# SELF-HELP GROUPS AND THEIR ROLE IN WOMEN'S HEALTH AND EMPOWERMENT A CASE STUDY OF PATNA DISTRICT

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I, the undersigned certify that the thesis entitled "**Self-Help Groups and their Role in Women's Health and Empowerment: A Case Study of Patna District**" submitted by me for the Degree of Doctor of Philosophy is my bonafide work and has not been submitted so far, in part or full for any other degree or diploma of this university or any other university. This thesis submitted by me may please be placed before the examiners for evaluation.

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# ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immuno-deficiency Syndrome |
| ANC | Antenatal Care |
| APHC | Additional Primary Health Center |
| ATMA | Agriculture Technology Management Agency |
| BDO | Block Development Officer |
| BLTF | Block Level Task Force |
| BPL | Below Poverty Line |
| CAG | Comptroller and Auditor General |
| CBCS | Community Based Convergent Services |
| CBO | Community Based Organisation |
| CCA | Convergent Community Action |
| CDP | Community Development Programme |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CHC | Community Health Center |
| CHRI | Commonwealth Human Rights Initiative |
| CLA | Cluster Level Animators |
| CRSP | Central Rural Sanitation Programme |
| CSOs | Civil Society Organisations |
| DLHS | District Level Household Survey |
| DLTF | District Level Task Force |
| DPAP | Drought Prone Area Programme |
| DRDA | District Rural Development Agencies |
| DST | Development Support Team |
| DWCRA | Development of Women and Children in Rural Areas |
| EAS | Employment Assurance Scheme |
| EPI | Expanded Programme on Immunization |
| ERA | Equal Remuneration Act |
| GKY | Ganga Kalyan Yojana |
| GMRLF | Group Managed Revolving Loan Funds |
| | Human Immuno-deficiency Virus |

| | |
|---|---|
| HSC | Health Sub-Center |
| IAY | Indira Awas Yojana |
| IDF | Integrated Development Foundation |
| IFAD | International Fund for Agricultural Development |
| ILO | International Labour Organisation |
| IMR | Infant Mortality Rate |
| IRDP | Integrated Rural Development Programme |
| JGSY | Jawahar Gram Samridhi Yojana |
| JJS | Jan Jagaran Sansthan |
| JRY | Jawahar Rozgar Yojana |
| KAP | Knowledge- Attitude - Practice |
| KVIB | Khadi and Village Industries Board |
| MDGs | Millennium Development Goals |
| MMR | Maternal Mortality Rate |
| MNP | Minimum Needs Programme |
| MWS | Million Wells Scheme |
| NABARD | National Bank for Agriculture and Rural Development |
| NCAER | National Council of Applied Economic Research |
| NFBS | National Family Benefit Scheme |
| NFE | Non Formal Education |
| NFHS | National Family Health Survey |
| NMBS | National Maternity Benefit Scheme |
| NPEW | National Policy of the Empowerment of Women |
| NGO | Non Government Organisation |
| NHDR | National Human Development Report |
| NHRC | National Human Right Commission |
| NOAPS | National Old Age Pension Scheme |
| NREGA | National Rural Employment Guarantee Act |
| NSAP | National Social Assistance programme |
| NSS | National Sample Survey |
| NSSO | National Sample Survey Organisation |
| OBC | Other Backward Class |
| PHC | Primary Health Center |
| PMGY | Prime Minister Gramoday Yojana |

| | |
|---|---|
| PRI | Panchayati Raj Institution |
| RFI | Rural Financial Institutions |
| RJD | Rashtriya Janta Dal |
| RKS | Rogi Kalyan Samiti |
| RMPs | Rural Medical Practitioners |
| SASD | Strategy Analysis and Study Design |
| SC | Schedule Caste |
| SEWA | Self Employed Women's Association |
| SGRY | Sampoorna Grameen Rozgar Yojana |
| SGSY | Swaranjayanti Gram Swarojgar Yojana |
| SHG | Self-Help Groups |
| SITRA | Supply of Improved Toolkits to Rural Artisans |
| STEP | Support to Training and Employment Programme for Women |
| STD | Sexually Transmitted Diseases |
| TBAs | Traditional Birth Attendants |
| TRYSEM | Training of Rural Youth for Self-Employment |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNIFEM | United Nations Development Fund for Women |
| WHO | World Health Organisation |
| WID | Women in Development |

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# CHAPTER – I

# INTRODUCTION

# CHAPTER I
# INTRODUCTION

Self-help Groups (SHGs) are small voluntary association of people from the same socio-economic background with a purpose of solving their common problems through self-help and mutual help. In other words, it is a collection of people who have common problems that can not be solved individually, and have therefore decided to form a group and taken joint action to solve their problems. These groups are known by different names in different places. Some of the terms used in India for these groups are – Sangha, Samooh, Mandal, Dangham, and Samiti etc. depending upon the region.

In India, usually Self-help Groups are women oriented and most of their activities are concentrated towards saving and credit activities (apart from other activities focusing on women's empowerment, health and educational attainment, etc). There is common perception in development literature that increased participation of women in saving and credit activities or economic attainment will empower women. Thus, Self-help Groups are considered as an important tool for empowering women. There is also the perception that economic attainment will empower women's status in family and in the community giving more power to women to participate in decision making process. Targeting women has been often explained as an endeavour to reach those who are in need of financial support. It is also assumed that providing women access to affordable credit can empower them economically (Zeller et al., 1997:25-8[1]). Further, it is believed that these women will take care of the health, nutritional, and educational status of her family and in particular that of her children (Goetz and Gupta, 1996:46[2]). Thus, women's participation in micro finance programmes and SHGs has been considered instrumental, not only in terms of her own socio-economic well-being, but also that of her family.

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[1] Zeller, M., Schreider, G., Von Braun, J. and Heidhus, F. (1997). Rural Finance for Food Security for the Poor. (Food Policy Review 4). Washington, D.C., International Food Policy Research Institute.

[2] Goetz, A. M., and Sen Gupta, R. (1996). Who Takes the Credit? Gender, Power, and Control over Loan Use in Rural Credit Programs in Bangladesh. World Development, 24 (1), 45-63

However, opinions regarding what constitutes 'empowerment' are expectedly divergent. There are different opinions and definitions of empowerment depending upon the context. Jo Rowland (1998) has rightly pointed out that "Current use of the term [empowerment] remains ill-defined, however, in the development context; its users tend to assume that the appropriate meaning will be understood without being explained[3]". Rowland also mentions that "Much use of the term has laid emphasis on economic and political empowerment and on a conception of empowerment well rooted in the 'dominant culture' of western capitalism".

Although there is no consensus over definition of empowerment, there is common understanding that the process of empowerment begins when an individual realises/becomes aware of his/her situation, the social reality and his/her rights with the assumption that this awareness should be followed by education, knowledge, skills and actions. In the context of women's empowerment, there is this assumption that when women come together, they find strength and move towards further knowledge and awareness. This process leads towards further empowerment. Thus, the collective action through Self-help Groups introduces an element of leadership, reduces risk and external threat, and enables women to overcome the oppression of patriarchy, and to realise their own true potential and achieve total well being.

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 by ignoring health. In other words women's empowerment cannot be achieved by ignoring or denying issues related to health of women. Although women empowerment has been a central issue on the agenda of various developmental programs 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

[3] Rowland, Jo. 1998. *A Word of the Times, but What Does it Mean? Empowerment in the Discourse and practice of Development* in Afshar, Haleh. 1998. *Women and Empowerment: Illustrations from the Third world.* London, UK: Macmillan Press Ltd. Pp 11

contraception. There has been no attempt to address the issue of women's health in a comprehensive way, touching multiple domains of her health so as to have an impact on her total well being.

While health is obviously an integral component of women's well-being and empowerment, it is also organically linked to the empowerment of women, within the household and the society. It is in this context, that SHGs may be able to play an important role in ensuring good health for the women through empowering women within the household as well as within the society. However, till date, the functioning of SHG 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 thesis/study explores the extent to which SHGs can be involved in attaining women's empowerment and better health for women. This analysis is based on the available literature on the functioning of SHGs and their role in women empowerment and health and data from a field study.

## CHAPTERISATION

The thesis is arranged in six main chapters apart from the introduction and concluding chapters. The second chapter of the thesis reviews and looks into the concepts, definitions, framework and perspectives on issues related to women's status, self-help groups, empowerment and more particularly the link between women's empowerment and overall development, inequality between women and men along with social, economic and community empowerment and self-help and women's health. The chapter also discusses different ways in which empowerment has been conceptualized, and how women's empowerment affects important development outcomes such as health, education, income levels, etc. The literature reviews are based on various primary and secondary sources and comprise the work of various researchers, activists and academics.

The third chapter reviews and looks into various women's empowerment related policies, programmes and schemes. The chapter also looks into various women's rights, policies (such as Five-Year Plans, National Policy for Empowerment of Women) and programmes (Centrally and State sponsored schemes and programmes, such as SGSY, JGSY, NREGA, etc) available and related to women's empowerment. It also discusses and presents the detail of Community Convergence Activity (CCA) programme of the UNICEF and its concept, strategies, objectives and vision. The chapter also presents the background to understand the gaps and loopholes in implementing these programmes at the ground level.

The fourth chapter presents the context, background, rationale of the study, objectives, research approach and study design. The chapter also presents in detail about the study area and the selection criteria, sampling, types, levels and indicators of empowerment, and tools and techniques of data collection. Using the study design, data on women's empowerment and its linkages with their health was collected and analysed.

The fifth chapter presents the socio economic and demographic profile of the women SHGs members and profile of self-help groups. The chapter looks into the respondents' demographic profile, such as marital status, caste groups, age group, education, occupation, income, annual income and unequal wages, ration card/BPL status, and ownership on agriculture land of the women participated in the study. Profile of SHGs are also presented in this chapter covering group size, groups covered in the study, type of members in a group, number of meetings in a group, timings of Group meetings, attendance of members, participation of women in SHG activities, saving/collection within the group, saving amount, interest on internal loans, utilisation of saving amounts, and loan recovery. The profiles were also presented across blocks and caste groups. The chapter also presents the social, economic and cultural context and background in which the women are living and its implications on empowerment, health belief and perception.

The sixth chapter presents the findings. The chapter presents the findings from the questionnaire, case studies and focus group discussions on issues related to women's empowerment and more particularly self-help groups and women's perception on social, economic and community empowerment. The chapter also looks into women's knowledge about empowerment schemes and programmes, information and knowledge about SHG programmes, motives behind joining SHGs, benefits and reach of the programme, source of income before and after joining the group, control on income, decision on domestic and other expenses, change in expenditure pattern, dependence on Sahukar, decision making power in the family, self-confidence, participation in property related decisions, role and opinion in matters related to children's education, immunization and other matters, about their freedom of mobility, extra income, participation in social life and social inclusion in the community. The chapter also presents the differences at Block and caste level.

The seventh chapter also presents the findings and data from the questionnaire, case studies and focus group discussions on issues related to health, perception of health, importance to health, health related practices, belief, disease pattern and prevalence, access to health services, women's role in accessing health services, role of SHG in facilitating health knowledge and related behaviour and practices, knowledge about family planning, use and type of family planning methods used, and discussion on health issues within the family. The chapter particularly looks into self-help groups and women's perception on health. The findings are also based on field observations and visits to several public and private health facilities which included a sub-centre, a primary health centre, community health centres and private clinics.

The final chapter on discussion and conclusions presents the analysis of the data and different viewpoints on self-help groups and their impact on women's empowerment and health. The chapter also addresses the issue of development and the role of social structure (particularly caste and class) in realisation of empowerment by the women and its impact on health.

## LIMITATIONS OF THE STUDY

The study was done with a purpose to understand the extent to which SHGs can be involved in attaining women's empowerment and better health for women. Due to lack of availability of sufficient number of active groups, a few inactive groups (which were active during the support from the NGO) had to be selected. Because of the limited resources, the findings and arguments of the study were drawn on the basis of only one programme (CCA). Moreover, the sample size is not very large, therefore, it cannot be representative of the entire state, and thus the findings cannot be generalised. And hence the conclusions can at best represent a glance in the gamut of problems facing implementation of SHGs and micro-credit programmes and its impact on people. But on the basis of these findings, one can understand the role of SHGs on women's empowerment and health.

# CHAPTER – II

# WOMEN'S SELF-HELP GROUPS: CONCEPTUAL AND ANALYTICAL FRAMEWORK

CHAPTER II

# WOMEN'S SELF-HELP GROUPS: CONCEPTUAL AND ANALYTICAL FRAMEWORK

This chapter review the concept, definitions, framework and perspectives on issues related to women, self-help groups, empowerment and more particularly link between women's empowerment and overall development, inequality between women and men along with social, economic and community empowerment. This chapter also discusses different ways in which empowerment has been conceptualized, and how women's empowerment affects important development outcomes such as health, education, income levels, etc. The literature reviews are based on various primary and secondary sources and comprise the work of other researchers, activists and academics.

## INTRODUCTION

There have been several programmes and policy initiatives for poverty alleviation both at national as well as state level. Most such programmes and policy initiatives have focussed on reaching out to the vulnerable and marginalised sections of population such as women. The approach adopted in such programmes has generally been through empowerment of women and their enhanced participation in social and political processes. Self-help Groups (SHGs) were initially thought of as one such initiative which will empower women economically[1], socially and politically. It was further assumed that these dimensions of empowerment would also get translated into greater welfare for women, particularly in terms of their health attainment. However, the extent and manner in which these groups can be involved in health related work and the kind of health spin-offs that can be expected from their (economic) activities is still not very clear. Further, the extent to which this initiative would result in women's empowerment is also not clear. Numbers of studies have shown that women may

[1] This means that in a situation where women are economically stronger than men, have equal status, but study after study has disproved this. (See, Batliwala, S. 1995).

be empowered in one area while not in others (Malhotra and Mather 1997[2]; Kishor 1995[3] and 2000[4]; Hashemi et al. 1996[5]; Beegle et al. 1998[6]). Thus, it should not be assumed that if a development intervention promotes women's empowerment along a particular dimension that empowerment in other areas will necessarily follow. Jejeebhoy (2000)[7] found that, in India, decision-making, mobility, and access to resources were more closely related to each other than to child-related decision making, freedom from physical threat from husbands, and control over resources.

In the context of providing micro credit to women, there is an extensive literature debating the effectiveness (or not) of this strategy in terms of empowering women. It does appear that many women have benefited from increased access to and control over cash but evidence also indicates that "female targeting without adequate support networks and empowerment strategies will merely shift the burden of household debt and household subsistence onto women" (Mayoux 2002[8]). The assumed economic and social empowerment of women through SHGs, through nurturing the existing and new income generating economic activities of poor households, is still a dream in many states. One of the reasons for its failure to translate it into actual empowerment for women is the way these SHGs are designed and implemented at the ground level, which in

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[2] Malhotra, Anju and Mark Mather. 1997. "Do Schooling and Work Empower Women in Developing Countries? Gender and Domestic Decisions in Sri Lanka." *Sociological Forum* 12(4):599-630.

[3] Kishor, Sunita. 1995. Autonomy and Egyptian Women: Findings from the 1988 Egypt Demographic and Health Survey. Occasional Papers 2. Calverton, Md.: Macro International Inc.

[4] Kishor, Sunita. 2000. *Women's Contraceptive Use in Egypt: What Do Direct Measures of Empowerment Tell Us?* Paper prepared for presentation at the annual meeting of the Population Association of America, March 23-25, 2000, Los Angeles, Calif.

[5] Hashemi, Syed M., Sidney Ruth Schuler, and Ann P. Riley. 1996. "Rural Credit Programs and Women's Empowerment in Bangladesh." *World Development* 24(4):635-653.

[6] Beegle, Kathleen, Elizabeth Frankenberg and Duncan Thomas. 1998. "Bargaining power Within Couples and Use of Prenatal and Delivery Care in Indonesia." *Studies in Family Planning* 32(2):130.

[7] Jejeebhoy, Shireen J. 2000. "Women's Autonomy in Rural India: Its Dimensions, Determinants, and the Influence of Context." In *Women's Empowerment and Demographic Processes: Moving Beyond Cairo.* Harriet Presser and Gita Sen, eds. New York: Oxford University Press.

[8] Mayoux, L. 2002 *Women's Empowerment or Feminisation of Debt? Towards a New Agenda in African Microfinance.* Report based on a One World Action Conference London March 2002 [Online] http://www.oneworldaction.org [accessed 8 January 2003]

many cases is through Non Government Organisations (NGOs) with explicit focus on financial services rather than on empowerment of women. The primary goal of self-help groups must be to enable sustained economic security for women from low-income households. Most of the NGOs encourage access to financial services through self-managed and controlled self-help groups and use of Group Managed Revolving Loan Funds (GMRLF), because SHGs are based upon the principle of enhancing community potential for self-reliance and independence.

In development literature as well as in the planning process, 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 the case of women SHGs. However, how these economic benefits are getting translated into change in women's status, particularly their heath status has not been explored in greater detail. This thesis aims to understand the non-financial aspect of SHGs, mainly its impact on women's empowerment and its inter-linkages with health.

## THE CONCEPTUAL FRAMEWORK

Gender inequities[9] throughout the world are among the most pervasive, though deceptively subtle forms of inequalities. Gender equality concerns each and every member of the society and forms the very basis of a just society. For the empowerment and participation of women in every field of society, economic independence is of paramount importance. However, along with economic independence, equal emphasis must also to be laid on the total development of women, creating awareness among them about their rights and responsibilities, the recognition of their vital role, and the work they do at home. If necessary, a new social system must evolve. The society must respond and change its attitude.

[9] It manifests itself in particular, rather than universal forms, being defined and elaborated by other social categories like caste, ethnicity, class, race, religion, culture, economic and political system, and geography. It is dynamic, rather than static, taking different forms in different times and regions.

Recognising the need for change, many programmes and policies have been designed at the national and international levels, to move towards a more equal society. The Preamble of the Indian Constitution refers to the promise of social justice. Right to equality has also been enshrined as a Fundamental Right under Chapter III of the Constitution, which has a provision for affirmative action in favour of women. Apart from these legal and constitutional safeguards, various policies and programmes have also been launched to ensure greater empowerment and participation of women in the social, economic and political spheres of society. However, despite these Constitutional provisions as well as affirmative actions on part of the State, the status of women continues to be a cause of concern not only in our country but also in most countries of the world.

The Head of States and Governments, gathered at the United Nations Headquarters in New York in September 2000, at the dawn of a new millennium adopted a historic Declaration, recognising that, in addition to their separate responsibilities to their individual societies, they also have a collective responsibility to uphold the principles of human dignity, equality, and equity at the global level. They recognised that they had a duty to the world's people, especially the most vulnerable. The Millennium Declaration asserted and affirmed their commitment to making the right to development a reality for everyone and to freeing the entire human race from want without distinction of race, sex, language or religion. Specific targets had been laid down under the categories of eradication of extreme poverty and hunger, achieving universal primary education, promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, combating HIV/AIDS, malaria and other diseases, environmental sustainability and a global partnership for development. All 189 United Nations member States have pledged to meet the above goals by the year 2015.

In this context, it is important to recognize the inclusion of promotion of gender equality and empowerment of women as a specific objective in the

millennium development goals[10]. However, it is hardly recognized that even the remaining objectives set out in the millennium development goals are crucially linked to the issue of women empowerment. While this is certainly true for goals such as reduction of child mortality and improvement of maternal health, even other goals such as eradication of extreme poverty, universal primary education and combating HIV/AIDS are dependent on the level of empowerment of women in the society as well as within the household. Gender inequities throughout the world are among the most pervasive forms of inequality. It is unfortunately true that a woman is, even in her own home given a rather subordinate role to play. For the emancipation of women in every field, economic independence is of paramount importance. But along with economic independence, equal emphasis must also to be laid on the total development of women, creating awareness among them about their rights and responsibilities, the recognition of their vital role and the work they do at home.

In this context, empowering women through SHG can be an effective tool for ensuring all-round development of women with regard to the targets set out in the millennium development goals. Women's involvement in SHG is not only cost effective in eliminating poverty, but also leads to women empowerment and consequently better outcomes regarding her health status. Although the links between SHGs, women's empowerment and health are always viewed as optimistic, 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 taken since 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. On the other hand, the governments in developing countries are guided/ influenced by the global neo-liberal agenda, which has resulted in withdrawal from investments in health and other welfare sectors, having negative impact on masses specially the poor and the marginalised.

[10] Gender equality and women's empowerment is the third of the Millennium Development Goals (MDGs) to achieve to reduce the gender gap in education at all levels; increasing women's share of wage employment in the non-agricultural sector; and increasing the proportion of seats held by women in national parliaments.

It is often assumed that SHGs will play an important role in improving health care delivery in low and middle income countries and contribute in improving population health outcomes in the face of reducing government health expenditure (Nayar et al 2004). This is against the background of "the paradigm of health sector reforms currently undertaken at the global level, and especially in structurally adjusting countries like India and elsewhere in the developing world, which enforces a move towards privatization of medical care services"[11].

In fact, all the MDGs are closely linked to one another and gender empowerment is the key for the realization of most of them. For instance, the goal of eradication of extreme poverty and hunger refers to the need for reducing by half the proportion of people living on less than a dollar a day and reducing by half the proportion of people who suffer from hunger. Among the poor, women and children constitute the most vulnerable group sharing a disproportionate burden of poverty with women accounting for 70 per cent of the world's poor [according to UNDP's Human Development Report (1995)]. This phenomenon, which is referred to as the 'feminization of poverty' calls for targeted response (towards women[12]) from governments and others. According to a study published by the Commonwealth Human Rights Initiative (CHRI) on 'Human Rights and Poverty Eradication', "two-thirds of illiterate people are women. Life expectancy in Africa and Asia is shorter for women than men, contrary to normal expectations elsewhere. 70 per cent of children out of school are girls; malnutrition and mortality rates are much higher among girls than boys". Studies have shown how education of a girl child has positive impact on infant mortality, maternal mortality, health and hygiene, and productivity. However, if a real dent is to be made in the fight against poverty and hunger, targeted efforts, keeping the gender dimension and gender empowerment in view, alone cannot bear fruits.

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[11] Nayar, K.R.; Kyobutungi, Catherine; Razum, Oliver. 2004. Self-help: What future role in health care for low and middle-income countries? International Journal for Equity in Health 2004, 3:1

[12] However, many scholars believe that the reasons behind targeting of women with financial services are because women are easily accessible and they have been found to be much better credit risks than male. In many countries (especially low income country and developing countries), women are relatively easy to locate, as they work in the home compound. Further, they are also perceived as more vulnerable to repayment pressure, both in terms of the social network as well as the social norms in which they operate that make them easier to intimidated.

## STATUS OF WOMEN

Before analysing the processes which facilitate or subvert women empowerment, it is important to understand empowerment in the broader context of a woman's existence in the society. Primarily, empowerment of women has to be defined vis-à-vis the existing power structure in the society. In other words, empowerment can also be interpreted as relative improvement in the status of women in the society. That is, empowerment is always a relative concept with its associated difficulties of quantifying or measuring. It also follows from the fact that the concept, "Status of Woman" itself is a relative term and therefore, one needs precise definition, for it to be measured. Status can be perceived in different ways, the extent of a woman's access[13] to social and material resources within the family[14], community and society (Dixon, 1978)[15], or her authority or power within the family/community and the prestige commanded from other members (Mukerjee, 1975)[16], or her position in the social system distinguishable from, yet related to, other positions (Committee on the Status of Women in India, 1974)[17], or the extent to which women have access to knowledge, economic resources, and political power as well as the degree of autonomy[18] they have in

[13] It is evident from many studies that access to basic resources has not enabled women to become equals. "If that were the case, then urban middle class women should enjoy relative equality with their middle-class husbands, brothers, and fathers, but we know this to be untrue (Batliwala, S. 1995)".

[14] Extent of a woman's access to social and material resources within the family includes discrimination in the allocation of household resources, such as food, and in access to health care and education, as well as marriage at young ages. In rural Bihar, generally, women eat after men, and even during pregnancy their diet is typically inadequate. A high proportion of women receive no treatment for illness; many use home remedies or traditional healers, while men are more likely to receive modem medical and institutional care.

[15] Dixon, Ruth B. 1978. *Rural Women at Work: Strategies for Development in South Asia.* Baltimore, MD, Johns Hopkins University Press.

[16] Mukerjee, B.N. 1975. "Multi-dimensional conceptualization of status of women", *Social Change*, 5(1&2):27-44.

[17] Government of India (1974). Towards Equality: Report of the Committee on the Status of Women in India, (New Delhi, Government of India).

[18] Joke Schrijvers uses the term "autonomy" and defines it to mean, "a fundamental criticism of the existing social, economic and political order...an anti-hierarchical concept, which stimulates critical and creative thinking and action... transformation which comes from within, which springs from inner resources of one's own as an individual or a collectivity" (Scrijvers, 1991 *quoted in* Stromquist, N. P. (1995) The Theoretical and Practical Bases for Empowerment *In*

decision-making and making personal choices at crucial points in their life-cycle (United Nations, 1975)[19]. The idea of status also connotes the notion of equality (Krishnaraj, 1986)[20]. There can be self-perceived status, group-perceived status or objective status (Mukerjee, 1975)[21], a situation which can lead to status inconsistency when a person is very high in one type of status and very low in another.

Acharya and Bennett (1981)[22] noted that status is a function of the power attached to a given role, and because women fill a number of roles, it may be misleading to speak of "*the* status of women". Another early writer on the topic, Mason (1986)[23], pointed out that the phenomenon of gender inequality is inherently complex, that men and women are typically unequal in various ways, and that the nature or extent of their inequality in different settings can vary across these different dimensions (as well by social setting and stage in the life cycle).

While there are different ways of looking at status of women, it is clear that there are wide disparities between the status of men and women. Today women constitute half of the world's population, perform nearly two thirds of work hours, receive one–tenth of the world's income and own less than one-hundredth of world's property (United Nations Report 1980)[24]. Association for

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Medel-Anonuevo, C. (Ed) *Women, Education and Empowerment: Pathways towards Autonomy* Hamburg: UNESCO Institute for Education)

[19] United Nations (1975). *Status of Woman and Family Planning.* New York, Department of Economic and Social Affairs.

[20] KrishnaRaj, Maitreyi (ed.) (1986). *Women's Studies in India: Some Perspectives.* Bombay, R-Popular Prakashan.

[21] Mukerjee, B.N. 1975. "Multi-dimensional conceptualization of status of women", *Social Change*, 5(1&2):27-44.

[22] Acharya, Meena, and Lynn Bennett. 1981. "Rural Women of Nepal: An Aggregate Analysis and Summary of 8 Village Studies." *The Status of Women in Nepal.* Volume II, Part 9: Field Studies. Centre for Economic Development and Administration. Kathmandu: Tribhuvan University.

[23] Mason, Karen. 1986. "The Status of Women: Conceptual and Methodological Issues in Demographic Studies." *Sociological Forum* 1(2):284-300.

[24] Pathak, N.K. 2003. Women's Empowerment through Judicial Process, in Ranjna Harish & Bharathi Harishankar (ed.). *Shakti: Multidisciplinary Perspective on Women's Empowerment in India.* New Delhi: Rawat Publications, pp 69.

in their bulletin 'Women's Right and Economic Change'[25] mention that globally:-

- Women earn 20 to30 per cent less than men. (ILO)
- Women remain at the lower end of a segregated labour market and continue to be concentrated in a few occupations, to hold positions of little or no authority, and to receive less pay than men. ( UN Department of Economic and Social Affairs)
- Women's unpaid household labour accounts for about one third of the world's economic production. (UNFPA)
- In developing countries, women's work hours are estimated to exceed men's by 30 per cent. (UNFPA)
- Whereas men are more likely to be hired in core and better paid positions, women are increasingly hired in peripheral, insecure, less valued jobs including home-based, casual and temporary work. (ILO)
- At times of economic crisis, women are the first to withdraw from wage and salaried work; they may be forced to enter the informal economy as a result. (ILO)

Inequality between men and women is one of the most critical disparities in India too. This is not only reflected in matters such as education and opportunities available but also in more elementary fields of nutrition, health and survival which is basic human right. This is well reflected in unbalanced sex-ratio (927 women per thousand men)[26] which has deteriorated over the time. Women are also vulnerable to diseases and their mortality is higher than men. Malnutrition and anaemia caused by poverty and aggravated by gender inequality, leads to problems during pregnancy and childbirth contributing more than any other factor to high maternal mortality. Further, low literacy rate (53.7 per cent)[27] among women has also led to ignorance about health issues.

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[25] *Women's Work exposed: New Trends and their* Implications in Women's Rights and Economic Change. No. 10, August 2004. Canada: Association for Women's Right in development.

[26] See, Census of India. 2001

[27] See, Census of India. 2001

According to Kalyani Menon Sen and A. K. Shiv Kumar (2001)[28] in a recent report commissioned by the office of the United Nations Resident Coordinator in India, women in India are outnumbered by men. There are an estimated 30 million missing women. They face nutritional discrimination and have little control over their own fertility and reproductive health. They are less literate with higher dropout rates. Although they work for longer hours than men, their work is largely undervalued and unrecognised and they earn lower wages for same work. They are under-represented in government and decision making. They are legally discriminated against land and property rights, and face violence inside and outside the family throughout their lives.

In his key note address, Justice A. S. Anand, highlighted the pathetic situation of women and pointed out the fact that internationally two-thirds of world's adult illiterates are women. Women number about half-a-billion adult population, 70 per cent of the world's poor are women, and women account for 50 per cent of those infected by HIV worldwide. In Africa that figure is now 58 per cent. Even at the national level, there are several areas of deep concerns like, sharp decline in juvenile sex ratio, continuing high maternal mortality rate and infant mortality rate, high gender gap in literacy at all levels, high rate of dropouts of girl students and increasing incidence of crime against women.[29]

The ground reality is that women are not treated as equal partners in all spheres and there is vast chasm in empowerment and freedom enjoyed by a microscopic number of women and the large majority who are illiterate, ignorant and poor. The common problems faced by these women are:

1. Inequalities in power sharing with men and in particular in the decision making at all levels.

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[28] Sen, Kalyani Menon & Kumar, A K Shiva. 2001. *Women in India, How free? How Equal?* New Delhi: Office of the United Nations Resident Coordinator in India as quoted in Meenai, Zubair. 2001. *Empowering Rural Women: An approach to Empowering women through Credit-Based, Self help Groups.* Delhi: Aakar Books. pp. 68-67.

[29] Keynote address by Hon' ble Dr. Justice A.S. Anand, Chairperson, NHRC on the theme "Women Empowerment - the key to achieving the Millennium Development Goals" at a function organized by the UN Information Centre at 3.30 PM on 7 March 2003.

2. Lack of awareness about their rights.
3. Insufficient machinery at all levels to promote advancement of women.
4. Inequalities in women's access to and participation in the economic structures and policies and the productive process itself; unequal access to education, health, employment, credit facilities and other means of maximising awareness of women's rights and the use of their capacities.
5. Violence against women.
6. Marginalisation in the decision making process, with women generally remaining invisible at most levels in public structures.

The National Policy for the Empowerment of Women has its impetus on their work force participation, education[30], health and political participation at the grassroots to deal with various atrocities. The policy emphasises the need for women to be empowered to monitor the different developmental programmes especially earmarked for women's development and more particularly social and economic upliftment of women belonging to scheduled castes, scheduled tribes, economically weaker sections, minorities and other backward caste communities. Further, the society and the male members need to have a positive attitude towards empowerment of women. Studies have shown how education of a girl child has positive impact on infant mortality, maternal mortality, health, hygiene, and productivity.

Welfare initiatives, by and large have failed to achieve the desired results. The primary factor responsible for this is the near total absence of appropriate community structures and peoples' institutions at the grassroots level. These peoples' institutions generally facilitate the process of collective decision-making and put a pressure on the machinery for delivery of services thereby ensuring greater accountability on the part of the latter. Significant social reform movements, particularly focusing on women are considered to be a necessary precondition for the emergence of such institutions. Two basic principles determine the growth and spread of such movements. Firstly, the initiative and

[30] There is considerable evidence for the claim that access to education helps to empower women. However, there are also studies that suggest that the potential of education to transform can be overstated.

leadership should come from within the community, although external change agents may have a role initially. Secondly, a majority of the members of the community should be able to perceive the immediate benefits from the movement, which should be reflected in better quality of life. Women's empowerment must become a political force if it is to transform society at large. This is only possible through mass movement[31] which challenges and transforms existing power structures[32].

## WHAT IS EMPOWERMENT

The term 'empowerment' means many things to many people, depending on their ideological position and their preconceived notions. It is such a complex phenomenon that its measurement remains a problem for academicians and policy makers. There is no single, widely accepted definition of empowerment. Some of scholars like Oakley (2001) have defined it as, "change in existing patterns of power and its use that any meaningful change can be brought about". On the other hand it can be said to involve "recognising the capacities of such groups (the women, marginalized and oppressed) to take action and to play an active role in development initiatives" (Oakley 2001[33]quoted in Sarah 2003[34]). Oakley identifies five key uses of the term empowerment. These are: empowerment as participation, empowerment as democratisation, empowerment as capacity building, empowerment through economic improvement and empowerment and the individual. Empowerment can be defined and understood from different perspective. As Batliwala notes that "the most conspicuous feature

[31] Mass movements and organizations of poor women (and men) can only bring about the fulfilment of women's needs, and change both the condition and the position of women.

[32] Existing power structure (notions of power), evolved in a hierarchical, male-dominated society are based on divisive, destructive and oppressive values which encourage aggression, competition, and corruption, regardless of whether it is men or women wielding power.

[33] Oakley, P. (Ed) (2001) Evaluating Empowerment: Reviewing the Concept and Practice. Oxford: INTRAC

[34] Mosedale, Sarah. 2003. *Towards a framework for assessing empowerment.* Paper prepared for the international conference, New Directions in Impact Assessment for Development: Methods and Practice, Manchester UK, 24 and 25 November 2003

of the term empowerment is that it contains within it the word 'power[35]'. Empowerment is therefore concerned with power and particularly with changing the power relations[36] between individuals and groups in society[37]". Batliwala further defines women's empowerment as "process, and the outcome of the process, by which women gain greater control over material and intellectual resources, and challenge the ideology of patriarchy and the gender-based discrimination against women in all the institutions and structures of society (Batliwala, S. 1995)". For some, "empowerment refers to increasing the political, social or economic strength of individuals or groups. It often involves the empowered developing confidence in their own capacities[38]" whereas others defines it as "how individuals/communities engage in learning processes in which they create, appropriate and share knowledge, tools and techniques in order to change and improve the quality of their own lives and societies. Through empowerment, individuals not only manage and adapt to change but also contribute to/generate changes in their lives and environments[39]". Others have defined empowerment as 'the process of increasing personal, interpersonal and political power to enable individuals or collectives to improve their life situation. It requires the full participation of people in the formulation, implementation and evaluation of decisions determining the functioning and well-being of the society'[40]. G. Sen (1993)[41] defines empowerment as "altering relations of power, which constrain women's options and autonomy and adversely affect health and well-being." Jejeebhoy (2000)[42] considers autonomy and empowerment as more

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[35] Here power can be defined as the degree of control over material, human and intellectual resources exercised by different sections of society.

[36] A woman's level of empowerment varies according to her class or caste, relative wealth, age, family position etc. Nevertheless, focusing on the empowerment of women as a group requires an analysis of gender relations i.e. the ways in which power relations between the sexes are constructed and maintained.

[37]Batliwala, S. 1995: *Defining Women's Empowerment: A Conceptual Framework.* Education for Women's Empowerment, ASPBAE Position Paper for the Fourth World Conference on Women, Beijing, September 1995, New Delhi, Asia-South Pacific Bureau of Adult Education.

[38] See, en.wikipedia.org/wiki/Empowerment

[39] See, www.unesco.org/education/educprog/lwf/doc/portfolio/definitions.htm

[40] See, www.polity.org.za/html/govdocs/white_papers/social97gloss.html

[41] Sen, Gita. 1993. *Women's Empowerment and Human Rights: The Challenge to Policy.* Paper presented at the Population Summit of the World's Scientific Academies.

[42] Jejeebhoy, Shireen J. 2000. "Women's Autonomy in Rural India: Its Dimensions, Determinants, and the Influence of Context." In *Women's Empowerment and Demographic*

or less equal terms, and defines both in terms of women "gaining control of their own lives vis-à-vis family, community, society, markets." In contrast, other authors have explicitly argued that autonomy is not equivalent to empowerment, stressing that autonomy implies independence whereas empowerment may well be achieved through interdependence (Malhotra and Mather 1997[43]; Govindasamy and Malhotra 1996[44]; Kabeer 1998[45]). Batliwala's (1994)[46] definition is in terms of "how much influence people have over external actions that matter to their welfare." Keller and Mbwewe (1991[47], as cited in Rowlands 1995)[48] describe it as "a process whereby women become able to organize themselves to increase their own self-reliance, to assert their independent right to make choices and to control resources which will assist in challenging and eliminating their own subordination." Kabeer (2001)[49] offers a definition of empowerment which effectively captures what is common to these definitions and that can be applied across the range of contexts that development assistance is concerned with:

> *"The expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them."*

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*Processes: Moving Beyond Cairo.* Harriet Presser and Gita Sen, eds. New York: Oxford University Press.

[43] Malhotra, Anju and Mark Mather. 1997. "Do Schooling and Work Empower Women in Developing Countries? Gender and Domestic Decisions in Sri Lanka." *Sociological Forum* 12(4):599-630.

[44] Govindasamy, Pavalavalli, and Anju Malhotra. 1996. "Women's Position and Family Planning in Egypt." *Studies in Family Planning* 27(6):328-340.

[45] Kabeer, Naila. 1998. 'Money Can't Buy Me Love?' Re-evaluating Gender, Credit and Empowerment in Rural Bangladesh. IDS Discussion Paper 363.

[46] Batliwala, Srilatha. 1994. "The meaning of Women's Empowerment: New Concepts from Action." Pp. 127-138 in *Population Policies Reconsidered: Health, Empowerment and Rights.* G. Sen, A. Germain, and L.C. Chen, eds. Cambridge, MA: Harvard University Press.

[47] Keller, B. and D.C. Mbwewe. 1991. "Policy and Planning for the Empowerment of Zambia's Women Farmers." *Canadian Journal of Development Studies* 12(1):75-88 [as cited in Rowlands, Jo. 1995. "Empowerment examined." *Development in Practice* 5(2):101-107].

[48] Rowlands, Jo. 1995. "Empowerment Examined." *Development in Practice* 5(2):101-107.

[49] Kabeer, Naila. 2001. "Reflections on the Measurement of Women's Empowerment." In *Discussing Women's Empowerment-Theory and Practice.* Sida Studies No. 3. Novum Grafiska AB: Stockholm.

Kabeer's definition contains two elements which help distinguish empowerment from other closely related concepts, 1) the idea of process, or change from a condition of disempowerment, and 2) that of human agency and choice, which she qualifies by saying that empowerment implies "choices made from the vantage point of real alternatives" and without "punishingly high costs." Kabeer defines empowerment as "the process by which those who have been denied the ability to make strategic life choices acquire such ability" (Kabeer 1999[50]). Mosedale has defined women's empowerment as 'the process by which women redefine and extend what is possible for them to be and do in situations where they have been restricted, compared to men, from being and doing (Mosedale, Sarah. 2003[51])".

The World Bank defines empowerment as 'the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives'[52]. The World Bank admits that empowerment, as a term, has meaning that changes with social and political context, depending on its interpretation, but its core significance always remains the same - putting people on equal footing with each other, by giving marginalized or victimized people the opportunity, voice and power to rise above their challenges. World Bank (2001)[53] identifies gender equality both as development objectives in itself and as a means to promote growth, reduces poverty, and promotes better governance. A similar dual rationale for supporting women's empowerment has been reiterated in the policy statements of several international conferences in the past (e.g,. the Beijing Platform for Action, the Beijing+5 declaration and resolution, the Cairo Programme of Action, the





[50] Kabeer, N. (1999) Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment. *Development and Change* Vol. 30 pp 435-464

[51] Mosedale, Sarah. 2003. *Towards a framework for assessing empowerment.* Paper prepared for the international conference, New Directions in Impact Assessment for Development: Methods and Practice, Manchester UK, 24 and 25 November 2003.

[52] See, http://www.worldbank.org/poverty/empowerment-/whatis/index.htm

[53] World Bank. 2001a. *Engendering Development: Through Gender Equality in Rights, Resources, and Voice.* World Bank Policy Research Report. Oxford: Oxford University Press.

Millennium Declaration, and the Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]).

UNICEF uses the Women's Empowerment Framework constructed by Sara Longwe, which encompasses welfare, access to resources, awareness-raising, participation, and control (UNICEF 1994)[54]. While resources, economic, social, and political, are often critical in ensuring that women are empowered, they are not always sufficient. The United Nations Development Fund for Women (UNIFEM) includes the following factors in its definition of women's empowerment which includes, acquiring knowledge and understanding of gender relations and the ways in which these relations may be changed; developing a sense of self-worth, a belief in one's ability to secure desired changes and the right to control one's life; gaining the ability to generate choices and exercise bargaining power; and developing the ability to organise and influence the direction of social change, to create a more just social and economic order.

Although there is no consensus on the meaning of the term empowerment, it is reiterated time and again in various conferences and policy papers that empowerment of women is very important for society and its development and addressing the existing inequalities between men and women[55]. The wider question is, 'what is empowerment', and 'who empowers whom?' Is it power over resources; is it ability to create 'effective demand; is it about the ability to make choices; or is it about access to resources and how they are controlled, politically or economically, by NGOs, by political parties, or by the State? To what extent is empowerment explicit or implicit? These are some of the questions which this section will try to understand and address[56].

[54] United Nations Children's Fund (UNICEF). 1994. The Women's Equality and Empowerment Framework. (See, www.unicef.org/programme/gpp/policy/empower.html)

[55] It is well accepted fact that (in Bihar) inequalities between men and women exist in all areas of development, like, human development (health and education), economic development, violence against women, participation in public life and policymaking and social attitudes and gender stereotyping.

[56] The answers to these questions may be different in different places and at different times.

Although empowerment has become a buzz word[57] after the 1990s, understanding of women's empowerment is clouded by the inability to differentiate between sex and gender[58] roles. Sex or biological roles shape the fundamental differences between women and men which are determined by social, economic, political and cultural forces. Although the boundary between these determinants is the subject of much debate, what can be said with certainty is that they vary across the world, within countries, and within castes and classes. There are a few key words that are most often used in defining empowerment like, options, choice, control, and power. Most often these words are referring to women's ability to make decisions and control over one's own life and over resources. Jo Rowlands (1998) has rightly pointed that "Current use of the term [empowerment] remains ill-defined, however, in the development context; its users tend to assume that the appropriate meaning will be understood without being explained[59]". Jo Rowlands also mentions that "Much use of the term has laid emphasis on economic and political empowerment and on a conception of empowerment well rooted in the 'dominant culture' of western capitalism". Another line of thought in development promotes social inclusion in institutions as the key pathway to empowerment of individuals and has at times tended to combine empowerment and participation. Capitalism, top-down approaches to development, and/or poverty itself are seen as sources of disempowerment that must be challenged by bringing "lowers" - the poor and disenfranchised - (Chambers 1997)[60] into the management of community and development processes.

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[57] "The term 'empowerment' has become a stock-in-trade expression wherever in the world women's issues are being discussed. It is one of the most loosely-used terms in the development lexicon, meaning different things to different people - or, more dangerously, all things to all people". (See, Batliwala, S. 1995: Defining Women's Empowerment: A Conceptual Framework. Education for Women's Empowerment)

[58] While sex is the biological and physiological difference between men and women, gender is socially constructed, partly through the process of socialization, and partly through positive and negative discrimination in the various institutions and structures of society (religion, media, economic structures, law and legal systems, cultural beliefs and practices, education, health care, etc.).

[59] Rowland, Jo. 1998. *A Word of the Times, but What Does it Mean? Empowerment in the Discourse and practice of Development* in Afshar, Haleh. 1998. *Women and Empowerment: Illustrations from the Third world.* London, UK: Macmillan Press Ltd. Pp 11

[60] Chambers, Robert. 1997. *Whose Reality Counts? Putting the First Last.* London: ITDG Publishing.

As Rowlands mentions, the term empowerment can be described and understood in the development discourse and within the 'Women in Development' (WID) perspective which predominated thinking on women and development in the 1970s, which is constructed on the 'power over[61]' view of power. The view is that women should somehow be 'brought into development' and become 'empowered to participate within the economic and political structure of the society'. They should be given the chance to occupy positions of 'power', in terms of political and economic decision making. This view of empowerment is consistent with the dictionary definition of the term[62], which focuses on delegation, which is power as something which can be bestowed by one person upon another. The difficulty with this view of 'empowerment' is that if it can be bestowed, it can just as easily be withdrawn. In other words, it does not involve a structural change in power relations[63]. It is therefore illusory.

Robert Dahl has defined power over as if, "A has power over B to the extent that he can get B to do something that B would not otherwise do" (Dahl, 1957[64]). In this context, it is necessary to understand and analyse 'power over' model in gender perspective. Power, in this 'power over' model, is infinite supply; if some people have more, others have less. Rowlands argues that if "power is 'power over', then it is easy to see why it is that the notion of women becoming empowered could be seen as inherently threatening, the assumption will be that there will be some kind of reversal of relationships, and people currently in position of power will face not only losing that power but also the possibility of having power wielded over them in turn. Men's fear of losing control is an obstacle to women's empowerment, but is it necessarily an outcome

[61] 'Power over' view of power refers to the capacity of some actors to override the agency of others through, for example, the exercise of authority or the use of violence and other forms of coercion. Agency in relation to empowerment implies not only actively exercising choice, but also doing this in ways that challenge power relations.

[62] 'The action of empowering; the state of being empowered' OED (1989: 192), where empower means 'Empower: 1). To invest legally or formally with power of authority; to authorize, license. 2). To impart or bestow to an end or for a purpose; to enable, permit'.

[63] Power structure comes into being through differential controls over resources and continuous resistance and challenge by the less powerful and marginalised sections of society, resulting in various degrees of change in the structures and relations of power.

[64] Dahl. R. (1957) The Concept of Power *Behavioural Science,* Vol. 2, pp201-215

of women's empowerment that men should lose power or, crucially, that a loss of power should be something to be afraid of? With a 'power over' view of power, it is hard to imagine otherwise[65]".

S. Wieringa has defined the term women's empowerment as 'exposing the oppressive power of the existing gender relations, critically challenging them, and creatively trying to shape different social relations'[66]. Shakuntala Narsimhan (2002) in her article emphasises that "Women's Empowerment Year as a Beginning with a Bang, Ending with a Whimper". This is the crux, till socio-cultural attitudes are addressed, there can be little meaningful empowerment for gender parity[67]".

Empowerment as a concept has become more and more vague the longer it has been used. Syed Hashemi and Sidney Schuler (1993) have defined empowerment with specific reference to the meanings of women's empowerment in Bangladesh as "the subordination of women is effected through the relationships that define the family and kin group (i.e., through patrilineal descent and residence) and society (i.e., Purdah practices) as well as the inequities of the legal system and inheritance laws. The process of empowerment must therefore be understood in terms of an erosion of the capacities of these structures to ensure acquiescence. While individual women may transgress specifically defined boundaries, ultimately empowerment must be conceptualised as a systematic weakening of the basis of gender subordination (Hashemi and Schuler 1993)[68] ".

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[65] Rowland, Jo. 1998. *A Word of the Times, but What Does it Mean? Empowerment in the Discourse and practice of Development* in Afshar, Haleh. 1998. *Women and Empowerment: Illustrations from the Third world.* London, UK: Macmillan Press Ltd. Pp 13

[66] Wieringa, S. 1979. *Some Preliminary Notes on Subordination of Women,* IDS Bulletin, 10 (3): 10-13.

[67] Shakuntala Narsimhan (2002) as quoted in Ranjana Harish & Bharathi Harishankar (eds.) 2003. *Shakti: Multidisciplinary Perspective on Women's Empowerment in India.* New Delhi: Rawat Publications, pp 18.

[68] Hashemi, Syed and Sidney Schuler. 1993. *Operationalising Indicators of Empowerment: A Methodological Note.* Dhaka: Unpublished mimeo in Goetz, Anne Marie. 2001. *Women Development Workers: Implementing rural credit Programmes in Bangladesh.* New Delhi: Sage Publications. pp. 44

Although the word empowerment stands for strength or power, Ranjana Harish and Bharathi Harishankar (2003) have rightly mentioned that "in the Indian psyche, it symbolises the ideal of woman. The irony in this situation is that the power of Shakti [empowerment] has rested in her [women] powerlessness. She has been an all-sacrificing, all-giving, benevolent, de-sexualised, de-humanised female image. The so-called empowerment is a reward bestowed upon her for all her sacrifices[69]". On the other hand, Bagchi (1999) saw it form another perspective and comments that, "the toiling (hard working and laborious) women of India are trapped by the mythic ideal of empowerment based on deprivation (Bagchi 1999)[70] ".

Justice V R Krishna Iyer has also pointed out that "Empowerment, Egalite and Dignity of women are the desiderata of contemporary womanhood, long subject to undeservedly humiliating inferiority of status, discrimination in civil and political rights and subordination in developmental opportunities, Women are human and, as of right, a radical transformation in women's position as just, fair and necessary to put an end to the current invidiously arbitrary situation[71]".

The concept of women's empowerment is the outcome of several important critiques and debates generated by the women's movement throughout the world, and particularly by Third World feminists. Its sources can be traced to the interaction between femininity and the concept of popular education developed in Latin America in 1970s. Abha Avasthi and A K Srivastava note that "some feminists feel that during the past two decades, empowerment practice in the human services has emerged from efforts to develop more effective and responsive service for women, people of colour and other oppressed groups. The goal of this method of practice is to address the role, powerlessness plays in creating and perpetuating personal and social problems. It can be distinguished

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[69] Harish, Ranjna & Harishankar, V. Bharathi. 2003. *Shakti: Multidisciplinary Perspective on Women's Empowerment in India.* New Delhi: Rawat Publications, pp 19.

[70] Bagchi, Jasodhara.1999. *"Women's Empowerment: Paradigms and Paradoxes". From Myth to Market.* Eds. Kumkum Sangari and Uma Chakravarti. Simla: IIAS

[71] Krishna Iyer, V R. 2004. *Search for A Vision Statement on Women's Empowerment vis-à-vis Legislation & Judicial Decisions.* Prepared by Indian Trust for Innovation & Social Change, New Delhi. New Delhi: National Commission for Women. pp. vii

by its focus on developing critical awareness, increasing feelings on collective and self-efficacy and developing skills for personal, interpersonal or social change. Within our increasingly diverse society, empowerment has emerged as one of perspective on practice that can be inclusive and supportive of diversity[72]". They further noted that "empowerment, in its simplest form, means the manifestation of redistribution of power that challenges patriarchal[73] ideology and the male dominance. It is both a process and the result of the process. It is transformation of the structures or institutions that reinforces and perpetuates gender discrimination. It is a process that enables women to gain access to and control of material as well as information resources".

The review of recent literature on the attempts to measure and examine the validity of indicators of women's empowerment by demographers and other social researchers suggests that the information collected to construct these indicators is sensitive, subjective, and varies in dimension. There is certainly a need to develop a standard and valid tool to measure the empowerment of women. There are various indicators and approaches that are collected by various large-scale surveys like the National Family Health Survey (NFHS). What should be the best approach, is it just educational attainment of women that should be included in measuring empowerment? Economic activity and independence, political participation, gender based violence or domestic violence, decision making in economic and especially reproductive health related aspects should also be an integral part of any such measure.[74]

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[72] Avasthi, Abha & Srivastava, A.K.(Ed.) 2001. *Modernity, Feminism and Women Empowerment.* New Delhi: Rawat Publications, pp 15.

[73] Patriarchy literally means 'rule of the father' (patriarch in Greek), but in social terms, refers to the system of male dominance, i.e., where descent is traced through the father; where the ownership, control and inheritance of all assets is in the hands of men; where males exercise the right of all major decision-making in the family, and hence maintain ultimate control over the family and its relations.

[74] Shastri, V. D. 2002. Measuring and Analyzing Women's Empowerment / Autonomy: A Cross State Comparative Study Based on National Family Health Survey-2. [Unpublished] 2002. Presented at the 25th Annual Conference of the Indian Association for the Study of Population, International Institute for Population Sciences, Mumbai, India, February 11-13, 2002. [14] p.

