ORIGINAL ARTICLE

Discovering the Process of Community Empowerment in Health among Internally Displaced Communities in the Philippines: A Grounded Theory

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ABSTRACT

Background and Objective. Due to disasters and calamities, the number of internally displaced persons (IDPs) in the country is steadily increasing. With their disadvantaged situation, this population is prone to experiencing powerlessness and poor health outcomes. However, there is limited information on how these communities can gain control over their health and well-being. While community empowerment is a crucial process in the health sciences, this concept remains understudied. Hence, this study aimed to explore the process of community empowerment in health and develop a theory grounded on the experiences of displaced communities.

Methods. This study utilized the classic grounded theory (CGT), primarily aimed at discovering a conceptual theory anchored on the experiences of internally displaced persons. Particularly, this GT variant sought to explicate a social process of community empowerment in health through the participants' lenses. A total of 45 individuals from six towns of Bulacan province, Philippines were purposively recruited to participate in focus group discussions and key informant interviews. Data analysis employed the constant comparison method, which involved concept development, reduction, and refinement to derive the emerging theory from the gathered information.

Results. The 5 C's Grounded Theory of Community Empowerment in Health depicts marginalization as the main context of internal displacement, where participants' experiences of resource deprivation and social neglect made them vulnerable to poor health outcomes. The theory further explicates five processes involved in the empowerment of IDPs, namely: consciousness-raising, collaborating, capacity building, carrying out responsibilities, and continuing work. Particularly, the key steps involve (1) raising the community's awareness on the importance of gaining control over their health and well-being; (2) establishing collaborative relationships within and outside communities; (3) developing competencies on various health-related domains; (4) assuming multiple roles and implementing programs; and (5) continuing efforts to train more people, sustain partnerships, and expand community involvement. These steps lead to the study's core variable of self-sufficiency, where communities are anchored on the philosophy of communal unity *(bayanihan)* in managing their own health needs, promoting healthcare access, and addressing other social determinants of health. Moreover, study findings highlight the unique contribution of women, spirituality, and multisectoral engagement in facilitating the process of community empowerment.

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Conclusion. This is one of the first few studies to explore the process of community empowerment in health, which guided the development of a theory based on the experiences of internally displaced communities. The theory emphasizes that community empowerment is an iterative and continuous process that involves interactions among community members and other stakeholders. Holistic social preparation and capacity building, together with the integration of local culture and philosophy, could support the successful transition of IDPs into their new lives. Hence, multisectoral collaboration involving government agencies, private offices, higher education institutions, healthcare facilities, and faith-based organizations is crucial in promoting the movement of IDPs from marginalization towards gaining control over their health.

Keywords: community development, community organizing, community empowerment, internally displaced persons, marginalized communities, 5 C's model of community empowerment

INTRODUCTION

Health is a shared reality among individuals, families, communities, and populations, and is continuously shaped by the conditions and contexts where people live. Moreover, employment, education, access to resources, and the physical environment where people live, work, and play are part of the social determinants of health (SDH).[1] The World Health Organization (WHO) underscored that the SDH account for almost half of health outcomes and help to explain the health inequities seen globally.[2] However, limited studies considered the basic role of community context and environment on the health of people and their life expectancies, especially among low- and middle-income countries (LMICs).[3]

Globally, more than 123 million people have been displaced from their primary place of residence, of which 73% are hosted in developing countries.[4] This movement of people happens across countries and borders, but also occurs internally in the name of economic gains. Internally displaced groups or persons (IDPs) are those who were compelled to leave their homes or habitual areas of residence due to problems that include, but are not limited to, conflict (civil unrest, civil war), disasters (natural, environmental, famine), or development projects, without crossing an international border.[5] The annual number of IDPs illustrates a crisis of enormous proportions, yet global attention remains inadequate.[6] Over the years, there has been an increasing number of studies examining the relationship between resettlement, health, and integration of people into new environments.[7] However, much of this literature focuses on refugees and their movement across international borders due to civil unrest, war, and political strife, instead of internal displacement of a community or population within a country.

Among LMICs, displacement across urban and rural communities impacts various health outcomes, which is increasingly becoming more complex due to climate change.[8] In the Philippines, internal displacement is mostly attributed to disasters (e.g., typhoons, landslides, volcanic eruptions), with some associated with armed conflicts in the Mindanao region.[9] Due to the displacement of communities, individuals and families are at increased risk of infectious diseases, mental health issues, unemployment, exposure to violence, including rape, and loss of access to financial, social, and familial resources.[10] Further, internal displacement of a community potentiates a vicious cycle of hopelessness, poor mental health, and powerlessness.[10] Hence, to empower IDPs in rebuilding and recovering their lives, a comprehensive understanding of their context and sustainable initiatives to engage them are vital.

Community empowerment has been defined by the WHO as an enabling process to enhance communities' control over their lives.[11] However, while empowerment is widely discussed in theory and practice, research about this topic in healthcare is limited. According to the concept analysis of Kruahong et al., community empowerment is a pillar in health promotion that can support communities in making informed choices, determining goals, and mobilizing programs to improve health outcomes and decrease health disparities.[12] However, most studies conducted on empowerment take an individualized perspective and then apply that perspective to specific groups, like among older persons, women, and youth.[13] The majority of research on empowerment also focused on measuring it in the context of managing chronic illnesses like diabetes or as a consequence of interventions in disease control programs.[14] Despite LMICs having various community development activities, research on community empowerment is mostly documented in high-income countries like the UK, Switzerland, and the United States, focusing on program evaluation and document analysis.[15-17]

IDPs are vulnerable to poor health outcomes from a multitude of factors, including resource scarcities, service access problems, and readiness concerns towards integrating with host communities.[18,19] Meanwhile, extant research among IDPs revolved around exploring their health needs/status, healthcare accessibility and utilization, and public response systems.[18-22] Exploring the process of community empowerment among this vulnerable yet understudied population is crucial, as enabling them to gain control over their lives could address various social determinants of their overall health and well-being. Remarkably, how the concept of community empowerment is used across disciplines support the premise that it requires grounding in concrete human situations.[12]

To the best of the researchers' knowledge, this is one of the first few studies to analyze the process of community empowerment in health among internally displaced persons. Therefore, this research aims to extend the literature by

providing empirical evidence of the process of community empowerment in health, anchored on the stories and struggles of IDPs, and consequently inform policy and practice in the country and beyond.

MATERIALS AND METHODS

Study Design

To capture the process that underpins how internally displaced communities achieve empowerment in health, the classic grounded theory (CGT) method, as developed by Glaser guided this research.[23] This Glaserian paradigm emphasizes the researcher's openness to what is taking place in the field and removing preconceptions that may prevent the emergence of the core concepts to the evolving theory. Unlike other approaches, the aim is generating the substantive theory from the data rather than organizing concepts to fit preconceived categories as used in other traditions.[24] Through constant comparison procedures, CGT seeks to generate "emergent conceptualizations into integrated patterns, which are denoted by categories and their properties."[23] The use of this method is deemed most appropriate since the aim of this research is to discover and explicate the process of empowerment in health, rather than describe and narrate the experiences of participants.

To ensure that both depth and breadth of information were satisfied, focus group discussions (FGDs) and key informant interviews (KIIs) were utilized. FGDs helped elicit how the dynamics of empowerment in health were achieved as a social reality experienced at an organizational level. Meanwhile, KIIs were conducted after theoretical saturation was reached in the FGDs, wherein no new categories were surfaced from the analysis of the transcripts.[25] This facilitated confirmation and critical appraisal of emerging concepts, which helped to establish the credibility of data obtained through FGDs. These data collection processes also ensured the congruence of information obtained from both organizational and individual perspectives.

Setting, Sampling, and Recruitment

Resettlement sites for IDPs in six towns in the province of Bulacan, Philippines served as the study setting. The urban-rural context in the province and its proximity to the National Capital Region (NCR) made it a common area for the relocation of IDPs from the nation's capital. Further, according to the National Disaster Preparedness Baseline Assessment, internal displacement due to environmental hazards commonly occurs in the greater Metro Manila area that includes Bulacan.[26] Each site had an average population of 500 families who had limited economic resources, with many originally residing in temporary makeshift housing in the highly urbanized area of the NCR. Majority of the study sites are located in second to first class municipalities (n = 5), while one is in a component city (n = 1). These localities are classified as mix rural and urban with agricultural, commercial, and industrial sources of income. Notably, the IDP communities were relocated in one of the barangays situated more than five kilometers away from the center or seat of local government of the town or city.

