India: Assessing the Reach of Three SEWA Health Services among the Poor

M. Kent Ranson, Palak Joshi, Mittal Shah, and Yasmin Shaikh

The Self-Employed Women’s Association (SEWA), a trade union of informal women workers, was founded in 1972 by Ela Bhatt in Ahmedabad, Gujarat State, India, and is headquartered there. It has more than 469,000 members in 9 of the state’s 19 districts.1 SEWA “is an organization of poor, self-employed women workers. These are women who earn a living through their own labor or small businesses. They do not obtain regular salaried employment with welfare benefits like workers in the organized sector. They are the unprotected labor force of [India]” (SEWA 1999, 83). The organization has two main goals: to organize women workers to achieve full employment and to make them individually and collectively self-reliant, economically independent, and capable of making their own decisions.

Illness, disability, and death are major threats to the overall security of SEWA members. Almost since its inception, SEWA has provided preventive and primary health care in one form or another. Unlike many other SEWA services, such as savings and credit through SEWA Bank and insurance through Vimo SEWA, the services provided by SEWA Health are available to nonmembers as well as to SEWA members. Providing health services to the very poor, particularly those living in areas not otherwise served by government or by nongovernmental organizations (NGOs), has been one of SEWA’s primary objectives. Providing health care services to this poor, largely illiterate, and geographically dispersed population poses many challenges.

In India, as elsewhere, the poor die earlier and have higher levels of morbidity than the better off (World Bank 2003). One reason is the difficulty they
face in obtaining health care services. In theory, government provision of health care should cover the poor, but in practice it often does not. This leaves health policy makers and donors with the vexing problem of identifying and overcoming constraints faced by the poor in accessing health care. Health care provision through NGOs—or member-based organizations, or community-based organizations, or people’s organizations—has been suggested as one means of “reaching the poor” (Pachauri 1994).

Research Questions and Background

District-specific data on the availability and utilization of health services are limited, especially with respect to the activities of private and unqualified practitioners. Gujarat, in comparison with India as a whole, has a thriving private for-profit health care sector. The problems with publicly and privately provided care are the same in Gujarat as elsewhere in India: a large but underfunded public sector, a fast-growing but unregulated private sector, and high out-of-pocket expenditures by patients (Peters and others 2002).

Most people in both urban and rural Gujarat use the private sector for outpatient and inpatient services. According to the 1995–96 National Sample Survey Organization (NSSO) survey, 81.8 percent of outpatient treatments among rural residents and 76.3 percent of treatments in urban areas were received from private sector providers. The private sector accounted for 71.0 percent of hospitalizations in urban Gujarat and for 67.4 percent in rural Gujarat (Mahal and others 2000). Among the areas included in this study, the public health care system is strong only in Ahmedabad City, where four large government hospitals provide outpatient and inpatient care.

Distance and lack of financial resources are major barriers to access to health care among the poor in Gujarat. In the districts covered in this study, health care, particularly expensive curative inpatient care, is widely available in urban centers. But for those who live in villages far from an urban center, the closest source of allopathic care may be many hours away. “Twelve percent of rural women have to travel at least 5 km to reach the nearest health facility” (IIPS and ORC Macro 2001, 33).

SEWA’s Health Services

SEWA first became actively involved in the public health field in the early 1970s with health education and provision of maternity benefits. In the early
India: Reach of Three SEWA Health Services

1980s SEWA negotiated with the government of India to help distribute maternity benefits to poor women. (Ghee, a dairy product similar to butter, was provided in kind.) A focus of SEWA Health has always been to build capacity among local women, especially traditional midwives (dais), so that they become the barefoot doctors of their communities. Today, SEWA’s health-related activities are many and diverse. They include primary health care, delivered through 60 stationary health centers and mobile health camps; health education and training; capacity building among local SEWA leaders and dais; provision of high-quality, low-cost drugs through drug shops; occupational and mental health activities; and production and marketing of traditional medicines.

Equity has always been a key concern at SEWA Health. SEWA Union targets the poorest women workers—those who work in the informal sector. SEWA Health aims to provide services to the poorest among SEWA Union’s members, particularly those who are living below the poverty line (less than $1 per day). Administrators at SEWA Health were particularly interested in this study because of their desire to assess the extent to which their services reach the poorest and to learn how the services might be better targeted. The study deals with three specific activities: reproductive health mobile camps, tuberculosis detection and treatment, and women’s health education, as described in table 9.1.

The size of SEWA Health’s target population varies somewhat by type of service. For example, tuberculosis detection and treatment services are delivered to men and women of all ages in two of Ahmedabad City’s five zones. The reproductive health mobile camps and the women’s health education sessions target women of reproductive age, particularly those who are SEWA Union members. SEWA Union’s total membership in Gujarat State is 469,306. In the areas covered by this study, membership is 153,813 in Ahmedabad City, 30,219 in Ahmedabad District (excluding Ahmedabad City), and 100,316 in Anand and Kheda Districts. (Anand District was formed from Kheda District in 2001; because the data cover Kheda District before the division, we refer to Anand-Kheda as a single district in the study.)

