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**SAVE THE CHILDREN/US
BANGLADESH FIELD OFFICE**

UNIVERSITY RESEARCH CORPORATION/BANGLADESH

**Participation in Women's Savings Groups
and Implications for Health Care Behavior
in Save the Children/US Catchment Areas**

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URC

(Bangladesh)

FINAL

**PARTICIPATION IN WOMEN'S SAVINGS GROUPS
AND IMPLICATIONS FOR HEALTH CARE
BEHAVIOR IN SAVE THE CHILDREN
(USA) CATCHMENT AREAS**

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**Submitted to:
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Preface

Although Bangladesh has achieved considerable success in its family planning program, despite considerable poverty and underdevelopment, there is no room for complacency. In order to achieve the national demographic goals, the program not only has to sustain the current users, but also and quite importantly, bring within its fold the never users and dropouts. Accordingly, there would be need to adopt various "beyond family planning" measures such as improvements in the status of women through women's savings groups, female education, female income-generating activities, etc. Toward this end, Save The Children (USA) has been undertaking an integrated community development program, focussed primarily on improvements in the lives of the women and their household members, including children.

This report is the outcome of untiring efforts of a number of persons, directly and indirectly, involved in this study. I am indebted to Mr. Thomas R. Krift and Mrs. Lisa L. Krift of SC (USA), Dhaka, for their encouragement and support at different stages of the study. I am grateful to Dr. Afzal Hossain, Program Officer (Health), SC (USA), Dhaka, for his critical inputs at various stages of the study. I appreciate the valuable insights and comments of Dr. Joe D. Wray on the draft report. I appreciate the helpful comments on the draft report from Ms. Ruchira Tabassum, Management Information and Research Coordinator, SC (USA), BFO, Dhaka.

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Barkat-e-Khuda, Ph.D.

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LIST OF ABBREVIATIONS

BFO	: Bangladesh Field Office
CPR	: Contraceptive Prevalence Rate
FP	: Family Planning
FWC	: Family Welfare Center
GOB	: Government of Bangladesh
IUD	: Intra Uterine Device
NGO	: Non-government Organization
ORS	: Oral Rehydration Solution
PMIS	: Project Management Information System
SAVE	: Save the Children (USA)
SC	: Save the Children (USA)
SN	: Sample Number
TB	: Tuberculosis
THC	: Thana Health Complex
TT	: Tetanus Toxiod
URC(B)	: University Research Corporation (Bangladesh)
WSG	: Women's Savings Group

EXECUTIVE SUMMARY

INTRODUCTION

In rural Bangladesh, women are traditionally subordinated and disadvantaged. However, it is argued that the involvement of rural women in income-generating activities alongside functional literacy and the use of primary health care facilities would enthruse certain degree of economic and social independence among them, that would help raise their consciousness, enhance their ability to think, and thereby ensure them a greater role in the household decision-making process. Recognizing this fact, Save The Children (USA) is implementing an integrated community based development program which is focussed on Women's Savings Groups as the key forum for development interventions. The major sectoral activities are in primary health care, economic development/sustainable agriculture and education. Through Women's Savings Groups (WSGs), Save The Children (USA) targets poor women, providing training, technical assistance and some service delivery to increase their family income, improve health and nutrition, and enhance awareness.

According to recent statistics, SC is currently operating in 10 (ten) unions under four thanas (Nasirnagar, Rangunia, Mirzapur, and Ghior) of Bangladesh, covering a total population of 76,041.

OBJECTIVES OF THE STUDY

The overall objective of the study was to investigate into the motives and factors that influence women's participation/non-participation in WSGs in the four project areas, as well as their (motives' and factors') implications/influences/relationship with health care behavior in terms of sustainability. The specific objectives of the study were to: (i) identify the characteristics of the respondents (WSG participants, dropouts, and never participants) and their husbands, e.g., age, number of children, education, occupation, religion, land ownership, adequacy of family income, husband's attitude toward wife's involvement in WSGs/income-generating activities, family health status, etc; (ii) determine the knowledge of, and attitudes toward, e.g., ideal family size, female age at marriage, familial harmony, desire for more children, sex preference for children, felt health needs, food needs for pregnant and lactating mothers, ages at which babies should be given weaning food/solid food/green leafy vegetables, etc.; (iii) understand the behavior and practices of the respondents, e.g., contraceptive behavior, pregnancy status, parental vs. husband's status, female education, religiosity, treatment in case of diseases, female mobility, role in family decision-making, practice regarding TT vaccine and immunization of children, use of ORS, schooling of children, etc.; (iv) determine the incentives/disincentives (direct or indirect), which motivate women to participate or not to participate in WSGs; (v) assess whether the motives and characteristics of WSG participants have any influence (direct/indirect) on health care behavior/service utilization, as well as their participation in health care system; and (vi) ascertain the feasibility of attaining sustainable health care goals (behavioral and institutional) through WSG as an institution, considering the motives and characteristics of the WSG members.

METHODOLOGY

Keeping in view the objectives of the study, it was decided that there would be three groups of respondents: WSG participants, dropouts, and never participants, to be selected from the four project areas.

Regarding the selection of sample, two different strategies were followed: one for WSG participants, and another for dropouts and never participants.

First, it was decided that the WSG participants would be selected, using proportionate stratified random sampling procedure to ensure adequate representation to the four project areas. In 1990, SC was covering a total population of 52,000 of which 44.2 percent, 25.0 percent, 11.5 percent, and 19.2 percent respectively were from Nasirnagar, Rangunia, Mirzapur, and Ghior (Khuda et al., 1990a). Using the formula proposed by Fisher et al.,(1991), the optimum sample size for a population of about 10,000 households becomes 278. Proportionate distribution of this optimum sample size (278) yielded 123, 70, 32, and 53 participants respectively for Nasirnagar, Rangunia, Mirzapur, and Ghior Thanas. Using the SC PMIS as the sample frame, the required sample of participants was randomly selected from among the WSG participants of the four project areas.

Second, assuming that the dropouts and the never participants each are homogeneous populations, a randomly drawn sample of 30 from each of the project areas for each of the two categories of respondents would be representative of their universe. Thus, the sample size for the dropouts and the never participants each was 120 (30 randomly selected respondents x 4 project areas). While the SC PMIS was used as the sample frame for the dropouts, the register maintained at the field SC office was used as the sample frame for the never participants. However, it may be pointed out that the PMIS sample frame for the dropouts yielded a total of 25 dropout cases from Ghior impact area, instead of the desired minimum of 30 for that area. Thus, the total sample size for the dropout category was 115 instead of 120.

Taking the three categories together, the total number of respondents covered by the study was 513.

FINDINGS AND IMPLICATIONS

An important methodological point to note is that viewed from socioeconomic indicators such as landownership, level of adequacy of income, occupational structure, education, and materials used for dwelling units the participants are certainly less well off than the other two groups. This implies that while comparing the health-related attitude and behavior of these groups, proper cautions shall have to be considered. Also, considering the relatively disadvantaged socioeconomic background of the WSG participants, almost equal degree of the relative value of this group in terms of health-related attitude or behavior with the other groups, especially with the never participants, should be treated as a sign of behavioral progress among the WSG participants.

The WSG participants and the dropouts are about the same age, and they are older than the never participants. The probability of participating in WSGs is higher among the currently married women and women having higher number of children. Socioeconomically disadvantaged group of women, i.e., the relatively less well-off women are more likely to benefit from participating in WSG.

The proportion of respondents knowledgeable about the special food requirement of the pregnant and the lactating mothers is highest among the participants, while it is lowest among the never participants. Compared to the never participants, higher proportion of the WSG participants intend to educate their children and hold the view that the level of education received by the daughters should be higher than that of the sons. Son preference is less pronounced among the participants than the never participants. Furthermore, compared to the other two categories of respondents lowest proportion of the participants expressed desire for more children.

Contraceptive prevalence is highest among the participants and lowest among the never participants. Again, among the respondents with 4+ living children, contraceptive use is highest among the participants and lowest among the never participants. Also, the participants uses 'clinical methods' to a greater extent than the others. The proportions of respondents taking TT vaccine themselves as well as having their children immunized are higher among the participants than the never participants. The proportions of respondents giving ORS to their children during diarrheal episodes as well as seeking medical doctors' advice in case of sickness are higher among the participants than either of the dropouts or the never participants. The participants have greater role in household decision-making and greater mobility than the never participants.

Taking the knowledge, attitude, and behavior of the respondents into consideration, it appears that women who have higher number of living children, who intend to educate their children, who have lesser desire for additional children, who are using contraceptives, who are utilizing health care facilities, who have relatively higher degree of mobility, etc., are more likely to benefit from WSG participation.

The primary consideration for joining the WSGs is economic: accumulation of savings, meeting various household expenses, etc. This implies that most women join the WSG with the expectation that they would be able to attain some "economic power", thereby improving their status both within the family and the community.

The major factor encouraging dropping out/discontinuation of membership is financial mismanagement of WSGs. This implies that financial management of group funds must be sound; otherwise, group members would dropout. Thus, there is a need to ensure sound financial management of group funds to be not only able to minimize dropout but also attract the never participants to join the group.

The major factor discouraging participation in WSGs is the dislike from husbands/in-laws. So, as part of its program, the SC needs to motivate and educate the husbands and in-laws of the potential benefits of participating in the WSGs. If this is undertaken with all seriousness, it would be possible to overcome their dislike and resistance.

The evidence found in this study indicates that in case the SC decides to phase out, it would be difficult on the part of the residents of its catchment areas to be able to sustain their health behavior. However, there are also some positive indications. Most of the participants, having received training in health and family planning, might be able to sustain some of the health care services currently provided by the SC. Also, a higher proportion of the participants compared to the other two groups have contacts with the health and family planning service providers. The proportion helping others in establishing contacts with the health service providers is higher among the participants than the others. Health-related topics are widely discussed in the WSG meetings, thereby helping raise health-related consciousness among the members. A very high proportion of the members also disseminate knowledge acquired in the group meetings with the non-members, thereby indicating that they help raise health-related consciousness in the community in general.

The community members, in general, seek medical advice in times of sickness. The proportions seeking such advice as well as using ORS and deworming medicines were higher among the WSG participants, suggesting that in the event of the SC withdrawing from the area the WSG participants would be more able than the community members to take care at least some of the essential health-related needs. However, the degree to which the WSG participants would be able to take care of some of their essential health-related needs in the event of the SC withdrawing of the area varies by characteristics of the participants. For example, the proportion seeking medical advice was highest among those aged 30-39 years, those with no schooling, and those with no household land ownership. Thus, in case the SC decides to withdraw from the area, it should ensure that the other participant groups as well as the community in general are able to take care of their essential health-related needs; otherwise, at least some of the SC's past efforts and resources would be considered not to have yielded the desired result.

CHAPTER 1

BACKGROUND

1.1 Introduction

In rural Bangladesh, women are traditionally subordinated and disadvantaged. However, it is argued that the involvement of rural women in income-generating activities alongside functional literacy and the use of primary health care facilities would enthruse certain degree of economic and social independence among them, that would help raise their consciousness, enhance their ability to think, and thereby ensure them a greater role in the household decision-making process. Recognizing this fact, Save The Children (USA) is implementing an integrated community based development program which is focussed on Women's Savings Groups as the key forum for development interventions. The major sectoral activities are in primary health care, economic development/sustainable agriculture and education. Through Women's Savings Groups (WSGs), Save The Children (USA) targets poor women, providing training, technical assistance and some service delivery to increase their family income, improve health and nutrition, and enhance awareness.

According to recent statistics¹, SC is currently operating in 10(ten) unions under four thanas (Nasirnagar, Rangunia, Mirzapur, and Ghior) of Bangladesh, covering a total population of 76,041.

1.2 SC's Women's Savings Groups

SC's women's program began in 1975 by offering family planning services only. The integration of other activities began in 1978, when the SC field staff became development agents. Savings groups were introduced on an experimental basis in 1982 in 13 villages of Nasirnagar, Mirzapur, and Ghior Thanas, and in 4 villages of Rangunia Thana in 1986. In Nasirnagar, additional villages were brought under the program in 1989. According to another recent statistics² as of 31st March 1993, SC was conducting, in the four selected thanas, a total of 383 Women's Savings Groups(WSGs), involving a total of 6,837 members in the WSGs.

All of SC's impact area residents are entered into the PMIS through a family registration system, and categorized by socioeconomic groups: A/B are the better-off households, while C/D are the poorest ones. Women in the C/D groups are targeted for interventions through WSGs. At present, on average, there are 18 members per WSG.

In Bangladesh, targeting poor women through women's groups has proven to be an effective strategy of women's empowerment and advancement. The group provides a forum for training and resource transfer in primary and maternal health care, income generation, and education, as well as awareness raising. The

¹ *An official document obtained through personal communication.*

² *An unpublished document.*

group acts as a support network, providing not only knowledge and resources but also the encouragement needed to undertake new activities and introduce new practices in the community. The group mechanism offers an efficient means of reaching a large number of target women (and their children), and provides them with a forum for discussions and decision-making on issues affecting their well-being and status within the family and the community. Studies of the Bangladesh Field Office's (BFO) experience has shown that participation in WSGs is associated with lower rates of mortality among girl children, higher contraceptive prevalence rates, and greater participation in the household decision-making (Khuda et al., 1990a).

Over the years, these indigenous small groups have evolved from simple "savings" groups to dynamic forums to improve the women's economic and social horizons, and enabled them to gain greater control over their lives and those of their children. However, it is also acknowledged that all the women in SC program areas are not becoming WSG members, and research findings suggest that some of the old members are discontinuing their membership with WSGs (Khuda et al., 1990b). Thus, it is considered appropriate to investigate into the motives and factors that influence women's participation/non-participation in WSGs in the four project areas, as well as their (motives' and factors') implications/ influences/relationship with health care behavior in terms of sustainability. Such a study would help identify the motives and factors which distinguish participants, never participants, and dropouts in respect of their behavioral pattern. Also, the study would provide insights about sustainability of the women's program, after the involvement of SC is phased out.