Prior to study implementation, the principal investigator (PI) actively engaged with the community leaders to establish rapport and develop trust, which helped facilitate entry to the community and its members. As rapport was developing with the community leaders, the PI conducted health education sessions in the community as requested by the organization leaders to demonstrate sincerity in wanting to engage with the community and to obtain credibility. These steps were carefully executed by the PI in keeping with the tenets of community engagement based on their experience as a public health practitioner. Once the community organization leaders were convinced of the merit of the study and its potential benefits, they granted permission to implement and collaborate with this research. Potential participants were then identified by the community organization leaders and were invited to a separate meeting to discuss the study information and clarify questions or concerns. Written informed consent was secured after full disclosure, and the preferred date and time for the FGD was agreed upon.

In alignment with CGT, both purposive and theoretical sampling were used.[27] Break and control characteristics of samples were observed to ensure multiple contexts, such that the relocation communities involved government and non-government-initiated sites; and people's organizations included health-focused and mixed types, formal and informal leadership, and mixed gender representation. While participant choice was anchored on a set of predetermined characteristics, recruitment was driven and shaped by emerging data as it relates to the evolving concepts of the theory.[27] Eligibility criteria include: (1) a lay adult person between the ages of 18 and 59, (2) with no professional background in health; (3) resident of the community for at least a year after being displaced; and (4) directly involved in the community organization for at least one year. The absence of a functional health committee or community organization in the resettlement sites was the exclusion criterion for this study.

After purposively identifying who will be initially included as participants, the investigators then made use of theoretical sampling to determine who will be included next and what information is still required to the evolving concepts. With the aim to refine and develop the theory as the study progressed, the next sample depended on what information had been obtained and analyzed from the previous interviews.[28] This method led to a deeper understanding and refinement of the evolving theory, as data collection and analysis were utilized simultaneously. Participant recruitment ceased upon reaching data saturation, which is described as the redundancy in the responses shared by participants.[28] Saturation was further ascertained when no new concepts were identified and the previously collected data were confirmed.

Data Collection

Data collection, together with theory validation, was completed from January 2018 to March 2021. FGDs and KII sessions were conducted for at least 90 minutes and required two to three sessions. Prolonged engagement was crucial to grasp the complexities and nuances of participants' experiences, thereby facilitating an in-depth understanding of the processes involved in their community health empowerment over time.

FGDs were comprised of six to 10 members, which is considered ideal for community-based research, and were conducted in a secure space normally in a social or function hall or in the private residence of the participants in the community chosen by the participants (i.e., organization's headquarters). In keeping with the CGT approach, interviews evolved from a semi-structured approach using an interview guide following the requirements of the research ethics board to a conversational mode shaped by the information obtained.[23] Likewise, interviews were conducted in the local language of the community to allow participants to freely express themselves. Initially, questions were formulated to elucidate their experience of internal displacement and relocation to the new community. Example of these questions include: "*How was your life after moving in to this new community?*" Later on, questions specifically delved into how they collectively worked to respond to their health concerns and steps undertaken in managing health needs of their communities. These questions include: "*What events led you to form a health group/committee?*"; "*Can you share what were the steps you went through in addressing your health needs as a group?*" The principal investigator, together with a research assistant, moderated the FGDs while the PI facilitated the KIIs. Upon obtaining the participants' permission, FGDs and KIIs were digitally recorded. Additionally, field notes were written to supplement major points and insights reflected from each session.

Data Analysis

An iterative process of collecting and analyzing data was used in this study. Interviews were conducted by the PI and analysis was performed by the entire research team. After each interview (FGD and KII), recordings were transcribed and subjected to line per line analysis before moving to the next set of participants. This process also enabled the PI to follow leads and modify future interviews to explore the emerging concepts. The research assistant transcribed verbatim the recorded interview in the local language. The PI then confirmed the completeness and accuracy of the transcribed words by listening to the recordings. Transcripts were also shared to all the participants during the follow up interviews, and they confirmed the accuracy of the information recorded.

Data analysis employing the constant comparison method occurred at three stages: concept development, concept reduction, and concept modification.[29] Manual coding was done using pen and paper to fully grasp the concepts emanating from both transcripts and field notes. Transcripts were read and significant statements depicting the social process of interest were highlighted into segments and labeled accordingly (concept development). These emerging concepts were words or phrases lifted directly from the data, yielding a total of 1,086 level I codes. Then, these initial concepts were compared with one another to identify commonalities or fit, which in turn facilitated the identification of 20 emerging categories. Eventually, categories were condensed and collapsed further to arrive at the core category (concept reduction). This was accomplished using illustrations (diagramming) and memos containing ideas and abstractions on how codes, termed as concepts, relate to each other. Memos include notes on patterns among emerging concepts that were initially recognized and guided the team in arriving at decisions during concept reduction. This ensured multiple perspectives in analyzing the data and minimizing bias from examining data from a single lens. The core category linked concepts together, explained what was going on, and accounted for variation in behavior patterns among the participants.[29] This process produced six key concepts explicating the process of empowerment in health, which served as the foundational concepts for the theory generation. Finally, integration was done through purposive sampling of data from key informant interviews and relevant literature, and combining it (concept modification) with the core category to address the gray areas of the emerging theory (Figure 1).

Coding Process

The team began by reading the transcripts multiple times, performing both macro and micro analysis to understand participant statements in isolation and within the group context. Open coding or level I coding was conducted line-by-line, dissecting statements into words, phrases, or segments, focusing on identifying issues and processes. Most labels used were gerunds to maintain the essence of the statements. To illustrate, a level I code of "volunteering" was used to capture the idea when a participant was asked about what they do in the community, with the response being "*We explain to them that when they join our group, they should be willing to make sacrifices. Regularly attend meetings, participate in our weekly activities. They must be ready to serve as volunteers for community work*" (FGD 2). Other key findings from the open coding included participants' activities in managing their own healthcare, such as "*giving medicines*," "*checking blood pressure*," and "*assisting with feeding program.*" The challenges cited, such as "*poor access to healthcare*" and "*lack of financial resources*," prompted participants to take collective efforts. The codes evolved across readings due to constant comparison and increasing theoretical sensitivity.

Selective coding involved shifting from concrete actions (level I codes) to more abstract concepts (level II codes). The research team continuously compared the level I codes, looking for similarities among social issues and processes to resolve them. Related codes were combined and clustered

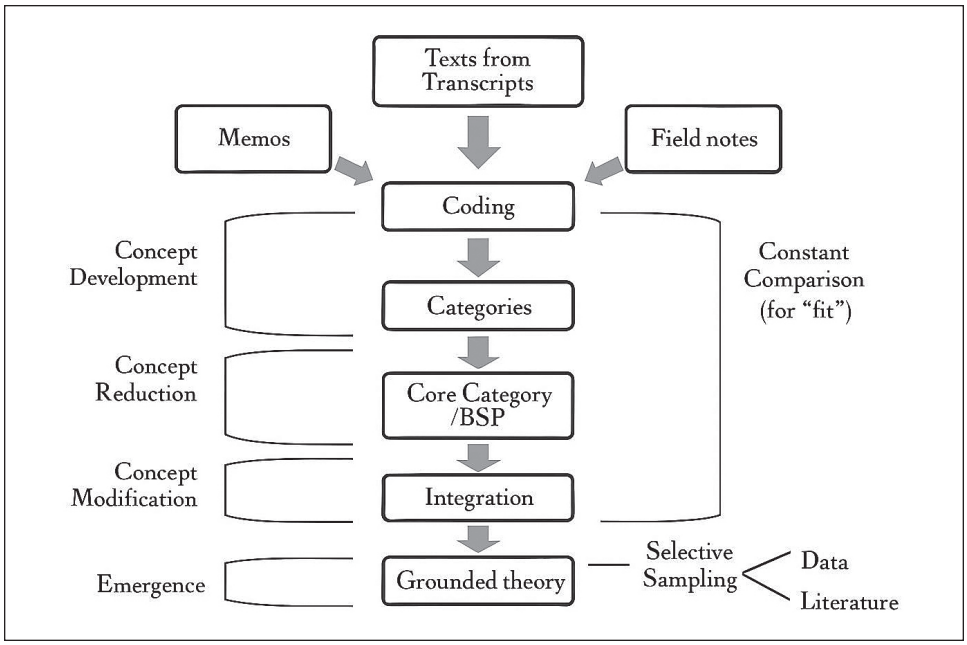

Figure 1. Schematic diagram of the process used in data analysis.

to form the level II codes, also referred to as categories. For example, codes like "*doing home visits*," "*rendering first-aid*," and "*dispensing medicines*" were combined under the concept of "*providing care.*" This stage of analysis resulted in 28 level II codes or categories. Some initial codes were dropped if they did not fit the emerging categories, reflecting the "fit" required for CGT. Thus, reducing the initial 28 to 21 level II codes. Finally, theoretical coding was reached with the primary objective of generating a theory by identifying concepts related to the participants' basic social problem and the basic social process (BSP) employed to resolve it. At this point, the level II codes were combined and reduced to form level III codes. For example, "*Organizing*" and "*Training*" were combined to form the category "*Capacity Building.*" Another is the category "*Carrying Out Responsibilities*" resulted from combining the level II codes of: "*Sharing Information,*" "*Providing Care*," and "*Assisting in Program Implementation*" (Table 1).

