"ROLE OF SHGs IN RURAL WOMEN'S HEALTH ADVANCEMENT"

(A case study of Andhra Pradesh)

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Abstract

The process of economic development induces several key changes in the structure of the developing economies that includes the most important change concerns with the participation of women in the health, education, economic, social and political activities. Eradication of poverty is the greatest global challenge facing the world and a core requirement for sustainable development, especially for developing countries like India. Various social groups, especially women bear disproportionate burden of poverty. Discrimination against women can cause deprivations for them in nutritional and health. A women needs to be physically healthy so that she is able to take challenges of equality. But it is lacking in a majority of women in rural areas. Healthy women can lead the family healthily and again it leads to healthy society and overall country. The government now needs to encourage women, especially the rural poor, to set up fresh legislation to give all women an equal right to inheritance and the upliftment of their status through providing financial assistance. Microfinance through Self-Help Groups (SHGs) has become the primary policy tool used by the post liberalization state to fulfill the credit needs of the poor. The main objective of the present study is to examine the microfinance assistance through SHGs impact on rural poor women's health advancement after joining in SHGs in Andhra Pradesh based on the comparison between before and after joining in SHG. Total of 300 women SHG members are randomly selected under SHG scheme from the selected districts of Andhra Pradesh for field survey by employing multi stage random sampling method. Information regarding to the before and after the credit program is collected by using well structured questionnaire through schedule method. The study reveals that the impact of SHGs on getting health advancement of sample respondents is in significant manner.

Key words: Self-Help Group, Rural Women, Health Advancement, Empowerment and Microfinance.

Introduction

The process of economic development induces several key changes in the structure of the developing economies that includes the most important change concerns with the participation of women in the health, education, economic, social and political activities. Eradication of poverty is the greatest global challenge facing the world and a core requirement for sustainable development, especially for developing countries. Poverty has been a pervasive problem in India. Around one-third of our people do not have the basic resources for survival. Even after so many years of independence, women in India continue to suffer economically as well as socially at different levels and in different forms and India still has the world's largest number of poor people in a single country with 260.3 million are below the poverty line. Out of which 193.2 million are in the rural areas and 67.1 millions are in urban areas. More than 75 per cent of people reside in villages, which have an extremely thin presence of financial institutions and government machinery. From the year 1972, poverty has been defined on the basis of the money required to buy food worth 2400 calories in rural areas and 2100 calories in urban areas.

Women are often more vulnerable than man, disproportionately concentrated in low wage sectors. Wage discrimination in the case of women is a big drawback and it affects their purchasing capacity. According to the Human Development Report (HDR, 1997), poverty was defined as deprivation in the valuable things that a person can do or be. The term human poverty was coined to distinguish this broad deprivation from the narrower income poverty, a more conventional definition limited to deprivation in income or consumption. Human development focuses on expanding capabilities important for all people, capabilities so basic that their lack forecloses other choices. Human poverty focuses on the lack of these same capabilities; to live a long, healthy and creative life, to be knowledgeable, to enjoy a decent standard of living, dignity, self respect and the respect of others. According to Adam Smith, man is rich or poor according to the degree in which he can afford to enjoy the necessaries, the conveniences and the amusements of human life.

According to the World Economic Forum's Global Gender Gap Report 2012, which considered factors like labour force participation, reproductive health and education, India ranks close to the bottom with 113 rd rank out of 135 countries in lowest percentage of women employees. While Indian economy has grown up since 1991, the participation of women in this economic growth has been negligible and lots needs to be done. After independence, India's economic growth is remarkable in its reach and impressive for pulling millions out of poverty but women are still missing at almost in every level of professional life. Hence, the loss in Gross Domestic Product (GDP) that India incurs as a side effect of low female economic participation in a major drag on its overall economic performance. In many parts of India women are viewed as an economic liability despite contributing in several ways to our society and economy. India's policies and projects for women are woefully inadequate. Women are discriminated socially because of lack of education and experience.