1.3 Objectives of the Study

The specific objectives of the study were to:

- (i) identify the characteristics of the respondents (WSG participants, dropouts, and never participants) and their husbands, e.g., age, number of children, education, occupation, religion, land ownership, adequacy of family income, husband's attitude toward wife's involvement in WSGs/income-generating activities, family health status, etc.;
- (ii) determine the knowledge of, and attitudes toward, e.g., ideal family size, female age at marriage, familial harmony, desire for more children, sex preference for children, felt health needs, food needs for pregnant and lactating mothers, ages at which babies should be given weaning food/solid food/green leafy vegetables, etc.;
- (iii) understand the behavior and practices of the respondents, e.g., contraceptive behavior, pregnancy status, parental vs. husband's status, female education, religiosity, treatment in case of diseases, female mobility, role in family decision-making, practice regarding TT vaccine and immunization of children, use of ORS, schooling of children, etc.;
- (iv) determine the incentives/disincentives (direct or indirect), which motivate women to participate or not to participate in WSGs;

- (v) assess whether the motives and characteristics of WSG participants have any influence (direct/indirect) on health care behavior/service utilization, as well as their participation in health care system; and
- (vi) ascertain the feasibility of attaining sustainable health care goals (behavioral and institutional) through WSG as an institution, considering the motives and characteristics of the WSG members.

1.4. Limitations of the Study

Unlike in an indepth, qualitative study, a study primarily based on survey type questionnaires suffers from several shortcomings. For example, responses to questions are often pre-coded, thereby being unable to reproduce verbatim what the respondents actually reported. Thus, such studies are less insightful compared to in-depth, qualitative studies. Also, and quite importantly, many of the explanations cannot be fully obtained. Nevertheless, studies based on survey data are useful in several ways. They help estimate, for example, prevalence and incidence of an event, which, often, is quite important in a research of this type.

CHAPTER 2

METHODOLOGY

2.1 Study Design

Keeping in view the objectives of the study, it was decided that there would be three groups of respondents: WSG participants, dropouts, and never participants, to be selected from the four project areas.

2.2 Sample Selection

Regarding the selection of sample, two different strategies were followed: one for WSG participants, and another for dropouts and never participants.

First, it was decided that the WSG participants would be selected, using proportionate stratified random sampling procedure to ensure adequate representation to the four project areas. In 1990, SC was covering a total population of 52,000 of which 44.2 percent, 25.0 percent, 11.5 percent, and 19.2 percent respectively were from Nasirnagar, Rangunia, Mirzapur, and Ghior (Khuda et al., 1990a). Using the formula proposed by Fisher et al.,(1991), the optimum sample size for a population of about 10,000 households becomes 278. Proportionate distribution of this optimum sample size (278) yielded 123, 70, 32, and 53 participants respectively for Nasirnagar, Rangunia, Mirzapur, and Ghior Thanas. Using the SC PMIS as the sample frame, the required sample of participants was randomly selected from among the WSG participants of the four project areas.

Second, assuming that the dropouts and the never participants each are homogeneous populations, a randomly drawn sample of 30 from each of the project areas for each of the two categories of respondents would be representative of their universe. Thus, the sample size for the dropouts and the never participants each was 120 (30 randomly selected respondents x 4 project areas). While the SC PMIS was used as the sample frame for the dropouts, the register maintained at the field SC office was used as the sample frame for the never participants. However, it may be pointed out that the PMIS sample frame for the dropouts yielded a total of 25 dropout cases from Ghior impact area, instead of the desired minimum of 30 for that area. Thus, the total sample size for the dropout category was 115 instead of 120.

Taking the three categories together, the total number of respondents covered by the study was 513 (Table 2.1).

TABLE 2.1: NUMBER OF RESPONDENTS BY CATEGORIES AND PROJECT AREAS

Areas	Respondent Categories			Total
	Participants	Dropouts	Never participants	
Nasirnagar	123	30	30	183
Rangunia	70	30	30	130
Mirzapur	32	30	30	92
Ghior	53	25*	30	108*
Total	278	115	120	513*

* *Nine(9) of the dropout cases (as identified from the PMIS sample frame) from Ghior impact area were not available for interview for the following reasons: three cases (SN. 480, 481, 482) left the place for parental home, two cases (SN. 477, 478) migrated to some other area, two cases (SN. 479, 483) left the place after marriage, one (SN.475) had died, and another one (SN.476) went to her sister's house and did not return during the period of data collection. Because of these nine ineligible cases, the actual size of dropout cases was 106, resulting in an overall sample size of 504 instead of 513.*

2.3 Variables studied

The variables and their indicators covered in this study are presented in Table 2.2.

2.4 Data Collection Instruments

One set of questionnaire was used for interviewing the respondents from the three categories, keeping provisions for adequate skipping instructions for the three different categories of respondents. The questionnaire was finalized in consultation with the SC personnel, and translated into Bangla for actual administration by the field interviewers (the Questionnaire presented in Annex A).

During the questionnaire preparation stage, it was also decided that in order to be able to obtain a more comprehensive picture related to sustainability issues, additional information will be collected, using two other instruments: an Indepth Interview Guide and a Checklist (information in the Checklist was collected by Study Group-1: Study on Health Services Utilization). The Indepth Interview Guide was used to interview selected community leaders (members/chairman), and SC workers/leaders of WSGs.

TABLE 2.2: STUDY VARIABLES AND THEIR INDICATORS

Variables	Indicators
01. Respondent Types.	1.1. WSG participants. 1.2. Dropouts (participants who discontinued membership with WSG). 1.3. Never participants.
02. Characteristics of the Respondents and their husbands.	2.1. Age. 2.2. Education, Occupation, Religion. 2.3. Land ownership, Adequacy of income, Type of dwelling units. 2.4. Marital status, Pregnancy status. 2.5. Number of children, family size norm.
03. Knowledge, Attitude, and Practice.	3.1. Ideal family size. 3.2. Female age at marriage. 3.3. Familial harmony. 3.4. Knowledge about giving colostrum to a new-born baby. 3.5. Husband's attitude toward wife's involvement in WSG/income-generating activities. 3.6. Desire for children, gender preference for children. 3.7. Schooling of children. 3.8. Contraceptive behavior. 3.9. Health-related practice. 3.10. Religiosity. 3.11. Female mobility. 3.12. Household decision-making. 3.13. Parental vs. husband's status.
04. Incentives/disincentives motivating participation or non-participation in WSGs.	4.1. Accumulation of enough money through deposits with savings group. 4.2. Opportunities of taking loans from the savings group in times of need. 4.3. Meeting educational expenses of children. 4.4. Meeting costs of medical treatment. 4.5. Opportunities to use the money to meet such important household expenses as marriage of daughters, etc. 4.6. Trust/confidence in the financial management of WSGs.

contd...

Table 2.2 (contd.)

Variables	Indicators
	<p>4.7. Opportunities to use the accumulated savings for investment purposes.</p> <p>4.8. Opportunities to acquire knowledge on various subjects such as family planning methods, child care, various income-generating activities, etc.</p> <p>4.9. Enhanced status in the family as a result of their "economic" power.</p>
<p>05. Influence of motives and characteristics of WSG participants on health care behavior.</p>	<p>5.1. Nature of motives: primary or secondary.</p> <p>5.2. Awareness level related to the age at which babies should be given weaning food.</p> <p>5.3. Awareness level related to the age at which babies should be given green leafy vegetables.</p> <p>5.4. Awareness level with respect to the food needs of pregnant and lactating mothers.</p> <p>5.5. Awareness about immunization of young children (two years of age or less).</p> <p>5.6. Developing the habit of visiting clinic, when a member of the family needs medical attention (instead of going to the quack or kabiraj).</p>
<p>06. Feasibility of attaining sustainable health care goals through WSG.</p>	<p>6.1. The extent to which SC's existing role can be taken over by WSG, i.e., whether WSG, as an institution, is capable of mobilizing local resources to ensure health care services, and whether WSG facilitates the linkage between the target population and the service providers.</p>

CHAPTER 3

CHARACTERISTICS OF THE STUDY POPULATION

One of the major objectives of the study was to assess the degree to which the characteristics of the WSG participants, the dropouts, and the never participants are similar/dissimilar.

3.1 Demographic Characteristics

The demographic variables covered in this study include age, marital status, number of children, and pregnancy status.

3.1.1 Age

The mean age of the respondents ranged between 30 and 34 years, with dropouts being the oldest and never participants being the youngest (Table 3.1). Mean age of the husbands of the currently married respondents ranged between 38 and 43 years, with the husbands of the dropouts being the oldest and those of the never participants the youngest. Thus, it is evident that both the dropouts and their husbands are the oldest, while both the never participants and their husbands are the youngest.

TABLE 3.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY AGE

Age	Respondent Categories					
	Participants		Dropouts		Never Participants	
	Respondent	Husband	Respondent	Husband	Respondent	Husband
<20	2.2	-	3.8	-	10.0	-
20-29	33.4	8.4	36.8	7.8	42.5	12.5
30-39	36.3	35.8	31.1	41.1	25.0	44.2
40-49	19.4	28.3	14.2	22.2	16.7	23.1
50-59	6.5	15.1	7.5	11.1	5.0	15.4
60 +	2.2	12.4	6.6	17.8	0.8	4.8
N	278	251	106	90	120	104
Mean	33.6	41.6	34.0	42.7	30.2	38.4

3.1.2 Marital Status

The proportion of the currently married women was highest among the WSG participants, while the proportion of unmarried women was highest among the never participants and the proportion of widowed/divorced/separated was highest among the dropouts (Table 3.2). Thus, it appears that the probability of participating in WSG is higher among the currently married women.

3.1.3 Pregnancy Status

Of the currently married women, in each respondent category, about 8 percent were pregnant at the time of data collection (Table 3.2).

3.1.4 Number of Children

The proportion of women having more than three children, both ever born and currently living, was highest among the WSG participants but lowest among the never participants (Table 3.3). This was consistent with the findings of Khuda et al., (1990a).

TABLE 3.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS AND PREGNANCY STATUS

Marital/ Pregnancy Status	Respondent Categories		
	Participants	Dropouts	Never Participants
Marital Status:			
Currently married	90.3	84.9	86.7
Unmarried	-	0.9	2.5
Widowed/ Divorced/ Separated	9.7	14.2	10.8
Total	100.0	100.0	100.0
N	278	106	120
Pregnancy Status			
Yes	7.5	7.7	7.7
No	92.5	92.3	92.3
Total	100.0	100.0	100.0
N	251	90	104

TABLE 3.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY NUMBER OF CHILDREN

Number of children	Participants	Dropouts	Never Participants
<u>Ever born:</u>			
0	2.9	1.0	6.0
1-3	44.2	46.7	49.6
4+	52.9	52.3	44.4
N	278	105	117
Mean	4.1	3.9	3.6
<u>Living children:</u>			
0	3.6	1.9	6.8
1-3	50.0	55.2	59.0
4+	46.4	42.9	34.2
N	278	105	117
Mean	3.6	3.3	3.1

3.2 Socioeconomic Characteristics

The socioeconomic variables covered in this study include religion, land ownership, income, education, and occupation.

3.2.1 Religion

The majority of the respondents (79%) were Muslims, and the proportion of such respondents was highest among the dropouts and lowest among the WSG participants (Table 3.4).

3.2.2 Land Ownership

Less than half of all the respondents belong to household possessing agricultural land. However, landownership was least prevalent among the participants and most prevalent among the never participants (Table 3.4). That is, the probability of participating in WSG is higher among the economically disadvantaged group. This is expected, because the WSG participants, by definition, have been drawn from relatively poor households (C and D categories).

TABLE 3.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY RELIGION, ADEQUACY OF INCOME, AGRICULTURAL LAND OWNERSHIP, AND

Religion, Land Ownership, Income	Respondent Categories		
	Participants	Dropouts	Never Participants
Religion:			
Islam	77.3	86.8	77.5
Hinduism	16.9	9.4	18.3
Buddhism	5.8	3.8	4.2
Total	100	100	100
Land Ownership:			
Yes	40.6	46.2	52.5
No	59.4	53.8	47.5
Total	100	100	100
Adequacy of Income*			
Quite sufficient	5.4	7.6	13.3
Moderately sufficient	53.6	54.7	53.3
Not Sufficient	41.0	37.7	33.4
Total	100	100	100
N	278	106	120

* Refers to the respondents' perceptions as to whether they feel that their household income is sufficient to meet their household expenses.

3.2.3 Income

About two-fifths of the respondents did not have sufficient income, and the proportion of such respondents was highest among the WSG participants and lowest among the never participants (Table 3.4). Similar to land ownership, the probability of participating in WSG is higher among the economically less well-off.

3.2.4 Education

Mean years of schooling of the respondents and their husbands (of those who were currently married) ranged from 1.5 to 2.6, and 3.0 to 4.6 years respectively. While the never participants and their husbands had the highest years of schooling, the WSG participants and their husbands had the lowest years of schooling (Table 3.5). The findings reinforce what has been reported above--the WSG participants are drawn from the socio-economically disadvantaged groups.

