of households in the highlands being food-insecure (World Food Programme, 2018, p. 3).

Nepal has been described as one of the "richest countries in terms of bio-diversity", despite their classification as a low-income country (Parajuli & Pokhrel, 2002, p. 409). The elevation in the country varies from 100 to 8848 metres above sea level, and the climatic conditions can range from arctic to sub-tropical (Government of Nepal, 2022, p. 1). Because of its vast terrain, Nepal is largely categorised into three landscape regions: mountains, hills and plains. The Upper Himalaya region (mountains) comprises 15 percent of the country that sits above 4000 metres in altitude, the hill region comprises 68 percent of the country, and incorporates

the capital Kathmandu, and the Tarai region of the plains occupies 17 percent (Government of Nepal, 2022). These climatic conditions, are the reason why the mountain region is more sparsely populated, providing livelihood to only 7 percent of the population, whilst the Tarai and hill regions provide for 47 and 46 percent of the population respectively (Mahat, 2004, p. 23). Consequently, for over 50 percent of the population, access to healthcare and regional centres can be a major issue and can set people at a health disadvantage from the outset. For administrative purposes and regional classification, the Demographic and Health Survey (2014, p. 4) outlines that the country is divided into 14 zones and 75 districts. This research is localised to a case study in the village of Balkumari in Bardiya District, which will be described in the following section.

3.2.1.1. Bardiya District

Bardiya is in the Tarai region of mid-western Nepal, southwest of Kathmandu. Bardiya borders India and has a population of 459,141 (Nonyane et al., 2016, p. 407). Since Bardiya is situated in the fertile lowlands of the nation, the district is primarily agricultural land and forests with the northern half of the district constituting Bardiya National Park. Below, Figure 3.2 identifies the location of Bardiya District within Nepal, and also shows Madhuwan Municipality's location within the district. Figure 3.3 depicts an enlarged map of Bardiya District, and pictorially represents that almost 50 percent of the district constitutes the Bardiya National Park.

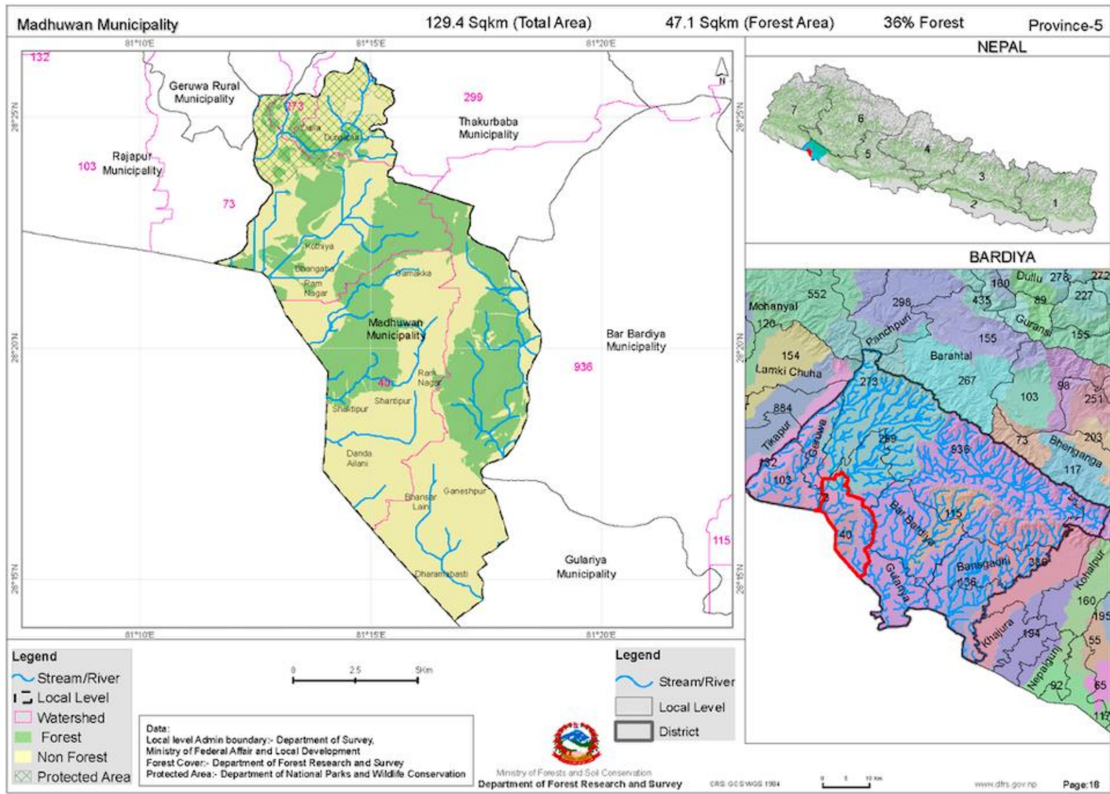


Figure 3.2: *Geographic Location of Madhuwan Municipality ("Nepal in data resource", 2022)*

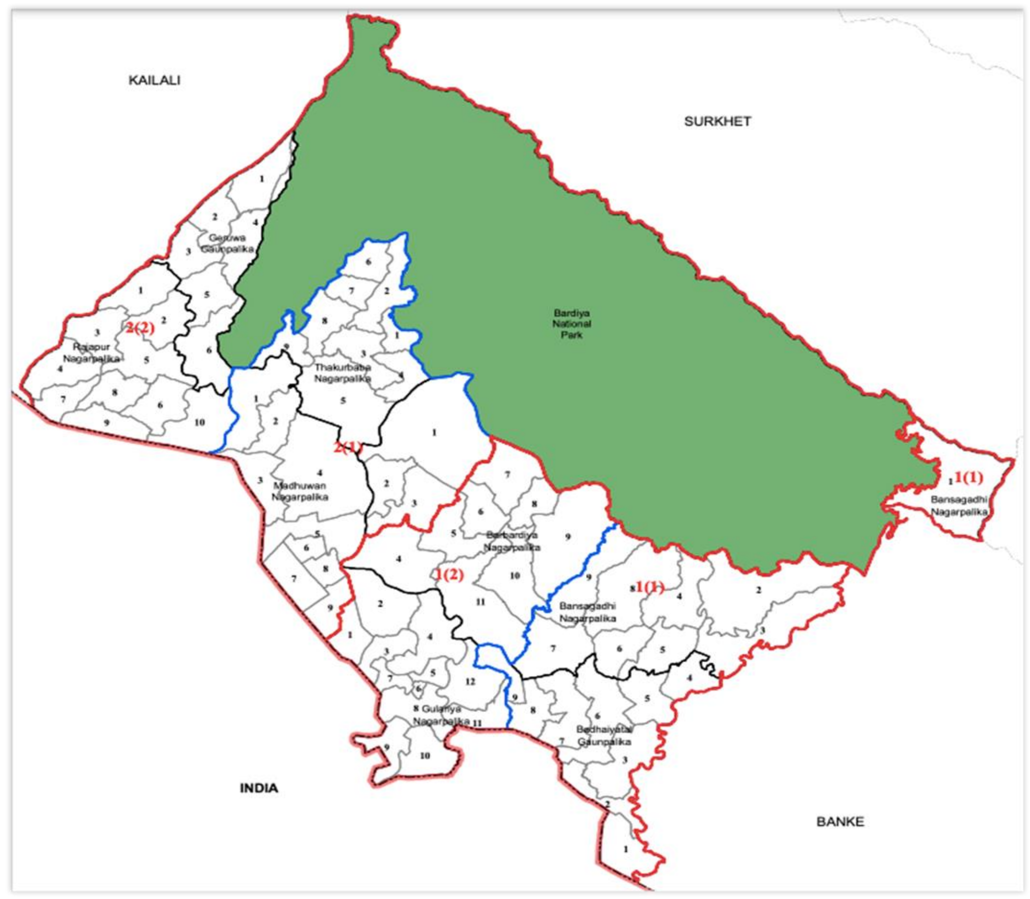


Figure 3.3: *Bardiya District ("Nepal in data resource",* 2022*)*

The Bardiya district has several health facilities, one district hospital in the district capital Gulariya, three primary healthcare centres, and 75 health posts (Nonyane et al., 2016, p. 407). There is a combination of both, health posts and basic health posts, at least one in each ward/village. The District Health Officer explained that the difference between a health post and a basic health post can be either due to the staffing or facilities at the health post. For example, a basic health post would not have a birthing centre and would commonly only have three staff; the health post in-charge, an auxiliary nurse midwife (ANM) and an additional worker to assist with the administration. A health-post, however, may have a birthing centre and up to five staff members. At the time of this study there were a total of 836 health volunteers across Bardiya District (Senior District ANM, personal communication, October 2022).

3.2.1.2. Madhuwan Municipality

Madhuwan Municipality was named in 2017 when four of the Village Development Committees (VDCs) were combined. The municipality comprises one of eight that form Bardiya District (eKantipur, 2022). Within the district, there are six urban municipalities, of which Madhuwan is one, and two rural municipalities. Madhuwan expands over almost 130 square kilometres and according to the 2021 national census has a population of 51,173 (eKantipur, 2022). The municipality is comprised of nine villages, referred to as wards, which consequently means there are nine health posts throughout the municipality. At the time of this research there were 107 female volunteers working throughout the municipality and reporting to the nine health posts (Senior Municipality Health Coordinator, personal communication, September 28, 2022).

3.2.1.3. Balkumari Village

Balkumari has the smallest population of the nine villages within the municipality, with a population of 4500 (Ward Chief, personal communication, October 2022). The village has one basic-health post with three permanent staff working there; the Health Post in Charge, a skilled birthing attendant (SBA), and administrator. At the time of this study, the Health Post in Charge was filled by someone who was trained in paramedicine and had been in the role

for three years, and the SBA was a qualified auxiliary nurse midwife. All staff are considered government workers, and hence received a government salary. Balkumari has ten female volunteers.

3.2.2. The political and cultural context of Nepal

Nepal has had a turbulent political history since 1990, with the country formally being ruled by a monarchy until 2008. Through revolution, in 1990 a multiparty democracy return occurred and an attempt to push through the Nepali constitutional monarchy, which ultimately led to unrest and the uprising of an insurgency (*"Nepal country review",* 2022). The insurgency was led by Maoists demanding the monarchy be abolished, which in 1996 led to the breakout of a decade of civil war between the insurgency and government forces (*"Nepal country review",* 2022). The civil war lasted until 2006 and the repercussions are still felt throughout Nepal to this present day as it saw over 15,000 Nepali people killed, and well over 150,000 citizens internally displaced (*"Nepal country review",* 2022, p. 2). A chairman of Nepal's Election Commission was appointed in October 2006, just one month prior to a peace agreement being made between the major political parties and Maoist rebels to end the ten-year conflict. After two years of further turbulence, elections were held in April 2008, which led to the abolition of the monarchy in its entirety and a dominant Maoist government taking office (Scharff, 2012). Throughout the ensuing years there was ongoing political unrest and infighting within Nepal that over the years has weighted heavily on the Nepali economic development. To add to the woes of Nepal, the country was struck by devasting earthquakes in 2015, one on 25 April and one on 12 May, with over 400 aftershocks (Raut, 2021, p. 1). This took an incredible toll on the country, across the economy, environment and human health. According to a Post Disaster Needs Assessment (PDNA), "lives of one-third of the population were affected, with 8790 deaths and 22,300 injuries, and the total value of damages and losses estimated to be about seven billion USD" (Raut, 2021, p. 1).

