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Health information needs assessment among self-help groups and willingness for involvement in health promotion in a rural setting in Puducherry: A mixed-method study

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Abstract:

BACKGROUND: Health promotion is the process of enabling people to increase control over their own health. Community involvement in social and environmental interventions tends to improve people's health and quality of life. Self-help groups (SHGs) primarily focus on microfinancing, thereby acting as a catalyst in bringing backward society to the mainstream. They possess huge potential to influence the health of the community.

OBJECTIVE: The objective of the study is to assess the willingness among SHGs for the involvement in health promotion activities and to assess their health information needs.

MATERIALS AND METHODS: A community-based, cross-sectional study was conducted during September 2017 in rural Puducherry. All 86 SHGs in four selected villages were covered, and their leaders were interviewed using a structured questionnaire on functioning of SHGs and their health information needs. Willingness for health promotion activities was rated on an interest scale (1–100).

RESULTS: Among the 86 heads of SHGs interviewed, 81 SHGs (94.1%) were registered. They were mainly involved in microfinancing. Health information needs expressed were cancer detection (45%), diabetes (60%), hypertension (56%) and vector-borne diseases (63%). When asked to rate their willingness on an interest scale for health promotion activities, nearly 64% showed a great interest (i.e., score > 60). Majority were willing to work for noncommunicable disease-related activities such as provision of drugs (86%) and for screening of various cancers (84%).

CONCLUSION: This study has shown that majority of SHG members have expressed willingness for the involvement in health-related activities, thereby can be utilized as an important resource for health promotion in rural areas.

Keywords:

Health promotion, self-help groups, willingness

Introduction

Universal health coverage means that all individuals and communities must receive the basic health services they need without suffering financial hardships. It encompasses all components of the health system: health service delivery

systems, health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, governance, and legislation.^[1] With the view of achieving it by 2030, many countries have adopted various methods of health promotion. Community participation is a key factor enabling effective health system functioning. There are quite

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a lot of disparities in accessing health care between the urban and rural areas. Major social determinants of health such as poverty, inadequate housing, and lack of education form the root cause of diseases in developing countries.^[2] Tackling these social determinants of health remains a pivotal role in improving health care.

Since the origin of microfinancing in Bangladesh as a tool to uplift the poor, many countries have adopted the same strategy at their convenience to start up an efficient self-sustaining financial body. Similar microfinancing organizations in India are referred to as self-help groups (SHGs), which are usually supported and registered under the government as community-based organizations (CBOs). The members of SHGs are usually working women/homemakers, willing to take up responsibilities to start a financial body by pooling money from the group members. They effectively use them as loans and grants for the members during emergencies. This strategy of empowering women has proved to be efficacious in addressing inequalities of power, money, and resources among different communities.^[3] The SHGs frequently hold meetings to discuss not only financial issues but also various issues affecting the community, thus providing a critical pathway for health promotion.^[4]

These SHGs also serve as a platform for the improvement in social capital. These microfinancing groups have emerged effectively to alleviate poverty. However, this will not help in developing the community unless health care is touched upon.^[5] Understanding the health information needs of these SHGs and involving them in targeted health interventions can potentially shoulder delivery of health care.

The major four dimensions of health care are availability, accessibility, affordability, and acceptability.^[6] SHG can effectively serve as a platform to increase the availability and accessibility of health services. The main barriers toward accessing health care are supply side and demand side barriers, lack of female autonomy, lack of social support, social exclusion, and marginalization.^[7] These microfinancing groups once sensitized can serve as a medium to enhance community participation and help in linking social capital as the group members get involved in activities.^[8] They can also serve as vital medium to advocate enable and mediate various health promotion activities.^[9] Thus, our study aimed at assessing the willingness among SHGs for the involvement in health promotion activities and to assess their health information needs.

Materials and Methods

For our study, we adopted a mixed-method approach taking up sequential exploratory design

(qualitative → quantitative).^[10] The data collection methods include focused group discussions (FGDs) and a pretested semi-structured questionnaire. The study was conducted between August 2017 and September 2017. The study was conducted among the SHG members in rural field setting in Puducherry. The study setting comprised four villages, namely Ramanathapuram, Thondamanatham, Pillaiyarkuppam, and Thuthipet, with a total population of around 10,000. We adopted a sequential exploratory design involving two phases, Phase I (qualitative) to explore the various functions and characteristics of existing SHG and Phase II (quantitative) to understand the health information needs of the SHGs and their willingness to provide health services.