## WOMEN'S EMPOWERMENT AND HEALTH

Women's empowerment has been a central issue on the agenda of various development programmes for many years. Many people have addressed the issue in various ways taking, political, economic, and social issues and realities but little attention has been given to women's health or it has been confined to the field of family planning, reproductive health and contraceptives only. While there have been debates to distinguish "women's health" as a more holistic concept from "reproductive health", the issue remains to define women's health and to locate the discourse within a framework of rights. While decision making linked to reproduction and regulation of fertility is important, meeting health needs of women through a system which is sensitive to the different needs and access to health care also needs to be taken into account. The division of the health delivery system in terms of two structures, family welfare and health, is not very conducive to a holistic approach to women's health. There has been no attempt to address the issue of women's health in a comprehensive way touching multiple domains of her health so as to have an impact on her total well being. For an empowerment approach to be well integrated into health programmes, it is important that women's participation is incorporated at each stage of the programme and issues regarding power structures are also dealt with. The entire conceptual shift from targeted family planning to reproductive health, which is based on informed choice, is to allow women to voice their preference and needs. However, for women to be able to speak out within the family and community social factors need to be addressed and create an enabling environment which would allow this to happen.

"Be it health, system after system, the story remains unchanged. Health is of course a big casualty, may be because of short sighted plans or absence of required infrastructures. But how long we let women and children continue to suffer? The UN and other donor agencies' funding also, often do not reach the people for whom it is meant for. The basic infrastructure though minimum in number has not been effectively functioning. People in the villages are still not

active partners in developmental programmes. They remain only as occasional beneficiaries. These are the real issues to explore[75]".

In fact there is no dearth of resources to educate and empower women and offer information about the various programmes to improve their health. However, women have always been most vulnerable to diseases and suffer discrimination in terms of education, nutrition and medical care. Therefore, access to and affordability of basic and sophisticated health services remain basic factors for medical needs. Low literacy level especially among rural women has aggravated their problems and has implications for their health. A big gap existing between available information and general awareness needs to be narrowed down.

It is necessary to understand gender specific health problems and address it at multiple levels. Women need to also be recognised as health care providers. In any family women are the providers of health care. Besides this women prepare the meals for the sick and feed the sick, care for the disabled at home, take care of children, take children for immunization and curative care. It is the woman who teaches the children personal hygiene and sanitation and lays the foundation for knowledge on health. Women bear the brunt of family planning.

Women also form the majority of professional health workers from dais to doctor. They need to be trained at various levels of supervision, management and decision making to fulfil their roles in the society. A sustained and long term commitment is essential so that women and men can work together for themselves, for their children and for the society to meet the challenges of the twenty-first century.

The National Council of Applied Economic Research (NCAER) in its Human Development Report of India (1999) reports that about 1.1 per cent women suffer from short-duration morbidity than men, and about 1 per cent

[75] *Search for a Vision Statement on Women's Empowerment vis-à-vis Legislation & Judicial Decisions*. 2004. Prepared by Indian Trust for Innovation & Social Change, New Delhi. New Delhi: National Commission for Women. pp. 4

women suffer major morbidity (primary anaemia). In 15-34 age groups, the disparity is much higher, with 1.31 per cent women reporting short-duration morbidity than men, and 1.27 per cent women reporting major morbidity[76].

Ill health and malnutrition among women continue to be serious problems in both rural and urban India, leading to high morbidity and mortality. Ill health related to reproductive functions remains as one of the most important obstacles to women's development. Empowerment of women has been taken up seriously over the last decade, but the approach has been linear. In this context, empowerment of women becomes even more significant as women's health and women's empowerment are closely related. A healthy woman is energetic, active, has endurance and therefore healthy women enjoy empowerment more. Less healthy women are less efficient, least productive in socioeconomic and political endeavours. On the other hand, women who are more empowered have greater access to resources and services and therefore a better health status.

Empowerment of women in different aspects has been brought in through knowledge, information, training, increased access to resources and services, constitutional amendments, legal acts and through policy interventions. Although the National Health Policy[77] pointed at the need to establish comprehensive health service to women and children who are the vulnerable groups of society, health status of women continues to be lower than that of men.

While policies are macro level statements, the realisation of the objectives has to come from micro level changes. The gap between macro level policy and micro level receiver constitutes the major obstacle to implementation of programmes.

The major health problems of women can be categorised as:

a) General problems caused due to infections, which are common to all.

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[76] *Proceedings of the Workshop on Empowerment of Women's with Special Reference to Women's Health.* 2000. New Delhi: National commission for Women. pp. 4

[77] National Health Policy, 2002. Ministry of Health and Family Welfare, Government of India.

b) Reproduction related health problems like anaemia, toxaemia, uterine prolapsus, infertility, abortion and other diseases, etc.
c) Occupation and environment related health problems.
d) Nutrition related problems, and
e) Emerging problems such as STD, HIV/AIDS, etc.

Although we have a clearly formulated National Health Policy which takes into consideration some of the above mentioned problems, it did not go that far enough to meet to needs of poor, powerless, pregnant women, partly because of poor implementation. The utilisation of existing services is also discriminatory; it is lower by women than men in all States. An important factor for low utilisation is the social distance between the health care providers and the people. The quality of services offered also is matter of great concern. Causes for poor utilisation of health services by women are several. Some of these are:

1. Poverty.
2. Heavy workload and drudgery.
3. Low priority given to self.
4. Lack of awareness and confidence.
5. Poor communication and transport facilities.
6. Inadequate guidance and support from the family to approach health care services.
7. Responsibility of childcare and household.

Even though traditional Indian system has been taking care of health problems in early stages, owing to knowledge erosion and explosion of media, dependency on services available at PHC has increased. This means extra time and effort on the part of women.

From the post independence period traditional knowledge of health got eroded with development of allopathic system of medicine. In addition migration to urban areas and breaking up of joint-family system increased dependence on outside resources. Allopathic system of medicine is substituted in place of home remedies even for small and simple problems. Health services in India are a joint effort of Central and State Governments, private and non-Government sectors.

While private sector has expanded the services, it is not affordable for majority of the low and middle income in unorganised sector and agrarian families. Besides, NGOs are unable to maintain effective quality services because of several constraints, the major constraints being lack of well-trained personnel and financial support.

## CONCEPT OF SELF-HELP GROUPS

The process of women's empowerment begins when a woman herself realizes/becomes aware of her situation, the social reality and her rights. This awareness should be followed by education[78], knowledge, skills and action. When women come together, they find strength and are encouraged to move towards further knowledge and awareness. This process leads towards further empowerment. Thus, the collective action through organizing for women's empowerment, such as through Self-help Groups introduces an element of leadership, reduces risk and external threat, and enables women to overcome the oppression of patriarchy, and to realise their own true potential.

Self-help Groups (SHGs) in India represent one of the most important phenomena to surface in decades, given their scale as a platform for poor people's development. A Self-help group is a collection of people who have common problems that cannot be solved individually, and have therefore decided to form a group and take joint action to solve these problems[79]. National Bank for Agriculture and Rural Development (NABARD) defines Self-help Groups (SHGs) as, 'Self-help groups are small voluntary association of poor people, preferably from the same socio-economic background. They come together for the purpose of solving their common problems through self-help and mutual help. The SHG promotes small savings among its members. The savings are kept with

[78] Education should be central to the process of empowerment which provides exposure and access to new ideas and ways of thinking, and triggers a demand for change.

[79] *Women's Empowerment Camps: Course Content.* New Delhi: National Commission for Women. pp. 135

a bank. This common fund is in the name of the SHG. Usually, the number of members in one SHG does not exceed twenty[80].

The SHGs comprise very poor people who do not have access to formal financial institutions. They act as the forum for the members to provide space and support to each other. It also enables the members to learn, to cooperate, and work in a group environment. The SHGs provide savings mechanism, which suits the needs of the members. It also provides a cost effective delivery mechanism for small credit to its members.

An SHG can be all-women group, all-men group, or even a mixed group. However, it has been the experienced that women's groups perform better in all the important activities of SHGs. Mixed group is not preferred in many places, due to the presence of conflicting interests. Although there are no fixed criteria, NABARD has mentioned some criteria which can be considered as indicators of a good SHG. They are:

*Homogeneous membership:* As far as possible, the membership of an SHG may comprise people from comparable socio-economic background. Though difficult to define in clear terms, a major indicator of homogeneity in membership is absence of conflicting interests among members.

*No discrimination:* There should not be any discrimination among members based on caste, religion or political affiliations.

*Small membership:* Ideally, the group size may be between 15 and 20, so that the members are participative in all activities of the SHG. In a smaller group, members get opportunity to speak openly and freely. However, the membership may not be too small that its financial transactions turn out to be insignificant. .

[80] http://www.nabard.org/roles/mcid/section7.htm

*Regular Attendance:* Total participation in regular group meetings lends strength to the effectiveness of SHGs. To achieve this, the SHGs should place strong emphasis on regular attendance in the group meetings.

*Transparency in functioning:* It is important that all financial and non-financial transactions are transparent in an SHG. This promotes trust, mutual faith and confidence among its members. Maintenance of books of accounts as also other records like the minutes book, attendance register, etc., are important.

Generally SHG has an average size of about 15 people from a homogenous class. They come together for addressing their common problems. They are encouraged to make voluntary thrift on a regular basis. They use this pooled resource to make small interest bearing loans to their members. The process helps them to imbibe the essentials of financial intermediation including prioritisation of needs, setting terms and conditions, and account keeping. This gradually builds financial discipline in all of them. They also learn to handle resources of a size that is much beyond the individual capacities of any of them. The SHG members have to appreciate that resources are limited and have a cost. Once the groups show this mature financial behaviour, banks are encouraged to make loans to the SHG in certain multiples of the accumulated savings of the SHG. The bank loans are given without any collateral and at market interest rates. The groups continue to decide the terms of loans to their own members. Since the groups' own accumulated savings are part and parcel of the aggregate loans made by the groups to their members, peer pressure ensures timely repayments.[81].

Many organizations in India, including non-governmental organizations (NGOs), community-based organizations, and local and national government bodies, now recognize the enormous potential of SHGs and devote significant efforts to forming groups and building their capacities. The activity for which the SHG movement is most widely known is the rapid growth of rural bank-SHG linkages to support SHG borrowing. Such government and non-government

[81] *Progress of SHG – Bank Linkages in India.* 2003-2004. Mumbai: microCredit Innovation Department, National Bank for Agriculture and Rural Development : pp. 3

support to SHGs over the past decade has emphasized progressive outreach to large numbers of poor, rural women across India. In 2004 -05, the National Bank for Agriculture and Rural Development's (NABARD) SHG-Bank Linkage Programme served approximately 24.25 million poor households[82]. This represents only part of an expanding movement to support the exponential growth of SHGs. And, like the development of the microfinance sector globally since the Grameen Bank's pioneering start more than 30 years ago, the movement to support SHG access to financial services has matured rapidly. There are now a significant number of training programmes offered by governmental and non-governmental agencies in all areas of rural banking and finance[83].

Financial linkages for SHGs have developed and organizational capacities to provide or facilitate these linkages have matured. However, the SHG movement has not seen a concurrent emphasis on capacity building by support organizations and SHGs themselves to consolidate and leverage these gains. Nor has there been a parallel emphasis on broader service needs of SHG members to address the dynamic and multifaceted nature of poverty, including the lack of skills, knowledge, and confidence to use finance to exploit opportunities, manage life-cycle events, and cope with crisis. Rural banks and the Indian Government itself have made phenomenal progress to increase poor people's access to financial services[84]. However, neither practice nor policy have matured to address poor people's broader integrated livelihood needs, to create and strengthen employment opportunities and help poor people to acquire, develop and maintain savings, investments, businesses, homes, land and other assets. Likewise, neither practice nor policies have matured to prepare and motivate clients to access health, education and other development services available to them. This is not to

[82] SHG bank linkage programme - Highlights- 2004-05. National Bank for Agriculture and Rural Development. (See, http://www.nabard.org/oper/oper.htm)

[83] During 2004 - 05, around 42,812 bank officials, 4,246 NGO staff, 7,063 government officials and 2,07,916 self help group members trained with grant support from NABARD. In addition, about 161 faculty members of various banks' training establishments were also trained. Cumulatively 1,016.600 persons trained through various SHG related capacity building programmes. (See, Capacity building initiatives- Highlights- 2004-05. National Bank for Agriculture and Rural Development.

[84] During the period April 2004 to March 2005 - 5,39,385 new SHGs were financed by banks to a tune of Rs 29.94 billion by way of loans.

say there has not been pioneering work on the part of many organizations to design livelihood strategies that integrate finance and knowledge. However, there is not, as yet, a dynamic and multifaceted nature of poverty strategies to be cost-effective and sustainable, and make these available for broad use by SHG-support organizations.

## SELF-HELP IN WOMEN'S HEALTH

Self-help in context of women's health is not new phenomenon or initiative. For centuries, women had knowledge and control over their own bodies. It was only with the "modernization" of our medical system that our bodies become the "property" of doctors[85].

India has made considerable progress in social and economic development in recent decades, as improvements in indicators such as life expectancy, infant mortality, and literacy demonstrate[86]. However, improvement in women's health, particularly in states like Bihar, has lagged behind. In rural areas women mostly rely on information gathered and shared from other women or elderly women in family or society to know about their health, changes, development and other health related problems and remedies. Although we can not say that these interactions take place in a formal SHG structure but it is a century old practice to help others. Whereas formal self-help groups consist of women of diverse sexual orientation, race, class, and age, who come together to explore various issues, mostly their economic needs and business, where they also discuss and share health related information and issues with other group members. As mentioned by a SHG member from the West, "it is very easy to begin a self-help group; we can start by discussing our gynaecological problems with friends. No problem is too trivial or 'untouchable' to be discussed openly. Discovering our common experiences with lovers, doctors and the health care

[85] Self-Help - What does it mean? 1996. HomeSpun - A Women's Networking Newsletter. Spring 1996 (See, http://www.sisterzeus.com/hsp2shlp.htm)

[86] See, Improving Women's Health in India. 1996. World Bank.

system, and with our own bodies, is exciting[87]. A group usually consists of five to ten women who meet regularly to examine their own and each other's bodies. We discuss changes we have noticed and learn to identify what is normal and what could signify a problem". To help with larger problems, groups often establish contact with health care providers who are familiar with and support the philosophy of self-help. It focuses on the prevention of health complications, as well as treatment.

Self-help groups are support groups whose members come together regularly to deal with a common problem. When it comes to women's health, it is assumed that members of self-help group come together to learn about their bodies and help each other to deal with common symptoms and problems. The main idea behind the self-help approach in health is to enable women to look at health in a holistic way, as something conditioned by physical, psychological, social, political and environmental situation; and help them to internalise the ethos of mutual support and sharing; and learn different ways of remaining healthy. The process also helps to enhance the self-esteem and self-confidence of the women involved in the group. The approach provides opportunities to women to share, express and experience their health and illness needs. It also helps women to know and understand how other women describe their experience of their body and health.

Although, Self-help in women's health has been emphasised more in western society and literature now a days, traditionally and culturally self-help in women's health is not a new phenomenon for India. One can find the practices in villages where women help each other on health and related issues on the basis of whatever knowledge they have on health and wellness. Their main source of information on these issues is based on traditional practices. Generally the information and knowledge are transferred from one generation to other. Still in villages women believe and practice traditional knowledge of health system in

[87]Author Unknown: HomeSpun - A Women's Networking Newsletter (www.sisterzeus.com/hsp2shlp.htm)

combination of modern allopathic system of medicine. Nevertheless, with more focus on modern medical model by private and public health care system, it is also matter of concern that women's traditional knowledge of managing their health problems appeared to be dying out.

It is also interesting to see and examine, "whether the western health care system, or for that matter any of the dominant, classical medical systems in India, really serve women. If they do, they do so in a limited way. These dominant systems are reluctant to look at the social roots of diseases. They ignore power relations that are embedded in gender, caste, class and religious identities, and their cumulative effect on people's bodies and lives[88]". In this context, SHG could be a strategy to improve women's health and well being by empowering them. However, due to the existing poor public health care system there are doubts in success of such experiments.

Considering the fact that the present medical care has limited reach to the vast majority of Indian women, it is important to strengthen the traditional system of knowledge as well as self-help in women's health. Present public health facilities and health care system do not have sufficient staff. It looks at women only as 'mothers' and targets mainly on family planning and population control programmes. Moreover, it is indifferent and sometimes even hostile attitude of the health personnel, instead of providing health care make a mockery of the health system. Therefore, in this context, self help strategy seems to be more relevant in helping women to maintain their health and well being.

In this chapter, various concept, views and perspectives on women, empowerment have been reviewed and discussed which played an important role in shaping, guiding and development of various programmes and policies related to women and empowerment. The following chapter presents and discuss the various policies and programmes of women's empowerment.

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[88] Khanna, Renu. Women's Health through Self-Help and Traditional Remedies: the Shodhini Experience, Tamil Nadu.

# CHAPTER – III

# WOMEN'S EMPOWERMENT: POLICIES AND PROGRAMMES

## CHAPTER III

# WOMEN'S EMPOWERMENT: POLICIES AND PROGRAMMES

Most of the programmes, policies and efforts on women's welfare and gender equality especially by the government departments, bilateral agencies and NGOs tend to lean towards women's empowerment. But at the same time, it has been observed that many of these programmes do not reach to poor and women, and even if they reach they do not have much impact on women's overall empowerment in many cases. Various reasons can be/has been attributed for improper implementation of these programmes such as, lack of political will to implement these programmes, societal constraints, corruption, patriarchy, and mind-set, etc. However, besides these hard realities in implementation of any programme, it is important to realise and understand that women's empowerment and gender equality can not be achieved without social change and influencing the mind sets of men in the society. It is also necessary to emphasise on social and political empowerment in the policies and programmes rather than focusing on economic empowerment only. It has been seen that just focussing on saving and credit alone may not bring desired results.

However, despite having various initiatives, policies, and programmes, desired progress has not been achieved in empowering women. By and large in the society, decision making, both in rural as well as in urban areas, is male dominated. In this context, it is necessary to review and understand women's empowerment policies and programmes. In this chapter, various policies and programmes on women empowerment, rights, the National Policy for the Empowerment of Women (NPEW), SHGs programmes and policies, Centrally Sponsored Schemes (CSS) and State Plan Schemes (SPS) has been reviewed and discussed. Finally, Self-help Group under Convergent Community Action (CCA) programme of UNICEF, on which the study is based, has been discussed in detail to have a broad understanding of the programme and its component[1].

[1] See, A draft concept on SHG of the organization: Empowering women through convergence strategy. Integrated Development Foundation (IDF), Patna.

## REVIEW OF WOMEN'S RIGHTS, POLICIES AND PROGRAMMES

In the early decades of planning problems of women were looked upon as problems of social welfare, rather than of development. The drawback of this welfare approach was that it did nothing to eliminate the social discrimination against and subordination of women[2]. In almost all plans for poverty alleviation and social change, disadvantaged women became a 'target' in developmental activities rather than a group to be co-opted as active participants. At the International level, prohibition against sex discrimination was first articulated in the United Nations Charter of 1945 and later reiterated in the Universal Declaration of Human Rights in 1948[3]. Since then, virtually all human rights instruments have reinforced and extended protections against discrimination. The International Covenant on Civil and Political Rights adopted in 1966 guarantees equal protection of the law to both sexes[4]. The International Covenant on Economic, Social and Cultural Rights adopted in 1966 also promises equal status to women. The Fourth World Conference on Women, in Beijing also reaffirmed gender equality as a fundamental pre-requisite for social justice[5].

Since 1970, policy makers and academicians started thinking as to how development programmes could be linked to poor women. Women issues are development issues and by-passing them in development programmes means leaving almost half of human resources outside development intervention

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[2]Anand, Jaya S. 2002. Self-Help Groups in Empowering Women: Case study of selected SHGs and NHGs. Discussion Paper No. 38. Kerala Research Programme on Local Level Development Centre for Development Studies Thiruvananthapuram

[3] See, the United Nations and Human Rights. 1945-1995. Department of Public Information, United Nations, New York.

[4] See, International Covenant on Civil and Political Rights, Articles 2, 23, 24, and 25. In: United Nations 1967. Text is also available from the web site of the United Nations High Commissioner for Human Rights: www.unhchr.ch/html/.

[5] United Nations. 1996. The Beijing Declaration and the Platform for Action: Fourth World Conference on Women: Beijing, China: 4-15 September 1995 (DPI/1766/Wom). New York: Department of Public Information, United Nations.

(CIRDAP Development Digest, 1998)[6]. Perhaps the most important conceptual advancement in the international law of women's rights is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), effective from 1981. It emphasises that women should be given rights equal to those of men. The Preamble of CEDAW says that "the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields[7]".

Amartya Sen (1999) has rightly put it that, "Nothing, arguably, is as important today in the political economy of development as an adequate recognition of political, economic, and social participation and leadership of women[8]". In India, the constitution, guarantees social, economic and political justice. On the matter of equality, Article 14 confers men and women equal rights and opportunities in the political, economic and social spheres. Article 15 prohibits discrimination against any citizen on the grounds of religion, race, caste, and sex, etc. Article 15 (3) makes a special provision enabling the State to make affirmative discriminations in favour of women. Similarly, Article 16 provides equal opportunities in matter of public appointments for all citizens. Article 39(a) lays down that the State shall direct its policies towards securing all citizens, men and women, equally the right to means of livelihood. While Article 39(c) ensures equal pay for equal work, Article 42 directs the State to make provision for ensuring just and humane conditions of work and maternity relief. Above all, the Constitution imposes a fundamental duty on every citizen through Article 51A (e) to renounce the practices derogatory to the dignity of women. However the women have not been allowed to reap the benefits provided to them under the Constitution of India. There is a long way to go to achieve the goals enshrined in the Constitution.

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[6] Anand, Jaya S. 2002. Self-Help Groups in Empowering Women: Case study of selected SHGs and NHGs. Discussion Paper No. 38. Kerala Research Programme on Local Level Development Centre for Development Studies Thiruvananthapuram

[7] United Nations. 1980. Convention on the Elimination of All Forms of Discrimination against Women: General Assembly Resolution 25 (XLIV): 44th Session: Supplement No. 49 (A/RES/44/25, reprinted in 28 I.L.M.1448), Preamble. The Convention's text is available from the web site of the United Nations High Commissioner for Human Rights: www.unhchr.ch/html/.

[8] Sen, A. 1999. Development as Freedom, Oxford University Press, Oxford.

In tune with various provisions of the Constitution, the State has enacted many women-specific and women-related legislation to protect women against social discrimination, violence and atrocities and also to prevent social evils like child marriages, dowry, rape, and practice of Sati, etc. Notwithstanding, the enactment of the laws relating to dowry, rape, violence against women, the factual position is rather distressing. The following section reviews the five year plan and various policies and programmes related with women's empowerment.

## FIVE YEAR PLANS: A REVIEW

**Sixth Five-Year Plan (1980-1985):** The term 'empowerment', with reference to women, became popular in the field of development in mid 1980s with the Sixth Five-Year Plan (1980-1985). The Plan can be taken as landmark for women and their empowerment. It was first time that the concept of 'women and development' was introduced[9].

**Seventh Five-Year Plan (1985-1990):** The development programme for women continued with the major objective of raising their economic and social status, in order to bring them into the mainstream of development. The Seventh Five-Year Plan started a move toward equality and empowerment. New institutions were established to expedite actions. These include the Department of Women and Child Development within the Ministry of Human Resources and Development and its counterparts in the States. In addition, Women's Development Corporations were also set up in most of the States to implement the new strategy of economic development by facilitating access to training, entrepreneurship development, credit, technical consultancy services and marketing facilities[10].

**Eighth Five-Year Plan (1992-1997):** The Eighth Five-Year Plan marked a further shift towards empowerment of women, emphasising women as equal partners in the development process. The plan marked a shift from development

[9] Sixth Five Year Plan (1980-1985). Government of India, Planning Commission, Yojana Bhavan, New Delhi

[10] Seventh Five Year Plan (1985-1990). Government of India, Planning Commission, Yojana Bhavan, New Delhi

to empowerment for women to ensure that the benefits of development from different sectors do not bypass women and they could function as equal partners and participants in the development process[11].

**Ninth Five-Year Plan (1997-2002):** Empowerment of women was one of the major objectives of the ninth plan. The approach paper for Ninth Plan recommended an integrated approach towards empowering women which underscores the harmonisation of different sectors, viz., social, legal, economical and political spheres[12].

**Tenth Five Year Plan (2002-2007):** The Mid-Term Review of the Tenth Plan has identified that empowerment of women cannot happen unless they are provided with adequate income generating activities, through wage and self-employment. There are number of schemes such as Swyamsiddha, Swablamban and Support to Training-cum-Employment Programme (STEP) which are in progress where women were mobilized as viable SHGs[13].

## NATIONAL POLICY FOR EMPOWERMENT OF WOMEN: A REVIEW

The National Policy for the Empowerment of Women was evolved in 2001. The year 2001 was also observed as Women Empowerment Year. National Policy for the Empowerment of Women (NPEW)[14] was culmination of international and national attempts to create a blueprint for a gender sensitive society. These attempts include the Mexico Plan of Action (1975), Nairobi Forward Looking Strategies (1985), The Beijing Declaration and Platform for Action (1995), Towards Equality (1974), and National Perspective Plan for Women (1988).

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[11]Eighth Five Year Plan (1992-1997). Government of India, Planning Commission, Yojana Bhavan, New Delhi

[12] Ninth Five Year Plan (1997-2002). Government of India, Planning Commission, Yojana Bhavan, New Delhi

[13] Empowerment of Women. 2006. Economic Survey 2005-2006. pp 218

[14] National Policy for Empowerment of Women. 2001. New Delhi: Department of Women and Child Development. Ministry of HRD.

The important feature of NPEW is that it raises issues, which are relevant in the present context and it provides possible suggestions to achieve the goal of empowerment. It emphasises the need for fundamental freedom in all sphere of life, access to health care, education and employment, legal redress and elimination of discrimination, and violence against women. It also highlights the need to create an environment through positive economic and social policies for full development of women, equal access to participation and decision making, changing societal attitudes and community practices and building and strengthening partnership with women's organisations.

NPEW recognizes that the underlying causes of gender inequalities are related to social and economic structure. Consequently, the access of women, particularly those belonging to weaker sections including scheduled castes, scheduled tribes and other backward classes and minorities (majority of whom are in the rural areas and in the informal, unorganized sector) to education, health and productive resources is limited. Therefore, they remain largely marginalized, poor and socially excluded. The policy underlines the need for mainstreaming a gender perspective in the development process. The economic empowerment of women through poverty eradication programmes, provision of micro-credit, and strategies to save them from the negative impact of globalization were stressed in the NPEW. Besides, it emphasises on economic and social empowerment of women by increasing their access to education, health, nutrition, drinking water, sanitation, housing, environment, science and technology. There is a need for targeted efforts to ensure that rights of women in difficult circumstances such as those in extreme poverty and destitution, affected by natural calamities, disabled, widows, and elderly. Single women in difficult circumstances, women who are heading households, migrants, and those who are victims of marital violence and prostitutes etc, are also need to be brought under the targeted interventions.

## GOVERNMENT OF INDIA: POLICIES AND PROGRAMMES

The Department of Women and Child Development was set up in the year 1985 as a part of the Ministry of Human Resource Development to give the much needed impetus to the holistic development of women and children. As the

national machinery for the advancement of women and children, the Department formulates plans, policies and programmes; enacts/ amends legislations, guides and coordinates the efforts of both governmental and non-governmental organizations working in the field of Women and Child Development. Besides, playing its nodal role, the Department implements certain innovative programmes for women and children. These programmes cover welfare and support services, training for employment and income generation, awareness generation and gender sensitization. These programmes play a supplementary and complementary role to the other general developmental programmes in the sectors of health, education, rural development etc. All these efforts are directed to ensure that women are empowered both economically and socially and thus become equal partners in national development along with men.

The Ministry of Rural Development recognizes that for an accelerated socio-economic development, the active participation of women in the entire process of development is essential. The ministry is implementing various poverty alleviation programmes. These programmes have special components for women and funds are earmarked as 'Women's Component[15]' to ensure flow of adequate resources for the purpose. The major schemes, having women's component implemented by the ministry include Sampoorna Grameen Rozgar Yojana (SGRY)[16], Swarnajayanti Gram Swarojgar Yojana (SGSY) and the Indira Awaas Yojana (IAY).

Given below is a brief review of Centrally and State sponsored schemes related to women empowerment and poverty alleviation. These schemes are (the major grant coming from the Center) sponsored by the Central Government either solely or partially with States. Besides these centrally sponsored programmes, the Rural Development Department of the state governments also implement several programmes which focuses on women empowerment and alleviation of poverty through the creation of infrastructure by generating sustainable employment

[15] See, Chapter XI, Empowerment of Women. The Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 69.

[16] The Sampoorna Grameen Rozgar Yojana (SGRY) was launched in September 2001 by merging the on-going schemes of Jawahar Gram samridhi Yojana (JGSY) and Employment Assurance Scheme (EAS).

il poor. The major schemes that have been undertaken by the Rural Development Ministries for enhancement of income and employment opportunities to the rural poor fall into two categories:

(a) Centrally Sponsored Schemes (CSS): This includes programmes like Swarnajayanti Gram Swarojgar Yojana (SGSY), Jawahar Gram Samridhi Yojana (JGSY)[17]/ National Rural Employment Guarantee Act (NREGA)[18], Indira Awaas Yojana (IAY), Employment Assurance Scheme (EAS)[19], and Drought Prone Area Development Programme (DPAP), etc.

(b) State Plan Schemes (SPS): This includes programmes like Community Development Programme (CDP), and Minimum Needs Programme (MNP), etc.

These programmes aim at direct and three-pronged attack on women's empowerment and poverty alleviation. They intend to (i) create income generating asset base for self-employment of the rural poor, (ii) create opportunities for wage employment for the poor, and (iii) develop backward regions like dry-land, rain-fed and drought prone areas. Apart from this, there are also programmes for providing basic infrastructure and basic civic amenities for better quality of life in rural areas, run by different concerned departments. This segment of schemes includes programmes related to rural health services, water supply, sanitation, housing, rural roads, etc. Besides these programmes, panchayats and Khadi and Village Industries Board (KVIB) also aim at overall development in rural areas. Hence, there is an array of rural development programmes being run by different departments of state government. A brief review of these programmes is attempted in this section with the aim of

[17] The programme was merged with the Sampoorna Grameen Rozgar Yojana (SGRY) in September 2001.

[18] See, the National Rural Employment Guarantee Act (NREGA). 2005. Ministry of Rural development, Department of Rural development, Government of India. New Delhi.

[19] The programme was merged with the Sampoorna Grameen Rozgar Yojana (SGRY) in September 2001.

understanding their implications on women empowerment in the rural areas of Bihar.

**Swaranjayanti Gram Swarojgar Yojana:** Swaranjayanti Gram Swarojgar Yojana (SGSY) was launched in April 1999[20]. It is the largest self-employment programme for the rural poor[21]. SGSY is a holistic programme covering all aspects of self employment such as organisation of the poor into self-help groups, training, credit, infrastructure and marketing. The objective of SGSY is to provide sustainable income to the rural poor and to bring the assisted poor families (Swarojgaris) above the Poverty Line by providing them income generating assets through a mix of bank credit and government subsidy[22]. The programme aims at establishing a large number of micro-enterprises in the rural areas, based upon the potential of the rural poor. It is envisaged that every family assisted under SGSY will be brought above the poverty-line within a period of three years. The programme covers families below poverty line in rural areas of the country. Within the target group, special safeguards have been provided by reserving 50 per cent of its benefits for schedule castes and schedule tribes, 40 per cent for women and 3 per cent for physically handicapped persons. Subject to the availability of the funds, it proposes to cover 30 per cent of the rural poor in each block in the next 5 years. SGSY is a centrally sponsored scheme and funding is shared by the Central and State Governments in the ratio of 75:25 respectively. SGSY is a credit-cum-subsidy programme. Under the programme, efforts would be made to involve women members in each self-help group. The Gram Sabha will authenticate the list of families below the poverty line identified in BPL census.

The trends of financial and physical targets and achievements under SGSY show that although the financial achievement has been closer to the

[20] The programme was launched after restructuring the erstwhile Integrated Rural Development Programme (IRDP) and its allied programmes such as Training of Rural Youth for Self Employment (TRYSEM), Development of Women and Children in Rural Areas (DWCRA), Supply of Toolkits in Rural Areas (SITRA), and Ganga Kalyan Yojana (GKY).

[21] See, the Annual Report (2005-2006). Ministry of Rural Development, Government of Ind New Delhi. Pp IX.

[22] See, Chapter VI, the Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 42.

targets, the physical targets lag behind the targets by a big margin. In fact, the physical performance does not show any qualitative difference under SGSY in comparison to that under different independent programmes of self-employment as they existed before 1999.

One of the major thrusts of the SGSY is organisation of self-help groups. The SHGs are supposed to go through three stages of evaluation, viz. (a) group formation, (b) capital formation through revolving fund and skill development, and (c) taking up economic activities for income generation. Hence, maturing and expanding the SHG movement initiated by the NGO sector with the active involvement of Rural Financial Institutions (RFIs) is envisaged as the main strategy of this programme. Although the performance of the SHG programme has been satisfactory in many parts of the country, it is yet to take firm roots in Bihar. Since the major thrust of the SGSY programme has been to finance SHGs, the slow progress of SHGs in the state has led to very low 'ground level credit flow' and overall poor performance of the SGSY in the state. Other related problems are the insistence by banks for collateral security for loan, and inadequate availability of credit[23].

**Jawahar Gram Samridhi Yojana:** The critical importance of rural infrastructure in the development of village economy is well known. A number of steps have been initiated by the Central as well as the State Governments for building the rural infrastructure. The public works programmes have also contributed significantly in this direction. Jawahar Gram Samridhi Yojana (JGSY) is the restructured, streamlined and comprehensive version of the erstwhile Jawahar Rozagar Yojana. Designed to improve the quality of life of the poor, JGSY has been launched on 1st April, 1999. The primary objective of the JGSY is the creation of demand driven community village infrastructure including durable assets at the village level and assets to enable the rural poor to increase the opportunities for sustained employment. The secondary objective is the generation of supplementary employment for the unemployed poor in the

[23] See, the Guidelines, Swarnjayanti Gram Swarojgar Yojana. 2003. Ministry of Rural Development, Government of India. New Delhi.

rural areas. The wage employment under the programme is to be given to Below Poverty Line (BPL) families. JGSY is implemented entirely at the Village Panchayat Level. Village Panchayat is the sole authority for preparation of the Annual Plan and its implementation. The programme will be implemented as centrally sponsored scheme on cost sharing basis between the Centre and the State in the ratio of 75:25 respectively. The programme is to be implemented by the Village Panchayats with the approval of Gram Sabha. No other administrative or technical approval will be required. For works/schemes costing more than 50,000/-, after taking the approval of the Gram Sabha, the Village Panchayat shall seek the technical/administrative approval of appropriate authorities. Panchayats may spend up to 15 per cent of allocation on maintenance of assets created under the programme within its geographical boundary. 22.5 per cent of JGSY funds have been earmarked for individual beneficiary schemes for SC/STs. 3 per cent of annual allocation would be utilised for creation of barrier free infrastructure for the disabled. The funds to the Village Panchayats will be allocated on the basis of the population. The upper ceiling of 10,000 populations has been removed.

**Indira Awaas Yojana:** Indira Awaas Yojana (IAY) is the flagship rural housing scheme which is being implemented by the Government of India with an aim of providing shelter to the poor staying below the poverty line[24]. The Government of India has decided that allocation of funds under IAY (Indira Awaas Yojana) will be on the basis of poverty ratio and housing shortage. The objective of IAY is primarily to help construction of new dwelling units as well as conversion of unserviceable kutcha houses into pucca/semi-pucca by members of schedule caste and schedule tribes, freed bonded labourers and also non-SC/ST rural poor below the poverty line by extending them grant-in-aid. IAY is a centrally sponsored scheme funded on cost sharing basis between the Govt. of India and the States in the ratio of 75:25 respectively. Grant of Rs. 20,000/- per unit is provided in the plain areas and Rs. 22,000/- in hilly/difficult areas for the construction of a house. For conversion of a kutcha house into in pucca house,

[24] See, Chapter V, Rural Housing. the Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 36.

Rs. 10,000/- is provided. The house is allotted in the name of a female member of beneficiary household[25].

**Credit cum Subsidy Scheme for Rural Housing:** There were a large number of households in the rural areas which could not be covered under the IAY, because either they do not fall into the range of eligibility or due to the limited budget. On the other hand due to limited repayment capacity, these rural households cannot take benefit of fully loan based schemes offered by some of the housing finance institutions. The need of this majority can be met through a scheme which is partly credit and partly subsidy based. The objective of this scheme is to facilitate construction of houses for rural families who have some repayment capacity. The scheme aims at eradicating shelterlessness from the rural area of the country.

All rural households, having annual income up to Rs. 32,000, are covered under this scheme. The funds are shared by the Centre and the State governments in the ratio of 75:25 respectively. A maximum subsidy of rupees ten thousand per unit is provided for the construction of a house. Sanitary latrine and smokeless chulha are integral part of the house. Cost effective and environment friendly technologies, materials, designs etc. are encouraged. However, in practice these are barely adhered to. Sixty per cent of the houses are allocated to schedule castes, schedule tribes and rural poor.

**District Rural Development Agency (DRDA):** DRDA has been the principal organ at the district level to oversee the implementation of the anti-poverty programmes of the Ministry of Rural Development[26]. Created originally for implementation of Integrated Rural Development Programme (IRDP), the DRDAs were subsequently entrusted with a number of programmes, both of the Central and State governments. Since its inception, the administrative costs of the DRDA (District Rural Development Agency) were met by setting aside a part of the allocations for each programme. Of late, the number of programmes had

[25] See, the Guidelines for Indira Awaas Yojana. 2005. Ministry of Rural Development, Government of India. New Delhi.

[26] See, Chapter IX, the Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 61.

increased and several programmes have been restructured with a view to making them more effective. While an indicative staffing structure was provided to the DRDAs, and experience showed that there was no uniformity in the staffing structure. It is in this context that a new centrally sponsored scheme, DRDA (District Rural Development Agency) Administration has been introduced from 1st April, 1999 based on the recommendations of an inter-ministerial committee known as Shankar Committee[27]. The new scheme replaces the earlier practice of allocating percentage of programme funds to the administrative costs. The objective of the scheme of DRDA Administration is to strengthen the DRDAs and to make them more professional and effective. Under the scheme, DRDA is visualised as specialised agency capable of managing anti-poverty programmes of the Ministry on the one hand and effectively relate these to the overall efforts of poverty eradication in the district on the other. The DRDA will continue to watch over and ensure effective utilisation of the funds intended for anti-poverty programmes. It will need to develop distinctive capabilities for poverty eradication. It will perform tasks which are different from Panchayati Raj Institutions and line departments. The DRDAs would deal only with the anti-poverty programmes of the Ministry of Rural Development. If DRDAs are to be entrusted with programmes of other Ministries or those of the State Governments, it must be ensured that these have a definite anti-poverty focus. In respect of such States where DRDA does not have a separate identity and separate accounts[28].

**Drought Prone Areas Programme:** The Drought Prone Areas Programme (DPAP) aims at mitigating the adverse effects of drought on the production of crops and livestocks and productivity of land, water and human resources. It strives to encourage restoration of ecological balance and seeks to improve the economic and social conditions of the poor and the disadvantaged sections of the rural community. DPAP is a people's programme with Government assistance. There is a special arrangement for maintenance of assets and social audit by Panchayati Raj Institutions. Development of all categories of land belonging to Gram Panchayats, Government and individuals falls within the limits of the

[27] See, http://www.drd.nic.in/aboutus.htm

[28] See, the Guidelines. 2002. DRDA Administration. Ministry of Rural Development, Government of India. New Delhi

selected watersheds for development. Allocation is to be shared equally by the Centre and State Government on 75:25 basis. Watershed community is to contribute for maintenance of assets created. Funds are directly released to Zila Parishads/District Rural Development Agencies (DRDAs) to sanction projects and release funds to Watershed Committees and Project Implementation Agencies. Village community, including self-help/user groups, undertake area development by planning and implementation of projects on watershed basis through Watershed Associations and Watershed Committees constituted from among themselves. The Government supplements their work by creating social awareness, imparting training and providing technical support through project implementation agencies[29].

**Support to Training and Employment Programme for women (STEP):** The STEP programme of the Department of Women and Child Welfare, Government of India aims to increase self reliance and autonomy of women by enhancing their productivity and enabling them to take up income generation activities. It provides training for skill up gradation to poor and assetless women in the traditional sectors like, agriculture, animal husbandry, dairy, fisheries, handlooms, handicrafts, khadi and village industries, sericulture, social forestry and wasteland development. The objective of the programme was to mobilise women in small viable groups and make facilities available through training and access to credit, to provide training for skill up gradation, to enable groups of women to take up employment-cum-income generation programmes by providing backward and forward linkages, and to provide support service for further improving training and employment conditions of women. The target group to be covered under the STEP programme includes marginalised assetless women and the urban poor. This includes wage labourers, unpaid daily workers, female headed households, migrant labourers and other dispossessed groups, with special focus on SC/ST households and families below the poverty line. The programme is implemented through State Government Departments of Social Welfare/Department of Women and Child Development.

[29] See, Chapter XXIII, the Annual Report (2005-2006). Department of Land Resources, Ministry of Rural Development, Government of India. New Delhi. Pp 130-132.

**Swawlamban:** Under Swawlamban programme, financial assistance is provided by the Department of Women and Child development to Women's Development Corporations (WDC), public sector corporations, autonomous bodies and voluntary organisations, to train poor women, mostly in non traditional trades and to ensure their employment in these areas. Some of the popular trades under the programme are computer programming, medical transcription, electronics, watch assembling, radio and television repairs, garment making, handloom weaving, secretarial practice, community health, embroidery, etc. Financial assistance is also provided to the grantee organisations for hiring of training-cum-production sheds, training cost, machinery and equipments, stipend to the trainees and remuneration for trainers. The upper ceiling for assistance under this scheme is normally confined to Rs. 8000 per beneficiary. The target groups under the scheme are the poor and needy women, women from weaker sections of society, such as scheduled castes and scheduled tribes, etc. Swawlamban is a good example of NGO – Government co-operation model. Training in specialise fields like computers, electronics are conducted through organisations or undertakings specialising in these field and having good extension network in the field. Women's Development Corporations are the nodal agencies for the implementation of the programme in the states.

**Swayamsidha:** Swayamsidha is an integral scheme of Women and Child Department for women's empowerment. It is based on the formation of women's self-help groups and aims at the holistic empowerment of women through awareness generation, economic empowerment and convergence of various schemes. The long term objective of the programme is all round empowerment of women by ensuring their direct access to, and control over resources through a sustained process of mobilisation and convergence of all the on-going special programmes. The immediate objectives of the programme are establishment of self-reliant women's self-help groups; creation of confidence and awareness among members of SHGs regarding women's status, health, nutrition, education, sanitation and hygiene. The other objectives are to make them aware of legal rights, ensuring economic upliftment, strengthening and institutionalising the

savings habit and their control over economic resources. Main features of the schemes are as follows:

1. Women will be encouraged to form groups according to their socio-economic status and felt-needs, after which they will network with other groups;
2. Formation of association of Government and Panchayat officials/Office-bearers as participants/facilitators';
3. Both Government departments/agencies, NGOs and also district/intermediary level Panchayat Institutions will be eligible to implement the project at the block level;
4. Office-bearers of IWEP societies will be elected from amongst the women members, including ex-officio women members;
5. In addition to empowering SHG members per se by federating and networking strong pressure groups for women's empowerment/rights will be formed;
6. A subsidy-free approach to women's empowerment will be inculcated; and
7. Convergence of difference agencies for women's empowerment and integrated projects accessing delivery of different schemes from a single window.

**Swa-Shakti Project:** The Rural Women's Development Project, known as the Swa-Shakti Project, is jointly supported by the World Bank and the International Fund for Agricultural Development (IFAD). The project aims at enhancing women's access to resources for better quality of life through skills upgradation, increasing their control over income and involving them in skill development and income generation activities. The project is being implemented as a Centrally Sponsored Scheme in the States of Bihar, Haryana, Gujarat, Karnataka, Madhya Pradesh, Uttar Pradesh, Jharkhand, Chhattisgarh and Uttaranchal through Women Development Corporations/Societies. The specific objective of the programmes is organising self-reliant women in to SHGs. The SHGs will improve the quality of their lives by increasing their access to and control over resources; sensitising and strengthening of institutional capacity of support agencies to address women's

needs; developing linkages between SHGs and lending institutions to ensure women's continued access to credit facilities. The group activities further intend to reduce poverty by improving women's access to resources for better quality of life.

## SELF-HELP GROUP UNDER CONVERGENT COMMUNITY ACTION (CCA) PROGRAMME OF UNICEF

**Introduction:** The States of India, in 1990, had submitted a list of their districts considered backward based on certain crucial indicators and guidelines as asked by the Government of India. Based on this baseline, 180 districts were identified for needful development interventions. In this regard CBCS (Community Based Convergent Services) Strategy was launched. Later this transformed into a CCA (Community Convergent Action) strategy, which aims to encourage bottom-up planning and greater responsiveness from line departments of Government for reaching the unreached women and children in the identified districts of Bihar and Jharkhand. Since a decade the CCA strategy has been used to reverse the prevailing top-down development approach by organizing and empowering women's groups, strengthening the Panchayat Raj or local government and establishing a cooperative framework in which women's groups, the Panchayat Raj and various sectors of the state could work together on community specified plans-of-action. The approach drew strength from the 73rd amendment to the Indian constitution, which gave rights to communities to determine their own development path. The districts were identified by UNICEF, Bihar Field Office, Patna, based on key indicators of female literacy, imbalances in the male: female ratio, geographic isolation, political polarization between rich and poor, higher and lower castes, etc.

The essence of Convergent Community Action (CCA) programme strategy was to initiate the process of empowering the women in the backward regions of Bihar and Jharkhand[30]. CCA was a strategy to reduce poverty and not

[30] See, Convergent Community Action (CCA) Bihar/ Jharkhand: A Brief Project Outline. Integrated Development Foundation (IDF), Patna.

a goal or a programme, as described at some quarters. The overall goal was to eliminate the phenomenon of absolute poverty through convergent community action.

CCA as a strategy aimed at realising the objectives of its precursor CBCS (Community Based Convergent Services) programmes. The CBCS was implemented by the line departments. However, due to flawed implementation it could not yield desired results. For achieving its said goal, the bottom-up strategy was restructured with the help of lead CSOs of the concerned districts. The idea was that community organizations would foster primarily the marginalized and least empowered women of those districts for needful participatory community actions and local governance aligning itself with the development initiatives of the various delivery systems of the government. It was started with a vision and goal to create a better environment for the women and children for their sustained development.

Convergent Community Action (CCA) was launched in 1992 as a joint programme of UNICEF and Government of India. CCA is perceived as a strategy relying not on physical infrastructure creation but on building human and institutional resources. To this end, it was a community approach, flexible and open ended, which relies on learning through implementation.

**The emergence of CCA:** The mechanics of development purport a holistic development that is self-sustainable and rejuvenating. This cannot be achieved until it takes into account the development needs of the most neglected and deprived sections of the society especially the' woman'. The concept of 'Gender Sensitivity' thus became the essential ingredient of all development activities so as to ensure a more favourable impact on women. But, the very fact is that women still excluded from the benefits of development process.

What is called for is to establish set standards for Women Empowerment, where each and every aspect of development, psychological, political, social, civil and cultural, economical, etc are taken into account and given equal thrust. Only then perhaps a holistic solution to women emancipation may be achieved.

In light of this, the study purports to bring into prominence the best emulative and replicable practices and performances emanated from CCA.

**CCA Strategy and Objectives:** The aim of CCA was to contribute to the fulfilment of the rights of the least served children and women in the deprived communities by ensuring the adoption of appropriate community development processes. It was felt that the focal point of the intervention would be woman since she is the most vulnerable among the marginalised and holds the promise of a holistic community development, including welfare of children. CCA as a strategy focused to address the following:

- Enabling and empowering the community to realize their entitlements and sustain development process for further growth through self-initiatives.

- Gender equity, human rights, focused targeting (reaching the unreached and convergence of various development programmes and schemes at household level).

Major Strategies adopted for CCA programme were:

- Promote and enable women's groups in self-help mode to undertake responsibilities of change at a local and larger framework of issues related to gender and community level development issues;
- Activities at grassroots level would be taken up through adoption of a group approach to promote self-help and joint action for problem solving among the women;
- Considerable investment would be made in terms of educating women in particular and the community in general and organize them around activities which are planned by them to address their immediate needs, promote their self esteem and enhance decision making abilities;
- Different inputs, coming into the community from outside through the established governmental service delivery channels, will be integrated

into a package of services which would meet the various needs of the women and their children; and,

- As far as possible, solutions to local problems will be sought from within the community through participation of its members. Solutions coming from outside are generally not sustainable and they create dependence in the group.

In the intervention, CCA thus considered the aspects of success of self-help groups in the sub continent, the overwhelming burden of debt on peasant households, the low status of women and girls and on the assumption that investment in women usually leads to investment in children. Thrifts and credits were adopted as an entry point for encouraging the formation of women's groups. These groups while helping to improve the family economy would also become empowered to organize and stimulate village development in favour of children. This approach demanded inter-departmental linkages with the developmental delivery mechanism of Government of India and cooperation with civil society organizations.

The strategy was implemented in cooperation with four partner NGOs, Jan Jagaran Sanstha, PRADAN, READ and Integrated Development Foundation, and Governments of Bihar and Jharkhand. UNICEF initiated CCA in 1992 in West Champaran in Bihar in collaboration with the district authority and a local CSO called READ. Subsequently it was piloted in Hazaribagh and Patna districts with PRADAN and IDF during 1995. In 1998 the CCA was implemented in Biharsharif through JJS. Hazaribagh was later divided into two districts viz. Hazaribagh and Koderma. Then in November, 2000, the State of Bihar was divided into two separate states, Bihar and Jharkhand. 5 CCA districts (Palamau, West Singhbhum, Garhwa, Hazaribagh and Koderma) came under the new State of Jharkhand. The other four CCA districts (Gaya, Nalanda, West Champaran and Patna) remained with Bihar. Beside the coverage of 9 rural project districts, CCA also intervened in 3 slum projects, in Gaya Ranchi and Patna with JJS, district administration and NIDAN respectively.

Emphasis was put on evolving appropriate processes of empowerment under the CCA. Under the CCA strategy, following three processes were identified, community organisation; capacity building; and sustenance (Linkages and Convergent Action).

The CCA programme in the villages of the Patna district contributed to evolutionary process in social development in general and women's development in particular. Impetus in capacitating the women's organisation in the grass root level served as channels for women to participate effectively in decision that affects their life. Though limited, the visible outcome was that CCA strategy had been able to evolve strong women groups that helped the women in their own development and also development of the community.

**CCA Processes, Concept and philosophy:** Convergent Community Action (CCA) Strategy was to organize and empower poor rural communities through SHGs and encourage direct participation of their representatives in planning, implementation and monitoring of developmental schemes in partnership with representatives of line departments at all level.

SHGs under CCA focused on approach to social change. It was a strategic process to assist people, in their family and community, to take charge of their own, and their children's lives. In this view a predominant emphasis of the CCA strategy was on training for teamwork. Necessarily, CCA implied three primary conditions for progressive reduction of poverty and for fulfilling human rights, including those specific to children and women-an organized community, house hold economic security, and basic health and education. Its main underlying objectives were:

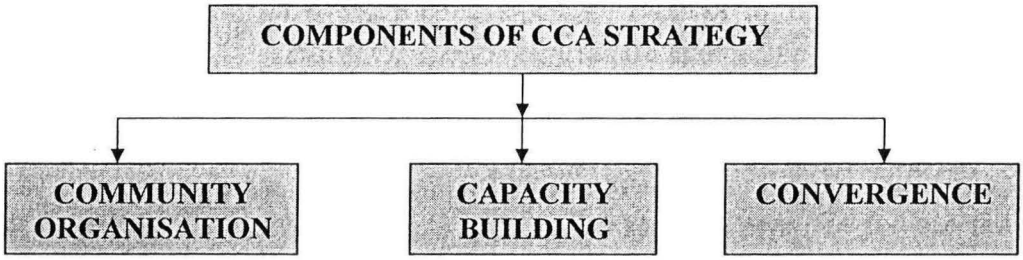
- To improve the quality of life of poor rural women and their families through increased access to health, nutrition, education services and productive assets.

- To establish an effective, alternative credit delivery system for working women in the rural areas.

- To enhance the income level of women producers in the rural areas by ensuring higher returns through improved access to credit, enhanced production skills, and access to market.

- To build the capacity of poor rural women in undertaking activities contributing to achievement of the above mentioned objectives through institutions created, collectively owned and managed by them.

**Components of CCA strategies were:**




**Strategies:** Activities at the grassroots level were taken up through adoption of a group approach to promote self-help and joint action for problem solving among the women.

Considerable investments were made in terms of educating women, in particular and the community in general. It was though out that the women would be organised in the groups for taking up the activities that were planned by them to address their immediate needs, promote their self esteem and enhance decision making abilities.