Out of the multitude of castes that exist in Nepal, the lowest caste is called Dalit and described to be "stigmatised in social, economic, educational, political and religious fields, and deprived of human dignity and social justice", and constitute 13.6 percent of the total population (Heera et al., 2021, p. 2). The majority of the Nepali population (approximately 80 percent)

are Hindu, with the second largest religious group (approximately 9 percent of the population) being Buddhists. The population of Nepal is young and has an average working age that spans from 15-64 years old (Khanal & Bracarense, 2021, p. 146). As Doss et al. detailed (2022), within mainstream Nepali culture society is structured according to patriarchal norms whereby male education is prioritised and male headed households are the norm. The next section explains the development situation in Nepal, specifically detailing how the human and gender development of the nation is regarded.

3.2.3. The development situation in Nepal

As a landlocked and geographically isolated country, Nepal has had a strong reliance on international aid over the years (Hosni & Lundberg, 2005, p. 74). Nepal is a member of the United Nations and adopted both the MDGs and subsequently the SDGs, thus showing their commitment to striving for gender equality and women's empowerment (Mahato et al., 2020). The 2016 Demographic and Health Survey for Nepal measured women's empowerment in terms of "employment, earnings, control over earnings, and magnitude of earnings relative to those of their partners" (2017, p. 301). The Human Development Index (HDI) was last assessed in 2019, and Nepal received an index of 0.602, ranking 142 out of 189 countries and territories (UNDP, 2020, p. 2). What this figure demonstrates is that over a 29 year period, from 1990 – 2019 Nepal has seen a 55.6 percent increase in the HDI, meaning that their population has experienced significant improvements in life expectancy, education, and Gross National Income (GNI) per capita (UNDP, 2020, p. 2).

With regards to gender equality, the Gender Development Index (GDI) measures sex disaggregated data across these same three basic dimensions of human development: health, education, and command over economic resources. The GDI for Nepal sits at 0.933 (females at 0.581, males at 0.623), which categorises Nepal as "medium equality in HDI achievements between women and men" (UNDP, 2020, p. 3). Conversely, the Gender Inequality Index (GII) reflects inequalities across reproductive health, empowerment, and economic activity. Nepal has a rather low value of 0.452 in its GII, ranking 110 out of 162 countries. This is likely due to statistics in the following areas, only 33.5 percent of parliamentary seats being held by women, 29.3 percent of women compared to 44.2 percent of men reaching secondary school

education level (UNDP, 2020, p. 5). The GII also is shaped by 186 deaths from pregnancy related causes out of 100,000 live births (UNDP, 2020, p. 5). Furthermore, Nepal has a large adolescent birth rate of 65.1 births per 1000 women between the ages of 15 – 19 years old (UNDP, 2020, p. 6). In terms of economy, the GII is influenced by a lower percentage of women in the labour market compared to that of men (UNDP, 2020, p. 3). This all demonstrates that for Nepal, there are high rates of gender inequality internally. Although by external comparison, there could be an underlying risk of gender inequality being overshadowed by the large human development progression that the nation has made, thus the prioritisation of HDI over GII.

In unison with the human development data, Nepal has been referred to as one of the poorest, most unequal and simultaneously most diverse nations of the world (Malagodi, 2018, p. 529). However, Paudel et al. (2017) concluded that since the abolition of the monarchy and the declaration of a secular state, the country's socio-political character has emerged and Nepal is rich in socio-cultural diversity with vastly improving gender equality. Mahato et al. (2020, p. 2) found that 70 percent of their modern research participants believed that childcare is no longer the sole responsibility of women, thus demonstrating an improvement in gender equality. Conversely, Malagodi's (2018, p. 528) intersectional analysis highlighted multiple marginalisation patterns that still exist within the country that extenuate gender inequities. Paudel et al. (2017) conducted an analysis into how specifically the abolition of the monarchy and arrival of democracy within the country has influenced women's empowerment.

Their study utilised two measures of women's empowerment: "(1) violence against women: justifications of beating a wife and (2) female autonomy: women's say in decision making in the household" (Paudel & de Araujo, 2017, p. 326). Mahato et al. (2020) emphasised that inherent gender norms within Nepal restrict women's decision making autonomy which takes a heavy toll on contraception use and overall women's reproductive health. More specifically their study revealed that 63 percent of their female participants were married during their teens, and over a third felt that it was impossible for role reversal to occur, whereby men took care of the family whilst women went out to work (Mahato et al., 2020, p. 2). Overall Nepal has come a long way in development and in identifying the inequalities embedded into the

country's cultural and social norms. Although, there is still a lot of improvement to be made. With low representation of women in parliament Nepal runs the risk that formal policy and human rights progression will be limited by the inherent bias and lack of gender conscious decisions being made. The next section will give oversight of how the social status of women in Nepal is regarded and how women's health is prioritised.

3.3. The context of women and women's health in Nepal

Women comprise more than half of the population of Nepal, although a multitude of gender based differences have resulted in a lag for women's status compared to that of men in almost all contexts (Mahat, 2004). This section will broadly discuss gender inequalities that exist across the country and the inequities within health.

3.3.1. Existing gender inequalities in Nepal

In Nepal gender is defined through "caste, ethnicity, language, religion, region, sexuality, age, and disability" (Malagodi, 2018, p. 528), and therefore, gender norms vary greatly throughout the nation. It is very common for women in Nepal to perform all household chores and carry out all reproductive household duties in accordance with the nation's patriarchal norms. In agreeance with how Malagodi found the Nepali construct of gender, Doss et al. (2022, p. 14) expanded on how these norms further restrict women's freedom of movement, employment, public voice, marriage choice, and receipt of healthcare. Doss et al. (2022) also presented how gender norms are more egalitarian amongst the lower castes within the country, such as Dalit, than they are among the higher Hindu castes. Despite the liberty of lower-caste women, it was found by Doss et al. (2022) that women can still face consistent disempowerment through their relative poverty, social stigma and exclusion. Poverty forces some women into employment, which may result in some empowering facets such as increased mobility and decision-making authority. However, when already living on the brink of poverty, the jobs available to women are usually low paying and exploitative in nature (Dahal et al., 2019). Consequently, this situation highlights the necessity to consider intersectionality with regards to gender and poverty when reviewing gender equality and empowerment of women in Nepal. The 2017 National Review of the SDGs identified the progress made in promoting

gender equality and women's empowerment, although acknowledged that the journey is still enduring (GoN, 2017).

Looking at the status of women within a Nepali household, men traditionally hold 'power over' women, and the mother-in-law of a household holds 'power over' her daughter-in-law (Doss et al., 2022). Women can therefore be empowered when living in a nuclear family and attempting to co-chair their own household with a husband rather than remaining subordinate to both their husband and mother-in-law. Women can also experience an increase in decision-making authority when husbands migrate for work, although this comes with risk of disempowerment through increased household responsibilities and domestic care work (Doss et al., 2022). A study in 2020 (Samata & Shreyashi) revealed that since the COVID-19 pandemic, migrant workers have returned home unable to work, which has created strain on families, increased gender-based violence, and decreased the reproductive rights of women. This situation further demonstrates the deeply engrained patriarchal societal norms exasperating women's subordination to men. Education and empowerment are often considered synonymous, and with Nepal being a patriarchal society and educational issues disfavouring female students, women's journey to empowerment can be fraught with complexity (Dahal et al., 2021, p. 1).

3.3.2. Inequities with regards to women's health

Good health amongst women is correlated to women's empowerment as it increases their chance of poverty alleviation, gender equality, and promotes child and infant health (Chhetri & Mitra, 2021, p. 82). When first addressing the MDGs, the government of Nepal adopted a sector-wide approach to improve aid effectiveness with the goal of giving all Nepali citizens free basic health services (Malla et al., 2011). Malla et al. (2011) described how the MoHP, and the Ministries of Women, Children and Social Welfare worked together utilising a Health Sector Strategy to guide a dedicated focus on women's empowerment, education and gender equality. Nepal has been a low resourced country which holds adverse effects on women's health, and as Salway (2006, p. 17) stipulated, gender inequality is often a barrier to improving maternal health in Nepal. Doss et al. (2022) concluded that a woman's position within a household can dictate her receipt of healthcare, and consequently, it is important to work

towards removing the barriers and making healthcare accessible for all. Within the resource poor and rural settings of Nepal, meeting basic health necessities can be difficult let alone the prioritisation of women's health needs. As a key indicator of a women's status in society, the MMR has been addressed in both the MDGs and SDGs and Nepal has made strong process in reducing it from "850 per 100,000 live births in 1990 to 258 in 2015" (GoN, 2017, p. 4). Subsequently, post 2015, there has been recognition that reduction efforts for the MMR need to be consistent across all geographic regions, social groups and income quintiles (GoN, 2017, p. 4). Women's health issues play a significant part of the poverty of Nepal and resourcing needs to be directed accordingly. It is in recognising the importance of women's health that the FCHV programme was established in Nepal, which will be discussed in the next section.

3.4. The Female Community Health Volunteer Programme

Recognising how women participate in both women's health and the overall health of a population, the FCHV programme was established by the MoHP in Nepal in 1988 to increase the overall health status of Nepalese people (MoHP, 2014). This section will discuss the role of the FCHV programme in Nepal, the selection process of the female volunteers, and the national goal and objectives for the programme.

3.4.1. The role of the FCHV programme in Nepal

The National Survey Report (MoHP, 2014, p. 23) outlined how the programme was designed to "enhance Nepal's primary healthcare network, improve community participation, and expand the outreach of health services". The intent behind the programme was to promote the status of women and children in rural areas, achieved through health education and the promotion and distribution of family planning commodities (MoHP, 2014). Initially the programme assigned one volunteer per village, but later grew to a population based approach for their services (DoHS, 2021).

The female volunteers in the FCHV programme are regarded as service providers and key educators on maternal health, particularly within the hill and Tarai regions of Nepal (Lee, 2020). The volunteers are trained local women from within the community who function as a

bridge between government health initiatives and their community (MoHP, 2014). Despite initially only being established in 27 districts, the programme has grown to cover all regions of Nepal and forms an integral part of the Nepali government healthcare system (Khatri et al., 2017). The Department of Health Services' (DoHS) 2019/20 Annual Report (2021, p. 236) stipulated that there were 51,423 female volunteers recruited, of which 49,481 were actively working. Khatri et al. (2017, p. 1) identified that despite initially being established to promote and distribute family planning commodities, the programme has now expanded to focus on holistic maternal and child health services. The primary role of the volunteers, as outlined by the DoHS (2021, p. 236) "is to advocate healthy behaviour among mothers and community people to promote safe motherhood, child health, family planning and other community-based health issues and service delivery".