Sample size and sampling procedures

There was no sample size calculation involved in the study as we included all the existing SHGs in the service area into the study. There were a total of 86 SHGs from the four villages. All the SHGs were actively functioning in the area. The heads of all SHGs were asked for verbal consent and were included in the study. For Phase 1, purposive sampling was employed to get either heads or members of the SHGs who were more vocal and willing to participate. Two FGDs were conducted among ten members each.

Study procedure

Phase I (qualitative)

Leaders and members representative of existing SHGs in all four villages were included in for qualitative part. A list of all actively functioning SHGs with address and contact details in our service area were prepared. Intimation regarding the necessity of the meeting and the importance of the project was provided to all SHGs by the respective area staff *a priori*. Descriptive approach was used for qualitative data collection. The principal investigator and the notetaker were chosen based on their fluency in local language and experience in qualitative research. Adequate training was again given to familiarize them with the study. The interview guide included important probing questions such as Can you tell me more about that? What makes you feel that way? Can you think of an example of that? What are some of your reasons for feeling as you do? Which were prepared by the study team? Before the interviews, the interview guide was pilot tested among a few members of SHGs (excluded from the main FGD) to assess its appropriateness; changes were made wherever necessary. Any query or difference that emerged during the process of pilot testing was resolved by the study team. Two FGDs were conducted among SHG members representative of all four villages. Summary sheets were used to capture the demographic details of the participants. Each FGD had 10 participants, and all were women, with a mean age of the participants

being 34 ± 8.4 years. The interviews were carried out in the participant's regional language (Tamil), and each interview lasted for 45–50 min. It was conducted at the primary health center, which was their place of convenience. After obtaining the consent and briefing the purpose of the study, FGD proceeded. No one other than the participant and the interviewer was present in any of the FGDs. Participants were ensured confidentiality of the information obtained through the interview. Probes were used wherever extraction of more relevant information was possible. All interviews were tape-recorded and field notes taken during the interview, to capture all important information. Verbatim transcript was transcribed first in Tamil and then back-translated into English the same day to prevent loss of information. At the end of each session, discussion summary was presented the participants for participant validation. The main theme of the FGDs was to capture the various functions and characteristics of SHGs. Based on information obtained, the questionnaire was modified.

Phase II (quantitative)

The quantitative survey was conducted over 1 month (September). We did face-to-face interviews, interviewing all 86 heads of SHGs after obtaining informed consent. House-to-house meeting was done to capture all the SHG members. A pretested semi-structured questionnaire was used for quantitative survey. The questionnaire had four sections: sociodemographic details, functions of SHGs, willingness for health promotion, and health information needs. The questionnaire was subjected to face validation and was reviewed by experts in the field before finalizing the content. Five training doctors posted in the center were chosen to be data collectors after training to familiarize them with the questionnaire and objectives of the study. The data collected were again reviewed and cross-checked by another team of three doctors, including the medical officer posted at the center, ensuring quality.

Data entry and analysis

Quantitative data

The data were entered into Epidata v 3.01 software (Manufactured by Epidata association on year 1999 in Denmark) and analyzed using IBM SPSS version 19 (IBM Corp, Armonk, New York). Continuous variables were summarized as mean (standard deviation), and categorical variables were summarized as proportions.

Qualitative data

The collected data were transcribed in verbatim format. Participant's statements were taken as a unit of analysis. Thematic descriptive manual content analysis was done to derive the categories. All data coded were again reviewed

by other investigators to reduce subjective interpretation. Constant comparative analysis was done to ensure the credibility, and final consensus was obtained. Recurrent themes that emerged were utilized in preparing a schematic diagram. The study was reported in accordance with the consolidated criteria for reporting qualitative research.

Results

A total of two FGDs and 86 personal interviews were done for the mixed-method approach. Major themes that evolved during the FGD were then grouped into existing functions, needs, and areas of interest. The information gathered during qualitative part was then used to develop the questionnaire. We noted that nearly 94% of the groups were registered under government. All 86 (100%) SHGs gave willingness to undergo training, thereby helping the health staff to deliver services. It was noteworthy that the health information needs exhibited by the SHGs group members were in line with the priority list prepared by the investigator earlier in consultation with the health staff.

