

WOMEN'S SELF-HELP GROUPS AND ROLE OF CASTE AND CLASS IN EQUITABLE HEALTH ACCESS



Anant Kumar

Centre of Social Medicine and Community Health

Jawaharlal Nehru University

India

Email: pandeyanant@hotmail.com

Concept - Self-Help Groups (SHGs)

- ❑ **Small voluntary association of people**
- ❑ **From the same socio-economic background**
- ❑ **With a purpose of solving their common problems through self-help and mutual help**
- ❑ **Known by different names - Sangha, Samooh, Mandal, Dangham, and Samiti**
- ❑ **Major activities: saving & credit activities (apart from other activities focusing on women's empowerment, health and educational attainment, etc).**

Perception - Self-Help Groups

- ❑ **Increased participation of women in SHGs and saving & credit activities will empower women economically.**
- ❑ **Economic empowerment will –**
 - **empower women's status in family & in the community**
 - **help women to access and utilize better health services & facilities**
 - **contribute towards improving women's health & empowerment**
 - **help in achieving 'Millennium Development Goals' in developing countries.**

Assumptions - SHGs, Caste and Class in Equitable Health Access

- ❑ **Current approach of empowerment through SHG will help to remove social exclusion**
- ❑ **Self-Help Groups -**
 - **will play a role in improving women's health**
 - **will provide equitable health access beyond caste and class distinction**
 - **will help in achieving 'Millennium Development Goals' in developing countries**

Behind the Assumptions

- ❑ **Based on the global neo-liberal agenda**
- ❑ **Suggests that the State should withdraw from social provisioning**

Issues of Concern

- ❑ **Resulted in withdrawal from investments in health & other welfare schemes**
- ❑ **Negative impact on masses (specially the poor, marginalised & women)**
- ❑ **Against the paradigm of health sector reforms**
- ❑ **Enforces a move towards privatization of medical care services**

The Study

- ❑ **Reviews the scope and limitations of SHGs in improving women's health and providing equitable health access**
- ❑ **Explores the role of caste and class in access to health services**
- ❑ **Explores the extent to which SHGs can be involved in attaining better health**
- ❑ **Critically explores the linkages between SHGs, role of class and caste and access to health services.**

Methodology

- ❑ **The Study**
- ❑ **Is based on field surveys, interviews, Focus Group Discussions, and select case studies**
- ❑ **On sample of 200 women SHGs members in Patna district of Bihar**
- ❑ **Findings are based on qualitative and quantitative analysis**

Demographic Profile

- ❑ **All the women interviewed were Hindu.**
- ❑ **The women represent different castes**
- ❑ **Not much difference was found except that OBCs are better positioned socially than the SCs**
- ❑ **Education - 74% are illiterate, 15.5 % are literate**
- ❑ **8 % have studied up to class 5, and 2.5 % of them have education till standard 10th.**

Findings - Access to Health Services

ACCESS TO HEALTH SERVICES			
Caste →	SC	OBC	Total
Nearby/village	7	2	5
Govt hospital/dispensary	7	32	18
Nearby Town	2	0	1
Private Doctor	84	66	76
Total	100	100	100

Impact of SHG on Health Knowledge

IMPACT OF SHG ON INCREASE IN KNOWLEDGE						
	Increase		Decrease		No change	
Caste →	SC	OBC	SC	OBC	SC	OBC
Health and Hygiene	40	78	0	1	60	21
Vaccination	49	72	0	2	51	26
Contraceptives	31	63	0	2	69	35
Care during pregnancy	22	58	0	3	78	39
Care of self post child birth	27	65	0	2	73	33
Care of Infant	27	72	2	1	71	27
Awareness of personal health care	36	70	0	2	64	28
Existing health services awareness	44	76	0	1	56	23

Impact on health behaviour & practices

IMPACT OF SHG ON HEALTH BEHAVIOUR AND PRACTICES						
	Increased		Decreased		No Change	
Caste →	SC	OBC	SC	OBC	SC	OBC
Visit to PHC	12	41	24	10	64	49
Visit to Private doctor/Nursing Home	49	74	0	15	51	11
Ante-Natal Care during Pregnancy	29	63	0	2	71	35
Pre-Natal Care during Pregnancy	27	61	0	3	73	36
Post natal care	27	73	0	1	73	26

Improvement in health

IMPROVEMENT IN HEALTH						
	Fully		Partly		No Change	
Caste →	SC	OBC	SC	OBC	SC	OBC
Improvement in personal health	16	48	22	25	62	27
Improvement in family health	14	50	23	24	63	26

Increase in expenditure

INCREASE IN EXPENDITURE ON						
	Increased		Decreased		No Change	
Caste →	SC	OBC	SC	OBC	SC	OBC
Food materials (Change in Expense pattern)	0	7	0	1	100	92
Children medicine	0	19	27	39	73	42
Preventive Medicine	5	23	14	36	81	41
Health	39	77	2	1	59	22

Findings from FGDs and Case Studies

- ❑ **Caste and class, health belief and perception came out as primary hindrance in access to health services**
- ❑ **Across caste groups better off caste groups witnessing more access to health services than the disadvantaged groups such as SCs**
- ❑ **Suggests that without changing the barriers of caste and class based discrimination, it is not possible to achieve inclusion of marginalized (especially women and poor) in providing better health access and life.**

Findings from FGDs and Case Studies

- ❑ **Higher percentage of OBC women visiting medical practitioners and services compared to SC women**
- ❑ **Increased awareness about health and health services among the OBC women compared to SC women**
- ❑ **OBC women are more prone to visiting the government PHC compared to SC women who mostly rely on local village level medical practitioners.**

Conclusions

- ❑ **Solutions such as self-help which emanate from the international policy circles do not capture the contextual issues leading to instrumentalized approaches and sub-optimal results**
- ❑ **The approach has its own limitation and without addressing the local contextual realities like caste and class, it is not possible to provide equitable health services to poor and marginalized.**



Thank You

**Suggestions and comments are welcome
at
pandeyanant@hotmail.com**