3.4.2. Selection process of female volunteers

There is a good connotation associated with female community health volunteers throughout the nation, and multiple reports note a particular uptake in their services in areas where healthcare centres and economic revenue are sparse (DoHS, 2021; MoHP, 2014). Panday's qualitative study in 2017 disclosed that within the hill villages female volunteers are occasionally the only trained healthcare workers available and thus are in high demand (Panday, 2017).

Women become volunteers within the FCHV programme through a general consensus. Women are selected by the local Mothers Group for Health (MGH) when a vacancy becomes available and a suitable female applicant applies for the role (GoN, 2010, p. 4). According to the National FCHV Programme Strategy, individuals are required to meet the following criteria to be a community health volunteer (CHV):

- Permanent resident of the related ward or VDC
- Interested to work as a CHV for at least 10 years
- Aged between 25-45 years
- Married or single (priority to be given to married women with up to three children)
- Unemployed
- Commitment to serve the community

- Priority to those, who can read and write
- Priority to women from Dalit, Janajati and marginalised castes

Women who are interested to be a CHV must apply to the MGH. However, those women who are involved in paid jobs, will not be considered. (GoN, 2010, p. 3)

Upon successful selection as a CHV, individuals are required to undertake basic training, consisting of two nine day phases prior to being issued their medicine kit boxes and equipment for community work (DoHS, 2021, p. 236). Despite minimal training, the programme is credited for large improvements in maternal health across the country, and the initiative has resulted in over 52,000 volunteers being trained (Panday et al., 2017, p. 2). The 2014 MoHP report found that for the poor and marginalised population, the CHVs trained through the FCHV programme are often the only means of health support and intervention that they have access to (MoHP, 2014). The volunteers have been continuously described to bridge the gap between poor healthcare provisions and the community, and consequently are a necessity rather than an option for some. Despite being volunteers, and therefore not financially remunerated for their roles, the female volunteers within the national FCHV programme are recorded to have a retention rate of 96 percent (Panday et al., 2017, p. 2) (also see Chapter 1). Panday et al. (2017) explained that the female volunteers have expressed feeling empowered through their volunteer roles because of their access to education, the ability to move about, and the authority to make decisions.

3.4.3. Goal and objectives for the FCHV programme in Nepal

There are a number of variants of the FCHV programme goal and objectives, which can be attributed to translation discrepancies. The most recent documentation is the DoHS annual report (DoHS, 2021, p. 236). This report provides the programme’s goal and objectives utilised for this research. The official goal of the FCHV programme is written as:

> Improve the health of local community people by promoting public health measures of health promotion and disease prevention. This includes imparting knowledge and skills for empowering women, increasing awareness on health related issues and involving local institutions in promoting healthcare. (DoHS, 2021, p. 236)

There are five objectives assigned to the FCHV programme:

- Mobilise a pool of motivated volunteers to connect health programmes with communities and to provide community-based health services;
- Activate women to tackle common health problems by imparting relevant knowledge and skills;
- Increase community participation in improving health;
- Develop female community health volunteers as health motivators; and
- Increase the demand of healthcare services among community people.

  (DoHS, 2021, p. 236)

As my research applies a gender lens, particular focus is to understand in what ways the programme practices its goal to incorporate women's empowerment. The following Chapters will therefore explore specifically how the programme prioritises women's empowerment in Balkumari.

3.5. Chapter conclusion

This chapter has explored the marginalisation of women in Nepal and the geographical context of the country and area for this case study. Nepal is located in rugged terrain and has limited health infrastructure. Within the dominating patriarchal social norms, historically women have been marginalised and have had limited access to healthcare. This chapter has identified significant gender inequities as still prevalent in Nepal. This chapter also showed that traditionally a woman's household status sits below that of her husband and her mother-in-law. This chapter provided an overview of the national FCHV programme, explaining that on national level the FCHV programme aims at giving attention to women's empowerment. The overall programme's objectives focus on enhancing community health. Nepal has made vast improvements in women's health, and yet social norms still need to change to support and prioritise gender equality and women's empowerment. The next chapter will explain the methodology and methods applied in this study.

Chapter Four: Methodology and Methods

4.1. Introduction

This chapter will present the methodology and methods used throughout this research. The first section of this chapter will present the rationale behind the qualitative methodology chosen and will explain the two methods that were applied for the conduct of the research. Secondly, the research journey of planning and preparing the fieldwork will be explained, inclusive of the limitations of the research. Lastly, this chapter will explain how research data was collected and analysed.

4.2. Research design

This research was guided by constructivist and interpretivist research paradigms, which infer that reality is socially constructed, and multiple realities can exist. Interpretations of reality can change over time and may vary between different sources collated through qualitative methods (Mackenzie & Knipe, 2006). Interpretivist research inherently identifies themes from research findings, rather than allocating a theory at the start of research (Mackenzie & Knipe, 2006). As conferred by Kahlke (2014, p. 39), there is no single point of truth since the meaning is socially constructed by individuals who interpret their own experiences and construct their individual meanings. As the aim of this study seeks to explore lived experiences, a research design that supports multiple realities was essential and a qualitative methodology was employed to support the collection of qualitative data.

4.2.1. Qualitative research methodology

Identifying the research approach and methodology allows a researcher to operationalise the research methods (Scheyvens, 2014). For this study, a qualitative methodology was employed in exploring the complexity of human experiences and rich descriptions of social constructs in the village of Balkumari (Wahyuni, 2012, p. 71). As Ayiro (2012, p. 13) explained, a qualitative

methodology allows for descriptive research, and acknowledges that the conditions and situations explored are according to a given point in time. O'Leary (2014) explained that qualitative research has the capacity to delve into social complexities, exploring lived experiences and interactions that create belief systems. Since the FCHV programme goal outlines the intent to impart knowledge and skills for empowering women (DoHS, 2021, p. 236), a qualitative research approach with two qualitative methods was applied for this study and will be described in the next section.

4.2.2. Research methods

The two research methods selected and utilised for this study were: semi-structured interviews and the use of a reflective research journal. O'Leary (2021) promoted the use of interviews for qualitative and interpretivist research, since these are recognised for their ability to draw out rich descriptions of lived experiences. Semi-structured interviews promote discussion through their flexible structure and hold the ability to analyse and conduct thematic analysis from what arises through the opinions of research participants (O'Leary, 2021). Interviews provide the means for gaining insight into the complexities and multitude of issues and experiences. More specifically, semi-structured interviews have allowed me to draw out key information in line with the research questions and objectives, by providing the flexibility to delve deeper into themes as they arose throughout the interview process. Corbin and Strauss (2015) promoted semi-structured interviews, as these ensure some level of consistency across all interviews conducted. For this study, I have recognised that it was important to have research participants feel free to explain their perspectives in accordance with their own lived experiences through the semi-structured interviews. The fieldwork preparations, which required ethical considerations and planning for the semi-structured interviews, will be explained next.

4.3. Fieldwork preparations

This section will discuss the Massey University's ethics process, which drew out key ethical considerations that facilitated me in understanding my positionality and enhanced my ability to keep participants safe in all processes of this research. I was fortunate in working with a

research assistant to support the process of working with local participants. Consequently, liaising and coordinating with this assistant was part of my fieldwork preparations which will be described below.

4.3.1. Ethical considerations

As Mahnaz et al. (2015) discussed, ethical considerations in qualitative research hold innate challenges because of the personal involvement and entwinement of a researcher and participants. In agreeance, O'Leary (2021) emphasised that a researcher holds moral and ethical obligations to uphold and protect the rights of those involved in the research. As I was travelling to Nepal to explore the FCHV programme in a rural village and conduct in-person semi-structured interviews, I needed to carefully consider the ethical conduct of my fieldwork and research. I have read the Massey University Human Ethical Code of Conduct (2017) and have engaged in discussions with my supervisor and one other staff member of the Development Studies team to ensure my research followed ethical principles. The Massey University's Human Ethics Committee then evaluated this research as low risk.

4.3.2. Positionality

In line with ethical considerations, Stewart-Withers et al. (2014, p. 62) have described the necessity to understand one's own personal attributes and experiences. Similarly, Billo and Hiemstra (2013) emphasised the importance of considering and acknowledging how one's gender, biology, religion and lived experiences all affect the positionality of a researcher.

Before and during my fieldwork, I considered how I am an educated New Zealand European, middle-class white woman, who has served in the New Zealand Army for twelve years and was studying within an education system that is dominated by Western thought. Prior to conducting this research, I had travelled to Nepal on an adventure holiday in 2018, and had also made some connections in Nepal with Gurkha Engineers through my brother's service in the British Army. I had worked in the field of women's empowerment in Afghanistan, and at the time of this research my position within the New Zealand Army was managing a programme striving for gender equality in the organisation. I acknowledge that I have only had limited exposure to Nepal, no experience in healthcare, and have not worked in the

development field outside of my military duties. Therefore, I needed to be humble and curious throughout my fieldwork experience, ensuring that I was open and sensitive towards talking to people who were willing to participate, and that I would be respectful to Nepalese culture and reflect the lived experiences of the interview participants. Consequently, I decided to work with a local research assistant, Monica Devkota, who supported me with recruiting, building rapport and explaining the lived experiences of research participants to me.

4.3.3. Working with a local research assistant

I was fortunate to have been offered translation support from my incredibly talented friend, Monica Devkota, in support of my research. As I had chosen to conduct my fieldwork in Balkumari village where most people did not speak English, I needed her support. Monica was a Nepali friend who was born in Madhuwan Municipality, and still had a family home in Balkumari. She generously offered to support me with translation of my semi-structured interviews and invited me to live with her and her family for the duration of my fieldwork.

I had to ensure that Monica's positionality was also considered throughout the fieldwork and that no conflicts of interest were involved. Monica also signed a confidentiality agreement. Monica is native to the area, a qualified nurse, and held qualifications in psychology. Having worked in the fields of women's empowerment and healthcare, Monica was the perfect person to help establish relationships in Balkumari and recruit voluntary participants for this research. As I had been invited to live with Monica and her family, and my fieldwork coincided with the Dashain and Tihar festivals, I was able to deeply become involved with people in the community and develop a fairly rich understanding of the local culture and customs. The festival periods in Nepal are a time of celebrations and happiness when families come together to give tika (blessings) to each other. These occasions were truly a special experience to be a part of whilst living in Balkumari.

4.3.4. Recruitment of research participants

As a first step, I was immersed in Nepali culture for seven weeks, which gave me a good understanding of the Nepali culture and spending time in the area enabled me to build

rapport and create friendships in the Balkumari community. Banks and Scheyvens (2014, p. 160) discussed how ethical research should do no harm, but also have the ability to do good within the area of research. A key consideration of achieving this was the selection and recruitment of willing research participants, obtaining their consent and ensuring the support and approval of local gatekeepers. Thankfully Monica had pre-existing relationships both at the district level and within the local village community. It was through her pre-existing relationships that I was able to ensure formal approval from the District Health Officer. Furthermore, to ensure all gatekeepers were informed of my presence and my research, I met with the local Mayor and Deputy Mayor of Madhuwan Municipality upon my arrival.