Figure 1 explains the qualitative analysis as a conceptual framework for easy understanding. The analysis is delineated into three categories, namely (i) existing functions, (ii) needs, (iii) areas of interest.

The needs

As our study aimed at capturing the health information needs of the SHG members, we enquired about the areas in which they were ready to take up training, thus empowering the health system. The participants

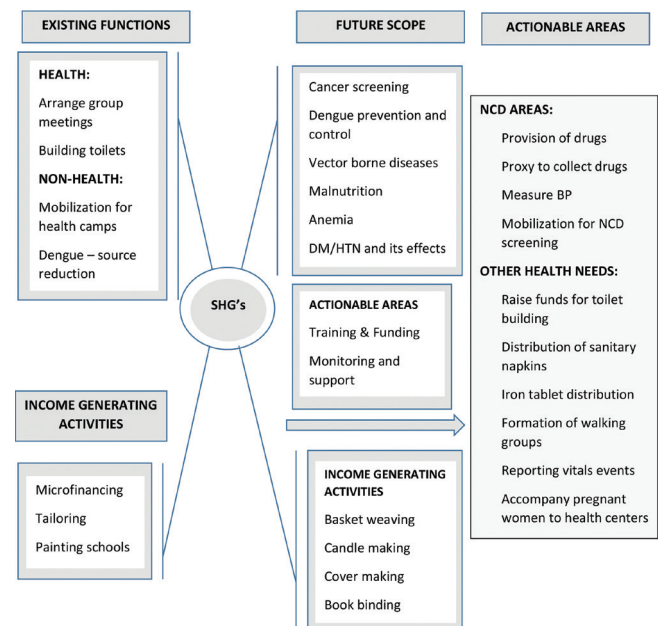


Figure 1: Conceptual diagram of qualitative analysis of health promotion needs of self-help groups

showed great interest in attending the training and came up with various health information needs. They also added that they would like to get additional vocational training in forms of basket weaving, candle making, and bookbinding to earn a living. Hindering factors that oppressed them from doing these activities in the past were also discussed, for which the two main reasons which they stated were lack of training and lack of appropriate funding from the government.

"I would like to know more on cancer and why is it occurring so commonly? How to detect it early? How to prevention? Especially about breast and cervix cancer."

I have very less knowledge regarding diabetes, hypertension, and its prevention. It would be nice if I know what are its effects? Why it affects only old age?

"I would like to know exactly about changes during menopause, periods, malnutrition, and its consequences."

"We have very less amount of fund to sustain ourselves, as there is no proper fund flow. We collect it from ourselves, pool it, and finally use it. Sometimes, there is lots of vocational training going on in other towns, but we don't find time and money to attend it; it would be useful if such meetings are conducted in our areas too."

The existing activities

The SHGs were involved in a wide variety of services other than microfinancing, which we thought would be their prime role. It was encouraging to note that SHGs were previously involved in health promotion activities even before the study. They also added that they helped the health staff regularly whenever approached.

"Usually, we gather members and community people for cleaning schools yearly once or twice in Ramanathapuram; we also arrange camps and have walls painted for primary schools."

"We have elected a leader for ourselves, she is appointed to carry out microfinancing. Thus the money we raise from these helps us to sustain our day-to-day needs and get financial support during emergencies."

"We help out in volunteering for dengue control, arrange social meetings and gatherings, and finance building toilets."

Areas of interest

Taking one step beyond the health information needs, we planned to discuss the ways through which they can provide help. We interestingly found that the SHG members were more interested in involving themselves in field service, thereby helping chronic disease patients.

Some were also interested in increasing the coverage of adolescent health by providing sanitary napkins and distributing iron and folic acid (IFA) tablets.

"I think Anganwadi can be utilized for providing treatment for diseases like diabetes and hypertension and also for monthly drug collection."

"Maximum, I can come and collect the monthly tablets if needed, and I think I can contribute in distributing sanitary napkins also."

"I will inform regarding bed-ridden chronic disease patients to sisters, and I can also remind the patients regarding sugar profile testing if they are not compliant."