In India, productive employment is central to poverty reduction strategy and to bring about economic equality in the society. But the results of unfettered operation of market forces are not always equitable, especially in India, where some groups are likely to be subjected to disadvantage as a result of globalization. Women constitute one such vulnerable group. Since the times immemorial, worth of the work done or services rendered by women has not been recognized. India is a multifaceted society where no generalization could apply to the entire

nation's various regional, religious, social and economic groups. Nevertheless, certain broad circumstances in which Indian women live affect the ways they participate in the economy. Generally, women are confined to home thus restricting their mobility and face privacy. Discrimination against women can cause deprivations for them in nutritional and health. A women needs to be physically healthy so that she is able to take challenges of equality. But it is lacking in a majority of women in rural areas. The greatest challenge is to recognize the obstacles that stand in the way of their right to good health. To be useful to the family, community and the society, women must be provided with health care facilities. Empowerment would become more relevant if women are educated, better informed and can take rational decisions.

The government now needs to encourage women, especially the rural poor, to set up fresh legislation to give all women an equal right to inheritance and the upliftment of their status through providing financial assistance. Earn money often equals power, so there is growing recognition that the status of women in societies like India can change significantly if they are able to gain financial independence, whether it is through employment where they are adequately compensated or by setting up and running their own businesses. An economic change in the life of women, especially of rural women will be possible if they take up entrepreneurial, cottage, industry, agricultural and allied activities independently. These activities will generate employment and income not only for these women but for other women as well. By forming collectives, networks and Self-Help Groups (SHGs) they gain strength and collective bargaining rights, as well as co-operative credit and saving systems, will create a united voice for communities of women and allow them to support each other. If these activities are undertaken on the basis of proper planning and training, they can emerge as profitable ventures.

Empowering rural women by implementing meager income generation projects or plans will not be sufficient to ameliorate the prospects for a better life for them. Thus, their empowerment in all economic, social and political activities is essential. Women are representing about half of the Andhra Pradesh's Population. Women are in backwardness in all developmental concepts and facing the poverty. In the eradication of rural poverty, Andhra Pradesh Government started the DWCRA programme in 1983. Later it was developed as the SHG-Bank Linkage Programme (SBLP). In the year 2005 it was named as Indira Kranthi Patham (IKP). Andhra Pradesh is the first state in the implementation of SHG programme in India. It has the half of the share in number of SHG groups and A.P is in the forefront under SHGs promotion through microfinance. The major share holders in this movement are rural women.

Need for the study

The effectiveness of anti-poverty programmes like SHG-Bank Linkage programme depends, at least in part, on whether the programs do, in fact, reduce poverty or, more generally, raise the incomes of the low-income population. On one level, it is obvious that they must do so to some extent, because they provide positive benefits and hence they have to raise incomes and standard of living. On second level, SHG bank linkage programme is even provided benefits to below poverty line, an important question concerns their distributional impact and whether they affect primarily those at the very bottom of the income distribution or those just below poverty line. The main

object of the SHG programme is providing access to credit in the context of poverty reduction and women empowerment. Women are the vital human infrastructure and their empowerment in economic, social, health, education, knowledge and political aspects would hasten the pace of social development. Investing in women's capabilities and empowering them to achieve their choices and opportunities is the surest way to contribute to their growth and development in health aspect.

Health and nutrition are two very important basic needs for empowerment of rural women. To achieve real and quicker development in health sector, an extensive and as well as intensive Health Education and Awareness Campaign (HEAC) needs to be given top most priority and it should mainly stress on nutritional education, benefits of immunization, family planning, etc. women should have access to comprehensive, affordable any quality health care. Healthy women can lead the family healthily and again it leads to healthy society and overall country. A healthy environment can lead the country economically forward. Therefore, it is important to study whether the SHG impact the health and nutritional status of sample respondents in a significant manner after joining in SHG in Andhra Pradesh on the basis of following objectives.