Living in the village community enhanced my ability to foster close relationships in Balkumari, to learn more about the local culture, and inform people of my research. In turn, it was possible to approach three female volunteers and four people in leadership roles within the FCHV programme who were keen and willing to participate in my research. All interview participants were presented with a copy of the information sheet before being interviewed (see Appendix), and were requested to sign a consent form.

4.3.5. Limitations

There are limitations associated with this case study. Primarily, my positionality as an outsider to Nepal, Balkumari, and the world of maternal health. Not intimately understanding the surrounding societal norms of Nepal and the village, nor understanding how healthcare and in particular maternal healthcare functions in Nepal I needed to remain deeply reflexive. Throughout the research process I relied on the support, knowledge and experience of my research assistant. Monica provided me with opportunities to connect with village members, research participants, and to collate research data. However, working with a research assistant does add complexity to positionality, as considerations needed to be made about both Monica's and my own positionality. Furthermore, as this research is a case study on a village conducted over a limited time period with limited research participants, it therefore holds the possibility of error through misinterpretation or misrepresentation. The above limitations do need to be considered for this research.

4.4. Fieldwork process and data analysis

All research data was collated over the seven-week fieldwork period. This section explains how the data was collected, and expands on how data was subsequently analysed.

4.4.1. Data collection

One interview was conducted at the district level, one at the municipality level, and the other five were all conducted at the village level in Balkumari. Out of the seven participants, two were male, and five were female. There were three female volunteers that were interviewed from Balkumari who each had more than thirteen years of experience working as CHVs in the village, and the other four participants were all in executive roles. Pseudonyms were allocated to the three volunteers, whilst those in executive roles are referred to by their titles. Information about participants can be seen in Table 4.1 below.

Participant #	Gender	Role	Level	Pseudonym
One	F	Senior District Auxiliary Nurse Midwife (ANM)	District	-
Two	F	Senior Municipality Health Coordinator	Municipality	-
Three	M	Ward Chairman	Village	-
Four	M	Health Post in Charge	Village	-
Five	F	Volunteer	Village	Ekta
Six	F	Volunteer	Village	Fatima
Seven	F	Volunteer	Village	Guneet

Table 4.1: *Research participants*

Conducting semi-structured interviews with both executives and volunteers invoked a deeper and broader understanding of the participants' lived experiences and opinions. To help foster open discussion, I made sure that each interview was conducted in an appropriate location to maximise the comfort and ease of the research participants. Consequently, all interviews were conducted in different locations. The four semi-structured interviews with people in

executive positions were held in the participants' individual offices. I travelled to their respective work locations, to ensure minimal disturbance to the participants' working days, and made sure participants were comfortable in their surroundings. Having the interviews in their work locations proved to be particularly useful, as when I went to the Balkumari Health Post to interview the Health Post in Charge, I was able to meet the other health post staff and see how the medical facility operated.

After consultation with Monica and getting to know the three female volunteer participants during the festival period, it became apparent that the best place to conduct their interviews would be at their respective houses. This was primarily because the volunteers invited me to conduct the semi-structured interviews at their houses, but it was also clear that they were the most at ease within their own home environments. By conducting the interviews at the volunteers' respective houses, I did not take the volunteers away from their household duties, nor make them feel uncomfortable in unfamiliar environments. Conducting the interviews at the volunteers' houses meant that during the natural flow of conversation, the women were able to go into their houses to collect items to show me that had arisen in conversation. For example, two of the volunteers wanted to get changed to conduct their interviews in their FCVH programme blue saris, and all women wanted to show me various resources that they had been provided with through the FCHV programme.

With all participants local to Bardiya District, it was important to reflect on my position relative to the participants socially and emotionally, as was emphasised by Mauthner and Doucet (2003, p. 419). I continually reflected on my fieldwork experience in my research journal, kept daily accounts of my interactions with people, and made entries after conducting each semi-structured interview, noting people's reactions and my own emotions during interviews. The journal provided an essential point of reflection after completion of interviews and gave me the opportunity to cross-check my understanding of local customs, individuals' responses to situations, and any questions that arose throughout my fieldwork with Monica.

4.4.2. Data analysis

I used the reflective field notes taken in my research journal to help maintain the validity of my research. This was in line with advice promoted by Stewart-Withers et al. (2014, p. 62) who emphasised the importance of using field journals and transcription of interviews to assist in data analysis and identify emerging themes within the data collection process. To support transcription, the semi-structured interviews were recorded on my personal device and were saved to my password protected OneDrive account. This gave me the ability to sit with Monica after the interviews, compile detailed transcripts, and compare my notes and understanding of the interviews. As O'Leary (2021) explained, this technique supports maintaining focus when analysing qualitative data and allows a degree of creativity balanced with rigour to meet the needs of the research questions and objectives. Srivastava and Hopwood (2009, p. 78) also recommended utilising a deeply reflective process of analysis rather than following a mechanical process throughout the analysis. This iterative process throughout the fieldwork after each semi-structured interview and throughout my data analysis supported my thematic analysis.

Thematic analysis provided me the opportunity as a researcher to apply a comprehensive process to analyse and code the data thoroughly. As the semi-structured interviews produced data based on peoples' lived-experiences, beliefs and opinions, it was important they were accurately transcribed. As Stewart-Withers et al. (2014, p. 76) emphasised, a researcher becomes intimate with their raw data by "reading and re-reading … transcripts, sorting and re-sorting and re-coding". This continually reflexive process mitigates a researcher, as the co-constructor of qualitative knowledge, injecting their own inaccuracies (Stewart-Withers et al., 2014).

4.5. Chapter conclusion

This chapter has outlined the qualitative approach applied for this research, whereby a qualitative methodology and two methods were utilised. This chapter explained the two methods, semi-structured interviews and journal writing, and expanded on why they were

the best way of collecting qualitative exploratory data for this research. The chapter has also discussed the considerations that were applied throughout the fieldwork planning process and the actual fieldwork phase. It was acknowledged that qualitative research is subjective and that there was a need to remain reflexive throughout the entire research process. Having chosen to work with Monica as a research assistant to support translation and provide contextual understanding during the fieldwork, this chapter has explained the processes of access to the seven research participants. Explaining my positionality was important as it explains the need for reflexivity. The next chapter will present the thematic analysis of findings.

Chapter Five: Research findings

5.1. Introduction

This chapter presents the findings of the research conducted. Six themes emerged during the analysis of the research findings, and these will be presented in this chapter under three overarching sections. The first section of this chapter broadly shows the responsibilities associated with the FCHV programme, both in terms of the local FCHV programme's responsibilities and the individual responsibilities of the volunteers. The second section focuses on the motivating factors for the CHVs to be involved with the local FCHV programme. Lastly, the third section explains how the female volunteers experience personal growth in their social status and consequently their self-esteem.

5.2. Responsibilities within the local FCHV programme

This section presents the FCHV programme's responsibilities and the responsibilities of the health volunteers. Interviews with people in executive roles primarily outlined the programme's responsibility to support community health, whilst the interviews with the CHVs divulged the primary role of the volunteers as providers of health education.

5.2.1. Responsibilities of the FCHV programme in Balkumari

The FCHV programme in Balkumari was regarded as the primary means of health intervention for the community. The Senior District Auxiliary Nurse Midwife (ANM), stated that the "FCHV programme is on a pull system", and that the female volunteers identify the health interventions required and request the resources they want through the FCHV programme executives. The Senior District ANM was responsible for coordinating the FCHV programme across Bardiya District. Therefore, she had the oversight to explain that: "the Government created the programme so that every person receives better education and better healthcare. This programme ensures that people are not left behind." She went on to say that:

> Bardiya District was one of the first District's to reach 100% COVID-19 vaccination rate, which would not have been possible without the hard work, education and community engagement of the local female volunteers.

This quote by the Senior District ANM's emphasises that the FCHV programme is responsible for community health, and how the programme has acted as a first level of health intervention in the village. One of the female volunteers, Fatima, explained this concept of community health intervention:

> The FCHV programme ensures that healthcare starts within the local community and reaches each person in society. In this way, Nepal is enhancing their community health to improve the overall health of our country.

In agreeance with this senior nurse, the young Health Post officer in charge in Balkumari described the FCHV programme and the CHVs as the "backbone of the health system". He explained that the ten female volunteers report to the Health Post in Charge as their manager, and it was his responsibility to ensure that each household within the village had a CHV assigned to it.

I found that each volunteer was assigned an area of responsibility and the Senior Municipality Health Coordinator explained that these are based on the geographical location of houses, the number of people living in them, and the level of experience of the CHV. For example, one volunteer interviewed was looking after 131 households, another cared for 207 households, and the third volunteer was responsible for 50 households. It was found that Balkumari's FCHV programme ensured that each household in the village had a CHV assigned to provide information to the individual household. The volunteers accountable to the Health Post in Charge complied to the health system's hierarchy.

5.2.2. Individual responsibilities of the female volunteers

When asked about their responsibilities as volunteers, the Senior District ANM, reflecting at the district level, mentioned that it was "their responsibility to be primarily focused on health, sanitation, environmental health and non-communicable disease". The health post manager with regards to the village level said that the "volunteers' responsibility was to keep records of all maternal medical cases within the local area"*.* These responses had a strong focus on the FCHV programme's expectations and required outputs. The female volunteers spoke about their responsibilities with a focus on what they contributed to the community. Ekta said it was her "responsibility to provide education to local mothers on safe motherhood, as without my training, the mothers have no opportunity to learn". Another volunteer, Fatima, stated that:

> I learn so much through my training and experience, and so it is my responsibility to grow individually and grow the community simultaneously. This is why my community chose me [to be a CHV].

In contrast, Guneet, simply said that it was her "responsibility to teach others who previously did not know about health and healthcare". These three volunteers saw their responsibilities spanning across a personal obligation to become educated, share their education, and improve the health of community members. One of the ways in which the volunteers achieved these responsibilities was the facilitation of monthly meetings for local mothers within their household clusters, referred to as Mothers' Group meetings.

5.2.3. Facilitating monthly Mothers' Group meetings

Both executives and volunteers explained how the volunteers were required to coordinate the monthly Mothers' Group meetings. The volunteers provide training and education opportunities for local mothers at the meetings to ensure that key health messages and treatments were conveyed to their local community. They also organise the venue, source snacks for attendees (when funding is available), deliver a topic of education, and facilitate discussion amongst the local mothers.

When interviewed, the three volunteers each referred to the monthly meetings as a key output of their role. Fatima stated that: “it is my responsibility as a volunteer to provide monthly educational opportunities for the women in my local Mothers’ Group”; whilst Ekta said:

> The mothers in my local Mothers’ Group selected me to be their volunteer, so it is my duty to ensure that they learn all the knowledge that I have, understand the healthcare that is available to them, and that our community remains as healthy as possible.

