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Health Care Governance and Social Network of Women in India

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Abstract:
The study attempts to enquire into local action for civil society by examining the role of social network of SHGs in strengthening Local Agenda 21 for Health Care Governance. The study investigates problems, opportunities and benefits of forming social network of SHGs for planning needs assessment at village level by examining community participation, facility groups and availability of health care groups as components of governance. The study uses operationalisation of efforts by presenting results from a survey of 340 socially networked women by carrying out ordered logistic regression for effective use of resources. Four models of social networks have been considered for understanding health care governance. A communication strategy has been development and study identifies nine indicators for local authorities to think that society has started sustainability process and concludes that such a participatory strategy leads to from mere 'presentation' to 'presence' of local people in health care governance.

Key words*: Health, Governance, Social Network, Women, Local Development*

1. Introduction

'Think globally and Act locally' is the adage which is used widespread in the local developmental literature all over the world. In this context, Local Agenda 21 as a guiding principle for local developmental actions is of immense importance.

2. Local Agenda21: International Context till Date

The Local Agenda 21(LA21) concept was formulated and launched by International Council for Local Environmental Initiatives (ICLEI) in 1991 as a framework for local governments worldwide to implement the outcomes of the United Nations Conference on Environment and Development (UNCED). ICLEI along with partner national and international local government associations and organizations championed the LA21 concept during 1991-92 UNCED preparatory process. Following UNCED, local governments, national and international NGOs, and international and UN organizations began experimenting with local agenda 21 concept. Some local governments often supported by national municipal associations, developed LA21 planning approaches appropriate to their situations (UN, 1992).

LA21 gets grips with capacity problems, which can help to address many weaknesses in many local development initiatives and environmental management and planning, they have increased the willingness of the citizens, community organizations and NGOs to 'buy in' planning and management where they are organized in such a way as to encourage and support their participation. They also have potential to integrate global environmental concerns into local actions.

LA21s represent a major innovation in local planning for sustainable development. They have an international identity and an international network, but are (meant to be) locally driven and implemented. At their best, local agenda 21s:

- are grounded in broad inclusive process of consultation, coordinated by a local authority and drawing in all key stakeholders
- ensure that environmental concerns, from the very localized to global, enter the mainstream of urban planning and management.
- provide and efficient and equitable means of identifying common goals, reconciling conflicting interests and creating working partnerships between government agencies, private enterprises and civil society groups.

Local Agenda 21 has encouraged different governments to share experiences. This has led to identify the LA practitioners following five key factors for success of LA 21(UN, 1992):

- **Multisectoral engagement** in the planning process, through a local stakeholder group which serves as the coordination and policy body for preparing a local sustainable development plans.

- **Consultations with community groups**, NGOs, business churches, government agencies, professional agencies in order to create a shared vision and to identify proposals and priorities for action.
- **Participatory assessment** of local, social, economic and environmental conditions and needs
- **Participatory target** –setting through negotiations among key stakeholders to achieve the vision and goals set forth in action plan.
- **Monitoring and reporting procedures,** including local actors, to track progress and to allow participants to hold each other accountable to the action plan.

3. Local Agenda 21, Civil Society and Health Care Governance

Local Agenda 21 provides a strong ground to involve all stakeholders in the development planning, one such area is the 'civil society and governance' where Government of India (GOI) has brought the 73rd constitutional amendment act (1992) (Act, 1992) (also called 'The Panchayati Raj Amendment Act' (Act, 1992) to involve the local actors at the district, block and village level in the process of development and planning to strengthen civil society and governance.

The issue of good governance is deemed central to the development throughout the world. Not only the 'good governance', a public good in itself, to be guaranteed to the people without exception, it is also accepted as crucial variable for development to proceed along a sustainable path. Sustainability in this context is predicted upon equity and justice (Deeming, 2008). Good governance has concurrently come to be seen at two planes. One at the operational level, where good governance is described in terms of efficiency, absence of corruption in public life, accountability and transparency. Two, at the institutional plane, where good governance is perceived in the forms it takes: democratic, decentralized and participatory and operated by political incentives or its obverse disincentives. Exercise of power by people's representatives in full view of electors is deterrence to gross abuse and misuse of the authority (Deeming, 2008)

Within the boundaries set by the paradigmatic shift and emergence of good governance as not only an imperative public good but also a critical variable that drives the development process and 'Panchayats' occupy one unique position. At the institutional plane, they provide all the ingredients of good governance: Democratic, decentralized, participatory and clearly equilibrated by political incentives or disincentives (Bandhopadhyaya and Mukherji, 2004).

