

Women's Self-Help Groups in India: Gender Equity, a Human Right

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About the author:

Heather Wurtz is a native of Topeka, Kansas. She is the recipient of the Level II Clinical Excellence Award from the KU School of Nursing for her clinical excellence in the pediatrics setting. She is an honors graduate from the School of Nursing. She is the recipient of the Helen Crilly, James D. Robinson, George and Margaret Varnes, and Marguerite Coffman Nursing Scholarships. She was also awarded a Shawnee County Medical Society Alliance Scholarship and received a Delta Chapter-Sigma Theta Tau travel award to present her honors research. Her ambitions for the future include pursuing dual graduate degrees in Public Health Nursing and Public health with a concentration in maternal Child Health. Eventually she sees herself as a nurse researcher focusing on maternal child health in the global arena.

She wishes to acknowledge the faculty, staff, students and patients at the Christian Medical College of Vellore, India for sharing their experiences, stories and lives with us when we traveled there for her professional practicum experience.

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Introduction

“Human development is an expansion of the real freedoms of people to pursue lives that they value and have reason to value” (UNDP, 2010, p. 85). Throughout the world, gender inequality—pervasive and deeply embedded in societal structures and ideologies—continues to inhibit human potential and retard the social and economic development of individuals, families, and entire populations. Viewed by many as an abuse of basic human rights, gender inequality perpetuates negative outcomes of health and well-being, and propagates undemocratic, unjust, and unproductive social patterns and political processes. Yet, despite these negative effects, gender inequality still exists—for many, to a devastating degree—in the daily lives of women in most parts of the world (Sen, 2004). Regional patterns of reproductive health—the greatest indictor of gender inequality (UNDP, 2010)—reveal that “the equivalent of five jumbo jets’ worth of women die in labor each day”ⁱ (Kritsof & WuDunn, 2009, p.98). Ninety-nine percent of these mortalities occur in developing countries (WHO, 2007).

India, a country vastly plagued by the ill effects of gender inequality, accounts for nearly 1/5 of total maternal deaths globally and only trails behind Sub-Saharan Africa for total losses due to reproductive health disparities (UNDP, 2010). According to the United Nations Human Development Report of 2010, India ranked 118 out of 138 countries, according to the gender equality indexⁱⁱ. Statistics demonstrate incredibly poor outcomes for women in India in nearly all indicators including health, education, economics, and political participation (UNDAF, 2000). In efforts to ameliorate these critical disparities, India has established Women's Self-Help Group (SHG) programs into their national plan as a keystone of development efforts to improve economic and social circumstances of women through grassroots microenterprise and group

solidarity. The impact of SHG's in India has the potential to contribute to the empowerment of women, as well as improved health for women, their families, and possibly subsequent generations.

The purpose of this article is to briefly describe the effects of SHG—within an Indian context—on the overall health of women, in order to grasp an understanding of this debated public health paradigm and to consider its applicability to a diversity of settings. As members of an increasingly globalized health care community, it is imperative that nurses and other health care professionals exercise a ‘global frame of reference’ by evaluating major global healthcare issues and emerging trends of respondent actions by authoritative international agencies (Austin, 2001, p. 1).

Review of Literature

In the 1990's, SHG's become a popular development strategy in India to alleviate poverty and empower women after the renown success of the Bangladeshi project, the Grameen Bank. The founder of the Grameen Bank, Muhammad Yunus, went on to receive a Nobel Peace Prize in 2006, for his achievements in microfinance (Nobelprize.org, 2011). The basic premise of the Grameen Bank and similarly modeled SHG's entails the attainment of economic autonomy and social capital by impoverished peoples through a peer-lending, microenterprise banking approach. “From the very outset the Bank was designed to be owned and controlled by the people who borrow from it (Jansen & Pippard, 1998, p. 109). In more recent years, SHG's have been considered a successful method of improving healthcare access and outcomes (ICDDR, 2001). A conference organized by a conglomerate of international health organizations, including three international Red Cross societies, United Nations Development Program, and

Plan International, "revealed renewed interest in self help, viewing it as a cost effective and sustainable approach to social development, especially health (Nayar, 2004, p. 6).

Women's SHG's are voluntary associations, generally consisting of 12-20 people from a similar background that engage in micro-lending through shared monetary savings and group accountability in efforts to generate income, reduce poverty, and participate in the local economy (Mohindra, 2008). Each member of the SHG contributes a small weekly deposit into a shared group savings account at a commercial bank. At the group's discretion, members may apply to receive a loan, which can then be applied towards economic activity or significant budgetary constraints. In addition to material assistance, SHG's provide emotional support and community building; "they are frequently cause-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of identity" (Katz, 1981). Members attend weekly meetings at where, in many cases, various relevant health issues will be discussed (Nayar, Kyobutungi, & Razum, 2004). Participants may also be involved in skills building sessions and/or leadership training (Jansen & Pippard, 1998).