REPRODUCTIVE HEALTH (RH) MOBILE CAMPS. In response to demand from people in remote and underserviced areas, SEWA Health began organizing mobile health camps in 1999. The camps typically address a certain set of illnesses—for example, general eye health, male reproductive tract infections, and female reproductive and child health. The RH mobile camps are the most frequently conducted and are the focus of this study. RH mobile camps...
operate mainly in Ahmedabad City, Ahmedabad District, and Anand-Kheda and Patan Districts. They are largely funded by the United Nations Population Fund (UNFPA) and the government of India. More than 35 camps are held each month, and the average attendance per camp is 60, with roughly equal numbers of women and children. The camps serve more than 12,500 adult patients a year. Health care at the camps is provided by

Table 9.1. Summary of the Three SEWA Health Services Covered by the Reaching the Poor Study, India

<table>
<thead>
<tr>
<th>Variable</th>
<th>Reproductive health mobile camps</th>
<th>Tuberculosis detection and treatment</th>
<th>Women’s health education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target population</td>
<td>Women of reproductive age</td>
<td>Men and women, all ages</td>
<td>Women of reproductive age</td>
</tr>
<tr>
<td>Geographic coverage</td>
<td>Mainly Ahmedabad, Kheda, and Patan Districts</td>
<td>North and East Zones of Ahmedabad City (population roughly 375,000)</td>
<td>Mainly Ahmedabad, Kheda, and Patan Districts but also the other districts where SEWA Union has members</td>
</tr>
<tr>
<td>Annual rate of utilization</td>
<td>About 12,500 women a year</td>
<td>575 patients under treatment at the DOTS center; 23 served by barefoot DOTS workers</td>
<td>Approximately 6,000 women per year</td>
</tr>
<tr>
<td>Cost to user</td>
<td>5 rupee consultation fee; medicines sold at wholesale price (approximately one-third market price)</td>
<td>Services free; indirect costs only</td>
<td>5 rupee SEWA Union membership fee</td>
</tr>
<tr>
<td>External donor</td>
<td>UNFPA and government of India</td>
<td>WHO, government of India, and Ahmedabad Municipal Corporation</td>
<td>Government of India, UNFPA, Ford Foundation, and MacArthur Foundation</td>
</tr>
<tr>
<td>Human resources currently devoted to activity</td>
<td>6 part-time physicians; 50 barefoot doctors and managers</td>
<td>5 stationary centers (each with 2 to 3 staff); 11 grassroots DOTS providers</td>
<td>35 grassroots workers and full-time staff</td>
</tr>
</tbody>
</table>

Source: Authors’ compilation.

Note: DOTS, directly observed treatment, short course; SEWA, Self-Employed Women’s Association; UNFPA, United Nations Population Fund; WHO, World Health Organization. All the programs listed began in 1999. In 2001 Kheda District was divided into Kheda and Anand Districts; SEWA operates in both.
impaneled physicians and 50 barefoot doctors and managers. The camps are repeated in each area, on average, once a year.

Activities at the RH mobile camps include education and training, examination and diagnostic tests (including cervical examination and Pap smears), treatment, referral and follow-up. Camps are usually held during the afternoon and last three to four hours. Those attending the camps are asked to pay a contribution of 5 rupees (Rs) and one-third of the total cost of medicines provided, although even these fees may be waived for those who are very poor.

Increasingly, particularly in rural areas, SEWA Health conducts the camps in collaboration with the government of Gujarat State at primary health centers (PHCs), which are usually located in or near small villages. These camps differ from the standard “area” camps described above in that medicines are given free of charge and are restricted to those in the government’s formulary, and health care is provided by public doctors and nurses. SEWA provides free transportation to women living in neighboring villages.

TUBERCULOSIS DETECTION AND TREATMENT. Since 1999, SEWA Health has collaborated with the World Health Organization (WHO), the government of India, and the Ahmedabad Municipal Corporation to provide tuberculosis treatment (directly observed treatment, short course, or DOTS) to residents of Ahmedabad’s North and East Zones, which have a total population of roughly 375,000. These zones were assigned to SEWA under the Revised National Tuberculosis Control Programme (RNTCP). Services are currently provided through five stationary centers, two of which include laboratory facilities, and 11 barefoot doctors. Patients are identified through local education and information meetings or are referred from the government hospital in the area. Diagnostic services and medicines, which would otherwise cost from 7,000 to 9,000 rupees per full course of treatment, are provided free of charge. To date, almost 4,500 people have received treatment for tuberculosis (4,135 through the stationary centers, and 230 from the barefoot DOTS workers). Among those overseen by the barefoot doctors, the dropout rate is almost nil, while the dropout rate at stationary centers is 7 percent. The sputum conversion rate among those who complete treatment is 97 percent.