Different inputs coming into the community from outside through the established governmental service delivery channels were integrated into a package of services which expectedly met the holistic needs of the women and their children.

As far as possible, solutions to local problems were sought from within the community through participation of its members. Solutions coming from outside were generally not sustainable and they created dependence in the target women.

**Area of Implementation:** The CCA was implemented in following blocks in Patna district. The Selected blocks were Maner, Danapur, Bihta, Phulwarisharif, Sampatchak, Bakhtiarpur, Khusropur and Atmagola.

In first five blocks of the district, IDF was implementing the project. The other three blocks were implemented by IDF in collaboration with a CHC (Community Health Centre), Bakhtiarpur.

**Development Support Team (DST):** DSTs comprising of rural development professionals was set up by IDF to act as "a facilitator and not a provider". With the ability to conceive plans with appreciable flexibility, the team manages to keep itself abreast with the latest developmental inputs/schemes sanctioned for the villages. Due to easy access to DST, the community felt comfortable to approach the DST members. Possessing professional skills, DST was supposed to be able to establish linkages between the government, non-government organisations as well as the community. Besides, DST's regular and extensive field visits promoted the process of facilitation, monitoring and evaluation. It, thus, acted as a spearhead team, which had to phase out once the community becomes self-reliant and sustainable to manage of its own.

## INTEGRATED DEVELOPMENT FOUNDATION'S (IDF) CONCEPT OF SHG: EMPOWERING WOMEN THROUGH CONVERGENCE STRATEGY

**Background and Rationale:** IDF concept of SHG was that empowerment process must begin with women changing their own ways of thinking and behaving. This means first and foremost, women's consciousness has to be changed. Women have to change the way they look at themselves. There must be a rise in their self esteem, self confidence and the understanding of their own

strength and potential. The external agents can only be a facilitator in the process of empowerment. They can only facilitate in the process of organization the women for women's capacity building and demanding for their entitlements. The mobilization of women was done to bring them together in SHGs for discussing the common problems and to work together for their collective empowerment. In addition, it allows women to pool together their material and human resources, reducing individual risk and promoting democratic ways of working.

To achieve the above mentioned progress there was a need to provide inputs to the women through training and orientations. Trainings upgraded their decision-making and problem solving abilities. It also equipped them with the skill to articulate and prioritize their needs. Training, thus, acted as a catalyst in the empowering process. It enabled the women to properly utilise the available resources to have a self-sustained impact. In the process of building a self-sustained people's organization there was a need to bring more and more people under one umbrella. Under CCA the SHGs were grouped under federations. These federations, by further empowering, provided the SHGs strength to sustain their activities.

**SPECIFIC OBJECTIVES OF CCA PROGRAMME**

I. To mobilize and organize the poorest rural communities, especially women and their families, to improve and demand better the quality of life.
II. To support establishment of effective community structures for increased access and improving service delivery in the health, nutrition, primary education, water and sanitation (hygiene), NRM sectors.
III. To establish an effective, alternative credit delivery system for the already existing Thrift and Credit groups.
IV. To enhance income level of rural women producers and an increased control over the income, by ensuring higher returns through improved access to credit and enhanced productive skills and access to market.

V. To create institutions/people's organisation collectively owned and managed by the poor women by building their capacity in undertaking activities contributing to achievement of the above mentioned objectives.

**SHG as change agents:** The SHG would initially act as a platform to mobilize and organize the groups around thrift and credit component leading further to community development and community empowerment. As the group would step further to consolidate itself through diversification of activities like IGP, community development activities, social welfare issues, forestry, watershed development, education, health etc. The Consolidated stage is reached in SHG through series of capacity building programme, orientation at field level, exposure etc which would enhance on the level of confidence of woman to handle the activities at the Group, Village, Cluster and Block level.

**Sectoral Interventions**

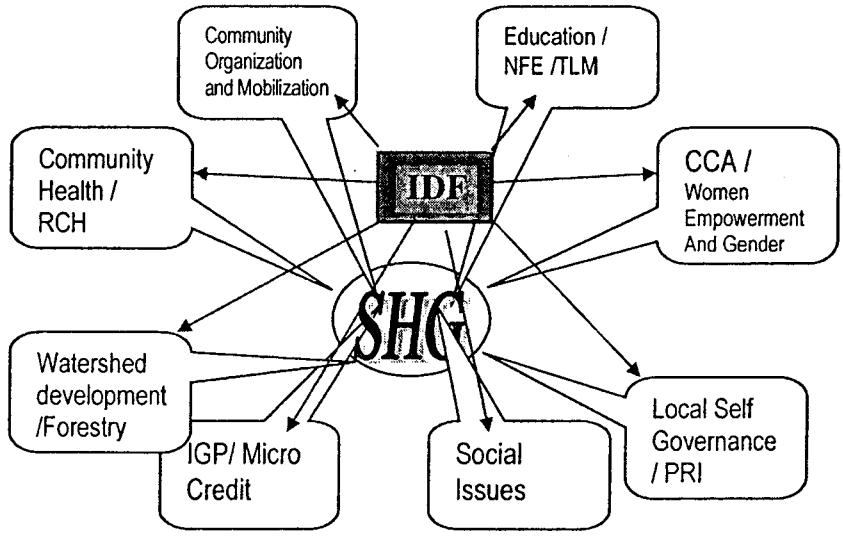



Figure 3.1: SHG as Change agents

## PROCESS ADOPTED IN MAKING SELF SUFFICIENT GROUPS

**Group mobilization:**

- House to house visits and awareness building
- Village meetings
- Baseline information
- The first group meeting

**Group formation**

- Bye laws and setting rules and procedures
- Choosing of group leaders(provision of rotatory leadership)
- First phase of awareness building training and orientation to group
- T and C component starts
- Provided with Ledger, meeting registers, pass book, thrift box
- Training on SHG-CCA package to GR'S

**Group normalization**

- Weekly meetings
- Consensus building
- Openness of the members to each other
- Members participation
- Attendance
- Loaning and repayment
- Bank Account opening
- Roles and responsibilities and clarity of vision
- Training

**Group Stabilization**

- Constant core membership
- Regular attendance and Saving
- Active participation of members
- Decision making through consensus
- Income generation activity
- Clusterisation process
- Selection of cluster leaders
- Training to cluster leaders
- Linkage and convergence process begins

**Withdrawal Stage**

- Convergence and linkage with Government programme, NABARD and other financial institution etc.
- Ownership and self management of activities at Group, Cluster and the Block level
- Federation formation
- Selection of representatives
- Federation Registration
- Handling over roles and responsibilities to federation
- Withdrawal of Facilitating agency

**Facilitating Factors –The Strategies**

- **Local Resource Mobilization:** Enhancing resource by ensuring participation of each member of group in resource generation has been a key element of the strategy. It has inculcated a sense of ownership among the SHG members about the programme.

- **Small Groups:** The Group should be small and consists of 15-20 members in order to ensure participation of group members. The group's size is an important factor in ensuring the continuation of the group.

- **Social and Cultural Similarity:** It is necessary to have social and cultural similarity among the group members. In others words groups should be homogenous in terms of caste, geographical locations and economic status.

- **Awareness Generation:** The members of the group should be provided awareness training/orientation/meetings on a regular basis with follow-up. The awareness generation programme may be conducted to explain the need of groups, strengths of groups and the statuary provisions etc.

- **Strengthening the Thrift and Credit activity:** T&C components act as a binder and initially it organises the members for a common objective. It brings about group and cohesiveness, discipline and unity among the group members. It is witnessed that each component of the T&C activity has brought in a visible change in the indicators of empowerment.

- **Leadership:** In order to achieve sustainability of the groups, it is necessary that the groups have proper executive body. The executive body may assign the roles and responsibilities to the members as per their ability. To have an executive body the groups should elect its president, secretary and treasurer from amongst the members after consulting all group members. Groups in which different members get an opportunity to lead the group tend to continue.

- **Group Meetings:** The group should regularly meet at a certain stipulated period. This brings an opportunity to interact and share information about the group activities with each other. This interaction improves the bonding/relationship between the group members.

- **Flexibility and Discipline**: The group should practice both flexibility and discipline. The flexibility should be in terms of the group's activities rules and regulations. The group should have flexibility to decide about savings, the name of the group, interest rate, periodicity of meetings, and the purpose for which the loan should be given.

- **Active Participation:** The group and its member should participate in all activities for better management of the groups. A team spirit helps the group to achieve its objectives and goals as well as sustainability of the group. The Significance of active participation of the members through raising important issues of concern for the community i.e. social issues should be addressed at the village level and at the broader canvas at a cluster level like, alcoholism, drudgery against women, education, health issues, village infrastructure development and castes and gender disparities

- **Linkages:** External supports plays important role in the stability of the group. This support can be in the form of technical, financial and Managerial assistance. In this regard the linkages with government agencies, banks (NABARD), welfare and rural development department and DRDA, etc. are essential.

- **Capacity Building of SHG:** The group would be made capable at different stages to consolidate and step ahead towards self reliance keeping in view sustainability and withdrawal of facilitator. Nevertheless, from time to time training inputs to SHG development will be provided for strong autonomous group, knowledge, skill building and dynamism in group activities.

- **Promotion Of income generation activities**: It is generally assumed that availability of adequate finance could be an important source to achieve sustainability in terms of promotion of income generation activities. It is an important component and boosts the concept of self reliance among woman.

- **Networking:** Networking is very important for ensuring the continuity of the development programmes. This can be facilitated between the members, inter groups, group and organization (external). It builds confidence and builds on local capacities and eliminates dependency. It believes in working with the people rather than working for the people. Networking brings local people in the mainstream of development. Nevertheless, it organizes the community and helps in developing and strengthening *meaningful local leadership*. It makes a community self reliant.

- **Convergence:** Convergence is the process by which government and Non government programme and other services for the downtrodden community are integrated and congregated at community level through an organized platform. The organized community acts as a point for distribution and sharing of information, a source for collection of information, can assist in

managing the programme, or simply become the users of the programme. The following activities can be taken up as part of convergence with SHG activity.

1. Credit and Financial assistance
2. Self employment and income generation
3. Agriculture development, dairy development and agro services.
4. NRM and watershed development
5. Social forestry
6. Non Conventional Energy
7. Community management of village sanitation, toilet construction
8. Community maintenance of village drinking water supplies
9. Maternal and Child nutrition and health
10. Education and literacy
11. Legal literacy and legal advice, for problems faced by women etc.

**Coordination with district administration /block administration / line departments:** The process of inter-sectoral convergence between different department like health, education, sanitation, PHED and rural development were initiated through a podium of *Block Level Task Force Meeting* (BLTF). BLTF aim was to facilitate *Synergistic Convergence* where in government, Panchayat and women representatives come to meet for imperative convergence mechanisms.

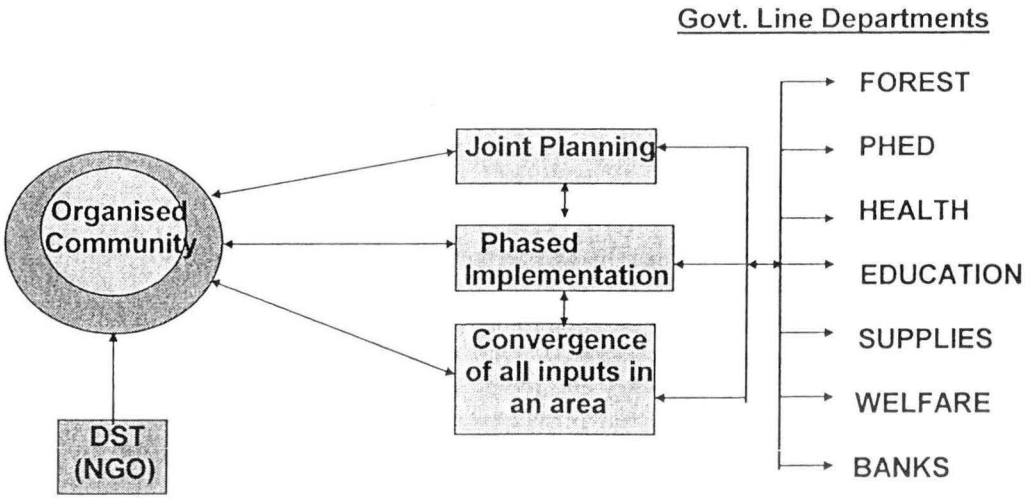



Figure 3.2: Process of inter-sectoral convergence between different departments (Source: Integrated Development Foundation)

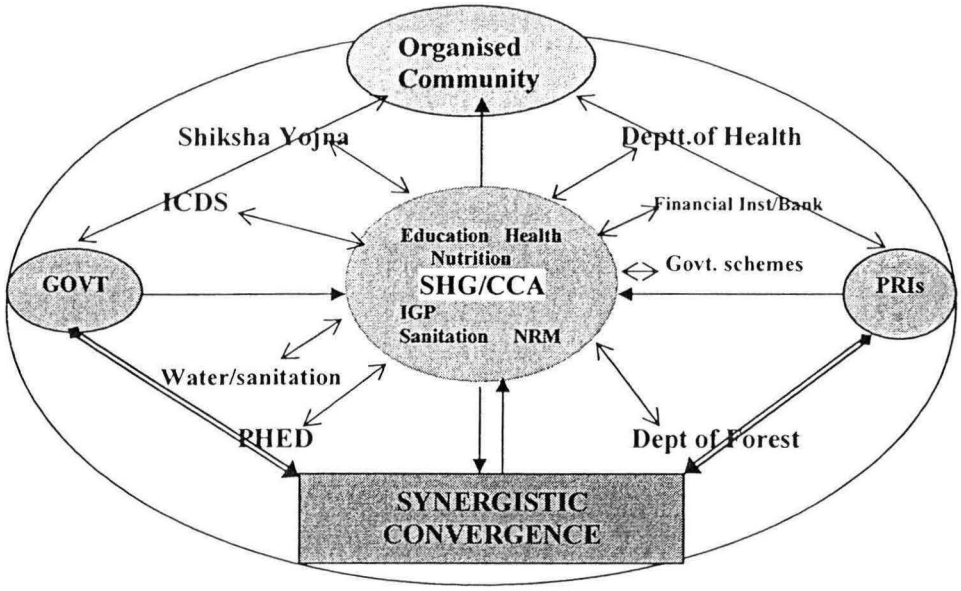



Figure 3.3: Process of synergetic convergence
(Source: Integrated Development Foundation)

- Inter-sectoral convergence
- Convergence with other programme / intervention for diversification in livelihood of the people.
- Inter sect oral Task Force (teams) at district, block and Panchayat level.

## PHASES OF IMPLEMENTATION OF CCA PROGRAMME

The DST (Development support team) selected the district, blocks and villages after a careful analysis of secondary data and based on the some parameters. After selection, the DST-IDF created their local base at the district and block level. The DST also set up an office at the district headquarters. The project villages were visited frequently by the team members for interaction with community members in general and women in particular. Baseline information was also gathered by the members through participatory skills, focus group discussion, Social mapping, etc.

After selection of villages, the initial rapport with the communities was established. The team tried to understand the economy of the area, economic activities of the families, dependence on the moneylenders, and assessed the

credit absorption potentials of the families. An activity which was having immense strategic importance was formation of women's Thrift & Credit (T&C) groups. This formed the basis for building a successful village level women's institution, which gradually took on several other activities for improving the quality of lives of its members. The DST- IDF initiated T&C groups right at the beginning of the implementation of the project and acted as a binding tool to further reinforce the SHG activities.

**PHASE 1: Group Formation:** During Phase I the DST members met village women in groups and discussed the issues pertaining to their daily lives. The groups were formed and by-laws were created with consensus of the members. Groups also discussed the roles and responsibilities of the members, day of the saving, meeting place etc. The group held meetings to discuss the rules and norms and certain operational rules were framed out through consensus building, like the amount of saving, interest rate etc.

**PHASE 2: Group Management:** Having established a rapport with the villagers during the initial phase and the objective of the project was made clear to all, the DST consciously promoted T&C groups in these villages. Then it began to diversify the activity of the group like loan analysis, micro planning, theme based meetings and visiting Blocks and banks and Cluster meetings to discuss the issues of Community.

Step 1: The DST identified a woman village animator from each village.

Step 2: Once the VA's (Village Animators) were selected they were trained

Step 3: Following the training the Village animators (VA) were sent back to their villages to start the process of group formation.

Step 4: Through the T&C activities the women in the villages acquired the habit of meeting regularly and they also gained the experience of handling an operation through a process of collective decision making.

Step 5: After the credit absorption potential of the women increased, the project also extended small credit for livelihood generation.

**PHASE 3: Group Clusterisation and Consolidation:** One of the critical components of this approach was consolidation and integration through building both horizontal and vertical linkages between group, cluster and block level and government as well as Non Government agency. Horizontal linkages were established between the individual level, village level units for consensus building, solidarity and joint action through creation of federations at the cluster block and district level.

Vertical linkages were established between the confederation of village groups and the other partners like the government and non-government agencies who could support the process of empowering community. Planning, implementation and management was done at three different levels – group level, community level and cluster level. Clusterisation process was further strengthened and effective networking between the groups of the same as well as the other Cluster. Every month Cluster meeting were organized which rotated to different villages of the same cluster. Cluster meeting were organised to act as a platform to discuss, analyze and take action on important issue of health, education, watershed development, social forestry, livelihood issue etc.

**PHASE 4: Group Sustainability and Withdrawal:** The Cluster level federated at the Block level and therefore, imperative that appropriate convergence mechanisms at the block level were set up to facilitate the process. This mechanism, known as the Block Level Task Force (BLTF) was a forum where heads of all the concerned line departments at the block level and the representatives of the women's groups from villages could come together once a month and review the progress of each sectoral scheme which was being implemented in these villages.

## CONCLUSION

In conclusion we can say that these programmes sound very effective and well planned but their implementation at the ground level requires further action and planning. There is no emphasis on gender sensitization which is required at all levels and in every sphere of work. As far as health, education, rural

development is concerned, there is a need to begin from the provider then move down the ladder ending with receiver. For this, gender component needs to be aggressively included in educations programme like Sarva Siksha Abhiyan vis-a-vis school text books. Further, for most of these programmes to be sustainable, there has to be a process of strengthening of the local level bureaucracy which supports their endeavour. Structural changes at the social level need long term action and planning. However, there are signs of such processes, both as a result of various programmes such as the ones mentioned above as well as a result of the normal process of strengthening of local level institutions and greater awareness on the part of various stakeholders. SHGs and other women groups have played an important role in this process. However, there is much scope for improvement in the functioning of the SHG as well as integrating them with other government schemes. Excessive focus of SHG on thrift and credit activities has also translated itself into neglect of other aspects of development and women empowerment. In this context, it is important to reiterate that group formation can not only be utilised as an essential tool for improving livelihood but such united actions can also be used to supplement other forms of group action which are important in empowering women to take care of their other developmental needs including health and education.

# CHAPTER – IV

# CONTEXT, BACKGROUND AND METHODOLOGY

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# CONTEXT, BACKGROUND AND METHODOLOGY

Women constitute one-third of the national labour force and a major contributor to the livelihood of the family[1]. Despite progress in several key indicators, a gender analysis of most social and economic indicators demonstrates that women in India continue to be relatively disadvantaged in matters of survival, health, nutrition, literacy, and social status[2]. More than 90 per cent of rural women in India are unskilled which restricts them to low paid occupations. Women generally have no control over land and other productive assets. This largely excludes them from access to institutional credit and renders them dependent on high-cost informal sources of credit to secure capital for consumption and productive purposes. Women form the backbone of agriculture, comprising the majority of agricultural labourers in India. Gender divisions in agriculture are stark. All activities including manual labour are assigned to women, while all operations involving machinery and others are performed by men. Female agricultural labourers are among the poorest sections of Indian society. Agricultural wages for women are on an average 30-35 per cent less than those for men. Social restrictions on women's mobility also contribute to lesser healthcare for women and children. About 75 per cent of married women need permission to visit even friends and relatives and 40 per cent do not have access to money according to NFHS II – 1998-99.

One of the major reasons cited for the disadvantaged position of women despite progress on economic and other fronts is the lack of empowerment of women which restricts their ability to take advantages of the overall buoyancy of the growth process. This recognition by the official machinery has also led to various schemes and plans being devised or reconfigured to allow better

[1] According to NSSO Employment and Unemployment Survey of 1999-00, women constituted 35% of the total workforce in the country. According to Census 2001, women constituted 32% of the total workforce in the country. However, it is also important to note that most of the secondary sources including NSSO and Census still underestimate women's contribution to the national economy.

[2] See "Women and Men in India", Government of India, Ministry of Statistics and Programme Implementation, 2004 for a comparative analysis.

utilisation and participation by women. Considerable efforts to improve their conditions have been put forth in the form of subsidy based government schemes during the last few decades. However, these benefits involving huge funds and facilities are being usurped by the better-off sections. Integrated Rural Development Programme (IRDP), Development of Women and Children in Rural Areas (DWCRA) and Training of Rural Youth for Self-Employment (TRYSEM), etc., are such few schemes. In recent years Micro-Credit programmes are viewed by policy makers, economist and bankers as a method of subsidy-less voluntary small saving scheme on the lines of Bangladesh Grameen Bank experience[3]. It has resulted into a forum for women empowerment by understanding their capabilities strengths and weaknesses. It encompasses elevating their socio economic status within and outside the family, because they have been considered as a major contributor in the situation of crisis. These micro-credit groups known as self-help groups have opened a new era in the field of women empowerment.

Self-help Groups (SHG) approach in India was initiated in early eighties with a specific section on 'Women and Development' in the Sixth Plan (1982-87) document, underlining a shift from earlier welfare dominated approach to the new focus on 'development through empowerment'[4]. Thereafter, the Seventh Plan (1987-92) document had gone further and had tried to operationalise the concern for women's equality and empowerment through programmes which inculcate confidence among women, generate awareness about their rights and privileges and train them for taking up economic activities (wage- or self-employment) and thus making them an integral part of development. The Seventh Plan document can be regarded as the country's commitment to the concept of 'gender and development'. This has moved ahead from the concept of 'women in development' which the Sixth Plan document had adopted. This new approach required an innovative grassroots institution to facilitate mobilization of women and to provide them a forum for collective action for their own development. The women's Self-help Groups (SHG) was primarily conceived to

[3] For detailed analysis of the Grameen Bank experience in empowerment of women, See, Yunus, M (1999), Pitt, Khandekar and Cartwright (2003), Schreiner (2003).

[4] See Chapter 27, Sixth Five Year Plan, Planning Commission, Government of India.

play this challenging institutional role. This new approach to women and development had also visualized a crucial role for development-oriented non-governmental organizations (NGO) which would provide the inspiration and initial support to the rural women to form the SHGs. Based on early feedbacks and prolonged deliberations, the basic objective of these SHGs were to empower women who (a) could demand their rights from family, community and government, (b) have increased access and control over material, social and political resources, (c) have enhanced awareness and improved skill, and (d) are able to raise issues of common concern through mobilisation and networking.

The concept of SHG is primarily focused towards economic activities like micro credit programmes without any specific focus on health, education and other development related issues. Most of the programmes are government aided, implemented by Government as well as NGOs. For most of the SHGs, their activities are limited to income generation among poor women in the name of women empowerment. The basic assumption behind such an approach is that progress made by the population as a whole is shared by all sections, and that whatever accrued to men (or to the family as a reckoning unit) would also percolate to women thereby removing their marginalization and resulting in their better status and gender equality. This, however, turned out to be a wrong assumption. Since the 'household' is generally targeted as the beneficiary unit in all development programmes, the approach is an extension of the concept of patriarchy. Moreover, in the Indian context, it is naïve to assume that economic independence is the sole route to women's empowerment in a patriarchal society. In SHGs, there is no mention of specific needs of women in any of the areas listed for priority attention. There is no follow up activities like how it is helping them in empowerment and how their status is affected by the programme. In other words, there has not been any explicit effort to include other dimensions of women empowerment such as health and education as part of the SHG activity.

In this context, the emphasis of this thesis is to understand the role of SHGs in women's empowerment and its impact on their health and well being in

the state of Bihar[5]. Self-help groups have been active in almost all states of the country. However, their impact on women empowerment or other gender related outcomes varies a great deal across states. While it is acknowledged that these programmes have been more successful in the southern states of Andhra Pradesh, Karnataka, Tamilnadu, Kerala and western states of Rajasthan, Gujarat (SEWA-Self Employed Women's Association, is a success story) and Maharashtra, similar programmes undertaken in other states mainly in eastern part of the country have not been successful to that level. Bihar, given its backward status and patriarchal social set-up presents an ideal case for understanding the impact of SHG on women's empowerment and its impact on their health. Bihar is well known for its resource imbalance, poor administration, poverty, poor health status and indicators like high infant and maternal mortality rates, as compared to the rest of the country. In population, Bihar is the third biggest state, next to U.P., and Maharashtra. It comprises the poorest regions having the lowest indicators of women's status in India[6]. These women are with a large unmet need for health, family planning and reproductive health services. Bihar is also known for a high proportion of young people (60 per cent of the population). Economic backwardness of the State can be judged from the fact that its per capita income is less than 40 per cent of the national average and the rural poverty ratio is as high as 43.1 per cent compared to a national average of 27.1 per cent.

## RATIONAL OF THE STUDY

The driving force behind taking the study was my interest in development programmes which motivated me to explore critically the linkages and its impact on people particularly the marginalised, poor and women. During my visits to Bihar to understand development programmes, I found that despite the claims made by various agencies and organizations, ground realities are different from the claims and achievements. This forced me to focus on Bihar and understand the underlying factors from policy perspective. I also wanted to understand and

[5] Bihar has total population of 82,878,796 (Male: 4,31,53,964 and Female: 3,97,24,832), with population density of 880 persons per Sq. Km. (Census: 2001). Sex ratio in the area is 921 female per 1000 male, literacy rate 47.53 per cent (Male: 60.3, Female: 33.6), Crude Birth Rate 30.4 per 1,000 population and Crude Death Rate is 9.1 per 1000 population (Population Census, 2001).

[6] See National Human Development Report, 2001, Planning Commission, Government of India

find out how our policy makers and planners are looking at developmental programmes as tools for empowerment of poor, women and marginalised.

## GENERAL AND SPECIFIC OBJECTIVES OF THE STUDY

The overall objective of the study was to explore and understand the role of Self-help Groups (SHG) in women's health and empowerment in Bihar. The specific objectives of the study were:

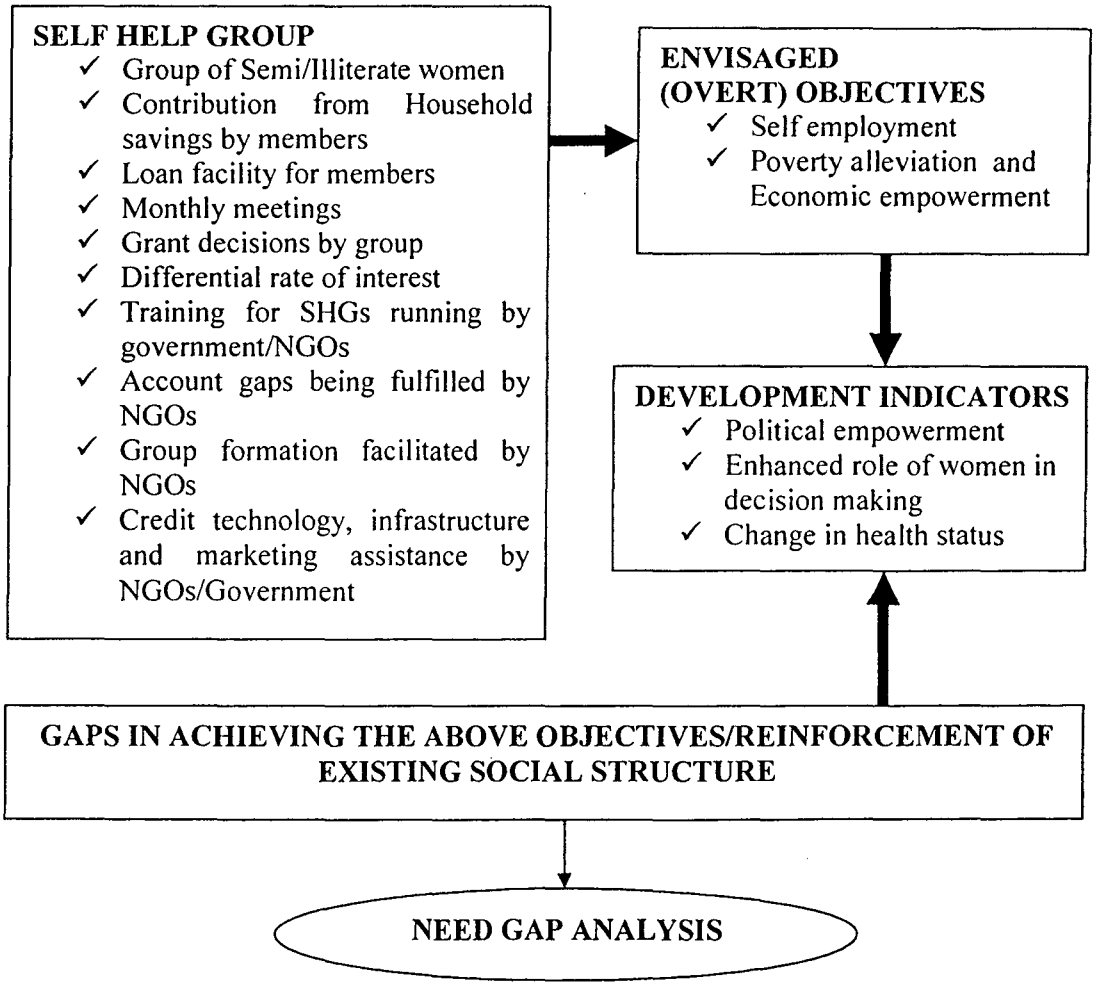
1. To understand the profile and structure of self-help groups in terms of categories, composition and activities.
2. To study various objectives / goals of SHGs in relation to women's health and empowerment.
3. To determine the extent to which SHG can be involved in health related work.
4. To determine whether any kind of health spin-off that can be expected from self-help groups.
5. To critically examine and understand whether present form of SHGs can be used as an alternative model for women empowerment for rural women.

These broad issues are explored through the help of various secondary sources as well as through a primary survey of two blocks of Patna district of Bihar, which included quantitative surveys as well as qualitative survey and focus group discussion with beneficiary women. To understand the impact of empowerment on women, the questionnaire as well as group-discussions focused and relied on the perception of women regarding various indicators of women empowerment.

## RESEARCH APPROACH

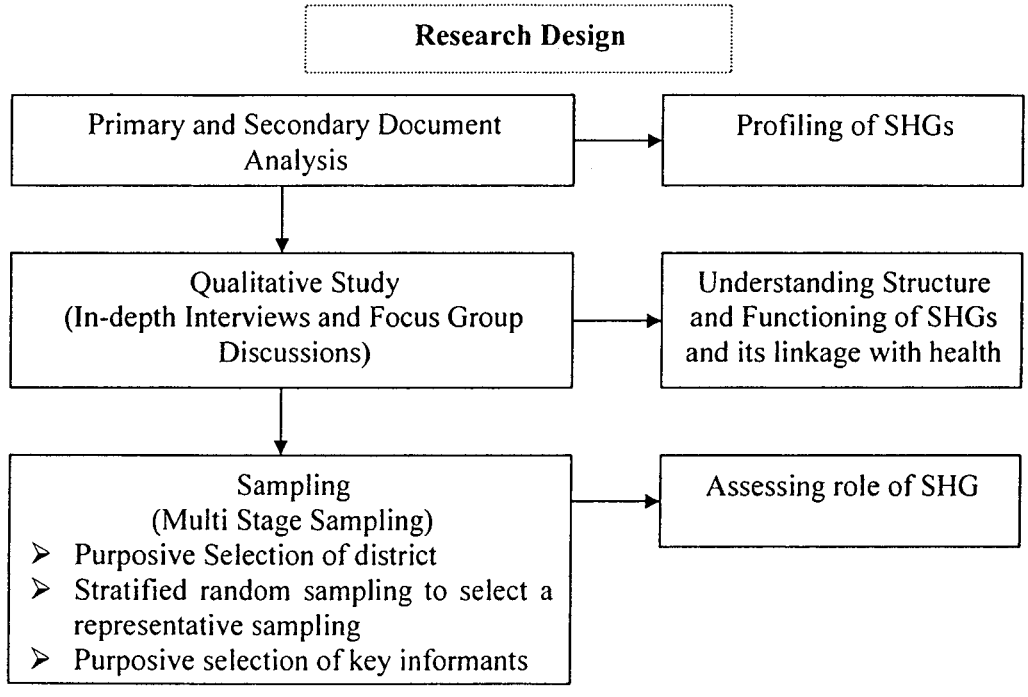
Given the stated objectives of this thesis, an attempt has been made in this thesis to analyse the role of SHGs in women's empowerment and its impact on their health, both by looking at the economic aspects and indicators of the SHG programme as well as its impact on women empowerment independent of

economic development. The underlying assumption of women benefiting from SHGs is the assumption that, SHGs and its microfinance activity will lead to women empowerment and consequently, women will be in a better position to take care of their health needs as well as family health needs. However, in what ways these economic impacts are influenced or influence social, gender and health outcomes depends a lot on the existing social and gender relations in the society. In this context, it is also interesting to analyse the strengths and gaps of the existing social structure which facilitate or hinder such a process. Based on this, a need gap analysis is also undertaken. The following diagram explains the process graphically.




**Research Design:** To understand the impact of SHGs on women empowerment and their health needs, the primary method used was to understand it through

their own perception. This was further supplemented by quantitative survey to understand their socio-economic condition. Apart from qualitative survey through structured questionnaire, focus group discussions were also conducted. Selected women were also interviewed in depth for case study purposes. This was also supplemented by collecting and analysing secondary materials from various sources. Primarily, the secondary sources were the documents available on the SHGs themselves, documents from the facilitator NGO, and UNICEF. Various other secondary sources from Government, media and individual researchers were also collected, discussed and analysed. The following chart presents the research design and study flow:




**Document analysis:** Documents and records available at state level for self-help groups (SHG) has been reviewed to determine the number of SHG that are currently registered. The different categories of SHGs have also been identified from here. Documents' relating to the administration of selected SHGs has also been reviewed. These include constitutions, code of conduct or any documents that has the group's objectives /goals.

**Key Informants Interviews:** Interview were also conducted with health sector managers, Doctors, district leaders, and NGO heads to determine their expectations and experiences as regards what SHG can or have been able to achieve in any aspects of women empowerment and its impact on their health. The interviews aimed at obtaining an idea of the problems envisaged and the prospects of involving SHGs in health related work. Key informants were interviewed at three different levels:

1. At the state level, the SHG programme manager and public health scholars were interviewed.
2. At the District level, the officer in charge of health and the SHG district coordinating officer were interviewed.
3. At the grassroot level, the leaders of five SHGs were also interviewed about their experiences and expectations.

**Focus group discussions:** Ten focus group discussions (FGDs) were conducted with group members from selected SHGs. FGDs were aimed at getting perceptions of individual members about their roles, expectations and their achievements in health and other area. This helped exploring the third, fourth and fifth objectives from another perspective. The FGDs were conducted with members of the groups that are different from those whose leaders were interviewed.

## STUDY AREA

The choice of study area was based on personal familiarity with the state as a native as well as my previous experience of working with the civil society organisation and stake holders. The fact that the state is my native state; it helped me understand and situate the socio-economic context of women and SHGs in a better way. My long association and interaction with various NGO activists as well as media and academicians was also helpful in getting a better idea and perspective of the happenings with regard to SHGs, women's issues and their health impact. Apart from my personal familiarity, what also worked in favour of selection of Bihar as the study area was the fact that it is among the poorest and most underdeveloped state of the country. The state is also well-known for its

patriarchal social base with very low levels of health facilities. The state, in this sense, also provided the opportunity to analyse the impact of SHGs on women empowerment and health status in an underdeveloped and primarily agrarian setting. Some brief background of the state in the following section is helpful in putting things in perspective.

The expression 'poverty in the land of plenty' applies well to the situation in Bihar. With 83 million inhabitants, Bihar has the second largest population of India. Other salient features of Bihar are the considerable area, the agricultural fertility and the immense wealth of its cultural past. However, in terms of Human Development Index calculated for 15 major states, in the year 2001, Bihar was ranked the lowest. Even concerning other development indicators, its performance compared to the national average is quite low.

With a population density of 880 persons per sq. Km (as compared to a national figure of 324 only), the state is not only overpopulated, but its demographic miseries are becoming more intense with a population growth of 28.4 per cent (1991-2001). This growth is much higher than 21.3 per cent for the country as a whole. Even for Infant Mortality Rate (IMR), it is only marginally higher in Bihar in comparison to India. The demographic situation of Bihar is extremely complicated. On the social front too, Bihar lags far behind than other states. The starting point of its social backwardness is obviously its educational backwardness. The overall literacy rate in Bihar is only 47.5 per cent as compared to 65.4 per cent for India. The disparity is even wider for female literacy - 33.6 and 54.2 per cent for Bihar and India respectively. This status will remain unaltered even in coming decades as more than half of the young boys and nearly three-fourth of the young girls are not enrolled in primary schools even today[7].

As regards the status of women, the abysmal scenario in Bihar is reflected by several indicators like lower percentage of working women, low exposure of women to mass media, high maternal mortality rate, low literacy levels,

[7] Seventh All India School Education Survey, 2005, NCERT, Government of India

prevalence of child marriage, and incidence of anaemia. Women's powerlessness and limited participation even in her ordinary decisions, like own health care increases her vulnerability. The Gender Disparity Index for Bihar is only 0.469, which is much lower than the national Index of 0.676 in 1991[8]. Other indicators also suggest that women's share in the benefits of the developmental interventions is minimal and insignificant. The declining sex ratio, high maternal mortality rate, low literacy rate and low level of participation in remunerative work are both manifestations and causes of such a dismal state of their existence. "Invisible half", as the female sex has often been referred to, most appropriately describes the status of women in Bihar. They are invisible because they are not organized and cannot assert their rights to decision making for their own affairs.

Health and medical facilities, though improving, are still inadequate outside the towns. Villages are served mainly by allopathic and Ayurvedic dispensaries. Unani and homeopathic systems of medicine are also popular in the area. Large and well-equipped hospitals and medical colleges are located at Patna, Darbhanga, and Bhagalpur. Respiratory diseases, dysentery, and diarrhoea figure prominently among the causes of death. Cholera and malaria seldom occur, and smallpox and bubonic plague is said to be eradicated. The table given below presents some basic facts about Bihar.

Table 4.1: Comparative demographic profile of Bihar and India

| DEMOGRAPHY | | | |
|---|---|---|---|
| Sl. | Indicators | Bihar | India |
| 1. | Total population – 2001 | 82,878,796 | 1,027,015,247 |
| 2. | Sex ratio – 2001 | 921 | 933 |
| 3. | Population density per sq. km – 2001 | 880 | 324 |
| **INCOME** | | | |
| 4. | Per capita net state domestic product (Rs. at 1993 - 94 prices,), 1999 – 00 | 3323 | 10068 |
| 5. | Percentage of population below poverty line, 1999 - 2000 | 43 | 26 |

[8] Source: Planning Commission (2002) National Human Development Report 2001, Government of India, New Delhi.

| | | | |
|---|---|---|---|
| **EDUCATION** | | | |
| 6. | Literacy rate - 2001(%) | 48 | 65 |
| 7. | Teacher - pupil ratio (primary school) 1999 - 2000 | 63 | 43 |
| **HEALTH** | | | |
| 8. | Life expectancy at birth, 1992 - 96 (Yrs) | 59 | 61 |
| 9. | Infant mortality rate – 2000 (per 1000 live births) | 62 | 68 |
| 10. | Under 5 mortality rate – 1991 (per 1000 live births) | 89 | 94 |
| 11. | Maternal mortality rate - 1998 (per 100,000 live births) | 452 | 407 |
| 12. | Total fertility rate – 1998 | 4 | 3 |
| 13. | Percentage of children underweight (-2SD), 1998 - 99 | 54 | 47 |
| 14. | Percentage of houses with access to safe drinking water – 1991 | 59 | 62 |
| 15. | Percentage of houses with access to toilet facilities - 1997 | 58 | 49 |

Source: [9]

In contrast to some other poverty stricken and backward regions of the country, such as part of central India where the natural productivity of agricultural land is very low, Bihar has a large alluvial river valley area. In view of such generous natural resource endowment, it seems that the state's backwardness is probably more related to its socio-economic-political structures, unresponsive political leadership, and the nature of development strategies that the state has pursued so far. Apart from the exploitative social and agrarian structure, Bihar is also experiencing an acute crisis of political leadership,

[9] Source:

a) Directorate of Economics & Statistics of respective State Governments, and for All-India -- Central Statistical Organisation

b) Indices, Govt. of India (2001), "National Human Development Report", Planning Commission, New Delhi

c) Demography - Total Population and Sex Ratio, Registrar General of India (2001), "Provisional Population Tables", Census of India, New Delhi; Dependency Ratio - National Human Development Report (NHDR)

d) Income - PCNSDP - Planning Commission, "Tenth Plan (2002 - 2007)", Vol. III, Annex.3.1, Persons in Labour Force, % of Population Living Below Poverty Line - NHDR

e) Education - Literacy Rate - Census (2001), Gross Enrollment Ratio and Teacher Pupil Ratio - Ministry of HRD, "Selected Educational Statistics" 2001.

f) Health - IMR and TFR - Planning Commission, Tenth Plan (2003 - 2007); LEB, MMR, Children Under weight, Under 5 Mortality Rate, % of Houses with access to safe Drinking Water, % Houses with Toilet Facilities – NHDR

bureaucratic inefficiency, and rampant corruption at all levels, and social disorder[10]. The almost total collapse of the administrative machinery is matched by the calamitous condition of the educational institutions. The division of society into caste has penetrated not only into politics but also in to the bureaucracy, academics and other professions, seriously affecting the efficiency and functioning of the entire system of governance, development machinery and other sectors. Caste tension, and in some parts of the state even caste riots, have seriously eroded social harmony. The serious breakdown of the law and order situation and the scenario of crimes, kidnapping, tensions and violence have prompted people to sarcastically remark that 'the state has withered away' in Bihar.

These unfavourable socio-economic conditions and in the wake of widespread poverty, a substantial number of poor people go outside the state in search of livelihood. In this otherwise bleak milieu, the only ray of hope is the increasing awareness and mobilization of the rural poor, whose potential can be harnessed to influence the state into being pro-poor in its governance.

## SELECTION OF DISTRICT

Having selected the state, Patna[11] district was selected based on the twin criteria of personal familiarity and the presence of relatively higher number of

[10] See, Bihar: Towards a Development Strategy. 2005. A World Bank Report

[11] Demographic profile of Patna district of Bihar.

| **Patna – District Demography** | | | | |
|---|---|---|---|---|
| Area | Population | | | Literacy |
| Sq. Km | Total | Rural | Urban | Rate % |
| 3202 | 36,23,225 | 22,41,510 | 11,19,800 | 63.82 |
| Sub Divisions | Patna Sadar, Patna City, Barh, DanaPur, Masaurhi, Paliganj | | | |
| Blocks | Patna Sadar, Phulwari sharif, Sampatchak, Fatuha, Khusrupur, Daniyawaan, Barh, Bakhtiarpur, Belchi, Athmalgola, Mokama, Pandarak, Ghoswari, Bihta, Maner, Danapur, Naubatpur, Masaurhi, Dhanarua, Punpun | | | |
| Agriculture | Paddy, Maize, Pulses and Wheat. Also oil seeds. Roughly one third of the area sown is under rice (paddy). Cash crops such as vegetables and water-melons are also grown in Diara belt | | | |
| Industry | Sugar factory at Bihta. Fire-works, Biscuit, Flour miils, Light-bulb at Patna City. Shoes at Digha and Mokameh. Wagon factory at Mokameh. | | | |
| Rivers | Ganges, Son, and Punpun | | | |

self-help groups[12]. Patna district is situated in the south Bihar. The district is bounded in north by river Ganga, in south by Jahanabad and Nalanda districts, in the east by Lakhisarai district and in the west by Bhojpur district. The geographical area of the district is 317236 hectare with 4.13 per cent land not suitable for cultivation. Patna, besides being the state capital, is also the biggest urban centre of the state. It has highest literacy rate among the districts of Bihar. It has a ready market for almost all farm and non-farm sector products and is well connected by rail, road and air with almost all the district headquarters and the major cities of the country. Administratively the district is divided into six subdivisions, twenty-three blocks, 344 Panchayats and 1433 villages (1294 inhabited and 139 uninhabited).

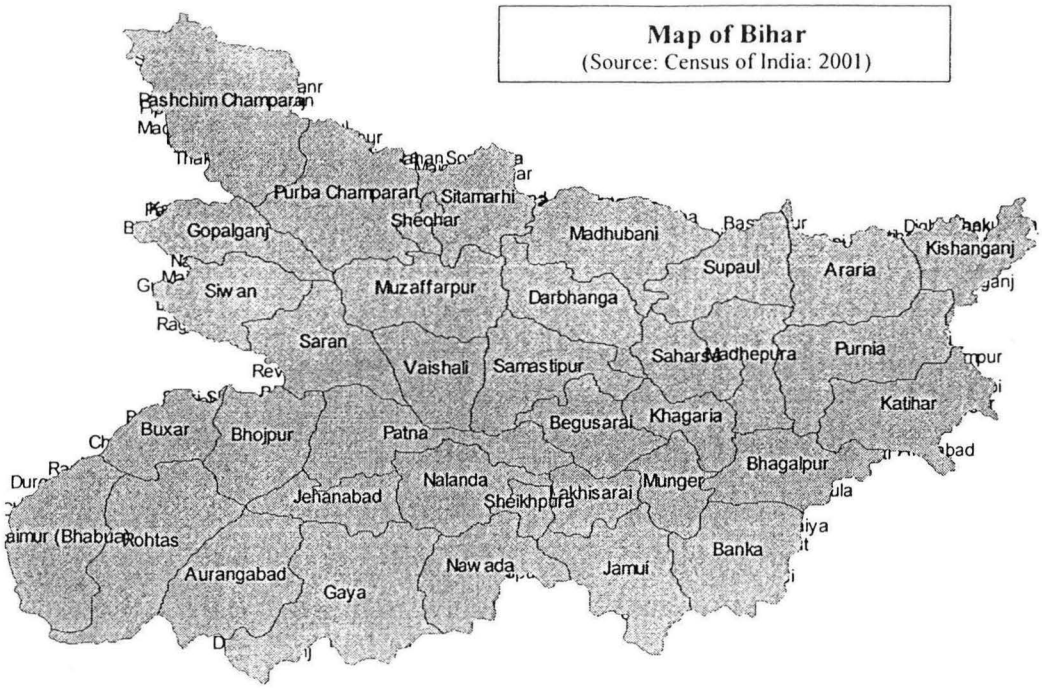
Patna district of Bihar state has been purposively selected from the 38 districts because it has a well established network of NGO supported SHG in addition to the government supported ones. The district has relatively higher number of Self-help groups. The following is the profile of Patna district of Bihar state.

Table 4.2: Demographic profile of Patna district of Bihar

| | | **Units** | | | **Units** |
|---|---|---|---|---|---|
| Headquarters: | PATNA | | Total Area: | 3202.0 | sq. Kms. |
| Total Population | 3618.21 | '000 | Total Literates | 1647.18 | '000 |
| Total Male | 1938.34 | '000 | Total Female | 1679.87 | '000 |
| Urban Population | 1376.7 | '000 | Rural Population | 2241.51 | '000 |
| Rural Population - Male | 1189.83 | '000 | Rural Population – Female | 1051.68 | '000 |
| Urban Population - Male | 748.51 | '000 | Urban Population – Female | 628.19 | '000 |
| Total SC Population | 560.09 | '000 | Total ST Population | 5.37 | '000 |
| SC Population - Rural | 423.09 | '000 | ST Population – Rural | 1.29 | '000 |
| SC Population - Urban | 137.0 | '000 | ST Population – Urban | 4.08 | '000 |
| Rural Male Literacy % | 60.79 % | | Rural Female Literacy % | 26.87 % | |
| Urban Male Literacy % | 81.63 % | | Urban Female Literacy % | 64.59 % | |

(Source: http://bihartimes.com/district%20profile/patna.html)

[12] See, "Mapping of SHGs in Bihar", UNICEF (Unpublished)




**Map of Bihar**
(Source: Census of India: 2001)

## SELECTION OF TWO INTERVENTION BLOCKS

An important criterion for selection of blocks was the presence of SHGs. Another important criteria or reason behind the selection of these blocks[13] for the study was the presence of Community Convergence Activity (CCA) programme of the UNICEF in these blocks. The CCA programme was implemented by a non government organization Integrated Development Foundation (IDF). After collecting information about the presence of various NGOs in the district and their area of operation; SHGs facilitated by Integrated Development Foundation (IDF) were selected because of their extended presence and successful implementation of the programme in the district. Further, out of total seven intervention blocks of Integrated Development Foundation (IDF) in Patna district, two blocks were selected for the study. Selection of the two intervention blocks were based on selected criteria of level of education, health and

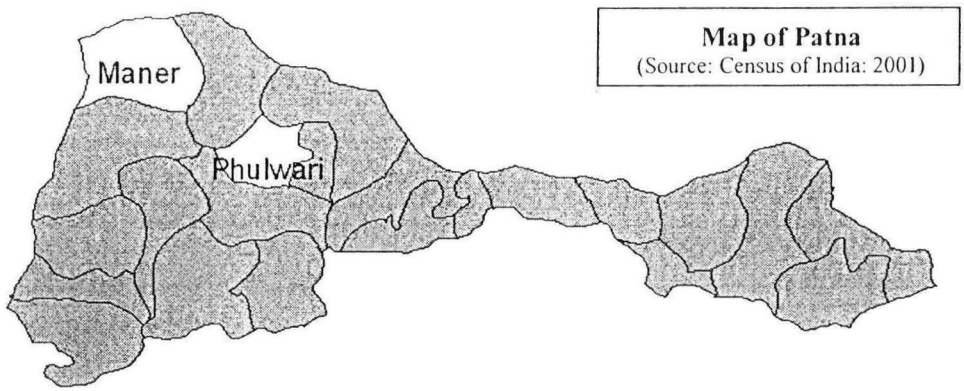
[13]In a district, block is the prime unit of development works. A group of villages form a block. Block has many Gram Panchayats and the administration of each block is handled by a 'Samiti' of Mukhiyas of the constituting Panchayats. This Samiti looks after primary health and education, animal husbandry and agricultural development of the village. The government appoints one block development officer for each block

infrastructure availability. The indicators chosen were those indicators which are supposed to have direct relevance for level of empowerment and health of women. For education, literacy was taken as the criterion, for infrastructure, percentage of households reporting use of electricity was taken as the criterion. For health, percentage of households reporting drinking water source outside premises along with percentage of households without latrine was taken as the indicator. For all these criteria, the blocks were ranked with the best block being given rank 1 and the worst being given rank 7. All these ranks were then added and the block with lowest rank and the block with highest rank were selected for study.

Table 4.3: Development indicators used in the study for selection of blocks

| Name of the Block* | Literacy Rate | Rank | Source of lighting - Electricity (%) | Rank | Drinking water source outside premises – (%) | Rank | No latrine within the house – (%) | Rank | **Total Rank** |
|---|---|---|---|---|---|---|---|---|---|
| Phulwari | 53.2 | 2 | 44.7 | 1 | 56.5 | 3 | 63.5 | 1 | **7** |
| Bihta | 48.7 | 4 | 24.3 | 4 | 52.8 | 1 | 69 | 3 | **12** |
| Patna Rural | 68.7 | 1 | 37.4 | 2 | 77.6 | 7 | 68.5 | 2 | **12** |
| Sampatchak | 46.7 | 5 | 36.2 | 3 | 60.3 | 4 | 75 | 6 | **18** |
| Dinapur | 52.8 | 3 | 24 | 5 | 64 | 5 | 73.2 | 5 | **18** |
| Naubatpur | 45.7 | 6 | 14.3 | 7 | 55.6 | 2 | 70.6 | 4 | **19** |
| Maner | 38.1 | 7 | 21.7 | 6 | 68.7 | 6 | 76.5 | 7 | **26** |

* All indicators are for rural areas only. (Source: Census of India, 2001)




**Map of Patna**
(Source: Census of India: 2001)

The emphasis was also laid on covering equal number of women's self-help group member from these two blocks. 51 per cent of respondents were from Phulwari block and 49 per cent were from Maner block.