Decentralization is basically about who makes decisions over what specific issues and how much choice they are able to make about these issues. If governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them, then decentralization is a specific case of governance (Bossert, 2000a; Bossert, 2000b; Bossert, 1998).It specifies the arena – national, provincial or state, district or county, or municipality – that is addressed by interest groups from civil society, where the political processes over specific policymaking is made. It determines who participates in those decisions and who is responsible for implementing those policies. In Health System 20/20's health governance model that frames the linkages among the state, providers, and clients/citizens, decentralization specifies where the responsibilities of the state lie. Since responsibilities for different issues are often shared among all levels of government, it is important to understand the specific allocations of decision-making power and responsibility at each level in order to develop appropriate strategies for strengthening the governance capacities at those levels (Bossert, 2008; Chee et. al, 2013).

In order to under the dynamics of health governance at the local by advancing the local agenda, the locally available health care resources and impact of the social network of SHGs on the health care governance is studied in this paper to carry forward the ideas given by Local Agenda 21.

4. Capacity Building, Leadership Development and Social Networks for Reproductive and Child Health (RCH)

Capacity building has been found to be very effectively affecting the Reproductive and Child Health of women which is a component of empowerment of women. Capacity building needs to be done because people have no knowledge of the methods of development processes or for inculcating in them new and timely skills or knowledge. Capacity building is expected to develop among them leadership quality (Kapoor, 1989). Further, capacity building and leadership development leads to development of social capital in the form of human or various capital resources or in the form of network of resources which they can directly or indirectly use (Mohindra,2003; Montgomery et.al. 2001; Philipov and Shkolnikov, 2001). Therefore, social network help development of health care and take to community involvement, work as facilitators for health development and form health care groups.

Through 73rd constitutional amendment act in 1992, the local governments of the district were empowered so that local agencies of development-village block and district may partake in local development planning. There are many developmental plans covering sectoral issues started by government and various donor agencies, but lack of awareness, knowledge of their rights and responsibilities and powers in Panchayats hinder villagers and quite often participation of democratically elected members of the Gram Panchayat and Gram sabha in the planning and needs assessment of village level problems and this condition is burdened if these members are women or of marginalized sections of the society where the benefits of the developmental activities are inappropriately taken away by the creamy layers of the society either by the misuse of powers and rights or by muscle power.

In this respect, the paper examines the role of social network of SHGs (Self Help Groups) in strengthening health care governance for taking initiative for their developmental needs and priorities. In order to understand the operationalisation of the issues in health care governance and sustainable society building, a case of self help groups in Faizabad district of Uttar Pradesh is selected where the self-help groups has reached to a level of sustainable society building after the formation of the groups. This paper has concentrated on selected indicators of impact of capacity building as leadership development among self help groups, network building and leadership development among women for developing sustainable health care governance.

5. The Study District: Faizabad

Faizabad is one of the districts of Uttar Pradesh. The districts have 13 blocks. The total land area of the districts is 2765 sq.kms. As shown in the table below, the population of Faizabad constitutes 1.2 percent of the state's population. The district has population density of 755 persons per sq.km. Which is very high compared to 689 of the state population density. The annual exponential growth rate of district during 2011-2011 is 2.1 percent. About thirteen percent of the total population lives in urban area compared to 20.8 percent of the state. The sex ratio of the district is 940 females per 1000 males.

Basic Demographic Indicators of Faizabad District, Uttar Pradesh			
Indicators	**Uttar Pradesh**	**Faizabad**	**Sohawal**
Population	166,052,859	2,087,914	322631
Average Annual Exponential Growth Rate (2001-2011)	2.3	2.1	-
Population Density (per sq.km.)			
Sex Ratio (females per 1000 males)	689	755	869
Percent Urban	898	940	947
Percent Scheduled Castes	20.8	13.5	-
Percent Scheduled tribes	21.1	22.6	26.1
Percent of Literate Population age 7+ years	0.1	0.0	0.001
Persons	57.4	57.5	46.3
Male	70.2	70.7	63.4
Females	43.0	43.4	36.1
Source: Census of India, 2011, Uttar Pradesh			

Scheduled castes and scheduled tribes constitute 22.6 percent of the population of district, which is higher as compared to the state's percentage (21.2 percent). The literacy rate of population (population aged 7 or more) of district is 57.5 percent, with 70.7 percent for the males and 40.4 percent for females. The literacy rate in district is more or less same as that of state.Sohawal is the study area and basic indictors are presented herewith.