After the interviews with the volunteers, it became apparent that these meetings provided an opportunity for education, social gathering, health check-ups of young babies and discussing current and topical health risks within the community. The volunteer would organise the meeting venue by taking into consideration where they would generate the greatest attendance from local mothers, and consequently the meeting locations varied. Sometimes the meetings were held at a volunteer’s personal house, sometimes under an outdoor shelter (as seen below in Figure 5.1), or sometimes in one of the other local women’s homes.

Figure 5.1: *Outdoor meeting location for Mothers' Group meetings used within the village of Balkumari*

Once a month the local mothers from each household cluster gathered with their respective health volunteer to discuss issues and share experiences and knowledge. Being in charge of the community health centre, the Health Post in Charge referred to these meetings as a "monthly source of knowledge sharing for all local mothers", indicating that everyone regarded them as important and effective ways to share knowledge. This officer explained how these meetings ensured that local women were educated about their rights to healthcare and consequently the local community had seen increases in the pursuit and receipt of healthcare. He said:

> Local women are now educated about their right to receive healthcare and deliver their babies at healthcare facilities despite what their mother-in-law or husband says. Women are less scared about childbirth. They now deliver their babies at healthcare facilities and are much safer and healthier.

This demonstrates that women are starting to disregard the tradition of homebirths and choose to deliver their babies within the safety of healthcare facilities due to being educated on their rights, empowered to pursue them and no longer subordinated within their household.

After understanding that the monthly meetings were a duty of the female volunteers, and that they delivered educational training for the local mothers, I made enquiries into how this made the volunteers feel. I discovered that there was a positive connotation associated with the volunteers' responsibility for these monthly meetings. The volunteers felt important by having official duties and the ability to impart education onto other women. Ekta explained how she enjoyed running the meetings, and how she was able to answer the local mothers' questions through various means:

> I enjoy running the monthly Mothers' Group meetings ... I teach the mothers good practices and when I cannot answer the mothers' questions I can refer to the health post, or other volunteers, or raise the questions at the semi-annual meetings.

This quote demonstrated that Ekta felt she had valuable input because of the need for her to run the local Mothers' Group meetings and her ability to source answers to questions through

her access to people with knowledge. When exploring the requirement to deliver health education to local mothers, the interviews with female volunteers revealed that education materials were provided to them throughout their training. The volunteers kept these materials and used them to support the educational training that they deliver at their Mothers' Group meetings. The next section explains how receiving these education materials were one of the physical incentives and motivations that the female volunteers gained through working as part of the FCHV programme.

5.3. Motivations of the female volunteers

As the female volunteers are not financially remunerated in their roles, I was intrigued to understand what some of the key motivations were behind the women wanting to work as part of the FCHV programme. A primary motivation was found to be the educational training received, which provided the volunteers with educational materials, and subsequently physical awards for their volunteer services.

5.3.1. Training and education

One of the questions allocated for the semi-structured interviews focused on whether the female volunteers were empowered as part of the programme, and responses to this question found a strong connection to the education the volunteers received. Receiving training and education through the FCHV programme was seen as empowering for the female volunteers and was also recognised as a huge motivating factor for the women to become volunteers. The Senior District ANM stated that "the volunteers are educated about child and maternal health. Through this education they are then able to educate others and save lives within their local communities". The Municipality Health Coordinator, stated that "prior to becoming a volunteer, some of the women had no education. So, by becoming a volunteer they gained a sense of pride in learning new knowledge and gaining new skills". Gaining knowledge and learning new skills were consistently viewed by all research participants as a motivating factor as to why the women wanted to become volunteers and stayed working as part of the FCHV programme. In agreeance, the Health Post in Charge stated:

> The volunteers are some of the most knowledgeable members within the community. They are educated by doctors and are seen to have the knowledge and the voice of doctors, which gives them the freedom to advise and educate others on health.

When Fatima discussed her motivation to be a volunteer, she explained “I feel proud because I act as a doctor for those who do not get to see the doctor. I am educated in healthcare and nutrition and people listen to the advice that I give them”. Becoming educated and gaining a sense of knowledge and authority was a motivating factor for all volunteers interviewed and was found to give them decision-making authority they previously did not have.

5.3.1.1. Initial training

Referring to the FCHV programme policy (DoHS, 2021, p. 236), the female volunteers are required to receive education and complete initial training. Receiving education is identified as one of the primary incentives of becoming a volunteer within the FCHV programme. When volunteers attend educational training, they receive a small financial remuneration. They also, as explained above, have enhanced decision-making authority within the community. Ekta mentioned that “we receive payment incentives of 400 NPRs [$4.70 NZD] to attend training days. This is not a lot of money, but I am paid to receive education on health matters, and I get to decide what is the best knowledge to share with my community”. Despite being a prime incentive, the frequency of the initial training was not predictable. The awareness of the initial training was known across all participants, although the reality of its conduct deviated from the programme’s policy, because of the low turnover rate of volunteers, and therefore only a small number of people requiring the training.

The three volunteers interviewed each had more than 13 years of experience. Ekta had been a volunteer for 21 years, Guneet for 16 years, and Fatima for 13 years. Because volunteers primarily stayed in their roles until the compulsory retirement age of 60, there was a low turnover rate and consequently long lapses in time between the conduct of initial training sessions. For example, Fatima was selected to be a volunteer in 2009, but did not participate in initial training until 2017 after working as a volunteer for eight years, since the district was waiting to conduct collective initial training for multiple volunteers requiring it. When I raised the lack of initial training in conversation with the Senior District ANM, she acknowledged its

occurrence, but referred to it in a positive light by saying, “the volunteers within our district all stay until retirement, which means that we have no requirement to conduct initial training often and instead focus on continual training sessions”. Despite this common delay in initial training, it was found that there were periods of continual training and annual and semi-annual meetings which also acted as educational opportunities for the female volunteers.

5.3.1.2. Continual training

As training was managed at district level, there were more opportunities for the female volunteers to access continual training since there were frequent training sessions combined with volunteers from other villages within the municipality. An example of this was that the last combined training that the volunteers from Balkumari attended was conducted over a four-day period in Dhodhari with their female volunteers. A total of twenty-three female volunteers attended this continual training, whilst concurrently eight volunteers who required their initial training attended that at the Municipality Office in Tarataal. The volunteers interviewed, all expressed positive feelings towards receiving continual educational opportunities through combined training experiences, and all had positive opinions of the annual and semi-annual meetings that were held.

The Health Post in Charge stated that: “our annual and semi-annual meetings are training opportunities for the volunteers. All volunteers attend these [meetings] and have opportunities to ask any questions they have to clarify their knowledge”. Since these meetings involved all the health staff throughout Bardiya District, there was a lot of experience and knowledge held across the attendees. Having those meetings gave the volunteers an opportunity to ask any questions that they may have, whilst also gain knowledge and experience from other medical staff present.

5.3.1.3. Education materials provided to female volunteers

Training could also be provided to the female volunteers by NGOs and INGOs supporting health initiatives throughout the country if approved at the district level. For example, additional training was often given for seasonal diseases, such as dengue fever, and was also

delivered during the COVID-19 pandemic. Since community health, and therefore educating members of the community, was the responsibility of the female volunteers, the organisations who delivered training to the volunteers usually supported the training by supplying them with education materials. Supplying the volunteers with education materials helped to ensure that accurate messaging and detailed information was passed onto the community when the volunteers chose to deliver a specific topic of educational training.

The education materials were commonly referred to as information, education and communication (IEC) materials. When supplied with IEC materials the volunteers subsequently utilised them as training aides to support the health education training that they delivered at their monthly Mothers' Group meetings. The volunteers interviewed during this research all alluded to their IEC materials being an attractive part of being a volunteer. During Fatima's interview, she voluntarily laid out her IEC materials (seen in Figure 5.2) and offered me to photograph them whilst stating "I have been taught everything that is included in these materials, so I now get to pick what is the most important knowledge to share with other mothers".

Figure 5.2: *Fatima's IEC materials and personal awards received through the FCHV programme*

Guneet showed me a fantastic example of how she used her IEC materials, seen in Figure 5.3 below, as a training aide. Figure 5.3 shows a book that covers twelve topics of health education that Guneet used monthly to plan and guide the health education topics she selected to share at her Mothers' Group meetings throughout the year.

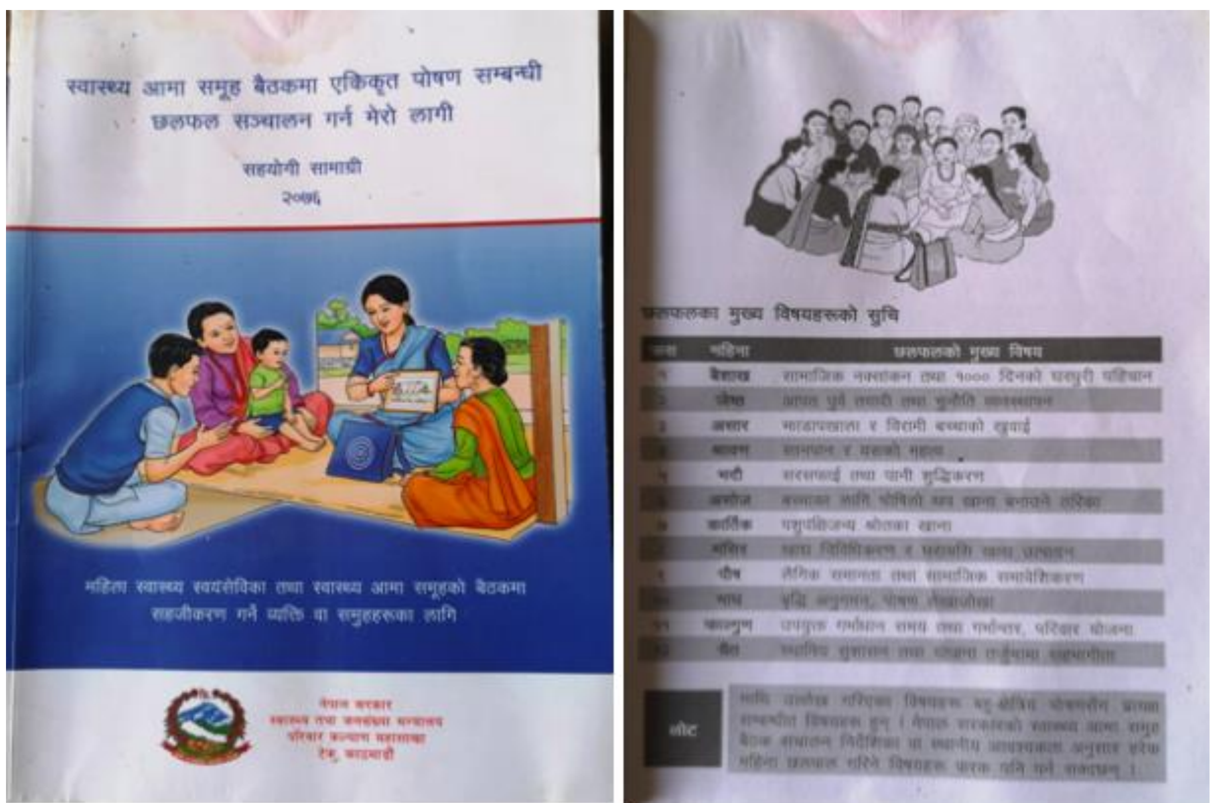


Figure 5.3: *Guneet's IEC materials – book providing twelve health education topics*

When showing me this book, Guneet emphasised:

> For me to deliver training is easy now. The information is already available within this training book, and it is all information that I have previously been taught during my volunteer training. I now hold the choice of what is the most relevant information to share with others.