WOMEN’S HEALTH EDUCATION. Apart from the education provided at health centers and health camps, SEWA Health organizes many health education sessions in the nine districts where SEWA is active, primarily in Ahmedabad, Anand-Kheda, and Patan. In 2000/01 approximately 6,000 adult women participated in these sessions, which are organized on
demand by barefoot doctors and managers. Each education session lasts two days, and six different packages are offered: SEWA orientation; first aid; general disease and HIV/AIDS; immunization and child care; airborne and waterborne diseases and tuberculosis; and “Know Your Body,” which focuses on sexual and reproductive health. Each woman’s name and address is recorded, and the woman obtains a certificate of participation for attending all six sessions. In all, 35 grassroots trainers and full-time staff provide education. These efforts are supported by the government of India, the UNFPA, the Ford Foundation, and the MacArthur Foundation.

**Potential Constraints on Utilization of SEWA Health’s Services**

Table 9.2 provides an overview of the conceptual framework that guided this study. It divides the constraints that may prevent SEWA Health from

<table>
<thead>
<tr>
<th>Demand side</th>
<th>Supply side</th>
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</thead>
<tbody>
<tr>
<td>Time constraints (work, domestic chores, child-care commitments, and the like)</td>
<td>Inappropriate timing (for example, conflicts with working hours)</td>
</tr>
<tr>
<td>Lack of transportation to or from the service</td>
<td>Inaccessible location</td>
</tr>
<tr>
<td>Lack of information or knowledge about the service (not knowing about the service; not understanding the potential benefit of the service)</td>
<td>Problems with service quality (for example, not user friendly)</td>
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<tr>
<td>Perceived cost (direct costs of the service; indirect costs of transportation)</td>
<td>Failure to adequately advertise and promote the services (for example, among those who are homebound because of a disability and those who do not leave the home for work)</td>
</tr>
<tr>
<td>Fear (for example, of high costs, condescending doctors, or being asked to read something)</td>
<td>Fees or medicine costs too high</td>
</tr>
<tr>
<td>Lack of trust in SEWA Health</td>
<td>Indirect costs, such as time lost from work, too high</td>
</tr>
<tr>
<td>Belief that health is not important</td>
<td>Infrequent visits by mobile camps</td>
</tr>
<tr>
<td>Lack of positive self-concept; for example, women may seek care for husbands and children but not for themselves</td>
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reaching the poorest women into demand-side factors (characteristics of individuals or groups in the target population) and supply-side factors (characteristics of SEWA Health).

Methodology

The research was carried out in the two districts where SEWA Health was functioning most intensively: Ahmedabad District (population 5.8 million, including Ahmedabad City, 2001 census) and Anand-Kheda District (3.8 million).

Data for the study were gathered in three phases. In the first phase, qualitative data were collected to identify possible constraints on utilization of SEWA Health services by those of low socioeconomic status (SES) and the nature of any such constraints. In the second phase, quantitative exit survey data were collected to assess the socioeconomic status of SEWA Health service users for comparison with that of nonusers and the population as a whole. In the third and final phase, in-depth interviews were conducted with SEWA Health workers to explore the factors underlying the success of the urban health services.

Phase 1

Six focus group discussions among SEWA Health’s target population and six in-depth interviews with SEWA Health functionaries were undertaken. Two interviews of each type were conducted for each of the three SEWA Health services being studied.

The focus group discussions were held in poor areas—either slums in Ahmedabad City or poor rural areas. For each group discussion, we purposefully selected two women of reproductive age who had recently used SEWA Health services and two women living in adjacent or nearly adjacent homes who had not used the services, for a total of four. To be eligible to participate, women had to be willing to spend at least one hour in the focus group discussion at the assigned time, at a place within their residential area. No attempt was made to select the poorest women living in these poor areas. Any attempt to exclude the “nonpoor” from the interviews would have been entirely subjective because we had not developed any objective indicators of socioeconomic status. In fact, that was one of the objectives of the focus group discussions. Each session began with a participatory wealth-ranking exercise. Women then discussed whether and why the poorest women or households in their area had difficulty in accessing SEWA Health services.
In-depth interviews were conducted with SEWA Health grassroots service providers. These women were asked to describe their work with SEWA Health and to discuss problems faced by the poor in accessing the services.

Focus group discussions and in-depth interviews were conducted in Gujarati. With the permission of respondents, they were videotaped. They were later translated into English and transcribed by the interviewer. The transcribed interviews were coded, applying predefined codes and using N-Vivo software.

Phase 2

SAMPLE SIZE. The aim was to interview 500 users of each of the three SEWA Health services, for a total of 1,500 interviews. We estimated the necessary sample size using proportions. For this calculation, we decided to look at whether the proportion of SEWA Health users falling below the 30th decile, which roughly approximates the poverty line in Gujarat, was significantly different from 30 percent. The standard error for the proportion of SEWA Health users below the 30th decile would be highest for a value of 50 percent. To achieve a 95 percent confidence interval of <5 percent—that is, of 47.5 to 52.5 percent—a total of 385 observations per service would be required. Our sample sizes were well above this figure.