6. Sample Design and Sample Size

A two-stage sample design was adopted. First, a list of all SHGs in all Gram Panchayats was prepared with the Help of NABARD, Lucknow and PANI Sansthan, Faizabad. Self Help Groups in selected Gram Panchayats were alphabetically arranged and all self help groups were interviewed which are 184 in selected gram panchayats. Study of only women self help group was done. Women in the age group 21-45 were selected for study purpose because generally married women in villages are SHG members and even if they are married at an earlier age, they join SHGs after three to four years of marriage. The ages of women have been cross-checked with the registers maintained by them for recording proceedings of meetings and revolving fund, and then from each self help group, women were selected by probability proportional to size of self help groups. In total data were collected from 341 women members of self help group members and one woman rejected from participating in the interview which gives a final sample size of 340 SHG members. SHG chairperson has not been considered in women sections as they have been interviewed as citizen leaders according to definition. At the most, four visits were made for contacting a respondent.

7. Data Collection and Interview Schedule

The data were collected in two phases: First quantitative data with the help of semi-structured interview schedule. It was analysed and gaps which were not possible to be analysed with the quantitative data, were included in the qualitative phase. As it has been proposed that focus group discussion will be done with at least one self help group in each gram Panchayat to understand the process of group formation and their health status strengthening and one case study of a woman who has excelled highly with the help of self help group and who has taken loan for health care at the time of their critical health needs.

The data was collected on the following characteristics: Background Characteristic of Self Help Group Women-Type of savings and utilization of loans, Housing Characteristics of Women, Age at marriage and Reproduction, Contraception and Fertility Preferences, Knowledge of Antenatal and Natal Care, Immunization and Child Care, RTI/STI and Awareness about HIV/AIDS, Capacity Building, leadership Development and Social Capital for Reproductive and Child health and Case study were also done as a tool for support for quantitative data analysis and the necessary permission were taken for research & publication and ethical issues were read out to the participants of the data collection process.

8. Analysis and Findings

8.1. Background Characteristics of Self Help Group Women

Background Characteristics	Percentage of Women	N
Age of SHG Women		
21-25	7.1	24
26-29	16.2	55
30-34	26.5	90
35-39	28.5	97
40-45	21.8	74
Religion of household head		
Hindu	89.1	303
Muslim	10.3	35
others	0.6	2
Caste of the women		
SC	49.4	168
ST	2.9	10
OBC	38.5	131
General	9.1	31
type of family		
nuclear	54.4	185
joint	45.6	155
Type of house		
Hut	15.3	52
tiled roofs	35.6	121
Mud walls with thatched roofs	16.5	56
Pucca	32.6	111
main source of lighting		
Electricity	78.5	267
(Kerosene oil Bio-Gas/hand Pump/LPG)	21.5	73
availability of separate latrine room		
Own flush toilet	5.6	19
No facility/bush/field	94.4	321
availability of separate room for kitchen		
yes	37.9	129
no	62.1	211
Source of Drinking Water		
Hand Pump	54.7	186
Others	45.3	154
Mean Time in Fetching Water (Min.)	6.5	
Total	340	

Table 1: Background and Housing Characteristics of Sampled Social Network of Self Help Group Women (SHG), Sohawal, Faizabad, U.P., 2006

It was found that highest 28 percent women are found in the age group of 35-39. In the age groups of 21-25 and 26-29 women are found to be 7.1 and 16.2 percent respectively. Among the religious groups 89 percent women are Hindus while 10.3 percent are Muslims. Scheduled castes women are 49 percent followed by 38.8 percent other backward caste women.54.4 percent are living in nuclear families. From the housing characterisitcs of these women, it is clear that 32.6 percent women live in pucca houses while 15.3 percent women are living in huts. Main source of lighting of 78.5 percent households is electricity and only 5.6 percent women have flush toilets in their households. Separate kitchen rooms are found in only 37.9 percent of the households, 54.7 percent women are having hand pumps in their houses. Means number of rooms per households is 2.3. For the women who do not have hand pumps in their households, mean time in fetching water is 6.4 minutes. Therefore, socio-economic and demographic differentials prevail among SHG women and the sample is dominated by Hindu women. Main source of lighting is though electricity and large chunk of households do not have toilet facilities in their home.

8.2. Economic Status of Self Help Group Women in the Social Network

Understanding the economic characteristics of SHG women is very important.24.7 percent women have no agricultural land, 70.6 percent women have marginal land. No woman is either a medium or large farmer family. 19.1, 59.1 and 21.8 percent of the women are in the low, medium and high standard of living categories respectively. It appears that due to the effect of social network of Self help group women has passed to the medium category of standard of living from low which shows a very good impact of SHGs on women's SLI. This is also supported by the mean monthly income of women and their families mean monthly income. Current mean monthly income of women is Rs.770.00 pm which is nearly twice to that of before joining SHGs. Also, mean monthly income of women have gone up from Rs.1360.00 pm to Rs.1953.00 pm after joining SHGs. It shows that there is a

great acceptance of SHGs among women. It is therefore obvious that after joining SHGs, mean monthly income of families have gone and this is the economic advantage of network formation.