The IEC materials are an educational incentive for the female volunteers, and they take pride in knowing the content and using them as educational resources to educate others within their community. Knowing all the content of their IEC materials has supported their decision-

making autonomy, as the volunteers could choose what information they believed was best support for their local mothers.

As explained before, volunteers are the gateway to educating the local community on relevant health matters. Therefore, it is important that these volunteers are supported with IEC materials to ensure that they can convey health information accurately, and appropriately educate local mothers within their communities. As could be seen in Figures 5.2 and 5.3 above, the volunteers are taking great care of their IEC materials and have kept these in pristine condition. Consequently, through this research I categorised the IEC materials as an incentive as they gave joy to volunteers within the local FCHV programme.

5.3.2. Awards for volunteers

During my fieldwork I found the volunteers were content with making a positive contribution to their communities and were also motivated by receiving recognition for their efforts in the form of awards. Some external recognition and motivating factors for the volunteers' work was described as certificates, physical awards, and having the 5th of December, as a National Day of Recognition for all CHVs (coinciding with International Volunteers Day). To support the volunteers' motivation, the local Chairman of the village said "previously awards were only given to a top volunteer, but I have now introduced prizes for all volunteers … This year I organised for each volunteer to be given a rice cooker". The chairman explained that each volunteer in Balkumari was presented with a rice cooker. The Health Post in Charge also mentioned that "by giving the volunteers each a rice cooker, they should have more time available for their FCHV programme duties". Both men in leadership roles felt that giving the volunteers an award of a rice cooker would support their extrinsic motivation to work as part of the local FCHV programme.

Similarly, I was under the impression that a rice cooker was a useful item for volunteers to receive, since women within the local community commonly cook rice three times a day. However, when interviewing the women, a different perspective prevailed. Ekta mentioned that since becoming a volunteer she was "given a mobile phone, a torch, a bicycle and now a rice cooker … the bicycle is useful since I can get around the village faster, but I have not used

the rice cooker". Fatima had also received a mobile phone, and a torch through the national FCHV programme, but her rice cooker was photographed still in the original box (see Figure 5.2). When asked, Fatima explained that she had not used her rice cooker:

> The items that directly support me in my role as a volunteer are useful. Receiving a rice cooker does not benefit me at all, since I already use my pressure cooker. It would have been more useful to receive a container to store medicines in.

This and Ekta's quote, did not demonstrate a lack of gratitude in receiving the awards. Both women appeared to be thankful for the items that they had received through the local FCHV programme, although they were clearly more satisfied with the items that directly supported their CHV outputs and responsibilities. Guneet's bike that she had received as part of a national FCHV programme initiative, seemed to be her most valued possession out of all the awards that she had received. Guneet said "I have learnt to ride a bike since becoming a volunteer. Previously I did not have a bike and did not know how to ride one. Now I use my bike daily to support my volunteer duties." The bike provided both personal development for Guneet and supported her in her role as a CHV.

The consensus from all research participants was that volunteers appreciated being rewarded for their work with awards, but items that did not support them in their roles were not seen as favourable. The research participants in executive roles portrayed a sense of pride that they had facilitated the distribution of awards. In response, the volunteers were appreciative but more positive about awards that directly supported their roles as volunteers and their personal growth.

5.4. Personal growth experienced by female volunteers

Throughout the research it was found that the female volunteers had a sense of value reflected synonymously as personal growth within both their social status and self-esteem. The research participants first have described how the social status of the volunteers had increased within their community caused by their positive contribution to the village. Then

subsequently, through this recognition the female volunteers experienced an increase in their self-esteem.

5.4.1. Increased social status of female volunteers

When spending time in the Balkumari community, it became apparent that the volunteers were trusted and well-respected members of the community. The Ward Chairman, stated that: "The social status of the volunteers is increased through their involvement in the programme. By being a volunteer, everyone in the community now knows who they are." As someone in a key position of community leadership, the Ward Chairman's recognition of the increased social status of volunteers demonstrates that the women are valued members of the local community, which is also reflected in the volunteers' opinions of themselves. Ekta gave an example recognising that her involvement in the FCHV programme had increased her social status and that everyone now respected her and knew who she was:

> Before being a volunteer there was no good environment for me, I had no opportunities … Now everyone knows who I am and really appreciates me. I have the opportunity to meet everyone, teach people, and educate other women … Before being a volunteer I was only known as a woman who took care of my house, and now people know me as a community health volunteer.

Ekta's quote explained that through her involvement with the FCHV programme, she had become a known and valued member of the local community, indicating that she had experienced an increase in social status. Along the same theme, Fatima explained that because they experience this increased social status, the female volunteers never want to retire:

> I only know of one volunteer who has retired before the age of 60, and this was because her family moved away for her husband's work. Nobody wants to retire from being a volunteer because we become pillars of the community.

By virtue of being known and regarded as a 'pillar of the community', the female volunteers have experienced an increase in social status through their involvement with the FCHV

programme. This increase in social status of the female volunteers was also recognised at the FCHV leadership level, through a comment by the Health Post in Charge:

> Just as everyone within the community knows who I am, everyone also knows who the ten volunteers are within Balkumari. The local Mothers' Groups select their own volunteers, and they all stay in this role until they reach the compulsory retirement age of 60.

Without taking on their roles as CHVs, the women would not be as widely known within their local community. It is through their involvement with the local FCHV programme that the volunteers have come to experience an increase in their social status and to be recognised and respected throughout the village.

The volunteers who were interviewed all lived without their husbands in Balkumari. Ekta was widowed, whilst the other two volunteers' husbands lived and worked outside of the village. As was explained in Chapter Three, Nepal is a patriarchal society, thus women traditionally held a lower social status than their husbands. Despite their husbands' absence, these female volunteers' social status did not appear to be negatively impacted nor influenced. Fatima, whose husband works in Eastern Nepal and only returns home twice a year for festivals, stated: "I have been a volunteer for 13 years and everyone in the community now knows who I am because I have done this role for a long time already". Despite her husband not being at home, Fatima holds a high social status within her community, and feels comfortable knowing that everyone knew who she was and appreciated the work that she conducted.

During my time in Balkumari, Fatima had to visit a newborn baby within her Mothers' Group and invited me to accompany her for the visit. When we arrived at the house of the new mother, the husband welcomed us in, and was delighted with Fatima's presence as a CHV. Whilst at the house, Fatima carried out her duties and rang the Health Post in Charge to verbally report the details of the birth and the baby for recording purposes. Fatima disclosed that "previously local women did not have permission from their mother-in-laws or husbands to deliver their babies at the healthcare facility, but through her support as a CHV they were now free to deliver their babies safely". As we walked away, Fatima portrayed happiness with the duties that she had completed and took immense joy in telling people we passed that she had just visited a new baby who was born at the health centre, and in return everyone

thanked her for the work she conducted as a volunteer. Everyone knew who she was and about her duty of care as a volunteer, and consequently seemed to regard her highly within the local community.

All the community women personally knew who their specific CHV was, and outside of the personal relationships, everyone recognised the blue sari of the volunteers. When interviewing Ekta and Fatima, they both voluntarily chose to be in their blue saris and asked to have their photos taken with beaming smiles on their faces. Figure 5.4a and 5.4b below, are the photos taken of Ekta and Fatima, although for their personal privacy their faces have been removed. Being asked to photograph these two ladies portrayed their happiness, and demonstrated the high social-status and increased self-esteem associated with wearing a uniform that was recognised and respected throughout the village.

Figures 5.4a and 5.4b: *Ekta and Fatima proud to be photographed wearing their uniform*

5.4.2. Increased self-esteem experienced by female volunteers

High self-esteem was common across the three women. These volunteers confidently described how they had been educated through their involvement with the FCHV programme and were consequently able to educate others within their community. As was just described, through being part of the FCHV programme, the volunteers had an increased social status. They also had gained an increased belief in their own abilities and self-esteem. For example, when Fatima was asked to describe her experience as a volunteer, she responded joyfully:

> I am really able to now help people within the community. I am able to support people who are not educated about health-related problems and who cannot do things on their own. With my support as a volunteer, they become more educated and learn about child and maternal health. People now really appreciate me and the work I do as a volunteer, which really makes me emotionally and mentally strong.

This quote demonstrated the increased self-esteem that Fatima had gained through her involvement with the FCHV programme, which was common across the other volunteers. Guneet demonstrated high self-esteem in her interview, by stating that:

> Since I have been a volunteer for so long, I am learning so much, and I am also teaching others when I go into the community and interact with other people. It has been a great experience, and my role really helps me to grow both individually and within the community as well… I was selected by the women within my local Mothers' Group to be the community health volunteer because they saw my capability.

In this quote, Guneet described that before becoming a volunteer within the FCHV programme people saw her potential, but since becoming a volunteer, through her education and ability to teach others, Guneet's self-esteem and social status within the community had increased.

Guneet also gave a wonderful example of how her education and knowledge had supported other people's knowledge and progression within the community:

> People used to weigh their babies in balance scales against cow poo. When the weight of the baby was balanced with cow poo, the women would then use the poo to create art work on the wall, in the shape of a baby. When the poo dried out and eventually fell off of the wall, it was believed that the baby would then be cured of malnutrition. This practice is no longer conducted within our community because I have educated women about malnutrition and what their babies should eat.

In this quote, Guneet recognised her positive influence within the community and her ability to educate local mothers on malnutrition. It also provided a success story for the local FCHV programme, and the positive impact the female volunteers have had within the community.

Through Guneet's involvement with the FCHV programme, she had gained invaluable knowledge and skills that she has been able to pass onto mothers within the community and that could change the lives and outcomes for malnourished babies.

5.5. Chapter conclusion

This chapter has presented the research findings and has highlighted the happiness and pride of the CHVs interviewed in Balkumari. This research analysis explained the responsibilities of the FCHV programme in Balkumari, and the responsibilities of the female volunteers. The results have identified tangible improvements in the local community health facilitated by the FCHV programme and the work of the CHVs. The findings drew out motivations as to why women wanted to be CHVs and remain in their roles until retirement. It was also found that the female volunteers were highly regarded and held high social statuses within Balkumari and were known for their positive contribution to society. The next chapter will discuss these findings in relation to the research questions and provide the conclusion of this research.

