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SHG IN EMPOWERING WOMEN'S HEALTH – AN EMPIRICAL STUDY

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Abstract
With the United Nations Millennium Declaration of 2000, the establishment of Self-Help Groups (SHGs) has been identified as a significant strategy in addressing the alarming levels of poverty and marginalization of women that have accompanied global development especially in Health aspects. The self-help groups (SHGs) will play a larger role in its contribution towards improving women's health and empowerment as well as for achieving 'Millennium Development Goals' in developing countries.[1] This paper investigates the functioning and limitations of self-help groups in improving the women's health and empowerment, focusing on the implementation of the concept through an empirical work undertaken in the Rural Villages of Puducherry. It critically analyses the extent to which SHGs can be involved in attaining better health for women and found that Self Help Groups focus mainly towards savings and credit activities than on empowering women and facilitating access to health services. The study further explores that women's economic empowerment through micro-credit programmes doesn't have a direct impact on women's health. However, there may be indirect positive impacts on health but ultimately there has been a lag in the implementation of SHG when empowerment in the Health of the Women is concerned.

BACKGROUND

Women, the gender that represents nearly half of the human resource are often not recognized and regarded as equal stake holders, due to their positioning in the society. Women themselves have failed to recognize that they are working though they are not paid. For the first time in 1981 the Indian Census included certain kinds of work which have market value on opportunity cost or imputation basis and succeeded in bringing activities such as fetching fuel wood, making pickle, etc. were included. However, even if women's work does get included will they fetch recognition to them is a question. There is a tendency in general to relate women and their role predominantly to reproduction particularly biological reproduction. Women perform in addition to biological reproduction, several other tasks, but often, they are not visible. It is their biology and their reproductive role that overwhelms their productive role of earning and meeting livelihood needs. Realizing this, the Millennium Development Goal [MDG][2] has been designed to enhance the economic and social well-being of the large majority of marginalized people throughout the world especially with special focus to women, the deprived sections of the nation.

One of the strategies identified for advancing these goals was the establishment of Self-Help Groups (SHGs)[3], particularly in rural regions especially to eliminate the social exclusion of poor women. In India, SHGs are usually oriented to the needs and interests of women, with most of their activities concentrated on economic empowerment by providing financial savings and credit activities apart from specifically designated activities focusing on health, personality and educational attainment.

While health is obviously an integral component of women's well-being and empowerment, it is also organically linked to their empowerment within the household and the society. It is in this context, that SHGs can play the important role of ensuring good health for the women through empowering them within the household as well as within the society.

Given the important role of health as an essential constituent of total well being, it has been reiterated time and again by researchers, policy makers, and in various policy documents that no society or nation can achieve total well being of its people ignoring health. In other words, women's empowerment cannot be achieved by ignoring or denying issues related to health of women. Although women's empowerment has been a central issue on the agenda of various developmental

[1] *Anant Kumar, Jharkhand Journal of Development and Management Studies, XISS, Ranchi, Vol. 4, No. 3, September 2006, pp. 2061-2079.*

[2] *The millennium development goals are (1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality, (5) improve maternal health, (6) combat HIV/AIDS, malaria, and other diseases, (7) ensure environmental sustainability, and (8) develop a global partnership for development..*

[3] *SHG's are small voluntary associations of people from the same socio-economic background established for the purpose of solving common problems through self-help and mutual help.*

programmes for so many years, women's health has got little attention or at best it has been confined to the field of family planning and contraception. There has been no attempt to address the issue of women's health in a comprehensive way, touching multiple domains of their health so as to have an impact on their total well being.

There is a common perception in development literature that the increased participation of women in savings and credit activities, or economic attainment, will empower women by helping them to access and utilize better health services and facilities, and by elevating the health, nutritional, and educational status of their families, in particular that of children. One of the major consequences anticipated to result from this empowerment is the enhancement of women's welfare, particularly in relation to their health. The underlying approach to women's participation in micro-finance programmes, then, has been highly instrumental, not only in terms of their own socio-economic well-being but in relation to that of their families as well. Numerous studies have shown, however, that while women may be empowered in one area, this does not necessarily translate into empowerment in others. This is attributable to a number of factors but fundamental to the constraints on interventions such as SHGs are structural inequalities.