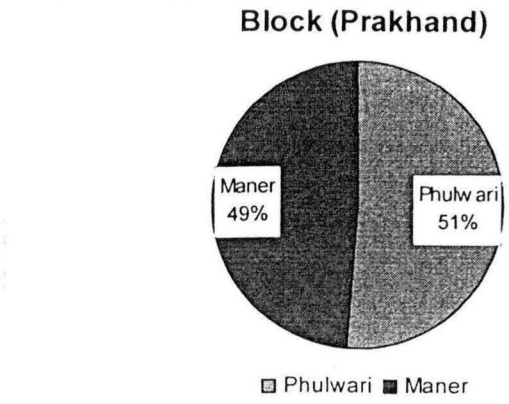



Figure 4.1: Percentage of women participated in the Study

## SELECTION OF PANCHAYATS

Further from the two blocks of Patna district of Bihar, six panchayats were selected for the study. They were Chipurakhurd, Khadiha, Sadiqpur, Bhelwara-Dariapur, Chilbilli and Darveshpur. Of these selected panchayats, Chipurakhurd, Khadiha and Bhelwara-Dariapur belong to Phulwarisharif block and Sadiqpur, Chilbilli and Darveshpur belong to Maner Block.

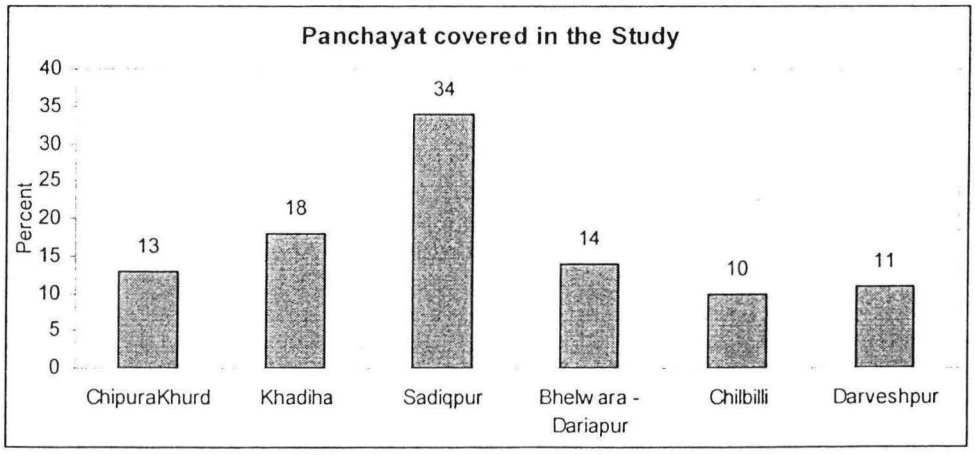



Figure 4.2: Panchayats covered in the study

The figure shows that distributions of respondents in these six panchayats of two blocks were not equally represented. The table also show that 34 per cent of respondents belong to Sadiqpur panchayat whereas Chilbilli covers only 10 per

cent of respondents. In other panchayats coverage of respondents varies between 11 to 18 per cent. This variation in coverage is primarily because of selection of groups (SHGs) for the study, their present status (active/inactive) and availability of group members for interview. Group status (active / inactive) categorization was based on their present functional status. Many of these groups are not fully active and functional whereas other groups are functional at some level in terms of monthly meetings and saving and credit activities.

## SELECTION OF INTERVENTION VILLAGES

Selection of villages was done on the basis of listing as intervention villages of IDF's SHG programme in Maner and Phulwari blocks of Patna district (list was provided by IDF); number of SHGs in villages and their status of SHGs (Active/inactive) (information gathered from IDF); and availability of health services in these villages (based on census data 1991). Availability of health services in these villages was based on existence of medical institutions (Available/Not Available). In case of non-availability of health care services the distance from the medical facilities was taken in to account. The medical facilities taken in to consideration mainly included - hospitals, maternity and child welfare centres, maternity homes, Child welfare centres, primary health centres, health centres, health sub centres, dispensaries, family planning centres, tuberculosis clinics, nursing homes, community health workers, registered private practitioners, subsidiary medical practitioners and other medical centres and facilities (Census 1991).

Based on these criteria, 9 villages were selected for the study from Phulwari and Maner blocks. In each block half of villages were selected where health services were available and other half were selected where these services were not available. In the selection of these villages, number of available SHGs and their status was also considered.

Nine villages and their extended tolas (hamlets) were selected for the study from the six panchayats of two blocks (Phulwari and Maner) of Patna District of Bihar. The villages selected for the study were Aachhechak, Ganpar

Kona, Sadikpur, Fajilabad, Ismailpur, Khadiha, Alipur, Suwarn Brahmachari, and NeelKanth Tola. Some of the villages were well connected to block, city and district headquarter whereas other were not or with limited or no transport facility. For example in Maner block villages were well connected with block and district headquarter because of comparatively better roads and transport facility whereas it is just opposite for Phulwari block. Though there is no huge difference considering both are close to district headquarter Patna which also happens to be capital city with all facilities available.

Highest numbers of respondents belong to Sadiqpur village and lowest from Khadiha village. This variation is primarily because of number of groups and members available for interview. The main focus of the study was to explore the role of SHGs in women empowerment and its impact on their health and empowerment. Considering this fact less emphasis was given on area and selection of respondents and more on women's empowerment and its impact on their health, life and living conditions.

## GROUPS COVERED IN THE STUDY

The groups were identified with the help of NGO, Integrated Development Foundation's representatives and animators. Each SHG was found to be consisting of about 20 members on an average. Available members of the selected SHGs were covered in the study sample. The respondents (women self-help group members) interviewed represents fourteen self-help groups. Presently these groups are not directly supported by IDF and are independent in their functioning. In some cases, not all members of the group could be interviewed. Interviews were conducted during agriculture harvesting (Katni) season and many of women were on the field during day time. It was not possible to interview them due to their schedule. However, effort was made to cover as many members as possible.

Besides, to be able to get the perceptions and experiences of other people in the community, in addition to the members of the SHGs, a few family members, neighbours and other people from the community, were also

interviewed. Field level functionaries of IDF who were actively involved with the SHGs were also interviewed. Discussions with the managerial staff and the founder members of IDF were also organised to get their perceptions on women empowerment as an outcome of their supported SHGs, their present and future strategies and plans, etc.

## TYPES, LEVELS AND INDICATORS OF EMPOWERMENT

The word empowerment is multidimensional and was studied at different levels. A pilot study was also conducted before this detailed field work. It helped in consolidating these dimensions at various levels in the context of SHGs in Patna, formed and supported by IDF. These are being outlined as follows. Empowerment can takes place at four mutually interconnected and interdependent levels: at individual level, relationship level, group level and community level. One can also talk about different types of empowerment in terms of political, economic, social, psychological and skill empowerment.

Some initial indicators for studying these levels and types of empowerment developed after the initial pilot study and from the review of secondary literature are outlined below. These indicators are as follows:

Table 4.4: Type and level of empowerment indicators

| Type | Level | Indicators |
|---|---|---|
| Political | Group and community | ▪ Leadership<br>▪ Voting behaviour<br>▪ Participation in elections<br>▪ Participation in meetings |
| Economic | Individual and relationship | ▪ Vulnerability reduction<br>▪ Opportunity creation<br>▪ Impact on productivity (self / family) |
| Social | Individual, relationship, group and community | ▪ Educational<br>▪ Status of women<br>▪ Interaction levels<br>▪ Social affiliation need<br>▪ Physical mobility |
| Psychological | Individual and relationship | ▪ Confidence<br>▪ Self esteem<br>▪ Self care<br>▪ Aspirations<br>▪ Change in mindset |

| | | |
|---|---|---|
| Health | Individual, relationship and community | ▪ Awareness levels regarding self health care<br>▪ Awareness regarding reproductive health<br>▪ Improvement in health indicators<br>▪ Perceptions regarding health<br>▪ Accessibility to health services<br>▪ Preparedness and dealing with critical health situations |
| Skill | Individual, group | ▪ Communication skills<br>▪ Entrepreneurship<br>▪ Numerical skills |

## TOOLS AND TECHNIQUES FOR DATA COLLECTION

Given the complex and multi-dimensional nature of issues involved in the study, the study used both qualitative and quantitative survey methods, and attempted to explore and evaluate critically the linkages between SHGs and women empowerment and its impact on their health. The respondent categories and tools/ techniques employed for data collection were as follows:

| **Respondent Category** | **Tool/ Technique of data collection** |
|---|---|
| SHG women members | ▪ In-depth survey interview with open and closed ended questions<br>▪ FGDs with all members of the selected SHGs<br>▪ Select Case studies |
| IDF functionaries at field level and their immediate supervisors, specific programme managers, founder members of IDF etc | ▪ In-depth Interview as well as GDs as the situation will allow |
| Family members of SHGs' members like husband, in-laws, parents, children etc. | ▪ In-depth Interview with the respondent category |
| Prominent people among the community viz. local political leaders- Sarpanch, Panchayat members, etc; AWW/ ANMs/ School Teachers, etc; shop owners, SHG members' neighbours etc. | ▪ Interview with the available respondents from this category |

The following matrix was followed to develop the methodology:

| Strategies | Key Process Areas | Methodology |
|---|---|---|
| Group formation | Identification and selection of Animators, training of Animators, initial communication with community, ice breaking with women community, rapport building, groups formation, communication tools | • Animators profile documentation on sample basis **(secondary data analysis)**<br>• Identify the strength of animators selection process and any selection criteria adopted **(Interview and Secondary Data Review)**<br>• Tools and techniques used for motivation and ice breaking process and for initial communications **(DST and animators interview and IEC materials review)**<br>• Review of group formation activities and input designs from **(secondary data at group level on sample basis.)**<br>• Group accreditation (A **rated group indicators** and their best practices through **focused group discussion** and indicator based rating through **appreciative enquiry** and **secondary data** review) |
| Capacity building of women groups | Training, Orientation, exposures, facilitation (SHG meetings, Cluster meetings and Block meetings, motivational inputs, IEC tools, small savings and internal lending, cluster and block level SHG institution building, community celebration | • Training module content review and their **impact mapping.**<br>• Facilitation process **(secondary data, interview of DST, SHG, and animators)**<br>• Successful stories **(Case studies)**<br>• Savings and Internal lending status **(secondary data review in a pre designed format)**<br>• Cluster and block level SHG functioning and dynamics **(case studies, group discussions)** |
| Linkages/ programme integration | Formation of BLTF and DLTF, regular meetings, facilitation, visits by women leaders to Government departments, information access, coordination, local initiative by SHG, cluster level and block level | • **Case studies**<br>• **Structured Interview**<br>• **Secondary data review**<br>• **DST and SHG (block level) representative meeting** |
| Exit strategy (Communit y level) | Shifting from consumption to livelihood lending, Loan analysis, Block and district level federation, initiatives by federations, self management, meeting group maintenance cost. | • The process review through group meetings, SHG documents review and **(Case studies)**<br>• Structural review and its dynamic and roles **(structured interviews)**<br>• Local initiatives on issues through **(secondary data review and DST & SHG meetings,** Case study)<br>• Loan analysis |

The study also attempted to understand the various activities and processes under taken to capture its impact on empowerment and health of the women. The study also focussed on following processes and achievement of the SHGs:

1. Community organization/group formation (expected performance and assumptions considered)
2. Capacity building (module, trainees profile, trainers profile, tools effectiveness)
3. Programme integration at community level (various line departments)
4. Local initiatives by local groups-up to cluster and federation level
5. Local initiative by groups/community for exit strategies

The main emphasis was to understand the process towards reaching the various development programmes on gender equity and human rights to the unreached, using the CCA strategy and its effect on health and empowerment of women. The methodology comprised activities like interview, case studies and focus group discussion with women SHGs members as per a pre-designed schedule. The field-work spanned for three months.

The context, background, study design, and research approach of the study have been presented in this chapter. Using the study design, data, on women's empowerment and its linkages with their health was collected and analysed in the following chapters.

# CHAPTER – V

# SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE OF RESPONDENTS AND SELF-HELP GROUPS

CHAPTER V

# SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE OF RESPONDENTS AND SELF-HELP GROUPS

This chapter presents the socio-economic and demographic profile of the respondents. The study area profile covers panchayats and villages covered in the study. The chapter also looks into respondents' demographic profile, such as marital status, caste groups, age group, education, occupation, income, unequal wages, ration card/BPL status, and ownership on agriculture land of the women participated in the study. Profile of SHGs are also discussed covering group size, groups covered in the study, type of members in a group, number of meetings in a group, timings of Group meetings, attendance of members, participation of women in SHG activities, savings/collection within the group, saving amount, interest on internal loans, utilisation of saving amounts, and loan recovery.

## RESPONDENT'S DEMOGRAPHIC PROFILES

All the women interviewed were Hindu. The region is predominantly inhabited by Hindus except some population in Phulwari block. Out of these two hundred women, 191 were married, and 9 widowed.

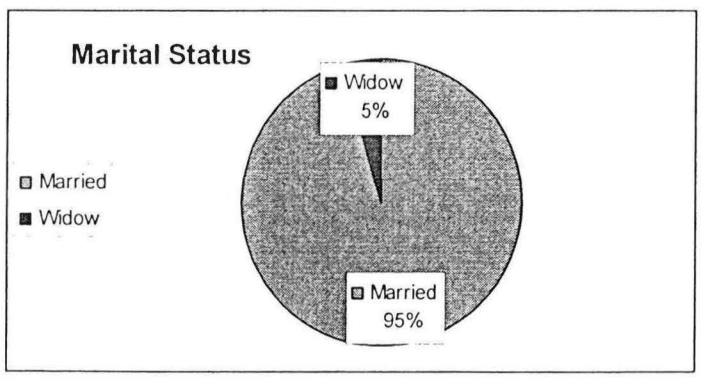



Figure 5.1: Marital Status of Women

The finding shows that 95 per cent of women were married, and 5 per cent were widows. Most interesting finding was that there was no representation or participation of unmarried girls/women. The main reason behind that was early

age of marriage, mostly in age of 17 to 20 years and in some cases before at the age of 13-14 or fifteen years.

*A girl of seventeen years was interviewed to know her views and perception of SHGs, who works for the health programme of the NGO Integrated Development Foundation (IDF) as a volunteer. Her mother and other women of family are member of SHG. The girl's response/perception of SHG was very positive and she reported that although she is not a member of the group, she helps the group members in keeping accounts and other works. She also said that given the opportunity and chance, she will join the group some day.*

This shows that although the young adolescent girls are not member of SHGs, they are influenced by it. These girls are also empowered in terms of knowledge, information and services available. They are also helping other women in their empowerment who are less educated and have limited opportunities.

**CASTE GROUP OF WOMEN**

Although the women represent different castes like Paswan, Yadav, Kurmi, Harizan Pal etc but class wise they are homogeneous considering their economic status. In life style also there is not much difference except that other backward class (OBC) population are better positioned socially than schedule castes (SC).

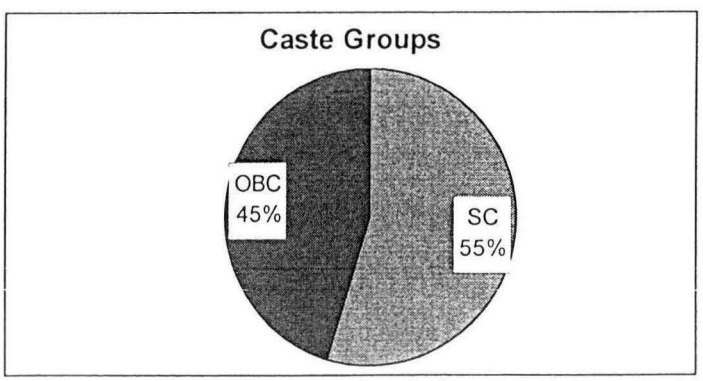



Figure5.2: Caste Groups of Women

Out of 200 women 3 were from general category, 108 from schedule castes and 89 from other backward classes. Indian society is influenced and based on caste system. The findings show that 55 per cent women belong to Schedule Caste[1] (SC) and 45 per cent belong to other backward caste (OBC). In Bihar Bauri, Bhogta, Bhuiya, Bhumij, Chamar, Mochi, Chaupal, Dabgar, Dhobi, Dom, Dhangad, Dusadh, Dhari, Dharhi, Ghasi, Halalkhor, Hari, Mehtar, Bhangi, Kanjar, Kurariar, Lalbegi, Mushar, Nat, Pan, Sawasi, Pasi, Rajwar, Turi comes under the schedule caste[2]; and other backward class comprise of Yadav[3], Gwalas, Kurmi, Pal and Vishwakarma etc.

The caste variations in respondents are due to coverage and accessibility to group members. Undoubtedly the focus of the CCA programme was to reach the marginalised section of the society. But it was found that other backward classes' participation in the programme represented almost half because of their better position in society in comparison to schedule castes. Geeta Devi, of Ravidas (schedule caste) says that, *"Sab fayada to bari Jaat le rahe hain, humlog ko koi fayada nahi mil raha. Na ghar hai na kamai. Fayda usiko pahunch raha hai jiske pas paisa or pahchan hai* (all benefits are taken by the upper castes, we are not getting any benefits. We neither have house nor job. Benefits of the programme are reaching to people who have money and connections).

Political environment of the state which was ruled for fifteen years (1990-2005) by RJD chief ministers also played a significant role in OBCs dominance over resources. The other reason was that OBCs were closer to general class and were more aware of resources, programmes than SCs who are/were more

[1] Scheduled Castes are communities that are accorded special status by the Constitution of India. These communities were considered 'outcastes' and were excluded from the Chaturvarna system that was the social superstructure of Hindu society in the Indian subcontinent for thousands of years. These castes have traditionally been relegated to the most menial labour with no possibility of upward mobility, and are subject to extensive social disadvantage and discrimination, in comparison to the wider community. The Scheduled Caste people are also known as Dalits.

[2] See, http://lawmin.nic.in/ld/subord/rule3a.htm (visited on 25 February 2006)

[3] Yadavas are the single largest community in India, estimated to constitute more than 19 % of the Indian population. In terms of sheer numbers, this translates to 200 million people. Through numerous political parties, such as the Rashtriya Janata Dal, Janata Dal (United), Janata Dal (Secular), this caste has considerable political influence, especially in the governments of India's most populous states, Uttar Pradesh, and Bihar.

marginalised and considered untouchable. The other important factor behind the reach of the programme to OBCs was their awareness about the programme and resources available at block and panchayat levels. In case of SCs, it was found that they were more marginalised in comparison to OBCs with limited opportunities and benefits. It was their position in the society which is based on class and caste structure/hierarchy with its associated discriminative attitude which made things more difficult for them to access and avail different programmes.

## AGE GROUPS OF WOMEN

Most of the women interviewed belong to young and the reproductive age group (18-45 years) which comprises 74 per cent of all respondents. 17 per cent women belong to middle age group (46 to 55 years) and 8 per cent belong to 56 years[4] and above heading towards old age but still active.

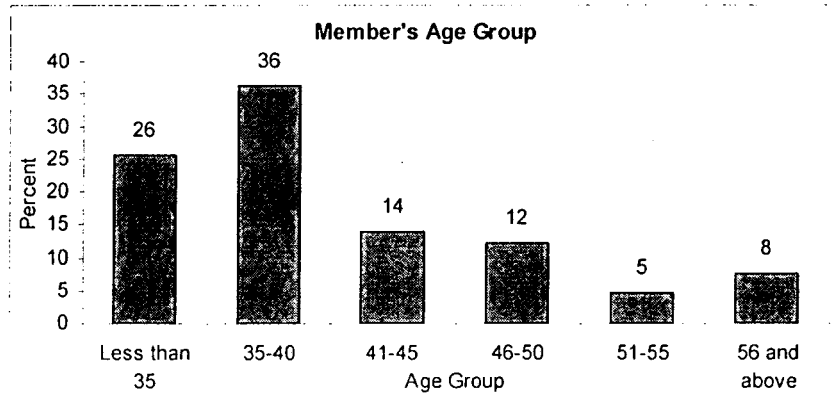



Figure 5.3: Age Groups of Women

From the table, it appears that there is more participation of young women in SHGs in comparison to middle age and old. The women are more conscious and knowledgeable and aware about their rights and are willing to fight for them

[4] According to the Planning Commission's National Human Development Report (NHDR), 2001, female life expectancy in Bihar and UP in 1992-96 was around 55 years. This compares to figures for sub-Saharan Africa.

although it is very challenging and at times difficult[5]. However many of them are fighting for their rights (especially for their subordinate position in the society and to avail health facility and education of their children).

Twenty-six per cent of women within the age group of less than 35 years are mostly daughters-in-law and young married women. Most of them have joined these groups on initiation of their mothers-in-law which is very significant in terms of realisation of SHG as source of empowerment and income. Sunita Devi, 24 years, of Ravidas caste says that. *"Saas ke kahne se samiti se jude, wahi bahar jat hain meeting ke liye. Jahan batawat hain, hum sign kar deye hain" (I joined the group on initiation of my mother-in-law. She goes out for meeting. I sign wherever she asks).* Other reason for encouraging daughters-in-law to join the group was mothers-in-laws' own position within the group. It was found that joining of daughters-in-law strengthens the mother-in-law's position in the group.

## EDUCATION OF WOMEN

The findings show that one-third (74 per cent) of members were illiterate[6], and 15.5 per cent were literate. The census 2001 shows that 30.7 per cent of rural women were literate in Maner block, and 47.6 per cent of rural women were literate in Phulwari block. Finding also shows that 8 per cent of women are educated up to class V and only 2.5 per cent women were educated up to class X[7].

Table 5.1: Educational qualification of women

| Educational qualification of women | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Illiterate | 66.7 | 81.6 | 88.0 | 58.4 | 74 |
| Literate | 14.7 | 16.3 | 10.2 | 20.2 | 15.5 |
| Class V | 13.7 | 2.0 | 1.9 | 15.7 | 8 |
| Class X | 4.9 | 0 | 0.0 | 5.6 | 2.5 |

[5] The divided nature of rural society in Bihar has severely limited the scope for public action - such as unanimous protest by people of a village against doctors and teachers who don't turn up for work.

[6] In 2001, around 70% of the women in rural Bihar were illiterate (NHDR, 2001).

[7] If we look at more meaningful indicators of literacy, the figures become more dismal. For example, in 1993 the percentage of girls enrolled in class IX and X in rural Bihar was only around 20 (NHDR, 2001).

Across blocks, the developed block of Phulwari had higher literacy compared to the underdeveloped block of Maner. While, 82 per cent of women in Maner were illiterate, only 67 per cent were illiterate in Phulwari. This was also true for higher levels of education with more percentage of women in Phulwari (13.7 per cent) reporting education upto class five compared to only 2 per cent women in Maner. Incidentally, while 5 per cent of women reported having completed secondary education in Phulwari, none reported having completed secondary education in Maner.

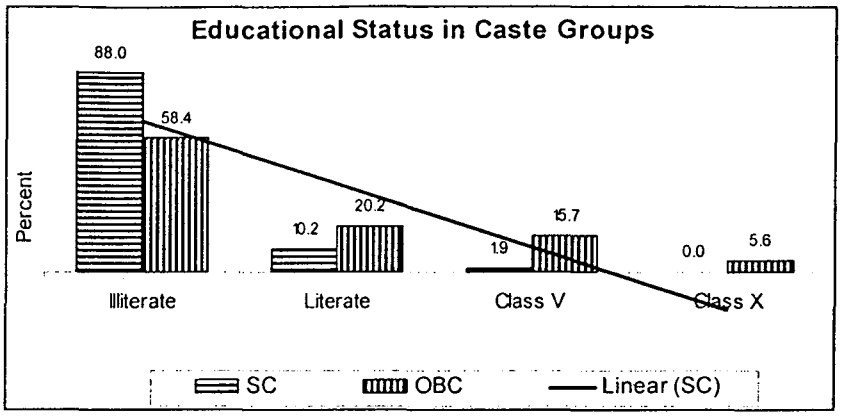



Figure 5.4: Education of Women

Across caste wise, the levels of literacy and educational attainment were as expected with the socially and economically better off caste group of OBCs having better educational attainment than SCs. Compared to 88 per cent of women among SC as illiterates, only 58 per cent among OBCs were illiterates. This was also more clear for higher levels of educational attainment with no SC women reporting studying up to class ten compared to 6 per cent among OBC women. The findings show that literacy among SC is very low in comparison to OBC population. It is also evident from the survey findings which show that only 15.5 per cent of rural women are literate.

The lower educational attainment also reflects the dependence of the women on others for information. Education statistics also show that poor families and those living in rural areas register the lowest rates of enrolment and

the highest dropout rates. Sarbatiya Devi, 45 years, says that, *"Padh ke nokri mile ke he. Paisa rahe to aadmi sochbo kare. Aas pas kauno school he, sarkari school bande rahe he. School jaibe na kare hai. Ose to thik hai, du paise kamave" (Education will not give job, if money is there people can think about it. Near by there is no school; government school is closed most of time. (He) does not go to school. In that case, it's better to earn).* Figures for 2000-2001 show that 24 per cent of primary school students transited to the upper primary level, 12 per cent transited from the upper primary to secondary level, and 10 per cent went from secondary to higher secondary. The figures were much lower for girls, and for rural as opposed to urban children[8].

The women also reported about their dependence on others for opening a bank account and loan processing. They also reported about their inability to access many benefits and programmes made for them. This realisation was also well reflected in their desire to educate their children both boys and girls. Sunayana Devi says that, *"Bache ko padhana to chahte hain lekin aas pass koi achha school nahi hai. Jo koi hai bhi wo itna mahanga hai ki sochna padta hai ki khaye ki bachhe ko padhaye. Humlog to padhe nahi, chahte hain ki bache padh-likh jaye" (we want to educate our children but there is no good school near by. Even if it is there, they are so costly that one needs to think about whether to educate children or eat. We are not educated but we want that our children should get education).* It was also found that other backward class women were more concerned about their children education in comparison to schedule castes. It was also fount that this consciousness about education is also influenced by their class status and position within the community and society.

A land mark in the field of policy on women's education in India, the National Policy on Education (1986) in its section on Education for Women's Equality (chapter XII, pp. 105-107) focuses on education of women as the critical precondition for their participation in empowerment process. For the first time official policy recognised the persistent gender imbalances in education and

[8] Dreze, Jean and Sen, Amartya (Ed). 1997. Uttar Pradesh: The Burden of Inertia published in India Development: Selected Regional Perspectives. Oxford University Press.

continued marginalisation of women which is well reflected from above findings. The situation with respect to education is a reflection of women's status in society. Their subordinate status and lack of control on any aspect of their lives; educational structures insensitive and inadequate to meet women's need; isolated and caught up in the struggles for survival of women have such a low self esteem and image that incapacitates them to such an extent that they are unable to make any demands from the system which is major hindrance in their empowerment.

The other important issue is the redefinition of education as an enabling and empowering tool, as a process that would enable women to 'think critically, to question, to analyse their own condition, to demand and acquire the information and skills they need to enable them to plan and act collectively for change'. Thus education must help women to question rather than accept, enable them to affirm their own potential and sustaining processes that would enable women to move from situations of passive acceptance of their situation to assertion and collective action, in short to take control of their lives; and building conscious and independent collectives of women which would initiate and sustain social change processes[9].

## OCCUPATION OF WOMEN

The findings show that 83 per cent women are agricultural labour. Nine per cent women are small farmer and 5.5 per cent have small business. Some women were also involved in cattle rearing[10]. Most of these respondents are landless and poor.

Table 5.2: Occupation of women across caste groups

| | Phulwari | Maner | SC | OBC | Total |
|---|---|---|---|---|---|
| Small Farmer | 11.8 | 6.1 | 4.6 | 13.5 | 9 |
| Lease Holder | 2.0 | 3.1 | 0.9 | 4.5 | 2.5 |
| Agriculture Labour | 80.4 | 85.7 | 91.7 | 73.0 | 83 |
| Business | 5.9 | 5.1 | 2.8 | 9.0 | 5.5 |

[9] Jandhyala, Kameshwari. 2004. Empowering Women, Education Girls: Reflections from the Mahila Samakhya Programme. Seminar on 'Strategies and Dynamics of Change in Indian Education. 25-27 November 2004. Delhi

[10] Rearing of Sheep, Goat and Pigs has been a good economic activity allied to agriculture, which helps generate additional income to rural poor. Mostly these activities are undertaken in villages by below poverty line people, particularly the schedule castes.

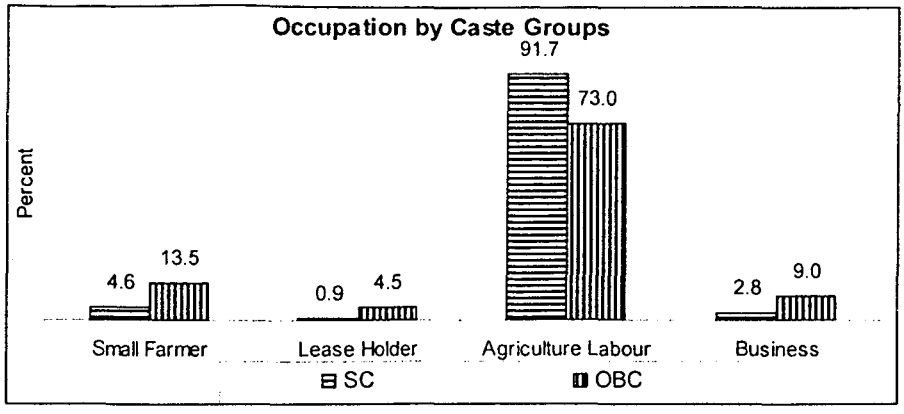



Figure 5.5: Occupation of women across caste groups

The findings also show that OBCs are economically superior over SCs as 13.5 per cent OBCs reported their occupation as small farmers whereas only 4.6 percent SC reported for the same. The trend was also reflected where more OBCs are involved in farming on leased land and business. 91.7 per cent SC women reported agriculture labour as their occupation where only 73 per cent OBC women reported for the same. A World Bank report shows that almost 75 per cent of the rural poor were landless in 1999-2000 (World Bank 2003). They work on fields as agriculture labour which heavily depends upon rain, weather, season and many other associated factors. Most importantly this (agriculture labour) work is not regular. Besides working on the field, many of the women also work in house construction work and other forms of work available at village, panchayat and block level. Some of them (5.5 per cent) are involved in small petty business like small general store in their house, papad[11] making, pickle making and embroidery work. They supply their home made products to market through retailers. Nine per cent of respondents belong to small farmers' category but in reality it was found that land holding possessed by them is a very small piece of land. Although it varies, some of them have one bigha and more. In fact they are the one who also have taken land on lease for farming. They grow food-grains for their own family consumption and vegetables which they sell in the nearby market.

[11] Papad is an India flat-bread. Typically, it is prepared using black gram bean flour, rice flour, or lentil flour with salt and peanut oil added. The ingredients are made into dough and formed into a thin, round shape similar to a tortilla. The papad can be seasoned with a variety of different ingredients such as chilies, cumin, garlic, black pepper, or other spices.

It was also found in the study that the women are equally contributing to their family income. In many families, especially amongst schedule castes, both husband and wife are found working as agriculture labour. Women are found more regular to their work in comparison to men. It was also found in the study that women are more concerned about house hold responsibility and care of children and family.

Variation across blocks also confirmed the selection of blocks as developed and underdeveloped blocks with the developed block having more cultivators than the underdeveloped block. Also, the underdeveloped block of Maner had marginally higher percentage of population employed as agricultural labourers compared to the developed block of Phulwari.

## RATION CARD/ BPL STATUS

Poverty[12] can be defined differently and it has different meaning depending upon context, people and society. Poverty has been mainly seen in terms of absolute and relative poverty. Absolute poverty is a condition where one has inadequate funds or resources to avail a minimum standard of living for oneself or one's family. Individual in absolute poverty are living under life-threatening conditions like, having not enough food to eat (or adequate required food), not having shelter, safe water, medical care or proper clothing. The consequence of poverty is worse and pathetic where individual and family may always be on the verge of not having enough money to eat, pay for basic essential needs. Relative poverty is living condition, resources and money possessed by an individual in comparison to other in society. More precisely it is defined as doing worse off financially in comparison to average person in a given society.

Table 5.3: Ration card/BPL listing across caste groups

| | Phulwari | Maner | SC | OBC | Total |
|---|---|---|---|---|---|
| BPL List | 52.9 | 3.1 | 22.2 | 37.1 | 28.5 |
| Red Card | 47.1 | 49.0 | 50.9 | 43.8 | 48 |
| Applied | 0 | 48.0 | 26.9 | 19.1 | 23.5 |

[12] Joseph M. Palmisano (2001). World of Sociology. Vol.2. Gale Group. USA. Pp 518-519.

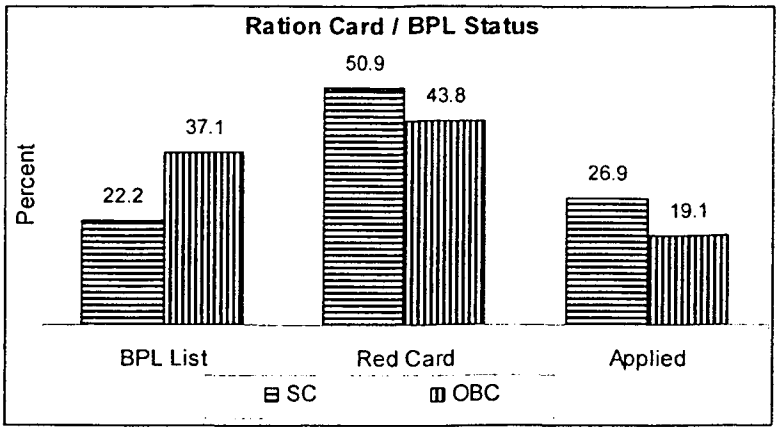


Figure 5.6: Ration card/BPL listing across caste groups

The findings show that 28.5 per cent of respondents were Below Poverty Line[13] (BPL), 48 per cent of them have Ration Card[14] or Red Card and 23.5 per cent of them have applied for it. It was also found during the interview that many of the women do not know about their real status whether they have red card or not or either they were enlisted in BPL list or not. Although the estimates of poverty in India do not give gender wise information (Bhalla, 2000[15]), BPL families in 1993-94 among agriculture labour constituted 77.22 per cent of rural

[13] Recently the Government of India has notified 13 new parameters for defining Below Poverty Line (BPL) category of people in the country. The revised definition is based on landholding, type of dwelling, clothing, food security, hygiene, capacity for buying commodities, literacy, minimum wages earned by the household, means of livelihood, education of children, debt, migration and priority for assistance. It has done away with the earlier definition based on food calories or annual earnings. The earliest definition of BPL in 1979 was based on consumption of 2,100 calories in urban areas and 2,400 calories for rural areas. In 1991-92, a household with an annual income of Rs. 11,000 was placed under the BPL category. In 1997, this criterion was raised to Rs. 20,000 per annum. Refer: New parameters for defining BPL category, The Hindu, 22 March 2006. (http://www.thehindu.com/2006/03/22/stories/2006032216750100.htm)

[14] The Government of India issues ration cards to the people which allow them to collect rations at a subsidized price from public distribution shops. Although ration cards are meant for the poor, middle class families also own ration cards. Depending on the financial status of the families, they are further classified into different categories.

[15] Bhalla, Sheila (2000). "Sustainable Agriculture: Poverty and Food Security in Asia: The perspective for the 21st Century", Third Asian Conference on Agriculture, Japan, Key Note Address, October 18-20, 2000.

poor[16]. And around 40 per cent of the state's population lives below the poverty line, almost double the national average of 26 per cent[17].

Having Red Card or enlistment in BPL list has lot of benefits for poor people and specially marginalised. Enlistment in BPL list or holding Red card usually helps in getting essential households consumption items through public distribution shops[18] (PDS) like grains, wheat, cooking-oil and other items at cheaper rates through public distribution system. Besides these benefits, there are various opportunities announced by State and Central government for people living below poverty line. The truth is that these benefits hardly reach the poor or people who need it because of various reasons like unsupportive bureaucracy, middlemen and corruption. Corruption in distribution of Red cards and distribution of food grains to BPL families is rampant across the state[19]. In 1999-2000, 89 per cent of BPL families did not get ration benefits, while 46 per cent of those who did get it were not qualified to get it[20].

It was found in the study that getting enlistment in BPL list or getting Red card is not an easy job for poor people. The findings also show that many of respondents (23.5 per cent) have applied for it several times in the past but have not received it yet.

Variations across caste groups and across blocks confirmed the developed and underdeveloped nature of blocks chosen as well as the practice of discrimination based on castes in accessing government services. In the developed block of Phulwari all households reported possessing ration cards but in the underdeveloped block of Maner, almost half of the respondents (48 per

[16] Krishnaraj, Maithreyi; Shah, Amita (2004). State of the Indian Farmer: A Millennium Study. Women in Agriculture. Vol. 25. Academic Foundation. New Delhi. Pp 76

[17] Dreze, Jean and Sen, Amartya (Ed) (1997). Uttar Pradesh: The Burden of Inertia published in India Development: Selected Regional Perspectives. Oxford University Press

[18] A public distribution shop, part of India's public distribution system, is a kind of shop in India which is used to distribute rations at a subsidized price to the poor.

[19] Uttam, Kumar (2006). Official used Bikes to Ferry Grains. The Asian Age. 17 February 2006. New Delhi. Pp. 3

[20] Dreze, Jean and Sen, Amartya (Ed) (1997). Uttar Pradesh: The Burden of Inertia published in India Development: Selected Regional Perspectives. Oxford University Press.

cent) reported that they have applied for the ration card but have not received it. This was also the case across caste groups with the vulnerable groups of SCs having larger percentage of population reporting applying for ration cards but not having received it on the date of survey.

## INCOME OF WOMEN

It was interesting to note that in response to a question about annual income all women replied that their annual income is less than rupees ten thousand. Although the per capita income in India has grown from Rs 8,760 in 1994 to Rs 13,332 in 2004, an increase of 52.2 per cent. Per capita income in Bihar has grown from Rs 3,333 in 1994 to Rs 4,088 in 2004, an increase of just 22.6 per cent[21]. More than 90 per cent of rural women in India are unskilled thus restricting them to low-paid occupations[22]. It was also found that calculating annual income in agriculture based economy among poor people is really difficult where income is based upon various factors like rain, drought, flood and seed-prices, etc. It was also found that many of the respondents are agricultural labour and they get these jobs for limited period of time within the agriculture season[23] besides having other construction works, etc. as and when it is available.

It was also found that agriculture labour wages are based on nature of work and gender. Agricultural wages for women are on average 30-50 per cent less than those are for men[24]. For example if a man works in the field, he gets rupees 50 to 60 a day but for a woman for the same work it is rupees 25-30. This

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[21] Dreze, Jean and Sen, Amartya (Ed) (1997). Uttar Pradesh: The Burden of Inertia published in India Development: Selected Regional Perspectives. Oxford University Press.

[22] Choudhry, A. 2002. Impact of Self Help Group [S.H.G] on Women Empowerment with Reference to Hazaribag District of Jharkhand state. [Unpublished] 2002. [21] p.

[23] Agriculture is the main occupation of people of rural Patna district. Cultivation is practiced in all the three cropping seasons i.e. Rabi (66.62 %), Kharif (57.8 %) and Jaid or Summer (2.38 %) in its net cultivated area. Bhadai-Kharif (June-Sept) crops are usually taken under unirrigated conditions (93.09 %of total crops in this season), whereas Aghani Kharif (June-Dec) crops under irrigated conditions (99.39 % of total crops in this season). Rabi crops are taken under irrigated as well as unirrigated conditions but summer (Jaid) are grown mostly under irrigated conditions only (89.91 %). (Source: http://patna.bih.nic.in/html/patnadistrict.htm, Visited 10 April 2006)

[24] Choudhry, A. 2002. Impact of Self Help Group [S.H.G] on Women Empowerment with Reference to Hazaribag District of Jharkhand state. [Unpublished] 2002. [21] p.

also depends upon the nature of work. If women are working on vegetable field, she will get rupees 20-25 for a day. There is no fix remuneration/wages for agriculture labour as well as for other forms of labour. In this context, it was found that it is really difficult to calculate real annual income where one gets job for ten to fifteen days a month but not sure for next month. It was also found that many of men migrate to neighbouring states and places in search of job and better opportunity. More than 30 per cent of young men in Bihar migrate to other places in search of jobs.[25]

It was also found that their remuneration of work is daily-based and it is difficult to calculate the income where need is more in comparison to income, which makes the life difficult especially among SCs. Sukhia Devi says that, *"ihan roj kamaye or khaye ke hai. Eko rupiya bache hai. Roj to udhari lage rahe he. Mahina me daso din kaam na mile hai" (Here you have to earn and eat daily, it is not possible even to save a single rupee. One has to take loan regularly; even getting ten days work in a month is difficult).*

It was also found that there were few families who have more than rupees ten thousand annual income but it was not reported or accepted by any of the respondents especially by the women belonging to OBCs and general class. Although there were only three women from general class but they also reported the same.

## ANNUAL INCOME AND UNEQUAL WAGES

Surprisingly this was the most difficult question. Almost all the respondents answered that their annual family income is below Rs. 10,000 per annum. Many of them are not able to mention the real figure because of rural agriculture economy. Most of them are agriculture labour and depends on the work they get and there are not fixes income for the family. The agriculture labour is also dependent on season, rain and productivity. If there is flood or

[25] India home to nearly eighteen percent of the world's youth, 14 December, 2005 (See: http://us.rediff.com/news/2005/dec/14youth.htm)

drought they find it difficult to get agriculture labour. Many of them also migrate to other states like Punjab and Haryana for agriculture labour because of good wages in comparison to Bihar.

Agriculture wages are also different for men and women for same work. For men is Rs 60/- a day at the same time it is Rs. 30 for women. Even women working on vegetable fields get amount less of Rs. 20-25 a day. (The Equal Remuneration Act was enacted in 1976. Even after three decades, non-payment of equal wages to women in the informal sector persists, especially in agriculture). The Act provides that no employer shall pay to any worker employed by him in an establishment or employment, remuneration whether payable in cash or in kind at the rates less favourable than those at which remuneration is paid by him to the workers of the opposite sex in such establishment or employment. The Act further provides that no discrimination should be made against women at the time of recruitment.[26]

Although the women are direct sufferer of wage discrimination and have complained about it, they never thought of fighting for it either through SHG groups or through any other forum. The reasons are multiple having its root in socio-cultural context and class differences which also control political power relation as well as social and local level control on decision making related to wages. The women are extremely poor and cannot raise their voice for the fear of not being employed again; further they are also suppressed by their men folk. In the agricultural sector, the wages of women labourers is significantly lower than the wage rates of the male labourers.

It can be argued that there is need to build capacities of women's self-help groups in demanding equal wages, including organizing them into cooperatives to enable them to collectively fight for their rights. The narrow understanding of SHGs, limited to savings and credit activities is also responsible for the situation. Most of the SHGs are dependent on NGOs representative for taking major decisions and activities within the group. In reality it should be decided by the

[26] See, the Equal remuneration Act, 1976.

group members. NGOs have their own limitations and they do not want to go into conflict with communities on such sensitive issues and their focus is more towards programme management rather social change and transformation.

There was no effort on the part of SHGs or by nurturing NGO to sensitize policy makers and project managers to the issue through advocacy, monitoring and experience sharing. Although the programme's main focus was towards convergence, making the women more empowered through interfaces with government programme, policies and officials to address their issues directly and fight for it, this is not reflected in any of the groups regarding their rights for equal wages which is basic to women empowerment by providing equal opportunity and wages. There were no initiatives either by SHG members or by supporting NGO and government to improve awareness among women workers of their legal rights and the requirement that employers are obliged to adhere to. There was not any initiative to generate awareness among social partners, and offering training on relevant legislation relating to minimum wages and equal remuneration.

These issues appear to have been taken up more by trade unions than development NGOs, as unions deal more readily with payment of wages and employer-employee contradiction but considering agriculture as profession employing highest number of agriculture work force and women constitute more than half of these work force, its necessary to address these issues.

The issue of unequal wages in the unorganized sector especially in agriculture is very important. In both Maner and Phulwari, women are engaged in agriculture works like in vegetable fields and other agriculture related works but they get lesser wages than men and they work for longer hours. They are not aware of their rights. It is important that women should be organized in cooperatives so that collectively they can fight for their rights. Women should also be organized in self-help groups with alternate income-generating skills. They should be made aware about their rights and labour laws so that they are not exploited.

In this context, women's self-help groups members need to be educated on these issues with other income earning opportunities and capacities, support on micro-enterprises development in terms of marketing linkages to enable them to be aware of prevailing market environment etc.

But this is only one aspect of the story. The fundamental basis on which wage inequalities actually operate is because women's wages are considered to be supplementary family income, which then provides social justification for lower wages for women. Such a position was articulated in the Fair Wages' Committee Report which came in the 1950s and provided the basis for several minimum wage notifications which explicitly provided for a lower wage for women. Such a practice was also known to be part of the wage awards in plantations. This is one area where some change has been brought about by the Equal Remuneration Act (ERA). In the informal sector, the problem is that labour law rarely reaches them, due to the limited nature of the labour law enforcement machinery, as well as the requirements of labour law, which include proper registers or muster rolls, identifiable employers and proof of an employer employee relationship, either by written records or physical inspection of establishments by labour inspectors. It requires stronger organization of workers.

The issue of unequal wages raised is intrinsically linked to a plethora of additional systemic and social problems and cannot be dealt in isolation. There are several key areas that need to be addressed through reforms to ultimately tackle the problem of unequal wages. These can be addressed through various ways involving women SHGs like, addressing systemic gender based discrimination in all aspects of the labour exchange: which range from whether women have paid work at all, the type of work women do and those that they are excluded from doing; the availability of equal employment benefits which also include compensation, benefits and conditions of work.

## OWNERSHIP ON AGRICULTURAL LAND

Table 5.4: Ownership on agricultural land

| | Phulwari | Maner | SC | OBC | Total |
|---|---|---|---|---|---|
| Landless | 90.2 | 100.0 | 100.0 | 88.8 | 95 |
| With land holding | 9.8 | 0 | 0 | 11.2 | 5 |
| Total | 100 | 100 | 100 | 100 | 100 |

The findings show that 95 per cent of respondents are landless and only 5 per cent of them have ownership on land although these land holdings are of different sizes but most of them have small land holdings except a few. It was found that amongst SCs no one has landholding of one bigha[27]. Some of them have land holdings of around five kattha[28] or hardly ten katthas on which they have built their houses and grow vegetables and grain for their own and family consumption.

The five per cent of land holdings are mostly occupied by OBCs and among them kurmis[29] and yadavs and three women belonging to general class. This is also reflected by the caste and block wise variation in land holdings. All the land holding families were located in the developed block of Phulwari and among caste groups among OBCs. This finding also goes on to confirm the assumption behind selection of blocks.

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[27] Bigha is a unit of measurement of area of a land, commonly used in a few states of India. The precise size of a Bigha appears to vary considerably. The measurement of Bigha range from 1,500 to 6,771 square meters. In Rajasthan in India, a Bigha equals 2500 square metres and in Bengal, India, a Bigha equals 1333.33 m². (See: http://en.wikipedia.org/wiki/Bigha). Bigha is a traditional unit of land area in South Asia. The bigha varies in size from region to another; in India it is generally less than an acre (0.4 hectare). In Bengal (both in Bangladesh and in West Bengal, India) the bigha was standardized under British colonial rule at 1600 square yards (0.1338 hectare or 0.3306 acre); this is often interpreted as being 1/3 acre. In central India bighas were standardized at 3025 square yards or 5/8 acre (0.2529 hectare). In Nepal the bigha equals about 0.677 hectare (1.67 acres). The bigha was divided into 20 katthas, and each kattha contained 20 dhurs.

[28] A small land-measure in use in Bihar, being the twentieth part of a *bigha*, and containing approximately eighty square yards.

[29] Kurmi is the name of one of the Jatis (castes) of the Hindus. Most Kurmis are land owning agrarians. Kurmis constitue around two-to-three percentage of the total population of India. (See: http://en.wikipedia.org/wiki/Kurmi)

In India among rural households, landless agricultural labourers have the highest incidence of poverty (51 per cent), followed by non-agricultural rural labour (35 per cent). Of the total rural poor, almost 42 per cent are agricultural labourers and about 33 per cent self-employed households in agriculture. Overall, 42 per cent of rural poor households are landless and over 80 per cent of them cultivate less than 1 hectare of land[30].

## NUMBER OF CROPS IN A YEAR

Table 5.5: Number of crops in a year

| Number of crops in a year | Phulwari | Maner | SC | OBC | Percent |
|---|---|---|---|---|---|
| One Crop | 0 | 11.3 | 8.4 | 1.1 | 6 |
| Two Crops | 100.0 | 88.7 | 91.6 | 98.9 | 94 |
| Total | 100 | 100 | 100 | 100 | 100 |

Cropping system[31] is the kind and sequence of crops grown over a period of time under the specific soil conditions. It may be a pattern of regular rotation of different crops or the crop composition. The land can be sown/ planted under a single crop during one season (mono-cropping) or under two crops in a year or double cropping or even more than two crops in the same piece of land in a crop year (multiple cropping). The decisions about the cropping systems are usually based on experience, tradition, expected profit, personal preferences, as well as technological and institutional factors.

Six per cent of women reported one crop or mono cropping[32] where as 94 per cent of respondents reported two crops a year. It was found that in general

[30] India: Bihar - Madhya Pradesh Tribal Development Programme (1998) Socio-economic and Production Systems Study. Series title: FAO Investment Centre Studies and Reports – 1998 (http://www.fao.org/ docrep/007/ae393e/ae393e00.htm)

[31] Deshpandey, R. S.; Bhende, M. J.; Thippaiah, P.; Vivekananda, M. (2004). State of the Indian Farmer: A Millennium Study. Crops and Cultivation. Vol. 9. Academic Foundation. New Delhi. Pp 103.

[32] Mono-cropping is the agricultural practice of growing the same crop year after year on the same land, without crop rotation through other crops. While economically a very efficient system, allowing for specialisation in equipment and crop production, mono-cropping is also controversial, as it often leads to depletion of the nutrients of the soil and problems with weeds and pesticides. These in turn lead to the mono-cropping system being dependent on pesticides and artificial fertilisers. Mono-cropping is most frequently practiced in industrialised countries' agricultural systems; maize (corn), soybeans and wheat are three common crops often grown using mono-cropping techniques.

households were growing two crops an year compared to Maner which is relatively underdeveloped. In other words, it also suggests that households in Phulwari, the developed block were also better endowed with other infrastructure such as irrigation and availability of inputs which are crucial in determining the cropping intensity in a region. This was expected considering that Phulwari is the better developed block among the two with better agricultural infrastructure.

But within these blocks, the choice of growing one crop or two crops also depends on availability of land holding and more importantly, required initial input cost. The SCs appear to have both these twin disadvantages and is also clear that compared to 99 per cent of OBC households growing two crops in a year only 92 per cent of SCs are able to do so.

## PROFILE OF SELF-HELP GROUPS

### GROUPS COVERED IN THE STUDY

Each SHG was found to be consisting of about 20 members on average. Available members of the selected SHGs were covered in the study sample. The respondents (women self-help group members) interviewed represents fourteen groups. The groups were identified with the help of NGO (Integrated Development Foundation) representatives and animators working for the programme. Presently these groups are not supported by IDF and are independent in their functioning, but at times they contact the animators for help in opening an account, loan application and other works. The table below gives the distribution of respondents by their affiliation to various SHGs.

Table 5.6: Self-help Groups covered in the study

| **Group's Name** | Percent |
|---|---|
| Krishna Mahila Samiti | 9.5 |
| Shanti Mahila Samiti | 3.5 |
| Khushbu Mahila Samiti | 7.5 |
| Saheli Mahila Vikas Samiti | 7.5 |
| Vishnu Mahila Vikas Samiti | 6 |
| Saraswati Mahila Vikas Samiti | 6.5 |
| Chanchal Mahila Vikas Samiti | 4 |
| Chandan Mahila Vikas Samiti | 7.5 |
| Jugnu Mahila Vikas Samiti | 17 |
| Jyoti Mahila Samiti samiti | 10 |
| Tulsi Mahila Samiti samiti | 0.5 |
| Laxmi Mahila Samiti samiti | 2.5 |
| Tara Mahila Samiti samiti | 4.5 |
| Santoshi Mahila Samiti | 13.5 |
| Total | 100 |

These groups have their own distinct character, identity and functioning. Many of these groups are functional only notionally, the members do not meet regularly; some of the groups have closed saving and credit activities due to various reason and inner dynamics of the group[33]. However the members still identify themselves with the group and help each other in times of need and crisis.

The structure of these groups is interesting. In some of the groups, it was found that out of 15-20 members, 7 to 8 members belong to one family and related to each other like, mother-in-law, daughter-in-law, etc. In two groups it

[33] The financial management of SHGs has been found to be major reason behind this. Specifically, internal controls at SHGs were lacking. Here internal control represents the systems and processes that manage the day to day transaction flow and ensure that roles and responsibilities are defined and executed to safeguard assets. It was also found during focus group discussion that systems and processes were poorly executed by members.

was found that all the members belong to two to three families or part of extended family.