Chapter Six: Discussion and Conclusion

6.1. Introduction

This report started with the premise that the FCHV programme in Nepal was established in recognition that women's empowerment needed to be prioritised simultaneously with women's health. This study began by explaining women's progress towards empowerment and has used a conceptual framework on women's empowerment. This study was prepared in the context of the FCHV programme in Balkumari village in Nepal. It was important to understand Nepal's patriarchal social norms and existing gender inequalities, especially in the context of women's health. Nepal's FCHV programme was described, including the reasons for being established and the role of female volunteers. This research has used a qualitative methodology, focusing on the FCHV programme in Balkumari as a case study. Seven semi-structured interviews were conducted during fieldwork in Nepal.

In Chapter Five an analysis of the findings from the semi-structured interviews was presented. This chapter will now discuss these findings with reference to the research aim: *to understand how the FCHV programme operates and in what ways empowerment of women involved in the programme is prioritised*. The first section of this chapter will address research question one, which focuses on the programmes' practices towards women's empowerment. The second section will respond to research question two, to understand what resources support the operation of the programme. I will relate my findings to the Rao and Kelleher framework (as shown in Figure 2.2), and will discuss how the empowerment of women is related to: *consciousness and capabilities*, *resources*, *rules and policies, and social norms and deep structures*.

6.2. The FCHV programme's efforts towards women's empowerment

This section will discuss the fieldwork data with regards to research question one: *does the FCHV programme in Balkumari support women's empowerment*? There were two objectives associated with this question, firstly what empowerment means to the FCHV staff and secondly whether the programme activities promote women's empowerment. Consequently, this section will draw on Chapter Five to discuss how education was regarded to be an important contributing factor to empowerment and will demonstrate the synergies between education, health and gender equality that were identified in Chapter Two.

6.2.1. How education contributes to women's empowerment

Education of women in Balkumari was regarded as a key contributing factor to women's empowerment. As Xie explained, improved education for women invests in areas creating equal opportunities and generating women's empowerment (2015, p. 67). My study on Balkumari, relates to Xie's findings, as female volunteers received education through their roles during initial training, annual and semi-annual meetings, and continual training opportunities. The annual and semi-annual meetings were explained as avenues for the volunteers to gather, gain new knowledge, and clarify queries with medical professionals, whilst local mothers received monthly education at the Mothers' Group meetings provided by the volunteers. These educational opportunities supported the increase in women's health and healthcare. The Municipality Health Coordinator mentioned that "before becoming volunteers, the women had no education" and that "by gaining new knowledge the volunteers became proud and able to share their knowledge with others, which enhanced community health". As was acknowledged by Deshpande and Bhat (2019, p. 30), there are synergies between education, health, poverty alleviation and gender equality. By increasing women's education in Balkmuari, the FCHV programme has enhanced women's health which contributes towards gender equality in the village. All volunteers interviewed discussed how providing educational opportunities to local mothers was essential for them to learn about health requirements and available healthcare treatments. Education was found to be a resource that supports and enhances the empowerment process of local women in

Balkumari. This finding links in with Grabe's (2012) concept, that resources are a means to empowerment.

Previously, women in Balkumari had minimal educational opportunities, although by educating local volunteers, the FCHV programme has exponentially contributed to women's education and their journeys towards empowerment. On an individual level, when women receive education on health and healthcare, they act on their ability to advance what Longwe refers to as the five hierarchical levels of equality, welfare, access, conscientisation, participation and control are enhanced (Longwe, 1994). Women in Balkumari have gained *welfare* through the existence of the FCHV programme and their increased availability of health support and knowledge. Women's *access* to education was drastically increased through the conduct of their monthly meetings, which raised women's awareness of their right to seek healthcare treatment, rather than stay at home as per the traditional wishes of their husband and mother-in-law (*conscientisation*). Women's *participation* was amplified through collective action of coming together to discuss health issues and solutions to overcome them, and their *control* was enhanced throughout all aspects of health awareness and education opportunities that have supported them to decide to pursue healthcare treatment as needed. By realising the benefits of each level of empowerment through the education provided by the FCHV programme, the local women in Balkumari are more likely to experience individual empowerment and realise the benefit of each level of Longwe's empowerment framework (1994). As shown, education can contribute towards the process of empowerment and the fulfilment of all hierarchal levels. These results align with Van Kempen (2009, p. 466) who described the process of empowerment as "the expansion of a person's ability to make strategic life choices previously denied to them" (see Chapter Two). Educational opportunities facilitated by the FCHV programme afforded empowerment processes to women in Balkumari by giving them awareness and knowledge to make strategic life choices about their health, and by increasing their capability, which will be discussed next.

6.2.2. Increasing the capabilities of women through education

The FCHV programme in Balkumari has increased local women's capabilities by providing health education and supporting them with healthcare. This result is an improvement to what Dahal et al. (2021, p.2) identified as an issue, that Nepal's patriarchal society and educational barriers disfavour women's education. The UNDP found that women usually only receive primary school education, stating that only 29.3 percent of women across Nepal reach and attend secondary school (UNDP, 2020, p.5). This data emphasises that women have limited opportunities for education, and therefore there is a need for educational opportunities to support the increase of women's capabilities. In accordance with the national FCHV programme policy, once female volunteers receive education, they subsequently share their knowledge with local mothers through monthly Mothers' Group meetings and by conducting health checks (DoHS, 2021, p.xix). Through such educational opportunities, the capabilities of local women and consequently their health and their babies' health was improved in Balkumari. An example from this research is how volunteer Guneet disclosed that the local women in her area now know how to effectively treat malnourished babies rather than defaulting to the myth of balancing babies' weight with cow poo. By increasing the capability of women, the local FCHV programme supports women, gaining what Rowlands' referred to as *power to* (1997, p.12). Local women, having received education and knowledge, now hold the *power to* transform their individual health and the health of their young children through their own capabilities. By receiving specific health education, local mothers have become able to identify and prioritise treating certain ailments. This finding aligns with improvements made towards women's empowerment through increasing their consciousness and capabilities, as the local FCHV programme has focused on increasing access to women's education and thereby enhancing their informal and individual empowerment (Rao et al., 2016).

Several authors have suggested that women's empowerment initiatives focusing on women's health improvements should combine empowerment with rights-based approaches (Painter, 2005; Barton, 2005; Gardyne & Malecki, 2022). By providing education on health and making healthcare available, the local FCHV programme empowers women by addressing both rights and empowerment. The FCHV programme not only empowers women through health

knowledge, but also by educating on their right to healthcare, in particular their right to deliver babies at a health centre rather than at home. It has been shown through this research that women are less fearful about childbirth as they are now more empowered to deliver their babies at healthcare facilities regardless of the views of their mother-in-law or husband.

This improvement implies that through education, local women have become aware of surrounding societal power relations that had previously lower priority and subjugated women's health. Women are now more able to begin transforming these power relations. This new knowledge also empowers women as conscious rights holders as women are now more aware that they can deliver their babies within safer environments. This finding supports Rowlands' idea that by receiving rights education and being supported to pursue their rights, local women can grow their sense of *power to* and *power from within (*Rowlands, 1997). As local women have increased their health capability and have seen benefits, they have become more likely to continue to prioritise healthcare. Thus, more awareness on women's rights may at least be slowly transforming earlier patriarchal power dynamics, whereby Nepali women did not have the freedom to prioritise their healthcare (Doss et al., 2022, p.17). This shows an increase in women's individual consciousness, sense of self-reliance, and *power from within* to be able to decide to prioritise healthcare. These results align with Cox et al. (2013) stating that raising self-reliance of individuals supports their empowerment process, and it can be concluded that the local FCHV programme in Balkumari supports women's individual empowerment by increasing their sense of self-reliance.

6.2.3. The transformation of social norms through the increase in female volunteers' social status

As was described in Chapter Five, female volunteers in Balkumari are holding a higher social status in comparison to other women. In some way, it can be said their volunteer work is slowly transforming the dominating patriarchal social norms, as these women have found ways to move outside their assigned household areas. During fieldwork, the female volunteers were described as 'pillars of the community' and were regarded as 'the voice and knowledge of doctors'. These findings lean on Doss et al. (2022, p.15) who had explained

Nepal's deep patriarchal norms, whereby traditionally the household status of women was dependant on their husband's and mother-in-law's, and are showing that there is some transformation occurring. One prominent finding that shows these changes is that the female volunteers in Balkumari held a higher social status than before taking up these roles, because of their ability to help people within their community.

The transformation of social norms, and the increased social status of the female volunteers, is a significant achievement of the local FCHV programme, as could be seen in Chapter Five. This observation aligns with Rao and Kelleher's (2016) conclusion that social norms can be one of the hardest, but most valuable factors for an organisation to be overcome. The FCHV programme has made a start in this direction as the experience of Ekta, a female volunteer, has shown. Ekta had explained that prior to being a volunteer she was "known as a woman who took care of her house, but now is known as a community health volunteer". Her experience demonstrates how people regard her more highly because of her volunteer role. The Health Post in Charge also explained that everyone in Balkumari knew who the female volunteers were, implying their increased recognition and higher social status within the village. Fatima, another female volunteer, described how she had become "emotionally and mentally strong since recognising that people in Balkumari appreciated her". Fatima's comment portrayed that she had individually grown in her self-esteem, through the systemic change in social norms of the village that recognised and appreciated her positive contribution to the community. This observation that some social norms in Balkumari are slowly changing supports Rao and Kelleher's suggestion that improvements on the informal and systemic scale of women's empowerment are important aspects of empowerment that create social change (Rao et al., 2016).

This section has explained how the FCHV programme in Balkumari has supported women's empowerment through increases in women's *capabilities and social norms* experienced. It was also discussed how this research found education to be a key contributing factor to women's empowerment and how it intimately supported the increase in women's health, contributing to gender equality and women's empowerment in Balkumari. By transforming local social norms and by raising capabilities of women, the FCHV programme in Balkumari has been found to support women's empowerment and their pursuit of healthcare. Rao and

Kelleher (2016) said that advancements in women's empowerment can only be achieved if advancements are made across all aspects of their empowerment framework. Therefore, the next section will respond to research question two and discuss how policy and resources have supported the operation of the FCHV programme in Balkumari.

6.3. The operation of the FCHV Programme in Balkumari

This section will discuss the fieldwork data with regards to research question two: *what resources support the operation of the FCHV programme in Balkumari*? There were two objectives associated with this question concerning the resources available, and how the programme's resources support the female volunteers. Accordingly, this section will discuss how the national policy supports the operation of the local FCHV programme, and secondly how physical and conceptual resources have supported the female volunteers.

6.3.1. National policy that enables the local operation of the FCHV programme

The national FCHV policy was found to support the local operation of the programme in Balkumari. The national strategy focused on meeting community-based health needs (DoHS, 2021), and therefore inherently promoted the autonomy of the local FCHV programme. When interviewed, the Senior District Auxiliary Nurse Midwife (ANM), described the FCHV programme to be on a pull system, which gave the volunteers the scope to intimately understand their community's needs and request specific support. This Senior District ANM also said that government has created the programme so that every person would receive better education and healthcare, and to ensure people would not be left behind. This quote aligns with the national programme's strategy to meet community-based health needs and shows that the national level policies support a decentralised healthcare model to enhance health outcomes for all, demonstrating in some ways the pursuit of SDGs and the universal principle of leaving no-one behind.