In this context, the establishment of SHGs as a major strategy for eliminating poverty and improving women's access to better health services and resources has attracted significant scholarly criticism. Contributors to this critique argue that SHGs can be used as a strategy for local level health interventions and development, but they cannot be adopted as a strategy to provide equitable health access. According to this view, economic benefits generated by SHGs may not necessarily empower women who participate in them. Moreover, women's access to health cannot be achieved in the absence of an adequate standard of living, including the public provision of functional health infra-structure, services and facilities. The researchers on this area argue that socio-economic and political conditions have a greater impact on access to health services. Without addressing these developmental issues and challenging the different social inequalities, it is simply not possible to provide equitable health access to women and children.

Although the links between self-help groups, women's empowerment and health are always viewed as optimistic, cost effective in eliminating poverty, empowering them and improving their health, it is evident from various studies that women have benefited to a limited degree in all the three aspects. Many women do not control the loan use, most of them are engaged in low paid, traditionally female activities, and increases in income are small/ marginal with minimal empowerment and very little impact on their health.

However, till date, the functioning of SHGs has been viewed only from an economic perspective. The existing approach emphasizes economic development of people and women in particular, in case of women SHGs. However how these economic benefits are being translated into change in women's status, particularly their health status has not been explored. The paper explores the extent to which SHGs can be involved in attaining women's empowerment and better health for them. This analysis is primarily based on the available literature on the functioning of SHGs and their role in enhancing women's empowerment and health, along with preliminary findings from a field survey using a participatory methodology.

METHODS AND ANALYSIS

The Union Territory of Puducherry was constituted out of the four erstwhile French establishments of Pondicherry, Karaikal, Mahe and Yanam. Puducherry and Karaikal are embedded with Tamil Nadu. The bulk of Puducherry region is an irregular stretch of land consisting, the municipalities of Puducherry & Oulgaret and commune panchayats of Ariankuppam, Villianur, Nettapakkam, Mannadipet and Bahour. In a broader view, Puducherry has three blocks, Villianur, Ariyankuppam and Oulgaret. The total area of Puducherry region and its eleven enclaves is 290 Sq. km, with the total population at 735,332 according to the 2001 census.

The broad research area selected for this particular study is Villianur block which consists of 11 circles (Table 1) and the research was concentrated on one particular circle, i.e, Villianur circle. Among the number of SHG in different circles in Villianur block, Kodathur has more number of SHG and Villianur circle which is selected for the study has less number of groups. Also while considering the year of formation of SHG, it could be seen that more groups have been formed in the year 2001, with respect to the blocks, similarly in the circle that is selected for the study. (Table- 2).

Villianur circle consists of 13 groups, in each of which the number of members differs (Table 3). The total numbers of members in the 13 groups are 208 members. This particular circle is selected for the study. An application of Participatory

Rural appraisal Methodology is applied for the analyzing the role of Self Help Groups in empowering the Health of the Women.

FIELD PREPARATION

Prior to conducting the PRA training, secondary sources were reviewed, including books, journal articles and unpublished documents on SHG Women in Puducherry, especially in the focused research area Villianur. While analysing, this review revealed a notable lack of detailed and reliable data on SHG and Women's Health in the area of research. Women self-help group members were interviewed and selected case studies were conducted. Later, Semi-Structured Interviews were also conducted with key informants in Villianur, Puducherry. The key informants included the representatives from Government under the SGSY programme includes the DRDA project officer, BDO Officer of Villianur, Gramsevaka of Villianur Circle and Training Institute officials to determine their expectations and experiences as regards what SHG can or have been able to achieve in any aspects of the health system. Selected focus group discussions (FGD) were conducted with group members from selected SHGs. FGDs were aimed at determining individual members' perceptions about their roles, expectations and their achievements in health. The interviews aimed at obtaining an idea of the problems envisaged and the prospects of involving SHG in health related work and highlighted the key issues related to women's health, specifically, on few concerned areas like

- SHG Women's Health Status
- Level of Health Awareness
- Role of SHG in promoting health empowerment

TOOLS ADOPTED

To approach the various topics and sub-topics, the researcher reviewed the range of existing RRA/PRA literature to select the most appropriate methods from the 'basket of tools'. Semi-structured interviewing of SHG women, groups and key informants, review of secondary sources, and direct observation were obvious choices.