Characteristics	Percentage	N
Own Agricultural Land		
No Land	27.4	93
Marginal (< 13 Bigha)	70.6	240
Small (13-30 Bigha)	2.1	7
Medium and Large	-	-
Standard of living		
Low	19.1	65
Medium	59.1	201
High	21.8	74
Current Monthly Income (Rs.)		
No Income	54.4	185
0-1000	20.9	71
1001-2000	14.4	49
2001+	10.3	35
Current Family Income (Rs.)		
<=1000	37.1	126
1001-2000	39.4	134
2001+	23.5	80
Current Mean Monthly Income (Rs.)	770.44	340
Current Family Monthly Income (Rs.)	1953.82	340
Mean Monthly Income-Before Joining SHG (Rs.)	368.61	340
Mean Family Monthly Income-before Joining SHG (Rs.)	1316.61	340
Total	340	

Table 2: Economic Status of Self Help Group Women in Social Network, Sohawal, Faizabad, U.P., 2006

No woman is either a medium or large farmer family. 19.1, 59.1 and 21.8 percent of the women are in the low, medium and high standard of living categories respectively. It appears that due to the effect of social network of Self help groups of women has passed to the medium category of standard of living from low which shows a very good impact of SHGs on women's SLI. This is also supported by the mean monthly income of women and their families mean monthly income. Current mean monthly income of women is Rs.770.00 pm which is nearly twice to that of before joining SHGs. Also, mean monthly income of women have gone up from Rs.1360.00 pm to Rs.1953.00 pm after joining SHGs. It shows that there is a great acceptance of SHGs among women. It is therefore obvious that after joining SHGs, mean monthly income of families have gone up for marginalized sections of society.

8.3. Educational Status of Self Help Group Women of the Social Network

Younger women are literate than older women. It appears that there is an increasing trend in education among women in self help groups.12.5 percent in age group 21-25 are educated high school and above. Highest 27.3 percentage women have completed their middle level of schooling in the age group 26-29 and the same is true with 10.0 percentages of women in the age group of 30-34. 77.6 percent Hindu women are illiterate and among the educated Hindu women 10.2 percent women have completed their middle level schooling. Highest 83.3 percent women are illiterate. Largest 29 percent general category women have completed their middle level schooling. There is not much difference is the type of family women are living, by the educational category of women. Though largest 5.8 percentages of women educated high school and above are living in joint families. The findings support that with the increase in the ownership of agricultural land, education of women also improve.57.1 percent of women with small land holding completed their middle level schooling.73 percent illiterate women have no current monthly income and 83.1 percent of illiterate women have current monthly income of less than Rs.1000.00 pm while there is no significant difference in monthly income of illiterate women with Rs 1000-2000 pm and for women with Rs 2000 or more. As expected, largest 84.6 percent women are in low SLI. High SLI women are highly educated with high school or more. Therefore, it is clear that education has substantial impact on socio-economic status of women. Strikingly, development of SHG from lower status of women shows that even without education, women can be better on many socio-economic indicators.

Characterisitcs	SHG Women Education				
	Illiterate	Primary Complete	Middle Complete	High School & Above	Total
Age Group					
21-25	45.8	25.0	16.7	12.5	24
26-29	61.8	9.0	27.3	1.8	55
30-34	74.4	8.9	10.0	6.7	90
35-39	85.6	3.1	7.2	4.1	97
40-45	89.2	5.4	5.4	-	74
Religion					
Hindu	77.6	7.9	10.2	4.3	303
Muslims	71.4	2.9	22.9	2.9	35
Others	50.0	50.0	-	-	2
Caste of Women					
SC	83.3	6.5	8.3	1.8	168
ST	70.0	10.0	10.0	10.0	10
OBC	74.0	9.2	11.5	5.3	131
General	54.8	6.5	29.0	9.7	31
Type of Family					
Nuclear	78.4	7.6	11.4	2.7	185
Joint	74.0	7.7	11.6	5.8	155
Own Agricultural Land					
No Land	77.4	5.4	11.8	5.4	93
Marginal (< 13 Bigha)	78.3	7.9	10.0	3.8	240
Small (13-30 Bigha)	14.3	28.6	57.1	-	7
Monthly Income (Rs.)					
No Income	73.0	8.6	13.5	4.9	185
<1000	83.1	7.0	7.0	2.8	71
1001-2000	79.6	4.1	14.3	2.0	49
2000+	80.0	8.6	5.7	5.7	35
Standard of Living					
Low	84.6	3.1	7.7	4.6	65
Medium	81.6	7.0	9.0	2.5	201
High	56.8	13.5	21.6	8.1	74
Total	261	26	39	24	340