Establishing Rigor

The team is composed of academics with postgraduate degrees, and with more than ten years of practice, led by the principal investigator (PI) whose specialization is in community and public health. Nonetheless, the study team allowed the participants to speak the local language (Tagalog) during the data collection. Meanwhile, they did not have previous relationships with the study sites.

The researchers utilized multiple strategies to uphold the trustworthiness of the study. At the outset, bracketing was done, and reflexive journaling was regularly completed. An example of a reflexive journal entry by the PI reads: "*When I came to visit these relocation sites, I brought with me three personas; first as a researcher, second as an educator, and third as a healthcare provider. My repeated visits to the community provided an opportunity to evolve my character. Initially, the participants were curious about the nature of our study then slowly, it transitioned into being a healthcare practitioner… Some community members asked for health information and I gladly accommodated them after doing interviews. All these made me realize that these people are aware of the value of health. However,*

Table 1. Codes, Key Concepts, and Core Variable in Analysis

Level II	Level III (Key Concepts)	Core Variable
Discussing problems Sharing vision	*Consciousness-raising*	**Self-sufficiency** (Cause)
Internal collaboration External partnerships	*Collaborating*	
Training Organizing	*Capacity building*	
Providing care Sharing information Coordinating resources Assisting in program implementation	*Carrying out responsibilities*	
Sustaining collaborations Updating capacities Expanding human resources	*Continuing work*	
Poverty and hunger Poor access to healthcare Poor access to utilities Poor sanitation Burden of disease Neglect from the authorities People's indifference	**Marginalization** (Context)	
21	6	1

I also reflected that my role as a healthcare provider should not precede my position as a researcher who was trying to capture the process they went through in achieving health through their own efforts during the interviews." These exercises of introspection enabled the person conducting the interviews to clearly distinguish personal beliefs from those of the participants.[30]

Moreover, peer debriefing, member checking, prolonged engagement, and data triangulation were used to promote rigor.[31] Initially, two members of the research team read and analyzed each transcript to facilitate the coding process. Their individual analyses were then compared with that of the PI and another team member. Differing findings were continuously discussed by the team before finalizing the results. Memos and field notes were used to guide the team in qualitatively reconciling their analyses. This step assisted with the development and revision of interview questions, review of interview transcripts, and offered insights into emerging codes.[32] Likewise, this facilitated the clarification and offered alternative interpretations of codes and categories to ensure the credibility of findings. Peer debriefing was carried out with the assistance of two experts in qualitative research who are editors of scientific journals but are not related to this study, reviewed the codes and categories identified by the research team. As mentioned above, prolonged engagement was crucial after initial data analysis and development of the emerging theoretical model to ensure that the theory is grounded in the participants' experiences. Member checking was carried out in two ways to ensure the credibility of the findings. First, recording transcripts with field notes taken during FGDs and KIIs were confirmed by the participants during follow up feedback. After initial analyses, the open codes were shown to all the participants to confirm an accurate representation of their statements, in which they affirmed the codes used. These were carried out within two weeks from the initial interview based on the availability of the participants.

Finally, data triangulation was used to overcome the intrinsic bias that comes from the single-method, single observer approach.[32] To achieve this, data collection involved different study sites, which offered multiple contexts; while the use of KIIs, rather than relying purely on FGDs, provided opportunities for more in-depth discussion of emerging codes/categories. To enable readers to establish connections between the results and the participants' shared information, and further assess their transferability to other groups/settings, representative statements in English are presented in this paper. Translation into English was initially done and discussed by the research team. Afterwards, the translated texts were reviewed and validated by an experienced researcher, academic, native Filipino speaker, and language specialist who ensured precision in the choice of words and helped capture linguistic nuances and cultural context.

Ethical Considerations

The study was reviewed and approved for ethical clearance by the University of the Philippines Manila Research Ethics Board (UPMREB 17201). The study adhered to the ethical guidelines for the conduct of research among human participants ensuring social value, autonomy and informed consent, confidentiality and anonymity, and community considerations. Notably, internally displaced communities form part of an understudied population in the Philippines, and studies like this provide them a platform to bring at the surface their struggles that can be addressed by policy and programs from various stakeholders.

The research team directly approached the community leadership to explain the study and its purpose, to initially invite their participation, without any intervention from the host community (i.e., municipal, city, or barangay administration). Upon obtaining their permission to conduct the study, the PI led the team in individually approaching the potential participants and fully disclose the study, including its background, risks and benefits, extent of participation, and individual rights. A study information sheet in the local language (Tagalog) was provided, and eligible participants were encouraged to ask any questions before signing an informed consent. Likewise, verbal consent was sought before commencing any interview session. We also emphasized that declining study participation will not put them at a disadvantage for receiving any form of social or health services. After joining the study, they can also withdraw anytime without any consequences or additional requirements. To prevent any undue influence to participation, no monetary or financial rewards were provided during recruitment or data collection. To minimize time inconvenience, interview sessions were scheduled at the participants' preferred time. Moreover, light refreshments were provided after sessions. Full contact details of the research team were shared to all participants should questions or concerns arise at any point of the study.

Anonymity was ensured through the use of codes and numbers while data confidentiality and privacy were done through the conduct of the interviews in a safe and private space, safekeeping of recording in a password encrypted computer, while all printed documents related to the study were kept in a secure cabinet inside the researcher's office and accessible only to the research team. For anonymity purposes, only code numbers or age and sex description were used, and individual responses were not linked to the participants upon reporting of the study results and only aggregate data was used for presentation. Participants were also informed of the plan to disseminate the work through presentation and/or publication, while only sharing summative results.

RESULTS

A total of 45 individuals (who contributed to six FGDs and five KIIs) contributed to the findings of this study (Table 2). Most participants came from resettlement sites that are developed by the national government, with one built by church organizations. Generally, the sites housed at least

Table 2. Characteristics of Study Participants

FGD	Developer	Host setting classification	Organization and Leadership	Number of Families	Years in Relocation	Participants' Demographic Profile	Group characteristics
1	Church	First class municipality	Formal	150	6	N = 9 F: 100% $\bar{x}$ age: 45.12	An all-women group composed of volunteers who run their own clinic in the community. The skills they employ in helping their neighborhood are a product of various partnerships with different organizations.
2	National Government	First class municipality	Formal	3,000	10	N = 6 F: 67%; M: 33% $\bar{x}$ age: 41.37	A community organization that started even before they were relocated to the current site. It operates apart from the homeowners' association. The group is composed of volunteers who are assigned to various committees, including health.
3	National Government	Component city	Formal	5,000	13	N = 6 F: 50%; M:50% $\bar{x}$ age: 50	The members of this organization have been part of social mobilization activities in the province and in the National Capital Region, clamoring for a more humane condition for displaced communities.
4	National and Local Government	First class municipality	Formal	1,000	8	N = 5 F: 50%; M: 50% $\bar{x}$ age: 37.39	An organization of a relocation site developed by both the national and local governments. This resulted in a difficult start but was eventually resolved. Healthcare remains a top priority since their location is remote, and access is limited.
5	National Government	Second class municipality	Formal	4,000	10	N = 5 F: 60%; M: 40% $\bar{x}$ age: 50.61	The members of this organization previously served as part of their homeowners' association and are working independently to promote better healthcare in their neighborhood.
6	National Government	First class municipality	Non-formal	3,500	7	N = 9 F: 100% $\bar{x}$ age: 43.82	A group that started as a women's committee in the relocation site and is now officially enlisted as volunteers in the community is composed of mother leaders and village health workers.