TABLE 3.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY YEARS OF SCHOOLING

Years of schooling	Respondent Categories					
	Participants		Dropouts		Never Participants	
	Respondent	Husband	Respondent	Husband	Respondent	Husband
0	70.9	54.2	62.3	52.2	53.4	40.4
1 - 2	6.5	5.2	9.4	4.4	9.2	1.9
3 - 5	12.9	17.1	17.9	20.0	20.8	18.3
6 - 10	9.0	20.3	10.4	13.3	13.3	28.8
10+	0.7	3.2	-	10.0	3.3	10.6
Total	100	100	100	100	100	100
N	278	251	106	90	120	104
Mean	1.5	3.0	1.8	3.3	2.6	4.6

3.2.5 Occupation

The proportion of respondents involved in income-generating activity was highest among the WSG participants (33%), followed by dropouts (25%), and never participants (20%).

Poultry farming and vegetable gardening were the two major income-generating activities in which the respondents were involved. Among those engaged in poultry farming, the proportion was highest among the WSG participants; while among those engaged in vegetable gardening, the proportion was highest among the dropouts (Table 3.6).

TABLE 3.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY OCCUPATION*

Occupation	Respondent Categories					
	Participants		Dropouts		Never Participants	
	Respon- dent	Husband	Respon- dent	Husband	Respon- dent	Husband
Poultry Farming	81.5	--	65.4	--	6.7	--
Vegetable Gardening	40.2	--	46.2	--	33.3	--
Earth Digging	3.3	--	--	--	8.3	--
Domestic Service	3.3	--	7.7	--	8.3	--
Others	21.7	--	15.4	--	4.2	--
Farming	--	27.5	--	30.0	--	31.1
Agr. Wage Labor	--	22.7	--	13.3	--	12.3
Non-Agr. Labor	--	13.5	--	12.2	--	14.2
Petty Business	--	15.9	--	20.0	--	18.9
Trading	--	1.2	--	--	--	1.9
Service	4.3	12.4	3.8	22.2	8.3	17.0
Unemployed	--	5.2	--	2.2	--	4.7
Fisherman/ carpenter Boatman	--	1.6	--	--	--	--
N	92	251	26	90	24	106

* In case of the respondents, it refers to involvement in activities other than normal household duties.

The major occupation of the husbands of the respondents was farming, followed by service, and agricultural wage labor (Table 3.6). While the highest proportion engaged in farming was the husbands of the never participants, the highest proportion engaged in the services sector were the husbands of the dropouts. The occupation "wage labor" (both agricultural and non-agricultural) was more prevalent among the husbands' of the WSG participants than among the other two groups (Table 3.6).

3.2.6. Structure of Dwelling Unit

Compared to the never participants and the dropouts, the WSG participants had relatively lower proportions of pucca/semi-pucca constructions and relatively higher proportion of them had dwelling units constructed with temporary materials straw/bamboo/mud, etc. (Table 3.7), indicating their relative disadvantage in terms of housing condition.

TABLE 3.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY MATERIALS USED IN THE CONSTRUCTION OF DWELLING UNITS

Dwelling Unit: by materials used for construction	Respondent Categories		
	Partici-pants	Dropouts	Never Participants
Pucca/semi-pucca	4.4	4.7	10.8
Tin and bamboo/wood	59.6	68.9	68.4
Chawn/Straw/bamboo/hut etc.	36.0	26.4	20.8
Total	100	100	100
N	278	106	120

The above evidence indicates that the WSG participants and the dropouts are about the same age, and they are older than the never participants. However, the socioeconomically disadvantaged group of women (in terms of landholding, adequacy of household income, and years of schooling) are more likely to benefit from WSG participation.

Thus, an important methodological point to note is that viewed from socio-economic indicators such as landownership, level of adequacy of income, occupational structure, education, and materials used for dwelling units, the participants are certainly less well-off than the other two groups. This implies that while comparing the health-related attitude and behavior of these groups, proper cautions shall have to be taken. Also, considering the relatively disadvantaged socio-economic background of the WSG participants, almost equal degree of the relative value of this group in terms of health-related attitude or behavior with the other groups, especially with the never participants, should be treated as a sign of behavioral progress among the WSG participants.

CHAPTER 4

KNOWLEDGE, ATTITUDE, AND PRACTICE

4.1 Knowledge

The variables covered include knowledge about food needs of pregnant and lactating mothers, ages at which babies should be given weaning food/solid food, green leafy vegetables, and knowledge about giving colostrum to newly-born babies.

4.1.1 Food Needs of Pregnant and Lactating Mothers

Regarding the special food needs of both the pregnant women and the lactating mothers the WSG participants were reported to be more knowledgeable than the never participants and the dropouts (Table 4.1). Considering the relatively disadvantaged socio-economic background of the WSG participants, their levels of knowledge regarding the special food needs for pregnant women and lactating mothers should be treated as a positive effect of participation in the WSGs.

TABLE 4.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR KNOWLEDGE REGARDING WHETHER THE PREGNANT WOMEN AND LACTATING MOTHERS NEED ANY SPECIAL FOOD

Status of knowledge regarding:	Respondent Categories		
	Participants	Dropouts	Never Participants
I. Whether pregnant women need any special food:			
Knows	97.2	95.3	93.3
Doesn't know	2.8	4.7	6.7
Total	100.0	100.0	100.0
II. Whether lactating mothers need any special food:			
Knows	98.2	96.2	97.5
Doesn't know	1.8	3.8	2.5
Total	100.0	100.0	100.0
N	278	106	120

4.1.2 Age at which Babies should be given different Foods

Mean ages at which babies should be given different foods ranged from 4.8 months to 5.1, 10.4 to 11.5, and 8.0 to 8.5 months respectively for weaning food, solid food, and green leafy vegetables (Table 4.2). There were no noticeable differences across the different categories of respondents.

TABLE 4.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY AGE AT WHICH BABIES SHOULD BE GIVEN DIFFERENT FOODS

Age of Babies (in months)	Respondent Categories								
	Participants			Dropouts			Never Participants		
	Wean- ing food	Solid food	Green leafy vege- tables	Wean- ing food	Solid food	Green leafy vege- tables	Wean- ing food	Solid food	Green leafy vege- tables
<5	35.3	2.9	7.9	39.6	1.9	6.6	25.8	0.8	1.7
5-6	54.0	19.1	24.5	45.3	16.0	24.5	58.4	19.2	33.3
7-9	5.0	22.7	23.7	0.9	20.8	31.1	0.8	26.7	25.0
10-12	1.4	38.9	34.9	-	34.0	17.0	0.8	25.8	20.0
13-18	-	4.3	1.1	-	4.7	61.98	-	3.3	1.7
19-24	-	6.5	1.1	-	11.3	1.9	-	9.2	-
25 +	4.3	5.6	6.8	14.2	11.3	17.0	14.2	15.0	18.3
N	278			106			120		
Mean	5.0	10.4	8.5	4.8	11.5	8.2	5.1	10.7	8.0

4.1.3 Knowledge about giving Colostrum to newly-born Babies

Though there was no pronounced difference among the respondent categories in terms of their knowledge as to whether colostrum should be given to newly-born babies, the proportion of women replying in the affirmative was highest among the WSG participants (Table 4.3). This may be treated as positive effect of participation in the WSG.

TABLE 4.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR KNOWLEDGE REGARDING WHETHER COLOSTRUM SHOULD BE GIVEN TO NEWLY-BORN BABIES

Whether colostrum should be given to a newly born	Respondent Categories		
	Participants	Dropouts	Never Participants
Yes	93.5	92.4	92.5
No	4.0	5.7	5.0
Don't know	2.5	1.9	2.5
N	278	106	120

4.2 Attitude

The variables covered include ideal age at marriage for girls, schooling of children, familial harmony, husband's attitude toward wife's involvement in WSG/income-generating activities, desire for children, and gender preference for children.

4.2.1 Ideal Age at Marriage for Girls

The mean ideal age at marriage for girls, as opined by the respondents, should be 18 years. Regarding the ideal age at marriage for the girls there was no difference across the respondent categories (Table 4.4). However, a higher proportion of the participants favor marriage of girls by 20 years of age compared to the other two groups of respondents.

TABLE 4.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY IDEAL AGE AT MARRIAGE FOR GIRLS

Marital Age	Respondent Categories		
	Participants	Dropouts	Never Participants
<18	34.5	33.0	35.8
18-20	58.3	55.7	51.7
21-23	3.6	7.5	7.5
24 +	3.6	3.8	5.0
Total	100.0	100.0	100.0
N	278	106	120
Mean	18.1	18.2	18.2

4.2.2 Schooling of Children

Almost equally high proportions of the respondents of all three categories expressed their intention to educate their children. However, the proportion of such respondents was highest among the WSG participants (Table 4.5). This apparently positive attitude may be ascribed to their participation in WSG.

TABLE 4.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR INTENTION TO EDUCATE THEIR CHILDREN

Intention	Respondent Categories		
	Participants	Dropouts	Never Participants
Yes	96.0	95.2	94.0
No	4.0	4.8	6.0
Total	100.0	100.0	100.0
N	278	105	117

Furthermore, about eighty percent of the WSG participants compared to about seventy-one percent of the never participants reported that the level of education received by the daughters should be higher than or equal to that of the sons (Table 4.6). This is in contrast with the general belief that the rural Bangladeshi women give higher weightage to the education of their sons. Also, this may be treated as a positive effect of the SC's intervention. As a result of their exposure to the SC's program, the women have learned that education helps expand their horizon of knowledge and consciousness. Particularly, educated women are in a better position to take care of the health and education of their children. Moreover, compared to the illiterate women, educated women have better income-earning opportunities. This economic power gives them a greater role in household decision-making. This is, perhaps, the reason why the women in the SC catchment areas give more weightage to the education of their daughters.

The mean number of children attending school/attended school in the past was 1.7 for the participants, 1.6 for the dropouts, and 1.5 for the never participants (Table 4.6). Considering the mean number of living children, which is slightly higher among the participants than the others (Table 3.3), the above differences in mean schooling should not be treated as difference. However, considering the socio-economically disadvantageous situation of the WSG participants, the responses of the participants should be considered more positive than the others for both the mean number of children attending/attended schools and the perceptions related to female education.

TABLE 4.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR ATTITUDE TOWARD FEMALE EDUCATION AND MEAN NUMBER OF CHILDREN ATTENDED/ATTENDING SCHOOL

Daughter's education should be:	Respondent Categories		
	Participants	Dropouts	Never Participants
Equal to son	12.9	13.2	8.3
Higher than son	66.6	64.2	62.5
Lower than son	20.5	22.6	29.2
Total	100.0	100.0	100.0
Mean number of children attended/attending schools	1.7	1.6	1.5
N	278	106	120

4.2.3 Familial Harmony

Ascertaining the extent and nature of familial harmony in a family is difficult in this type of a study. However, some direct questions were asked to the respondents. A better way of interpreting the responses would be to analyze the categorically negative answers, example, "no peace at all", or "little peace". About 11 percent of the WSG participants compared to about 16 percent of the never participants reported "little/no peace at all" in the family (Table 4.7). Thus, the situation regarding familial harmony is likely to be better for the WSG participants than the never participants.

TABLE 4.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY DEGREE OF FAMILIAL HARMONY

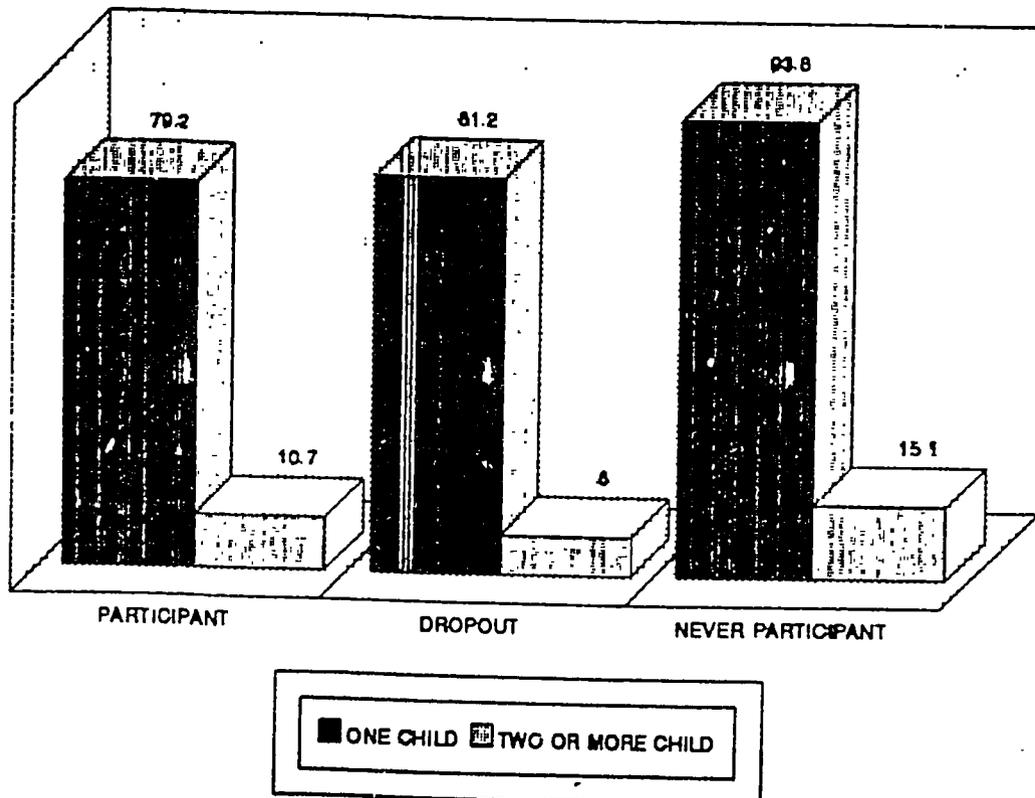
Degree of Familial Harmony	Respondent Categories		
	Participants	Dropouts	Never Participants
To a great extent	14.7	17.0	19.2
Moderate	74.5	75.5	65.0
Little	7.9	4.7	12.5
No peace at all	2.9	2.8	3.3
Total	100.0	100.0	100.0
N	278	106	120

4.2.5 Desire for More Children

Of the currently married women who did not undergo sterilization the proportion expressing desire for additional children was lowest among the participants and highest among the never participants (Table 4.10). Although the reverse was true with respect to the number of surviving children (see Table 3.3), the difference being quite small, it can be argued that the relatively lower proportion expressing desire for additional children among the participants may have resulted from their participation in the WSGs. The mean ideal family size norm expressed by all the categories was similar, 2.5 children (Table 4.10). Thus, the gap between the expected family size (actual plus the desired) and the perceived ideal size was lower among the participants than the never participants, implying a real attitudinal change among the WSG participants.