Table 3: Educational Status of Self Help Group Women by their Background Characteristics, Sohawal, Faizabad, U.P., 2006
-: N.A.; No Women are found in Medium and large category

8.4. Socio-Economic and Demographic Differentials among Self Help Group Women in Capacity Building in Reproductive and Child Health

58.5 percent women develop leadership among them. A differential in leadership development of women is found. Women aged 40+ are the largest beneficiary of leadership development programme along with women living in urban areas. It is found that primary level educated women develop highest level of leadership among educated women. The parity of women also has a great impact on leadership development. It is found that women with three or more children have parity-wise the highest development of leadership among them which suggests that leadership development comes among women only with age and over time. Muslim women have developed better leadership than other women who are in the religious category. Primary level schooling completed women have developed highest level of leadership, it appears that in the beginning, women follow and turn to applying the leanings of training programmes who can be developed further as a trainer in leadership development. Therefore, socio-economic and demographic differentials exist in leadership development among women and parity and age is found to be highly affecting the leadership development among women along with rural urban differentials. It is observed that 82.4 percent women have been trained about RCH issues. Age-wise differentials exist. Highest 85.1 percent women in age-group 40+ have received some training on RCH. Strikingly, more rural women than urban received training. It appears that there has been higher need of training to illiterate women who have received training with 84.7 percent followed by women 82.1 percent middle educated women. Highest 84.8 percent Hindu women have attended training programme. Medium SLI women 84.6 percent are the largest participant to these training programmes followed by the women in high SLI (92.4 percent). It further appears that women with large number of issues realize the importance of training importance. Highest 85.2 percent women with three or more issues received training on RCH. Also, it is interesting to find that women with two children are the least participant to these training programmes. Therefore even in the most active women of society in this area, two child norm does not appear to be in adoption though there are other indicators of the society progressing towards such norm.

Characteristics	Leadership Development	N
Age		
21-29	46.8	37
30-39	61.0	114
40+	64.9	48
Place of Residence		
Urban	64.6	31
Rural	57.5	168
Education		
Illiterate	57.1	149
Primary Complete	73.1	19
Middle Complete	59.2	23
High School and Above	57.1	8
Religion		
Hindu	57.8	175
Muslims	62.9	22
Others	100.00	2
Caste of Women		
SC	59.5	100
ST	70.0	7
OBC	56.5	74
General	58.5	18
Standard of Living		
Low	52.3	34
Medium	59.5	120
High	60.8	45
Number of Living Child		
No Child	33.3	6
One Child	47.4	9
Two Child	52.5	31
Three or more Child	37.3	153
Total	58.5	199

Table 4: Social network and leadership Development about Reproductive and Child Health among Women in Self Help Groups of Social Network, Sohawal, Faizabad, Uttar Pradesh, 2006

8.5. Impact of Social Network Building on Current Use of Contraceptives: Results of Ordinal Logit Regression

The impact of availability of the supportive relationships on respondents' contraceptive use is analysed in four steps. First, a baseline model is estimated that considers only socio-economic characteristics of the respondents. In second step, separate model explore the effects of the number of partners in the following networks: receiving money, receiving non-monetary resources and receiving money and/or non-monetary resources. Because the networks of giving money or non-monetary resources to the network partners are very small, only size of summarized networks has been used. The last column in table 5.10 considers the number of all network partners that gave resources to the respondent and/or received resources from her. A third group of estimation explores the influence of the number of multiplex and reciprocal relationship. It is also described in the case study of Ms. Gita how her supportive relationship from NGO and group members have improved her knowledge about various factors affecting RCH and her contribution and extension of her knowledge about contraception to next generation.

The results of baseline model document a strong positive effect of the respondent's age on current contraceptive use for the younger women of 21-29 age groups. A significant effect of womens' education is found as contraceptive use also increases consistently with the education of women. Current monthly income does not show a strong positive effect on women's current contraceptive use. It may be because even contraceptives are freely available from NGOs or ANMs or TBA for networked women. More networked Muslim women are currently using contraceptives than Hindus.

The models for different networks of receiving and giving support have been explored. It is found that a large number of network partners are positively and significantly associated with the current use of contraceptives by SHG women. This especially holds for the number of network partners that gave money to the respondents but also for the partners that received support from her.