Semi-structured interviews were carried out with about 60 SHG women, several key informants, and a Focused Group Discussion with few groups of women. The information from these interviews formed the core results of the PRA.

RESULTS AND FINDINGS

I. CONSTITUTION OF SHG

As stated above, one of the major programme of poverty alleviation in India using SHGs is the "Swarnajayanti Gram Swarojgar Yojana" (SGSY). Under this, the government appoints a Non-Governmental Organisation (NGO) or its own workers to help the rural poor women to come together to form a SHG. Once the women have formed the SHG, they start saving small sums of money which belongs to the group. This is known as the "Revolving Fund (RF)" stage. The monthly contribution ranges between Rs 50 to Rs 100 per person. This amount is collected every month by the secretary of the SHG and is deposited in the bank account of the SHG. Individual members can borrow money from this fund for their personal purposes. Members do borrow from this. The amount borrowed can be anything but it is normally seen to be around Rs. 300 to Rs.1000. Interest is charged on these internal borrowing, normally at the rate of two percent per month.

Once an SHG reaches 'A' grade in the RF stage, i.e. it shows financial maturity in handling large amounts of money, it is eligible for a loan from scheduled commercial banks in multiples of its savings. This loan amount is to be distributed amongst the members as per the discretion of the SHG, but has to be for an income generating activity. Hence women, when applying to the bank for the loan have to specify what they intend to use it for. This is part of the activity selection in which the women are helped by the NGO workers. Normally, under SGSY a loan of Rs. 2,50,000 is given to each SHG. Of this, Rs. 1,00,000 are the subsidy component and the remaining Rs.1,50,000 are meant to be the credit component. The rate of interest charged by the bank is between 9.5 % to 10.5%. The total loan given to the group is generally shared equally between the members. Repayment is to be made in monthly installments. The amount of installment is decided by the women at their monthly meetings. These range between Rs. 300 to Rs. 500 per person per month. This is the overall structure of SHG in Puducherry.

SEMI STRUCTURED INTERVIEW RESULTS

The semi structured interview was based on several health indicators on which the Health empowerment of the women were analysed. The indicators were categorised under three broad headings (Table v)

- Impact of SHG on Women Empowerment
- Impact of SHG on Health Knowledge and Awareness

- Impact of SHG on Women's Health Perception and Behaviour
- Impact of SHG on Empowerment and Health

Mainly for analysing all three aspects, more than 30 indicators are used. The respondents were interviewed on the basis on the indicators on the above Four categories. They were asked to mark their desired replies in a paper using symbols. If there is an impact of any particular indicator, a cross has been made to mark. The respondents showed high interest in participating and based on the marked indicators, interview discussion was continued in order to find out the reason it. The first objective on the impact of SHG on Women Empowerment focussed to find out the overall empowerment level of respondent with regard to SHG. Though the respondents feels that the SHG gave them a stand in their economic level, by increasing their income through employment opportunities, still others factors like family empowerment, importance in family and community, health awareness are still having a long way to go. (Table VI)

Similarly, the second objective on Impact of SHG on Health Knowledge and Awareness clearly depicts that the SHG has not brought any change in their knowledge level as well there is no awareness about Child Care, family planning methods, contraceptive usage, post natal care which are more crucial for nation development. Thus SHG's role in transforming and generating the health knowledge among the women is minimal. (TableVII).