Generally, a higher proportion of the respondents having one child expressed desire for additional children and the highest proportion of such respondents were the never participants (Figure 4.1). Also, the desire for additional children decreased with the increase in number of living children and, compared to the never participants, relatively lower proportion of the WSG participants desired so (Figure 4.1).

FIGURE 4.1: PERCENTAGE DISTRIBUTION OF THREE CATEGORIES OF RESPONDENTS HAVING DESIRE FOR ADDITIONAL CHILDREN BY NUMBER OF LIVING CHILDREN



4.2.6 Gender Preference for Children

Though the majority of the respondents of all categories expressed their preference for son, the proportion desiring daughter was highest among the WSG participants and lowest among the dropouts (Table 4.10). This was consistent with the findings of Khuda et al. (1990a), indicating reduced son preference among the participants.

4.3 Practice

The variables covered include contraceptive behavior, health-related practice, religiosity, female mobility, household decision-making, and parental versus husband's status.

4.3.1 Contraceptive Behavior

Among the three categories of respondents, the contraceptive use rate was reported to be highest for the WSG participants (43%), followed by the dropouts (37.8%), and the never participants (33.7%) (Table 4.11). This was consistent with the findings of Khuda et al., (1990a), which found that contraceptive use was higher among the WSG members than the non-members. The evidence, thus, suggests that the probability of contraception is higher among the WSG participants.

Among those contracepting at the time of the survey, the pill was the most popular method, followed by tubectomy (Table 4.11). Also, in terms of the use of clinical methods, estimates based on information in Table 4.11, the use rate among the participants was twice as high (more than 20%) compared to the never participants (about 12%). Thus, the participants had not only higher overall contraceptive use rates but also higher use of clinical methods of contraception (see Figure 4.2).

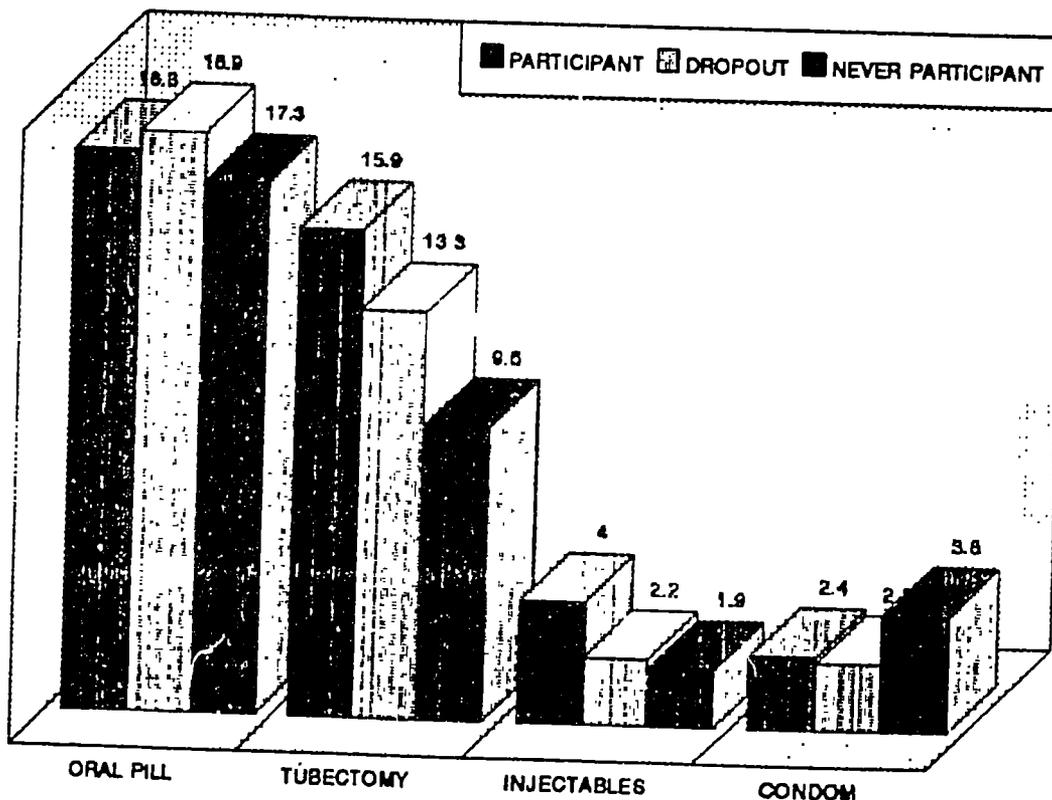
TABLE 4.10: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY DESIRE FOR MORE CHILDREN, GENDER PREFERENCE, AND PERCEPTION ABOUT IDEAL FAMILY SIZE

Desire for more child, sex preference, and ideal family size	Respondent Categories		
	Participants	Dropouts	Never Participants
<u>Desire for more children</u> Yes	25.4	29.3	38.9
Don't know	1.5	1.3	2.2
Total	100.0	100.0	100.0
N	205	75	90
<u>Sex preference for children</u> Daughter	32.3	9.1	25.0
Son	67.7	90.9	75.0
Total	100.0	100.0	100.0
N	31	11	24
Mean Family Size Norm	2.5	2.5	2.5
N	278	106	120

TABLE 4.11: CURRENT USE OF CONTRACEPTION AMONG CURRENTLY MARRIED WOMEN BY CATEGORIES OF RESPONDENTS AND BY FP METHODS

Contraceptive use	Respondent Categories		
	Participants	Dropouts	Never Participants
Modern Methods (Total)	41.0	36.7	33.7
Oral pill	18.3	18.9	17.3
Condom	2.4	2.2	3.8
IUD	-	-	1.0
Injectables	4.0	2.2	1.9
Tubectomy	15.9	13.3	9.6
Vasectomy	0.4	-	-
Traditional Methods (Total)	2.0	1.1	-
Any method	43.0	37.8	33.7
No method	57.0	62.2	66.3
Total	100.0	100.0	100.0
N	251	90	104

FIGURE 4.2: CONTRACEPTIVE USE RATES AMONG THE THREE CATEGORIES OF SAMPLE WOMEN BY MAJOR FP METHODS

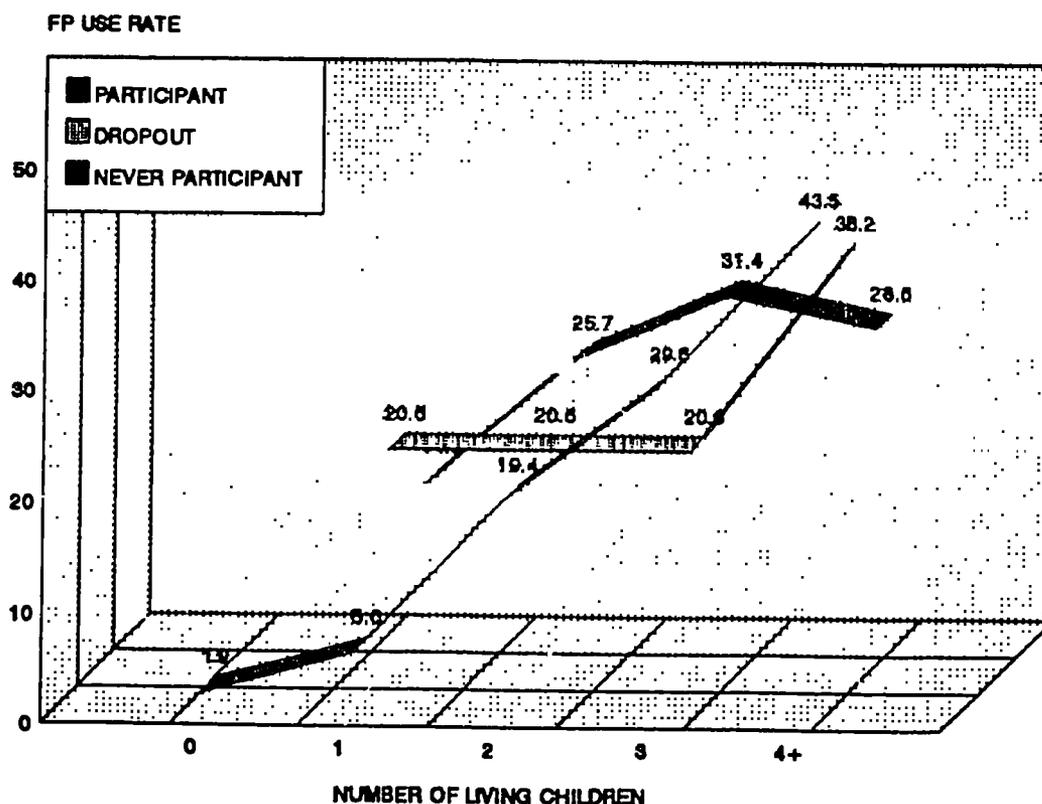


Relating contraceptive use (respondents currently using any method) with number of living children, it was observed that a higher percentage of the participants with 4+ children contracept compared to the dropouts and the percentage of such respondents was lowest among the never participants (Table 4.12). That is, the WSG participants with higher number of living children are more likely to contracept (see Figure 4.3).

TABLE 4.12: PERCENTAGE DISTRIBUTION OF RESPONDENTS USING CONTRACEPTIVES BY NUMBER OF LIVING CHILDREN

Number of living children	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
No children	1.9	--	--
1 child	5.6	20.6	14.3
2 children	19.4	20.6	25.7
3 children	29.6	20.6	31.4
4+ children	43.5	38.2	28.6
Total	100.0	100.0	100.0
N	108	34	35

FIGURE 4.3: DISTRIBUTION OF RESPONDENTS USING CONTRACEPTIVES BY NUMBER OF LIVING CHILDREN

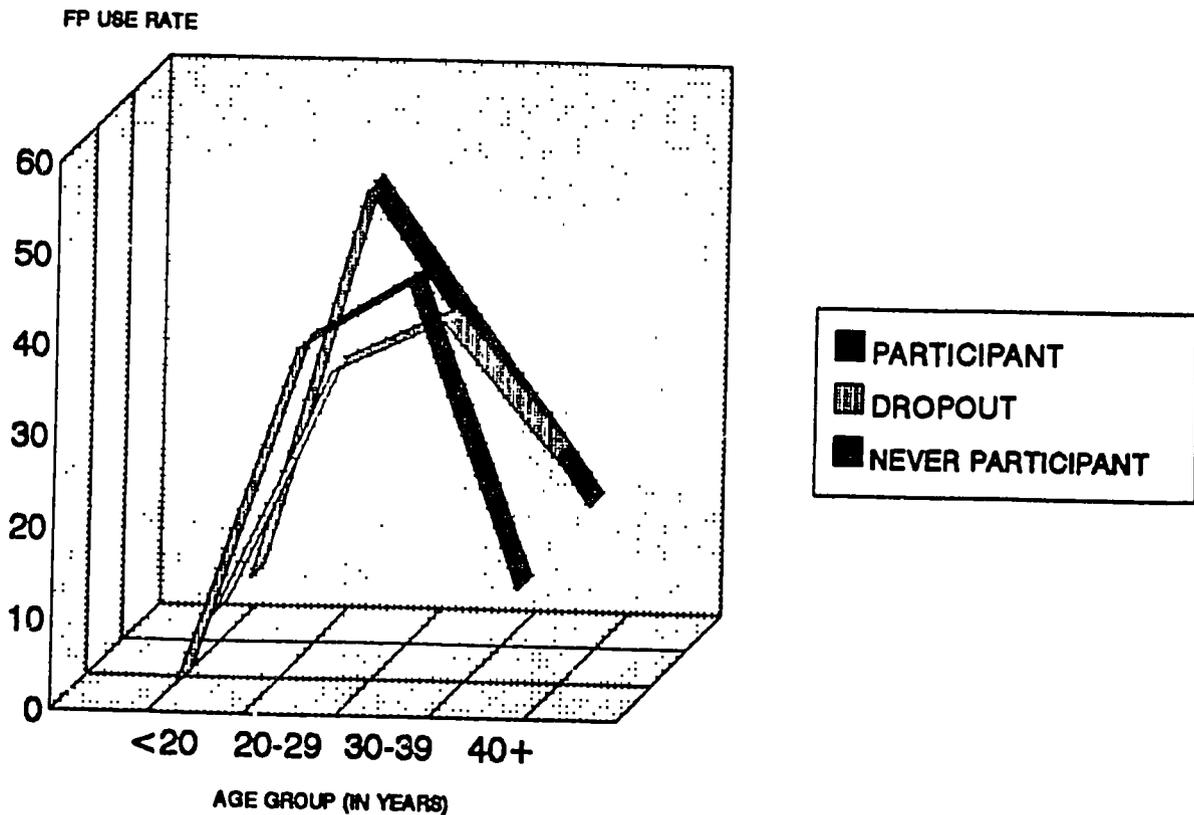


Highest proportion of the respondents belonging to the age-group 30-39
 contracept and highest proportion of such respondents were the WSG participants
 (Table 4.12b) (also, see Figure 4.4).