Objectives of the study

1. To examine the microfinance assistance through SHGs impact on rural poor women's health after joining in SHGs in Andhra Pradesh.

2. To assess the impact of SHG programme on women health, especially in the broad categories of health facilities, namely, taking service of qualified doctor, family planning, vaccination, cleanliness, access to health service, sanitary facilities, taking nutritious food and take insurance policy.

Methodology

A stratified multi stage random sample method is used for the purpose of the study. In the first stage two districts were selected from the two regions of Andhra Pradesh. One district was selected from each region. In the second stage one mandal was selected at random from the selected district. In the third stage one village was selected at random from the selected mandal of each district. In the fourth stage hundred and fifty SHG women members, who have taken minimum of four bank linkages and above were selected at random from each village. Total of 300 women SHG members were randomly selected under SHG scheme. The position before and after joining in SHG of women was collected. Comparing the before and after joining SHG conditions of the respondents in the study area will give an idea about the impact of SHGs on sample rural women. The responses are recorded on the basis of the opinion of the sample respondents themselves on each aspect through schedule method with a well structured questionnaire. Both primary and secondary data was used for the study. For the statistical analysis of the data pertaining to the study, the collected data is processed through using Statistical Package for Social Sciences (SPSS) software.

Results and discussion

In order to understand the impact of SHG programme on sample women respondents were studied by analyzing the respondent's position with respect to social group, literacy level, age of SHG, number of bank linkages, loan amount, occupation, Monthly income and health factors.

Social group

The objective of SHG-Bank linkage programme (SBLP) is to provide financial services to poor, deprived and weaker sections of the population, particularly social groups like Scheduled Castes (SCs), Schedule Tribes (STs) and Backward Classes (BCs). For this reason the study was taken the respondents from all social categories namely, Forward Castes (OCs), Backward Castes (BCs), Scheduled Castes (SCs) and Schedule Tribes (STs). The social group composition of sample respondent is presented in table 1.

Table-1
Distribution of the respondents by social group

Caste Category	Total Number of Respondents	Percentage to Total
O.C	28	9.3
B.C	186	62.0
S.C	76	25.4
S.T	10	3.3
Total	300	100.0

Source: Primary data

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Note-1: O.C- Socially, Economically Forward caste communities.
B.C- Socially, Economically Backward cast ecommunities.
S.C- Scheduled caste communities.
S.T- Scheduled Tribe communities.

The distribution of sample respondents according to the social groups reveal that that proportion of women members belonging to BCs accounted for 62 per cent followed by SCs and STs at 28.7 per cent. Among the 300 sample SHG members only 9.3 per cent belonged to forward castes (OCs) (table 5.1.). Based on the social classification, SC, ST and backward castes are considering as weaker sections. The present study covered majority of the respondents are from weaker sections totally accounted for 90.7 percent .It reveals that sample of this study represents the objective of SBLP.

Literacy level of the respondents

The level of literacy of SHG members is an important characteristic for the functioning of the group. Education will impact maintenance of records, starting of development schemes, linkage with banks, etc. Hence, the data regarding literacy level of SHG members in the study area is reported in table 2. The weaker sections that are the focus of the SHG Bank Linkage programme are generally characterised by high levels of illiteracy without any formal education. As contradictory to this the educational status of the sample respondents revealed that about 25.3 per cent of them were illiterate.

Table-2
Education level of the Respondents

Educational Status	Total Number of Respondents	Percentage to Total
Illiterate	76	25.3
Literates (can sign)	158	52.7
Primary	33	11.0
Middle/High	12	4.0
10th pass/Plus 2	21	7.0
Total	300	100.0

Source: Primary data.

Among the literates, about 52.7 per cent of the respondents could only sign, 11 percent of the women respondents are completed primary education, 4 percent of the respondents are studied up to middle and high school level and 7 percent of the respondents are studied up to tenth and intermediate education. Joining SHGs also made them realize the importance of education, which resulted in increased number of members being able to sign. This trend was due to the group effort to improve literacy levels of its members through informal education.