QUESTIONNAIRE. The questionnaire included items about the service user, family characteristics, household assets, utilities, dwelling, and land ownership, as well as several questions about respondents’ perceptions of the SEWA Health service used.3 We were careful to include all questions about household assets, utilities, dwelling, and land ownership that were in the 1998–99 Demographic and Health Survey (DHS) in Gujarat State. The wording of the questions asked was identical to that in the DHS, and our interviewers were trained using the DHS instruction manuals.

The questionnaires were administered by six female grassroots researchers who received more than two weeks of training. Pilot testing was conducted for one week, with each researcher administering between 8 and 10 questionnaires. Throughout the survey, all questionnaires were carefully checked by two field supervisors.

SAMPLING. Methods of sampling varied slightly between the three SEWA Health services in order to capture as random a set of respondents as possible.

In the case of the reproductive health mobile camps, a list of camps planned for a one-month period was compiled. (The camps operate Mon-
day through Saturday.) The number of camps ranged from one to three per day. For each day, one camp was randomly selected (if only one camp was planned, that one was automatically selected), and all users at the selected camps were interviewed. After completing the 500th interview, we continued until all respondents at the final camp had been interviewed; thus, we ended up with a sample greater than 500.

For the women’s education sessions, we received the schedule one week at a time. The number of camps ranged from three to four per day. Each day, two sessions were randomly selected, and all users at the selected sessions were interviewed. Again, this resulted in a sample slightly larger than 500.

For the tuberculosis detection and treatment services, the interview team was divided to cover the five DOTS centers. The list of patients kept by the centers was found to include many people who had discontinued or completed their course of medication, and these lists were deemed inappropriate for sampling. Over approximately four weeks, all people presenting to these centers were interviewed, resulting in a sample size substantially greater than 500.

**REINTERVIEWS.** To check the reliability of responses, we reinterviewed approximately 10 percent of all respondents in both urban and rural areas. The reinterviews were generally conducted within 72 hours of the first interview, at the respondent’s home and by a different interviewer from the one who conducted the first interview.

**DATA ENTRY AND ANALYSIS.** Questionnaire data were double-entered into a custom-made EpiInfo database. Data were analyzed using Stata statistical software.

Socioeconomic status indexes were constructed on the basis of factor analysis of a reference standard database. These indexes were then applied to the users surveyed in our study. Urban and rural data were analyzed separately, on the assumption that wealth indicators vary markedly between urban and rural Gujarat.

For the urban sample, we chose from three reference databases: DHS 1998–99, all urban Gujarat State (N = 1,709); DHS 1998–99, Ahmedabad City (N = 476); and a Vimo SEWA 2003 database for Ahmedabad City (N = 746). After comparing these databases, we chose to use Vimo SEWA 2003 as the reference standard. A small number of variables that were available both in the Vimo SEWA database and from our exit surveys were dropped from the analyses on the basis of comparisons between the DHS and Vimo SEWA databases. It was believed that differences between the databases with
respect to these specific indicators were attributable to the limited reliability of the indicator rather than to changes in socioeconomic conditions in Ahmedabad City during the five-year period.

For our rural sample, we chose from three reference databases: DHS 1998–99, all rural Gujarat State (households from 19 districts, N = 2,223); DHS 1998–99 for only the two districts where our exit surveys were conducted (N = 309); and a Vimo SEWA 2003 database for nine rural Gujarati districts, including the two districts where we conducted exit surveys (N = 784). Ultimately, it was impossible to choose between the DHS 1998–99 database for all rural districts and the Vimo SEWA 2003 database, so we used both in turn as reference databases and tested the sensitivity of results to choice of database.

**Phase 3**

Six in-depth interviews were conducted with SEWA Health grassroots managers. These women were asked to describe their work with SEWA Health and to discuss whether they thought SEWA Health services reached poorer residents of Ahmedabad City and why they thought so.

The interviews were conducted in Gujarati and were audiotaped. They were later translated into English and transcribed by the interviewer. The transcribed interviews were coded, applying predefined codes and using N-Vivo software.

**Nature and Sources of Data**

This section briefly describes the two reference databases—DHS 1998–99 and the 2003 Vimo SEWA (SEWA Insurance)—that provided information on the socioeconomic status (SES) of the general population.

**DHS Database**

The SES indexes were derived from DHS 1998–99, also known as the National Family Health Survey–2 (NFHS–2). Data were collected by the International Institute for Population Sciences (IIPS), Mumbai. The NFHS-2 (IIPS and ORC Macro 2001) was a follow-up to the first National Family Health Survey (NFHS–1), conducted in 1992–93. The primary aim of the NFHS–2 was to provide state- and national-level information on fertility, family planning, infant and child mortality, reproductive health, child health, nutrition of women and children, and the quality of health and fam-
ily welfare services and to examine this information in the context of related socioeconomic and cultural factors.