TABLE 4.12b: PERCENTAGE DISTRIBUTION OF RESPONDENTS USING
 CONTRACEPTIVES BY THEIR AGE

Age of the respondents	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
<20	1.9	5.9	5.7
20-29	38.9	32.4	48.6
30-39	46.2	38.2	31.4
40+	13.0	23.5	14.3
Total	100.0	100.0	100.0
N	108	34	35

FIGURE 4.4: DISTRIBUTION OF RESPONDENTS USING
 CONTRACEPTIVES BY THEIR AGE GROUPS



4.3.2 Health-related Practice*

Over eighty seven percent of the WSG participants reported that they go first to a doctor (degree-holder) in case of sickness, while the proportion of such respondents was lower among the never participants and the dropouts (Table 4.13). Thus, the probability of consulting a doctor first in case of sickness is higher among the WSG participants than among the other categories of respondents. This might be attributed to the participants' increased consciousness resulting from their involvement in WSGs.

TABLE 4.13: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY FIRST CONSULTATION IN CASE OF SICKNESS

Person first consulted	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
Religious leader	0.7	--	0.8
Quack/Kabiraj	12.2	24.5	27.5
Doctor	87.1	75.5	70.8
Neighbors	--	--	0.8
Total	100.0	100.0	100.0
N	278	106	120

The proportion of ever married women who reported of taking TT vaccine was almost similar among the WSG participants and the dropouts, but lower among the never participants (Table 4.14), indicating greater awareness among those exposed to WSG participation than those not exposed to such participation regarding the importance of taking TT vaccine. The mean number of living children immunized was just over two for all three categories of respondents (Table 4.15).

*. At one stage of analyzing health-care related data, it was felt that it would be better to compare the participants and the never participants, controlling for their socioeconomic condition. Thus, an attempt was made to isolate the never participants who were socioeconomically less well-off (i.e., comparable to the WSG participants who belong to 'C' and 'D' categories). In this respect, the health care behavior (refer to data in Tables 4.13 to 4.16 and 6.2) of the never participants were observed, after controlling for income (excluding those reporting "sufficient" income) and housing conditions (excluding those having "pucca/semi-pucca" structures). However, this analysis did not show any differentials in health-related behavior among the different categories of respondents.

TABLE 4.14: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY EXPERIENCE OF TAKING TT VACCINE

Taking TT	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
Yes	79.1	80.0	73.5
No	20.9	20.0	26.5
Total	100.0	100.0	100.0
N	278	105	117

TABLE 4.15: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY NUMBER OF LIVING CHILDREN IMMUNIZED

Number of children	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
0	10.8	10.5	10.3
1-2	57.2	56.2	58.1
3-4	23.0	23.8	26.5
5-6	6.5	8.6	3.4
6+	2.5	1.0	1.7
Total	100.0	100.0	100.0
N	278	105	117
Mean	2.2	2.2	2.1

About 90 percent of the WSG participants reported that they "always" give ORS to their children in case of diarrhoea, and the proportion of such respondents was about 85 percent among the never participants and 79 percent among the dropouts (Table 4.16), indicating that the participants are more conscious of the need to give ORS to their children during diarrhoeal attacks.

TABLE 4.16: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY USE OF ORS

Use of ORS	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
Always	89.5	79.0	84.8
Sometimes	10.5	20.0	14.3
Never	-	1.0	0.9
Total	100.0	100.0	100.0
N	275	105	112

4.3.3 Religiosity

The proportion of the respondents reporting 'more strict religious practice' in their households compared to other households in the locality was highest among the never participants and lowest among the WSG participants (Table 4.17), indicating that the degree of observance of religious practices "more strictly than others" is more likely to be inversely associated with WSG membership.

TABLE 4.17: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY DEGREE OF OBSERVANCE OF RELIGIOUS PRACTICES IN THE HOUSEHOLD

Degree of religiosity	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
More strictly than others	13.7	17.0	19.2
Less strictly than others	18.7	19.8	20.8
Average	67.6	63.2	60.0
Total	100.0	100.0	100.0
N	278	106	120

4.3.4 Female Mobility

Female mobility was assessed by asking each respondent whether she can do a number of specified things alone (i.e., unaccompanied). The items used and the proportions giving positive answers are shown in Table 4.18. Data on female mobility have been summarized by assigning a score of one for each positive answer. The mean scores, presented in Table 4.18, indicate self-reported autonomy or mobility of women for the three categories of respondents.

A very high proportion of the WSG participants compared to the never participants can go outside the village, can talk to an unknown person, go to the FWC/THC, mother's club, and can work outside home (Table 4.18). Regarding all the specified activities, the proportion having freedom was highest among the participants and lowest among the never participants, indicating that freedom associated with mobility was most pronounced among the WSG participants. This is clear from the mean scores on self reported autonomy: 4.2 for the participants, 3.8 for the dropouts, and 2.6 for the never participants. Thus, the self-reported autonomy or mobility of women rises sharply with ever participation in WSG, and moreso for the current participants of WSG. The findings were consistent with the findings of Khuda et al., (1990b).

TABLE 4.18: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO REPORTED OF HAVING FREEDOM IN VARIOUS ACTIVITIES

(Multiple responses)

Freedom in various activities	Respondent Categories		
	Partici-pants	Dropouts	Never Participants
Can go to any part of the village	86.7	83.0	80.0
Can go outside the village	55.4	54.7	33.3
Can talk to an unknown man	62.2	56.6	42.5
Can work outside home	42.8	34.0	18.3
Can go to a mothers' club/ other clubs*	85.3	71.7	30.8
Can go to the FWC/THC	84.2	78.3	57.5
Mean female mobility scores	4.2	3.8	2.6
N	278	106	120

*. Refers to any other place where rural women may meet.

4.3.5 Household Decision-making Power, and Control Over Household Resources

Decision making power was assessed by asking each respondent whether she, her husband, or both of them jointly decided on the following: schooling of children, medical treatment for a sick family member, marriage of children, buying and selling of assets, daily household expenses, and the use of FP methods. The six items have been summarized to give an overall score of husband's dominance (or wives' dominance) in decision-making. A score of one was assigned, if the husband alone decides; else, a score of zero was assigned. The scoring was reverse insofar as the wives' dominance score is concerned.

Though the majority of the respondents of all three categories reported that household decision-making in the specified areas was a joint function of both husband and wife, the proportion of respondents who reported that household decisions were taken by themselves was consistently higher, except regarding the buying and selling of assets, among the WSG participants than the other two categories of respondents (Table 4.19). This indicates that the WSG participants had a greater role in household decision-making related to schooling of children, medical treatment of family members, marriage of children, daily household expenses, and family planning use. The mean score of husband's dominance was 1.1 for the participants, and 1.3 for the dropouts as well as for the never participants, implying that the participants are less dominated by their husbands than the other two categories. This is also evident from wives' dominance scores.

The participants' enhanced household decision-making role can be explained in terms of their WSGs membership as well as their involvement in income-generating activities. According to the participants themselves, the reasons for their increased role in household decision-making can be assessed from the findings of a previous study: "(i) many members have earned some level of economic independence through their income-generating activities, and thus, have the authority to decide on such matters; (ii) since they have some savings with the group, which, if necessary, they can borrow to bear the educational expenses of their children, they feel confident to send their children to school; and (iii) because of their involvement in various group activities, husbands now believe that their wives can take such decisions without having to depend on them" (Khuda et al., 1990b, p.24).

The household decision-making power of the participants has other implications. To quote Khuda et al. (1990b):

"As time passes and as savings accumulate, women become more self-assured, and then other issues as family planning, maternal and child health care, etc. receive more consideration" (p.7).

Thus, the women's savings groups not only increase women's mobility (autonomy) and decision-making role in the family, but also facilitate their thinking toward better quality of life.

TABLE 4.19: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING DECISION MAKING ROLES IN VARIOUS ACTIVITIES

Areas of household decision-making	Respondent Categories								
	Participants			Dropouts			Never Participants		
	Res-pondent	Hus-band	Both	Res-pondent	Hus-band	Both	Res-pondent	Hus-band	Both
Schooling of children	13.5	7.2	79.3	7.8	12.2	80.0	7.7	10.6	81.7
Medical treatment of family members	10.8	10.0	79.3	10.0	20.0	70.0	6.7	17.3	76.0
Marriage of children	2.4	13.1	84.5	2.2	15.6	82.2	1.0	20.2	78.8
Buying and selling of assets	1.6	35.5	62.9	3.3	36.7	60.0	1.0	34.6	64.4
Daily household expenses	8.4	35.5	56.2	5.6	38.9	55.6	4.8	34.6	60.6
Family planning use	13.5	5.6	80.9	8.9	10.0	81.1	15.4	9.6	75.0
Mean score:									
a) Husbands' dominance	1.1			1.3			1.3		
b) Wife's dominance	0.82			0.38			0.35		
N	251			90			104		

A summary of the major findings of this chapter appears in Table 4.20. Compared to the non-participants (dropouts and never participants), the WSG participants are more knowledgeable about various things. For example, the proportions of respondents knowledgeable about special food requirements of pregnant and lactating mothers as well as giving colostrum to the newly-born babies are higher among the WSG participants. Also, the WSG participants have more favorable attitudes toward various things. For example, the proportions expressing their intention to educate their children, expressing their view that the level of education received by the daughters should be higher than or equal to that of sons, and those desiring no more children are higher among the WSG participants.

TABLE 4.20: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY SELECTED INDICATORS OF KNOWLEDGE, ATTITUDE AND PRACTICE

Knowledge, attitude and behavior	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
1. Knowledge about:			
(a) food needs of pregnant women	97.0	95.0	93.0
(b) food needs of lactating mothers	98.0	96.0	97.0
(c) giving colostrum to new born babies	94.0	92.0	93.0
2. Attitude:			
(a) intention to educate children	96.0	95.0	94.0
(b) female education higher than or equal to son	80.0	77.0	71.0
(c) desire no more children	73.0	69.0	59.0
3. Practice:			
(a) contraceptive use	43.0	38.0	34.0
(b) consulting doctor in case of sickness	87.0	76.0	71.0
(c) taking TT vaccine	79.0	80.0	74.0
(d) using ORS (always, in times of need)	90.0	79.0	85.0
(e) observing religions practices more strictly than others	14.0	17.0	19.0
4. Female mobility:			
(a) can go alone to any part of the village	87.0	83.0	80.0
(b) can go outside the village	55.0	55.0	33.0
(c) can talk to an unknown man	62.0	57.0	43.0

contd...

Table 4.20 (contd.)

Knowledge, attitude and behavior	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
(d) can work outside home	43.0	34.0	18.0
(e) can go to a mothers' club/other clubs	85.0	72.0	31.0
(f) can go to the FWC/THC	84.0	78.0	58.0
5. Respondents' role in household decision-making:			
(a) schooling of children	45.0	8.0	8.0
(b) medical treatment of family members	11.0	10.0	7.0
(c) marriage of children	2.0	2.0	1.0
(d) daily household expenses	8.0	6.0	5.0
(e) FP use	14.0	9.0	13.0

Prepared on the basis of information contained in Tables 4.1, 4.3, 4.5, 4.6, 4.10, 4.11, 4.13, 4.14, 4.16, 4.17, 4.18, and 4.19.

Furthermore, compared to the other two categories of respondents, the WSG participants' behavior are more in the expected direction. For example, contraceptive prevalence is highest among the participants, while it is lowest among the never participants. The proportions taking TT vaccines themselves are almost similar among the participants and the dropouts, but the proportion of such respondents is lowest among the never participants. The proportion giving ORS to their children during diarrhoeal episodes is also higher among the participants than the never participants. Observance of religious practices "more strictly than others" is less prevalence among the WSG participants than the other two categories of respondents. Female mobility is consistently higher among the participants than the other two categories of respondents, especially the never participants. Similarly, the WSG participants have greater role in household decision-making than the never participants. All these imply that the WSGs provide facilitating roles insofar as increase in awareness and knowledge among the rural women is concerned, and thereby motivate them to adopt behavioral pattern in the expected direction.

CHAPTER 5

INCENTIVES/DISINCENTIVES MOTIVATING PARTICIPATION IN WSGs

This chapter deals with the incentives/disincentives (direct or indirect), which motivate participation in WSGs.

5.1 Factors Encouraging Participation

As shown in Table 5.1, the three major considerations for joining Women's Groups, both among the participants and the dropouts, related to (i) accumulation of savings through deposits with the savings groups; (ii) meeting educational expenses of children; and (iii) apprehension of not getting loans, if not organized in such groups. The other important reasons for participation in WSGs include costs of medical treatment and expenses related to marriage of daughters. The findings were consistent with those of Khuda et al., (1990c), which found that the members joined the savings groups in the expectation that they would be able to save enough money as well as raise money through their involvement in income-generating activities, and thereby contribute to their family budget to meet essential needs, educational expenses of their children, and marriage of their daughters.

As a matter of fact, every behavior is motivated and this is strengthened by the incentives. A close look at Table 3.4 would show the majority of the respondents did not have any agricultural land and about two-fifths of the respondents did not have sufficient income to meet family expenses. The proportion of such respondents was highest among the WSG participants. For these poor families, it is neither possible to conceive of educating children on their own expenses nor is it possible to spend money for medical treatment or for marriage of their daughters. Hence, the potential contributions to various household expenditures resulting from the WSG participation has motivated many to join the WSG.

5.2 Factors Responsible for Dropout

The three major reasons identified by the WSG participants for their feeling inclined to discontinue membership of the WSG are (i) lack of cooperation and understanding among the members, (ii) financial mismanagement, and (iii) lack of adequate amount of loans. The three major reasons for dropping out, as reported by the past members, are (i) financial mismanagement, (ii) lack of cooperation and understanding among the group members, and (iii) not getting loans in times of need (Table 5.2). These findings are consistent with the findings of Khuda et al., (1990b), which found that the main reasons for leaving the group were financial mismanagement within the group, the expected level of financial gains being not met, and not getting loans. Thus, it is evident that unless the above causes can be overcome, dropout would be encouraged, and it is obvious that unless dropout can be minimized the WSGs cannot be made sustainable. The above evidence also suggests that in order to be able to deal with the factors responsible for dropout, the issues pertaining to the managerial sustainability should be resolved first.