Age of SHG

The age of SHG is an important indicator to measure the sustainability of the SHG. It is bond that higher age of SHGs means these groups have performed the group activities successfully over a long period of time. Distribution of the respondents by the years of experience in the SHGs is presented in table 3.

Table-3
Age wise Distribution of Sample SHG Members

Age of the SHG (Ranges in years)	Total Number of Respondents	Percentage to Total
5 to 10 years	180	60.0
10 to 15 years	81	27.0
Above 15	39	13.0
Total	300	100.0

Source: Primary Data

It is evident from the table that majority 60 per cent of the respondents have 5 to 10 years of experience in joining in SHGs. Further, it shows that 27 per cent of the respondents have 10 to 15 year of experience and only 13 per cent of the members have above 15 year of experience. It is observed from the 5 to 10 years age of SHGs, year by year the strength of the SHGs is increasing. This may be due to the increased levels of awareness among the respondents to join the self help groups to avail its benefits. This is a positive sign towards the empowerment of the rural women through self-help groups.

Linkage and amount of bank loan

Table 4 represents the linkage wise bank loans distribution of the respondents. It is inferred from the table that majority of the respondents have given an amount ranging between Rs.15,000 to 30,000 (47.3 per cent), followed by 29.7 per cent of the respondents are received the bank loan amount below RS.15,000, 20.7 per cent of the respondents got loan amount between Rs. 30,000 to 45,000 and only 2.3 per cent of respondent are received the bank loan amount above Rs. 45,000. According to the current bank linkage of the respondents, it is observed that 41.4 per cent of the sixth linkage respondents are received loan amount below Rs.15,000, followed by 29.5 per cent of respondents under fourth bank loan and 22.7 per cent of the fifth linkage respondents. Further, it is observed that 45.8 per cent of the fourth bank linkage respondents received the loan amount ranges between Rs.15,000 to Rs.30,000, followed by 55.2 per cent of respondents of sixth linkage and 50 per cent of fifth bank linkage respondents, respectively.

Table-4
Linkage wise Distribution of the Sample Respondents by the Amount of Bank Linkage

Number of Bank Linkages	Range of bank loan amount (in Rupees)				Total
	below 15000	15000 to 30000	30000 to 45000	Above 45000	
4.00	67 (29.5) (75.3)	104 (45.8) (73.2)	51 (22.5) (82.3)	5 (2.2) (71.4)	227 (100.0) (75.7)
5.00	10 (22.7) (11.2)	22 (50.0) (15.5)	10 (22.7) (16.1)	2 (4.5) (28.6)	44 (100.0) (14.7)
6.00	12 (41.4) (13.5)	16 (55.2) (11.3)	1 (3.4) (1.6)	0 (0.0) (0.0)	29 (100.0) (9.7)
Total	89 (29.7) (100.0)	142 (47.3) (100.0)	62 (20.7) (100.0)	7 (2.3) (100.0)	300 (100.0) (100.0)

Source: Primary Data

It is observed that 22.7 per cent of fifth bank linkage respondents have received the loan in the range between Rs 30,000 to Rs 45,000, followed by 22.5 per cent of fourth bank linkage and only 3.4 per cent of the respondents under the bank linkage. Further, 4.5 per cent of respondents under 5th bank loan have taken the loan about above Rs.45000, followed 2.2 per cent of the sixth bank loan respondents. It is concluded that from the study one-third of the respondents have received the loan amount in the range between rs.15000 to 45000. However, there is a sharp decline in receiving the loan amount of sixth linkage respondents. This might indicate that the demand for loan of most of the respondents have decreased from the amount rang after Rs.30,000. This could be the result that sample respondent are less dependent are less dependent on bank for loans to manage their economic activities or reached a point beyond which they cannot absorb high amount of credit.