Our third objective of research, on the Impact of SHG on Women's Health Perception and Behaviour clearly summarises their perceptions towards Health. Respondent's opinion on sickness is very unique and different. Self Medication found in major cases. If in need of a treatment, the first level contact for care is Primary Health Centre, Villianur. Very rarely the respondents opt for Private clinics, since it's too expensive. Also, since first deliveries are not undertaken in that PHC, due to lack of facilities, those cases would be sent to Government Hospitals for further treatment.

The final objective of exploring the Impact of SHG on Women Empowerment and Health shows that the health awareness and the knowledge of women are much less. The women SHG members are not that exposed to Health schemes of the Government as well as other bodies. On the whole, The Health Empowerment of the Women through SHG is very low.

SUMMING UP FROM THE FOCUSSED GROUP DISCUSSION AND KEY INFORMANT INTERVIEWS

Findings from the Focus Group Discussion suggest that health related expenditure is the major cause of indebtedness. It is well known that health care costs have a devastating effect, particularly on the lives of low income individuals, often impoverishing them. Although poor in India are entitled to almost free medical treatment in public health facilities, they end up paying a significant part of their income on account of medicines and visiting private health facilities where public health facilities are either non-existent or bad.

The findings show that the goal to promote and enable women's groups in the self-help mode to undertake responsibilities of change at a local and larger framework of issues related to gender and community level development was not fully achieved and it is not reflected in their day to day life. There is not much change in their living standard and development at community level. They live in villages where there are not proper sanitation and water facility available despite various government programmes at the Block and District level. Although these women are aware and conscious of their rights, this is not realized and translated in their life due to various social, cultural and economic factors. Education is a major hindrance in this process of women's empowerment where these women are dependent on others for information and official work.

May be, the women agreed that there has been change in their status after joining the group. Many did not know how to sign their name but the facilitators have taught them and they are interested to join adult education classes. They say that they are having respechey have associated with SHG activity as the family members think that SHG activity will help the family in the times of need as they have seen in the case of other group members who are in SHG for longer time and have shown better examples. Transformation is not only reflected in her character and attitude but is also well reflected in her pursuit, which is to excel, to improve her household's quality of living, to see her children go to school, to help her man with resource support during crisis, to work for the common good, to participate in the development planning and initiatives, etc. In reality, most of these are still at the need level and have not been achieved and realized.

CONCLUSION

As long as improving health outcomes through the SHGs is concerned, it has again been found that most SHGs having focussed only on economic issues, have not been able to raise the knowledge and awareness on health related issues among

women. The field study shows that although as a result of participating in the SHGs, women are less dependent on the informal money-lenders for meeting their health expenses, there has not been any significant improvement in health behaviour or knowledge about health related issues. There has been however a slight increase in access to private health services.

Women's health is very much dependent on existing gender relations, access to health care among the poor and income and quality of life of the poor. The SHGs can play an important role in creating awareness on health issues through group meetings with women, by holding specific capacity-building trainings with the women on health issues, giving them exposure to larger issues and so on. However, this can have a substantial influence on women's health and empowerment only when these activities are taken up along with attempts to question the existing (gender) power relations in the community and within the family and improving the public provision of health care facilities.

The study found that Self Help Groups major activities are more focused towards savings and credit activities than on empowering women and facilitating access to health services. Although SHGs were expected to play a significant role in women's health and empowerment, basic need of food, shelter and work came out as primary to their life and well being and without achieving or fulfilling these basic primary needs of food, shelter and work, one cannot empower the women or provide better health and life. The study further explores that women's economic empowerment through micro-credit programmes doesn't have a direct impact on women's health. However, there may be indirect positive impacts on health but ultimately there has been a lag in the implementation of SHG when empowerment in the Health of the Women is concerned, which has to be taken under consideration by the policy makers.