TABLE 5.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY FACTORS ENCOURAGING PARTICIPATION IN WSG

(Multiple responses)

Motivating factors	Respondent Categories	
	Participants	Dropouts
Accumulate savings through deposits with the group	90.6	90.6
We cannot get loans if we don't form a group	46.4	57.5
Meet educational expenses of children	68.7	72.6
Meet costs of medical treatment	27.7	19.8
Meet expenses regarding marriage of daughters	21.2	22.6
Use accumulated savings for investment	19.8	14.2
Acquire knowledge on various subjects	19.4	16.0
To enhance status in the family	4.0	0.01
To enhance decision making power in the family	4.0	0.05
N	278	106

TABLE 5.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY FACTORS RESPONSIBLE FOR FEELING INCLINED TO DISCONTINUE/DROPOUT FROM WSG MEMBERSHIP

(Multiple responses)

Demotivating factors	Respondent Categories	
	Participants	Dropouts
Financial mismanagement of WSG	50.0	38.7
Not getting loan from the group in times of need	25.0	24.5
Lack of cooperation and understanding among group members	58.3	33.0
Lack of adequate amount of loans	41.7	15.1
Bad financial condition/ can't pay subscription	--	15.1
Familial/social obstacle/ Husband violent	--	0.1
Old age/'B' category/others	--	12.3
N	12*	106

* Refers to the present members, who sometimes feel inclined to discontinue membership with WSG.

5.3 Factors Discouraging Participation

Among the never participants, the three major reasons for not joining the WSGs are (i) the dislike from husbands or in-law, (ii) bad financial condition, and (iii) lack of desire, interest and time (Table 5.3).

The most important discouraging factor is dislike from husband/in-law. It is a known fact that the prosperous or landed households as well as households with strong religious or social norms and traditions impose greater restrictions on the movement of their female members than the relatively less well-off households and those which attach lesser importance to religious and social norms and traditions. In fact, some of the never participants belong to A/B category, who are not supposed to become members of WSGs. It is also evident from Table 4.16 that compared to the other two categories of respondents, a higher proportion of the families of the never participants observe religious practices more strictly. As a result, women from such families cannot become members of WSGs, unless they get positive support from their husbands/in-laws.

TABLE 5.3: PERCENTAGE DISTRIBUTION OF NEVER PARTICIPANTS BY FACTORS DISCOURAGING PARTICIPATION IN WSG

(Multiple responses)

Discouraging factors	Never participants
Husband/Mother-in-law dislikes	52.4
Bad financial condition	31.0
Don't desire/Don't like/can't afford time	31.0
Neighbor's negative attitude	28.6
A/B category, and therefore, ineligible for WSG membership	21.4
N	42*

* Refers to the never participants, who reported that they know about WSG.

The above evidence indicates that the primary consideration for joining the WSG is economic: accumulation of savings, meeting various household expenditures, etc. This implies that most women join the WSG with the expectation that they would be able to attain some "economic power", thereby improving their status both within the family and the community.

Financial management of group funds must be sound; otherwise, group members would drop out. Thus, there is a need to ensure sound financial management of group funds to be not only able to minimize drop out but also attract the never participants to join the group.

As part of its program, the SC needs to motivate and educate the husbands and in-laws of the potential benefits of participation in the WSGs. If this is undertaken with all seriousness, it would be possible to overcome their dislike and resistance.

CHAPTER 6

FEASIBILITY OF ATTAINING SUSTAINABLE HEALTH CARE GOALS THROUGH WSG

This chapter deals with the feasibility of attaining sustainable health care goals through WSG.

6.1 Training Received and Contacts with Service Provider(s)

Most of the participants, be it a current or past participant (dropout), reported that they received training in health and family planning, while the proportion of such respondents was quite low among the never participants (Table 6.1). This indicates that if the SC withdraws from its catchment areas, most of the current or past participants, having received training in health and family planning, might be able to sustain some of the health care services currently provided by the SC.

TABLE 6.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY TRAINING RECEIVED IN HEALTH AND FP

Training Received	Respondent Categorie		
	Participants	Dropouts	Never Participants
Yes	90.6	83.0	36.7
No	9.4	17.0	63.3
Total	100.0	100.0	100.0
N	278	106	120

Over 90 percent of the WSG participants, 80 percent of the dropouts, and 57 percent of the never participants reported that they have contacts with the health and family planning service providers (Table 6.2).

TABLE 6.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY MAINTAINING CONTACT WITH HEALTH AND FP SERVICE PROVIDER(S)

Responses	Respondent Categories		
	Participants	Dropouts	Never Participants
Yes	92.1	81.1	56.7
No	7.9	18.9	43.3
Total	100.0	100.0	100.0
N	278	106	120

Population coverage by health service facilities and manpower in the four thanas of SC project areas, shown in Table 6.3, indicate that taking both the physical facilities and manpower into consideration, Nasirnagar is in the most advantageous position while Mirzapur is in the most disadvantageous position. However, unless the geo-physical conditions are taken into account, such an analysis could be misleading.

Nasirnagar, a thana under Brahmanbaria District, is a 'haor' area, which is largely under water for 4-6 months of the year, thereby limiting agricultural production to one season. It is also the poorest and has the least developed infrastructure, service facilities and markets. Rangunia, a thana under Chittagong District, is located relatively close to Chittagong city with very good road communication and health facilities. Also, the Chandragona Mission Hospital provides good services to the poorer sections of the community members in Rangunia. Ghior, a thana under Manikganj District, is relatively close to the district headquarters with a good district-level hospital and easily accessible by car. Mirzapur, a thana under Tangail District, is not far away from the Capital City of Bangladesh and is easily accessible by car. The Kumudini Hospital in Mirzapur offers relatively better facilities than the average Thana Health complex can provide. Considered from this point of view, Nasirnagar seems to be the least advantaged area in respect of access to health facilities and services. To quote a recent report, "In general, patients from households with large landholdings tended to use modern health care more than their counterpart landless and near landless" (World Bank, 1990, p.51). Thus, broadly speaking, the target group of SC's Women's program are still largely beyond the reach of modern health facilities and services because of the geo-physical limitations.

TABLE 6.3: POPULATION^a COVERAGE BY HEALTH SERVICE FACILITIES AND MANPOWER IN THE FOUR SC THANAS

Physical facilities and manpower	Thanas			
	Nasirnagar	Rangunia	Mirzapur	Ghior
Facilities:				
a) GOB:				
THC	193,122	238,087	288,341 ^b	108,535
FWC	64,374	79,362 ^c	288,341	108,535
Dispensary	193,122	238,087	-	108,535
b) NGO Clinic	96,561	79,362	288,341	108,535
* Manpower:				
a) GOB	10,164	10,822	24,028	10,854
b) NGO	3,714	13,227	18,021	4,341
c) Private	2,646	5,669	9,011	3,289

a) Refers to 1981 Population Census as reported in Upazila Statistics of Bangladesh, Dhaka: BBS, 1988.

(b) In fact, there is no THC in Mirzapur. However, there is a hospital, named "Kumudini Hospital", located at the thana headquarters.

(c) Reported to the nearest whole number.

* Includes TFPO, AIFPO, MO, Senior FHV, FPI, FV and MA.

6.2 Health Consciousness

Over four-fifths of the respondents reported that they help others (non-family members) in establishing contacts with the health service providers, and the majority of such respondents were WSG participants. Among the latter group of respondents, over four-fifths reported that they used to help others in establishing contacts with service providers, even before becoming members of WSG. This implies that the habit of helping others was independent of their WSG membership status.

Out of 278 WSG participants, almost all (99%) reported that they discuss health-related issues in WSG meetings. The specific issues generally discussed relate to children's health and nutrition, mothers' health and nutrition, cleanliness/hygiene, and family planning. The findings clearly indicate the importance given to health-related issues in the WSG meetings.

Out of the 276 WSG participants who reported that they discuss health-related issues in their group meetings, about 88 percent reported that they disseminate health-related knowledge acquired through their discussions to the non-members. Knowledge disseminated by the members during the last three months covered such issues as pregnant women's health and nutrition, children's health and

nutrition, lactating mothers' food needs and child care, use or preparation of ORS, FF, late marriage, etc. This implies that the WSGs help raise health-related consciousness among the community members in general. About 72 percent of the non-participants (dropouts and never participants taken together) also reported that the WSG participants have higher degrees of health-related consciousness compared to them.

6.3 Health-related Needs and Actions Taken

The most common health-related needs felt by the respondents during the last one year included fever/typhoid/malaria, diarrhoea/ dysentery/stomach ailments/worm, and cold/cough/asthma (Table 6.4). Other less frequently cited health-related needs were scabies/itching/measles/pox/gastric, etc.

TABLE 6.4: PERCENTAGE DISTRIBUTION OF THE RESPONDENTS BY HEALTH-RELATED NEEDS FELT DURING THE LAST ONE YEAR

(Multiple Responses)

Health-related needs	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
Fever/Typhoid/ Malaria	39.6	36.8	37.5
Cold/Cough/Asthma	27.7	20.8	23.3
Diarrhoea/Dysentery /Stomach ailment	29.5	23.6	27.5
Measles/Pox/TB/ Gastric	0.7	-	4.2
Scabies/Itching/ Others	4.0	6.6	4.2
N	278	106	120

Majority of the respondents, irrespective of their categories, said that they sought the doctor's advice in case of the above health-related needs (Table 6.5). While the highest proportion of such respondents was among the WSG participants, the lowest proportion was among the dropouts. Also, the proportion using ORS/deworming medicine was considerably higher among the WSG participants compared to the other groups, suggesting that in the event of the SC withdrawing from the area, they would be able to take care at least some of their essential health-related needs.

TABLE 6.5: PERCENTAGE DISTRIBUTION OF THE RESPONDENTS BY HEALTH-RELATED ACTIONS TAKEN DURING THE LAST ONE YEAR

(Multiple Responses)

Health-related actions	Respondent Categories		
	Partici- pants	Dropouts	Never Participants
Doctors' Advice	58.6	45.3	54.2
Hospital/Clinic (SC/NGO)	15.8	18.9	17.5
Village doctor/ Quack/Kabiraj	30.9	21.7	30.8
Used ORS/Deworming medicine	22.3	11.3	7.5
Homeopathy/Others	24.1	35.8	21.7
N	278	106	120

6.4 Changes in the Respondents' Status: Social, Economic and Nutritional

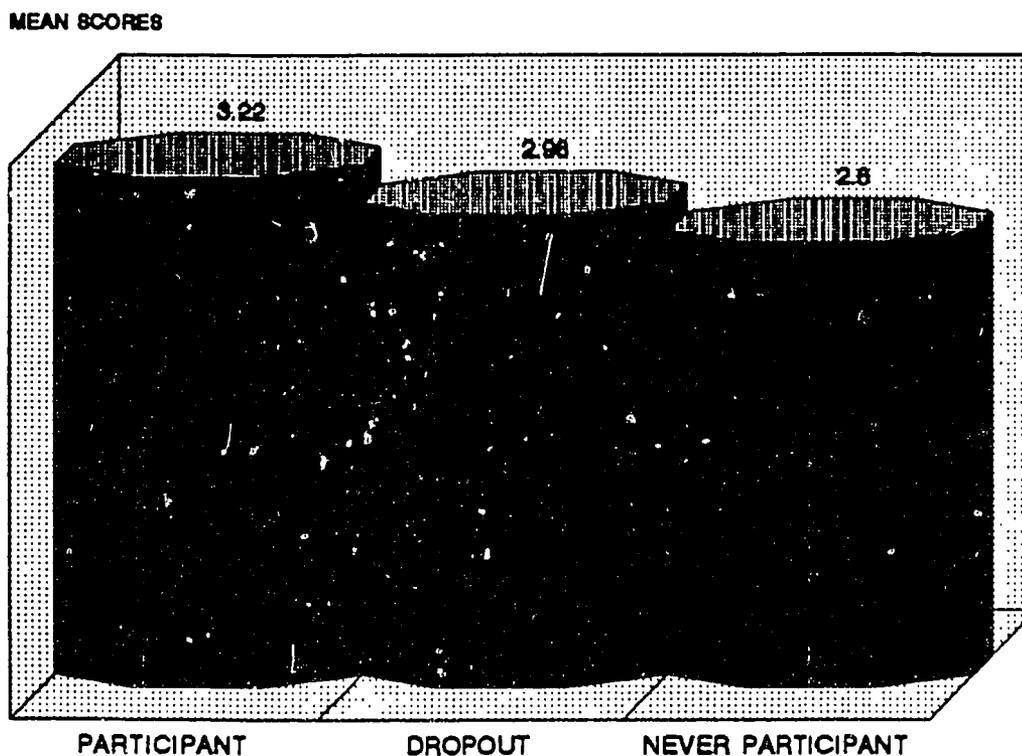
Changes in the social, economic, and nutritional status of the respondents' households during the last three years have been assessed by asking each respondent whether there has been any changes regarding five specified items: economic condition of the family, nutritional status of the family, as well as of children; respondent's status in the family and in the community. These five items have been summarized to arrive at an overall score of "Changes in the Status". Scores assigned were 1 to 'betterment', 0.5 to "same as before, and '0' to "worse than before". Thus, for each type of respondent, the range of scores would be 0 to 5, whereby higher score would indicate improvement.