Primary occupation

The economic status of women depended on their income gaining occupation. Type of occupation and the main occupation of the respondents is help to know the economic status of women. Occupation pattern helps to know the members of the SHGs whether they are taking the income generating activities or not. Occupation impacts socio-economic status of the household. So

occupational distribution of the sample members are examined to know the levels of living. Distribution of the respondents by their main occupation is presented in table 5.

Table-5
Main Occupation of the Respondents

Name of the Occupation	Total Number of Respondents	Percentage to Total
Housekeeping	40	13.3
Cultivation	11	3.7
Agricultural Labour	109	36.4
Artisan, Weaving, Tailoring, Basket making, Handicrafts	48	16.0
Dairying	37	12.3
Petty business	55	18.3
Total	300	100.0

Source: Primary data.

The above table reveals that, agricultural labour constituted the major share accounting for 36.4 per cent of the sample SHG women. About 18.3 per cent of the sample respondents depended exclusively on petty business followed by artisan (16 per cent), housekeeping (13.3 per cent), dairying (12.3 per cent) and cultivation (3.7 per cent) respectively. It is observed from the above table 13.3 per cent of respondents do not have any economic activity they are engaged in household duties only. Most of the SHG sample respondents are engaged in income generating activities. It reveals that SHGs are motivated financially 86.7 per cent women members to choose occupation towards the income generating activities.

Income generation

The SHG bank linkage programme with better access to credit expected to brings in increased income to the SHG members. The distribution of the respondents by their average level of monthly income is presented in the table 6.

Table-6
Distribution of the Sample Respondents by the Level of Monthly Income

Monthly Income (in Ranges)	Pre-SHG	Post-SHG	Per cent of Change
Below Rs. 500	27(9.0)	10(3.3)	-5.7
Rs. 500 to Rs. 1,000	20(6.7)	14(4.7)	-2.
Rs. 1,000 to Rs. 2,500	34(11.3)	64(21.3)	10.0
Rs. 2,500 to Rs. 5,000	3(1.0)	47(15.7)	14.7
Above Rs. 5,000	4(1.3)	13(4.3)	3.0
No Income	212(70.)	152(50.)	-20.0
Total	300(100.0)	300(100.0)	-

Source: Primary Data.

Note: Figures in parentheses are percentages to the total.

The frequency distribution of monthly income of the sample respondents revealed that out of the total sample respondents 11.3 per cent of the respondents are having income in the range of Rs. 1,000 to Rs. 2,500 during pre-SHG situation, followed by 9 per cent having income less than Rs. 500, 6.7 per cent having monthly income in the range of Rs. 500 to Rs. 1,000, 1.3 per cent in the range of monthly income above Rs. 5,000 and only one per cent having in the range of Rs. 2,500 to Rs. 5,000. Further, it is observed that 70.7 per cent of the sample respondents have no income during pre-SHG situation. Similarly, it is observed that during post-SHG situation out of the total sample respondents, 21.3 per cent of respondents are having monthly income in the range of Rs. 1,000 to Rs. 2,500, followed by 15.7 per cent in the range of Rs. 2,500 to Rs. 5,000, 4.7 per cent in range of Rs. 500 to Rs. 1,000, 4.3 per cent in above Rs. 5,000 monthly income and 3.3 per cent have income less than Rs. 500. Further, it is observed that 50.7 per cent of the respondents have no income during post-SHG situation.

The percentage of respondents under Rs. 1,000 category during pre-SHG situation is decreased and it is shifted to above Rs. 1,000 income ranges during post-SHG situation. The number of respondents who do not have income decreased by 20 per cent from pre-SHG situation to post-SHG situation; it indicates that there is a 20 per cent shift from no income category to income generated category due to joining in SHG. It is revealed that 14.7 per cent of the sample respondents increased their monthly income in the range of Rs. 2,500 to Rs. 5,000 during post-SHG situation, followed by 10 per cent in the range of Rs. 1,000 to Rs. 2,500 and 3 per cent is having the monthly income above Rs. 5,000.