In all, 4,153 households were selected in Gujarat. Rural and urban areas were sampled separately. The rural sample was constructed in two stages: the selection of 87 villages (or groups of villages, in the case of small, linked villages) with probability proportional to population size (PPS), followed by the selection of 15 to 60 households within each village. In urban areas a three-stage sampling procedure was followed. First, 46 wards were selected with PPS. Next, from each selected ward, one census enumeration block was selected with PPS. Finally, households were selected using systematic sampling in each selected enumeration block.

**Vimo SEWA Data**

The Vimo SEWA data were collected from May through August 2003 under a joint project carried out by Vimo SEWA (SEWA Insurance) and the London School of Hygiene and Tropical Medicine and funded by the Wellcome Trust. This survey was part of baseline work intended to assess the socioeconomic status of Vimo SEWA members (in comparison with the general population) prior to implementation of interventions intended to optimize the equity impact of the insurance scheme. The Vimo SEWA questionnaire was based on a standardized tool developed by the International Food Policy Research Institute (IFPRI) to measure the poverty of microfinance institution clients (Henry and others 2000). The questionnaire included sections on dwelling-related indicators (size and condition of dwelling and facilities available), family structure, food-related indicators, and other asset-based indicators.

This survey was administered to 800 households in Ahmedabad City and 800 households in the nine rural districts of Gujarat where Vimo SEWA has members. Two-stage random cluster sampling was used. In Ahmedabad City 50 enumeration blocks (out of 10,385) were first randomly sampled. Within each enumeration block, 16 households were randomly selected from the enumeration block maps (2001 census). In rural Gujarat 50 towns or villages were randomly sampled with PPS (1991 census) of the town or village. As in Ahmedabad, 16 households within each town or village were randomly sampled from enumeration block maps.

**Findings about Distribution**

The socioeconomic status of SEWA Health service users is compared here with that of the general population, first for urban and then for rural areas.
Urban Findings

For all three services in urban areas, the mean SES scores of the users are significantly lower than the mean SES score (by definition, 0) of the general population (reference population: Ahmedabadis in the Vimo SEWA survey, 2003). The mean SES scores are –0.42 for RH camp users (95 percent confidence interval = –0.51 to –0.34), –0.36 for tuberculosis detection and treatment users (95 percent confidence interval = –0.43 to –0.29), and –0.61 for women’s education participants (95 percent confidence interval = –0.88 to –0.35).

As can be seen in figure 9.1, the percentage of users falling below the 30th decile of the SES score—which roughly approximates the poverty line in India—was about 50 percent for all of the services. The percentage of users falling below the 30th decile was 51.9 percent for RH camp users (95 percent confidence interval = 46.7 to 57.0 percent), 47.4 percent for tuberculosis detection and treatment users (95 percent confidence interval = 43.5 to 51.2 percent), and 47.5 percent for women’s education participants (95 percent confidence interval = 36.2 to 59.0 percent).

The concentration curves for all three services suggest that SEWA Health services are equitably distributed in Ahmedabad City and that they are predominantly used by people from poorer households (figure 9.2). All three concentration curves lie well above the line of equality. The concentration indexes are –0.37 for RH mobile camps, –0.33 for tuberculosis detection and treatment, and –0.37 for women’s education sessions.

Of the urban users, 104 were reinterviewed at their homes. The index scores for these reinterviews correlate highly with scores based on the original interviews. A paired t-test shows no significant difference; first interview to reinterview, \( p = 0.25 \).

Rural Findings

The mean SES scores of RH camp users do not differ significantly from the mean score for the general population, regardless of which reference standard database is used. The women’s education participants have a significantly higher mean SES score relative to the Vimo SEWA 2003 database but not the DHS 1998–99 database. Using the Vimo SEWA 2003 database as reference standard, the mean SES scores are 0.024 for RH camp users (95 percent confidence interval = –0.054 to 0.10) and 0.19 for women’s education participants (95 percent confidence interval = 0.12 to 0.27). Using the DHS 1998–99 database (all 19 rural districts) as reference standard, the mean SES scores are –0.068 for RH camp users (95 percent confidence interval = –0.14
Figure 9.1. Frequency Distribution of Urban SEWA Health Users by Deciles of the Socioeconomic Status Index Score

Reproductive health camps (N = 376)

Tuberculosis detection and treatment (N = 661)

Women’s health education (N = 80)

Source: Authors’ calculations.
to 0.0082) and 0.068 for women’s education participants (95 percent confidence interval = –0.0086 to 0.15).

