Short Communication

Impact of Self-Help Groups among Persons With Disabilities in Rural Karnataka - A Comparative, Cross-Sectional Study

Minitta Maria Regy, Deepthi N. Shanbhag, Naveen Ramesh, Elaina Pasangha, Alex Fernando, Monisha Maria, Cyriac Jogi

Department of Community Health, St. John's Medical College, Bengaluru, Karnataka, India

Abstract

Background: The prime concern for an individual with disability is independence. Self-help groups (SHGs) provide opportunities for those with such needs. **Objectives:** The objectives of the study were (i) to assess the impact of SHGs on the livelihood, social inclusion, and community participation of those with disability and (ii) to evaluate the self-esteem and assess the role of such SHGs among those with disability. **Materials and Methods:** This was a community-based, cross-sectional study. An interview schedule captured responses to standardized questionnaires (community-based rehabilitation assessment tool, Rosenberg's self-esteem score, and Social Inclusion Scale). Responses were scored and compared among the two groups of those with disability (member or nonmember of SHGs). **Results:** The median scores for all our outcome variables were found to be more among those with disabilities enrolled in SHGs than those who were not with a significant association in the component of empowerment, sociocommunity participation, social inclusion, and self-esteem. **Conclusion:** SHGs improve social and community participation of individuals with disability. It empowers them to lead independent lives and also contributes to social inclusion.

Keywords: Disability, empowerment, self-esteem, self-help groups, social inclusion

Introduction

The Ministry of Statistics and Program Implementation, Government of India data 2016, states that 2.68 Cr persons are disabled which is 2.21% of the total population.[1] It is important to include persons with disabilities under an umbrella of self-help groups (SHGs) as part of a community-based rehabilitation (CBR) strategy.[2]

CBR is a strategy for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of people with disabilities, and its needs are assessed under the subclasses of health, education, livelihood, social, and empowerment.[3] Participating in SHGs provides an enabling forum for individuals to address challenges and limitations. Peer support delivered through the structured self-help environment can facilitate the development of self-awareness, promote adjustment, and facilitate the establishment of new skills. This, in turn, leads to the development of potential work capacity.[4]

SHGs allude to organizations which aim to improve individual lives through collective action. Collective action implies that individuals share their time, labor, money, or assets within the group to produce both collective and individual benefits.[5] While these informal services are of considerable importance, SHG platforms which have reached 57.9% of villages in India, resulting in 4.8 million credit-linked groups in 2010, have demonstrated the broad potential to demand accountability from government functionaries.[6]

No matter when or how the disability occurs, those affected by a disability often share a common value – that of living as independently as possible. Therefore, by providing opportunities for socialization with peers and mentors, with a good exposure to community resources, development of self-care skills and independent living can be achieved.[7]

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Address for correspondence: Dr. Deepthi N. Shanbhag, Department of Community Health, St. John's Medical College, Bengaluru - 560 034, Karnataka, India.
E-mail: deepthi.shanbhag@gmail.com

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Materials and Methods

This was a community-based, cross-sectional, comparative study covering 12 villages under the Sarjapur Primary Health Center (PHC), rural Karnataka, over a period of 2 months (December 2020 to February 2021).

The sample size was calculated using the online OpenEpi software[8] with the mean values taken from a previous study done in rural Karnataka[3] with confidence interval of 95%, power of 90%, ratio of sample size taken as 1 with mean difference of 6.3, and standard deviation and variance of each group taken as 9.2 and 84.64 and 10.5 and 110.25, respectively. The total sample size of 104 was calculated and a purposive sampling method was used. Institutional Ethics Committee approval was obtained (IEC no: 64/2021) before the initiation of the study.

After explaining the purpose of the study, written informed consent was obtained from the participants and a face-validated, pretested study tool was administered. This was a semi-structured interview schedule consisting of sociodemographic details; CBR assessment tool for empowerment, livelihood, and sociocommunity participation; and Social Inclusion Scale and Rosenberg's self-esteem scale. All the questionnaires were scored on a Likert scale.

Data were collected using Epicollect5, entered into MS Excel 2017, and analyzed with SPSS v21.0 (Statistical Package for the Social Sciences (SPSS) analytic software version 21.0); the normality of data was tested using Kolmogorov–Smirnov test and outcome variables were compared using tests of significance such as Mann–Whitney U test, Kruskal–Wallis test, and Chi-square test. $P < 0.05$ was considered significant.