Jugnu Mahila Vikas Samiti had 34 members which was the highest among all groups. Most of the members of Jugnu Mahila Vikas Samiti were related to each other as family members. It was found that usual number of group members varies between 10 to 20 members which is also considered ideal (for smooth functioning and management of the group) and many of the groups were having members in this range.

**GROUP SIZE**

Table 5.7: Group Size

| **Group Size** (Members) | Percent |
|---|---|
| 15-20 | 37 |
| 10-15 | 63 |
| Total | 100 |

It was found that 37 per cent groups have members ranging from 15-20 members and 63 per cent groups have 10-15 members. For efficient group functioning, this number is considered ideal. Generally it is considered that group should have minimum ten members and maximum twenty members. It was found that all the groups have balanced 10-20 members in each group. Group size is always dependent upon availability of members and their interest in the group. It was also found that some of the groups which have more than twenty members later opened the new group for better functioning and opportunities.

It is generally suggested that in each group there should not be more than one family-member, but in some of the groups it was found that more than one family members are involved, viz, mothers-in law and daughters-in-law. In some of the groups, it was also found that extended members of family are part of the group. Which at times facilitates the group functioning but most of the time goes against group values and spirit. It was also found that in loan distribution and lending the family factor played its role in decision making which is not ideal for group functioning which facilitated groups within the group and inter-group

politics, and disinterest of some of members in the group, which had negative impact on group meetings, saving and credits.

It was also found that older women have more say or influence in the group because of their position within the family, community and society because of their age and mobility. However, it is not true for all the groups. In some of the groups it was found that young women are very vocal and intelligent who understand the issues, group functioning, dynamics and politics.

## TYPE OF MEMBERS IN A GROUP

Table 5.8: Type of members in SHGs

| **Type of members** | Percent |
|---|---|
| Only very poor | 81 |
| Not poor members | 19 |
| Total | 100 |

Although the members of the groups were supposed to be from the poorer sections, it was found that 81 per cent of the members consist of poor people. It was difficult to assess the level of poverty among the group members but basic indicators were considered for the same. These were structure of house (kaccha-pucca), income, availability of sanitation facilities and living conditions. Members having BPL card were considered for the same although it is not a foolproof criteria considering the problems in distribution of BPL cards. It was found that members belonging to schedule castes are poorer in comparison to other backward classes.

It was also found that members from OBC sub-caste were well-off in comparison to SCs because of their caste dominance within the society which enables them to access various services. It was also found that OBCs were better positioned socially, politically and economically to use available services and opportunities.

It was also found that the programme has been successful in reaching the poor and disadvantaged people.

## NUMBER OF MEETINGS IN A GROUP

Table 5.9: Number of meetings in groups

| Number of meetings | Percent |
|---|---|
| 4 meetings in a month | 85 |
| 2 meetings in a month | 1 |
| Less than 2 meetings in a month | 14 |
| Total | 100 |

It was found that 85 per cent of the groups have four meetings in a month. One per cent reported two meetings in a month and 14 per cent reported less than two meetings in a month. It was also found that members have sometimes over reported that they have 4 meetings in a month. It was found that many of these groups are inactive because the programme does not have continued support from IDF due to funding constraints (the UNICEF withdrew support to the CCA programme two years back). The members still have group feeling, help each other and meet each other but its structure is informal. Most of the groups members are from the same community and live together and meet in groups more than four times but these meetings are not always for SHGs related work and activities.

It was also found that most of these groups are directionless and they are not able to develop themselves or sustain the activities of the group in the absence of outside support. Most of these groups have stopped saving and credit activities which was main motivation behind joining the group. Only few groups meet regularly now, those who have been able to sustain saving-credit activities and have bank[34] accounts. It was also found that these groups were focused towards saving-credit activities rather than other activities of mobilization on the issue of discrimination, demand for their rights, skill-development, training and

[34] There are at present 29 scheduled commercial banks working in Patna district, and the lead bank of the district is Punjab National Bank, which has maximum branches located in rural areas. The State Bank of India has the largest presence in the district with 69 branches spread all over the district but mostly in urban areas. The total number of branches of banks in Patna is 316, with 144 urban, 131 semi urban and 141 rural branches.

other activities which will help them in starting their own business or employment.

It was also reported by some groups that groups have stopped meeting because of politics within the group. Politics was present earlier also but they were able to resolve it with the intervention of animator and there was the perception that their activities are under observation and animators and social workers were having important place among these women, so they always obeyed keeping aside their personal ego, enmity and fight for influencing positions within the group.

## TIMINGS OF GROUP MEETINGS

Table 5.10: Timings of group meetings

| **Timings of meetings** | Percent |
|---|---|
| night or after 6 pm | 11 |
| between 7 and 9 am | 15 |
| Other timings | 74 |
| Total | 100 |

Eleven per cent women reported that they have group meetings at night or after six in the evening, 15 per cent women reported the meeting timings between 7 and 9 A.M. in the morning and 74 per cent women reported no fixed timings for the meeting. It was also found that they are very informal about group meeting and most of the groups do not have fixed timings for that which is good and bad in a sense that it is not possible for all the women to be present all the time to attend the meetings. Mostly, these meetings were organized taking into account convenience of group members.

Generally it is considered that mornings and evenings are the best time for organizing the meetings. It is easy to contact all the group members during this time. It was also found that in the morning and evening meetings, there was more attendance of the members in comparison to groups having no fixed time for the meetings. It also reflects the voluntary structure and functioning of the group where there are no fixed timings for the meetings and discipline. It also

constrains some women from attending all the meetings. If there is fixed timings and date, one can plan other work and schedule accordingly but in the absence of fixed timings, many woman found it difficult to attend the meetings and were dependent on other members to know about meetings and group activities. It was also found that there was group cohesiveness which also encouraged non-participation in group meetings with the belief that whatever will be decision, it will be communicated later. This was also because of the trust within the group despite internal politics and group dynamics. It was also found that group members have a feeling that meeting was necessary because they have to report or show to animators or social worker that they are regularly meeting, maintaining the register and other formalities rather than their own motivation to perform these activities for better functioning of the groups.

## ATTENDANCE OF MEMBERS

It was reported that the groups were having more than 90 per cent attendance in group meetings which was over reported. It was found in focus group discussion that when group was very active during the support period, attendance was high around 80 to 90 per cent. But at present it is less than 50 per cent in many groups. There are no saving and credit activities which have been major motives behind joining these groups along with other benefits and opportunities.

## PARTICIPATION OF WOMEN IN SHG ACTIVITIES

It was also reported that there is a very high level of participation of members in meetings and SHG activities. It might be true earlier when programme had external support but it was found that at present the participation of members is minimal. Many of them are not interested any more and many of the groups are defunct, or functional on paper. Even at times, it is difficult to locate the register. Besides there are no motivation to be part of the group as there is no saving-credit activities in many groups. They do not remember any convergence programme or activities in which they have participated in the last two years.

In some of the groups it was found that participation of members is high. But these are the groups which have taken loan from Banks and engaged in small business. Besides, these groups have also taken benefits of other SHG programmes apart from CCA like Swaranjayanti Gram Swarojgar Yojana (SGSY) etc. The women have also formed another SHG group which shows that concept of SHG has not been taken as concept of empowerment rather it has been taken as mechanism to take benefits of government programmes and future of these groups are dependent upon outside available support and benefit.

It was also found that some of the groups which have been inactive for over a year now have started functioning again being part of another SHG programme implemented by NGO IDF funded by Women's Development Corporation and supported by the World Bank. This shows that these groups are very much dependent upon outside agencies. And the motivations behind joining these groups are guided by utilizing benefits rather than using SHG as model of their empowerment and development.

## SAVINGS/COLLECTION WITHIN THE GROUP

Table 5.11: Savings/collection within the group

| **Savings/collection within the group** | Percent |
|---|---|
| Four times a month | 84.5 |
| Less than 3 times a month | 15.5 |
| Total | 100 |

Eighty-five per cent women reported that they do savings /collection four times a month and around 15 per cent women reported that they do savings /collections less than three times a month. It shows that most of the groups are very functional and doing excellent in saving-credit activities. In reality, it was found that what they reported might be true when these groups were getting support from IDF but it was found that most of these groups are not functional and even if they are functional, it is for the name sake. Most of the groups have closed saving-credit activities. The same is true for the groups who reported that they do collect the savings less than three times a month.

It was found that after discontinuation of support from the NGO, some of the groups continued their saving-credit activities for a year and some of them continued it for more than a year. But with times, there were issues within the group which group members were not able to handle and resolve in absence of animators or social worker. This in-group conflict, ego problems among group members and groupism within the group led to disinterest among other members in the group and they withdrew from the group. In some of the groups conflicts were so visible that it started affecting the social fabric and these groups were closed with community intervention like settling of accounts and the groups stopped savings-credit activities. Although all the members of the group do not wanted to close the group or stop its activities because of one or two group members. But still they feel that they are suffering because of closing of group savings-credit activities. Many women reported that it was because of one or two members who were responsible for group conflict and they all are paying for it.

## SAVING AMOUNT

Table 5.12: Saving amount

| **Amount to be saved** | Percent |
|---|---|
| Fixed amount | 99 |
| Varying amounts | 1 |
| Total | 100 |

99 per cent women reported that fixed amount was saved during weekly savings, which shows formal and disciplined savings in the group. This also helped in estimation of accumulation of funds, loaning capacity and other planning within the group. The amount saved was decided within the group by group members so it was easy for every member to contribute in group savings regularly. This made the group more functional and economically stronger. It was easier for women to contribute to group savings as they were aware in advance that they have to contribute fixed amount in group savings.

## INTEREST ON INTERNAL LOANS

Table 5.13: Interest on internal loans

| **Interest on internal loan** | Percent |
|---|---|
| Depending upon the purpose | 10 |
| 24-36% | 90 |
| Total | 100 |

Ten per cent women reported that interest on loan was dependent upon the purpose of the loan and 90 per cent women reported that interest on loan was ranging between 24-36 per cent per annum which is high and difficult to pay for many women. These interest rates are lower than the interest rates charged by Sahukars and moneylenders but higher than other loans given by government agencies and banks. There were no set rules for charging the interest rates in the groups which also affected the group functioning and raised questions about favouritism within the group.

## UTILISATION OF SAVINGS AMOUNT

Table 5.14: Utilisation of savings amount

| **Utilisation of savings amount by SHG** | Percent |
|---|---|
| Fully used for loaning to members | 16 |
| Partly used for loaning | 85 |
| Total | 100 |

Sixteen per cent women reported that they fully utilised the savings amount for loaning it to members and 85 per cent women reported that they partly utilised the savings for loaning to members. Despite this it was found that women were satisfied with the group loaning system except some women who reported that they were not able to get loans because they have taken loan from the group earlier and their loan repayment is still due and not complete. Others reported that they were not able to get loans because group's saving was not enough to give loans to more members at a time. Although 85 per cent women reported that they partly used group savings for loaning, it was not clear, why this was done.

## LOAN RECOVERY

Table 5.15: Loan recovery

| **Loan recovery** | Percent |
|---|---|
| More than 90% | 75 |
| 70-90% | 19 |
| Less than 70% | 6 |
| Total | 100 |

Seventy-five per cent women reported that there was more than 90 per cent loan recovery, 19 per cent women reported loan recovery between 70 to 90 per cent and 6 per cent women reported less than 70 per cent loan recovery. Overall it seems that the women were sincere in loan repayment. It was found that there were several reasons behind timely loan repayment. Foremost was ones own image within the group and secondly it was by and large mandatory that before you take a second loan, you must repay the first loan amount. It was also found that loan amount was not huge and it was within the paying capacity of the women with minimal rate of interest in comparison to Sahukars and moneylenders which they were paying earlier. It was also found that loaning facility made the group very popular and more women got attracted towards it. Although there was fixed rate of interest and duration for the loan repayment, it was found that group members were considerate and flexible to members paying capacity and inability within the stipulated time and in some cases they waived the interest charged on loan amount. All SHGs were involved in savings and credit activities and other activities got secondary attention with more focus on savings and credit activities. This made the groups members more particular about savings-credit activities and loan repayment.

## SUMMARY

In this chapter, socio-economic profile of the study area, demographic profile of the women SHG members and profile of SHGs was developed and discussed. The profiles were also developed across blocks and caste groups. This will help in understanding the social, economic and cultural context and background in which the women are living and its covert and overt impact on

empowerment, health belief and perception. In brief, the profiles show that socio-economic conditions, social structure and development play a major role in implementation, utilisation, reach and access of services and programmes. The following chapters will discuss in details the impact of these factors on SHG programmes, women's empowerment and women's perceptions on health.

# CHAPTER – VI

# SELF-HELP GROUPS AND WOMEN'S PERCEPTION ON EMPOWERMENT

CHAPTER VI

# SELF-HELP GROUPS AND WOMEN'S PERCEPTION ON EMPOWERMENT

This chapter presents the findings from the questionnaire, case studies and focus group discussions on issues related to women's empowerment and more particularly their social, economic and community empowerment. The chapter also looks into their knowledge about women's empowerment schemes and programmes, information and knowledge about Self-help Groups (SHGs) programmes, motives behind joining SHGs, benefits and reach of the programme, source of income before and after joining the groups, control on income, decision on domestic and other expenses, change in expenditure pattern, dependence on Sahukar, decision making power in the family, self-confidence, participation in property related decisions, role and opinion in matters related to children's education, immunization and other matters, about their freedom of mobility, extra income, participation in social life and social inclusion in the community. The findings are also based on extensive field visits and discussion with family members of women's SHG members, panchayat leaders, local leaders, teachers, local NGOs and other stake holders who provided relevant information about the changes (visible and non-visible) in the women's life. Wherever, there are significant differences at Block or Caste level, they were also highlighted.

## KNOWLEDGE OF WOMEN EMPOWERMENT SCHEMES AND PROGRAMMES

In response to the question about their knowledge about various government schemes and programmes, all women reported that they do not know about any women's empowerment scheme and programmes[1]. This revelation was

[1] Government Sponsored Programmes and Other Important Programmes in Patna District: The major credit linked Government sponsored programmes undergoing in the district for poverty alleviation and employment generation are the Swarna Jayanti Gram Swarojgar Yojana (SGSY), the Prime Minister Rojgar Yojana (PMRY). Other credit linked programmes are Gramin Awas Yojana (GAY) Gramin Yojana (GY) and the Scheduled Caste Action Plan (SCAP). (Source: http://patna.bih.nic.in/html/patnadistrict.htm, Visited 10 April 2006)

surprising considering that these women were selected for the study because of their association and participation in SHG programme of the Convergence Community Action (CCA) programme of the UNICEF implemented by an NGO, Integrated Development Foundation (IDF). Moreover, they were beneficiaries of the programme someway or other. When this was discussed in detail with them during focus group discussion, it was found that they do not know much about the programme per se except the savings-credit activities of the SHG and select convergence programmes organised by the NGO (IDF) in which many of them participated and learnt about facilities, services and special provisions available for them at village, panchayat and particularly at block levels. Many of them also participated in interface programme organised by the NGO with bank officials, health functionaries, Block Development Officers (BDO) and other officials.

It is important in this context, that, despite having participated in various convergence programmes organised by IDF, the women do not know about welfare schemes and programmes specially meant for them. For example there are various social security programmes and schemes by the Central and State governments for their welfare. It is expected that they will know about these programmes after their participation in convergence programmes and take benefits of these programmes. However, the ground reality was just the opposite.

The National Social Assistance programme (NSAP)[2] was launched in August 1995 comprising of National Old Age Pension Scheme (NOAPS), National Family Benefit Scheme (NFBS) and National Maternity Benefit Scheme (NMBS). National Old Age Pension Scheme provides pension to people above the age of 65 with no source of income or financial support. National Family Benefit Scheme provides Rs 10,000 to families living below the poverty line when their main earning member dies. National Maternity Benefit Scheme provides Rs 500 to pregnant women of families living below the poverty line. Rural Group Insurance Scheme, which provides a maximum life insurance of Rs 5,000 covering the main earning members of families living below the poverty line on a group insurance basis; the government pays half the premium of Rs 50 -

[2] See, Chapter VIII, National Social Assistance Programmes (NSAP) and Annapurna. The Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 60.

Rs 70. When these programmes were mentioned during focus group discussion, none of the women reported that they knew about these programmes. Their whole activity is centred on savings-credit activities.

It was also found that these women were very much dependent on animators (facilitators) and social worker of the NGO for their savings-credit activities and other help. They also developed a very close relationship with animators as they were from their own area and some of them from their own community. Further probing was done to understand their perception of the SHGs, knowing well that they are part of the CCA programme of UNICEF[3]. It was found that the respondents identified themselves with animators or social worker rather than the NGO or the CCA programme of UNICEF.

They were asked further that whether they have heard of anganwadi worker[4], immunization programme or any other programmes, only some of them reported that they have heard of it. It was also reported that some of the groups have applied for loan from Swarna Jayanti Gramin Swarojgar Yojana (SGSY), the other centrally sponsored women's empowerment programme. The fact that some of the women members were utilising these government programmes despite this, they reported ignorance of these programmes as women empowerment programmes shows that even if some women are taking benefits of these schemes and programmes, they view these programmes differently and their perception about the programme is somewhat different and they are not able to associate these programmes with their empowerment or women's empowerment.

## MOST IMPORTANT NEED OF WOMEN'S PARTICIPATED IN THE STUDY

[3] The probing was essentially to know whether these women identified themselves with the CCA programme of UNICEF or the local NGO (IDF) or with the animators.

[4] Anganwadi Worker is the focal point of delivery of various services to improve the nutritional and health status of children in the age group of 0-6 years, to reduce the incidence of infant mortality, mortality, morbidly, malnutrition, to co-ordinate the activities of various departments to promote child development and to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

To understand the needs of the women participating in the study, two complementary questions were asked. One was regarding their own perception of their need and the second inter-related but complementary question was the need and issues before the family. In an attempt to get to the range of issues which might come up, the first question on woman's need was a multiple response question.

Before analysing the responses, it is important to clarify that response to the questions regarding perceptions of the women regarding her own needs or her family's needs are conditioned by many factors which include apart from level of knowledge of various issues to socio-political factors. In response to most important perceived needs, residence and employment emerged as the most important needs. The responses in this case were not mutually exclusive and women were asked to report more than one need. Out of 200 women respondents, 177 reported residence (housing[5]) and 161 reported employment as most important need followed by drinking water and sanitation facility. Around 40 per cent of respondents reported need for water and sanitation facilities.

*Sheela Devi, 39 years of village Neelkanth Tola lives in one room with seven family members. The room is about 10X12 ft without ventilation and very dim light. All her family members are living and sleeping in the same room. Sheela's husband Sajjan is habitual drinker and in the night, he demands sexual relationship in front of sleeping children. When Sheela denies with the pretext that children are there, he starts abusing and beating her and establishes relationship without her consent ignoring whether children are awake or sleeping.*

[5] "Ownership of a house provides significant economic security and dignity in society to an individual. In the case of shelterless, rural below poverty line person, possession of a house brings about a profound social change in his existence, endowing him with an identity, providing his family with sense of security, thereby integrating him with his social milieu. House ownership enhances the basic confidence of a BPL household, thereby instilling a progressive mindset which is so essential for poverty alleviation". (See, Chapter V, Rural Housing. The Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 35.

*Now, Sheela is very disturbed and upset because following his father, her 16 years old son has started approaching her twelve years old sister. She also finds it difficult to talk to his husband on these issues because of his attitudes. Sheela says that it is not only her problem, it is with other families also. She knows the solution but she does not have money to build another room. Even if she manages money, she does not have space in the house for extension of another room.*

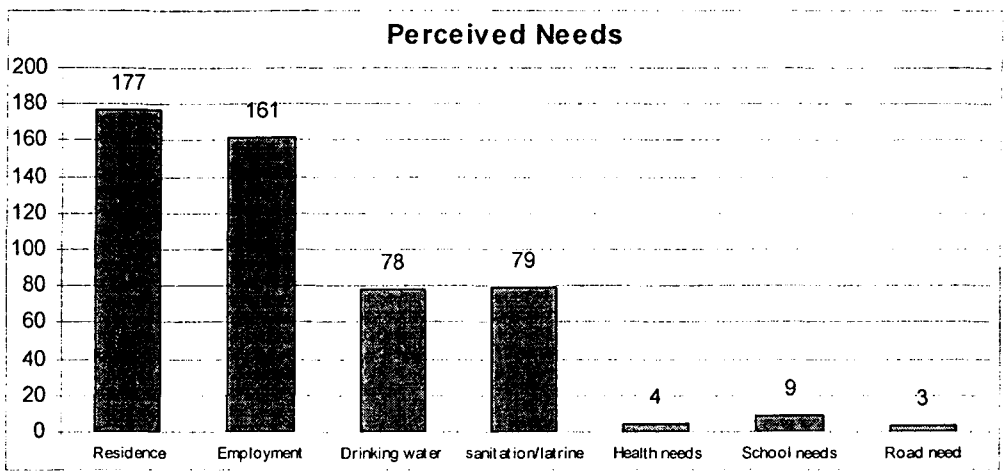


Figure 6.1: Women's perception of their varying needs

It was interesting to note that out of the 200 respondents only 4 perceived health need as the most important need. One of the possible reasons for this could be the low level of understanding of the women about what constitutes health needs for them. On the other hand, it could also represent the low priority given to health needs by the women (of the surveyed areas) compared to shelter and employment. Nine women perceived schooling[6] and three perceived need for proper road[7] as the most important need. The findings also show that the needs of poor are determined and guided by the social structure. These findings also show

[6] Despite the fact that Primary school enrolment in Bihar is 52 percent only, as against the national average of 77 percent; it is the only state where primary school enrolment fell in the 1990s. (See, http://www.empowerpoor.org/backgrounder.asp?report=187)

[7] Bihar only has 77 km of road length per 100 sq km, worse than Orissa which has 169 km. Interestingly, Bihar failed to use the Rs 7,000 crore it got under the Pradhan Mantri Gram Sadak Yojana. Pradhan Mantri Gram Sadak Yojana, launched in December 2000, to provide road connectivity to 1.6 lakh remote habitations with a population of over 500 by the end of the Tenth Plan period. Till December 2002, connectivity was provided to over 12,000 habitations at the cost of around Rs 3,300 crore. (See, http://www.empowerpoor.org/backgrounder.asp?report=187)

the same. The residence[8] or shelter emerged as the most important need where 88 per cent of respondents reported it, followed by need for employment which is directly associated with food and cloth, considering most of the respondents belong to poor community and work as agriculture labourer as daily wages workers.

78 and 79 (around 40 Per cent) women reported drinking water and sanitation need as most important need which show the poor drinking water source availability and lack of sanitation facilities[9]. Most of the houses do not have latrines (toilets[10]) and women and children were compelled to go to the fields. The practice of open defecation is also because of combination of reasons, the most prominent of them is the traditional behavioural pattern and lack of aware ness of the people about the associated health problems. In certain cases, lack of access to affordable and appropriate technology is also one of the constraints. Despite this, one can imagine the situation where women have to go to the field at nights for this purpose. Secondly it is also associated with the issue of security. At the time of floods, situation becomes even worse.

It was found that non-availability of proper drinking water and sanitation facilities was one of the major causes of water borne disease like diarrhoea and other infectious disease such as Schistosomiasis, Dysentry, Japanese Encephalitis, Malaria, Dengue fever, Trachoma and women and children were more vulnerable to it. Moreover, indirect loss of working days due to repeated episodes of these diseases results in huge economic loss. It was also interesting to note that despite having poor health status, health need as most important need was reported by only four respondents, which also show that these women were

[8] The fact is that in any given village/block/district a large number of eligible families have not yet been covered by the Indira Awaas Yojana (IAY). According to the mid-term appraisal of the Ninth Plan by the Planning Commission, "This is dividing the poor instead of helping them to organise into groups". In 2001, the housing shortage in the rural areas was estimated at about 148 Lakhs. (See, Chapter V, Rural Housing. The Annual Report (2005-2006). Ministry of Rural Development, Government of India. New Delhi. Pp 36.

[9] The figures show that spending on health, family, water supply and sanitation has come down in the last three years, from 6.5 per cent to 5.49 per cent of total public expenditure. (See, http://www.empowerpoor.org/backgrounder.asp?report=187)

[10] According to Census, 2001, only about 22 per cent of households in rural areas are estimated to have toilet facilities.

so occupied with their day-to-day living and survival that health hardly matters for them.

Only 9 women reported need of schooling which shows that there is less or no importance to children's education. But in later part of the findings, it was found that these women were very much concerned about their children's education. This contradiction was the reflection of priority for these women. In other words need for shelter, employment and drinking water, sanitation were so important for them that need for health facility and services, schooling and roads become or seem secondary although these were not secondary.

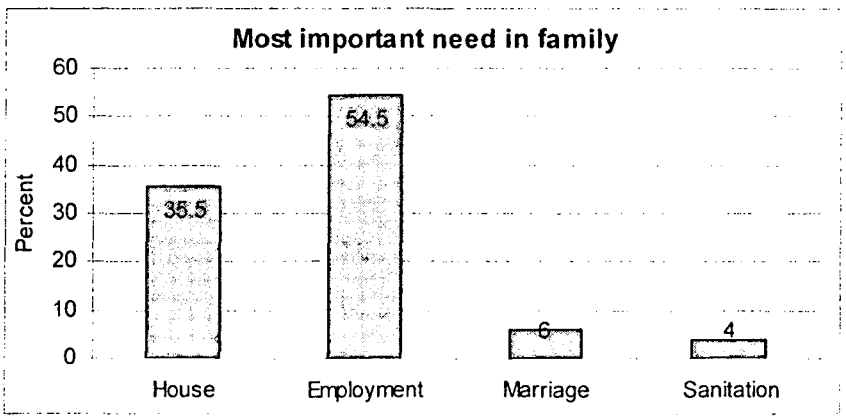


Figure 6.2: Women's perception of most important factor/need in the family

In response to the question about the most important factor/need in the family, housing and employment again emerged as most important factors where 33.5 per cent women reported for house, and 54.5 per cent reported for employment. Other important factors or challenges reported were marriage (with increasing dowry and associated cost) and sanitation (specially making latrine and installing hand-pump inside houses or in premises). It is interesting to note that none of the women were aware of the Central Rural Sanitation Programme[11] (CRSP), which provides 100 per cent subsidy for construction of sanitary latrines for Schedule Castes and landless labourers as per the prevailing rates in the States for the general public. Most of these women were using common well and

[11] The Central Rural Sanitation Programme (CRSP) was launched in 1986 by the Ministry of Rural Development with the objective of improving the quality of life of rural people and to provide privacy and dignity to the women.

community hand pump which is not well maintained and unhygienic conditions prevail around them.

Housing or home emerged as the important factor for the family because of various reasons. Firstly the same old house has more members with children getting married leading to extended family. Most of the houses are traditional Khaprail (mud-thatched) houses with no provision of extending extra floors and land is limited in which extension of house in old house is also limited (See the case study mentioned above, para 3, page 4). Now many of the families are forced to live in the same house leading to over-crowding. Although only 6 per cent of the respondents reported marriage as the important factor for the family, it was found that dowry and associated cost of marriage like reception and consummation (Gaunna) is one of the reasons for loans from Sahukars which amounts to thousands. There are lot of societal pressures for spending on marriage ceremony and dowry.

Dowry emerged as one of the most serious problems touching women's lives in modern India. "Taking dowry has emerged as a crucial index for women's status, not as a static custom but as a product of changing political, economic and social processes (Sheel, Ranjana. 1999[12])". Initially dowry was particularly linked with Bramha form of marriage which was prevalent among the propertied and upper castes. Initially it was gift given to daughter, but in modern time dowry has emerged as a practice with its forced demands for gift-giving. Later with time this practice has become institutionalized among other classes and castes of the society. Despite the concerns raised by social reformists and groups, the status remains unchanged.

Dowry, an integral part of the modern marriage system in India, has closely and crucially affected the status of women in contemporary Indian society and it prevails beyond the class and caste distinction with its wider ramifications visible in the form of bride-burning, suicides and harassments. Professor M.N.

[12] Sheel, Ranjana. 1999. The political Economy of Dowry: Institutionalization and Expansion in North India. Manohar Publishers and Distributors. New Delhi.

Srinivas (1984) has rightly commented that, "It is necessary to remember that dowry is the suttee of the twentieth century[13]".

## INFORMATION ABOUT SHG PROGRAMME

In response to the question on how the women came to know about IDF's CCA programme, 92 per cent women, reported that they came to know about this programme through the NGO and 8 per cent of them reported that village women or activists as the main source of information.

Table 6.1: Knowledge about SHG programme

| **Knowledge about SHG programme** | |
|---|---|
| NGO | 92 % |
| Village women or activist | 8 % |
| Total | 100 |

In focus group discussion, most of the women reported that they came to know about this programme through animators and social workers of the organization Integrated Development Foundation (IDF). These animators were appointed and trained by the NGO (IDF) to form self-help groups and organise meetings (on health, education and other related issues of their concern and convergence meetings with bank officials, panchayat leaders, block and health officials) and trainings (on skill development like candle-making, papad-making, sewing, and toy-making, etc) for the women. Some of the women also reported that they came to know about this programme through their relatives in another village and contacted animators and social workers showing their interest in forming the group.

## MOTIVATION BEHIND JOINING THE GROUP

In response to the question on what motivated them to join the group, 71 per cent women reported that it was increase in income, which motivated them to join the group. They also reported that they were also able to save money (some

[13] Srinivas, M. N. 1984. Some Reflections on Dowry. CWDS, New Delhi.

of the groups have good savings). Many of these groups have also opened their bank accounts.

Although the prime motive behind joining the group was increase in income, it was found that it is applicable to only one or two groups which are involved in some business and joint ventures like *Sattu* (flour of fried grams) and *Papad-making* business or embroidery. For rest of the groups and members, it was savings-credit activities without much impetus on increase in income. The women also reported various reasons associated with it which was a hindrance in starting any income generation activity. Primarily, it was lack of financial resource for starting an income generation activity. Group members were not able to generate enough money to start any income generation activity or small business despite having training and skills. Other problem was getting loans from the Bank because of women's lack of confidence in banking system and other associated apprehensions[14].

*Kaushlya Devi, 45 years, of schedule caste from Sadikpur Village is member of self-help group since last four years and has training in sewing and embroidery. She wants to set-up embroidery business with other group members for which there is market and she knows that one of the groups involved in the business is doing well and making profit. Nevertheless, she is not able to start the business because of lack of money. The others members do not want to invest initial amount involved. Besides the group does not have enough saving to start the business. Whatever savings the group is able to generate most of it goes in loan to members. She does not want to take Bank loan because other members are not sure of success of business and they are apprehensive of market.*

[14]Series of research studies done by NABARD, independently and in association with MYRADA, a leading non-governmental organization (NGO) shows that despite having a wide network of rural bank branches servicing the rural poor, a very large number of the poor continued to remain outside the fold of the formal banking system. The studies also showed that the existing banking policies, systems and procedures, and deposit and loan products were perhaps not well suited to meet the most immediate needs of the poor. It also appeared that what the poor really needed was better access to these services and products, rather than cheap subsidized credit. (See, Reddy, C. S., Manak, S. 2005. Self-Help Groups: A Keystone of Microfinance in India - Women empowerment & social security. Mahila Abhivruddhi Society, Andhra Pradesh)

Some of the women also reported that motivation behind joining the group was credit facility in hard times like health emergency, calamities or other personal and family need. It was also found that most of the women members used this facility.

In response to the question on motive of joining SHGs, 48 per cent women reported that saving money was primary motive whereas 42 per cent women said that it was common solution for major problem as well saving of money. This was also reflected during interview and case studies that major activity of the SHG was savings and credit, which helped members to save money and take loan or credit from the group in times of need and emergency.

Table 6.2: Motive behind joining SHGs

| **Motive of SHG** (Percent) | | | | |
|---|---|---|---|---|
| | | SC | OBC | Total |
| 1 | Common solution of major problems | 5.6 | 4.5 | 5.5 |
| 2 | Save money | 60.2 | 34.8 | 48 |
| 3 | Monetary help to members | 4.6 | 1.1 | 3 |
| 4 | 1 & 2 | 28.7 | 57.3 | 42 |
| 5 | 2 & 3 | 0.9 | 2.2 | 1.5 |
| | Total | 100 | 100 | 100 |

However, a relatively lower percentage of women reported finding common solutions to major problems as the motive for joining the SHG. It is also interesting to note that the notion to help other members was limited to providing loan from the group rather than other form of group help and support such as fighting against atrocities made on them or their group member or for the demand of their rights. Only 5.5 per cent of women reported that motive behind joining SHG was to find common solutions to major problems. Forty-two per cent women also reported that saving money and finding solutions to major problems was the prime motive. However, the women have not taken any initiative for common good except some initiatives taken on behalf of animators, social workers or the NGO.

Even though, there were no major differences as far response to this question is concerned, it was observed that the response to this question varied across caste groups. This was certainly more visible in terms of the responses related to saving money. While 60 per cent of SC women reported this to be the prime motive for joining SHG group, only 35 per cent of OBC women found this to be the major motive. On the other hand, a large majority of OBC women responded that saving money as well as finding common solution to problems as the prime motive for joining SHGs compared to SC women. It does appear that for SC women, who are mostly the poorer section in these sampled villages, the real motive of joining SHG is monetary benefits and savings and credit activity compared to OBC women who also see this as a forum for finding common solution to problems along with savings and credit activity.

## BELIEF IN SELF-HELP GROUPS

In response to the question about women's belief that SHG is the best help or unity is strength, 84.7 per cent women reported that self-help group is the best help, 8.2 per cent women reported that they believe that unity is strength whereas 7.1 per cent women reported that they believe in both.

Table 6.3: Women's believe in self-help groups

| **Do you believe in SHGs** (Percent) | | |
|---|---|---|
| 1 | SHG is the best help | 84.7 |
| 2 | Unity is strength | 8.2 |
| 3 | 1 & 2 | 7.1 |
| Total | | 100 |

Interestingly in focus group discussion, it was not very reflective that SHG is the best help except in case of savings-credit activities and that also for one or two groups involved in business. Unity was stronger in these women group members and it was very much reflected. It was interesting to find that despite the fact that many of these groups are not active today, group feeling among these women still persist and they consider themselves as unit of one family or group. Definitely, group formation has played an important role in uniting these women although they have not been able to achieve their rights and

respect in society considering the societal constraints, patriarchy and other social evils but they are aware of their poor status and denial of rights. They are still fighting for it within the boundary of their house and community. This is only possible because of their unity, strength, and support they get from each other.

## BENEFITS AND REACH OF THE PROGRAMME

To understand the impact of SHG programme on empowerment of women, a set of questions were asked on their perception of benefits from the programme in various spheres of activity of the women such as the household, society and other spheres. Needless to say these questions on perception are an important indicator of the way the women feel in terms of empowerment and access and reach of the programme in delivering such processes. Nonetheless, it is important to mention at the outset that these questions, which are based on the perception of women, are prone to the kind of subjective bias that would be visible in the case of questions related to perception. The answers to most of these questions were categorized under three categories, fully benefited, partly benefited and no change (not benefited).

In response to the question about benefits and reach of the programme, 71 per cent women reported that they have partly benefited from the programme, 22 per cent women reported full benefit and 7 per cent women reported that they have not benefited from the programme. In focus group discussion, it was found that those who reported benefits were mostly women who participated in the savings and credit activities like taking loans from the group or bank and participated in training programmes and skill development programmes organized by the NGO.

Table 6.4: Benefits of the programme across blocks and caste groups

| **Do you feel the benefit of CCA programme** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Fully beneficial | 29.4 | 13.3 | 10.2 | 36.0 | 22 |
| Partly beneficial | 70.6 | 72.4 | 82.4 | 58.4 | 71 |
| Not at all | 0.0 | 14.3 | 7.4 | 5.6 | 7 |

Considerable variation was seen across blocks as well as caste groups regarding women's perception of benefits from the SHG programme. It appears from the responses that women in Phulwari were more satisfied by the extent and reach of the programme than the women in Maner. In fact, 14 per cent women in Maner did not see any benefit of the programme. On the other hand, 29 per cent of women in Phulwari reported full benefit from the programme compared to only 13 per cent women in Maner. Similarly, across caste groups, OBC women reported greater satisfaction from the programme compared to SC women. Compared to 36 per cent of OBC women reporting full benefit from the programme, only 10 per cent of women from SC community felt full benefit from the programme. It does appear from the responses that the programme has benefited the developed block as well as developed community (OBC) more than the underdeveloped block of Maner and the disadvantaged community of Schedule Castes[15]. This is particularly worth noticing given the fact that the programme is supposed to have special focus on SC women.

The women also reported during focus group discussion that they benefited in terms of knowledge, skills, awareness and rights, which they did not have before joining the group. All the group members were given training in first-aid and provided with first-aid tool kit within the reach of the group. Many of them also benefited through training programmes where they learnt about candle-making, papad-making and other skills such as sewing, knitting and embroidery work. They also benefited by participating in convergence programmes and interface meeting organized by the NGO (IDF) to help the women to reach and access banks, hospitals, block and panchayat officials, etc. It was also found that the women who reported that they have not benefited were having more expectation from the programme in terms of help, services and provisions.

In response to the question on 'how this programme helped them', 53.5 per cent women reported that the programme helped them economically, 26 per cent reported that it helped them in saving money whereas 18.5 per cent women

[15] However, more SC women did report partly benefiting from the programme compared to OBC women. Moreover, even though marginal, more percentage of SC women have reported no change compared to OBC women.

reported that it provided them economic independence. Two per cent women reported that the programme helped them by providing training and skills.

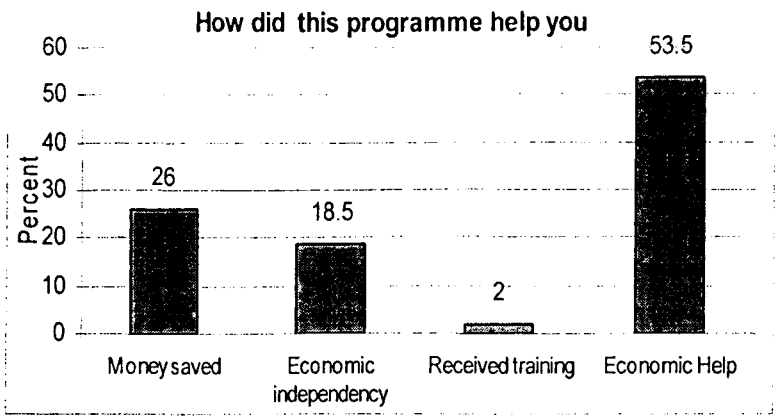


Figure 6.3: Women's perception of benefits of the programme

Table 6.5: Help from the programme across blocks and caste groups

| **How did this programme help you** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Money saved | 48.0 | 3.1 | 39.8 | 10.1 | 26.0 |
| Economic independency | 31.4 | 5.1 | 6.5 | 33.7 | 18.5 |
| Received training | 2.0 | 2.0 | 0.9 | 3.4 | 2.0 |
| Economic Help | 18.6 | 89.8 | 52.8 | 52.8 | 53.5 |
| Total | 100 | 100 | 100 | 100 | 100 |

In response to this question also, considerable variation was seen across blocks and caste groups. The major form of benefit for women in Maner was in terms of economic help from the SHG. Very few women reported benefiting in terms of money saved, economic independence and training. On the other hand, almost 48 per cent of women in Phulwari reported benefiting from the SHG activity in the form of money saved. Around 31 per cent of women in Phulwari also felt that it helped them in terms of economic independence compared to only 5 per cent women in Maner.

Across caste groups, the major variation was seen in terms of benefit in the form of money saved and economic independence. While a greater percentage of OBC women felt that it benefited them in terms of economic independence,

more percentage of women among SC households felt that it benefited them in terms of money saved. It appears from the above table that for poorer women from the Schedule Castes, the benefit of the programme is more in terms of saving and credit activity of the SHGs. On the other hand, participation in the SHGs activity is also leading to OBC women feeling economically independent. The differences on this count are not easily explainable but a possible explanation of such different responses could be the fact that the OBC women are also able to translate this gain from economic help or other economic activities into economic independence. Which in the case of SC women despite economic gain and money saved does not translate into economic independence. In many cases, especially in the rural context of Bihar, access to money saved or economic help need not translate into economic independence, if the woman does not also gain the independence to spend it or decide on the possible expenditure pattern. Such factors are also conditioned by the social factors such as the power relations within the household as well as the status of women within the family and society.

The programme helped more than half the members by providing credit and loans in emergency and need. It is important to note that earlier the women were dependent on moneylenders and Sahukars for loans, which were available on higher rates and it was almost a loan-trap for them from which it was very difficult to come out. The programme provided them a forum where they can get loans at very nominal rates and it was a loan from their own group where they had a say and they were very much part of it.

The programme also helped the women in saving money, which provided them economic independence. This independence was very much reflective in their confidence and behaviour. This confidence was there because of their belief and confidence in the group. This confidence was also there because of the feeling in the women that they have their own system, which is for their own benefits and support in times of need and emergency. Another factor, which helped them, was the accessibility of the programme. It was easier for women to borrow money from the group any time without any problem. Moreover, they have to approach their own group members.

## WOMEN'S PERCEPTION OF BENEFITS FROM THE SHG PROGRAMME

In response to the question on how this programme benefited them, there were varied opinions on different issues. Broadly, responses were under three categories of fully benefited, partly benefited and not benefited.

This question was asked to women to understand their perception of benefits from SHG programme in various spheres of their day-to-day life. The question elicited responses on their perception of benefits in terms of increase in income, increase in employment opportunity, help, importance in the family, importance in the community, social security, family empowerment, cooperation in social processes, relationship among friends, change in awareness levels, and improvement in their own health as well as family health.

Table 6.6: Benefits from the programme across blocks and caste groups

| **How has the programme benefited you** (percent) | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Fully benefited* | *Partly benefited* | *Not benefited* | *Fully benefited* | *Partly benefited* | *Not benefited* | *Fully benefited* | *Partly benefited* | *Not benefited* | *Fully benefited* | *Partly benefited* | *Not benefited* | *Fully benefited* | *Partly benefited* | *Not benefited* |
| | **Phulwari** | | | **Maner** | | | **SC** | | | **OBC** | | | **Total** | | |
| Increase in income | 25 | 9 | 67 | 8 | 31 | 61 | 5 | 16 | 80 | 31 | 24 | 45 | 17 | 20 | 64 |
| Employment Opportunity | 25 | 17 | 59 | 7 | 58 | 35 | 4 | 33 | 63 | 31 | 40 | 28 | 16 | 37 | 47 |
| Some help | 34 | 63 | 3 | 24 | 62 | 14 | 14 | 77 | 9 | 48 | 45 | 7 | 29 | 62 | 9 |
| Got importance in family | 74 | 2 | 25 | 78 | 16 | 6 | 64 | 11 | 25 | 89 | 7 | 4 | 76 | 9 | 16 |
| Got importance in community | 73 | 2 | 25 | 74 | 20 | 5 | 66 | 10 | 24 | 82 | 12 | 6 | 74 | 11 | 16 |
| Social security | 73 | 3 | 25 | 67 | 26 | 7 | 63 | 15 | 22 | 78 | 13 | 9 | 70 | 14 | 16 |
| Family empowerment | 73 | 2 | 25 | 72 | 21 | 6 | 62 | 15 | 23 | 84 | 8 | 8 | 73 | 12 | 16 |
| Cooperation in social processes | 72 | 8 | 21 | 81 | 14 | 5 | 69 | 13 | 19 | 84 | 9 | 7 | 76 | 11 | 13 |
| Better relations and more friends | 71 | 28 | 1 | 87 | 12 | 1 | 67 | 31 | 2 | 91 | 9 | | 78 | 21 | 1 |
| Awareness levels increased | 44 | 27 | 28 | 47 | 33 | 20 | 34 | 33 | 34 | 61 | 26 | 13 | 46 | 30 | 24 |
| Improvement in personal health | 38 | 27 | 34 | 43 | 22 | 35 | 26 | 30 | 44 | 58 | 18 | 24 | 41 | 25 | 35 |
| Improvement in family health | 39 | 25 | 36 | 44 | 24 | 32 | 26 | 25 | 48 | 61 | 20 | 19 | 41 | 24 | 34 |

About increase in income, 17 per cent women reported that they fully benefited, 20 per cent women reported that they partly benefited and 64 per cent women reported not benefited. In fact, the women engaged in or associated with group business like, *Papad-making* and other initiatives reported fully benefited. Twenty per cent women reported partial benefit from the programme because of their short-term investment or failure of initiatives taken by them due to various reasons of limited investment, lack of support from other members, and in-group politics and dynamics. However, compared to 25 per cent women in the developed block of Phulwari reporting full benefits from SHG activity, only 8 per cent women in Maner felt that they fully benefited from the programme. This was also the case across caste groups with only 5 per cent of SC women reporting full benefit of the programme compared to 31 per cent of OBC women reporting full benefit from the programme. Interestingly, while a large majority of SC women (80 per cent) reported no increase in income, the percentage in the case of OBC women was much lower at 45 per cent only. Nonetheless, it is important to note that, despite the stated objective of increasing income opportunities through SHG activity, majority of women (64 per cent) reported no noticeable change in income.

Similar trend was seen in terms of women's perception of change in employment opportunity. Roughly, half (47 per cent) of all women reported no change in employment opportunity as a result of SHG activity. However, even among respondents of this question, there was considerable variation across blocks and caste groups. While 25 per cent of women in Phulwari reported full benefit from SHG activity, only 7 per cent women in Maner reported that they benefited fully from SHG activity. This was also seen across caste groups where compared to 31 per cent of OBC women reporting full benefit from SHG activity, only 4 per cent of SC women reported full benefit from SHG activity. Moreover, compared to 28 per cent of OBC women reporting no benefit from SHG activity with regard to increased employment opportunity, 63 per cent of SC women felt that SHG activity did not result in increased employment opportunity. The trend was more or less similar for the next question on whether SHG activity helped them in anyway. That is, while the programme does seem to indicate that the developed blocks and better off castes have been able to utilize and benefit from

SHG activity, the poorer caste groups as well as backward blocks seem to be lagging behind on this aspect.

The next set of questions was on whether participation in SHG activity has helped them in anyway in getting more importance either in the family or in the community. This is expected, if SHG activity is successful, not only because of its monetary spillover in terms of women having more access to income and employment opportunity but also by the fact that such group activity may encourage women to feel empowered and thus stake a greater role in decision taking within the household as well as within the community. In other words, these are also an indicator of the changing status of women within the household as well as within the community as a whole. On this count, there was a large response in favour of the fact that SHG activity has helped them in getting importance within the family as well as within the community.

*Gita Devi, 44 years (Schedule Caste) of Ganparkona is member of SHG since last four years. She feels that although she gets importance in the family, the importance and respect is because of her association with the group. Moreover, the family members believe that this association will bring money from the group to meet family needs in emergency. It happened in past that she has taken loan from the group to meet family members need but none of the family member asked from where is she paying the loan amount. Therefore, this importance is also opportunistic and need based. Whereas importance in the community is concerned, she does feel that there is some change because of her association with SHG.*

Around 75 per cent women reported that they got importance within family and household, while 16 per cent did not feel any change in their relative importance within the family or community. Interestingly, there was almost negligible variation across blocks in response to these questions. But in terms of women who reported no benefit, there was greater dissatisfaction in Phulwari compared to Maner where there were very few women who reported no benefit on this count. However, across caste groups, the OBC women felt more benefit in

terms of importance within the household and within community compared to SC women. Nonetheless, the difference was marginal.

This was also the trend for the next set of questions, which asked on their perception about benefits from SHG activity in terms of social security, family empowerment, cooperation in social processes and better relation and more friends. Even the block wise and caste wise trends were similar in this regard. In all of these questions, almost three-fourth of women felt that they benefited out of the SHGs activity. These responses tend to confirm the finding that even though the SHG activity has not been beneficial in terms of economic empowerment, its impact on social and community empowerment has been significant and positive. However, even here, the OBC caste group seems to have benefited more than the SC women have.

The next question was on whether they felt that awareness level among them have increased. While the response to this question was not categorically in favour of positive impact with 46 per cent women reporting full benefit, almost one fourth of women also felt that they did not benefit in terms of increase in awareness. Within caste groups, awareness level increased more for OBC women compared to SC women.

Finally, the last two questions in this sub-section dealt with the health status of women respondents and their families. Around 41 per cent women reported that felt that their health status as well as their families' health status has increased because of SHG activity. But what was equally important to notice was the fact that close to 35 per cent women also felt that it did not benefit them or their families at all.

The overall findings show that these women benefited from the programme through increase in income, employment opportunity and recognition within the family, community and society. They also benefited in terms of knowledge and awareness. The women also reported during focus group discussion that their knowledge level has increased on issues related to health improvement and care of personal health as well as family health.

Although all members of the programme did not fully benefit by the programme, it reached most of the women. Practically also, it was not possible to get benefit of the programmes for all women, because of various reasons like group dynamics and performance, etc. It also emerged that reporting of benefits is also dependent on individual and group expectations from the programme and their perception.

## SOURCE OF INCOME BEFORE AND AFTER JOINING THE GROUP

Given the predominant role played by SHG activity in income generation, it was also asked from the respondents, if there were changes in the primary source of income of the households before and after joining the SHG. The first set of responses regarding the primary source of income before joining the SHG indicated the overwhelming presence of agriculture labourers among the respondents.

Table 6.7: Source of income before the help across blocks and caste groups

| **Source of income before the help** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Agriculture in own land | 13.7 | 0 | 0 | 16.1 | 7.1 |
| Share-cropping | 1.0 | 0 | 0 | 1.1 | 0.5 |
| Agriculture on Leased land | 1.0 | 1.1 | 0.9 | 1.1 | 1.0 |
| Agriculture Labour | 77.5 | 78.9 | 87.9 | 66.7 | 78.2 |
| Non agriculture labour | 0 | 13.7 | 8.4 | 3.4 | 6.6 |
| Business | 6.9 | 1.1 | 0.9 | 8.0 | 4.1 |
| Regular Employment | 0 | 5.3 | 1.9 | 3.4 | 2.5 |
| Total | 100 | 100 | 100 | 100 | 100 |

However, as expected there were some variations expected across blocks in the occupational pattern of respondents. As is evident from the table above, in the developed block (Phulwari) around 14 per cent women reported themselves as cultivators (agriculture in own land). On the other hand, in Maner, there were no households which identified themselves as cultivators. On the other hand, an equal percentage of households reported engaged in non-agriculture labour. Similarly, the developed status of Phulwari also meant that there were 7 per cent

households engaged in business while there were only 1 per cent families engaged in business in Maner. However, in Maner there were also some households which reported themselves as employed in regular employment. Further probing revealed that these were low caste workers working as menial labourers in the nearby Bata shoe factory.

But the variation across caste groups was clearly reflective of the disadvantaged position of the SC households' vis-à-vis OBC households. Compared to around 18 per cent households among OBC who were engaged in cultivation either as own land cultivators or leased land cultivators, there were no families who declared themselves as cultivators. Most of the SC households were agricultural labourers with 88 per cent of them reporting as agricultural labourers compared to only 67 per cent among OBC households. Also important to note is the variation between SC and OBC households in the own business category. While only 1 per cent SC households reported business as primary source of income, 8 per cent of OBC households reported business as primary source of income.

The findings show that these households were primarily dependent on agriculture labour as the main source of income. However, this income is dependent upon agriculture, crop- patterns and other agriculture related factors like, rain, drought, flood, seed prices etc.

It was found that after joining the group or getting some help through the programme, source of income were largely same with some variations. It was found that before joining the group or help, 78.2 per cent women were getting income from agriculture but after help, it declined to 72.6 per cent. It was also found that there is increase in income from service and business after joining the group. Although this change is not very significant but the new group emerged, which was dependent on business, and agriculture labour, which is important change showing increase in business and income generation activity among group members.