TABLES FOR REFERENCE

Table 1, Circle Wise Distribution of SHG in Villianur Block

S.NO	Name of the Circle	No of Groups	Percentage
1	ARIYUR	28	6.7
2	G.N. PALAYAM	27	6.5
3	KODATHUR	57	13.7
4	KOODAPAKKAM	41	9.8
5	MADAGADIPET	39	9.4
6	SEDARAPET	49	11.8
7	SUTHUKENY	52	12.5
8	THIRUBUVANAI	38	9.1
9	URUVAIYAR	23	5.5
10	VATHANUR	50	12.0
11	**VILLIANUR**	**13**	**3.1**
	TOTAL	417	100.0

Table 2

Year of Formation of SHG	No of Groups	Percentage
1999	2	0.5
2000	16	3.8
2001	**103**	**24.7**
2002	50	12.0
2003	22	5.3
2004	1	0.2
2005	23	5.5
2006	66	15.8
2007	61	14.6
2008	44	10.6
2009	29	7.0
Total	417	100.0

Table Iii - Year of Formation of SHG in Villianur Circle

Year	No of Groups	Percent
2001	**5**	**38.5**
2002	2	15.4
2006	1	7.7
2007	3	23.1
2008	2	15.4
TOTAL	13	100.0

Table IV - Distribution of SHG in Villianur Circle

SL. NO	Name of The SHG& Village	Date of Formation of SHG	Total Members
1	SRI ANDAL SHG,KANUVAPET, VILLIANUR	24/01/2001	10
2	SRI EZHAIMARIAMMAN SHG, MOORTHY NAGAR, VILLIANUR	20/12/2001	11
3	THIRUMAGAL SHG, VILLIANUR	22/10/2001	12
4	SRI GANGAIMARIAMMAN SHG, PUDHU NAGAR, VILLIANUR	23/10/2001	13
5	SRI PORAIYATHAMMAN SHG,PORAIYATHA NAGAR, VILLIANUR	19/12/2001	14
6	KAVIKUIL SHG, PUDHU NAGAR, KANUVAPET, VILLIANUR	22/05/2002	15
7	SAVITHA DEVI SHG, PATTANIKALAM	12/07/2002	16
8	SRI AMMAN SHG, PORAIYATHA NAGAR VILLIANUR	13/11/2006	17
9	VASANTHAM SHG, KANUVAPET	11/08/2007	18
10	SUBAM SHG, PUDU NAGAR - II, VILLIANUR	25/09/2007	19
11	VALLAUVAN VASUGI SHG, THIRUVALLUVAR NAGAR, VILLIANUR	11/12/2007	20
12	MUTHUMARIAMMAN SHG,PUDUPET, VILLIANUR	13/03/2008	21
13	PODHIGAI MAHALIR SHG,KANUVAPET,VILLIANUR	27/04/2008	22
	TOTAL		208

Table V

Participant Category	Technique Of Data Collection
SHG Women Members	• Semi Structured Interviews • Focussed Group Discussions • Selected Case Studies
Family members including husbands, in-laws, parents and children	• Observation Method
Representatives from Govt Officials like DRDA project officer, BDO, Gram Sevaka and Training Institute Officials	• Key informant interview

Table VI - Impact of SHG on Women Empowerment

S. No	STATEMENTS	Notable Change	Somewhat Change	Unnoticeable
1	Increase in income	×	-	-
2	Employment Opportunity	×	-	
3	Got importance in family	-	×	-

4	Got importance in community	-	-	×
5	Social security	-	×	-
6	Family empowerment	-	×	-
7	Better relations and more friends	×	-	-
9	Awareness levels increased	-	×	-
10	Improvement in personal health	-	-	×
11	Improvement in family health	-	-	×

Table Vii - Impact of SHG on Health Knowledge and Awareness

S. No	**STATEMENTS**	Increase	Decrease	No change
1	Health and Hygiene	-	-	×
2	Vaccination	-	-	×
3	Contraceptives	-	-	×
4	Care during pregnancy	-	-	×
5	Pre-Natal Care during Pregnancy	×	-	
6	Post-natal care	-	-	×
7	Care of Infant	×	-	-
8	Awareness of personal health care/needs	-	-	×
9	Awareness about existing health Increase services	-	-	×
10	Do you know about family planning	-	-	×

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