Among the WSG participants, the proportions reporting that their conditions on all the five specified indicators improved over the last three years were higher than the proportions reporting that their conditions had remained either unchanged or even worsened. In contrast, among the dropouts and the never participants, the proportions reporting that their conditions improved were lower than the proportions reporting that they were unchanged (Table 6.6). Also, the mean score indicating such changes was highest for the participants (3.22), followed by the dropouts (2.98), and the never participants (2.80). The findings are consistent with the findings of Khuda, et al., (1990b) (also, see Figure 6.1). Moreover, indepth interviews conducted as part of the present study also lend support to the above observations. To quote verbatim the observations of some of the indepth interview respondents:

TABLE 6.6: PERCENTAGE DISTRIBUTION OF THE RESPONDENTS BY CHANGES IN STATUS OVER THE LAST THREE YEARS

Status	Respondent Categories								
	Participants			Dropouts			Never Participants		
	Bet-ter	Same as be-fore	Wor-se	Bet-ter	Same as be-fore	Wor-se	Bet-ter	Same as before	Wor-se
Economic condition	39.9	34.2	25.9	42.5	30.2	27.4	31.7	35.0	33.3
Family nutrition	41.7	36.3	21.9	34.9	41.5	23.6	31.7	40.6	28.3
Nutrition of children	43.2	35.6	21.2	35.8	39.6	24.5	35.0	37.5	27.5
Respondent's status in the community	47.8	47.5	4.7	40.6	50.0	9.4	31.7	62.5	5.8
Respondent's status in the family	50.7	44.6	4.7	36.8	52.8	10.4	34.2	57.5	8.3
Mean scores of changes in the status	3.22			2.98			2.80		
N	278			106			120		

FIGURE 6.1: MEAN SCORES OF CHANGES IN THE STATUS OVER THE LAST THREE YEARS BY PARTICIPANTS, DROPOUTS, AND NEVER PARTICIPANTS



"Compared to the past, our status in the family has improved. Because of our membership in the women's savings groups, we now know many things about health, nutrition, family planning, income and savings, which we did not know before joining the savings groups. Though little, we are also contributing to family income by way of poultry raising or vegetable gardening. As a result, husbands or in-laws now give relatively more importance to our views and ideas, and consult us on various matters than before" -- (Vice President, Bodhu Kalyan Samity, Kulkurmai, Rangunia; President, Joty Sanchay Samity, Jabra, Baniajuri, Ghior).

"Our status in the community has also improved. As leader of the group, I am sometimes asked to speak in, or attend, various meetings, where respectable people are present. Besides, in case of any quarrel or misunderstanding among the neighbors, I am asked to mitigate the same" -- (Vice President, Bodhu Kalyan Samity, Kulkurmai, Rangunia; WSG leader, Gukorna, Gukorna Union, Nasirnagar). Thus, the above evidence suggests that membership in the WSG has helped the members in improving their conditions on various aspects of life.

6.5 Health Care Behavior by Characteristics of the Participants

The proportion of the WSG participants seeking advice of medical doctors (degree-holder doctor/Hospital-Clinic/SC's doctor) in case of sickness was highest among those aged 30-39 years, followed by those aged 20-29 years (Table 6.7). Similarly, the proportions who took TT vaccine and who got their children immunized were highest among those aged 20-39 years. The proportion who reported that they 'always' give ORS to their children in case of diarrhoea was highest in the age-group 30-39, followed by the age-group 20-29. That is, women in their twenties and thirties are more likely to benefit from participating in the WSGs.

The proportion of the WSG participants seeking advice of medical doctors in case of sickness was highest among those who did not have any schooling. Similarly, the proportions who took TT vaccine, who had their children immunized, and who reported that they 'always' give ORS to their children were consistently higher among those who did not have any schooling. That is, the illiterates are more likely to benefit from participating in WSGs.

The proportion of the WSG participants seeking advice of medical doctors was highest among those who did not have any land ownership. The proportions who took TT vaccine, who had their children immunized, and who reported that they 'always' give ORS to their children were higher among those who did not own any agricultural land. That is, the women from landless families are more likely to benefit from participating in WSGs.

The above discussion reflects some positive indications toward health-related behavioral sustainability of the WSG members: more training, more contacts with the providers, and assistance to others in establishing contacts with service providers, dissemination of knowledge, seeking medical advice, and using ORS and deworming medicines. However, such positive indications are relatively more pronounced among those in their twenties and thirties, among the illiterate, and among those belonging to landless households. However, in-depth discussions with selected community leaders³, SC workers, and WSG leaders indicate low potential of financial and managerial sustainability of the WSG as an institution. Most of the above categories of respondents were categorical in saying that the community would not be able to provide cash resources to meet the required health-related expenses, although they pointed out the potential of voluntary community labor. Also, they noted that leadership skill has not been developed to the extent that it can take over the responsibility of providing health services in the event of the phasing-out of the SC. To quote verbatim the observations of some of the in-depth interview respondents: "It will not be possible to raise any fund (in cash/kind) locally, since most people are poor and there are no rich persons in the area. However, free labor may be available, if necessary" (UC member, Ward No.3, Rangunia Union, Rangunia; Headmaster, Primary School, Gukorna Union, Nasirngar; and Headmaster, Shahid Swaranika Girls High School, Jabra, Baniajuri, Ghior)".

3. *The community leaders interviewed included members of union council, headmasters of selected primary and selected schools, informal community leaders, etc.*

TABLE 6.7: PERCENTAGE DISTRIBUTION OF THE PARTICIPANTS BY THEIR HEALTH CARE BEHAVIOR AND CHARACTERISTICS

Characteristics	First advice sought			TT Vaccine		Children immunized		Use of ORS	
	Religious Leader	Quack/Ka-biraj	Medical doctor	Yes	No	Yes	No	Always	Sometimes
<u>Age:</u>									
<20	--	--	2.5	2.3	1.7	2.0	3.3	2.4	--
20-29	--	44.1	32.2	38.2	15.5	35.9	13.3	33.7	31.0
30-39	100.0	14.7	38.8	37.3	32.8	36.3	36.7	36.6	31.0
40+	--	41.2	26.4	22.3	50.0	25.8	46.7	27.2	37.9
N	2	34	242	220	58	248	30	246	29
<u>Schooling:</u>									
No Schooling	100.0	55.9	72.7	64.1	96.6	69.0	86.7	67.5	96.6
Grades 1-5	--	26.5	18.6	23.6	3.4	21.4	86.7	67.5	96.6
Grade 6+	--	17.6	8.7	12.3	--	9.7	10.0	10.6	3.4
N	2	34	242	220	58	248	30	246	29
<u>Land ownership:</u>									
Yes		41.2	40.9	40.0	43.1	41.9	30.0	40.7	44.8
No	100.0	58.8	59.1	60.0	56.9	58.1	70.2	59.3	55.2
N	2	34	242	220	58	248	30	246	29

"It would have been possible on our part to continue existing health care facilities in future, if SAVE could leave with us a substantial fund, doctor/hospital/clinic for availing the required services, or introduce us to other doctor/hospital/clinic from where health care facilities will be provided in exactly the same manner as SAVE is providing now" _____(Vice President, Bodhu Kalyan Samity, Kulkurmai, Rangunia).

"Though the members are being trained in leadership, they cannot be at par with men. Moreover, there are very few educated women among the participants. Thus, it will not be generally possible on their part to organize group meetings solely on their own" (SAVE worker, Jabra, Baniajuri, Ghior).

"Now, the WSG activities are being organized and coordinated by the SAVE workers. In the absence of SAVE, the WSGs will be leaderless. Moreover, there will be problem of leader's credibility" (UC member, Ward No.3, Rangunia Union, Rangunia).

"In the absence of SAVE, it will not be possible to continue our group activities; the WSGs may wither away" (WSG leader, Asha Samity, Jabra, Ghior).

CHAPTER 7

SUMMARY AND CONCLUSION

An important methodological point to note is that viewed from socioeconomic indicators such as landownership, level of adequacy of income, occupational structure, education, and materials used for dwelling units the participants are certainly less well off than the other two groups. This implies that while comparing the health-related attitude and behavior of these groups, proper cautions shall have to be considered. Also, considering the relatively disadvantaged socioeconomic background of the WSG participants, almost equal degree of the relative value of this group in terms of health-related attitude or behavior with the other groups, especially with the never participants, should be treated as a sign of behavioral progress among the WSG participants.

The WSG participants and the dropouts are about the same age, and they are older than the never participants. The probability of participating in WSGs is higher among the currently married women and women having higher number of children. Socioeconomically disadvantaged group of women, i.e., the relatively less well-off women are more likely to benefit from participating in WSG.

The proportion of respondents knowledgeable about the special food requirement of the pregnant and the lactating mothers is highest among the participants, while it is lowest among the never participants. Compared to the never participants, higher proportion of the WSG participants intend to educate their children and hold the view that the level of education received by the daughters should be higher than that of the sons. Son preference is less pronounced among the participants than the never participants. Furthermore, compared to the other two categories of respondents lowest proportion of the participants expressed desire for more children.

Contraceptive prevalence is highest among the participants and lowest among the never participants. Again, among the respondents with 4+ living children, contraceptive use is highest among the WSG participants and lowest among the never participants. Also, the participants use 'clinical methods' to a greater extent than the others. The proportions of respondents taking TT vaccine themselves as well as having their children immunized are higher among the participants than the never participants. The proportions of respondents giving ORS to their children during diarrhoeal episodes as well as seeking medical doctors' advice in case of sickness are higher among the participants than either of the dropouts or the never participants. The participants have greater role in household decision-making and greater mobility than the never participants.

Taking the knowledge, attitude, and behavior of the respondents into consideration, it appears that women who have higher number of living children, who intend to educate their children, who have lesser desire for additional children, who are using contraceptives, who are utilizing health care facilities, who have relatively higher degree of mobility, etc., are more likely to benefit from WSG participation.

The primary consideration for joining the WSGs is economic: accumulation of savings, meeting various household expenses, etc. This implies that most women join the WSG with the expectation that they would be able to attain some "economic power", thereby improving their status both within the family and the community.

The major factor encouraging dropping out/discontinuation of membership is financial mismanagement of WSGs. This implies that financial management of group funds must be sound; otherwise, group members would dropout. Thus, there is a need to ensure sound financial management of group funds to be not only able to minimize dropout but also attract the never participants to join the group.

The major factor discouraging participation in WSGs is the dislike from husbands/in-laws. So, as part of its program, the SC needs to motivate and educate the husbands and in-laws of the potential benefits of participating in the WSGs. If this is undertaken with all seriousness, it would be possible to overcome their dislike and resistance.

The evidence found in this study indicates that in case the SC decides to phase out, it would be difficult on the part of the residents of its catchment areas to be able to sustain their health behavior. However, there are also some positive indications. Most of the participants, having received training in health and family planning, might be able to sustain some of the health care services currently provided by the SC. Also, a higher proportion of the participants compared to the other two groups have contacts with the health and family planning service providers. The proportion helping others in establishing contacts with the health service providers is higher among the participants than the others. Health-related topics are widely discussed in the WSG meetings, thereby helping raise health-related consciousness among the members. A very high proportion of the members also disseminate knowledge acquired in the group meetings with the non-members, thereby indicating that they help raise health-related consciousness in the community in general.

The community members, in general, seek medical advice in times of sickness. The proportions seeking such advice as well as using ORS and deworming medicines were higher among the WSG participants, suggesting that in the event of the SC withdrawing from the area the WSG participants would be more able than the community members to take care at least some of the essential health-related needs. However, the degree to which the WSG participants would be able to take care of some of their essential health-related needs in the event of the SC withdrawing of the area varies by characteristics of the participants. For example, the proportion seeking medical advice was highest among those aged 30-39 years, those with no schooling, and those with no household land ownership. Thus, in case the SC decides to withdraw from the area, it should ensure that the other participant groups as well as the community in general are able to take care of their essential health-related needs; otherwise, at least some of the SC's past efforts and resources would be considered not to have yielded the desired result.