Table 6.8: Source of income after the help across blocks and caste groups

| **Source of income after the help** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Agriculture in own land | 22.5 | 0 | 0 | 26.4 | 11.7 |
| Agriculture on Leased land | 0 | 1.1 | 0.9 | 0 | 0.5 |
| Agriculture Labour | 71.6 | 73.7 | 84.1 | 58.6 | 72.6 |
| Non agriculture labour | 0 | 13.7 | 9.3 | 2.3 | 6.6 |
| Business | 5.9 | 4.2 | 1.9 | 9.2 | 5.1 |
| Regular Employment | 0 | 7.4 | 3.7 | 3.4 | 3.6 |
| Total | 100 | 100 | 100 | 100 | 100 |

Although, for majority of the households, there was no change in primary source of income after SHG help, there were some noticeable changes, which also throw light on the pattern of utilization of SHG's help in terms of income opportunities. First thing to note is that in all the categories, there was a negligible decline in the percentage of households reporting agricultural labour as primary source of income. The only group, which has seen a larger decline in share of agricultural labourers, is the OBC group where it declined from 67 per cent to 59 per cent. But apart from this, the real change is among the cultivators group with the percentage of such households increasing in the developed block of Phulwari as well as among the relatively well off caste group of OBCs. There was also some increase in business activity in Maner with 4 per cent households reporting own business as primary source of income. But, a closer look at the caste wise column also suggests that again the OBC households seem to have gained much more than the SC households. However, overall the distribution of households by primary source of income does not suggest that SHG involvement has altered the primary source of income for majority of the households and agriculture continues to be the major source of income for majority of the households. This fact is worth noting, for the simple fact that SHG activity is supposed to provide savings and credit to these households to start their own business or diversify their primary source of income towards other non-agricultural activities. However, it appears from the observations that such a process even though visible, is negligible to have any substantial impact on the income pattern of the women's households.

## CONTROL OVER INCOME

Further probing questions were asked to understand the extent of economic empowerment of the women in terms of their control over income and their involvement in the decision making process of expenditure. These are important indicators of how much of economic empowerment has been achieved by the women with regard to their role in economic issues.

In response to the question on who controls your income, 76.8 per cent women reported that they themselves control, 14.1 per cent women reported that it is controlled by husband and 6.1 women per cent reported that it is controlled by both husband and wife together. It is a good sign of independence and autonomy[16] as seen by the women's on control over their income. Most of the women reported during focus group discussion that their income is so marginal that hardly they get money accumulated. Most of the money, which they earn, was spent in day-to-day house hold management, children's education and health etc.

*Sharbatia Devi, 38 years old (Schedule Caste) of Alipur village is associated with the group since last three and half years. She says that she herself keeps the money and decides about spending. In her family two children and husband is there. She says that whatever she has, she spent on children and for household expenses and husband knows about it. But for bigger spending such as buying sewing machine, she took permission of her husband despite the fact that she got half of money from her mother.*

Although the women reported that they do not have huge personal savings or money, the autonomy to spend their own income is a very good sign of their empowerment and independence. In general, it is believed that husband or male member in the family controls the income and decide about spending which was not found here except in a few cases. Secondly here income means income generated by these women through agriculture or non-agriculture labour.

[16] It is also a fact that female autonomy has been found to change over the course of a women's lifetime. Women acquire more autonomy as they age and produce sons, and then lose autonomy when they are elderly or widowed.

Table 6.9: Control on income across blocks and caste groups

| **Who controls your income** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Self | 93.0 | 60.2 | 74.1 | 80.5 | 76.8 |
| Husband | 6.0 | 22.4 | 14.8 | 12.6 | 14.1 |
| Fathers-in-law | 0 | 3.1 | 0.9 | 2.3 | 1.5 |
| Mothers-in-law | 0 | 2.0 | 1.9 | 0 | 1.0 |
| Son | 1.0 | 0 | 0.9 | 0 | 0.5 |
| Together | 0 | 12.2 | 7.4 | 4.6 | 6.1 |
| Total | 100 | 100 | 100 | 100 | 100 |

Although variation in responses to this question across caste groups was marginal with 81 per cent of OBC women reporting controlling income themselves compared to 74 per cent of SC women, the variation across blocks was clearly indicative of the fact that in the developed block (Phulwari) women had greater say in controlling income (93 per cent) compared to women in Maner (60 per cent). In Maner, while 22 per cent women reported that their husbands control income, in Phulwari this was only 6 per cent of women. Also, while no women reported that their income is controlled by their in-laws in Phulwari, around 5 per cent of women in Maner reported that their income is controlled by their in-laws. However, 12 per cent women in Maner also reported that they jointly control income along with husbands.

## DECISION ON DOMESTIC AND OTHER EXPENSES

In response to the question on who plans or decides your domestic and major expenses, 47 per cent women reported that it is by self, 38 per cent women reported that it is decided by husband and 12 per cent women reported that it is controlled by both. It is interesting to note the difference between control over income and control over decisions on domestic and major expenses.

Table 6.10:
Decision on domestic and major expenses across blocks and caste groups

| Who plans your domestic and major expenses (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Self | 51.0 | 42.3 | 43.9 | 49.4 | 47 |
| Husband | 37.0 | 39.2 | 39.3 | 36.8 | 38 |
| Fathers-in-Law | 0 | 3.1 | 0.9 | 2.3 | 2 |
| Mothers-in-Law | 0 | 1.0 | 0.9 | 0 | 1 |
| Son | 2.0 | 0 | 1.9 | 0 | 1 |
| Together | 10.0 | 14.4 | 13.1 | 11.5 | 12 |
| Total | 100 | 100 | 100 | 100 | 100 |

To the question on control over income, 76.8 per cent women reported that it is control by them but only 47 per cent of them plan the major expenditure or spending on domestic and other major expenses. It is also interesting to note that 14.1 per cent husbands have control over their wives' income but whereas spending in concerned, 38 per cent husbands decide and plan for it. Only 12 per cent women reported that it is decided jointly. It was also found that fathers-in-law, mothers-in-law and sons have a minimal role over control on both income and expenditure.

It was also found that most of these expenses are related to day-to-day living. As far as variations across blocks and castes is concerned, the trends are along similar lines as was the case with previous question with women from developed block (Phulwari) and well-off castes (OBC) marginally better off in terms of decision making role in expenditure.

## CHANGES IN EXPENDITURE PATTERN

To ascertain the impact of SHGs activity on women empowerment, questions were also asked regarding changes in expenditure pattern for some broad group of expenditures. These were expenditure on food, children's education, children's medicine, medicine to prevent diseases, health, social festivals, family clothing, house maintenance, entertainment and comfort. In response to the question on change in expenditure before and after joining the SHGs, it was found that there is no exceptional change except for increase in

expenditure on health[17], and children's education. The major noticeable increase was on health and medicines. For food, social festivals, family clothing, house maintenance, entertainment and comfort, majority of the responses were no change in expenditure pattern. On the other hand, responses on children's education, children medicine, medicine to prevent diseases and health did suggest changes in expenditure pattern as a result of SHG activity. However, within these broad groups of expenditures, there was considerable variation across blocks and caste groups.

Table 6.11: Change in expenditure pattern across blocks and caste groups

| **Has your expenditure on the following changed** (Percent) | *Increased* | *Decreased* | *No Change* | *Increased* | *Decreased* | *No Change* | *Increased* | *Decreased* | *No Change* | *Increased* | *Decreased* | *No Change* | *Increased* | *Decreased* | *No Change* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Phulwari** | | | **Maner** | | | **SC** | | | **OBC** | | | **Total** | | |
| Food materials | 1 | 0 | 99 | 9 | 1 | 89 | 5 | 0 | 95 | 6 | 1 | 93 | 5 | 1 | 94 |
| Children education | 61 | 0 | 39 | 48 | 3 | 48 | 40 | 2 | 58 | 72 | 1 | 27 | 55 | 2 | 43 |
| Children medicine | 0 | 50 | 50 | 29 | 23 | 48 | 12 | 22 | 65 | 17 | 53 | 30 | 14 | 37 | 49 |
| Medicine to prevent deceases | 0 | 42 | 58 | 38 | 22 | 40 | 16 | 14 | 70 | 22 | 52 | 26 | 19 | 32 | 49 |
| Health | 61 | 0 | 39 | 76 | 3 | 21 | 55 | 2 | 43 | 84 | 1 | 15 | 69 | 2 | 30 |
| Social festivals | 2 | 1 | 97 | 2 | 3 | 95 | 1 | 2 | 97 | 3 | 2 | 94 | 2 | 2 | 96 |
| Family clothing | 4 | 0 | 96 | 4 | 1 | 95 | 3 | 0 | 97 | 6 | 1 | 93 | 4 | 1 | 95 |
| House maintenance | 7 | 0 | 93 | 4 | 1 | 95 | 3 | 0 | 97 | 9 | 1 | 90 | 6 | 1 | 94 |
| Entertainment | 3 | 0 | 97 | 1 | 1 | 98 | 0 | 0 | 100 | 5 | 1 | 94 | 2 | 1 | 97 |
| Comfort | 8 | 0 | 92 | 1 | 1 | 98 | 1 | 0 | 99 | 9 | 1 | 90 | 5 | 1 | 95 |

Major items of expenditure where there was clear evidence of increase in expenditure were education of children and health. Of which, the highest percentage of responses of increase were for health. It was found that this increase was because of two reasons. Firstly, because of the women's awareness and consciousness about health and hygiene have increased. This increase was primarily because of women's participation in the SHG programme and secondly, because of other influences like awareness through media, etc. The other major reason behind increase in spending was lack of functional availability of

[17] It is estimated that health related expenditure is the major cause for rural indebtedness and out of pocket expenditure on hospital care causes almost 25 per cent of hospitalised Indians to fall below poverty line (Source: Singh, Subhra. 2005. National Rural Health Mission. Yojana. Vol. 49, July 2005. Ministry of Information and Broadcasting: New Delhi.)

government health facilities and services at cheaper rates and people's dependence on private doctors and quacks for health services, who charge them high prices for medicines. Generally, they charge double the price of the medicines, and in many places they sold physicians sample which these private practitioners get free of cost from pharmaceutical company representatives or medical representatives. It is well known that health care costs have a devastating effect, particularly on the lives of the poor, often impoverishing them. The other important finding was their belief in private doctors and health services. There is the belief that, they will get better treatment from private practitioners in comparison to government dispensaries, sub-centres and primary health centres, where medicines are hardly available. 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[18]. Another reason for approaching the private practitioners and quacks are their easy reach and availability. It is difficult to reach the government dispensaries and sub centres in emergency because of poor roads and communication, timing of the centres and non-availability of the doctor and the para-medicals.

The other noticeable increase in expenditure was on children's education. It was found that most of the women are concerned about their children's education and some of them send their children to private schools. There is awareness about importance of education and the women also feel that education is one of the major reasons behind their backwardness. Most of the children go to government schools which at many places are functional sub-optimally with only two or three teachers for seven classes. There are no adequate classrooms, toilets and teaching aid facilities. Besides, teacher's attendance in schools is very poor.

Expenditure on children's education while in Phulwari showed 61 per cent of the women reporting increase in expenditure, it was 48 per cent in Maner. The increase in expenditure in Phulwari compared to Maner could be due to the

[18] Ahuja, Rajeev. 2005. Universal Health Insurance Scheme. Yojana. Vol. 49, July 2005. Ministry of Information and Broadcasting: New Delhi

increased demand for education in the developed block of Phulwari which also has higher literacy levels compared to Maner. It is possible that the higher demand for education has also meant more number of private educational institutions filling up the gap in demand and supply. However, a look at the caste wise trends also suggests that this is primarily among the well-off OBC households (72 per cent) compared to SC households (40 per cent).

The trend for health expenditure also suggests a similar trend with health expenditure increasing by 84 per cent among OBC women households compared to only 55 per cent households within SC community. A possible explanation for this could be the low level of awareness among SC women regarding their health needs and lack of knowledge regarding need for medical attention. However, in some ways the presence of better public health institutions in Phulwari also explains partially the variation across blocks on this count where increase in health expenditure in Maner is higher for 76 per cent of households compared to only 61 per cent households in Phulwari.

However, the curious aspect of the finding regarding change in expenditure pattern is the decline in expenditure reported by households on medicine both with regard to children's medicinal expenditure as well as expenditure on prevention of diseases. Overall 37 per cent women reported decline in expenditure on children's medicine while 32 per cent women reported decline in medicine expenditure for preventive purposes. Incidentally, no women reported any increase in expenditure on these heads in Phulwari block while 29 per cent women in Maner reported increase in expenditure in children's medicine and 38 per cent women reported increase in medicinal expenditure on preventive purposes. One of the possible reasons for this appears to be the low level of penetration of government health services in Maner both in terms of access and availability. In other words, high dependence on private medical care might be responsible for increase in medicinal expenditure in Maner block. Low level of access to government health services also means that even the associated government programmes on immunisation and children health programmes have not been able to have a significant impact in this block.

Another interesting observation in this regard which justifies the previous reasoning is the variation across caste groups where the decline in medicinal expenditure is higher for OBC caste groups compared to SC caste groups. It could possibly be due to the fact that the well off castes such as the OBC castes are in a better position to take advantage of the government health services both due to high level of literacy and awareness as well as due to less discrimination in accessing these services compared to SC households. Compared to SC households (22 and 14 per cent) who have reported decline in expenditure on medicines, 53 and 52 per cent of OBC households have reported decline in medicinal expenditure.

## DEPENDENCE ON SAHUKAR

It is interesting finding to note that 99.5 per cent women reported that their dependence on Sahukars[19] or moneylenders has decreased. Before joining the group, they were fully dependent on Sahukars for money in time of need and urgency because there was no other place or source on which they can rely. It was found that after joining the group most of the women took loan from the group and repaid it within stipulated times. It was also found that their dependence on Sahukars has decreased but not ended because of the group's limited saving capacity and loan amount. That is, the women are still approaching the Sahukars for bigger amounts.

The loan from the group was very attractive to the women because of various reasons. First of all the interest rate on loan money was very nominal and within the paying capacity of the women whereas loan repayment to Sahukar was based on compound interest system and it was beyond the reach of many women to repay the loan within the stipulated time considering the very high interest rate charged by the Sahukars. The other negative aspect of loan from Sahukar was exploitation by Sahukars in terms of taking their property documents or jewellery

[19] The word 'Sahukar' derived for those individuals offering finances without any proper Government licenses is commonly observed in rural areas and semi-urban places. These persons (Sahukars) used to pledge valuables and fixed assets as collateral security against loans offered by them and used to charge extra interest on delays and repayments.

as security which many a time moneylenders and Sahukars did not give back which is required even for taking loan from government for agriculture and for other government programs. What makes the debt-trap more dangerous is the heavy dependence on professional moneylenders and Sahukars, who charge annual interest rates as high as 60 per cent. The NSSO survey shows that they comprise the second most important source of loans for farmers (26 per cent), after banks (36 per cent). Despite their 100-year-old existence and grassroots reach, cooperative institutions are a poor third source (only 19.6 per cent)[20]. An interesting finding of NSSO's survey is that many of the country's poorest states have a considerably better debt record: Bihar (33 per cent), Uttar Pradesh (40 per cent), Orissa (48 per cent) and Jharkhand (20.9 per cent).

Twenty-five per cent women reported that they regularly take loans from Sahukars, which shows their dependence on the Sahukars. They take loans from the Sahukar because there is no fixed income in the family. Most of the women are agricultural worker and workers in informal sector without any social security and benefits. Even if they fall ill, they do not get work and lose income but it increases expenditure heavily on the family in terms of medicine and consultancy fee charged by quacks and private doctors.

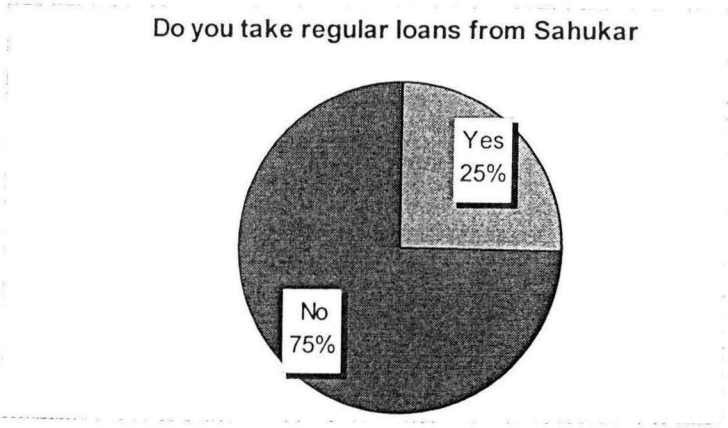


Figure 6.4: Loaning pattern and dependence on Sahukar

[20] National Sample Survey Organisation (NSSO), under the Union ministry of statistics and programme implementation. The report was released on May 3, 2005.

The other reason for taking loans from Sahukar is heavy spending on social functions like, marriage, death and other occasions where they spend money beyond their capacities because of societal pressure and demand. Dowry is another evil for which at times they take loans from Sahukar.

Table 6.12: Loan from Sahukar across blocks and caste groups

| **Do you take regular loans from Sahukar** (Percent) | | |
|---|---|---|
| | Yes | No |
| Phulwari | 15.0 | 85.0 |
| Maner | 35.7 | 64.3 |
| SC | 30.6 | 69.4 |
| OBC | 19.5 | 80.5 |
| Total | 25.3 | 74.7 |

It was also observed that more households from the underdeveloped block of Maner and the disadvantaged group of SC households were dependent on loan from Sahukar than the developed block of Phulwari and the relatively better off group of households represented by the OBC households.

Ten per cent women reported that rate of interest charged by the Sahukars or moneylenders is 10 per cent monthly where as 8.9 per cent women reported 10-12 per cent rate of interest and 13.5 per cent women reported that rate of interest varies between 5 to 10 per cent.

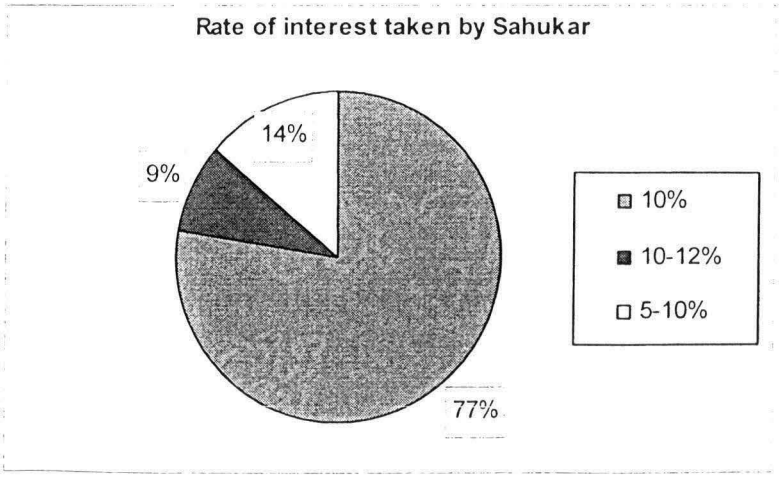


Figure 6.5: Rate of interest charged by Sahukar

It was reported during focus group discussion that the rate of interest also depends upon individual Sahukars and their relationship and terms with borrower. It was found that the general rate of interest is ten per cent monthly, which is high, considering the women's economic status and income. If one compares the interest rate between the loans taken from the group and Sahukars, there is a huge gap. The group provided loan to members on interest rate of 1 to 2 per cent and in some cases, they waived the interest considering the economic condition of the borrower. However, there was no evidence of differential rate of interest being charged by different caste groups.

The findings show that most important reason for taking loan was illness. Out of 200 women, 180 reported that they take loans from Sahukars or moneylenders for health care, and treatment.

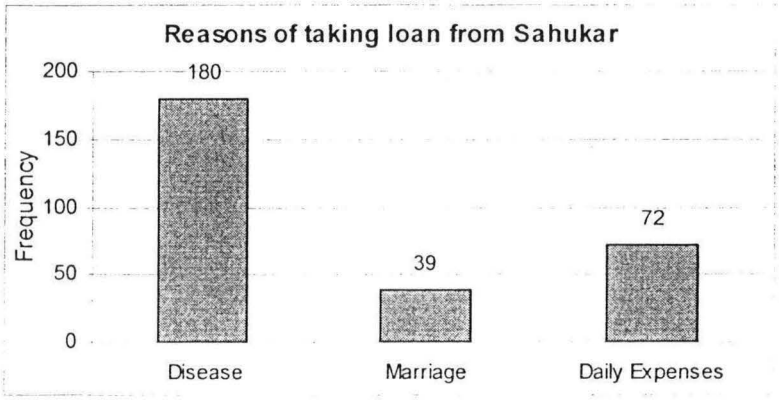


Figure 6.6: Reasons for taking loan from Sahukar

It was also observed that they fall ill frequently because of lack of proper water and sanitation facilities. They live in very unhygienic conditions. They also have limited government health facility. It was also found that although the women are aware about various diseases, they have limited facility for vaccination. Mostly the women suffer from, viral disease, water-borne infections and other communicable and non-communicable disease. It was also found that they are very much vulnerable to communicable diseases because of their living conditions and the resulting behaviour and practices.

The poor health of the people has direct impact on their pocket because of lack of social security and poor government health facilities, which force them to visit private doctors, and quacks who charge exorbitantly high prices for even common diseases. Most of the private practitioners are not well qualified and unregistered.

It was found that many of the rural medical practitioners (RMP) have no formal training in treating and curing people and handling serious cases. Most of the practitioners are also involved in illegal practices such as sex-selective abortion and female feticide.

Seventy-two women reported that they take loan for daily expenses whereas 39 women reported that they take loan for marriage expenses. It was also found that because of no fixed income, these women find it difficult to run their houses and they are forced to take loan for even their daily expense and day-to-day living.

Marriage is another reason for taking loan where one is forced to spend money on reception and other associated ceremonies because of societal pressure. Dowry is another evil for which they take loan to meet the demands of in-laws.

In focus group discussion it was also found that there is excessive lending amongst the members and this saves them from the clutches of the moneylenders as the money is readily available without any jewellery security and it has been observed that there is more than 90 per cent recovery of loans. There is lending even to pay for dowry and the women understand that it is evil but are helpless about the practice.

The maximum petty lending are for medical purposes, agriculture, house making, buying buffalo and social functions like marriage etc. Even many a times, women have taken loan to pay back moneylender to free their land and jewellery from the clutches of moneylenders which was pledged to them before their association with the SHG group.

In Some groups, the money is also borrowed for more concrete works like opening a shop of Sattu and food items.

## DECISION MAKING POWER IN THE FAMILY

The position of women can be measured by their autonomy in decision-making and by the degree of access they have to the outside world. In these measures, women in rural Bihar fare poorly. These women are dominated not only by the men but also by their in-laws. Women are frequently prevented from working outside the home and travelling without a companion (especially among upper castes and other backward classes and among newly married among schedule castes). This has profound implications for their access to health care.

In response to question about decision making power in the family, 83.5 per cent women reported that their decision making power has increased in the family which is very positive sign of women empowerment within the family. However, It was not very clear what type of decision making power they were involved in and how much.

Table 6.13: Change in decision making power across blocks and caste groups

| **Has your decision making power increased in the family** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 77.5 | 89.8 | 72.2 | 97.8 | 83.5 |
| No | 22.5 | 10.2 | 27.8 | 2.2 | 16.5 |

Further in focus group discussion, it was found that the decision making is mostly related to their mobility and small initiatives within the parameter of family, society and cultural values. It was also observed that with the breaking up of joint family system and fragmentation of existing families, nuclear families are becoming the norm in the rural areas as well. The nuclear families, because of their size and unitary structure allow women more autonomy and decision making power than in the joint family system.

In joint families, there are various restrictions where major and minor decisions are taken by the elders or head of the family. This was also because of economic control by the head of the family. In a nuclear family, women are free to take decisions because of their position in the family as income earning member. Women are no more dependent on male members or husband for small spending and decisions.

Variations across blocks do not suggest any clear explanation with regard to change in decision making power and its linkages with development level of the block. In fact, in the underdeveloped block of Maner, 90 per cent women reported that their decision making power has increased in the family compared to 77.5 per cent women in Phulwari. On the other hand, across castes it was clear that the relatively well-off cast group of OBC women has seen greater increase in decision making power within the family with almost 98 per cent reporting increase. On the other hand, only 72 per cent SC women felt that their decision making power within the family has increased after participation in SHG.

**SELF CONFIDENCE**

In response to the question on any type of increase in their self-confidence, 98 per cent women reported that their self-confidence has increased. It was also observed that this increase in self-confidence was shared equally across blocks and caste groups. It is generally believed that membership in self-help groups and access to credit will nurture and promote social, political and psychological empowerment of women, their economic empowerment as well as their practical needs as given in the Moser[21] (1989) framework. For a woman who seldom if ever comes into contact with a significant amount of money, an SHG loan can result in greater feelings of self-confidence and self-worth. In addition, SHG membership can provide access to a congregation of community women or the credit group. Thus, a women's access to credit can allow her broader participation in community social networks and social programmes, in

[21] Moser, C. (1989). Gender Planning in the Third World: Meeting Practical and Strategic Gender Needs. World Development, 17, 1799-1825.

turn enhancing wider opportunities and self-esteem (Bennett et al., 1996:285[22]; Hulme and Mosley, 19961:125-8[23]).

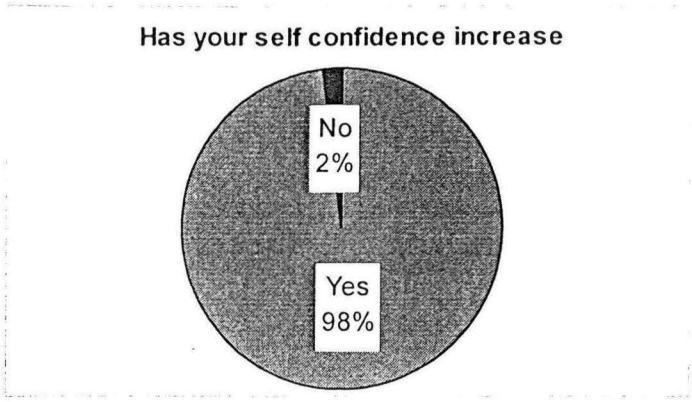


Figure 6.7: Increase in self-confidence

Table 6.14: Change in self-confidence across blocks and caste groups

| **Did your self-confidence increase** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 98.0 | 98.0 | 98.1 | 98.9 | 98.0 |
| No | 2.0 | 1.0 | 0.9 | 1.1 | 1.5 |

It was found during focus group discussion that the women are aware and full of confidence to take the lead and initiatives given any opportunity. It was their confidence which help them in fighting for their rights and respect within the family and in the society. They are aware that there are special provisions for them to safeguard their rights and dignity. They also know how difficult it is to get it because of societal discrimination and non-friendly bureaucracy and corruption.

## FEELING OF SECURITY

83 per cent women reported that they feel more secure now. The concept of security for them is also associated with self-confidence. The women reported that they feel more secure now and move alone independently without any

[22] Bennett, L.; Goldberg, M.; and Hunte, P. (1996). Ownership and Sustainability: Lessons on Group-Based Financial Services from South Asia. Journal of International Development, 8 (2), 271-288.

[23] Hulme, D., and Mosley, P. (1996). Finance Against Poverty, Volumes I and II. London/New York: Routledge.

support and escort. However, they face problems at times. The trend across blocks also mirrored their response to the question in increase in decision making power within the family with larger percentage of women in Maner reporting an increase in feeling of security compared to women in Phulwari. Similarly for castes, greater percentages of OBC women were reporting increase in feeling of security than SC women.

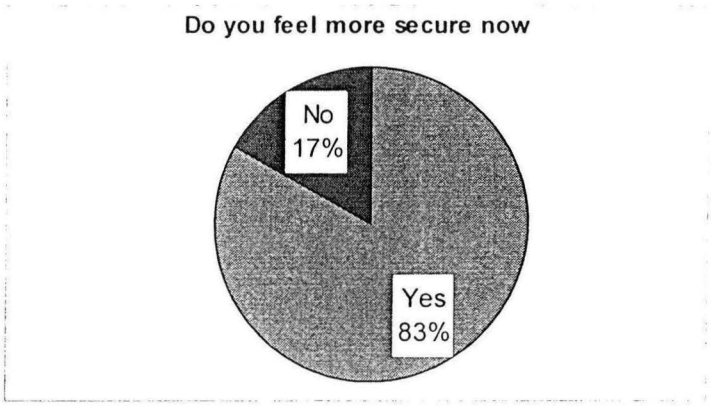


Figure 6.8: Feeling of security

Table 6.15: Feeling of security among women across blocks and caste groups

| **Do you feel more secure now** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 73.5 | 92.9 | 73.1 | 95.5 | 83.2 |
| No | 26.5 | 7.1 | 26.9 | 4.5 | 16.8 |

Feeling of security was also visible in their action and behaviour. Realization of this security was also because of other reasons apart from their association with self-help groups. The state was run by Rashtriya Janta Dal for 15 years and almost 7 years of it was ruled by women Chief minister who belonged to OBC, Yadav Caste. This also gave confidence in the women that if an uneducated (semi-literate) women of their caste group can run a state, why not they, given an opportunity and chance. During this period (1990-2005), upper caste and class also realized that they have to change their attitude towards SC and OBC. However, it was difficult to accept these but it was more of compulsion with changing caste and class dynamics politically as well as socially. All these factors boosted and worked positively for the women in realization of their self-confidence and security.

## WOMEN'S PARTICIPATION IN PROPERTY RELATED DECISIONS

In response to the question about the women's participation in property related decision in last one year, only 6 per cent women reported that they have been part of decision making or consulted by the family on property related matters. This shows that although the women have some rights in the family, are fighting for their rights and making decisions about day-to-day living; they are largely kept out from property related decision making. This also shows that ultimate power and control is still controlled by male or head of the family. It does not matter that they have contributed in creation of that property and they have legal rights on the property. It is also true for large number of women in rural Bihar as well. Gender equality can not be reached without influencing the mindsets of men in the society. Unfortunately, gender equality has suffered because our society is still patriarchal.

Table 6.16:
Decisions making on property related matters across blocks and caste groups

| **Did you decide on property related matters in last one year** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 1.0 | 10.2 | 8.3 | 2.2 | 5.5 |
| No | 99.0 | 89.8 | 91.7 | 97.8 | 94.5 |

Although the situation is changing with emergence of nuclear families where women have more say and negotiating power but the fact is that still male dominates the property related decisions considering it their area where women have no role. Other reason is that from the beginning women have been denied of their property rights on different grounds. It was also found that many of the women have no property like land[24] and what they have is jewelry, which they have got during their marriage from their husband's family, parents and in-laws.

[24] A 2003 World Bank study reports that 75 per cent of the rural poor were landless or almost so, in 1999-2000.

## WOMEN'S ROLE AND OPINION IN MATTERS CHILDREN'S EDUCATION, IMMUNIZATION AND OTHER MATTERS

Seventy eight per cent women reported that they decide about their children's education. It was also found that the women are very much concerned about their children's education. However, there was marginal difference in the responses across blocks and across castes.

Table 6.17: Decision on children's education across blocks and caste groups

| **Do you decide about the education of children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 83.0 | 72.4 | 75.5 | 80.9 | 77.8 |
| No | 17.0 | 27.6 | 24.5 | 19.1 | 22.2 |

In focus group discussion, many of the women reported about difficulties they are facing like improper and ill-maintained government schools, etc. Private schools are there at some places near the urban centers but they are very costly and beyond their reach and paying capacity. It is interesting to note that the women were most concerned about male-child's (son) education rather than girl-child's (daughter[25]) education. It is also interesting to note that the women reported that there are no difference between a son and a daughter but this discrimination was noticeable. However, it is not true for all women. It was also found that there are societal factors in preference for son's education than girl's education. Even where girls are getting education, it is only up to the primary education on the pretext of protection of girl. Girls have always been considered as a commodity, which one has to protect until she gets married. So girls are seen more as liability than asset. Although the women were empowered and open to new ideas, this attitude was prevailing which needs to be changed.

[25] Daughters are generally considered a net liability, they often require a dowry, they leave their natal homes after marriage, and their labour is devalued. This results in neglect of female children, who are weaned earlier than males, receive smaller quantities of less nutritious food and less medical care, and are more likely to be removed from school. (See, Improving Women's Health in India. World Bank, 1996).

Table 6.18: Initiatives to vaccinate children across blocks and caste groups

| **Do you take initiative to vaccinate your children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 85.3 | 67.3 | 74.1 | 78.7 | 76.5 |
| No | 14.7 | 32.7 | 25.9 | 21.3 | 23.5 |

Seventy six per cent women reported that they take initiative to vaccinate their children. It was also found that almost all women are aware about polio immunization. Although they do not know about other immunizations available but they take their children to sub-centre for vaccination and some of them have vaccination card for their children[26].

The responses across caste groups in this case did not show large variations. But across blocks the variations were noticeable and in some cases appear correlated to the presence and access to public health services. As mentioned earlier, the public health facilities in Phulwari were better functioning and were more accessible than the additional PHC at Maner. It is quite possible that the increase in initiatives by women to vaccinate their children is also partly due to the better reach of government services in this regard.

It was found that there is massive awareness about polio immunization programme because of the initiative of government and the UNICEF to mobilize all resources and machinery for polio immunization with the aim to eradicate polio. The UNICEF along with the World Health Organization (WHO), and the government of Bihar are trying to reach every child in the state under the age of five[27]. Although it is a challenging task because many adults and women work as migrant worker and labour, moving constantly between states in search of employment, a large number of children in the region do not benefit from regular

[26] The aim of an immunization programme is to reduce the incidence of, or to eliminate a particular disease. Vaccination of children against six serious but preventable diseases namely tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles has been a cornerstone of the child health care system. As a part of the National Health Policy, the National Immunization Programme, the expanded programme on Immunization (EPI) was initiated by the Govt. of India in 1978 with the objective of reducing morbidity, mortality and disabilities occurring from these diseases by making free vaccination services available to all the eligible children. The achievement of universal immunization of children against all vaccine preventable diseases by the year 2010 is one of the socio-demographic goals of National Population Policy, 2000.

[27] http://www.unicef.org/infobycountry/india_27265.html (visited 5 April 2006)

vaccination drives. "*I wanted to get my children vaccinated, but there were many other priorities and I forgot,*" says one mother. It was also found that all children were not immunized for DPT and BCC because of distance to sub-centre and lack of awareness and concern. District Level Household Survey (DLHS) 2002-04 shows that between the two rounds, 1996 and 2001, there is noticeable drop in full immunization coverage, utilization is low and drop out is high. The extent of no vaccination is as high as 45 per cent in Bihar[28]. Although the Government of India statistics suggest a much higher level of vaccination coverage than NFHS-2 (1998-99) estimates. However, the state level data collected on immunization coverage in NFHS-2 shows that the coverage of all the vaccines is much below the universal coverage in the states of Bihar, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh. These states are lagging behind the other states in the immunization coverage of all the vaccines (BCG, three DPT and Polio, and Measles).

It was also found that many of the women know about immunization for other diseases but they do not believe in it. Their argument is that they have not been immunized and they had no problems. "*And even if God wants to afflict someone from disease or disability, no vaccine or power can stop it*". But definitely the pulse polio immunization programme is well spread despite its shortcomings and coverage.

Table 6.19: Opinions in matters of children across blocks and caste groups

| **Do you keep opinions in the matters of your children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 93.1 | 93.8 | 92.5 | 94.4 | 93.5 |
| No | 6.9 | 6.2 | 7.5 | 5.6 | 6.5 |

Ninety-three per cent of women reported that they do keep opinion in matters of their children education, growth, social behaviour and discipline. Although they have high values and standards for their children, they found it difficult to provide them adequate environment. They also reported that they

[28] http://www.iipsindia.org/ns/seminar.htm (visited 3 April 2006)

were not able to provide time to their children because of their work. Their own educational status is another constraint in guiding their children. Beside many of them were not getting needed attention from their husbands in matters related to children.

Table 6.20: Opinions on marriage of children across blocks and caste groups

| **Is your opinion taken in the marriage of sons/daughters** (percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 89.8 | 89.8 | 97.8 | 93.5 |
| No | 2.9 | 10.2 | 10.2 | 2.2 | 6.5 |

Ninety-three per cent women reported that their opinions were taken in the marriage of sons and daughters. In detailed probe, it was found that although their opinions were taken, male members of the family took final decisions. Women have less or no say in final decisions made in this regard. It was also found that although these women were consulted for fixing the marriage, the opinion of son or daughter who is getting married is not entertained. Even for girls it is a disrespect to go against family decision or express her will and opinion about it.

It was also found that the age of marriage for girls is many times below the legal age of 18 years for marriage. Many women also do not find it wrong considering the social pressures and practices. Although it was not expressed openly, girls are still considered a burden on the family. This burden is not in form of financial burden to save money for dowry but it is also related to the security of the girl including protection of virginity of the girls before marriage.

The National Family Health Survey (NFHS) II (1998-99), in a survey of women who were married below the age of 18 years, found that in Bihar they accounted for 71 per cent. One needs to understand that the material cost of the consequences of child marriage is far exceeded by the intangible costs relating to the quality of life, the suppression of human rights, and the denial of women's

potential to participate fully in the development process[29]. The consequences of early marriage for women are rather apparent such as, early pregnancies, obstetric complications, higher rates of neonatal mortality, infant mortality and under-five mortality. Apart from serious health consequences, child marriage also takes away the educational opportunities of adolescent girls, limiting their opportunities for employment and income generation and sowing the seeds for a lifetime of dependency.

## MOBILITY

In response to the question about their mobility, 81 per cent women reported that they go out on their will. Initially it looked like a very positive sign of empowerment where women are independent in their mobility. Generally, women are confined to their households, due to societal norms, and because it is perceived as unnecessary for them to leave their homes. In order to participate in SHG meetings and activities, the women were required to exit their homes, thus opening opportunities to gain social autonomy. Many women now claim they have acquired freedom not only to attend meetings and SHG functions, but also can travel for other purposes.

Table 6.21: Freedom of mobility across blocks and caste groups

| **Can you go out on you will** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 64.3 | 78.7 | 84.3 | 81.0 |
| No | 2.9 | 35.7 | 21.3 | 15.7 | 19.0 |

However, the variation across blocks suggests that even though presence and participation in SHG could be an enabling factor for such trends, some of this may also be due to the nature of development of these blocks. Women in the developed block of Phulwari (97 per cent) were more mobile than the underdeveloped block of Maner (64 per cent). Although at caste level, the

[29] Krishnakumar, Asha; Rajalakshmi, T.K. (2005). The High Social Cost. Frontline. Vol 22 Issue 14, 2-15 July 2005

differences are narrowed down, but still OBC women have greater mobility than the SC women.

However, during focus group discussion, it appeared that this mobility or independence is more a compulsion rather than respect to their rights. Although they are free to go out on their will but it is within the set parameter of work and it is limited to fields and near by market. But for going to their mother's place and to visit relatives, they need to take permission from their husband or from the head of the family. Although the situations are different in nuclear families, where women are more influential and have more mobility in comparison to joint families.

Other interesting finding was related to the women's class and caste. It was found that women from SCs are more mobile in comparison to OBCs and general class, which has strong norms for their women and restriction on their mobility. Moving alone or going out alone is not appreciated and restricted.

## EXTRA INCOME

The extra income comprises income from other sources which are occasional like getting money in marriages and on other occasions. Besides extra income also comprise income not informed to family or at times personal saving.

Table 6.22: Extra income across blocks and caste groups

| **Do you keep extra income** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 67.3 | 89.8 | 73.0 | 82.5 |
| No | 2.9 | 32.7 | 10.2 | 27.0 | 17.5 |

Eighty-two per cent women reported that they do keep extra income. The women mostly use this extra income in time of need and emergency like health, accident, disease etc. The women also use the extra money to buy household items of their use as well as of family use. While 97 per cent women in Phulwari were reporting that they were keeping extra income, only 67 per cent women in

Maner did so. A possible reason for this could also be the fact that the developed block also provides greater opportunities for economic activities and hence greater possibility of earning and keeping extra income. In Maner, with its level of development, it is possible that women did not earn enough extra income to keep with them. This was later confirmed during focus group discussion where the women from Maner reported that they were not able to earn extra income.

## PARTICIPATION IN SOCIAL LIFE AND SOCIAL INCLUSION IN THE COMMUNITY

Table 6.23: Participation in social life across blocks and caste groups

| **Has your participation increased in the social life** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 99.0 | 90.8 | 94.4 | 96.6 | 95.0 |
| No | 1.0 | 9.2 | 5.6 | 3.4 | 5.0 |

95 per cent women reported that their participation in social life and activities has increased. Now some of them also go out to participate in political rallies and meetings. One of the assumed benefits of SHGs is women's empowerment and this can be seen with the number of women involved in public affairs. While the number of women actually involved in politics was found none except that one woman was nominated as member of school committee. As mentioned, the number of women involved in politics is low. But, some women were conscious about political development at local level. These women are also going out for work to banks, block offices and cities for health care etc. This has broken the age old norms where women were confined to periphery of the house. Role of economy has also played an important role in it. These women are also earning and contributing to family income which has also enabled them to take decisions and to participate in social life.

Government policies and programmes have also played a positive role in it[30]. For instance specific panchayats are reserved for women members and for

[30] The 73rd (panchayati raj) amendment to the Constitution of India mandates the transfer of decision-making powers and resources in rural areas to local democratic bodies called panchayats. It aims at giving women, scheduled castes and scheduled tribes wider representation. The amendment was a revolutionary step in enabling true local self-governance. However, the level of progress made by different states towards this goal varies.

women belonging to schedule castes and other backward classes which has given them rights and respect in society and social life. Fifteen years of Rashtriya Janta Dal (RJD) rule in Bihar has also given them opportunity and motivation to come forward. Though the situation has not changed fully in their favour, still they face discrimination and insult, despite moving ahead for their rights and respectful position in the society.

Another reason behind increase in their social life is due to group feeling. They also go in group and they also feel more secure in the group.

## SOCIAL INCLUSION IN THE COMMUNITY

Table 6.24: Social inclusion in the community across blocks and caste groups

| **Social Inclusion in Community** (Percent) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Phulwari** | | **Maner** | | **SC** | | **OBC** | | **Total** | |
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| Status increased in the village level | 26 | 74 | 69 | 31 | 38 | 62 | 61 | 39 | 48 | 53 |
| More people come in my contact | 100 | 0 | 97 | 3 | 98 | 2 | 100 | 0 | 99 | 2 |
| Improvement in the marriage market | 100 | 0 | 96 | 4 | 99 | 1 | 98 | 2 | 98 | 2 |
| Higher acceptability in the community | 8 | 92 | 37 | 63 | 19 | 81 | 24 | 76 | 22 | 78 |
| More participation in the panchayat and other activities | 4 | 96 | 17 | 83 | 11 | 89 | 9 | 91 | 11 | 90 |

To assess the impact of SHGs participation on social inclusion in the community, set of related questions regarding women's participation in community activities were asked. These were, increase in status at village level, more people in contact, improvement in marriage market, higher acceptability in the community and more participation in panchayat and other political activities. Of these, there was near unanimity regarding two questions, that is, on improvement in marriage market and more people coming in contact with the women. However, in response to the question on whether the women felt that their status in the village has increased, 48 per cent women reported that it did

increase. But within this, majority of the women were in Maner block and from OBC community. Compared to 61 per cent OBC women reporting increase in status in the village, only 38 per cent SC women felt that their status in the village has increased. Similarly across blocks, while 69 per cent women in Maner felt that their status has increased, only 26 per cent women in Phulwari felt so.

However, on the issue of higher acceptability in the community and participation in political processes, the responses were overwhelmingly in favour of negative responses. Almost 78 per cent of women felt that they have not felt higher acceptability in the community. The percentage of women who did not feel that participation in SHG has led to their increased participation in political processes was 90 per cent. However, across blocks, women in Maner did feel some positive changes compared to Phulwari where there was negligible evidence of any such change.

It was also found that the women association with SHG programme has helped them significantly in their social inclusion in the community. They are now more respected in the community because of their knowledge and actions. Now the women are not only recipients but contributor to family income as well. During focus group discussion, it was found that despite inclusion at the community level, ground reality was just opposite in terms of initiatives and contribution for community development by SHG members. Recent analysis has also shown that the impact of SHGs on the community at large have been minor. There have been few instances of significant contributions from SHGs to education, family planning, eradication of child labour, etc. But, such community problems need large financial commitments which SHGs simply do not have the capacity to afford[31].

[31] Reddy, C. S., Manak, S. 2005. Self-Help Groups: A Keystone of Microfinance in India - Women empowerment & social security. Mahila Abhivruddhi Society, Andhra Pradesh (APMAS)

## PLANNING FOR FUTURE

Table 6.25: Planning of the future across blocks and caste groups

| **Can you plan your future better** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 94.1 | 85.7 | 87.0 | 93.3 | 90.0 |
| No | 5.9 | 14.3 | 13.0 | 6.7 | 10.0 |

Ninety per cent women reported that they could plan their future better given an opportunity, resources and facility. They also want to live good life, educate their children and have secure productive life. They also said that they can think and plan but when it comes to implementation and realization of their dreams, they feel helpless and forced to live in an environment which has no better future for them. The women do not have adequate money for themselves and their family. In this situation, how can they educate their children?

There are lot of policies and programmes for their better future and upliftment but they cannot avail these opportunities as they are not educated or even fulfilling the basic minimum requirement. The women also reported that the opportunities and policy benefits are reaching to those who are affluent and well connected. Planning and resources are very close to each other. One can only plan on the basis of resources, money, support and contact and they are lacking in all these aspects. It is very difficult for them to realize and execute their plans for better future.

## ORGANISATIONAL MEMBERSHIP

Except political parties and organizations, there is no presence of other organization in the villages. The women are least interested in joining any party although they vote for political parties during elections. The voting in favour of parties depends on decision of the family head. Money, power and muscles also influence the voting.

There are women organizations in Bihar but they are not active in this area except for taking issues highlighted by media or political parties.

## CONCLUSION

The findings reported in this chapter based on questionnaire analysis, case studies and focus group discussion suggest some positive impact of women's participation in empowering the women in various spheres of life. However, it was also observed that these changes are not shared equally across blocks or across caste groups with the developed block and better off caste groups witnessing more empowerment than the disadvantaged groups such as SC households or the underdeveloped block (Maner).

However, these findings and observations need to be addressed from a different perspective if any substantial conclusion on women empowerment as a result of SHG participation is to be drawn. The reasons of being cautious in analysing these findings results from various factors which work in conjunction with each other to either complement these individual processes or sometimes obstruct or negate the positive impact of some of these processes. But before that, it is important to state at the outset that quantifying women empowerment is in itself a complex task and identifying the various causal factors for it is even more difficult.

The first point to note in this regard is the fact that the findings and observations are mostly based on perception of women regarding their empowerment as understood from the research point of view. Needless to say that there is a huge gap between perceptions and their translations in to actual events of empowerment. However, such hard data is seldom available to researchers in a manner which can quantify the extent of empowerment or change in status of women. Nonetheless, since empowerment in a social context is also related to the way women are able to assert their individualities, even though relative to what earlier existed, any such increase felt by them suggests positive changes as a result of SHG activity.

However, the real complexity arises when one tries to distinguish between the effect of SHG activity on empowerment with those which have been guided by other external factors operating simultaneously but unrelated to the SHG activity. For example, women empowerment which has a strong impact on the way they understand health and access health services can also come through various other government programmes and incentives which are designed to support women to access health services better. Or for that matter, a better functioning government health system such as the one in Phulwari may also enable women to access health services better. Of course, even in these cases SHG participation may facilitate such processes. But it can also happen that these processes take place independently and would have worked even without SHG activity in the selected blocks.

Despite these caveats, it does appear from the findings that the women did benefit out of SHG participation in terms of women empowerment even though the extent of it varied across blocks and across castes. It did come out quite clearly that SHG participation did result in the women becoming or at least feeling economically empowered. However, the associated process which followed in terms of it being also reflected in social empowerment does appear to have taken place. It appears from the responses that women were feeling greater benefit in terms of social participation and empowerment.

However, it was also evident that these processes were more evident in the case of the developed block of Phulwari than the underdeveloped block of Maner. A part of this may be attributed to the choice of sampled blocks which also implies that the developed blocks would have already been in a situation with greater women empowerment than the underdeveloped block. For example, female literacy was higher in Phulwari than in Maner. That is, women in Phulwari were already in a better off situation to begin with, if participation in educational activities is any measure of it. The fact that women in Phulwari were more literate and more aware than women in Maner also implies that they were already in a better position to take advantage of the opportunities being offered to them as part of SHG activity. Same argument holds true for the OBC women who

with better literacy and awareness did make better use of these programmes and policies both by the government as well as by SHG.

Given the explicit focus of the SHG programme on SC women, it was expected that the SC women will also feel similar if not lower level of empowerment. However, the findings do not suggest any evidence that the SC women have done any better or even come closer to the levels of empowerment being enjoyed by the OBC women. It is important to clarify here that SC women need extra effort for the twin disadvantages faced by them in terms of social exclusion as well as economic deprivation. On the other hand, OBC women are better placed not only in terms of better social standing but also due to better economic situation of the household. On some of these issues, the extent of variation seen between the SC women and the OBC women suggests that the explicit focus on monetary activities by the SHG facilitator agency might not be enough to bring the SC women in mainstream.

# CHAPTER – VII

# SELF-HELP GROUPS AND WOMEN'S PERCEPTIONS ON HEALTH

CHAPTER VII

# SELF-HELP GROUPS AND WOMEN'S PERCEPTIONS ON HEALTH

This chapter presents the findings from the questionnaire, case studies and focus group discussions on issues related to health, women's perception on health, importance to health, health related practices, beliefs, disease pattern and prevalence, access to health services, women's role in accessing health services, role of SHGs in facilitating health knowledge and related behaviour and practices, knowledge about family planning, use and type of family planning methods used, and discussion on health issues within the family. The findings are also based on field observations and visits to several public and private health facilities which included a sub-centre, a primary health centre, and community health centres and private clinics.

## PERCEPTION AND UNDERSTANDING OF HEALTH

The first set of questions was regarding the women's perception on 'what is health'. Since this was an open ended question, all the responses were recorded, which in some cases were also multiple answers. Some of the salient responses were as follows: 'cleanliness and good food, cleanliness is important, disease, do not even get good water, do not get time to bath, drink clean water, for poor no need of health, health is important, health is important to earn more, health should be fine, to keep fit, live and eat properly, no disease is health, proper food is important, proper living keeps you fit, should be fine, think well stay well, timely eating, to die happily, to live and eat properly, to live properly, walk work and earn, we know but cannot follow, weakness, working body is healthy'.

This was a very crucial question about people's perception of health. It was found that different people have different understanding and perception of their health and concept of health per se. But most interesting finding was that

everyone defined health in the context of their environment and need. Another interesting finding was that none of the women defined health as perceived and practiced by health professionals, practitioners and clinicians.

This also seriously raises question about understanding and definition of health held by Professionals and policy makers. Does it make sense to develop policy and programmes for communities without taking into account their understanding and need?

For many women, health means, "cleanliness and good food, drinking good water, keeping fit, live and eat properly, timely eating, to die happily, walk, work and earn where as for others it was absence of disease is health, think well and stay well and working body is healthy". If we closely define each of the statements, proverbs and objectives to define health, we find that it has covered the social, cultural and economic and environmental factors while defining health. It was also found that health is a broader concept and it needs to be defined and understood in a way that takes into account the social, cultural and environmental factors rather than the stricter clinical definition of health.

Given the women's perceived notion of health, the second question was about the relevance of health in their day to day life. In response, almost every one, except one reported that their health is important for them. Even though the concept and meaning of health as understood by them is different from the bio-medical understanding of health, for most of them, health is something which is related to functional ability to perform work and live. It is far from a medical and Western understanding of health which sees body and patient as machine and doctor as mechanic who can repair and correct the malfunctions and infections in the system.

In further probing during the focus group discussions and in the case studies, it was also revealed that the women give their own perception about life. It is difficult to define life but it is necessary to understand the women's perception of life to understand their perception of health. Life is something, which comprises everything, relation, emotion, joy, pains everything under the

sky, which they can feel. The women believe that they have got life and it will end according to their Karma and no body is *amar* (live forever) or born to live without death. The duration between births and deaths is life which comprises love, joy and pain, suffering and disease. They take disease or bodily malfunction as part of their life experience. There is human touch in their concept of life and death, which is totally different from present day medical understanding of life, birth and death. Death is experience for them. The women do not want birth and death to be controlled by doctors (mechanics) and their technologically advanced tools like ventilator, oxygen etc. The women want to live and die in the presence of their family rather in presence of whispers of helplessness of present day doctors (mechanics).

The next related question regarding the women's perception of health was "why is health important to them". Since this was also an open ended question, the responses were many and reflected their perception of importance of health. This was obviously guided strongly by their perception of health. The women reported that they want to live healthy to enjoy life rather to enjoy health. They want to roam around, take care of others, work in and out, and earn. Their health is important because they are important for others to feed them, to cook for them, and to support their family. They see health which provides them strength, motivation, and independence. They want to be healthy because no one is there to take care of them. They want to be healthy because their work at home and outside will be affected. The other reported response were as follows, can have some saving, can roam around, can take care of others, can work in and out, do not have to depend on somebody, to earn, every thing is based on health, family depends on my health, health gives strength and motivation, health is life and earning, health of women is important than men, independence, it is important, it's our priority, to look after family, manage outside as well as home, no dependency, nobody is there to take care, to live, will be fit if health is fine, to work, to work and earn, work and walk, work at home and outside, work at home and outside will affected, work efficiency, to work in fields, you do not fall sick and various other response.