Figure 9.3 shows the frequency distribution of rural SEWA Health users by deciles of SES index score for both reference standards. Users of both the RH camps and the women’s education sessions are significantly less likely to fall below the 30th percentile than are households in the general population. Using Vimo SEWA 2003 as the reference standard, only 5.7 percent of RH camp users (95 percent confidence interval = 2.6 to 10.5 percent) and 8.5 percent of women’s education participants (95 percent confidence interval = 6.0 to 11.6 percent) fall below the 30th percentile. Similarly, with DHS 1998–99 as the reference standard, 8.2 percent of RH camp users (95 percent
(95 percent confidence interval = 4.5 to 13.7 percent) and 16.4 percent of women’s education participants (95 percent confidence interval = 13.0 to 20.2 percent) fall below the 30th percentile.

The concentration curves for both services, like the frequency distributions above, suggest that SEWA Health’s rural services do not effectively target the very poorest (figure 9.4). The concentration indexes (using Vimo SEWA 2003 as the reference standard) are 0.091 for RH mobile camps and 0.16 for women’s education sessions. (Concentration curves and indexes

Figure 9.3. Frequency Distribution of Rural SEWA Health Users, by Deciles of the Socioeconomic Status Index Score

Source: Authors’ calculations.
using DHS 1998–99 as the reference standard are very similar and are not presented here.)

Of the rural users, 60 were reinterviewed at their homes. The index scores for these reinterviews correlate highly with scores based on the original interviews. A paired $t$-test shows no significant difference; first interview to reinterview, $p = 0.286$.

**Reasons for the Distribution**

Drawing on focus group discussions with SEWA Health users and nonusers and on in-depth interviews with SEWA Health functionaries, this section explores factors that underlie SEWA Health’s success in reaching the poor of Ahmedabad City and the nature of constraints on utilization of SEWA Health services by people of low socioeconomic status, particularly in rural areas.

**Success Factors in Reaching the Poor**

Several grassroots workers attributed SEWA Health’s success in reaching the poor to the fact that it treats poor people with respect and “warmth”:

The patients say that, “at other places, people don’t listen to us, and respond to us, like you do.” Since this is SEWA’s center, they choose
to come here. (SEWA Health tuberculosis grassroots worker, Amraiwadi, Ahmedabad City)

Other organizations do not give out detailed information the way the SEWA workers do. We treat the women like they are our family members. The members say that, “Compared to other organizations, you work closely and warmly with us.” They say, “We need warmth, and the rich people can not give us that.” (SEWA Health grassroots worker, Dholka, Ahmedabad District)

The fact that the services are generally free or low cost makes them more accessible to the poor:

When we made home visits, we saw that the patients did not even have money for food. Then we explained to the patients that, “It is okay if you don’t have money. You don’t have to spend any money at the [tuberculosis DOTS] center. If you take medicines and get cured, then you will be able to earn money.” (SEWA Health tuberculosis grassroots worker, Amraiwadi, Ahmedabad City)

... and the medicines [at RH mobile camps] are also good and low cost. The same medicines are available for Rs 200 to Rs 250 outside [in private drug shops] but we give them for Rs 20 or Rs 25 in our health camps. (SEWA Health grassroots worker, Daskroi Taluka, Ahmedabad District)

Convenient timing was cited as a factor in utilization of the tuberculosis detection and treatment services:

The hours of the center are good, since the patients have to go to work early, and our center operates from 7:30 in the morning to 4 in the afternoon. (SEWA Health tuberculosis grassroots worker, Amraiwadi, Ahmedabad City)

Physical location was seen as contributing to the success of SEWA Health services:

... another reason being that we go right to their doorsteps, and we discuss their problems and the positive happenings in their lives. (SEWA Health grassroots worker, Daskroi Taluka, Ahmedabad District)

We provide a convenient location to the patient, telling them that, “This is an easy location for you to come and take the medicines.” (SEWA Health tuberculosis grassroots worker, Amraiwadi, Ahmedabad City)
Finally, the fact that SEWA Health’s services are delivered largely by women was also perceived as increasing their reach among poor women:

We give our introduction as a union of self-employed women, which means poor women. So the women think that, “Since this is a women’s organization, wherever we go we will be dealing with women,” and so they feel secure. (SEWA Health grassroots worker, Daskroi Taluka, Ahmedabad District)

For area [RH mobile] camps we get female doctors for the women, which is very good, and more and more women attend because of this. Since there is a female doctor, they feel secure. (SEWA Health grassroots worker, Daskroi Taluka, Ahmedabad District)

**Constraints**

The cost, or perceived cost, of services is at times a barrier to using the RH mobile camps. In one interview women explained that on hearing that some charge is being levied for the medicines, the poorest would simply not come:

*Participant 1:* Since it is an issue of money they don’t come . . . Some people would like to come to get the medicines. But then they would wonder as to whether it would cost them. Then they would not come.

*Interviewer:* But then you would have the information that the medicines are at low cost?

*Participant 1:* That they [the health workers] would inform, but then it would cost at least something . . . So when they hear this some people would not come. (focus group discussion 6, Varna Village, Dholka Taluka, Ahmedabad District)

For some, even the Rs 5 registration fee is enough to prevent utilization:

*Interviewer:* There were other women in the area who said they wanted a checkup [as mentioned earlier by one woman]. What happened to them?