F = Female, M = Male, $\bar{x}$ = mean

1,000 families and have been established for 6 to 13 years. The majority of the organization members from the six sites were females and focused on health and social mobilization activities for the communities they serve.

The constant comparison and iterative analyses resulted in six key concepts encapsulating the process of community empowerment of IDPs towards health. The experience of marginalization was identified as the basic social problem or context among internally displaced communities that led them to a journey of self-sufficiency by going through the steps of (1) consciousness-raising, (2) collaborating, (3) capacity building, (4) carrying out responsibilities, and (5) continuing work. Notably, the core variable of self-sufficiency is the basic social process (BSP) that underpins the process of community empowerment. It links all the components of the theory explaining the steps and strategies undertaken by communities to address their health needs and problems. Table 1 illustrates the coding tree resulting from the data gathered from the study participants. Meanwhile, Table 3 details the results of the constant comparative analysis across the sites in line with the core concepts.

The Basic Social Problem of Marginalization

Displacement from one place to another was a major source of stress for families who had been accustomed to their place of origin. While they were in poor living conditions in Metro Manila, being transferred to another residential location where they were not familiar with the surroundings, facilities, and support services brought a multitude of problems. Marginalization was characterized by people from internally displaced communities with a sense of deprivation of social resources, together with neglect and indifference from the host community, which in turn made them vulnerable to adverse health outcomes.

Participants shared that when they moved to the relocation site, it looked unfinished and not yet conducive to mass and long-term occupancy. As such, relocating communities brought with it a myriad of health threats and a multitude of social inequities: "*When we moved here, roads were muddy, and we had no access to potable water. The water was unsafe, so diarrhea was rampant.*" (FGD 2). They also noted that the access to resources and social agencies that they once enjoyed were eventually lost as they transferred

Table 3. Table of Comparison and Assertion through Constant Comparative Analysis

	FGD 1	FGD 2	FGD 3	FGD 4	FGD 5	FGD 6	Patterns/Assertions
Consciousness-raising	"One of the first groups we organized here is our health committee. We realized that this is what the community really needs."	"We believe that coordinating with our local government unit is crucial in our activities. Calling for accountability among our leaders is an inherent power of the people since government officials should be public servants."	"No matter what happens, it is our firm conviction that we will stay here and fight for our rights."	"There is nothing wrong with speaking up for your rights."	"Take advantage of your close relationship with the mayor to help our community address drainage and sanitation problems here."	"We are concerned about their lack of income."	The community's encounter of marginalization and other social issues shaped their beliefs and attitudes in life leading them to heightened awareness.
Capacity building	"Each of us need to participate and join committees in our community."	"We attend trainings and seminars to learn."	"Until today, we hold regular community meetings to discuss issues and problems."	"We think that it is best for our community to pursue those initiatives."	"We organize ourselves and facilitate among our neighbors."	"Four of us are working together for unity."	Experiences and learnings from attending trainings and seminars provided the impetus for the people in relocation communities to act collectively and form their own organizations to address their issues on healthcare.
Carrying out responsibilities	"We assist in the implementation of nutritional programs for our community which includes feeding and weight monitoring."	"We attend to our neighbors who are not feeling well and check their vital signs like blood pressure."	"We do home visits and conduct vitamin-A supplementation and deworming among children."	"We monitor progress in the nutritional status of children after giving them vitamin A by checking their weight."	"We ensure that we distribute to the community the goods given to us."	"We go around the community and encourage pregnant women to have their prenatal visits in the clinic."	Members of the community organization offer services to address health and health related concerns.
Continuing the work	"We dedicate our time to serve our community."	"He volunteers his time to serve. We learned from our community organization and in our church."	"We have been here for 12 years already, and each are contributing ever since."	"We are here for each other and that we have a sense of initiative in doing things."	"We devote and spend time serving."	"We respond to the call of duty at any given point in time."	Driven by the spirit of volunteerism and animated by compassion, the members of the organization continue to provide service to their neighborhood.
Collaborating	"We coordinate with the local government of the town in helping our children in need."	"We link our organization with the local government of our town. We value our partnership with people in politics."	"As a leader in our community, we work closely with national organizations."	"We hope you could link us with agencies or organizations that can help us sustain our feeding program here."	"We send out request letters through her that are approved by the community organization."	"When we have members in the community in need of a wheelchair for example, our organization reaches out for them."	Acknowledging limitations in their resources, the community establishes partnership with government and non-government organizations to access support services.
Analytic memos	Realizing the value of health, the community mobilized to form a health committee. This organization initiates various activities to ensure health of the neighborhood. Devoting time for service and working with local government units are crucial in sustaining their own healthcare initiatives.	Trainings equipped the community with basic skills like checking vital signs and providing first-aid. Conscious of the government's responsibility to its citizens, the community organization establishes linkages with agencies to avail of healthcare support for the benefit of the community.	Radical awareness of human rights inherent in each person, the community collectively makes a stand in crucial social issues affecting them. As an organization, the community conducts meetings to discuss their health concerns and carry out services like vitamin supplementation.	Animated by the spirit of volunteerism, the health committee strives to provide and assist in healthcare activities for the community.	The community organization serves as an advocate in channeling people's health concerns to local authorities.	Unity and teamwork are crucial to sustaining the community's efforts to improve their own health. Out of compassion, the volunteers of the health committee willingly shared acquired health knowledge and skills to the community.	**Key Assertion/ Substantive Theory** Self-sufficiency is the core variable that accounts for the 5 C's. Self-sufficiency is the community's response to deprivation/ marginalization. It is a collective process characterized by gaining control over their circumstances and taking necessary steps to improve their own health.

to the new site. For instance, they were distant from health facilities, and public transportation services were not yet accessible from their area. Moreover, they did not know how to navigate the healthcare services in the area to manage new and prevalent conditions: *"When we moved here, we don't know where and how to access healthcare; we needed medicines for our common ailments. A lot of times, we ran out of supplies since we have so many people residing here."* (FGD 6). These struggles of the IDPs were further aggravated by insufficient economic resources and opportunities for them to start over and improve their livelihood. There was a perceived mismatch of their work experiences and capacities with the occupational prospects available in the area. Consequently, the experience of poverty led to food insecurity among the newly adjusting families: *"It was very difficult to find a job here; when we were in Manila, there were at least (extra) jobs that we could refer to. It was difficult to put food on the table, and there were times we had to skip meals."* (FGD 1).

The IDPs intended to seek help from the *barangay* leaders to seek support in familiarizing and integrating into the host community. However, they perceived a sense of indifference towards them. As the number of families in their resettlement site seemed to have outnumbered the current population in the community, they felt unwelcomed by the *barangay* leaders: *"We tried asking for help from a lot of government officials here… I don't know, we felt unwelcomed because probably we're considered threats to their resources."* (FGD 5). Meanwhile, the local (municipality) and national [National Housing Authority (NHA)] government agencies seemed to have lagging responses to their calls for help in improving the living conditions in their community. These led to feelings of neglect among the IDPs, almost like individuals thrown to a piece of land and left to fend for themselves: "*We felt ignored that we have to repeatedly visit their (government) offices for assistance; sometimes they will say they will do something about it (problems), but I really do not know if something happened. It's up to everyone if they can survive this place.*" (FGD 2).

These experiences of marginalization, coupled with the psychological burden of adapting to a new environment, placed the health of these IDPs at risk. With unfavorable living conditions, infectious diseases became rampant among the vulnerable community members: *"When we were transferred here, many of us fell ill. Children were infected with dengue, while others suffered from other infections (diarrhea) since the relocation site had not been fully completed."* (FGD 3). Plagued with multiple problems and resource constraints, feelings of powerlessness and helplessness were experienced by the IDPs. They perceived being unable to address the situation their families experienced, and being dependent on others to survive their daily lives. Notably, while being marginalized influenced others to have negative feelings, participants shared holding on to their faith to live through and hope for a better outcome: "*It's already difficult to be poor; sometimes you feel you can't do anything about it unless someone gives you money to survive. Still, we believed that we would not be put in this situation if we couldn't handle it. God is merciful.*" (FGD 1).