Table 1 depicts the sociodemographic profile of the heads of the SHGs; of the total 86 SHGs under our service, we found 81 (94%) were registered under government and were actively involved in women empowerment. We found that almost 39 (45%) of the SHG heads were falling in the age category of 30–40 years, with the mean age being 36.7 ± 8.7 years. Nearly 80% of the heads had a basic education of higher secondary and above. Among them, nearly 75% were employed and almost 95% were married. The average number of members in each group is 12, all being women.

With respect to the functional characteristics of the SHGs, we found that almost half of the SHGs conduct regular meetings, i.e., every week, with most of the meetings lasting for around 30–60 min. The major functions being performed by the SHGs were unanimously microfinancing done to meet the basic financial needs and economic upliftment of the members. They were also involved in other functions such as raising money to build toilets and vocational training such as tailoring

Table 1: Sociodemographic characteristics of leaders of self-help groups among the selected villages of rural Puducherry (n=86)

Variable	Category	Frequency (%)
Age (years)	20-30	21 (24.42)
	31-40	39 (45.35)
	41-50	22 (25.58)
	>50	4 (4.65)
Education	No formal education	5 (5.81)
	Primary	13 (15.12)
	Higher secondary	53 (61.63)
	Graduate	15 (17.44)
Employment status	Employed	65 (75.58)
	Unemployed	21 (24.42)
Marital status	Unmarried	4 (4.65)
	Married	82 (95.35)
Registration status of the SHGs	Registered	81 (94)
	Not registered	5 (4)

SHGs=Self-help groups

and sanitation (cleaning of temples and schools). Apart from the general meetings of the SHGs, they also hold discussions analyzing the financial constraints, health problems faced by the community, and ways to improve vocational training [Table 2].

Table 3 depicts the health information needs among the participants. All the SHGs heads agreed to join hands and work with the health staff after necessary training. When asked to list out their areas where they would like to acquire training, it was noted that many were interested in vector-borne diseases, diabetes, hypertension, menstrual problems, and malnutrition in the decreasing order of importance. We also used the same opportunity to ask the type of contribution which they could provide, for which many were willing for provision of IFA tablets, as a proxy for chronic disease medications and mobilization for screening of diseases such as diabetes and hypertension. Some showed interest in undergoing training and take up cancer screening and measurement of blood pressure. Figure 2 displays the level of interest among the SHG heads to deliver health services; it was interesting to find that almost 55 (64%) SHG heads exhibited great interest, i.e., more than a score of 60 on an interest scale when asked to mark their level of interest in a scale of 0–100.

Discussion

This was a mixed-method study consisting of FGDs and questionnaire-based quantitative survey conducted among the members of SHGs in rural Puducherry. The main objective of this study was to understand the willingness of SHGs to work for various health promotion activities and to explore their various health information needs.

SHGs from different countries have been constantly involved in various functions depending on their local settings. In our area, we found that the main function of SHGs was microfinancing and raising funds for building toilets and vocational training. We also noted that they were involved in various social reforms such as cleaning schools and streets and hold health meetings

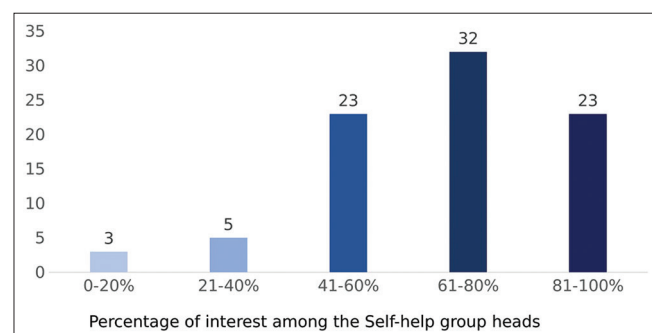


Figure 2: Willingness among self-help group leaders for health promotion activities

for various medical camps. Studies from other parts of the world have also stated the potential of these CBOs and its impact on social, financial, and health-related

Table 2: Functional characteristics of self-help groups among the selected villages of rural Puducherry (n=86)