*Participant 2:* I had five or six other women with me. But then they all left. They said that “they ask for money over here” so they all left.

*Interviewer:* But then it was Rs 5?

*Participant 1:* The situation is not good.
Participant 2: Where to get Rs 5 from? (focus group discussion 5, Chamanpura Area, Ahmedabad City)

Even SEWA Health grassroots workers acknowledged that the fees charged at the RH mobile camps prevent some from using them:

Grassroots worker: No we cannot provide free medicines for half of these people. Only around two to three women [per camp] are able to get it for free.

Interviewer: So what about the rest?

Grassroots worker: They don’t come!

Interviewer: They would not visit at all?

Grassroots worker: No, they would not come to the camp. We cannot tell everyone that we will get them medicines for free! (in-depth interview 4, Gangad Village, Bawla Taluka, Ahmedabad District)

Women also reported that the RH mobile camps are difficult for women to attend, as they often coincide with working hours:

Interviewer: What are the reasons why people who should ideally visit the camp are not able to do so?

Grassroots worker: At times there is a season in the village [presumably referring to seasons when there is work in the fields]. Then these women go to do work. Because of which they cannot come [to the camps]. If the work is going on, and the women have gone for that, can they come [to the camps]?

Grassroots worker: Mostly the poorest of women would go out and do work [for daily wages]. They would say that “I will have to lose my wages [to be able to attend the camp].” (in-depth interview 4, Gangad Village, Bawla Taluka, Ahmedabad District)

For the health education sessions, the fact that the timing may coincide with work was reported as a major barrier to access:

Interviewer: What are the reasons why some women would not sit in the training?

Grassroots worker: If the woman has gone to work. She would come for the first and the second session, but then if she starts working
after that she is not able to sit for the training. She would tell us that, “since I have started working I cannot sit.” (in-depth interview 1, Shankarbhuvan, Ahmedabad City)

Interviewer: So are the women of very poor category [as classified in the focus group discussion] also able to take advantage [of the training sessions]?

Grassroots worker: When we went to give this training they [the women] told us that you should keep it for two days only, because if we have to go and work outside then how can we sit in your training? (in-depth interview 3, Vanoti Village, Thasra Taluka, Kheda District)

Interviewer: In our women’s education program, are the very poor women able to come?

Grassroots worker: The very poor women are not able to sit. But if we do the training at night, only then they are able to sit with us. Because during the day, they have to go to do work. Hence the very poor women are not able to sit in our trainings . . . So they would say, “Please come at night.” (in-depth interview 4, Gangad Village, Bawla Taluka, Ahmedabad District)

The health education sessions are unique among the services studied in that a full course consists of 12 days of training (2 days per month) spread over six months. Any barrier to access may prevent women from attending the training sessions entirely or may prevent them from attending the full 12 days of training.

Limitations

This section highlights some of the key methodological weaknesses (and strengths) of the study.

Reference Standard Databases

When our draft questionnaire was conceived, it was assumed that our sole reference standard database would be DHS 1998–99. Thus, we were restricted by the contents of the DHS questionnaire and database as to the kinds of assets and household characteristics that could be included in the SES index. For example, it was noted during our fieldwork that the wealth of rural households in Gujarat can be measured by their possession of
kitchen utensils such as brass and steel plates (thalis) and water vessels, but because this category of asset was not included in the DHS questionnaire, it could not be examined as an indicator in our study. Similarly, variables relating to food security and household spending on clothing and footwear—which are found in other studies to be reliable indicators of socioeconomic status—were not available in the DHS database.

Our analyses comparing the DHS 1998–99 survey data with Vimo SEWA 2003 data suggest that urban (or, more specifically, Ahmedabadi) households have grown significantly wealthier, while rural households have grown significantly poorer. We cannot completely rule out the possibility that these changes stem from methodological differences. (For example, the Vimo SEWA surveyors may have been more persistent in revisiting rural households where nobody was present on the first visit, and these might have been the poorer households.) We were able to overcome limitations in the older DHS data by relying more heavily on comparisons with the Vimo SEWA reference standard. (This raises an important methodological question for future studies: when should a reference standard be considered too old to be useful?)

Sample Size

When we calculated our sample size, we assumed that urban and rural areas would be treated as one. But when we started analyzing the qualitative and quantitative data, we realized that urban and rural data would have to be analyzed separately. Thus, we ended up with sample sizes for rural RH mobile camps (N = 158), urban RH mobile camps (N = 376), and urban women’s education (N = 80) that are well below the desired sample size of 500. For the urban results, this is somewhat irrelevant, given that even with these small sample sizes, all three urban services were found to be used by people who were significantly more likely than the general population to fall below the 30th decile.