Consciousness-raising

For several months to years, these displaced families had been used to the status quo, where embracing problems was a part of nature without taking any steps to address them. While some members received training in community organizing (CO) from the NHA prior to their relocation, they found it challenging to mobilize the population due to the perceived variety of readiness among the members, as well as their own adjustment to the various personalities in the community. Notably, the experience of prolonged marginalization led to a critical mass of individuals convinced that more could be done about the circumstances they are in. Despite individual differences, they noted that health is a shared concern among all community members, and they should do something to improve their current situation: *"After going through all the hardships and experiencing the worst, it helped us understand that we should not simply accept this as our fate, but we should face and solve it." (FGD 4).*

Since the community was not organized yet, usual gatherings occurred during church celebrations and other religious activities (e.g., block rosary). Participation in these events served as opportunities for people to share their experiences, which enabled the residents to be more aware of the problems of their neighbors and the multiple factors influencing their living situation. These informal, yet significant discussions, provided members with a realization that their problems of poor healthcare could be solved through collective efforts: *"Based on our experience, we have seen that these health problems in our community are all connected. We realized that healthcare is important to people." (KII 2, community leader)*. Valuing health more than anything else and recognizing that each was responsible for nurturing one's health was a testament to their heightened awareness. Moreover, the messages they received from the spiritual celebrations in the community, inspired them further to think beyond themselves and clamor for change in the system and among leaders.

Aside from the residents with prior CO training, women took an active role in raising the consciousness of the community members to act together to solve their health problems. While most men prioritized the provision of income, women were able to spend more time in community gatherings and discuss the concerns of their families. Hence, participants perceived women as highly motivated to improve the well-being of the whole community. They also considered mothers representing the voices of the family members, since they were the ones who took care of the households and saw how the community lived through its situation: "*Most of the leaders started with women, they seemed to be more concerned in mobilizing the whole community, probably because they spent more time here… they have seen it all (living conditions).*" Eventually,

these continuous movements motivated the residents to explore key people and organizations that could support their shared goal of improving the health of the community.

Collaborating

When the IDPs' consciousness reached the tipping point, their journey towards working together to improve health commenced. Initially, this involved collaborating within the community, as they identified key members who could advocate for their shared goals. Realizing though, that their limited resources hampered their progress, they also noted the importance of establishing relationships outside their borders. Hence, they explored potential support from government and non-government organizations (NGOs), so they can obtain the means and competencies for attaining the best health possible.

The NHA requires that relocation communities establish a homeowners' association (HOA) to manage shared resources, organize programs, and promote peaceful relationships among the community members. However, our findings noted that less than half of the six communities were able to establish a HOA upon their relocation to their new site. Meanwhile, those communities with HOAs do not seem responsive to the needs of the residents, which could possibly be due to their inadequate preparation to mobilize the community and their limited resources: "*The HOA did not know what to do when we asked them to help the residents who are sick… where to go, what to do next… They have their own problems in their families, and I don't think the government prepared us well enough to be in this place.*" (FGD 3).

Participants shared that organizing a community composed of people who barely knew one another was a daunting task. At first, residents with prior CO training began stepping up and called the need for groups that will lead the community. This opened opportunities for residents to volunteer and participate in developing initial plans for their relocation site. However, initial challenges were encountered in this process, which mainly involved conflicts in authority and responsibilities between existing HOAs and volunteer groups. Some participants also noted that the culture of gossiping or perceived competition in their neighborhoods impeded their collaborative efforts: "*Here in the Philippines, it's very common to talk behind the back of people you don't like, and sometimes they will spread false information about your group. We also experienced that here, and it did not help at first because the HOA thought that we were stepping on their yard.*" (FGD 5). Notably, volunteer groups and the HOA eventually found a common ground to work together – the former will contribute to the community's health objectives, while the latter will manage the other needs like peace and order, financial management, and facility maintenance. They emphasized the anchor of their collaboration: health is a common vision for all community members.

Apart from working together within their relocation site, the IDPs also began integrating into their host community. Particularly, most residents began transferring their voter registration to the municipality, while others volunteered for the barangay activities. This enabled them to gradually gain the trust of the local leaders, which helped in establishing an official representative of their site to the barangay and including families in some of its projects. They shared that their motivation to build a better community, both within and outside, manifested through their sincere interactions with the host community: "*Slowly but surely, we showed to them (barangay) that we genuinely wanted to be part of the bigger community… we also wanted to help in improving the whole barangay.*" (FGD 1). Moreover, participants recognized the value of gaining recognition from the local government, so that their planned programs could be endorsed and their requests could be properly coursed through official channels.

As they began organizing themselves, community leaders also searched for non-government agencies, charitable organizations, and educational institutions that could support them in their health-related goals. They started writing letters, sending social media messages, and visiting nearby offices to invite collaborations with the community. Gradually, these small and continuous attempts to invite partners led to referrals from one agency to another, which helped in conducting various activities, such as feeding programs, physical activity projects, medical missions, and livelihood training. Notably, participants perceived that the NGOs filled the service gaps that the government was not able to provide to them: "*I am grateful to all those people who helped us, especially from private institutions. Without them, we will not have those activities that cater to children, pregnant women, and older people. Even if the government could not fully support us, they (NGOs) extended their hands to help us manage the various health problems of the community.*" (FGD 4). Additionally, external partners also provided educational activities to teach residents about common health topics. Hence, these collaborations not only contribute to improving their health resources but also to developing their capacities to be more independent in managing their health.

Capacity Building

As cooperative relationships were established within the community, as well as with external agencies, the health capacities of some members were slowly built. Beyond receiving assistance from several groups, IDPs felt the importance of being empowered to manage their own health needs and those of the community. When the local health office called for potential trainees to become barangay health workers, the community members began organizing volunteers for the program. While participation in the sessions was not paid, they expressed their enthusiasm to join because they could apply their learnings to the community: "*We're excited to attend these trainings because we're able to use our time productively. We were able to apply the basic lessons from the training when we dealt with daily health issues in the community.*" (FGD 2).

Primarily, health and educational institutions facilitated training activities on specific health topics, ranging from basic health assessment, health promotion and risk reduction, communicable and non-communicable diseases, first aid, vital signs, and basic medications. They also provided leadership and community organizing sessions to volunteer residents, which further strengthened the mental readiness of community members to organize themselves. Nonetheless, participants did not obtain the competencies by a single attendance at the sessions. With their non-medical backgrounds, learning was initially difficult, but continuous participation and regular practice helped them incorporate the relevant knowledge and skills: "*I did not finish high school, so learning all those health topics was hard… even taking pulse and blood pressure. It was a good thing that the teachers and students were patient with us… Even though the topics were discussed a few months ago, we attended again because it helped us master the skills.*" (FGD 3).

However, participants recalled that inviting more people to engage in community activities was not easy at first. Given the experience of marginalization, some community members were passive in participating in trainings and discussions, while others preferred attending dole-out activities. Notably, people began noticing the improvements in those residents who continuously attended the capacity-building programs, such as being more confident in sharing health knowledge and insights, and being able to provide basic teachings to their immediate families and neighbors. Longing for the acquisition of competencies that people can use for their daily lives served as the starting point of educating themselves to increase their understanding of health and illness. "*We saw that the mothers in our community are willing to learn. They attend seminars regularly, and they try to understand the information they acquire to share it with others. Later, we realized the importance of health in our lives.*" (KII 2, Female community leader). Over time, families in relocation sites felt the need to work together in translating their knowledge to serve their neighborhood. Cognizant of their situation and realities, these families started to form an official group of residents who would help the community in managing their own needs for healthcare. "*We pushed for the creation of our health committee so we can help our neighborhood. This was made possible through the assistance of partner institutions who conducted various trainings.*" (FGD 2). Eventually, these key individuals became the recognized village health workers (VHWs), who organized health resources and mobilized the members to support the community's health needs.