Variable	Category	Frequency (%)
Functions of SHGs*	Microfinancing	81 (94.19)
	Raise funds to build latrines	46 (53.49)
	Tailoring	30 (34.88)
	Sanitation and cleaning activities	28 (32.56)
	Mobilization for camps	8 (9.3)
	Volunteer for disease control	2 (2.33)
	Others	9 (10.45)
Number of meetings in a month	1	12 (13.95)
	2	29 (33.72)
	4	45 (52.33)
Duration of meetings	<30 min	19 (22.09)
	30 min-1 h	56 (65.12)
	>30 min	1 (12.79)
Topics discussed during meetings*	Financial issues	82 (95.35)
	Health needs	39 (45.35)
	Vocational training	15 (17.44)
	Others	0 (2.33)

*Multiple options possible. SHGs=Self-help groups

Table 3: Health information needs of the self-help groups among the selected villages of rural Puducherry (n=86)

Variable	Category	Frequency (%)
Health information needs*	Fever and vector-borne diseases	54 (62.79)
	Diabetes and its effect on organs	52 (60.47)
	Hypertension and its effect on organs	48 (55.81)
	Cancer detection and prevention	39 (45.35)
	Menstrual problems	31 (36.05)
	Malnutrition among children	14 (16.28)
	Tuberculosis	13 (15.12)
	Others	7 (8.14)
Areas of interest to work for care of chronic diseases*	Provision of drugs	74 (86.05)
	Screening for breast and cervical cancer	72 (83.72)
	Proxy to collect drugs	68 (79.07)
	Measurement of BP	62 (72.09)
	Mobilization for NCD screening	19 (22.09)
	Others	0
Preferred mode of receiving training	Committee meetings	81 (94.19)
	Health center	5 (5.81)
Preferred frequency of health training	Once in a fortnight	42 (48.84)
	Monthly once	34 (39.53)
	During meetings	10 (11.63)

*Multiple options possible. BP=Blood pressure, NCD=Noncommunicable diseases

interventions.^[11,12] Studies have also proved that effective use of the SHGs and adequate intervention will lead to improvements in mental health, income generation, and quality of life among women.^[12,13]

Globally, integrating health promotion into SHG functioning has resulted in positive outcomes in primary care and prevention of diarrheal diseases, breastfeeding, nutrition, reproductive health, infectious diseases, sexually transmitted diseases, and reducing gender violence.^[14-18] Similar models have already proved effective in many states of India covering various aspects.^[19-22] Effective health education regarding nutrition, adolescent health, and enhancing positive behavioral change can also be delivered during their regular meetings.

Our study also showed similar areas for health promotion such as prevention of vector-borne diseases, diabetes, hypertension, menstrual problems, and malnutrition in the decreasing order of importance. Various other studies published in the Asian context have emphasized the greater picture of involving SHGs in providing health services.^[23,24] They were willing to take up jobs such as provision of IFA tablets, serving as proxy for bed-ridden noncommunicable disease (NCD) patients, and mobilization for NCD screening. Some showed interest in taking up cancer screening and measurement of blood pressure. This adds to the list of various other activities where their involvement is found to be effective.^[25,26] We also noted that the results obtained through both qualitative and quantitative parts were comparable, thereby enabling triangulation of the data. This model will be even more effective if these vibrant members are given adequate training not only regarding their perceived needs but also regarding their experiment incorporating training programs on leadership and advocacy, thereby stressing upon how leadership qualities can pave to organizational success.

The major strength of the study was the fact that we employed a mixed-method design for capturing the health information needs and assessing willingness which would enable us to know in-depth about the needs and why they see it as a priority. Our study also adds to the limited literature involving SHG for health promotion in South India. This model of utilizing readily available workforce would also serve as an effective platform for health promotion activities in resource-poor setting.

However, our study had certain limitations. We did only the initial phase of a broader study where we attempted to capture the health information needs of the SHG members. The quantitative part of the current study is

done as a single cross-sectional interview. This study could serve as a baseline for further research providing interventions and assessment of their contribution. As these health information needs represent problems pertaining to the South Indian context, generalizability will be an issue. Similar research needs to be encouraged to improve community action in setting priorities, making decisions, and implementing them to achieve universal health care. This act of empowerment of the community is also shouldered by the Ottawa Charter.

Conclusion

Thus, SHGs can function as a potential source in reorienting health services, thereby ensuring community empowerment and participation. Considering the level of interest among SHG heads to deliver health services, we could probably vision the accessibility of services that can be achieved through community participation.

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Conflicts of interest

There are no conflicts of interest.

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