SHG's have frequently been reported to help reduce poverty and increase participation in the work force among impoverished groups of women (Larance, 2001; Reddy & Manak, 2005). Further studies, however, have also demonstrated that SHG's may serve as a significant tool of empowerment via women's increased participation in community action, political affairs, and household decision-making. In Tesoriero's study among SHG's in Southern India, 72% of SHG member were involved in community building activities; 67% participated in the local village council; 56% were part of social action programs (2005). Leaders of SHG's are often asked to attend and speak at local village meetings (Reddy & Manak, 2005). "It serves to show how, from the women's perspectives, identities have changed in relation to their position in their

families and communities, from being oppressed towards active engagement as citizens in their village and Panchayat (council)" (Tesoriero, 2005, p. 329).

Additional studies have revealed that SHG's in India positively affect the psychological health of poor women. According to a study by Mohindra, women in SHG's were less likely to report emotional stress and poor life satisfaction (2008). Furthermore, it was found that among SHG members, emotional stress declined with increased membership duration (2008). In another study, by Rajandran & Raya, over 94% of participants who were SHG's members reported increased courage, self-confidence, and empowerment due to their involvement (2010).

SHG's have also been found to yield more direct positive health outcomes. Women in SHG's are able to borrow loans to cover costly health expenditures, thereby preventing exclusion from necessary health care services (Nayar, 2004; Mohindra, 2008). Even women who are not participants themselves but who live with SHG participants may experience less exclusion from healthcare services (Mohindra, 2008). Although SHG originally focused primarily on economic activities, several groups are now integrating health campaigns and health education into their regular activities (Nayar, 2004). Weekly meetings provide opportunities for women, to discuss issues related to nutrition, immunizations, hygiene, and maternal child health care (Gov. of Kerala, 2011). Several studies from Bangladesh reinforce positive health outcomes related to SHG's by describing increased knowledge of health, increased disease prevention, and decreased rates of domestic violence among SHG members (Hadi, 2002; Bhuiya, Hanifi, Hossain, & Aziz, 2000).

A large literature suggests that in addition to the individual benefits of SHG participation, the overall improved status of women may foster improved health for the entire family, especially regarding child health and nutrition (Angrist, 2002; Chiappori, Fortin, & Lacroix,

2002; Duflo, 2005). Throughout the developing world, maternal malnutrition is a primary cause of low birth weight in infants (Ramakrishnan, 2004)—which can be a source of a myriad of additional complications, even into adulthoodⁱⁱⁱ-- by improving the health of women, positive health outcomes for subsequent generations will also likely increase. Children's health may also improve when women have more control of household finances and decision-making. Women tend to prioritize health needs over other expenditures and “are less likely to squander funds” (Jansen and Pippard, 1998, p. 111). “It is argued that women invest the money in goods and services that improve the well-being of families, in goods that are conducive to development” (Duflo, 2005, p. 12).

Conclusion

SHG's has become a major strategy in India for combating gender inequality through a holistic approach to health and well-being. It is estimated that in 2005, over 2 million SHG's had been established throughout the country (Reddy & Manak, 2005). Although the sustainability of poverty reduction measures has been questioned in recent years (Kumar, 2007), the impact on other avenues of health in the lives of participants has been exhaustively demonstrated—especially in the testimonies of SHG members. “While a range of sources of data has contributed to building a picture of change and transformation, none has been so powerful as the stories of the women themselves” (Tesoriero, 2005, p. 327).

Gender inequality, within India and on a global scale, has become a pressing issue that requires aggressive and definitive action. The Millennium Development Goals for 2015, adopted by 189 countries, has prioritized the reduction of gender inequality as a key objective. In order to achieve this international endeavor, partnerships and mutual understandings must be established at the national level, but must be executed in the local arena by local leaders. Nurses

throughout the world have a unique opportunity to contribute to this cause. Nurses are on the forefront of social and community change action; nurse's all-encompassing approach to health and ability to engage women in the community, allow them to facilitate health improvement as a development tool. The many 'faces of gender inequality' (Sen, 2004) must not be obscured by contextual or cultural differences; they must be viewed through the lens of these differences in order to realize their common threads. Issues that may seem quite foreign at first glance, may, in fact, not be so far from home and ultimately, from a global mindset, "the health threats faced by any one country are ultimately faced by all countries" (Huston, 2008, p.3-4). Through awareness of global issues and reactionary interventions, nurses can better understand these challenges within their own cultural context and may do their part to contribute to a brighter future in their own communities and, consequently, throughout the world.

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ⁱ In 2005, 536,000 maternal deaths occurred worldwide (WHO 2007)

ⁱⁱ The Gender Inequality Index reflects inequality within three primary dimensions: reproductive health, empowerment and the labor market. "The Gender Inequality Index is designed to reveal the extent to which national human development achievements are eroded by gender inequality, and to provide empirical foundations for policy analysis and advocacy efforts"(UNDP, 2010).

ⁱⁱⁱ Recent findings have shown that low birth weight may contribute to higher incidence of hypertension, glucose intolerance, and other cardiovascular problems (Barker, 2006).