Moreover, two constellations of network support enhance the current contraceptive use among SHG women. Either the respondent does not have to face a, probably critical living situation, in which she needs to be supported by her social environment or she is able to cope with such a situation by having a large supportive network partners. The effect of the network of money and/or non-monetary support given to the network partners is similarly explained. However, as in the case when women does not have network partners, effects on contraceptive use is positive means either the respondent is able to concentrate her resources on personal issues and/or she does not have more to spread them on her personal network.

Characteristics	Base Line	Resources Received from network Partner			Resources Given to Network Partners	Complete Supportive Network
		Monetary	Non-monetary	Monetary and Non-monetary both		
Age						
21-29	.161*	-15.73	-1.14	-0.430	6.39*	1.26
30-39	0.662*	1.27	-0.036	-.133	-3.23	7.74**
40+ (R)						
Education						
Illiterate	-0.09	13.46*	-0.64*	.04	-3.02	3.08*
Primary Complete						
Middle Complete	0.54	15.99*	-3.57*	.50	-6.33	4.29**
High School and Above (R)	0.65	-2.64*	.16*	.15	3.26	3.00
Current Monthly Income						
Non Income	-3.91	1.36*	3.72	-1.28*	-6.49*	1.58**
< 2000	-5.41*	16.70	4.69	-7.91	-9.56	1.28*
2000+ (R)						
Religion						
Hindu	.20	30.01*	.24	3.46	-16.01*	1.71
Muslim	.31	26.85	.45	3.75	12.68*	1.66
Others (R)						
Place of Residence						
Urban						
Rural	0.09	1.57	-1.41*	-.81*	3.29*	-1.04**
Network Size						
No NP		-16.73	.66	-.35	12.88	-30.34*
One NP		15.49	4.65	-.40	-3.24	3.51*
More than One NP (R)						
-2Log Likelihood	174.20	1.622	30.74	103.86	53.54	4.26
$\chi 2$	26.07	18.135	59.97	30.85	15.32	48.27
(df)	(12)	(12)	(12)	(12)	(12)	(12)
Pseudo R^2 (percent)	9.9	83.5	61.1	21.2	15.9	92.9
Total	179	179	179	179	179	179

Table 5 Ordered Logit Regression on Current Use of Contraceptives among Women in Self Help Groups: Socio-Economic Characterisitcs and Network Size, Sohawal, Faizabad, Uttar Pradesh, 2006

*NP: Network Partner; R: reference; Note: *-Significant at 5 percent, **- significant at 10 percent*

Link Function: Complementary LogLog, Nagelkerke Pseudo R^2 has been taken

Reference Category: 40+, High School and above, 2000+, others in religion, Rural, more than one NP

8.6. Qualitative Data Analysis

Case Study of Smt. Gita from Sarangapur, Sohawal, Faizabad, Uttar Pradesh, 2006

Gita, 33, from Sarangapur, separated, dedicated to social cause, with a 16 years daughter, working in a local NGO aspires to provide best education to her daughter. Became independent due to SHG membership, learnt through training about RCH care, women empowerment, and panchayat rights. She has given all vaccines to her daughter though have not taken proper ANC because then she was not SHG member. She knows about RTI/STI/HIV-AIDS. As an empowered mother, she has given knowledge of contraception and AIDS to her daughter and is open to discuss sexual issues with her. She keeps herself informed of programmes and policies and was happy when her daughter got Rs.20000.00 after 12^{th} from Govt. to continue her education. She has many good friends in and outside SHG/NGO. She took Rs.5000.00 loan for her daughter's illness. She accords SHG the reason of her happiness and daughter's education though there remains a grumbling due to separation from her husband. Has she not been the member of SHG, she cannot imagine the course of her life!

Therefore, in-depth data analysis shows that development and joining of social network of women has led the women realize their health care goals and they accord a very high to their relationship with the network. It is observed that women feel a lot of happiness in sharing the story of their success in health care achievement through development of social network.

9. Conclusion and Policy Implications

It was found that highest 28 percent women are in the age group of 35-39. Among the religious groups 89 percent women are Hindus while 10.3 percent are Muslims. Scheduled castes women are 49 percent followed by 38.8 percent other backward castes women.54.4 percent are living in nuclear families.