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APPENDIX 1

PARTICIPATION AND NON-PARTICIPATION IN SAVE THE CHILDREN (USA)
WOMEN'S SAVINGS GROUPS (WSG) AND THEIR IMPLICATIONS WITH
HEALTH CARE BEHAVIOR IN TERMS OF SUSTAINABILITY

Interview Schedule

Sample No. □ □ □	□ □ □												
Respondent category: Participant □ 1 Dropout □ 2 Never-participant □ 3	□												
Address: Thana: Nasirnagar □ 1 Rangunia □ 2 Mirzapur □ 3 Ghior □ 4	□												
Union : _____ Village: _____													
Interview Information:													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Interview Call</td> <td style="width: 15%;">1</td> <td style="width: 15%;">2</td> <td style="width: 15%;">3</td> </tr> <tr> <td>Date</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Result Code*</td> <td></td> <td></td> <td></td> </tr> </table>	Interview Call	1	2	3	Date				Result Code*				□
Interview Call	1	2	3										
Date													
Result Code*													
*Result Code: Completed =1, Respondent not available=2 Deferred =3, Refused =4, Dwelling vacant =5 Address not found = 6 Others _____ 7 (Specify)													
Supervisor Scrutinized _____ Date _____	Signature of the Interviewer _____ Date _____												

Others _____
(Specify)

106. What is your religion ?

Islam

Hinduism

Buddhism

Christianity

Others _____
(Specify)

107. Does your household own any agricultural land ?

Yes

No

108. To what extent is your family income sufficient to meet all of your family expenses ?

Quite sufficient

Moderately sufficient

Not sufficient

109. INTERVIEWER: Check the categories below and put tick mark in the appropriate box.

Currently married

Unmarried

(SKIP TO 118)

Widowed/Divorced/Separated

(SKIP TO 117)

5i

110. What is your husband's present age ?

_____ (in years)

111. What is the highest class your husband passed ?

_____ class

If no class, write '00'

112. What is your husband's primary occupation ?

- 1 Farming
- 2 Agricultural wage labor
- 3 Non-agricultural labor
- 4 Petty business
- 5 Trading
- 6 Service
- 7 Others _____
(Specify)

113. INTERVIEWER: Check the categories below and put tick mark in the appropriate box.

- 1 Participant
- 2 Dropout
(SKIP TO 115)
- 3 Never participant
(SKIP TO 115)

114. What is your husband's attitude toward your involvement in WSG ?

- 1 Highly positive
- 2 Somewhat positive
- 3 Indifferent
- 4 Somewhat negative
- 5 Extremely negative

115. Are you involved in any income generating activities ?

1 Yes

2 No

(SKIP TO 117)

116. What is your husband's attitude toward your involvement in income generating activities ?

1 Highly positive

2 Somewhat positive

3 Indifferent

4 Somewhat negative

5 Extremely negative

9 Not applicable

(If unmarried/widowed/
divorced/separated)

117. What is the number of children you gave birth to?

Total living children ____ Son(s) ____ Daughter(s) ____

Children who died _____

Pregnancy wasted _____

Total	S.	D.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

118. What is the condition of your dwelling unit ?

1 Pucca

2 Semi-pucca

3 Tin and Bamboo/
Wood

4 Others _____
(Specify)

119. What latrine facilities do you use?

1 Hygienic (Slab/
Safety tank/Pit
latrine)

2 Non-hygienic
(e.g., open space)

55

SECTION 2

KNOWLEDGE AND ATTITUDE

201. What, according to you, should be the ideal family size ?

_____ (ideal size)

202. What, according to you, should be the ideal age at marriage for girls ?

_____ (age in years)

203. To what extent do you think that you have peace and harmony in your family ?

1 To a great extent

2 Moderate

(SKIP TO 205)

(SKIP TO 205)

3 Little

4 No peace at all

204. Why do you think so ?

[INTERVIEWER: Probe whether the husband is violent/
non-violent)

205. During the last one year, what health-related needs were felt by the members of your family and what did you do to satisfy those needs ?

[INTERVIEWER: Enquire about the health problems faced by different categories (children, mother, and other elderly persons) of members].

Health needs

Action taken

Needs

Action

<input type="checkbox"/>	<input type="checkbox"/>

206. Do pregnant women need any special food ?

1 Yes

2 No

3 Don't know

207. Do lactating mothers need any special food ?

1 Yes

2 No

3 Don't know

208. At what age should babies be given weaning food ?

(age of baby in months)

99 Don't know

209. At what age should babies be given solid food ?

(age of baby in months)

99 Don't know

SECTION 3

BEHAVIOR

301. INTERVIEWER: Check the categories below and put tick mark in the appropriate box.

- | | | | |
|----------------------------|---|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | Currently married | <input type="checkbox"/> 2 | Unmarried
(SKIP TO 311) |
| <input type="checkbox"/> 3 | Widowed/Divorced/Separated
(SKIP TO 310) | | |

302. Are you/your husband currently using any contraceptive method?

- | | | | |
|----------------------------|-----|----------------------------|---------------------|
| <input type="checkbox"/> 1 | Yes | <input type="checkbox"/> 2 | No
(SKIP TO 304) |
|----------------------------|-----|----------------------------|---------------------|

303. Which method are you/your husband currently using ?

- | | | | |
|-----------------------------|-------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> 01 | Pill | <input type="checkbox"/> 02 | Condom |
| <input type="checkbox"/> 03 | IUD | <input type="checkbox"/> 04 | Injection |
| <input type="checkbox"/> 05 | Foam/Jelly/Emko | <input type="checkbox"/> 06 | MR/Induced abortion |
| <input type="checkbox"/> 07 | Tubectomy (SKIP TO 309) | <input type="checkbox"/> 08 | Vasectomy
(SKIP TO 309) |
| <input type="checkbox"/> 09 | Safe period | <input type="checkbox"/> 10 | Abstinence |
| <input type="checkbox"/> 11 | Withdrawal | <input type="checkbox"/> 12 | Others _____
(Specify) |

304. Are you currently pregnant ?

1 Yes

2 No

305. Do you intend to have any more children?

1 Yes

2 No

3 Don't know

(SKIP TO 309)

(SKIP TO 309)

306. How many more ?

_____ (number of children)

307. Do you have any gender preference for children ?

1 Yes

2 No

3 Don't know/
God knows

(SKIP TO 309)

(SKIP TO 309)

308. What is the preference ?

1 Daughter

2 Son

309. Do you think that compared to your father, your husband is enjoying a higher/equal/lower socio-economic status ?

1 Higher

2 Equal

3 Lower

310. Do you intend to educate your children ?

1 Yes

2 No

311. Do you think that the level of education received by daughters should be equal to/higher/lower than sons ?

<input type="checkbox"/> 1	Equal	<input type="checkbox"/> 2	Higher	<input type="checkbox"/> 3	Lower	<input type="checkbox"/>
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312. Does your household observe religious practices more strictly or less strictly than other households in this locality ?

<input type="checkbox"/> 1	More strictly	<input type="checkbox"/> 2	Less strictly	<input type="checkbox"/> 3	Average	<input type="checkbox"/>
----------------------------	---------------	----------------------------	---------------	----------------------------	---------	--------------------------

313. To whom do you normally go first if anyone is sick in your family ?

<input type="checkbox"/> 1	Religious leader	<input type="checkbox"/> 2	Quack/Kabiraj	<input type="checkbox"/>
<input type="checkbox"/> 3	Doctor	<input type="checkbox"/> 4	Nearby hospital/ clinic	
<input type="checkbox"/> 5	Others _____ (Specify)			

314. Can you do the following alone ?

	Yes	No	
Can go to any part of the village	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Can go outside the village	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Can talk to a man you don't know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Can work outside home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Can go to a mothers' club/ other clubs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Can go to the FWC/THC	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>

6

315. INTERVIEWER: Check the categories below and put tick mark in the appropriate box.

<input type="checkbox"/> 1	Currently married	<input type="checkbox"/> 2	Unmarried	<input type="checkbox"/>
(SKIP TO 317)				
<input type="checkbox"/> 3	Widowed/Divorced/Separated			
(SKIP TO 317)				

316. Who takes decision in your family in respect of the following ?

	<u>Respondent</u>	<u>Husband</u>	<u>Both</u>	
Schooling of children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
Medical treatment of family members	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
Marriage of children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
Buying and selling of assets (e.g., land, bullock, rickshaw, furniture, radio, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
Daily household expenses	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
Family planning use	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>

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317. During the last three years, to what extent has there been change in the following: economic condition of the family, nutritional status (family and children), and your status in the community ?

	<u>Better</u>	<u>Same as before</u>	<u>Worse</u>	
Economic condition	1	2	3	<input type="checkbox"/>
Family nutrition	1	2	3	<input type="checkbox"/>
Nutrition of children	1	2	3	<input type="checkbox"/>
Your status in the community	1	2	3	<input type="checkbox"/>
Your status in the family	1	2	3	<input type="checkbox"/>

318. INTERVIEWER: Check the answers below and tick appropriate box.

<input type="checkbox"/> 1 Currently married	<input type="checkbox"/> 2 Unmarried (SKIP TO 401)
<input type="checkbox"/> 3 Widowed/Divorced/Separated	

319. Have you ever taken TT vaccine ?

<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/>
--------------------------------	-------------------------------	--------------------------

320. How many of your living children have been immunized ?
 _____ (number immunized)

321. Do you give oral saline to your children if they are attacked by diarrhoea?

1 Always 2 Sometimes 3 Never

322. How many of your living children are currently attending school and/or attended in the past?

_____ (number attending/attended)

SECTION 4

INCENTIVES/DISINCENTIVES MOTIVATING PARTICIPATION OR NON-PARTICIPATION IN WSGs

401. INTERVIEWER: Check the answers below and tick appropriate box.

- 1 Participant
- 2 Dropout
(SKIP TO 407)
- 3 Never participant
(SKIP TO 412)

402. For how long have you been a member of WSG ?

_____ Years

403. What were the three primary considerations which motivated you to become a member of women's savings group (WSG)?

INTERVIEWER: First, try for unprompted answers. Then prompt, if necessary.

	Yes	No	
Accumulate savings through deposits with the group	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
We cannot have loans if we don't form a group	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Meet educational expenses of children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Meet costs of medical treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Meet expenses regarding marriage of daughters	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Use accumulated savings for investment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>

65

Acquire knowledge on various subjects e.g., family planning, child care, income generating activities, etc.

To enhance status in the family

To enhance decision-making power in the family

Others _____
(Specify)

404. To what extent do you feel that your expectations (as above) have been fulfilled after becoming a member of WSG ?

1 Highly

2 Moderately

3 Little

4 Not at all

405. Do you sometimes feel inclined to discontinue your membership with WSG ?

1 Yes

2 No

(SKIP TO 501)

66

406. What makes you feel so ? (Multiple answers).

	Yes	No	
Financial mismanagement of WSG	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Not getting loan from the group in times of need	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Lack of cooperation and understanding among group members	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Lack of loans in adequate amounts	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Others _____ (Specify)			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

407. INTERVIEWER: Check the answers below and tick appropriate box.

<input type="checkbox"/> 1	Participant (SKIP TO 501)	<input type="checkbox"/> 2	Dropout	<input type="checkbox"/>
<input type="checkbox"/> 3	Never participant (SKIP TO 412)			

408. Were you a member of WSG ?

<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 2	No	<input type="checkbox"/>
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(Correct 407)

409. What were the three primary considerations which had motivated you to become a member of WSG?

	Yes	No	
Accumulate savings through deposits with the group	1	2	
We cannot have loans if we don't form a group	1	2	
Meet educational expenses of children	1	2	
Meet costs of medical treatment	1	2	
Meet expenses regarding marriage of daughters	1	2	
Use accumulated savings for investment	1	2	
Acquire knowledge on various subjects e.g., family planning, child care, income generating activities, etc.	1	2	
To enhance status in the family	1	2	
To enhance decision-making power in the family	1	2	
Others _____ (Specify)	1	2	

410. After how many years of membership did you decide to discontinue?

_____ years

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411. Why did you discontinue your membership with WSG ?

	<u>Yes</u>	<u>No</u>	
Financial mismanagement of WSG	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Not getting loan from the group in times of need	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Lack of cooperation and understanding among group members	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Lack of loans in adequate amounts	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Others _____ (Specify)			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

412. INTERVIEWER: Check the answers below and tick appropriate box.

<input type="checkbox"/> 1	Participant (SKIP TO 501)	<input type="checkbox"/> 2	Dropout (SKIP TO 501)	<input type="checkbox"/>
<input type="checkbox"/> 3	Never participant			

413. Do you know of women's savings group (WSG) ?

<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 2	No (SKIP TO 501)	<input type="checkbox"/>
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414. Please tell me the three major reasons why you do not want to get involved with WSG?

<input type="checkbox"/>

SECTION V

FEASIBILITY OF ATTAINING SUSTAINABLE HEALTH CARE GOALS THROUGH WSG

501. Have you been trained in health and family planning ?

1 Yes

2 No

502. Do you maintain close contact with the health and family planning service provider(s) in your locality?

1 Yes

2 No

503. What do you usually do if EPI/FP workers do not come to you in times of need ?

	<u>Yes</u>	<u>No</u>	
I myself go the provider	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Send someone to the provider	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Call the provider at home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Do nothing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Others _____ (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

504. How would you get the required health services if SAVE or other NGOs do not provide the services ?

505. Do you help others (except your household members) in establishing contact with the health service providers ?

1 Yes

2 No

(SKIP TO 508)

506. INTERVIEWER: Check the answers below and tick appropriate box.

1 Participant

2 Dropout

(SKIP TO 512)

3 Never participant

(SKIP TO 512)

507. Did you use to help others in establishing contact with the health providers before becoming member of WSG ?

1 Yes

2 No

508. Do you discuss health issues in your group meetings ?

1 Yes

2 No

(INTERVIEW ENDS)

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509. What do you usually discuss on health matters ?

510. Do you disseminate, among non-participants, health-related knowledge acquired through WSG meetings ?

1 Yes

2 No

(INTERVIEW ENDS)

511. What health-related knowledge did you disseminate during the last three months?

(INTERVIEW ENDS FOR PARTICIPANTS)

512. Is the extent of health consciousness among the WSG participants more/equal/less than others (non-participants) in the community ?

1 More

2 Equal

3 Less

[INTERVIEWER: Check Q.413. If the respondent is "not aware of WSG", write '9'.]

INTERVIEWER: Please check and recheck that all relevant questions are asked and all 'SKIP' instructions are correctly followed, 'THANK' the respondent for her time and cooperation.

INTERVIEWERS NAME: _____

TIME END: _____

INTERVIEWER CODE

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APPENDIX 2

SAVE THE CHILDREN (USA):WSG

Guide for conducting Indepth Interviews with some selected Community Leaders (Members/Chairmen)/SAVE workers/Leaders of WSG:

1. What is the extent of women's (WSG participants, dropouts, never participants) status in the family. That is, to what extent they have control over household resources and say in household decision-making (Source: Community Leaders and leaders of women's savings group).
2. Managerial efficiency (organizing groups, conducting meetings, taking decisions and implementation of the same) of WSGs. That is, to what extent WSG participants have been trained in managing the activities of the group (Source: SAVE workers and leading members of WSG).
3. What resources (cash/kind/space/time) will be locally available in order to ensure continuation of existing health care services in future. (Source: Community Leaders, SAVE workers, and leading members of WSG).
4. Government and other Non-government organizations with whom WSGs are collaborating and the areas of collaboration.(Source: SAVE workers and WSG leaders).