Carrying Out Responsibilities

Resolved with the commitment and equipped with the competencies to contribute to the community, members of the health committee assumed multiple roles in delivering healthcare to their neighborhood, which included direct care provision, education/training, agency coordination, and program support/implementation. From the continuous capacity building programs they have participated, the VHWs became skillful in assessing community members and enrolling them in various health programs: "*We assess patients, especially the children, older people, and pregnant women… For example, children who are possibly malnourished are weighed regularly, and we include them in our feeding program.*" (FGD 5). Moreover, VHWs conducted information campaigns on common communicable (e.g., respiratory tract infections, diarrhea, dengue) and non-communicable diseases (e.g., diabetes, hypertension) during home visits, as well as during their community health meetings. Through their initiative, families and people with chronic illnesses had regular health checks without going out far from their homes. Having established better relationships with the host community and health provider networks, VHWs were able to effectively coordinate with the barangay health station (BHS) and municipal health center to facilitate the continuous care of their residents: "*Instead of going to private clinics, we are the ones monitoring their blood pressure since we are already trained as village health workers. We refer them to our midwife at the community health station so they can avail of maintenance medicine for free.*" (FGD 2).

Being recognized by their residents as comprising the health committee, VHWs also led in mobilizing the community to discuss their common health concerns and propose solutions to address them appropriately. They tried to schedule these meetings regularly, sometimes after attending Sunday masses together, which they identified as an opportune time for community gatherings. However, they noted that such meetings were not always easy to facilitate because of the residents' differing opinions and inadequate resources to carry out the planned activities. While they expressed frustration at times, they realized that such circumstances were crucial turning points for open-mindedness and creativity in finding solutions for their health problems: "*Community meetings are not always easy to conduct because we have different personalities and ideas. Sometimes, people would say, 'how can we manage our plans if we don't have money to buy equipment?'… We get tired sometimes, but we think those feelings pushed us to find more ways to make things happen.*" (FGD 3). This led them to be more persistent in seeking local authorities and philanthropists for potential funding for their community's initiatives. For instance, some participants shared that their community leaders continuously lobbied the local government to help them build a community gymnasium where physical activities and assemblies can be held. Since their land area can accommodate a large venue, they argued that the gym can also be utilized by the barangay for related events: "*We just needed to be persistent in communicating with the authorities what we need and tell them that they could also benefit from it. It should be a two-way benefit, otherwise they will not support us.*" (FGD 1).

VHWs also served as leads and partners in implementing collaborative projects to support the population's health needs. These include facilitating medical-surgical missions for the chronically ill, vaccination drives for the eligible

groups, and feeding programs for the malnourished. They also mobilized the community in handwashing campaigns, waste management, backyard gardening, and other environmental sanitation projects. Participants shared that engaging residents to take an active role in their community was a long process of small and repetitive efforts that created ripples of movement among the members: *"If we had given up (in helping and organizing the community) early, things might have been different. You just have to be really patient with everyone… involve them slowly, little by little… In time, when they see that they are making small but steady improvements, they will join."* (FGD 4). Moreover, participants of previous capacity-building programs joined collaborative partners involved in making bags, preparing food products, and sewing clothes, and this contributed to the livelihood of other residents.

Continuing the Work

Despite their accomplishments in empowering the community towards better health, IDPs realized the importance of exerting continuous and consistent efforts to stay on track with their goals. Hence, they emphasized the importance of sustaining and increasing partnerships with organizations, continuing education and training, and expanding the human resources to other community members. However, when participants were asked about the evaluation of their community programs, they noted that they have yet to establish mechanisms to systematically evaluate the outcomes of their activities. Rather, they only have informal discussions regarding program attendance and verbal feedback among the participants.

Driven to serve yet grounded in their realities, the community members continued to manage their resources to address their community needs. Thus, they strengthened the existing linkages and formed new partnerships with different agencies to gain support for their projects. They were able to establish memoranda of understanding with various institutions to formalize their collaborations and secure the interests of the community. Aside from contributing resources for the community, organizations participated in reinforcing the existing capacities of the community to ensure that trained and motivated members can sustain the achievements initially made: "*We continue to participate in refresher trainings and seminars to ensure that we are updated with the latest practices, and involve the youth as early as possible. When we can't do this anymore, we will pass the leadership and responsibility to them.*" (FGD 6). Through coordination with their collaborative partners, some communities eventually worked on establishing youth committees, which focused on promoting important skills such as leadership, communication, and lifelong learning. They also received further education and shared discussions on relevant topics like mental, sexual, and reproductive health.

Meanwhile, participants emphasized the value of encouraging active participation of other members for promoting a stronger sense of ownership in the community. For instance, recipients of community programs were also invited to assume roles and responsibilities in the implementation, and not simply to attend or receive support. For them, each one can share and contribute to the community, since health is a shared reality: *"We cannot do it all alone. In conducting our feeding programs for malnourished children, we ask their mothers to take an active part. Some of them assist in cooking, while others wash the dishes. On our end, we check their weight and report it to our rural health unit."* (FGD 1). Notably, the sense of accountability was not only called for among members but also their elected officials. After years of passivity, the community, through the experiences and lessons they gained, had a better understanding of their rights as citizens. They perceived that having dialogs with the local authorities were not simply a plea for help, but their right as stakeholders: *"Talking to our elected village leaders is a day-to-day activity for us. We do this to inform them of our activities and to tap for the assistance they can provide in our ongoing projects." (FGD 3)*. They believed that support from local government ensured not only funding but also fostered a working relationship that allowed the community to access social services.

Self-sufficiency: The Basic Social Process (BSP) of Community Empowerment in Health

The journey of internally displaced communities from marginalization towards gradually gaining control over their own health is grounded in the core category of self-sufficiency. Self-sufficiency is a process where internally displaced communities develop a sense of ownership of their health and healthcare problems, and a collective response to address them using their own efforts. Triggered by a shared consciousness on the importance of health, IDPs sought support within and outside their communities, which eventually equipped them with basic competencies to manage their current situation. Consequently, trained volunteers were able to assume various roles to address the multiple health concerns, expressing their commitment to continue the groundwork and sustain their path towards health empowerment: "*We hope that we can sustain our organization and stay united. Over the last 10 years, I must say that we have learned so much from our experiences and training. In my perspective, I know we can continue doing things on our own because we have been prepared well.*" (FGD 2).

Participants expressed that the spirit of communal unity or *bayanihan* has fanned the flames of service to ensure that their community will be self-sufficient. Noting that there was no financial gain to attending trainings or contributing to community programs, participants showed strong sense of commitment was anchored deeply in their consciousness that they were contributing to a greater purpose, that every member of the community should be able to attain the best health possible: *"The feeling of satisfaction knowing you can help your neighbors achieve better health and recover from their illness is priceless. Like for children, seeing them gain weight after nutritional counseling and feeding programs is truly rewarding…*

We can only say that we have succeeded in achieving health if no one is left behind." (FGD 5). The sense of community and helping one another were recurring messages from the interviews, and these sustained them despite the limited resources and support they had in the early part of their stay in the relocation site. These motivated them to continue serving, with the goal of having a self-reliant community that can meet the needs of its people.

The continuous efforts of volunteer health workers and community leaders led to notable improvements in how the community managed its health. For instance, trained VHWs were able to perform basic assessments of common health problems and provide health teachings for home care. Improved coordination with the nearby BHS allowed them to refer patients more efficiently. Through strengthened relationships with provincial healthcare networks, they were also able to formalize the use of emergency response vehicles to be used for referring patients to hospitals: "*When people get sick, we manage on our own first. There is a nearby BHS, and the health center can also be accessed if needed. At times, we arrange transportation for those who need to be brought to the hospital for medical care.*" (FGD 5). In addition, some IDP sites were able to set up a clinic within their village where the health committee members were able to perform basic consults, maintain family health records, and organize medical equipment (assessment tools, scales, basic medications). Meanwhile, regular health promotion programs included information campaigns, physical activities, and nutritional education among mothers. Notably, the IDPs conveyed being able to exercise decision-making and assert their autonomy by coming up with a collective stand on issues concerning their health and welfare: "*As an organization, we develop our own strategies and implement ways to help our neighborhood. For example, we use our own funds to aid those who are sick and need of hospitalization.*" (FGD 3). This shift from powerlessness due to marginalization to gaining control over their health and managing their needs supports their path towards empowerment in health.

Beyond healthcare provision, the IDPs conveyed their continuous efforts to address various factors affecting the community's overall health. For instance, with the support of the local water district and relevant government offices, the participating communities were able to have a cleaner water supply that reduced the diarrheal cases among the population. Trained members who previously joined sponsored livelihood projects of partner organizations were able to put up their own small groups within the community, contributing to the household and community incomes. IDPs also utilized the training they received to establish community gardens and livestock farming, to promote better food supply among the vulnerable households. With their families' registration as residents of the province, younger individuals were accommodated in publicly-funded schools. Reflecting on their journey, participants noted some relief after everything they were able to surpass as a resilient community. However, they hoped that the government could have contributed to improving the health of internally displaced communities by providing a more comprehensive and reliable support upon their transition: "*This experience taught us how to become stronger in the face of adversities, but I do not wish this to happen again to others. I hope that the government could improve its processes, so that people who are displaced and relocated are more prepared to embrace their new homes and neighbors… with those come better health for all.*" (FGD 4).