It is interesting to note that their salient response is not guided by individual or internal happiness. It is guided by concerns for others. It is guided more by human bonding, emotions, feelings, cultural values, norms and belief. This cannot be understood in modern western medical framework of health, medicine, and society.

## DISEASE PATTERN AND PREVALENCE

In response to the question on their frequency of falling sick almost four-fifth of women reported falling sick regularly.

Table 7.1: Disease pattern and prevalence across block and caste groups

| **Do you fall sick regularly (Percent)** | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Rarely | 9 | 8 | 4 | 14 | 8 |
| Regularly | 89 | 66 | 82 | 74 | 78 |
| Sometimes | 2 | 26 | 14 | 13 | 14 |
| Total | 100 | 100 | 100 | 100 | 100 |

Seventy eight per cent women reported that they fall sick regularly, 14 per cent women reported that they fall sick sometime and 8 per cent women reported that they fall sick rarely. It is interesting to note that despite their knowledge about prevention and awareness of various diseases, majority to them fall sick regularly. The incidence of falling sick regularly was reported to be higher in Phulwari Block compared to Maner. In Phulwari, 89 per cent of the women reported falling sick regularly, on the other hand, only 66 per cent of women in Maner reported regularly falling sick. Across caste groups, schedule caste households were more prone to falling sick regularly (84 per cent) compared to other backward class households (76 per cent). Focus group discussions and case studies revealed that many of them fall sick because of anemia[1] and lack of proper nutrient food. Another reason was living condition and unhygienic environment. It was also found that the women are hardly concerned about their

[1] Because the nutritional status of women and girls is compromised by unequal access to food, by heavy work demands, and by special nutritional needs (such as for iron), females are particularly susceptible to illness, particularly anaemia. (See, Improving Women's Health in India. World Bank. 1996).

own health or take precaution because of the hard realities which force them to ignore their health because of other pressing issues which are more important for them and their family survival.

*Chinta Devi, 45 years old of Schedule caste community is associated with SHG since last four years. Her family comprises husband, four children and in-laws. Chinta's major worries are health expenses. She says that all the time someone is ill in the family. It is not like that any of family members have serious chronic disease. But seasonal and other diseases because of unhygienic conditions are regular. She spends half of her earning on children and family health. Although her own health is matter of concern but she hardly consults doctor for the same. Whenever she visits doctor for her children or in-laws medicines she takes some pain killers form the quacks for her. She has back-pain since last two years but she does not consult doctors because she has to go to city and she anticipates that it would be costly beyond her capacity to meet the expenses. She says that children's health are important than her. She has lived her life and she is living for children and the family.*

It was also reported during focus group discussion that there are no adequate food for the family in many households. Many women and their family consume food which is not enough to meet their nutritional requirements. They do not have access to safe drinking water and sanitation facility. Medical services are for name sake and on paper with limited facilities which even do not fulfill the bare minimum requirement prescribed[2].

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[2] The number of Government health facilities in Bihar falls far short of national norms. Bihar has 396 PHCs and 101 CHCs which means that each PHC caters for more than 200,000 patients while each CHC caters for more than 800,000. These figures should be compared to national targets to have one PHC cater for a population of 30,000 and one CHC to cater for a population of 100,000. It is reported that there are 15,426 beds in Bihar in both the public and private sectors less than one bed per 5,000 population. The table given below presents current data on public health facilities in Bihar.

**Bihar, Government Health Infrastructure 2002.**

| Facility | Bihar No. of Facilities | Bihar Population Covered | Indian average |
|---|---|---|---|
| Sub Center | 10,332 | 8,033 | 5,401 |
| Additional PHC | 1,247 | 66,560 | |
| PHC | 396 | 209,596 | 32,169 |
| CHC | 101 | 821,782 | 243,729 |
| Hospitals & Med. Col[1] | 53 | | |
| Other[2] | 140 | | |

Besides, private medical health care system is very costly and uneven[3]. It is very difficult to access and pay for private practitioners which constraints them to visit the doctor for minor infections and ailments which need to be taken care of to control and prevent the spread of disease in community.

In response to the question on specific diseases which affect them, a wide spectrum of diseases in various combinations were reported. The disease comprises both communicable and non-communicable diseases[4]. The major disease reported during focus group discussions were Anaemia, Arthritis (Gathia), Asthma (Damma), Kala-Azar , Back ache, Blood Pressure, Body ache, Arthritis, Breathing problem, Chest Pain, Cold, Dental pain, Eczema, Fever, Filariasis, Gastritis, Head-ache, Itching, Leg ache, Leg swallow, Leprosy[5], problems related to menstrual cycle, Mumps (Gilti), Lumps in Breast, Old age, Piles (Bawasir), Seasonal, Sleeplessness, Stomach-ache, Stone, Uterus infection, low- vision, Weakness, White Discharge, etc.

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Source: Department of Health, Government of Bihar.

[1] Includes sub-division and district hospitals.

[2] Includes TB centers, blood banks, filarial and leprosy centers and other facilities.

[3] As a result of inadequate public health facilities, Bihar leads in terms of private health care delivery for both inpatient and outpatient services. This is despite the fact that most of the patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition. Studies have shown that hospitalizations often result in patients and their families dropping below the poverty line.

[4] Although accurate burden of disease information is not available, it is clear that given Bihar's level of development tackling communicable diseases is an immediate priority for government. The table below indicates some of the major diseases detected recently.

**Bihar, Status of Health Programs, 2002-2003**

| Disease | Number of Cases |
|---|---|
| Filaria | 411,076 |
| T.B. | 53,804 |
| Kala-Azar (Leishmaniasis) | 101,129 |
| Malaria | 3,683 |
| Leprosy | 38,588 |
| HIV/ Aids | 11.5% |

Source: Bihar State Health Profile at a Glance, 2003.

[5] Preliminary data for 2003 indicates that with 15,634 new cases of leprosy detected in 2003, Bihar accounts for more new cases of leprosy than another state in India and almost a quarter of all newly detected infections. (Source: Ministry of Health and Family Welfare, Government of India 1999)

## WOMEN'S PARTICIPATION IN PROPERTY RELATED DECISIONS

In response to the question about the women's participation in property related decision in last one year, only 6 per cent women reported that they have been part of decision making or consulted by the family on property related matters. This shows that although the women have some rights in the family, are fighting for their rights and making decisions about day-to-day living; they are largely kept out from property related decision making. This also shows that ultimate power and control is still controlled by male or head of the family. It does not matter that they have contributed in creation of that property and they have legal rights on the property. It is also true for large number of women in rural Bihar as well. Gender equality can not be reached without influencing the mindsets of men in the society. Unfortunately, gender equality has suffered because our society is still patriarchal.

Table 6.16:
Decisions making on property related matters across blocks and caste groups

| **Did you decide on property related matters in last one year** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 1.0 | 10.2 | 8.3 | 2.2 | 5.5 |
| No | 99.0 | 89.8 | 91.7 | 97.8 | 94.5 |

Although the situation is changing with emergence of nuclear families where women have more say and negotiating power but the fact is that still male dominates the property related decisions considering it their area where women have no role. Other reason is that from the beginning women have been denied of their property rights on different grounds. It was also found that many of the women have no property like land[24] and what they have is jewelry, which they have got during their marriage from their husband's family, parents and in-laws.

[24] A 2003 World Bank study reports that 75 per cent of the rural poor were landless or almost so, in 1999-2000.

## WOMEN'S ROLE AND OPINION IN MATTERS CHILDREN'S EDUCATION, IMMUNIZATION AND OTHER MATTERS

Seventy eight per cent women reported that they decide about their children's education. It was also found that the women are very much concerned about their children's education. However, there was marginal difference in the responses across blocks and across castes.

Table 6.17: Decision on children's education across blocks and caste groups

| **Do you decide about the education of children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 83.0 | 72.4 | 75.5 | 80.9 | 77.8 |
| No | 17.0 | 27.6 | 24.5 | 19.1 | 22.2 |

In focus group discussion, many of the women reported about difficulties they are facing like improper and ill-maintained government schools, etc. Private schools are there at some places near the urban centers but they are very costly and beyond their reach and paying capacity. It is interesting to note that the women were most concerned about male-child's (son) education rather than girl-child's (daughter[25]) education. It is also interesting to note that the women reported that there are no difference between a son and a daughter but this discrimination was noticeable. However, it is not true for all women. It was also found that there are societal factors in preference for son's education than girl's education. Even where girls are getting education, it is only up to the primary education on the pretext of protection of girl. Girls have always been considered as a commodity, which one has to protect until she gets married. So girls are seen more as liability than asset. Although the women were empowered and open to new ideas, this attitude was prevailing which needs to be changed.

[25] Daughters are generally considered a net liability, they often require a dowry, they leave their natal homes after marriage, and their labour is devalued. This results in neglect of female children, who are weaned earlier than males, receive smaller quantities of less nutritious food and less medical care, and are more likely to be removed from school. (See, Improving Women's Health in India. World Bank, 1996).

Table 6.18: Initiatives to vaccinate children across blocks and caste groups

| **Do you take initiative to vaccinate your children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 85.3 | 67.3 | 74.1 | 78.7 | 76.5 |
| No | 14.7 | 32.7 | 25.9 | 21.3 | 23.5 |

Seventy six per cent women reported that they take initiative to vaccinate their children. It was also found that almost all women are aware about polio immunization. Although they do not know about other immunizations available but they take their children to sub-centre for vaccination and some of them have vaccination card for their children[26].

The responses across caste groups in this case did not show large variations. But across blocks the variations were noticeable and in some cases appear correlated to the presence and access to public health services. As mentioned earlier, the public health facilities in Phulwari were better functioning and were more accessible than the additional PHC at Maner. It is quite possible that the increase in initiatives by women to vaccinate their children is also partly due to the better reach of government services in this regard.

It was found that there is massive awareness about polio immunization programme because of the initiative of government and the UNICEF to mobilize all resources and machinery for polio immunization with the aim to eradicate polio. The UNICEF along with the World Health Organization (WHO), and the government of Bihar are trying to reach every child in the state under the age of five[27]. Although it is a challenging task because many adults and women work as migrant worker and labour, moving constantly between states in search of employment, a large number of children in the region do not benefit from regular

[26] The aim of an immunization programme is to reduce the incidence of, or to eliminate a particular disease. Vaccination of children against six serious but preventable diseases namely tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles has been a cornerstone of the child health care system. As a part of the National Health Policy, the National Immunization Programme, the expanded programme on Immunization (EPI) was initiated by the Govt. of India in 1978 with the objective of reducing morbidity, mortality and disabilities occurring from these diseases by making free vaccination services available to all the eligible children. The achievement of universal immunization of children against all vaccine preventable diseases by the year 2010 is one of the socio-demographic goals of National Population Policy, 2000.

[27] http://www.unicef.org/infobycountry/india_27265.html (visited 5 April 2006)

vaccination drives. "*I wanted to get my children vaccinated, but there were many other priorities and I forgot,*" says one mother. It was also found that all children were not immunized for DPT and BCC because of distance to sub-centre and lack of awareness and concern. District Level Household Survey (DLHS) 2002-04 shows that between the two rounds, 1996 and 2001, there is noticeable drop in full immunization coverage, utilization is low and drop out is high. The extent of no vaccination is as high as 45 per cent in Bihar[28]. Although the Government of India statistics suggest a much higher level of vaccination coverage than NFHS-2 (1998-99) estimates. However, the state level data collected on immunization coverage in NFHS-2 shows that the coverage of all the vaccines is much below the universal coverage in the states of Bihar, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh. These states are lagging behind the other states in the immunization coverage of all the vaccines (BCG, three DPT and Polio, and Measles).

It was also found that many of the women know about immunization for other diseases but they do not believe in it. Their argument is that they have not been immunized and they had no problems. "*And even if God wants to afflict someone from disease or disability, no vaccine or power can stop it*". But definitely the pulse polio immunization programme is well spread despite its shortcomings and coverage.

Table 6.19: Opinions in matters of children across blocks and caste groups

| **Do you keep opinions in the matters of your children** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 93.1 | 93.8 | 92.5 | 94.4 | 93.5 |
| No | 6.9 | 6.2 | 7.5 | 5.6 | 6.5 |

Ninety-three per cent of women reported that they do keep opinion in matters of their children education, growth, social behaviour and discipline. Although they have high values and standards for their children, they found it difficult to provide them adequate environment. They also reported that they

[28] http://www.iipsindia.org/ns/seminar.htm (visited 3 April 2006)

were not able to provide time to their children because of their work. Their own educational status is another constraint in guiding their children. Beside many of them were not getting needed attention from their husbands in matters related to children.

Table 6.20: Opinions on marriage of children across blocks and caste groups

| **Is your opinion taken in the marriage of sons/daughters** (percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 89.8 | 89.8 | 97.8 | 93.5 |
| No | 2.9 | 10.2 | 10.2 | 2.2 | 6.5 |

Ninety-three per cent women reported that their opinions were taken in the marriage of sons and daughters. In detailed probe, it was found that although their opinions were taken, male members of the family took final decisions. Women have less or no say in final decisions made in this regard. It was also found that although these women were consulted for fixing the marriage, the opinion of son or daughter who is getting married is not entertained. Even for girls it is a disrespect to go against family decision or express her will and opinion about it.

It was also found that the age of marriage for girls is many times below the legal age of 18 years for marriage. Many women also do not find it wrong considering the social pressures and practices. Although it was not expressed openly, girls are still considered a burden on the family. This burden is not in form of financial burden to save money for dowry but it is also related to the security of the girl including protection of virginity of the girls before marriage.

The National Family Health Survey (NFHS) II (1998-99), in a survey of women who were married below the age of 18 years, found that in Bihar they accounted for 71 per cent. One needs to understand that the material cost of the consequences of child marriage is far exceeded by the intangible costs relating to the quality of life, the suppression of human rights, and the denial of women's

potential to participate fully in the development process[29]. The consequences of early marriage for women are rather apparent such as, early pregnancies, obstetric complications, higher rates of neonatal mortality, infant mortality and under-five mortality. Apart from serious health consequences, child marriage also takes away the educational opportunities of adolescent girls, limiting their opportunities for employment and income generation and sowing the seeds for a lifetime of dependency.

## MOBILITY

In response to the question about their mobility, 81 per cent women reported that they go out on their will. Initially it looked like a very positive sign of empowerment where women are independent in their mobility. Generally, women are confined to their households, due to societal norms, and because it is perceived as unnecessary for them to leave their homes. In order to participate in SHG meetings and activities, the women were required to exit their homes, thus opening opportunities to gain social autonomy. Many women now claim they have acquired freedom not only to attend meetings and SHG functions, but also can travel for other purposes.

Table 6.21: Freedom of mobility across blocks and caste groups

| **Can you go out on you will** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 64.3 | 78.7 | 84.3 | 81.0 |
| No | 2.9 | 35.7 | 21.3 | 15.7 | 19.0 |

However, the variation across blocks suggests that even though presence and participation in SHG could be an enabling factor for such trends, some of this may also be due to the nature of development of these blocks. Women in the developed block of Phulwari (97 per cent) were more mobile than the underdeveloped block of Maner (64 per cent). Although at caste level, the

[29] Krishnakumar, Asha; Rajalakshmi, T.K. (2005). The High Social Cost. Frontline. Vol 22 Issue 14, 2-15 July 2005

differences are narrowed down, but still OBC women have greater mobility than the SC women.

However, during focus group discussion, it appeared that this mobility or independence is more a compulsion rather than respect to their rights. Although they are free to go out on their will but it is within the set parameter of work and it is limited to fields and near by market. But for going to their mother's place and to visit relatives, they need to take permission from their husband or from the head of the family. Although the situations are different in nuclear families, where women are more influential and have more mobility in comparison to joint families.

Other interesting finding was related to the women's class and caste. It was found that women from SCs are more mobile in comparison to OBCs and general class, which has strong norms for their women and restriction on their mobility. Moving alone or going out alone is not appreciated and restricted.

## EXTRA INCOME

The extra income comprises income from other sources which are occasional like getting money in marriages and on other occasions. Besides extra income also comprise income not informed to family or at times personal saving.

Table 6.22: Extra income across blocks and caste groups

| **Do you keep extra income** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 97.1 | 67.3 | 89.8 | 73.0 | 82.5 |
| No | 2.9 | 32.7 | 10.2 | 27.0 | 17.5 |

Eighty-two per cent women reported that they do keep extra income. The women mostly use this extra income in time of need and emergency like health, accident, disease etc. The women also use the extra money to buy household items of their use as well as of family use. While 97 per cent women in Phulwari were reporting that they were keeping extra income, only 67 per cent women in

Maner did so. A possible reason for this could also be the fact that the developed block also provides greater opportunities for economic activities and hence greater possibility of earning and keeping extra income. In Maner, with its level of development, it is possible that women did not earn enough extra income to keep with them. This was later confirmed during focus group discussion where the women from Maner reported that they were not able to earn extra income.

## PARTICIPATION IN SOCIAL LIFE AND SOCIAL INCLUSION IN THE COMMUNITY

Table 6.23: Participation in social life across blocks and caste groups

| **Has your participation increased in the social life** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 99.0 | 90.8 | 94.4 | 96.6 | 95.0 |
| No | 1.0 | 9.2 | 5.6 | 3.4 | 5.0 |

95 per cent women reported that their participation in social life and activities has increased. Now some of them also go out to participate in political rallies and meetings. One of the assumed benefits of SHGs is women's empowerment and this can be seen with the number of women involved in public affairs. While the number of women actually involved in politics was found none except that one woman was nominated as member of school committee. As mentioned, the number of women involved in politics is low. But, some women were conscious about political development at local level. These women are also going out for work to banks, block offices and cities for health care etc. This has broken the age old norms where women were confined to periphery of the house. Role of economy has also played an important role in it. These women are also earning and contributing to family income which has also enabled them to take decisions and to participate in social life.

Government policies and programmes have also played a positive role in it[30]. For instance specific panchayats are reserved for women members and for

[30] The 73rd (panchayati raj) amendment to the Constitution of India mandates the transfer of decision-making powers and resources in rural areas to local democratic bodies called panchayats. It aims at giving women, scheduled castes and scheduled tribes wider representation. The amendment was a revolutionary step in enabling true local self-governance. However, the level of progress made by different states towards this goal varies.

women belonging to schedule castes and other backward classes which has given them rights and respect in society and social life. Fifteen years of Rashtriya Janta Dal (RJD) rule in Bihar has also given them opportunity and motivation to come forward. Though the situation has not changed fully in their favour, still they face discrimination and insult, despite moving ahead for their rights and respectful position in the society.

Another reason behind increase in their social life is due to group feeling. They also go in group and they also feel more secure in the group.

## SOCIAL INCLUSION IN THE COMMUNITY

Table 6.24: Social inclusion in the community across blocks and caste groups

| **Social Inclusion in Community** (Percent) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Phulwari** | | **Maner** | | **SC** | | **OBC** | | **Total** | |
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| Status increased in the village level | 26 | 74 | 69 | 31 | 38 | 62 | 61 | 39 | 48 | 53 |
| More people come in my contact | 100 | 0 | 97 | 3 | 98 | 2 | 100 | 0 | 99 | 2 |
| Improvement in the marriage market | 100 | 0 | 96 | 4 | 99 | 1 | 98 | 2 | 98 | 2 |
| Higher acceptability in the community | 8 | 92 | 37 | 63 | 19 | 81 | 24 | 76 | 22 | 78 |
| More participation in the panchayat and other activities | 4 | 96 | 17 | 83 | 11 | 89 | 9 | 91 | 11 | 90 |

To assess the impact of SHGs participation on social inclusion in the community, set of related questions regarding women's participation in community activities were asked. These were, increase in status at village level, more people in contact, improvement in marriage market, higher acceptability in the community and more participation in panchayat and other political activities. Of these, there was near unanimity regarding two questions, that is, on improvement in marriage market and more people coming in contact with the women. However, in response to the question on whether the women felt that their status in the village has increased, 48 per cent women reported that it did

increase. But within this, majority of the women were in Maner block and from OBC community. Compared to 61 per cent OBC women reporting increase in status in the village, only 38 per cent SC women felt that their status in the village has increased. Similarly across blocks, while 69 per cent women in Maner felt that their status has increased, only 26 per cent women in Phulwari felt so.

However, on the issue of higher acceptability in the community and participation in political processes, the responses were overwhelmingly in favour of negative responses. Almost 78 per cent of women felt that they have not felt higher acceptability in the community. The percentage of women who did not feel that participation in SHG has led to their increased participation in political processes was 90 per cent. However, across blocks, women in Maner did feel some positive changes compared to Phulwari where there was negligible evidence of any such change.

It was also found that the women association with SHG programme has helped them significantly in their social inclusion in the community. They are now more respected in the community because of their knowledge and actions. Now the women are not only recipients but contributor to family income as well. During focus group discussion, it was found that despite inclusion at the community level, ground reality was just opposite in terms of initiatives and contribution for community development by SHG members. Recent analysis has also shown that the impact of SHGs on the community at large have been minor. There have been few instances of significant contributions from SHGs to education, family planning, eradication of child labour, etc. But, such community problems need large financial commitments which SHGs simply do not have the capacity to afford[31].

[31] Reddy, C. S., Manak, S. 2005. Self-Help Groups: A Keystone of Microfinance in India - Women empowerment & social security. Mahila Abhivruddhi Society, Andhra Pradesh (APMAS)

## PLANNING FOR FUTURE

Table 6.25: Planning of the future across blocks and caste groups

| **Can you plan your future better** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Yes | 94.1 | 85.7 | 87.0 | 93.3 | 90.0 |
| No | 5.9 | 14.3 | 13.0 | 6.7 | 10.0 |

Ninety per cent women reported that they could plan their future better given an opportunity, resources and facility. They also want to live good life, educate their children and have secure productive life. They also said that they can think and plan but when it comes to implementation and realization of their dreams, they feel helpless and forced to live in an environment which has no better future for them. The women do not have adequate money for themselves and their family. In this situation, how can they educate their children?

There are lot of policies and programmes for their better future and upliftment but they cannot avail these opportunities as they are not educated or even fulfilling the basic minimum requirement. The women also reported that the opportunities and policy benefits are reaching to those who are affluent and well connected. Planning and resources are very close to each other. One can only plan on the basis of resources, money, support and contact and they are lacking in all these aspects. It is very difficult for them to realize and execute their plans for better future.

## ORGANISATIONAL MEMBERSHIP

Except political parties and organizations, there is no presence of other organization in the villages. The women are least interested in joining any party although they vote for political parties during elections. The voting in favour of parties depends on decision of the family head. Money, power and muscles also influence the voting.

There are women organizations in Bihar but they are not active in this area except for taking issues highlighted by media or political parties.

## CONCLUSION

The findings reported in this chapter based on questionnaire analysis, case studies and focus group discussion suggest some positive impact of women's participation in empowering the women in various spheres of life. However, it was also observed that these changes are not shared equally across blocks or across caste groups with the developed block and better off caste groups witnessing more empowerment than the disadvantaged groups such as SC households or the underdeveloped block (Maner).

However, these findings and observations need to be addressed from a different perspective if any substantial conclusion on women empowerment as a result of SHG participation is to be drawn. The reasons of being cautious in analysing these findings results from various factors which work in conjunction with each other to either complement these individual processes or sometimes obstruct or negate the positive impact of some of these processes. But before that, it is important to state at the outset that quantifying women empowerment is in itself a complex task and identifying the various causal factors for it is even more difficult.

The first point to note in this regard is the fact that the findings and observations are mostly based on perception of women regarding their empowerment as understood from the research point of view. Needless to say that there is a huge gap between perceptions and their translations in to actual events of empowerment. However, such hard data is seldom available to researchers in a manner which can quantify the extent of empowerment or change in status of women. Nonetheless, since empowerment in a social context is also related to the way women are able to assert their individualities, even though relative to what earlier existed, any such increase felt by them suggests positive changes as a result of SHG activity.

However, the real complexity arises when one tries to distinguish between the effect of SHG activity on empowerment with those which have been guided by other external factors operating simultaneously but unrelated to the SHG activity. For example, women empowerment which has a strong impact on the way they understand health and access health services can also come through various other government programmes and incentives which are designed to support women to access health services better. Or for that matter, a better functioning government health system such as the one in Phulwari may also enable women to access health services better. Of course, even in these cases SHG participation may facilitate such processes. But it can also happen that these processes take place independently and would have worked even without SHG activity in the selected blocks.

Despite these caveats, it does appear from the findings that the women did benefit out of SHG participation in terms of women empowerment even though the extent of it varied across blocks and across castes. It did come out quite clearly that SHG participation did result in the women becoming or at least feeling economically empowered. However, the associated process which followed in terms of it being also reflected in social empowerment does appear to have taken place. It appears from the responses that women were feeling greater benefit in terms of social participation and empowerment.

However, it was also evident that these processes were more evident in the case of the developed block of Phulwari than the underdeveloped block of Maner. A part of this may be attributed to the choice of sampled blocks which also implies that the developed blocks would have already been in a situation with greater women empowerment than the underdeveloped block. For example, female literacy was higher in Phulwari than in Maner. That is, women in Phulwari were already in a better off situation to begin with, if participation in educational activities is any measure of it. The fact that women in Phulwari were more literate and more aware than women in Maner also implies that they were already in a better position to take advantage of the opportunities being offered to them as part of SHG activity. Same argument holds true for the OBC women who

with better literacy and awareness did make better use of these programmes and policies both by the government as well as by SHG.

Given the explicit focus of the SHG programme on SC women, it was expected that the SC women will also feel similar if not lower level of empowerment. However, the findings do not suggest any evidence that the SC women have done any better or even come closer to the levels of empowerment being enjoyed by the OBC women. It is important to clarify here that SC women need extra effort for the twin disadvantages faced by them in terms of social exclusion as well as economic deprivation. On the other hand, OBC women are better placed not only in terms of better social standing but also due to better economic situation of the household. On some of these issues, the extent of variation seen between the SC women and the OBC women suggests that the explicit focus on monetary activities by the SHG facilitator agency might not be enough to bring the SC women in mainstream.

# CHAPTER – VII

# SELF-HELP GROUPS AND WOMEN'S PERCEPTIONS ON HEALTH

CHAPTER VII

# SELF-HELP GROUPS AND WOMEN'S PERCEPTIONS ON HEALTH

This chapter presents the findings from the questionnaire, case studies and focus group discussions on issues related to health, women's perception on health, importance to health, health related practices, beliefs, disease pattern and prevalence, access to health services, women's role in accessing health services, role of SHGs in facilitating health knowledge and related behaviour and practices, knowledge about family planning, use and type of family planning methods used, and discussion on health issues within the family. The findings are also based on field observations and visits to several public and private health facilities which included a sub-centre, a primary health centre, and community health centres and private clinics.

## PERCEPTION AND UNDERSTANDING OF HEALTH

The first set of questions was regarding the women's perception on 'what is health'. Since this was an open ended question, all the responses were recorded, which in some cases were also multiple answers. Some of the salient responses were as follows: 'cleanliness and good food, cleanliness is important, disease, do not even get good water, do not get time to bath, drink clean water, for poor no need of health, health is important, health is important to earn more, health should be fine, to keep fit, live and eat properly, no disease is health, proper food is important, proper living keeps you fit, should be fine, think well stay well, timely eating, to die happily, to live and eat properly, to live properly, walk work and earn, we know but cannot follow, weakness, working body is healthy'.

This was a very crucial question about people's perception of health. It was found that different people have different understanding and perception of their health and concept of health per se. But most interesting finding was that

everyone defined health in the context of their environment and need. Another interesting finding was that none of the women defined health as perceived and practiced by health professionals, practitioners and clinicians.

This also seriously raises question about understanding and definition of health held by Professionals and policy makers. Does it make sense to develop policy and programmes for communities without taking into account their understanding and need?

For many women, health means, "cleanliness and good food, drinking good water, keeping fit, live and eat properly, timely eating, to die happily, walk, work and earn where as for others it was absence of disease is health, think well and stay well and working body is healthy". If we closely define each of the statements, proverbs and objectives to define health, we find that it has covered the social, cultural and economic and environmental factors while defining health. It was also found that health is a broader concept and it needs to be defined and understood in a way that takes into account the social, cultural and environmental factors rather than the stricter clinical definition of health.

Given the women's perceived notion of health, the second question was about the relevance of health in their day to day life. In response, almost every one, except one reported that their health is important for them. Even though the concept and meaning of health as understood by them is different from the bio-medical understanding of health, for most of them, health is something which is related to functional ability to perform work and live. It is far from a medical and Western understanding of health which sees body and patient as machine and doctor as mechanic who can repair and correct the malfunctions and infections in the system.

In further probing during the focus group discussions and in the case studies, it was also revealed that the women give their own perception about life. It is difficult to define life but it is necessary to understand the women's perception of life to understand their perception of health. Life is something, which comprises everything, relation, emotion, joy, pains everything under the

sky, which they can feel. The women believe that they have got life and it will end according to their Karma and no body is *amar* (live forever) or born to live without death. The duration between births and deaths is life which comprises love, joy and pain, suffering and disease. They take disease or bodily malfunction as part of their life experience. There is human touch in their concept of life and death, which is totally different from present day medical understanding of life, birth and death. Death is experience for them. The women do not want birth and death to be controlled by doctors (mechanics) and their technologically advanced tools like ventilator, oxygen etc. The women want to live and die in the presence of their family rather in presence of whispers of helplessness of present day doctors (mechanics).

The next related question regarding the women's perception of health was "why is health important to them". Since this was also an open ended question, the responses were many and reflected their perception of importance of health. This was obviously guided strongly by their perception of health. The women reported that they want to live healthy to enjoy life rather to enjoy health. They want to roam around, take care of others, work in and out, and earn. Their health is important because they are important for others to feed them, to cook for them, and to support their family. They see health which provides them strength, motivation, and independence. They want to be healthy because no one is there to take care of them. They want to be healthy because their work at home and outside will be affected. The other reported response were as follows, can have some saving, can roam around, can take care of others, can work in and out, do not have to depend on somebody, to earn, every thing is based on health, family depends on my health, health gives strength and motivation, health is life and earning, health of women is important than men, independence, it is important, it's our priority, to look after family, manage outside as well as home, no dependency, nobody is there to take care, to live, will be fit if health is fine, to work, to work and earn, work and walk, work at home and outside, work at home and outside will affected, work efficiency, to work in fields, you do not fall sick and various other response.

It is interesting to note that their salient response is not guided by individual or internal happiness. It is guided by concerns for others. It is guided more by human bonding, emotions, feelings, cultural values, norms and belief. This cannot be understood in modern western medical framework of health, medicine, and society.

## DISEASE PATTERN AND PREVALENCE

In response to the question on their frequency of falling sick almost four-fifth of women reported falling sick regularly.

Table 7.1: Disease pattern and prevalence across block and caste groups

| **Do you fall sick regularly (Percent)** | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Rarely | 9 | 8 | 4 | 14 | 8 |
| Regularly | 89 | 66 | 82 | 74 | 78 |
| Sometimes | 2 | 26 | 14 | 13 | 14 |
| Total | 100 | 100 | 100 | 100 | 100 |

Seventy eight per cent women reported that they fall sick regularly, 14 per cent women reported that they fall sick sometime and 8 per cent women reported that they fall sick rarely. It is interesting to note that despite their knowledge about prevention and awareness of various diseases, majority to them fall sick regularly. The incidence of falling sick regularly was reported to be higher in Phulwari Block compared to Maner. In Phulwari, 89 per cent of the women reported falling sick regularly, on the other hand, only 66 per cent of women in Maner reported regularly falling sick. Across caste groups, schedule caste households were more prone to falling sick regularly (84 per cent) compared to other backward class households (76 per cent). Focus group discussions and case studies revealed that many of them fall sick because of anemia[1] and lack of proper nutrient food. Another reason was living condition and unhygienic environment. It was also found that the women are hardly concerned about their

[1] Because the nutritional status of women and girls is compromised by unequal access to food, by heavy work demands, and by special nutritional needs (such as for iron), females are particularly susceptible to illness, particularly anaemia. (See, Improving Women's Health in India. World Bank. 1996).

own health or take precaution because of the hard realities which force them to ignore their health because of other pressing issues which are more important for them and their family survival.

*Chinta Devi, 45 years old of Schedule caste community is associated with SHG since last four years. Her family comprises husband, four children and in-laws. Chinta's major worries are health expenses. She says that all the time someone is ill in the family. It is not like that any of family members have serious chronic disease. But seasonal and other diseases because of unhygienic conditions are regular. She spends half of her earning on children and family health. Although her own health is matter of concern but she hardly consults doctor for the same. Whenever she visits doctor for her children or in-laws medicines she takes some pain killers form the quacks for her. She has back-pain since last two years but she does not consult doctors because she has to go to city and she anticipates that it would be costly beyond her capacity to meet the expenses. She says that children's health are important than her. She has lived her life and she is living for children and the family.*

It was also reported during focus group discussion that there are no adequate food for the family in many households. Many women and their family consume food which is not enough to meet their nutritional requirements. They do not have access to safe drinking water and sanitation facility. Medical services are for name sake and on paper with limited facilities which even do not fulfill the bare minimum requirement prescribed[2].

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[2] The number of Government health facilities in Bihar falls far short of national norms. Bihar has 396 PHCs and 101 CHCs which means that each PHC caters for more than 200,000 patients while each CHC caters for more than 800,000. These figures should be compared to national targets to have one PHC cater for a population of 30,000 and one CHC to cater for a population of 100,000. It is reported that there are 15,426 beds in Bihar in both the public and private sectors less than one bed per 5,000 population. The table given below presents current data on public health facilities in Bihar.

**Bihar, Government Health Infrastructure 2002.**

| Facility | Bihar No. of Facilities | Bihar Population Covered | Indian average |
|---|---|---|---|
| Sub Center | 10,332 | 8,033 | 5,401 |
| Additional PHC | 1,247 | 66,560 | |
| PHC | 396 | 209,596 | 32,169 |
| CHC | 101 | 821,782 | 243,729 |
| Hospitals & Med. Col[1] | 53 | | |
| Other[2] | 140 | | |

Besides, private medical health care system is very costly and uneven[3]. It is very difficult to access and pay for private practitioners which constraints them to visit the doctor for minor infections and ailments which need to be taken care of to control and prevent the spread of disease in community.

In response to the question on specific diseases which affect them, a wide spectrum of diseases in various combinations were reported. The disease comprises both communicable and non-communicable diseases[4]. The major disease reported during focus group discussions were Anaemia, Arthritis (Gathia), Asthma (Damma), Kala-Azar , Back ache, Blood Pressure, Body ache, Arthritis, Breathing problem, Chest Pain, Cold, Dental pain, Eczema, Fever, Filariasis, Gastritis, Head-ache, Itching, Leg ache, Leg swallow, Leprosy[5], problems related to menstrual cycle, Mumps (Gilti), Lumps in Breast, Old age, Piles (Bawasir), Seasonal, Sleeplessness, Stomach-ache, Stone, Uterus infection, low- vision, Weakness, White Discharge, etc.

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Source: Department of Health, Government of Bihar.

[1] Includes sub-division and district hospitals.

[2] Includes TB centers, blood banks, filarial and leprosy centers and other facilities.

[3] As a result of inadequate public health facilities, Bihar leads in terms of private health care delivery for both inpatient and outpatient services. This is despite the fact that most of the patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition. Studies have shown that hospitalizations often result in patients and their families dropping below the poverty line.

[4] Although accurate burden of disease information is not available, it is clear that given Bihar's level of development tackling communicable diseases is an immediate priority for government. The table below indicates some of the major diseases detected recently.

**Bihar, Status of Health Programs, 2002-2003**

| Disease | Number of Cases |
|---|---|
| Filaria | 411,076 |
| T.B. | 53,804 |
| Kala-Azar (Leishmaniasis) | 101,129 |
| Malaria | 3,683 |
| Leprosy | 38,588 |
| HIV/ Aids | 11.5% |

Source: Bihar State Health Profile at a Glance, 2003.

[5] Preliminary data for 2003 indicates that with 15,634 new cases of leprosy detected in 2003, Bihar accounts for more new cases of leprosy than another state in India and almost a quarter of all newly detected infections. (Source: Ministry of Health and Family Welfare, Government of India 1999)

Most of the women reported that they were suffering from anaemia, problem of the uterus and white discharge. Focus group discussions revealed that the women mostly ignore the initial symptoms and problems. The other problem was that they are hardly aware of signs and symptoms of serious diseases. Moreover, they have little access to a specialist doctor. Usually the women visit nearby village quacks[6] who have limited exposure in treating patients. Although untrained, the quacks are trusted by many women not for their healing skills but because they are available when needed and offer an affordable and courteous service. A quack who lives at his place of practice, as many do, is available 24 hours a day, seven days a week. They also accept cash or in kind payments for services rendered and often offer credit for those who cannot afford to pay on delivery of services. The quacks are giving general medicines for fever, pain and ache besides they have learnt the name of common medicines for certain diseases. Most of the quacks do not know the compositions of medicines, dosages, and side effects.

The women have accepted certain diseases as part and parcel of their life like water borne disease, seasonal disease, stomach ache, back-ache, and gastritis etc. Communicable diseases reoccur at regular interval because of unhygienic living conditions and positive environment for the spread of disease. It was a chance that there is no major epidemic occurring but considering the living condition, if it occurs, it will not be easy to control. There was no initiative by the people or government for prevention of diseases except child immunization programmes, which has its own shortfalls[7].

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[6] They include a range of providers such as informal unqualified providers, Traditional Birth Attendents (TBAs), faith healers, pharmacists or pharmacy assistants in medicine shops (for self-medication).

[7] It is disappointing to note that in Bihar, the current rate of children who are fully immunized has dropped from a high of 90 per cent in 1990 to just 11 per cent. (Source: NFHS-2 1998/9)

## ACCESS TO HEALTH SERVICES

In response to the question about access[8] to health services, 91 per cent women reported that they visit the doctor for treatment. It was found that although the women visit the doctors/ quacks for treatment and consultation, they visit them mostly in emergency when there are no other options. The health-seeking behaviour of the people is largely determined by many interconnecting factors, such as gender, traditional beliefs, customs and norms, level of education, socio-economic status, and physical factors like distance and lack of transportation. These in turn have a great influence on where care is sought.

Table 7.2: Access to health services among caste groups (SC and OBC)

| Percentage of women reporting visiting Doctor for Treatment | | |
|---|---|---|
| Schedule Castes | Other Backward Castes | Total |
| 89.8 | 92.1 | 91.0 |

No major difference was observed regarding women's visit to doctors across blocks. But by caste groups, 89.8 per cent of schedule caste households reported visiting doctors compared to 92 per cent for other backward class households. Findings also show that 91 per cent women have visited the doctor at some point of time but this consultation is not regular. Most of the women have visited the doctor for their children's health concern rather than their own health. When it was probed during focus group discussion that why their health is not given importance in comparison to children's and husband health, their usual answer was '*hamara kya hai*'. This fatalistic attitude towards their health was very common.

The women also reported during focus group discussions that considering the limited resource of family, it is not possible for them to go for long-term medication, which is costly[9], and beyond their capacity.

[8] Here access refers not only to proximity to facilities, but also access to a female provider, flexible hours, availability of doctors, service on demand and availability of good quality medicines

[9] The burden of medical costs is higher for the poor, and in extreme cases, may push families who

Most of the Rural Medical Practitioners (RMPs) are quacks, who do not have essential training and registration which is mandatory. There is a strong nexus between regulatory bodies, pharmaceutical companies and doctors, which makes it difficult to address this problem. Some of the doctors have put the signboard on RMPs clinic but they visit there only once a week. It is the RMPs, who run the show in the name of the doctor and whenever there is any complaint or enquiry, they settle it because of doctor's influence, connections and money, etc.

*Dr. Kiran Devi, 44 years is RMP (Rural Medical Practitioners) at Gaureyasthan in Maner since last eight years. Her clinic sign board shows that she is RMP (Registered Medical Practitioner) and women's specialist and there are 24 hours delivery services available. She has also contracted two MBBS doctors who visit her clinic weekly which gives her clinic a legitimate status but in reality the doctors are hardly visiting. She claims that she is the most popular Dr (RMP) in the area and earns around 20,000 Rs a month. She also does abortions and she is reputed for abortion because of confidentiality maintained by her. She charges Rs. 400 to 600 for abortions. She also has an underground room in her clinic to maintain privacy and confidentiality which matters a lot for villagers and the community. Her husband also helps her in managing the clinic. Surprisingly he also treats patients in absence of Kiran Devi. When asked about abortion and legal problems as she is not authorised to do abortions, her husband jumped in and said that there is no problem and every thing is set. If you have money and power you can manage anything. He also said that they have two MBBS male and female doctors and it does not matter who does the actual work. If problems arise doctors are helping them. Kiran Devi also shared that most of the cases coming to her are related to abortion. She also has the advantage of being a woman and there are very few women quacks or Rural Medical Practitioners in the area besides the Dais and Trained Birth Attendants who are mostly helping in home based deliveries.*

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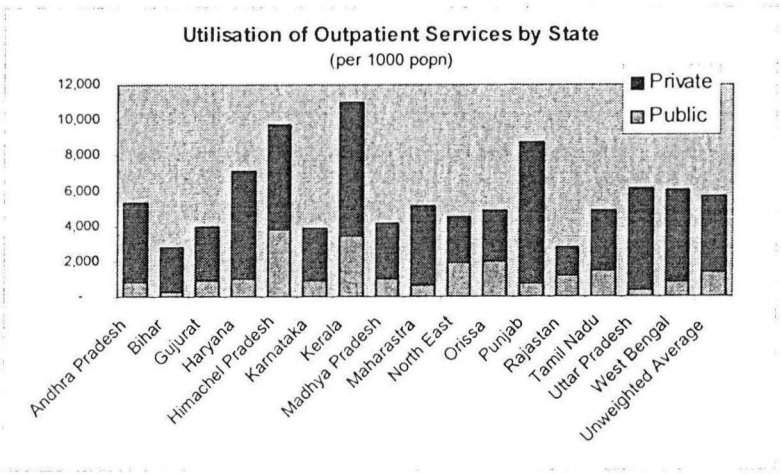
are just above the poverty line, into destitution (See, Krishnan, T.N. 1999. Access to health care and the burden of treatment in India: an inter-state comparison. In M.Rao (Ed.), *Disinvesting in Health. The World Bank's Prescriptions for Health* (pp. 208-230) New Delhi: Sage Publications.)

For those women, who did visit doctors for treatment, it was reported that three fourth of them were consulting private medical services[10]. Although Bihar has a BPL population of 42.6 per cent[11], the poor depend on private providers for their medical needs. This also means the near absence of public health services for majority of the rural population in the blocks and in the district[12]. The reasons cited by the women were non-availability of doctors or no staff[13] in time of need; indifferent and bad behaviour of staff; inaccessibility due to distance; belief that drugs provided were substandard and ineffective; and lack of awareness about the range of services provided by the Health Centres.

[10] NSS data from 1995/6 shows that residents of Bihar depend on the private sector almost entirely for in-patient and outpatient services




Source: National Sample Survey 1995-96, 52nd Round

[11] National Health Policy 2002

[12] Number of Sub Centre, Addtitional Primary Health Centre (APHC), Primary Health Centre (PHC), Referral Hospital, Sub Divisional Hospital and Sadar Hospitals in Patna District (2003-2004)

| District | Health Sub Centre | APHC | PHC | Referral Hospital | Sub Divisional Hospital |
|---|---|---|---|---|---|
| Patna | 48 | 71 | 16 | 4 | 3 |

Source: Health Department, Govt. of Bihar.

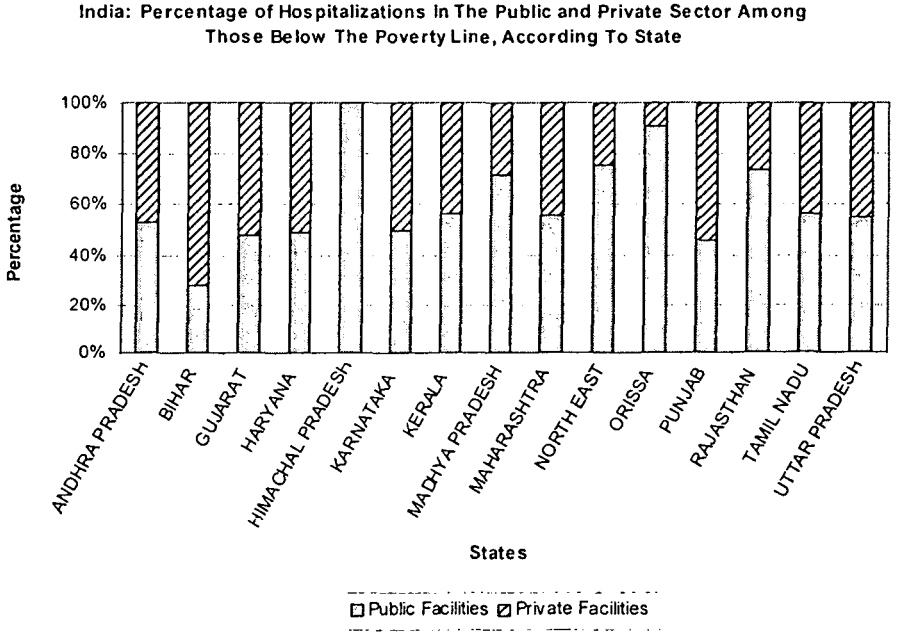
[13] Statistics on absenteeism provide a glimpse into the problem of quality in health services. Bihar's absentee rate for health workers and staffs in public facility is 58 per cent. (Source: Choudhary and others, 2003). See, Bihar towards a Development strategy: A World Bank Report)

Table 7.3: Access to health services across block and caste groups (SC and OBC)

| **Access to health services** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Nearby/village | 4 | 5 | 7 | 2 | 5 |
| Govt hospital/dispensary | 27 | 9 | 7 | 32 | 18 |
| Nearby Town | 1 | 1 | 2 | 0 | 1 |
| Private Doctor | 68 | 85 | 84 | 66 | 76 |
| Total | 100 | 100 | 100 | 100 | 100 |

Seventy six per cent women reported that they visit private doctors for treatment and consultation[14], followed by 18 per cent women who reported that they visit the Government hospital/ dispensary /PHC/ or Sub-centre. Five per cent women reported that they visit near by village and only one per cent women reported that they visit near by town for treatment and consultation. Access to government hospitals also varied across blocks with more women in Phulwari (27 per cent) compared to Maner (9 per cent) reporting visit to government hospitals. In Maner, women were more dependent on private health services. Similar variation is observed across caste groups with OBC women having better access to government hospitals (32 per cent reported going to government hospital)

[14] The graph given below shows the percentage of hospitalization in the public and private sector in Bihar.




Source: National Sample Survey 52nd Round

compared to SC households (7 per cent). The NSSO, 2006 report[15] on Morbidity, Health Care and the Condition of the Aged reveals use of public health care facilities for treatment of ailment was lowest in the rural areas of Bihar (5 per cent), preceded by Uttar Pradesh, Jharkhand, Maharashtra, Punjab, Uttaranchal and West Bengal. In the urban areas, although the proportion of treated cases of ailments was, in general, higher than in the rural, the reliance on the government health institutions was less than in the rural areas. This is perhaps, to some extent, due to easy availability of and accessibility to the private health institutions in urban area. The percentage of ailments treated by government sources was reported to be as low as 11 per cent in the urban areas of Bihar.

One of the interesting finding was that despite the high cost charged by private practitioners, most of the women were visiting them. Several reasons were found behind their visit to private doctors and practitioners. The foremost was their belief that they get effective drug from them and quick relief. More drugs also meant that doctor is more knowledgeable. Mostly these doctors are prescribing antibiotics and vitamins, which is very costly. Second reason for their visit to private practitioners was their round the clock availability and services. It was also found that there is perception amongst women that high cost of treatment means serious disease. They always talk and see the disease in terms of expenses. How much they have spent in treatment and how many places they have visited for treatment and consultation. It was also found that confidentiality maintained by private practitioners also attracts the women to visit private practitioners and quacks.

Only 18 per cent women reported that they visit the government health facility and services for treatment and consultation. Health infrastructure and services delivery in Bihar are in a shambles state[16]. The NSSO, 2006 report[17] also

[15] NSSO, 2006: Report No. 507: Morbidity, Health Care and the Condition of the Aged, Jan.-June,2004. pp. 22-23

[16] There are 2,992 registered doctors in Bihar or about 1 per 28,000 of the population compared to the national average of one per 2,100. These disparities are repeated for all other types of health worker. In theory each PHC in Bihar is staffed with between two and four doctors. In practice, doctors rarely show up, especially in the rural areas. The government salary, although described as "reasonable" by government officials is only a third of what they could earn in the private

shows the changes in the share of government institutions in the case of non-hospitalised treatment of ailments for different states over the periods. It can be seen that there has been a marginal change in the share at the all-India level in both rural and urban areas. Bihar showed a decline in the share of public institutions in treatment of non-hospitalised ailments in both rural and urban areas, a significant decline in the share of public institutions in treating ailments. The Comptroller and Auditor General (CAG) report for the year ended March 2004 state that the state's rural healthcare system is literally gasping for breath. Forty-nine per cent of health sub-centres, 41 per cent of primary and auxiliary health centres and 5 per cent of referral hospitals have no buildings of their own. Referral hospitals do not provide emergency services. There is a huge shortfall in health facilities. Health sub-centres are short by as much as 52 per cent, primary health centres by 29 per cent, and there is a staggering shortfall of 88 per cent in referral hospitals. The CAG report blames this dismal state of affairs on "under spending" against budget provisions, resulting in lack of essential infrastructure[18]. The women know that even if they consult government hospital services, they need to go to private medical shops or RMPs for medicines. It was also found that government facilities are good for nothing, without, beds, water facilities, toilets and electricity[19].

***ADDITIONAL PHC SHERPUR, MANER, BIHAR***

*Additional PHC, Sherpur comes under Maner PHC, situated on Patna – Ara Main Road. In first sight it does not look like an APHC because there is not any sign board. It is in bad shape structurally. In this APHC there is no power, no water, bathrooms are for name shake without water and non-functional. There should be six beds as sanctioned but in reality*

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sector. It is clear that the PHC could be managed with a single dedicated doctor rather than four absentee doctors. (Source: Bihar: A Rapid Private Sector Assessment - A Discussion Document. 2004. South Asia Region, World Bank)

[17] NSSO, 2006: Report No. 507:Morbidity, Health Care and the Condition of the Aged, Jan.-June,2004. pp. 23

[18] Dreze, Jean and Sen, Amartya (Ed) (1997). Uttar Pradesh: The Burden of Inertia published in India Development: Selected Regional Perspectives. Oxford University Press.

[19] The National Family Health Survey confirmed the unacceptable state of Bihar's primary health facilities. Less than a third of PHCs have electricity and more than a third have no running water.

*there are no beds. In one corner of the hall one rusting cot is lying in the name of bed.*

*This APHC at present is having 2 Male doctors, 1 Clerk, 3 ANMs, 1 Lab technician, 1 female ward attendant to serve the population of approximately 20,000 with four sub centres. During his visit to the APHC, the researcher did not find any other staff other than the Doctor. The researcher was informed that ANMs are in the field and in afternoon the researcher met them. This APHC also serves as DOTS clinic – microscopic centre. The researcher did not find any lab, microscope and other basic infrastructure needed. Timing of the OPD in this APHC is 8-12 A M (Monsoon), 8.30-12.30 (Winter), Monday to Saturday and generally it opens everyday. Limited medicines are available; patients have to buy the medicines from outside. The researcher was informed that non availability of medicines is due to some administrative problems.*

*The common diseases reported in men were seasonal cough/cold/fever/dysentery. There were 6 cases of reported TB (including male and females) and 61 cases of Leprosy. Common diseases reported for women are RTIs, common cold, fever, TB, leprosy, back-ache, and problems due to menopause. The main causes of diseases as perceived by the doctor are poverty[20], lack of education, lack of awareness and poor sanitation.*

Five per cent women reported that they visit near by villages for treatment. Generally they visit local traditional healers, like Vaidya (Ayurvedic practitioner), priests, sadhus and tantriks. Many of the women who visited these places reported that they have consulted private and government medical doctors and the patient situation had worsened under their treatment. The women also believe that patient is afflicted with evil spirits.

[20]Poverty is widely accepted to be a root cause of ill-health (See, Wagstaff, A. 2001. Poverty and health.*CMH Working Paper Series. Paper No. WG1:5.* Commission on Macroeconomics and Health).

Moreover, the differential access by caste groups and by blocks also suggests that the government hospitals are not accessible to the marginalized sections of the population. While the traditionally better off caste groups such as OBC households were able to utilize the government health services, the same was not true for the SC households who were reluctant to use the government health system. Apart from the various reasons outlined earlier, it also appears that the SC households were not confident of accessing the government health services.