Exit Survey Data

Since the exit survey was conducted at the same site where the SEWA Health service was delivered, respondents may have misrepresented their wealth. We reinterviewed approximately 10 percent of all respondents, however, in both urban and rural areas. The SES index scores generated, based on the reinterviews, were consistent with scores based on the original interviews. This suggests that there were no large, systematic errors in responses given during the exit survey.
Comparability between Reference Standard and Exit Survey Data

The rural DHS data were collected from rural areas throughout the state of Gujarat (19 districts), while our exit survey data were collected in only two rural districts. Similarly, the rural Vimo SEWA data represent 9 districts. Rural RH camp users and women’s education recipients were found not to be among the poorest. It might be asked whether the two districts where the study was carried out, Ahmedabad and Anand-Kheda, are wealthier than other rural districts in the state. But our comparison of the study districts with the whole state (the 19 districts covered in DHS 1998–99) showed no significant difference in the mean SES score and very few significant differences on the basis of individual variables.

Implications

The study found that in Ahmedabad City, SEWA Health’s services are used disproportionately by the poor (table 9.3). Differences between the three urban health services studied were not statistically significant. In rural areas SEWA Health’s services are used by people who do not differ significantly in socioeconomic status from the general population. The rural health services do not effectively target those below the 30th percentile. In the case of rural RH mobile camps, reaching the poorest may be hindered by the cost (or perceived cost) of services at the health camps. In addition, the rural poor may have difficulty attending the rural health camps and the women’s education sessions because the schedules of these services coincide with working hours.

For the most part, the urban services seem to be effectively targeting the poor. Some likely reasons for this success can be identified:

- Services, especially RH mobile camps and women’s education sessions, are offered “right at people’s doorsteps.” In other words, SEWA Health takes the services to the poor rather than trying to bring the poor to the services.

Table 9.3. Percentage of All Service Users in Poorest Three Deciles

<table>
<thead>
<tr>
<th>Service</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health camps</td>
<td>51.9</td>
<td>5.7–8.2</td>
</tr>
<tr>
<td>Tuberculosis detection and treatment</td>
<td>47.4</td>
<td>8.5–16.4</td>
</tr>
<tr>
<td>Women’s health education</td>
<td>47.5</td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors’ calculations.
• The services are delivered by (or at least in part by) the poor themselves.
• The services are generally combined with efforts to educate and mobilize the community. For example, in advance of the RH mobile camps, SEWA Health workers go door to door, educating people about the service and motivating them to use it.
• Costs are low—certainly, relative to the private for-profit sector.
• SEWA is an entity that people know and trust.

As SEWA Health grows and evolves, efforts should be made not to alter or disturb the characteristics that are likely to have contributed to success in reaching the poor.

The study suggests several changes that can be made by SEWA Health to better reach the poorest in the target population, particularly in rural areas. The first is to hold RH mobile camps and adult health education sessions outside normal working hours. The second is to ensure that the cost of seeking care (registration fees and payments for medicines) at the RH mobile camps does not pose an impediment to access among the poorest. Already, SEWA Health waives the registration fee and the medicine fee for those who appear to be particularly poor—typically, a few women at each camp. Perhaps these exemptions could be granted more liberally and in a more objective manner—for example, by exempting all who possess a below-poverty-line card.

There are likely to be other, broader reasons underlying the difficulties in delivering services to the rural poor. Studies in other SEWA departments have documented similar discrepancies in the equity of utilization of rural versus urban services. For example, the poorest rural members of SEWA’s insurance scheme, Vimo SEWA, have lower rates of claims than the less poor. Reasons for this differential include:

• Problems of geographic access, both to inpatient facilities and to Vimo SEWA’s grassroots workers
• Weaker links (less frequent and less intensive contact) between members and local Vimo SEWA representatives in rural areas
• Weaker capacity among Vimo SEWA grassroots workers in rural areas.

It must be remembered that failure of a service to reach the poorest of the rural poor does not necessarily mean that the service has failed in reaching the poor. Even households that fall in the higher deciles of the SES index in rural areas should be considered “less poor” rather than “wealthy.” Compared with their urban counterparts, these rural house-
holds have less in the way of cash reserves, material wealth, and, thus, economic security.

More generally, our findings suggest that delivery of services through a broad-based, development-oriented union can facilitate equitable delivery of health care services. Government and donors can help ensure that established NGOs with an interest in providing health services have the capacity and the resources to do so.

Notes

This chapter is a condensed version of a study prepared for the World Bank’s Reaching the Poor Program. The full study is available from the authors on request.

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1. In 2001 several districts in the state were divided, and the number of districts increased from 19 to 25. Today, SEWA works in 11 (before the split, 9) of these districts. To facilitate comparison with DHS 1998–99, we refer to the 19 districts as they existed prior to 2001. The redistricting most important for our report is the division of Kheda District into Anand and Kheda Districts.

2. The focus of this chapter is on adult women users of the reproductive and child health camps. For this reason, these camps are referred to as reproductive health (RH) mobile camps throughout the chapter.

3. The full questionnaire and the detailed technical appendixes are included in the longer version of this chapter, which can be obtained from the authors.

References