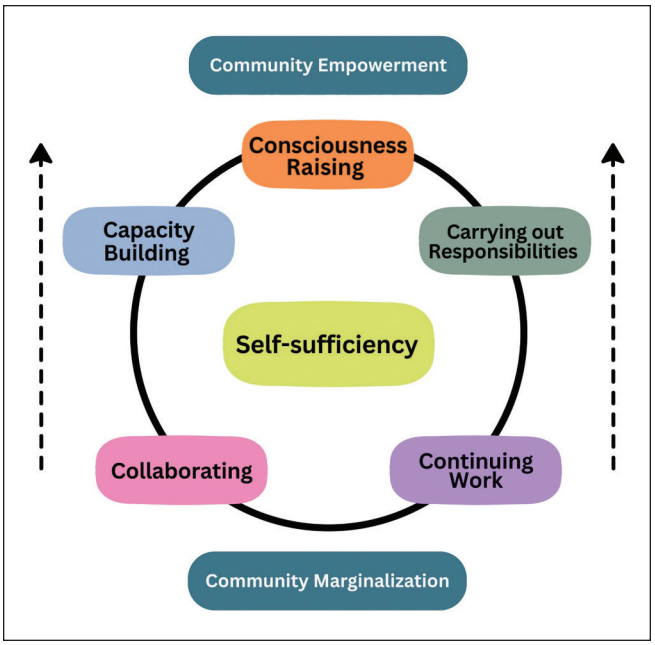

Figure 2. 5 C's Grounded theory of community empowerment in health.

The key concepts of marginalization, together with the steps involved in the empowerment of IDPs (consciousness-raising, collaborating, capacity building, carrying out responsibilities, and continuing work), are depicted in the 5 C's Grounded Theory of Community Empowerment in Health (Figure 2). With the core variable of self-sufficiency, the theory illustrates the process of how internally displaced communities gradually shifted from resource deprivation towards enabling themselves to manage their own health. Particularly, the process of empowerment was triggered by a shared consciousness among community members on the importance of health, and that something can be done to improve their marginalized situation. Eventually, the communities sought support within and outside their walls so they could increase their resources and address various factors affecting their health. This facilitated the development of knowledge, skills, and attitude among community members, which prepared them for organizing themselves and developing programs that will benefit the population. Equipped with the necessary competencies, the trained volunteers assumed multiple roles to promote health – as a care provider, educator, coordinator, program implementer, and community organizer.

Realizing the importance of sustainability towards health empowerment, IDPs saw the need to strengthen internal and external collaborations, reinforce education and training, and engage more community members in their shared cause. Hence, this theory highlights that the process of community empowerment in health involves continuous and long-term efforts among leaders, residents, and relevant stakeholders.

DISCUSSION

This is one of the first few studies that investigated the process of community empowerment in health, grounded in the experiences of internally displaced communities. In this study, IDPs highlighted the experience of marginalization - being deprived of access to health and social services, obtaining insufficient support from local and national agencies, and perceiving neglect from appointed authorities. Against such a backdrop, the process of empowerment in health involved an iterative process of raising consciousness among residents, collaborating within and outside communities, building capacities of key individuals and groups, carrying out various health-related roles and programs, and continuing efforts to maintain goal achievement. The community empowerment process leaned towards achieving self-sufficiency, where internally displaced communities acquired abilities to manage their members' health needs, facilitate service access, establish health-related facilities, conduct health promotion activities, and address other social determinants of health. This paper contributes key insights and practical implications on how policymakers and relevant agencies could better support IDPs in their transition to new settings, as well as empower them to gain control over their health.

The findings highlight the importance of social preparation prior to relocating IDPs to permanent residential sites to promote their adaptability and minimize further marginalization. It is crucial that IDPs be provided opportunities to re-establish their lives, and not simply be transferred from hazardous areas. In a study on the post-disaster relocation experience of Typhoon Haiyan (Yolanda) victims in the Philippines, Iuchi noted that some residents encountered reduced opportunities for livelihood and access to community facilities/services, with others experiencing unsanitary conditions in their new housing sites.[33] Published after completing the data collection of this study, the National Resettlement Policy Framework of the Philippines outlined the guidelines and procedures in social housing plans and resettlement projects for IDPs.[34] This framework emphasized the importance of stakeholder consultation, adequate disclosure of relocation-related information, and resident-engaged planning upon initiation of the resettlement process; however, the actual implementation and outcomes of such guidelines are yet to be evaluated. While there is a paucity of research on the post-disaster relocation of IDPs, the results indicate the importance of multidomain preparation (e.g., physical, social, economic, and health) to equip the disadvantaged IDPs with the necessary skills to thrive, not only survive, in their new communities. Hence, coordination of both local and national government agencies (e.g., NHA, Department of Health, Department of Interior and Local Government, Technical Education and Skills Development Authority), together with collaborative NGOs, would be crucial in this endeavor.

The study expands the body of knowledge about community empowerment in health, stressing that a vital antecedent of this process is developing a shared consciousness among all stakeholders on the importance of gaining control over one's health. As IDPs are being relocated to a new environment, participants shared the difficulties in being organized due to their individual differences and perceived resignation to being marginalized. Notably, a small yet critical mass of individuals continuously increased the awareness of the residents of their problems, together with the realization that they need to work together to manage their situation. In their community-based participatory research of ethnically diverse and low-income neighborhoods in Sweden, researchers found that participants' problems and aspirations served as a crucial starting point for residents to be engaged, despite their cultural differences.[35] Having a shared vision among members could drive their engagement in internal and external collaborations, capacity building programs, mobilization and project implementation, and continuing development initiatives. By integrating local philosophies (spirituality, communal unity) in community consciousness, government-facilitated social preparation of IDPs should be critically positioned to trigger the community empowerment process.

With the impact of social determinants on health, this study also provides grounded evidence on the importance of multisectoral involvement in promoting empowerment in health among IDPs. Both multisectoral involvement and community empowerment are critical aspects of ensuring good health and wellbeing of peoples using Primary Health Care (PHC) according to the WHO.[36] Following the whole of society approach as espoused in PHC, IDPs can work with both government and private sectors to aid them in addressing their health concerns. Examples include but not limited to capacity building activities through NGOs, creation of healthcare provider networks using public-private partnerships. However, in low- and middle-income countries like the Philippines, the government's capacity to address multiple domains (i.e., economic stability, education, healthcare, and built environment) might not be sufficient. This study noted the key role of NGOs and private institutions in bridging service gaps to complement resource provision and capacity building for IDPs. NGOs could provide immediate assistance and long-term recovery among displaced communities by supporting their basic needs (e.g., food, clothing) and bridging critical services (e.g., health and livelihood training) that would help in rebuilding their lives.[37] Notwithstanding, there are limited

studies evaluating the actual impact of NGOs' involvement in community empowerment process. Meanwhile, studies found that NGOs might also encounter several constraints in funding, networking, internal governance, and political support.[38] It is crucial for the government (e.g., social welfare department and national volunteer service coordinating agencies) to strengthen support for NGOs to address their existing challenges and supplement local/national efforts for community empowerment. This could minimize overlaps and gaps in the programs extended to communities, thereby streamlining the multifactorial support for community empowerment.

Primarily, higher education institutions (HEIs) are crucial partners of internally displaced communities in health empowerment. Most universities worldwide have programs for promoting community engagement among students and faculty, which are generally aimed at enriching learning, research, and public service outcomes. However, there has been modest investigation into the impacts of HEIs on local community development. Hence, there is a need for future studies to explore community outcomes from these partnerships to ensure that the needs of the community are adequately addressed and areas for improvement can be identified. Sugawara et al. proposed a framework to reinforce the local capacities for community development through community-engaged universities, which support the promotion of multiple domains: community assets (knowledge, skills, sense of community, resource/mobilization), functioning capacity (leadership/participation, social networks, community structures), and transformational capacity (good governance, strategic development, policy practice).[39] To ensure that HEIs provide engagement programs that are responsive to the needs of faculty/learners and communities, co-designing activities would be helpful. Moreover, curricular (and extra-curricular) activities should be anchored on the community capacities that HEIs can provide and aim to develop, with consideration to the multidimensional, iterative, and continuous process of community empowerment.