Health Advancement

Table-7 discusses the SHG impact on health empowerment of the sample respondents. The SHG create health awareness among its members. The opinion of the sample respondents on the health impact are examined with the help of the health indicators like, taking the service of qualified doctor, awareness about family planning, vaccination to children, cleanliness, access to health service, sanitary facilities, Taking nutritious food and taking an insurance policy. Sample respondents are asked to express their opinion on health impact indicators. The details of indicators of change in health empowerment of sample respondents are given in table-7. Further, only 18 per cent had awareness about access to health services during pre-SHG situation while it is improved to 84 per cent during post-SHG situation. During pre-SHG situation only11 per cent of the respondents possessed the sanitary facilities. It is improved to 91.3 per cent after joining in SHG. Only 4 per cent of the sample respondents were takes nutritious food during pre-SHG situation. It is improved to 87.7 per cent during post-SHG situation. Further, no respondent had the insurance policy during pre-SHG situation while it is increased to 65.3 per cent during post-SHG situation.

The table 7 reveals that only 14 per cent of the respondents taking the service of qualified doctor during pre-SHG situation. It is improved to 80.3 per cent during post-SHG situation. It is observed that only 19.7 per cent of the respondents have awareness and implemented the family planning during pre-SHG situation and it is improved to 64 per cent during post-SHG situation. Similarly, 21.6 per cent took vaccination to their children during pre-SHG situation. It is improved to 88.7 per cent after joining in SHG. 18.1 per cent of the respondents followed and aware of importance of cleanliness in the health context during pre-SHG situation. It is improved to 84 per cent during post-SHG situation.

Table-7
Indicators of Change in Empowerment in Health Aspect of Sample Respondents

Sl. No	Indicators of Changes	Pre-SHG	Post-SHG	Per cent of Change
1.	Taking Service of Qualified Doctor	42(14.0)	241(80.3)	66.3
2.	Family Planning	59(19.7)	192(64.0)	44.3
3.	Vaccination	65(21.6)	266(88.7)	67.1
4.	Cleanliness	49(18.1)	252(84.0)	65.9
5.	Access to Health Service	54(18.0)	252(84.0)	66.0
6.	Sanitary facilities	33(11.0)	274(91.3)	80.3
7.	Taking Nutritious Food	12(4.0)	263(87.7)	83.7
8.	Take Insurance Policy	0(0.0)	196(65.3)	65.3

Source: Primary data.

Note: figures in parenthesis are percentages.

The percent of change in all the health aspects of sample respondents is positive due joining in SHGs. The percent of change in the aspect of taking nutritious food is 83.7 per cent, sanitary facilities is 80.3 per cent, vaccination is 67.1 per cent, taking service of qualified doctor is 66.3 per cent, access to health service is 66 per cent, cleanliness is 65.9 per cent, take insurance policy is 65.3 per cent and family planning is 44.3 per cent, respectively.

Conclusion

By applying the methodological framework to estimate the impact of SHG programme on women health reveals that during post-SHG situation both category of respondents that the respondents who do not have any income and less income category respondents are significantly benefited. It is concluded that the impact of SHG has highly significant on the health aspects of taking nutritious food and sanitary facilities and it has moderately significant on vaccination, taking service of qualified doctor, access to health service, cleanliness and take insurance policy, respectively. It has low impact on family planning aspect.

Suggestions

Based on the conclusions drawn from the study area, the following suggestions could be offered to improve the functioning of SHG programme:

1. Education is an essential factor to empower women. Therefore, Government should take steps to educate women through SHGs about their rights, legal rules, laws in favour of women in the constitutional amendments and logical reasoning in the place of already existed just can sign, read and write. This must be made available to the women to mainstream women into development of health.
2. Efforts should be made to increase the regular participation of SHG members in group activities, since this sort of exercise will create more awareness and empowerment among them.
3. Undertake adequate research studies to examine individual and cultural barriers, to understand the psychology of rural women. Such findings would help make the promotional programmes more realistic on health factors to contribute better health of SHG women.

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