- Mean number of rooms per households is 2.3. For the women who do not have hand pumps in their households, mean time in fetching water is 6.4 minutes.
- The more intensive the exchange of resources is either in terms of Multiplexity or reciprocity, the more she is willing to use contraceptives. It is argued that embeddedness of SHG women as a decision-maker of contraceptive use in her personal social environment has to be considered for a better understanding of contraceptive use related decision-making.
- It is necessary to understand the reason for going away from membership when it is contributing to their health strengthening. Only 20.6 percent SHG women have joined SHG with the sole aim of health strengthening which can be increased.
- Though through SHGs, health care revolving fund is available, only a small 20.6 percent of women are using this which can also be increased.
- Illiteracy among SHG women should be reduced. There is also need of economic empowerment. As very high percentage of women are using withdrawl method and appears to be successful, the method can also be increased.
- Highest 28.8 percent women have been motivated by NGOs to contraceptives use at the time of first use followed by 19.2 percent women by their husbands and 16.9 percent women by friends/relatives and the contribution of TBAs and mothers-in-law is very less. As the contribution TBA and private doctors is very less which needs attention for increasing their role in advocacy for contraceptives for their near and dear ones. Also, religious leaders can play a significant role in advocating the contraception.

10. Policy Recommendations

10.1. Starting the Sustainability Process and its Management at the Local Level

The Problem of civil society of Faizabad district at the village level is that there are a number of village level developmental planning from the governments or other stakeholders for strengthening health care governance in villages. The Panchayati Raj system also appoints democratically elected Pradhan (village headman) and Gram Sabha and Gram Panchayat members at the village level through 73rd constitutional amendment, though the government machinery had vested in them the power to take decisions for their developmental activities but the very functioning of the government machinery, sometime political pressure, muscle power, illiteracy, lack of awareness about the powers and responsibilities vested in them holds back them in participation from planning process at village level.

For making a *sustainable society*, there is a need for developing mechanism which will encourage the participation of villagers, who are ultimate beneficiary of the local development plans.

The *opportunities* are that there always exist some human resources at the village level that are aware, organized and motivated to act for their own development. Since the people have long been deprived of capacity to think and act independently, they have been robbed of faith, confidence and hope in themselves, others and system as well. We need to tap the existing capacities to involve them in the process of their development. One such is the process for forming social network of women in SHGs at the local level in the villages as the as the agent for making plans to recommend to the highest plan formulating authority through local level plan formulating and implementing agencies. SHGs though mostly formed to access the immediate financial gain; it has certainly provided a platform for the villagers to come to a platform to unite and emerge as a successful model for organization of people and therefore promoted by govt. and NGOs at a large scale. As sheer organization generates strength, these SHGs are capable to initiate action for their socio-economic, cultural and political development. Their further capacity is built by mutual learning, training and information sharing. With these qualities, they are the most effective agent to initiate village level development initiative which will be sent to the highest authority to consider for final recommendation and this will really empower villagers to participate in the process of their development planning.

The *Benefits* of forming SHGs at the local village level as the starting point for community participation by assessing their developmental priorities and needs by themselves shall surely motivate, force and build pressure on authorities, when they come through institutionalized groups with some degree of legal authority (73rd Constitutional Amendment Act) and financial independence. Therefore, Social network of SHGs can be an effective medium for Panchayats strengthening and it will lead the villagers from mere 'representation' to their 'presence' in their developmental needs and priorities for health care governance.

10.2. Communication strategy for strengthening Panchayats by involving different local Actors

To bring sustainability in the process of forming local development plans; just forming the SHGs will not suffice unless an effective communication strategy is developed for their awareness and educating them about Panchayati Raj Institutions and roles in empowering local community. The effective communication strategy (Rockefeller Foundation, 1999) for improving the lives of the politically and marginalized deprived people is given by the principles of tolerance, self-determination, social justice and active participation of all. The following heads should be considered to promote public access to health care and Participation in formulation of developmental plans:

- Analyze the need to access to information of PRIs by age, gender, socio-economic status, cultural and geographic location of social network of SHGs by village/block/district.

- Use more inclusive method of dialogue and foster a culture of dialogue among district/block and Gram Panchayat level authorities (both government and democratically elected members of the PRIs who take of health care governance through elected Gram Sabha health committee).
- Empower SHGs, individuals and communities to partake in learning, knowledge action, sharing and use of local resources through and the mechanism created for them.
- Under the PRI information and communication need of the various social network of SHGs, block and district level authorities; enable them for learning the strategy development process and their involvement in its implementation.
- Capitalize on traditional and indigenous knowledge and culture for dissemination of knowledge and education to SHGs.