The national FCHV policy holds the objective "to impart relevant skills and knowledge to tackle common health problems and to develop female volunteers as health motivators" (DoHS, 2021, p. 236). The programme's strategy stipulates criteria that all health volunteers must

meet (GoN, 2010, p. 3), and DoHS mandates that they undertake educational and basic training (DoHS, 2021, p. 236). These national level policy requirements demonstrate that formal direction is given for CHVs to be educated and hold decision-making authority, which consequently supports the local operation and success of the FCHV programme in Balkumari. This research found that Bardiya District managed the continual training and education of the volunteers as per this national level guidance. Although there were discrepancies found with the timings of when the female volunteers' initial training was conducted, the volunteers still received ample training opportunities. For example, this research found that the health volunteers in Balkumari had recently undertaken a four-day period of combined training in another village, and the Health Post in Charge described the annual and semi-annual meetings as additional training opportunities that all volunteers attended. The analysis of interviews found a correlation between the education of the female volunteers and their increased decision-making authority. By being broadly educated they were able to choose the education topics pertinent to present at their monthly Mothers' Group meetings.

It was both Mahato et al. (2020), and Paudel and de Araujo (2017) who recognised that gender norms in Nepal restrict women's decision-making authority and consequently used it as a measure of women's empowerment. Through the autonomy and decision-making authority of the female volunteers, Balkumari's FCHV programme operates effectively and meets the national policy objectives on community health. This research found that despite the national FCHV policy being over ten years old, it gave formal direction that enhanced the female volunteers' decision-making authority. By complying to policy that prioritised their training and education these women became able to appropriately address community health. This observation aligns with Rao and Kelleher's quadrant, *formal rules and policies,* showing an example of how the national FCHV policy is a formal and systemic improvement contributing to women's empowerment. Rao and Kelleher (2016) said it was often formal factors that take precedence for development programmes, as they generate easily quantifiable improvements. In contrary, this research found that the national FCHV programme strategy was in excess of ten years old, suggesting that the formal systemic improvements towards supporting women's empowerment had not taken precedence over the less tangible measures such as women's capabilities or invigorating social change.

Despite the lack of priority placed on formal rules and policy, the MoHP's national FCHV policy (created over ten years ago) gave a level of autonomy to the FCHV programme in Balkumari, whereby the volunteers were able to cater their services to the community needs. The findings show that Balkumari has a pool of highly motivated female volunteers who supply relevant community-based health education to tackle common health problems, and therefore meet objectives of the national FCHV programme (DoHS, 2021, p. 236). Having formal rules and policies at the national level, whilst maintaining autonomy at the local level, has enabled the successful operation of the local FCHV programme and has simultaneously provided appropriate support to the female volunteers.

6.3.2. Resources that supported the female volunteers

The female volunteers in Balkumari were found to receive both conceptual and physical resources to support them. As already mentioned, findings showed that volunteers received the conceptual resource of education and training through the FCHV programme, both in the form of multiday training periods and the annual and semi-annual meetings. Being able to engage in health education demonstrates that Balkumari is making improvements towards SDGs 3 and 5, whereby targets 3.7 and 5.6 specifically focus on increasing education and access to health and healthcare services (SDGs, 2023). The female volunteers described how education has provided them with strong support to undertake their roles. In this context, the Health Post in Charge also found the female volunteers as some of the most knowledgeable members of the community. This education achievement was also reflected in Fatima's self-assessment, by explaining that she felt proud to be the voice of a healthcare professional for those who do not get to see the doctor, giving an example of what Rowlands referred to as generating *power from within* (Rowlands, 1997).

By receiving the conceptual resource of education, the female volunteers have generated a sense of self-belief, and as said by Van Kempen (2009, p.466) "expanded their ability to make strategic life choices, previously denied to them". Guneet described her self-belief saying:

> I am learning so much, and I am also teaching others when I go into the community and interact with other people. It has been a great experience, and my role really helps me to grow both individually and within the community.

The female volunteers' personal growth, supported by conceptual resources aligns with Kabeer's (2005) concept of immediate empowerment, whereby receiving education provided the women with cognitive empowerment to generate agency and obtain achievements in the community's health.

The female volunteers in Balkumari were also found to receive physical resources through the FCHV programme in the form of IEC materials and awards that supported their duties as CHVs. One of the volunteers emphasised how training delivery had become easy since the IEC materials held all the information readily available to support her training of local mothers. The IEC materials were found to be an incentive for the female volunteers, as they regarded them as a physical representation of the knowledge they held. Other physical resources, such as bikes, torches, and mobile phones awarded to the female volunteers gave them agency to perform their reporting requirements when conducting household visits. This was observed when Fatima visited a newborn baby and phoned through to the health centre with all the required information. Guneet also explained that when awarded her bike, she had to learn how to ride it. Since receiving her bike, Guneet described that she used her bike daily to support her volunteer duties. Having the support of physical resources supported Rowlands' theory of enhancing their *power to* fulfil their roles as CHVs and achieve positive health outcomes in Balkumari's community (Rowlands, 1997). Increasing the female volunteers' individual resources aligns with Rao and Kelleher's aspect of *resources,* showing formal and individual improvement towards their empowerment (Rao et al., 2016).

Policy and resources are presented in the two quadrants on the right-hand-side of Rao and Kelleher's empowerment framework that formulate the formal side of the scale of women's empowerment (Rao et al., 2016). This section has discussed how formal policy supports women's empowerment in the sense that is gives direction on the requirement to promote women's education and invigorates autonomy in their decision-making authority. This section has also explained how the local programme has enhanced the female volunteers' access to

resources, both conceptual and physical, which supports them in their roles. The next section will conclude this research and how the empowerment of women is prioritised by Balkumari's FCHV programme.

6.4. Conclusion

This study aimed to understand how the FCHV programme operates in Balkumari and in what ways the empowerment of women involved in the programme was prioritised. It can be concluded that the local FCHV programme has strongly supported the increase of women's education and consequently has made a significant enhancement to community and women's health in Balkumari. At the start of this research report it was identified that significant inequalities existed in maternal and women's health in Nepal. Although this research found that the local FCHV programme has made large improvements in community health, and contributes to 'leaving no-one behind', maternal health is still an area that requires attention and support across Nepal. Four key findings demonstrate ways in which women have benefited from how the local FCHV programme has prioritised women's empowerment.

The first finding of this research was that education on health and healthcare has increased the capability of women in Balkumari. In can be concluded that because of the local FCHV programme facilitating the education of the female volunteers, who subsequently educate local mothers, the programme is transforming power relations and giving the volunteers the *power to* and *power from within* to prioritise healthcare (Rowlands, 1997). By increasing women's health capability, the local FCHV programme makes specific progress towards SDG 3, *good health and wellbeing*, SDG 4, *quality education*, and SDG 5, *gender equality.* This research has shown how providing education to women can make improvements across these SDGs and has highlighted the synergies between education, health, and gender equality that was discussed by Deshpande and Bhat (2019, p. 30).

The second key result is the transformation of social norms, whereby the female volunteers in Balkumari hold higher social statuses than before taking on their roles, because of their support of community needs. This result has shown that the local FCHV programme has

progressed gender equality in the village by slowly transforming some of the power relations that are based on traditional patriarchal norms. Men value women being CHVs and have become more aware of women's needs to give birth in safe conditions. This result shows that there is less subjugation of women and less *power over* some women's social status (referring to Rowlands, 1997).

The third conclusion of this research is that as the local FCHV programme in Balkumari operates autonomously, health volunteers have freedom in their decision-making authority. Women CHVs identify and work towards what they perceive to be their responsibilities to support their community's health needs by addressing each household's individual circumstances. The female volunteers were found to confidently pass on their knowledge to local mothers and use their decision-making authority when addressing community needs. As presented by Paudel and de Araujo (2017, p.326) women's decision-making authority is an indication of social status and women's empowerment in Nepal, and therefore it can be concluded that Balkumari's FCHV programme has contributed to progressing both the empowerment and social status of the female volunteers.

The last of the key results is that because the local FCHV programme has prioritised resources to be available to female volunteers in Balkumari all women involved, CHVs and local women receiving health care have benefited. The local programme has provided resources for the female volunteers through education, IEC materials, and gifted awards. By granting these resources, the FCHV programme in Balkumari generates agency for the women to achieve positive results in community health. Making resources available also demonstrates that the Balkumari's FCHV programme has addressed an immediate level of empowerment for the women, which links with Kabeer's (2005) concepts that resources are generating agency and achievements.

These key results show that, as was outlined in the programme's objectives, women's empowerment is actively prioritised by the FCHV programme. Progress has been made across all aspects of empowerment outlined in Rao and Kelleher's framework. Mahmud et al. (2012, p. 611) have emphasised that empowerment is contextual and specific in any given environment or organisation, and this idea has remained central to this research. As my study

is grounded on seven weeks of fieldwork in Balkumari village, all findings remain specific to the situation in this local setting. Noting the specificity to that location and point in time, it will be interesting to see contributions of more comprehensive research on the FCHV programme in Nepal and how the programme supports and prioritises women's empowerment more widely.

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Appendix

Information Sheet:
A case study on the Female Community Health Volunteer Programme in Balkumari, Nepal

Namaste,

My name is Francesca Thompson and I am currently enrolled in the Masters of International Development Studies programme at Massey University in New Zealand. The aim of my research is to explore how the Female Community Health Care Volunteer (FCHV) programme in Balkumari operates and whether it contributes to women's empowerment.

I am hoping to talk to people who are currently involved or have previously worked for the FCHV programme within the last five years. If you meet this criteria, I would like to invite you to participate in an interview. The interview will be conducted in English unless you would prefer for this to be conducted in your native tongue, in which case, please let me know and I will ask a research assistant to interpret. The interview will last approximately one hour and will focus on your understanding and perspective on the role and operations of the FCHV programme, and whether you believe the programme has been empowering or enabling for either yourself and/or others. If you will allow me to do so, I would like to have the interview voice recorded for my personal records, which I will delete once my research report is completed. Should you be happy for me to record the interview, you can still at any time ask me to turn off the voice recorder. You also have the right to ask any questions at any time, and you can withdraw from the interview at any stage. You can also decide to withdraw from the research at any time during the interview and until one week after the interview.

All information provided during the interview will be kept confidential, and it is important to me to protect your privacy throughout the process. For this purpose I will discuss with you the use of a pseudonym or position description to keep your information private. If you would like to have a copy of the research report, please let me know of your email address and I will send the report to you once this research is completed.

Thank you very much for supporting my research! If you have any questions please contact me or my supervisor (see contact details on the second page).

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email: humanethics@massey.ac.nz.

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