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Effect of combining a health program with a microfinance-based self-help group on health behaviors and outcomes

S. Saha ^{a,b,*}, M. Kermode ^a, P.L. Annear ^a^a Nossal Institute for Global Health, University of Melbourne, Australia^b Indian Institute of Public Health Gandhinagar, Gujarat, India

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ABSTRACT

Objectives: Women's participation in microfinance-based self-help groups (SHGs) and the resultant social capital may provide a basis to address the gap in health attainment for poor women and their children. We investigated the effect of combining a health program designed to improve health behaviours and outcomes with a microfinance-based SHG program.

Design: A mixed method study was conducted among 34 villages selected from three blocks or district subdivisions of India; one in Gujarat, two in Karnataka.

Methods: A set of 17 villages representing new health program areas were pair-matched with 17 comparison villages. Two rounds of surveys were conducted with a total of 472 respondents, followed by 17 key informant interviews and 17 focus group discussions.

Results: Compared to a matched comparison group, women in SHGs that received the health program had higher odds of delivering their babies in an institution (OR: 5.08, 95% CI 1.21–21.35), feeding colostrum to their newborn (OR: 2.83, 95% CI 1.02–5.57), and having a toilet at home (OR: 1.53, 95% CI 0.76–3.09). However, while the change was in the expected direction, there was no statistically significant reduction in diarrhoea among children in the intervention community (OR: 0.86, 95% CI 0.42–1.76), and the hypothesis that the health program would result in decreased out-pocket expenditures on treatment was not supported.

Conclusion: Our study found evidence that health programs implemented with microfinance-based SHGs is associated with improved health behaviours. With broad population coverage of SHGs and the social capital produced by their activities, microfinance-based SHGs may provide an avenue for addressing the health needs of poor women.

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Introduction

Self-help groups (SHGs), usually comprising 10–20 individuals (predominantly women) and organized to save money and

obtain microfinance, are an important initiative that provide access to capital and promote livelihoods among the rural poor in India. These SHGs are promoted extensively through government and non-government organizations and were estimated to reach 93 million members in 2012.¹ The SHG

* Corresponding author. Indian Institute of Public Health Gandhinagar, Drive-in Road, Thaltej, Ahmedabad, Gujarat, 380054, India.

E-mail address: ssaha@iiphg.org (S. Saha).

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structure facilitates significant face-to-face interaction between members and promotes mutual trust, solidarity and social capital.^{2,3} Women's participation in microfinance-based SHGs and the resultant social capital may provide a basis for improving health outcomes and addressing the gap in health attainment for women and their children.

In a previous study in India, we found that the presence of an SHG in a village was associated with improved maternal and child health knowledge and practice.⁴ Elsewhere, a clustered randomized trial among indigenous communities in Jharkhand and Odisha states of India found that newborn babies born in communities with an SHG had a significantly improved likelihood of surviving the first six weeks of life compared to babies born to analogous households in non-SHG communities.^{5,6} Within a broader holistic community development initiative in the early 1970s in Jamkhed, Maharashtra state of India, a program was implemented among women's groups in which one woman from each group was trained as a health worker and funds were provided to assist the group members in the event of health emergencies. During the first 20 years, the project showed a reduction in infant mortality rate from 176 to 19 per 1000 live births, and the birth rate declined from 40 to 20 per 1000 people. Access to antenatal care, safe delivery and immunization was nearly universal and malnutrition declined from 40% to less than 5% in the study population.^{7,8} A study of women's participation in savings groups in Bangladesh found that membership of microfinance programs was associated with an increased probability of children being fully immunized.⁹ A study of the microcredit forum of BRAC, a non-government development organization in Bangladesh, found a significant positive effect of membership in the forum on maternal knowledge of prenatal care, increase use of contraceptive use, and a decline in fertility.^{10,11}

However, despite this evidence, using these mechanisms to address the health needs of the poor does not appear to be a high priority for health planners in India. And while India has large programs – both government and non-government organized – to promote microfinance schemes to poor women, there is limited evidence on the role of health programs attached to microfinance-based SHGs in improving health outcomes of the poor. This paper reports on the findings from a field study designed to investigate whether combining a health program with a microfinance-based SHG program improves health behaviours and outcomes.

Methods

Study design and sites

To assess the effect of combining a health program with a microfinance-based SHG program, a difference-in-difference analysis was conducted through two rounds of surveys to collect baseline and one-year follow-up data from intervention and matched comparison group. The quantitative field study was conducted during 2012 and 2013, followed by a qualitative investigation of the contextual factors and challenges associated with the health program. The study was conducted among 34 villages selected from three blocks or

district subdivisions of India: Dahegam in Gujarat, Udupi and Gadag in Karnataka.

Women in these villages had access to microfinance programs from two organizations: the Self Employed Women's Association (SEWA) in Gujarat, and the Shri Kshetra Dhar-amstala Rural Development Project (SKDRDP) in Karnataka. Both organizations provided a health program for member groups. In the case of SEWA, the health programs were organized as member-owned cooperatives, and included primary health care delivered through stationery and mobile health camps, health education and training, and the production and marketing of traditional medicines. The SEWA health program was supported by funding from philanthropic organizations. SEWA also offered insurance schemes that included health cover for its members. The health package covered hospitalisation costs up to Rs. 2000 (US \$33) annually for an individual, with options for family coverage up to Rs. 25,000 (US \$416) per year, against payment of an annual premium. Health and hygiene programs at SKDRDP started as a *Jana Jagruthi* or public awareness program and included health awareness sessions at routine credit group meetings, home visits by a village health worker, the promotion of low cost sanitary latrines, and *Sampoorna Suraksha*, an insurance scheme with health cover. For the health insurance, an annual contribution of Rs. 190 (US \$3) was collected from each member, providing protection for up to Rs. 5000 (US \$83) in medical expenses per year.

These health programs were available to some, but not all, program areas of the two organizations. At the start of this study, half of the participating villages were identified for roll out of the health program – the intervention villages. For the purpose of this study, we selected matched comparison villages from the same block. The comparison villages were from the microfinance program areas with no health program. Village pairs were matched on four criteria: population size, SHG membership, location in the same block but not with a common boundary. The matching exercise was carried out primarily by the program managers from the participating organizations. To test the validity of the matching process, before the start of the health program we conducted a survey of the intervention and comparison villages to collect information regarding key socio-economic characteristics. These characteristics were compared to evaluate the effectiveness of the matching process.

Improving the health of mothers and children by improving the quality of sanitation and reducing financial burden due to illness were priority issues common to both organisations. Hence, five indicators were selected to assess the benefit of combining a health program with SHGs: diarrhoea among children, institutional delivery of babies, colostrum feeding to newborns, having a toilet at home, and money spent on treatment. These indicators were selected in consultation with the respective program managers of the two organizations.

The survey questions were defined in the following ways: diarrhoea in the youngest child less than two years old, and occurring in the two weeks preceding the survey; institutional delivery and feeding colostrum to newborn babies (for the youngest child less than two years old during the baseline survey and less than one year during the follow-up survey).

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