The communication strategy (See Figure 1) among three actors of local development may be considered in the following steps:

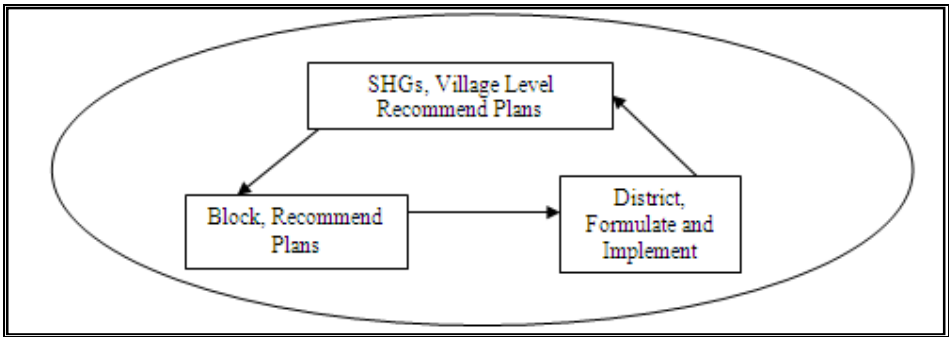

Figure 1: Communication Strategy among Different Local Actors for Plan Formulation and Implementation

- Step1: In each gram Panchayat, form social network of SHGs of people coming from different socioeconomic status and gender, each SHG covering sectoral issues and integrating inter-sectoral issues.
- Step2: These social networks of SHGs will recommend their developmental needs and priorities to democratically elected Gram Pradhans and Gram Panchayat Members who subsequently will recommend this to block level planning and implementing authorities.
- Step3: The block level authorities will recommend this plan to district level authorities for consideration.
- Step4: Establishing a Panchayati Information Resource Center (PIRC) and Involving Citizen Leaders in each gram Panchayat which will educate its citizens and citizen leaders and they can come forward voluntarily to integrate various levels of planning agencies through elected Gram Sabha health committee).

10.3. Recommendation for Local Authority/Government for beginning the development of local Sustainability Indicators

The development of Faizabad District will take place only by the participation of the villagers initially if its SHGs participate in the process of development planning and formulation of plans for health care which will ultimately lead to the development of the Faizabad district. The local authorities should start getting a pulse of the sustainable society development in Faizabad district if following indicators are being seen:

- **Preparation through effective participation:**
- Various stakeholders at the village level like SHGs and citizen leaders and democratically elected members of the Gram Panchayat should be able to identify problems, set priorities, determine their responsibilities and represent them Panchayats developmental planning and formulation.
- **Demand for Decentralization:**
  SHGs and citizen leaders, local NGOs, block and district level Panchayati planning authorities should be trained to facilitate preparation of the local developmental action programmes and be able to build partnerships between government and donors.
- **Participation of Stakeholders of civil society building:**
  Participation and consultation by SHGs, block and district level officials and other CSO in local development planning of gram Panchayat and Gram Sabha.
- **Clear responsibilities**
  Members and chairperson of SHGs and local level development planners should have clear responsibilities for Panchayat development planning and needs
- **Quick Action:**
  SHGs and other NGO should be able to provide concrete, short-term results of Panchayati developmental plans which would give the process a visibility and long term gain.
- **Building on Existing Frameworks:**
  These are various frameworks of village and district level plans; start utilizing these for Panchayat strengthening before bringing in new plans and policies.
- **Role of the Private Sector:**

The private sector and NGOs at the local level should start joining the hands with the formation of the Panchayati developmental plans and district steering committee should involve with themselves the NGOs/private sector stakeholders.

- **Integration with National Policies and Strategies:**
  Role of SHGs of Gram Panchayat should be in affecting the district level developmental plans integrated through 'Bottom –up' approach to national Panchayati Development Plans.
- **Harnessing Local Expertise:**
  The Gram Sabha/Gram Panchayat already have some local expertise to tackle their developmental needs which SHGs should tap and emphasis should be placed on tackling operational and management capacity at the village/local level as well as to promote participatory process. Also, when the role of SHGs in the formulation of the development plans is flexible and adaptable and promotes coordination and vertical and horizontal integration of various programmes, and is dynamic and iterative, it should be considered as a part of sustainability indicators.

Therefore, development of social network strengthens health care governance through democratically elected Gram Sabha Health Committee members and becomes basic to realization of health care through governance.

11. Notes

- **Terms Used in the Paper:**
- **Panchayat (**An Institution of Local Self Government elected under The 73rd Constitutional Amendment, 1992**):** Means an institution of local self-government under article 243B (The 73rd Constitutional Amendment, 1992)
- **Gram Sabha (Elected Village Committee):** means a body consisting of persons registered in the electoral rolls relating to a village comprised within the area of Panchayat at the village level
- **Panchayat Area:** means the territorial area of a Panchayat

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