Table 1: Sociodemographic details and self-help group enrolment (n=110)

Variable	SHG member		P*
	Yes (n=37), n (%)	No (n=73), n (%)	
Age			
18-30 years	15 (45.4)	18 (54.6)	0.234
31-45 years	12 (30)	28 (70)	
46-60 years	10 (27.1)	27 (72.9)	
Gender			
Female (n=49)	14 (28.6)	35 (71.4)	0.213
Male (n=61)	23 (37.7)	38 (62.3)	
Education			
Illiterate (n=37)	12 (32.5)	25 (67.5)	0.147
Primary school (n=11)	3 (27.7)	8 (72.3)	
Middle school (n=23)	12 (52.2)	11 (47.8)	
High school (n=33)	10 (30.3)	23 (69.7)	
Diploma (n=1)	0	1 (100)	
Graduate (n=3)	3 (100)	0	
Professional degree (n=2)	2 (100)	0	
Occupation			
Unemployed (n=66)	24 (36.3)	42 (63.7)	0.621
Unskilled (n=20)	6 (30)	14 (70)	
Semiskilled (n=8)	2 (25)	6 (75)	
Skilled (n=5)	1 (20)	4 (80)	
Clerical/shop/ farm (n=9)	4 (44.4)	5 (55.6)	
Semiprofessional (n=1)	0	1 (100)	
Professional (n=1)	0	1 (100)	
Socioeconomic class (Modified BG Prasad, 2020)			
Lower (n=71)	39 (54.9)	32 (45.1)	0.331
Middle (n=32)	11 (34.3)	21 (65.7)	
Upper (n=7)	1 (14.2)	6 (85.8)	

*Chi-square test. SHG: Self-help group

Results

A total of 12 villages were covered under Sarjapur PHC. A total of 110 persons with disability were interviewed in our study, where 37 were members of SHGs and 73 were not members of any SHGs. The age group of our study participants varied between 18 and 60 years with a mean age of 40.6 ± 12.9 years. There is no significant difference in sociodemographic profile of Persons with disabilities (PWD) enrolled in SHGs and not enrolled and hence comparable, as shown in Table 1. Since the data were not found to be normally distributed, the median scores of the outcome variables were compared between the two study groups. Table 2 shows that the PWDs enrolled in SHG scored significantly better in livelihood, empowerment, participation, and self-esteem.

Discussion

From the conceptual point of view, there is no universal definition of what constitutes a disability; instead, it can be explained as the interaction between a person with health condition and particular environmental context where individuals with similar health conditions may not be similarly disabled or share the same perception of their disability.[9] According to the National Bank for Agriculture and Rural Development, SHG means twenty or less people from a homogenous class who are willing to come together to voice their common problem with the main objective to bring poor families above the poverty line by ensuring significant increase in income, social mobilization, skill development, and training.[10]

A study done by Normal in 2006 which gauged perception toward rehabilitation process described SHGs as an arena for learning social skills, establishing and maintaining social relations which could eventually lead to better social participation.[11] Our study showed significant social and community participation among those in SHGs as compared to those who were not in any group ($P = 0.012$). Considering the increased participation observed among those in SHGs, an increased number of SHGs would influence the overall perspective of the community toward disability.

Table 2: Median scores compared between the two groups (*n*=110)

Variable (maximum score)	SHG member		*P**
	Yes (*n*=37)	No (*n*=73)	
Livelihood (10)	5 (2-8)	4 (2-8)	0.495
Empowerment (9)	4 (4-7)	0	0.001
Legal rights/aid (4)	4 (3-4)	3 (3-4)	0.492
Social and community participation (12)	10 (9-11)	9 (7-10)	0.012
Social inclusion score (50)	38 (30-45)	32 (25-40)	0.032
Self-esteem score (30)	19 (15-20)	16 (11-19)	0.031

*Mann–Whitney test. SHG: Self-help group

An interventional study by Stang and Mittelmark in 2009 on women suffering from chronic conditions described how learning from SHGs can empower women with long-term disease.[12] Similarly, our study showed a higher median for empowerment among those in SHGs ($P = 0.01$). An increased number of SHGs for those with disability will increase both financial and nonfinancial independence among those with disabilities.

A study done published in 2020 by Landstad *et al*. on the psychosocial rehabilitation in a person-centric environment showed that members of SHGs became empowered to understand themselves and believe in their potential as social individuals through their participation in the group.[4] Our study showed that members of SHGs are likely to be included socially as opposed to those who are not in any SHGs ($P = 0.031$). With SHGs, a symbiotic environment is created where individuals are empowered to make a significant contribution to society.

Conclusion

SHGs improve social and community participation of individuals with disability. It empowers them to lead independent lives and also contributes to social inclusion and higher self-esteem.

Ethical approval

Institutional Ethical Clearance (IEC) from St. John's Medical College Bangalore was obtained prior to the study (IEC Ref No: 64/2021).

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Conflicts of interest

There are no conflicts of interest.

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