The study findings indicate existing gaps in the evaluation of processes and outcomes of community empowerment from various stakeholders – the community itself, government agencies, NGOs, and educational institutions. While there are some studies describing various outcomes, such as community adaptability post-relocation, extent of engagement and perceived benefits/problems, and satisfaction, these assessments were facilitated by collaborative partners.[40-42] It is crucial to enable the community to conduct self-evaluation of their own initiatives and projects to ensure that they are responsive to their members' needs and community resources. While community empowerment is a complex concept, quantitative assessment of its attributes would also be valuable, apart from qualitative feedback. A classic tool for measuring community empowerment is the Organizational Domains of Community Empowerment (ODCE), published in 2011.[43] It aimed to assess community empowerment in terms of four aspects: (1) community activation, (2) ability to solve its own problems, (3) skills in program management, and (4) capacity to foster a supportive environment. A model for evaluating community empowerment is the action-reflection-action framework, which enables stakeholders to obtain feedback and establish lessons to support the continuation or changes in program direction. Instead of relying on pass or fail cutoffs, goals be modified based on the community context and new mechanisms to improve monitoring and innovation practices may emerge.[44] However, as this study findings imply, together with the evolving knowledge on the multidimensional aspects of community empowerment, comprehensive assessment tools would need to be developed.

In focus: Women, Spirituality, and *"Bayanihan"* in Community Empowerment

Notably, our findings also showed the vital roles of women in leading communities towards empowerment in health. This study showed that women, particularly mothers, mainly contributed to increasing the consciousness of community members on the importance of improving their health, facilitating collaborations within and outside their borders, participating in capacity-building activities, and assuming multiple health-related roles. Despite existing patriarchal norms in most societies, the increasing participation of women in community-based organizations has been highlighted in the literature.[45,46] Others might also argue that the nature and level of women's participation might have been reflective of traditional gender roles in health, education, and household/community management. Nonetheless, such opportunities could serve as entry points for women to impact the direction of community empowerment. Filipino culture puts high respect on mothers, as the latter symbolize caring and collectivism in the family.[47] Programs by multilateral development organizations, such as the Asian Development Bank and the United Nations, emphasized the importance of empowering women to promote community development and resilience.[48,49] Particularly, women are perceived to promote social cohesion by shaping values and influencing decisions among their families and communities, as well as recognizing and intervening at early signs of problems within their groups.[49] With their unique assets and skills, women are critically positioned in communities to enhance collective action and yield sustainable solutions.

Hence, the findings showed that internally displaced communities valued the leadership and volunteerism manifested by their female members and perceived the importance of contributing to their shared cause of promoting health for all. In studies in the low-resource settings of Cameroon and Senegal, researchers found that women's involvement in community development ranged from passive to substantive participation, and was further influenced by existing household power dynamics and income generation capacities.[45,46] Notably, participants in these two studies mentioned that training and development of personal and professional com-

petencies increased their sense of empowerment and impact in community decision-making. Hence, our study contributes promising evidence on achieving community empowerment through the active involvement of women in all phases – from decision-making, collaboration, capacity building, implementation, and sustenance activities. For empowerment to be gender-responsive and inclusive, women should have adequate representation in most community organizations, and not only in health-related committees.

This research also surfaced the significant influence of spirituality in promoting community empowerment. We found that IDPs found the opportunity to share their problems through religious gatherings, and upheld their faith as a guide to continuously support one another and advocate for systemic improvements. Hence, faith could be expressed as an intangible yet a potent asset for community empowerment, permeating social, cultural, and political structures. As central activity hubs, religious institutions also contribute to social cohesion among residents. In their research on a marginalized community in the US, Forenza et al. found that residents were engaged in community development through multiple organizational venues where people gathered informally.[50] Meanwhile, belief in the power of a Supreme Being could also influence people to feel empowered to extend their talents and resources to those who are in need.[51] The Catholic faith is deeply ingrained in the Filipino culture and is associated with Christian teachings on community resilience during sociopolitical crises or natural disasters through the context of unity, group identity, and cooperation.[52] Accordingly, previous literature underscored the role of spirituality in supporting recovery among post-disaster survivors in the US and Canada.[53,54] Religious leaders are also held to a higher level of respect in society, making them influential actors in political and social justice movements. The role of church- or faith-based organizations could be considered to assist IDPs in finding meaning in rebuilding and regaining control over their lives.

Despite these potentials, clear and sustainable linkages between faith-based organizations and community development institutions were found to be limited in the Philippines.[55] Evidence also showed that while engagement of faith institutions in community development activities were productive, they were mostly short-term and occurred during natural disasters.[55] Religious sectors should be included in relevant conversations regarding community empowerment, as they also carry vital perspectives from other marginalized groups. Coordination among faith-based organizations and other stakeholders, such as NGOs, private entities, and government agencies could minimize redundancy of efforts and maximize empowerment areas in internally displaced communities. While religion-based institutions could be a source of external support for IDPs, enhancing the values of marginalized groups through their spirituality could be a contributory approach towards sustainable empowerment. Facilitating spiritual gatherings such as block rosary, gospel sharing, and other evangelization activities in communities were found to promote inclusion, coping, and advocacy for social justice, which could contribute to community solidarity.[56] Given the large Catholic population in most Filipino communities, these actions may support not only IDPs, but also other communities working towards empowerment.

Meanwhile, the participants' religious beliefs were also found to be aligned with their cultural precept of community spirit. Known as *bayanihan* in the local language, this core value embodies solidarity, mutual support, and volunteerism, which are aimed at achieving the best interest of the collective.[57] In a recent study on an underserved community in the Philippines, researchers found that residents shared their strengths, such as solidarity and generosity to help one another despite their resource limitations.[58] They capitalized on these communal principles to identify their priority problems and suggest potential solutions to them. With its coherence with the principles of community empowerment, philosophies that are similar to the *bayanihan* should serve as crucial components in community development/organizing trainings. Promoting mental and spiritual fortitude is vital in supporting empowerment among disadvantaged communities like IDPs, given the notable barriers they could encounter in their transition to their new lives. Notably, social preparation among IDPs may incorporate faith-based activities while also respecting the potential differences among its members, to foster an inclusive and purpose-driven action towards community empowerment.

Limitations

While the study provided interesting and crucial insights on the process of community empowerment in health among IDPs, it has several limitations. First, the study participants were recruited from one province, and the contexts involving other host provinces/regions where IDPs are relocated may have some differences. Hence, the transferability of the findings to other settings may not be fully established. While the issues and perspectives expressed by the internally displaced persons may still have some parallels with communities from other regions, further studies would be vital to expand knowledge in this area. Meanwhile, given the authors' background in public health, the potential influence of their beliefs and prior experiences on the data collection and analysis cannot be ruled out. Nevertheless, the study team utilized strategies to promote reflexivity and establish rigor in the findings. Given the limitations of qualitative studies, future research could also utilize quantitative or mixed-method designs to comprehensively capture the community empowerment process and outcomes among disadvantaged communities.

CONCLUSION

This study developed the 5 C's grounded theory of community empowerment in health, which highlights the

processes of how internally displaced persons move from marginalization to gradually attaining self-sufficiency in managing their health needs and healthcare access. Particularly, the key processes include: raising the community's consciousness on the importance of health and their potential to improve their status; collaborating within their locality and external partners; building various health-related capacities among key individuals and groups; carrying out planned programs and initiatives; and continuing efforts to train more people, sustain partnerships, and expand community involvement.

This is one of the pioneering studies that attempted to understand the process of community empowerment from the lenses of internal displacement, which is an important yet understudied area in public health. Our findings could provide valuable insights on various stakeholders involved in community empowerment, including government agencies, policymakers, non-government organizations, healthcare organizations, faith-based societies, and educational institutions, on how to better support marginalized communities. Hence, a holistic approach towards social preparation and capacity building of IDPs, anchored on the local culture and shared philosophy, could support IDPs in re-establishing their lives and gaining control over their well-being. While the study focused on the experiences of internally displaced persons, relevant implications could be applied to other disadvantaged communities in the country, so that no one is left behind in the vision of health for all.

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