Only 9 per cent women reported that they do not visit to doctors for treatment and consultation. When it was probed further that why they do not go/visit or consult doctors, 96 per cent women did not respond. 4 per cent women reported their inability to pay medical expenses. It was found that there is very close relationship between cost/expenses and visit to doctors. Even among people who visit the doctors and practitioners for consultation and treatment, it was found that they do not visit regularly and visit only for disease, which could not be ignored due to pain and their inability to move and work.

Besides the reason of lack of money, it was also found that somewhere the women's belief in modern medical system is also responsible for their negative attitude towards the system. Some of them believed that god is taking care of everything. He has given life and only he can take. The pains, sufferings, and disease are punishment of their sins of past life and this life.

## WOMEN'S ROLE AND DECISIONS IN ACCESSING HEALTH SERVICES

In response to question that who decides about going/visit to the doctor, 77 per cent women reported that it is decided by themselves followed by husbands' decision[21] (16.5 per cent), and together (3 per cent).

[21] Generally, in both rural and urban areas, the majority of women are accompanied by a family member, usually the husband, when seeking health care.

Table 7.4: Decisions in accessing health services across block and caste groups

| **Who decides about going to doctor** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| Self | 89 | 64 | 74 | 80 | 77 |
| Husband | 11 | 22 | 19 | 14 | 16.5 |
| Mother in Law | 0 | 3 | 2 | 1 | 1.5 |
| Father in Law | 0 | 3 | 0 | 3 | 1.5 |
| Sons | 0 | 1 | 1 | 0 | 0.5 |
| Together | 0 | 6 | 4 | 2 | 3 |
| Total | 100 | 100 | 100 | 100 | 100 |

The table above shows that more than one-third of the women are independent to take decision about their health and visit to the doctors. However, there was considerable variation across blocks regarding decision about visiting doctor or accessing health services. While 90 per cent of women in Phulwari were deciding themselves about accessing health services, in Maner only 64 per cent of women were taking decision themselves. However, no difference was observed across various caste groups regarding decision to access health services. In focus group discussion also, it emerged that decision-making and control does not ensure visit to doctor. There are other underlying factors like, money, and accessibility to health services etc which influences visit to doctor. Many women also reported that they prefer to be seen by a female health provider, but unfortunately female providers are almost entirely absent from the public primary health system and scarce in the private system. Although the women are taking decisions themselves, they visit more for their children's and family members' health rather than their own health. Reason for self-decision is also influenced by easy reach to RMPs within the village and nearby market for which they do not need to plan or ask anybody to accompany them. Another reason reported is control over money. The women are earning and their spending in health is always justified so they have freedom to decide themselves considering the negative health consequence because of late attention or doctor consultation.

Another reason behind women's self-decision is based upon availability of husband or other person within the family. The male members are also in the field and other work and at times it is not possible to wait for husband's decision or other family member's decision. Despite this situational need, it is interesting to note that still in 17.5 per cent of the cases the husbands take decision about

visit to doctors. It was also found and reported that male members give less importance to women's health and consider many of the disease as women's disease, which is part and parcel of their body, and there is no need to worry about them. Although this attitude is changing because women are also becoming vocal and aware of negative consequence of ignorance about their health.

The women are also aware about health issues because of their association and participation in SHGs where they discuss about their health problems and get the opinion and help of other women.

Table 7.5: Satisfaction with decisions made

| **Are you satisfied with that decision** | |
|---|---|
| Yes | 28.5 % |
| No | 71.5 % |

In response to the question about women's satisfaction and dissatisfaction with the decisions made by family members, 71.5 per cent women reported that they are not satisfied with their in-laws' decision about visit to doctor and consultation. It shows that the women are bound to live within the parameter of family-decision regarding health access and utilization of services. The women are dependent on head of family for money. The other significant finding reported was that many of the women are asked to reveal the problems (to the head of family or husband) and the head of the family (male or female) will arrange medicines. This also shows the patriarchal attitude towards women's health.

## IMPACT OF SELF-HELP GROUPS ON INCREASE IN HEALTH KNOWLEDGE

In response to the question on impact of SHGs on women's knowledge of health and health awareness, it was found that overall their knowledge/ information and awareness has increased significantly.

Table 7.6: Impact of SHG on increase in health Knowledge

| **Impact of SHG on increase in knowledge about** | Increase | Decrease | No change |
|---|---|---|---|
| Health and Hygiene | 138 | 1 | 59 |
| Vaccination | 134 | 3 | 63 |
| Contraceptives | 111 | 3 | 86 |
| Care during pregnancy | 100 | 4 | 96 |
| Care of self post child birth | 113 | 3 | 84 |
| Care of Infant | 123 | 3 | 74 |
| Awareness of personal health care/needs | 125 | 3 | 72 |
| Awareness about existing health services | 137 | 2 | 61 |

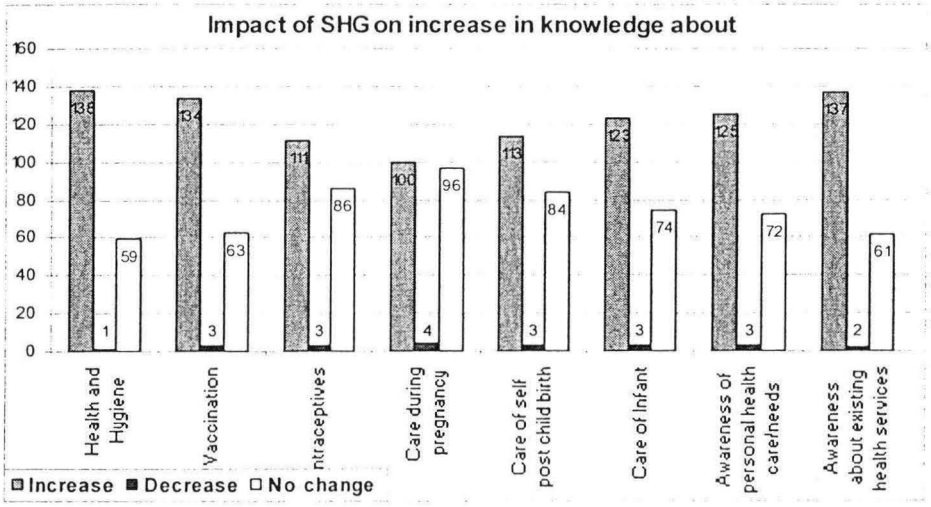


Figure 7.1: Impact of SHG on increase in health Knowledge

Out of the total of 200 women, 138 women reported that their knowledge on health and hygiene has increased. This increase in knowledge was also reported in other area of health like vaccination, contraceptive knowledge[22], care during pregnancy, care of self during post child-birth, care of infant, awareness of personals health care/needs and awareness about existing health services.

Here it is interesting to note that although their level of awareness has increased, and there is acceptance and attitude to information gained, but in focus

[22] It is interesting to note that despite the fact that Bihar has the lowest contraceptive prevalence rate (24.5 percent); the women reported increase in knowledge about contraception.

group discussions, it was found that practice and use of this knowledge and information is very low. For example they know about contraceptive choices and it is available to them but they do not use it. Some women also reported that they do not enjoy sex using condoms.

It was also reported that male members do not want to use condoms for contraception and they feel uneasy. Some of them reported side effects like *garmi*[23] (heat) etc. One of the respondent reported that in their community no one uses condoms. Some of the women have opted for tubectomy. They prefer tubectomy in comparison to other contraceptive choices available.

The women also reported in focus group discussion that they know about care during pregnancy and have new information related to precautions, and dietary needs but practically it is not possible to follow it because of poor economic condition of the family. They know that they should take care of cleanliness and hygiene during menstrual period and should change sanitary pads regularly, but they do not have money to buy sanitary pads and despite being aware and knowing negative consequences of it, they are compelled to use old clothes even for longer periods during their work.

They know and understand the importance of health and hygiene but it is not in their capacity to have safe water and sanitation[24]. They live in the same unhygienic environment, knowing that it is not good, but they have their own limitations.

[23] Garmi indicates the prevalence of STDs among men. Sores and various forms of pus discharges and appearance of boils and pimples are thought to be representing Garmi.

[24] In Bihar less than 17 per cent of populations have access to adequate sanitation and more than one quarter of households do not have access to clean water. (Source: Bihar- A Rapid Private Sector Assessment - A Discussion Document. 2004. South Asia Region, World Bank)

## IMPACT OF SELF-HELP GROUPS ON HEALTH RELATED BEHAVIOUR AND PRACTICES

Table 7.7: Impact of SHGs on health knowledge

| **Impact of SHGs on health related behaviour and practices** (Percent) | |
|---|---|
| No new Information | 16 |
| No health information | 1 |
| No change | 5 |
| Got awareness | 78 |

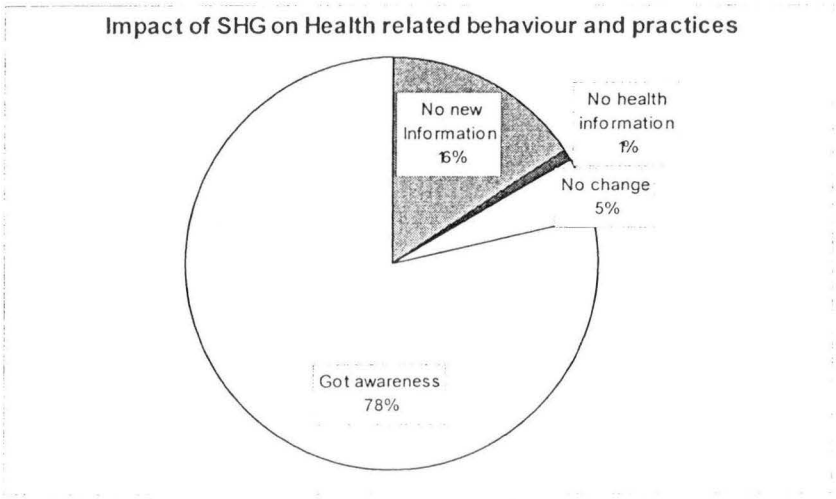


Figure 7.2: Impact of SHG on health knowledge

In response to the question on impact of SHG on health related behaviour and practices, 78 per cent women reported that they are now more aware on health related issues, where as 16 per cent women reported that they did not get any new information or knowledge. It was found in focus group discussion that although the women became aware and have information about health, health care, first-aid and emergency care for better health, they are hardly practicing those learning and information for better health. Through SHGs first-aid box were provided to the groups. It was found that none of the groups have those first-aid boxes now. The women are not even in a position to locate the first aid-box. This also shows that until or unless, they realize the need for first-aid, through training, exposure awareness and information, it cannot be imposed on

them. It was also found that Knowledge- Attitude - Practice (KAP) relationship is not harmonious. During the interview, the members repeatedly complained that government is not providing adequate health care facility, services and care but in reality it was found that they never fought for their demands for better health care.

In rural Bihar the percentage of births delivered in medical institutions in 1998-99 was around 12 per cent and only around 20 per cent of births were attended by health professionals in 1998-99[25] (NHDR, 2001). IDF also provided training to some of women members for first aid and TBA (Traditional Birth Attendant) training with delivery kits. The study did not find any trained TBAs having a delivery kit. Despite the training and exposure they are delivering the babies in the traditional way which many a times is fatal and harmful to mother and child because of infections and other complications.

Table 7.8: SHG's impact on health behaviour and practices

| **SHGs impact on health behaviour and practices** | Increase | Decrease | No Change | No Response |
|---|---|---|---|---|
| Visit to PHC | 70 | 26 | 96 | 8 |
| Visit to Private doctor/Nursing Home | 137 | 23 | 36 | 4 |
| Ante-Natal Care during Pregnancy | 109 | 3 | 85 | 3 |
| Pre-Natal Care during Pregnancy | 106 | 2 | 89 | 3 |
| Post natal care | 122 | 1 | 73 | 4 |

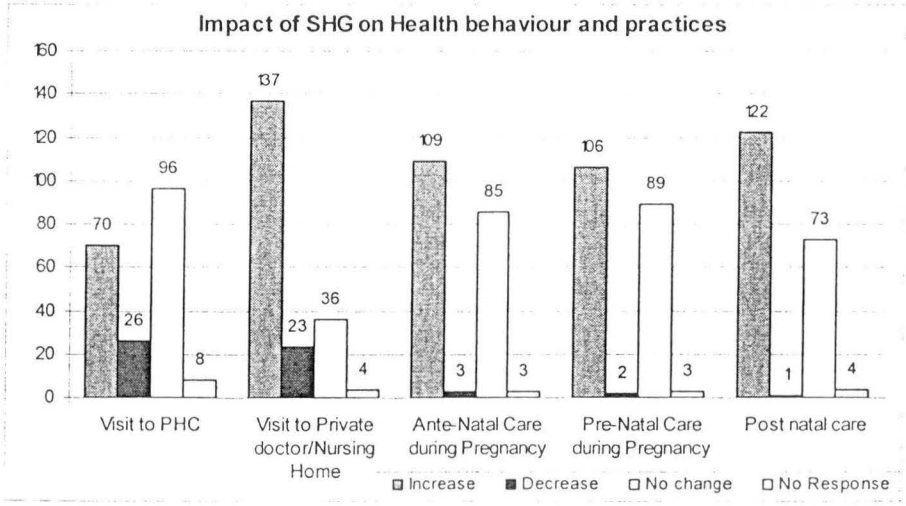


Figure 7.3: SHG's impact on health behaviour and practices

[25] National Human Development Report (NHDR), 2001. Planning Commission, Government of India

It was also found (as it was reported) that there is positive change in the women's health behaviour and practices like their visit to PHC and doctors/ nursing home has increased. Ante-natal care during pregnancy and pre and post-natal care during pregnancy have increased. Although this was not found very strong in subsequent findings and in focus group discussion but undoubtedly there is a change. It is also interesting to note that 26 and 23 women reported that their visit to PHC and to private doctor/ nursing home has decreased respectively. It was found in focus group discussions that people are more aware of ante-natal, pre-natal and post-natal care, STIs etc in comparison to other communicable and non-communicable diseases. It was further found that knowledge about pregnancy care and Reproductive Health (RH) is more talked about because of Pathfinder International's on going Prachar Project (covering RH, STI, STD, pregnancy and providing contraceptive choices). It was difficult to ascertain whether this information and awareness reporting is due to their association with SHG or because of Prachar Project intervention with large manpower involved to reach each and every newly married couple and pregnant women. It was also found that the women are intelligent and sharp and grasp any information and knowledge fast but when it comes to practices they lag behind due to various reasons.

The main issue, which emerged during focus group discussions, is that most of the programmes are imposed on them. Although they are benefited by the programme, it never got acceptance as a concept which was the major reason behind unsustainable nature of the programmes. On the issue of impact of SHGs on health awareness, it was also found out that the scheduled caste women have benefited more than the women from other backward castes.

## KNOWLEDGE ABOUT FAMILY PLANNING

Regarding their knowledge about family planning and contraceptive choices, 74 per cent women reported that they know about it while 26 per cent women reported that they do not know about it.

Table 7.9: Knowledge about family planning

| **Do you know about family planning** (Percent) | | | |
|---|---|---|---|
| | Phulwari | Maner | Total |
| Yes | 83 | 64 | 74 |
| No | 17 | 36 | 26 |
| Total | 100 | 100 | 100 |

Again, there was considerable variation across blocks regarding information about family planning. While 83 per cent women in Phulwari reported knowledge about family planning, only 64 per cent women in Maner reported knowledge about family planning. It was surprising that nearly one-third of women reported that they do not know about family planning. Having knowledge and information and its practice are two things. Considering the Government of India's more than fifty-four years old family planning programme and its focus towards rural health through Sub-centers, PHCs, CHCs with a mission to reach to everyone through *anganwadi worker*[26], compels us to think about strategies adopted by government and the ground reality. It is true that SCs, PHCs, CHCs are in bad shape, facing resources crunch with basic minimal services where at many places even basic infrastructure facilities are not available.

It was also found in focus group discussions that among the women who know about family planning have also heard of various methods and techniques and contraceptives available. Although it is not true for all but they have heard of tubectomy, condoms, pills, Copper T and other contraceptive methods. Some of the women have gone for tubectomy in government-organized camps. They also got small incentives prescribed. Most of the women know about condoms. They also reported that they do not use condoms as their husbands do not like it and they also do not enjoy sex using condoms. It was interesting to note that although condoms are not used, it is available there, as at some places children were found

[6] Anganwadi workers are workers engaged by the Government to work in the State operated Integrated Child Development Services (ICDS) which cater to the health and pre school education needs of 0-6 year old children as also the health and nutrition needs of pregnant women, nursing mothers and adolescent girls. All 0-6 year old children, all pregnant women, nursing mothers and adolescent girls in India are entitled to access to this Service.

playing with condoms as balloons. This also raises questions about safe use and handling of condoms after use, which is important from public health perspective. There is a no proper demonstration and people do not know how to use them.

It was found that some of the women are using oral pills but most of them reported about irregularity in taking these pills because sometimes they forget to take, at times they do not find it, etc. Some of them also reported about side effects. It was found that there also exist a section of women mostly in middle and old age who believe that using family planning methods as unnatural and one should not regulate and control fertility as it is God's gift (to women) and wish to have children. The women do see population as a problem but child bearing is something different, which cannot be associated with population problem. The women also complain that the government is not able to manage population by not providing education, employment and health. Otherwise they consider population as strength. More people mean more strength.

**Source of knowledge about family planning:** Around 25 per cent women chose not to respond to the question about their familiarity to family planning methods. Twenty eight per cent women reported that they came to know about it through NGOs. The NGO IDF had organized various health related awareness programmes, in which many of the women had participated. Besides this, animators and social workers of the NGO also talked about health, population, reproductive health, family planning, first-aid and covered wide range of disease and its prevention during weekly meetings. Convergence meeting with health functionaries also helped the women to get information about family planning methods, available services and related information. However, their effort has yielded different results in different blocks. In Phulwari, only 22.5 per cent women reported that they knew through NGO. On the other hand, 34 per cent women in Maner had benefited from NGO intervention and reported NGO as the source of information.

Table 7.10: Source of information about family planning across block and caste

| **How do you know about family planning** (Percent) | | | | | |
|---|---|---|---|---|---|
| | Phulwari | Maner | SC | OBC | Total |
| No Response | 17 | 35 | 28 | 22 | 25.5 |
| Women | 7 | 14 | 12 | 9 | 10.5 |
| Advertisement | 10 | 0 | 9 | 0 | 5 |
| Husband | 1 | 5 | 4 | 2 | 3 |
| Hospital | 36 | 9 | 17 | 32 | 23 |
| Organisation | 23 | 34 | 28 | 26 | 28 |
| During Education | 7 | 2 | 2 | 9 | 5 |
| Total | 100 | 100 | 100 | 100 | 100 |

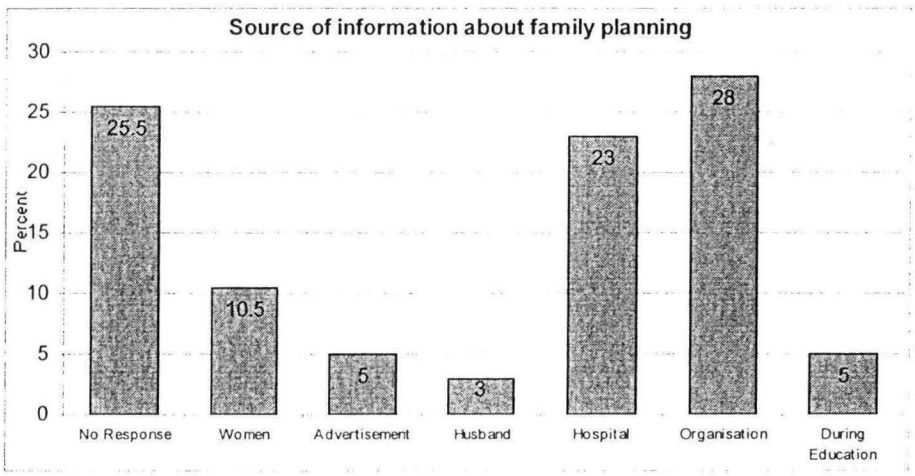


Figure 7.4: Source of information about family planning

Twenty three per cent women reported that they came to know about family planning services through hospitals. Here hospital comprises Sub Centers, Additional PHC, PHC, and Community Health Centre (CHC). Although these are not very functional infrastructure wise, they were able to provide information and awareness services. Besides time to time family planning camp organized at block level by health functionaries also contributed to their awareness about family planning. Here also, the reach of government hospitals in spreading information was clearly linked to their access to government hospital. In Phulwari where more women had access to government hospital 36 per cent were also reporting hospitals as source of information. In contrast, in Maner only 9 per cent women reported hospital as source of information. Similarly, while only 18 per cent of schedule caste women reported hospital as source of information, 25

per cent of other backward caste women reported hospital as source of information.

Around 11 per cent women reported that they came to know about family planning services, and its availability, etc from other fellow women in their community, relatives and fellow members of their group. It was found that groups also provided a space to the women to discuss their health problems and they learnt from other suggestion and experience about its ramification. Even at times other members of group accompanied them to health centre for seeking such services. It was also reported in focus group discussion that group played an effective role in providing such services and help to fellow members. This method of spread of information was more accessible to the schedule caste women compared to other backward class women. For the other backward class women, this kind of peer interaction was the source of information to only 8 per cent of women.

Five per cent women reported that they came to know about family planning through advertisements. Here advertisements includes wall-writing, posters, hoardings, loudspeaker announcement, radio programmes and advertisement, television programme and advertisements, newspaper and other mode of communication. It was found that mostly the women got aware through wall-writings, posters and loudspeakers besides other forms of advertisement. Incidentally, all the women who came to know about family planning through advertisement were from Phulwari block.

Five per cent women reported that they came to know about it during their education. It was interesting to find this, because there is a general complaint that sex-education is not part of education and even wherever it is included in syllabus, teachers do not teach those chapters which are on sex education and family health education. It was interesting to note that only 3 per cent women reported that they come to know about it through their husband. It also shows the husbands' level of awareness of family planning, methods, services and other related information.

**Use of family planning methods:** In response to the question about use of family planning methods, 57 per cent women reported that they do not use any of family planning method and rest 43 per cent women reported that they use it. Again, more women from Phulwari were using any family planning method than women in Maner. But across caste groups, it was the schedule caste women who were using family planning methods more than other backward class women. It is interesting to note that out of 74 per cent women who are aware of family planning, only 43 per cent of them are using that. It also shows that awareness and information does not ensure practice and use of that information. It was also found in various KAP (knowledge-Attitude-and Practice) studies. It was found in focus group discussion that there are various reasons behind not using family panning methods despite having information and awareness about it and its positive and negative consequences. Foremost reason reported was husband's permission. Some women reported that their husband do not want to use family planning methods. They also reported various underlying reasons behind it like, they do not enjoy sex, they feel that using family planning method is unnatural practice against the God's wish and finally they believe that population is not a problem, it is an asset so, why one should stop producing children. If god has given the birth, he will also take care of it. They do believe that poverty, unemployment, etc are problem but they are not related with population. They see that the root of the problem is management and government's attitude. They are appreciative of various programmes started by the government for their benefit, but it did not reach to the women because of middleman, corruption and bureaucratic failure to implement these programmes efficiently.

Another reason of non-use of family-planning methods despite having knowledge is various misconceptions and side-effects. Some women reported that their husbands believe that after using family planning methods they will not get enjoyment in sex. Some of the cases of contraceptive failure, infections and further complications has sent wrong message to women.

This also shows that population "stabilization" cannot be achieved by mere physical provisioning of contraception and availability of obstetric care. It is necessary to involve people (particularly men) and enable women in particular

to have a say in decisions relating to reproduction and livelihood. This also brings in the issues of reproductive rights of women and of the larger conceptual issues of gender equality and of empowerment of women within and outside the household. To understand the issue of health and reproductive health which also underlies the issue of good health and nutrition of women, it is necessary to understand the dynamics of power and the nature of gender relations between men and women within the family and community.

**Type of family planning methods used:** In response to question about type of family planning methods used, again 54 per cent women chose not to respond.

Table 7.11: Type pf family planning methods used

| **Family Planning Methods** | Percent |
|---|---|
| No Response | 54 |
| Operation | 32 |
| Nasbandi (Tubectomy) | 4 |
| Pills | 10 |
| Total | 100 |

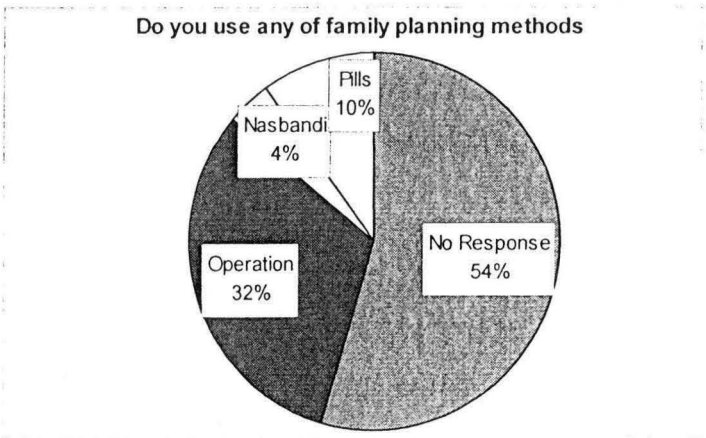


Figure 7.5: Type pf family planning methods used

Amongst 46 per cent women who reported using family planning methods, 36 per cent women reported that they went through the operation or *nasbandi* (tubectomy), and ten per cent women reported that they were using pills (Mala-D and other available brands in the market). The reason behind no response of women was due to their shyness to share this information in group

because many a times these question were asked in group or in presence of animator. It was also interesting to note that no one reported about condoms and natural methods. It was found during interaction with the women that some of them are using condoms but no one reported it in survey questionnaire.

Thirty six per cent women went for tubectomy because it was permanent method with fewer problems and was also incentive based where the women got incentive in term of money. Secondly for tubectomy they do not need to go far as this facility is available at Community Health Centre and district hospitals besides camps organized by health functionaries in different panchayats. The women who chose for tubectomy are mostly young with three to five children. They also reported during focus group discussion that they went for tubectomy because they want to restrict family size. They also reported that by restricting family size they can provide better education, care and attention to their children. Some of them also reported that population is problem and one should restrict family size considering limited resources available and over growing demands.

It was also observed that more women in Phulwari were using tubectomy compared to Maner. This again reflects the reach and access to health services which is better in Phulwari compared to Maner. That is, access to health services is some ways influences the choice of family planning method. On the other hand, more women in Maner were using pills compared to Phulwari.

Table 7.12: Decision about using a particular contraceptive choice

| **Decision about using a particular method/s** | Percent |
|---|---|
| No Response | 59 |
| No Expense + Rs 175.00 | 6 |
| To stop damage of body | 3 |
| Family Planning | 25 |
| Uterus Problem | 7 |
| Health did not allowed to operate | 1 |
| Personal Problem | 1 |
| Total | 100 |

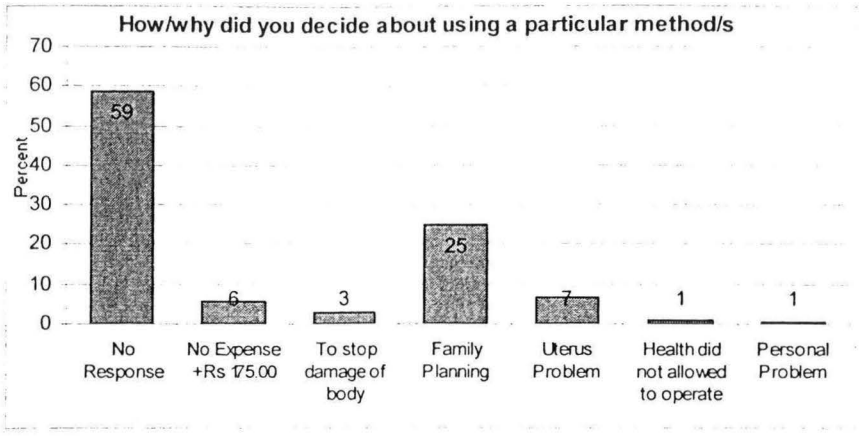


Figure 7.6: Decision about using a particular contraceptive choice

In response to the question on decision about using a particular contraceptive choice, again 59 per cent women chose to not to respond. The rest who responded come out with variety of reasons for using particular method. Some of the reported reasons behind choosing a particular method over other methods are as follows. 25 per cent women reported that they chose it to restrict the number of children and they wanted to plan their family. Seven per cent women reported that they chose for family planning because of abnormalities in the uterus. Their uterus has problem of displacement and they wanted to remove it on doctor's suggestions. Six per cent women reported that they chose tubectomy because it was easily available, permanent and safe method with added incentive of Rs 175. Three per cent women reported that they do not want to damage their body any more by producing more children with less care and facilities available. One per cent women reported that they wanted to go for tubectomy. One per cent reported personal problem behind tubectomy.

Incidentally, the incentive system was also related to access to health services. All the women who reported getting tubectomy done were from Phulwari where the government health system was more accessible than Maner.

Table 7.13: Discussion with husband about reproductive health issues

| **Do you and your husband ever discuss about your reproductive health issues** (Percent) | |
|---|---|
| Yes | 39 |
| No | 61 |
| Total | 100 |

In response to the question 'do you and your husband ever discuss about your reproductive health issues', 61 per cent women said no and only 39 per cent women said yes. It was found during focus group discussion that husbands generally do not want to talk on these issues and it is mostly initiated/ started by women to share their reproductive health problem, disease etc. The overall structures of society where women are seen as object of sexual satisfaction, and as reproductive machines, men hardly think of taking their opinions and suggestions on these issues. It was also found in FGD that although the women's opinion or suggestions are not welcome but they do have their opinion about reproductive health issues, issues of reproduction and sexuality. They do not believe that they are object of sexual gratification or satisfaction for men folk and they do have equal right to protect their rights and health.

Some of the women reported that their husband establish sexual relationship with them without considering their will, health and physical condition, which many a times equals rape. But they have their own limitations and they have to live in the same society with the same person. It was also found that even though 39 per cent women reported that they discuss about it, the form of conversation is not always healthy discussion rather more in the form of complains, dissatisfaction and problems. For healthy reproductive and sexual health life, it is necessary to see reproductive health beyond sexuality and reproductive health, which was found missing in their discussion and conversation.

**Key topic/issues of discussion:** Despite this it was found that they discuss about variety of issue related with reproductive health. They discuss about family planning, birth control, post delivery issues, safe sex, pregnancy, sex-safety and infections, on daily sex, births and personal health, mutual relationships, sexual health and other needs, STDs and sex, agreement/disagreement on sex related issues, sex education, physical relationship, about family planning operation, and its after effect on health, gap/difference between children, precautions and birth measures, etc,. This shows that they cover a number of issues related to

reproductive health. This also shows that now women are aware of reproductive health issues and its positive and negative consequences on their health.

It was also found that the discussions on reproductive health issues was also influenced by the ongoing Prachar project[27] of Pathfinder International covering all married couples of reproductive age group. They provide them information related to contraceptive services and choices available and other related issues. The focus of the programme is to reach both male and female member through volunteers who organize talk on these issues and also training workshops where one can share their problems and issues related to reproductive health. The Prachar project of Pathfinder International is also covering adolescents' youth of age group of 10-19 years which created a positive environment to talk about these issues but still there is taboo to talk on these issues openly. Although it is not true for all but findings show that they know almost all areas related to reproductive health and had discussions on it.

In response to the question on agreement with husband's decision, there were wide varieties of answers. 5 per cent of women chose not to respond. 35 per cent women reported that they always agree with their husband's opinion, 32 per cent women reported that they agree with their husband's opinion sometime and 25 per cent women reported that they never agree with their husband's opinion.

Table 7.14: Agreement/disagreement with husband's opinion

| **How often do you agree with what your husband thinks is right** | Percent |
|---|---|
| No Response | 5 |
| Always | 35 |
| Often | 25 |
| Sometime | 32 |
| Never | 5 |
| Total | 100 |

[27] Promoting Change in the Reproductive Behaviours of Youth, Pathfinder International's PRACHAR Project, in Bihar was intended to introduce young couples to the concept of moulding their own lives by working together to build a strong spousal bond and partnership at the beginning, family planning and building a financial base before taking on the responsibilities of childbearing.

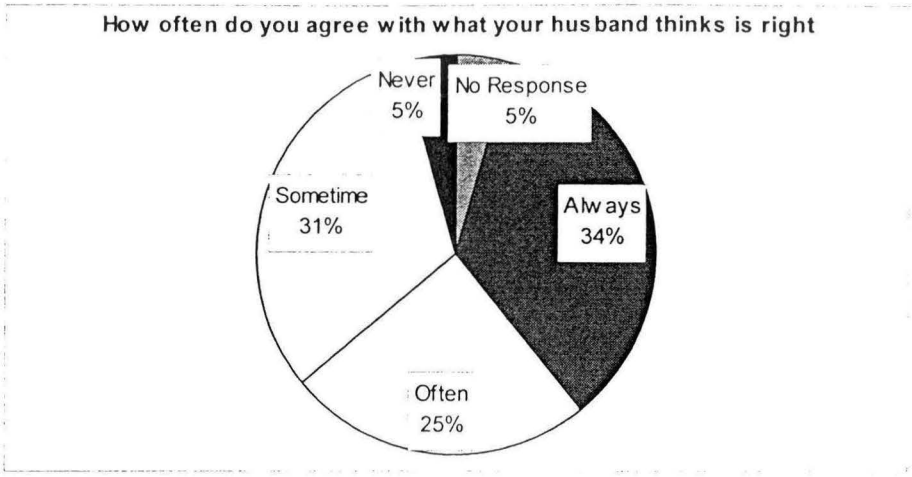


Figure 7.7: Agreement/disagreement with husband's opinion

In focus group discussions, it also emerged that the women do have their own opinion about issues and do not accept everything imposed on them and many a time they disagree with their husband's opinion and suggestions. This is not only true for health related issues but applicable to other issues also. It was also found that through group meetings, the women get opportunity to share their problem and have other member's opinion, which helped them to build their own opinion about specific issues. This was not possible earlier where women were dependent on others for information and knowledge and husband was considered only source of information in absence of alternative knowledge system available to the women. Here undoubtedly it was reflected that SHG played an important role in providing a platform to women to discuss and share their problems (health as well as other issues) in group and discuss about available solutions.

In response to the question on reasons behind their agreement or disagreement, the women reported that they agree with the husband to avoid disputes.

Table 7.15: Reasons for agreement/disagreement across block and caste groups

| **Reasons for your agreement/disagreement** (Percent) | | | | | |
|---|---|---|---|---|---|
| | SC | OBC | Phulwari | Maner | Total |
| No Response | 5 | 3 | 4 | 4 | 4 |
| Avoid dispute | 10 | 1 | 9 | 3 | 6 |
| He is husband/head | 20 | 27 | 10 | 36 | 23 |
| He should be obeyed | 2 | 0 | 2 | 0 | 1 |
| Fear of beaten up | 9 | 6 | 13 | 2 | 8 |
| No other option | 6 | 3 | 8 | 1 | 5 |
| We are weak | 1 | 0 | 1 | 0 | 1 |
| No disagreement | 37 | 47 | 45 | 37 | 41 |
| Do not care | 10 | 12 | 8 | 17 | 12 |
| Total | 100 | 100 | 100 | 100 | 100 |

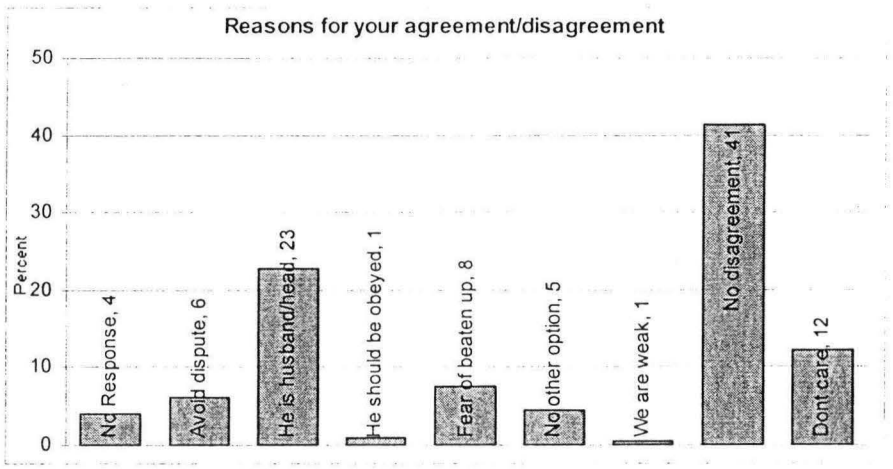


Figure 7.8: Reasons for agreement/disagreement

Interestingly 41 per cent women reported that they do not disagree with their husband's decision and opinion which shows that despite several changes, mindset of society is still patriarchal and male dominated where women have a subordinate role. 23 per cent women reported that they obey their husband because he should be obeyed. When it was further probed during focus group discussion that why 'husband should be obeyed', the women reported that they have been taught to obey, they have seen their mother obeying their father and moreover husband is head of the family with power, may be the physical power and most importantly he is protector of their *izzat* (reputation and character). 8 per cent women reported that they obey their husband in fear of beaten up. It was found that wife beating is in practice and somewhere it is associated with male

false belief of control over their women. It was sad that some of the women have accepted it as way of life and they cannot do any thing. Violence against women is still a challenge and it is across caste, and class. This was more prevalent for the SC households compared to OBC households. While 9 per cent of SC women reported fear of being beaten up as reason for not disagreeing with husband, only 6 per cent OBC women felt so.

## CONCLUSION

This chapter reported the perception of women SHG members regarding health and their use of various health services in the two blocks of Phulwari and Maner. While it was stressed in the previous chapters that SHG activity on its own need not translate into increased health awareness and practices, it was implied by the design of the CCA programme of the UNICEF that convergence of SHG activity should also lead to women being empowered which should subsequently reflect on their health awareness and their use of health services and practices. Unfortunately, the findings from this study do not allow one to make a definitive statement on this count. While there are some instances of increased awareness and their decision making regarding health practices, it does not appear to be uniformly shared by all sections of the population. Moreover, there is also variation across blocks which also stems from the fact that the two blocks differ in terms of provisioning of government health services and development.

While both the blocks had government PHC, it was quite evident from the respondents that the reach of Phulwari PHC was more influential in determining the access of women regarding various health services compared to the additional PHC at Maner (see block on Maner PHC). It was reported earlier that women in Phulwari were reporting falling sick more often than those from Maner. At the outset it is important to clarify the fact that these are figures reported on the basis of self-perception of the respondents rather than on the basis of any medical examination. There are two ways of looking at this, first, it is possible that women in Phulwari are more prone to falling sick because of various health related factors as well as environmental factors which induce spread of infection or other forms of illness. In that case, at first sight it would appear that women in

Maner are enjoying better health status and therefore less prone to falling sick than women in Phulwari. However, the other argument which is also supported by other national level surveys such as the NSSO and NFHS is the possibility of higher reporting of incidence of falling sick by women of Phulwari due to high level of health consciousness compared to women in Maner. The second reasoning appears more plausible given the fact that this kind of phenomenon is also observed in national data on questions of morbidity based on respondents' perception[28]. In other words, the low level of reporting of sickness in Maner is also a reflection of the underdeveloped status of Maner compared to Phulwari. This argument is also the possible clue to the finding of higher percentage of BC women visiting medical practitioners and services compared to SC women. Increased awareness about health and health services among the OBC women compared to SC women also explains the fact that OBC women are more prone to visiting the government PHC compared to SC women who mostly rely on local village level medical practitioners.

The other findings on this count also support the observation that health perception and practices are lower in the underdeveloped block of Maner compared to Phulwari. For example, more women in Phulwari reported visiting the PHC compared to Maner despite the fact that there is PHC in both places. It was also clear that women in Phulwari were more independent in terms of decision to visit the health services compared to women in Maner. A clear indication of this is also the findings on family planning. Not only did the women in Phulwari more aware of family planning practices compared to women in Maner, they also reported that a comparatively larger percentage of women in Phulwari got to know about it from government hospital compared to Maner.

While, it does appear that the presence of functioning PHC also translates into greater awareness and greater access and use of government health facility in the developed block, it is not possible to deny the role of CCA programme and

[28] For Example, Report 507 of NSS mentions that the morbidity rate based on respondents' perception is higher in the case or urban areas where there is increased health consciousness compared to rural areas. Incidentally, even within rural and urban areas respectively, states like Kerala have highest morbidity based on respondents' perception compared to states like Bihar and Jharkhand which have lowest morbidity rates based on respondents'' perception.

SHG activity in ensuring or facilitating such behaviour. However, on this count, the evidence is not very clear. On the other hand, it does appear that OBC women who show greater signs of empowerment compared to SC women are better equipped to utilise health services and are also more conscious of health aspects. It was reported earlier that a greater percentage of SC women tend to agree with their husbands compared to OBC women for fear of being beaten up or simply to avoid family dispute. It is also expected that such fears will also condition women's response to their health needs and they will be less willing to share their health needs or access health services without adequate family support.

The findings from this chapter along with those from the previous chapter on empowerment do suggest that the link between SHG activity and its impact on empowerment which gets reflected on their health behaviour is not linear. While SHG activity does appear to have lead to some levels of increased empowerment, it is also clear from the previous chapter that this empowerment is not necessarily reflected in their awareness about their health needs. While women did show greater awareness about their perceived needs as well as increased benefit on account of housing and employment, it was not very clear on their perception of benefit with regard to health. Needless to say, empowerment in the context of health needs much more than economic empowerment of women which in the present case appears to be the first beneficiary of such activity. But in terms of it being translated into health awareness and health practices, there is no clear evidence of it being channelled as a result of group activity of the SHG. An example of this is the source of awareness about family planning; on this question only 25-30 per cent women reported that they got to know from IDF.

However, what does complicate any clear separation of the impact of SHG activity on health related practices is the absence of any tool to separate the impact of various other government sponsored schemes and those undertaken by the implementing agency for CCA programme.

# CHAPTER – VIII

# CONCLUSIONS

## CHAPTER VIII

# CONCLUSION

This final chapter presents and discusses the findings drawn from the study. The chapter also discusses different assumptions and viewpoints on self-help groups and their impact on women's health and empowerment. Primarily, the thesis looks into self-help groups and its implications on women empowerment (particularly social and economic empowerment), and impact of empowerment on health and its inter-relationship. Firstly, the question was 'whether self-help groups can be involved in health related works, and even it can be, to what extent'. The second related question is 'whether any kind of health spin-off can be expected from Self-help groups' or 'whether SHGs can be used as strategy to improve women's health and wellness'. The thesis also addresses the issue of development and the role of social structure (particularly caste and class) in the realisation of empowerment by the women and its impact on their health.

It is assumed by various scholars and policy makers that economic empowerment of women leads to social empowerment also. They also assume that this empowerment will be automatically translated to other field of development and issues related with women viz., their health, education, and social status etc. These assumptions are guided by neo-liberal agenda and the World Bank strategy for tackling poverty in developing world and particularly Third World countries, although there are no evidences supporting such assumptions.

There is another group of scholars who do not consider SHGs as a solution to tackle poverty. They think that SHGs can be used as a strategy for local level interventions and development, but it cannot be adopted as a strategy for women empowerment and community development. According to this view, economic benefits may not neccssarily empower women economically and socially and that women empowerment cannot be achieved by denying adequate environment like infra-structure, services and facilities. They argue that socio-economic and political conditions have greater impact on realisation and

achievement of empowerment by the women. Without addressing these developmental issues and challenging the social structures (oppressive class and caste system), it is not possible to achieve empowerment of women.

Despite the critique of SHGs as a strategy for women empowerment and its loopholes, it is interesting to note the overwhelming support it has got (as strategy of women empowerment). No doubt, supportive literature and reports of SHGs positive impact on life of women has played an important role in this[1]. There is considerable literature generated by independent researchers, programme evaluators and civil society organisation and other national and international agencies supporting success of SHG movement and its positive impact on people. But one should not forget that most of these studies and reports are funded by agencies which are already advocating such a role and they focus on indicators which are not appropriately measuring empowerment because of its subjectivity, different ideologies, goals and environment. Secondly, most of these studies and conclusions are based on select case studies focusing primarily on saving-credit activities and measuring specific programme goals.

It is in this context, it was realised that there is a need to do an in-depth study to explore and understand the role of Self-help Groups (SHGs) in women's health and empowerment in Bihar. The thesis explores the implications of empowerment on health; it's inter-relationship with economic benefit, empowerment, development, and other inter-related factors. The thesis also looks into various views and perspective on SHG and empowerment. This study, it is hoped will help in understanding the debate whether SHGs can be used as an effective strategy of empowerment and to improve women's health and well-being.

Before discussing the findings and the impact of SHG on women's health and empowerment in detail, it is necessary to understand the socio-cultural context and position of women in Bihar. The status of women in Bihar presently

[1] See, quarterly compendium of news clippings on Micro Finance and Related Environment. 2006. Micro Finance Resource centre. Sa-Dhan, New Delhi.

is quite low which can be inferred from the fact that in Bihar the sex ratio at present is 921 which is below the National average of 933[2]. Further, the mean age of marriage is about 17 years in this state. The percentage incidence of adolescent marriages below the age of 18 years is 71 per cent (in Bihar), in contrast with Kerala (17 per cent)[3]. Similarly, the infant mortality rate is 66.5, which is on higher side. The work participation rate of women in Bihar to the total work force has been steadily declining over time which is estimated to be about 18 per cent as per 2001 census with about 92 per cent women being engaged in the primary unorganised and informal sector. The female literacy rate in the state is also dismally low at about 33.57 per cent only. Besides it has been estimated that only 0.1 per cent of the female population of Bihar is able to avail higher educational facilities and the dropout rates for girls, particularly, in the classes I – VIII is as high as 80 per cent. It is evident form these figures that a lot remains to be done for the empowerment of women in Bihar.

The State, as a whole has a strong patriarchal tradition and feudal system, which has contributed, significantly to the prevailing low levels of social and economic status of women. Besides, the low level of education, lack of information and awareness of women also hampers their growth and development. There are many social evils presently prevalent, which directly or indirectly affect women and impinge on their freedom and life. Foremost among these is the problem of dowry, female infanticide, child marriages, and domestic violence, etc. Besides, the pressure of globalisation and economic liberalisation has also affected the women most as the community has marginalised their role in production process consistently. There is, thus, by and large, an absence of an enabling environment. Further due to lack of opportunities, the progress of women is also adversely affected. Hence, the issue of gender and particularly empowerment encompass the overall development of women as an individual in her own right as a dignified human being.

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[2] Census of India. 2001.

[3] See Sharma, Suresh. 2003. "Adolescent Fertility in Selected States of India". Population Research Center, Institute of Economic Growth, University Enclave, Delhi-7

## FINDINGS OF THE STUDY

Before looking into the data and findings, it is necessary to state that the findings are based on women's perceptions of their empowerment and health, which the researcher has tried to analyse and understand. It is also important to note here that, it is difficult to distinguish between the effect of SHG activity on empowerment from those which have been guided by other external factors operating simultaneously but unrelated to the SHG activity. The same is true for clear separation of the impact of SHG activity on health related practices.

Despite these limitations, the findings help to understand the implications and process inputs behind empowering the women in Patna District of Bihar in reference to empowerment and its effect on their health. The findings are based on interview schedule survey, select case studies and focus group discussion with two hundred women self-help group (SHG) members representing two hundred households. All these women were part of different SHG formed under Convergent Community Action (CCA) Program of UNICEF by Integrated Development Foundation (IDF) in two blocks Maner and Phulwari of Patna district of Bihar. The purpose behind the study was not to come out with statistics, facts and figures which are already available in plenty, but to get an understanding of the dynamics of the development of the marginalized women in two blocks of Patna district.

Coming to the findings of the study, in summary, it shows that women benefited from SHGs and its saving and credit activities to an extent but its impact on their life is not very much visible. There are not many changes in their living standard, wealth, asset building, employment generation, health status, social status and security. Findings also indicate that there are economic benefits of SHG programme which have not necessarily impacted on health behaviour significantly. Even less than half women perceive that SHG has brought improvement in health fully. However, SHG has made them less dependent upon the Sahukars on whom they have been dependent in case of illness[4]. Although the

[4] The findings show that most important reason for taking loan was illness.

findings and data show that the women's dependence on Sahukars or moneylenders has decreased, it was also found that their dependence on Sahukars has not ended[5]. The women are still approaching the Sahukar for bigger amounts. The findings suggest some positive impact of women's participation in SHGs in empowering the women in various spheres of life. However, it was also observed that these changes are not shared equally across blocks or across caste groups (Schedule Castes and Other Backward Classes) with the developed block (Phulwari) and better off caste groups (Other Backward Classes) witnessing more empowerment than the disadvantaged groups such as SC households or the underdeveloped block (Maner).

Although the finding show that with the help of SHG's economic benefit, women's sense of control has gone up, findings do not indicate that SHGs has been successful in enhancing knowledge levels significantly; however utilization of Private Health Services has increased[6]. But it is matter of concern that despite the increase in knowledge about health they fall sick regularly[7].

The findings show that the SHGs' goal to promote and enable women's groups in self-help mode to undertake responsibilities of change at a local and larger framework of issues related to gender and community level development issues was not fully achieved and it is not reflected in their day to day life. There are not many changes in their living standard and development at community level. They live in villages where there are no proper sanitation and water facility available. The finding show that although various government programs are available at the block and district level for the women and their upliftment but they are not reaching the women due to their marginalised position in the society. Because of this, most of the opportunities and policy benefits are reaching those who are affluent and well connected. This also shows that by providing economic benefit only, one cannot ensure empowerment and access and utilization of services. It was also found that although a few women were utilising government

[5] The groups have limited saving capacity and it is not possible to meet credit needs of members.

[6] See, Chapter VII, Table 7.3: Access to health services across block and caste groups.

[7] See, Chapter VII, Table 7.1: Disease pattern and prevalence across block and caste groups.

programmes such as SGSY, they were not able to associate these programmes with their empowerment or women's empowerment. This shows that women's perception of empowerment is different from policymaker's perception of empowerment.

Despite the claim of the NGO and other agencies involved that women are empowered, it was interesting to note that the women are very much dependent upon animators for their saving-credit activities and other help. This shows that there is not much effort from the women to take the lead for their empowerment. Secondly, practically it is also not possible to empower women by providing credits and economic benefits. They need to be organised to enable them to use the services and benefits available.

It was found that most of the women joined SHGs for economic benefits and income generation. It is important to note here that the primary motive to join the group was not their empowerment but economic benefits[8]. Although the policy makers believe that economic benefits will be translated into women's empowerment, this was not found here. It shows that the assumption is not applicable here.

Although the prime motive of SHG was women's empowerment through convergence activities and economic benefits, the women reported various hindrances in starting any income generation activity. Despite the fact that whole focus of the programme was on savings-credit activities, it was not able to provide or help women in generating financial resource for starting an income generation or group business.

A few women reported that prime motive of joining SHG was to find common solutions to major problems. But this was not feasible given the social context. However, the women could identify several problems in common such as drinking water, sanitation need, atrocities made on them or their group member or for demand of their rights, etc.

[8] See, Chapter VI, Table 6.2: Motive behind joining SHGs.

Although these women are aware and conscious of their rights but it is not realised and translated in their life due to various social, cultural and economic factors. Education is a major hindrance in this process of women empowerment where these women are dependent on others for information and official works.

The other goal of SHGs was to promote activities at grassroot level through the adoption of a group approach to promote self-help and joint action for problem solving among the women. Although the women have group feeling and commitment to do something but they have not done anything except for saving and credit activities. The findings show that only two groups have started small scale business such as pickle-making and home based food products. They supply these products to small hotels and shops and they are also making some profits out of it.

Another goal of the SHG program was to make considerable investment in terms of educating women in particular and the community in general and organize them around activities which are planned by them to address their immediate needs, promote their self esteem and enhance decision making abilities. Although the women reported that they can plan their future better given an opportunity, but when it comes to implementation and realization of their dreams, they feel helpless and are forced to live in an environment which has no better future for them. Although various initiatives have been taken by the program like organising special classes, orientation programs etc, their effect was not reflected in their activities. Although the women reported that their decision making power has increased in the family[9], it was found that this decision making is mostly related to their mobility and small initiatives within the parameter of family, society and cultural values. Although the data show that women's mobility has increased[10] and they can go out on their will, which is good sign of empowerment, it was found that this mobility or independence is more a compulsion rather than respect to the rights of the women. Although they are free

[9] See, Chapter VI, Table 6.13: Change in decision making power across blocks and caste groups.

[10] See, Chapter VI, Table 6.21: Freedom of mobility across blocks and caste groups.

to go out on their will, it is within the set parameter of work and it is limited to fields and near by market only. The women also reported that although they have some rights in the family, they are still fighting for their rights and they are largely kept out from properly related decision making. This also shows that ultimate power and control is still patriarchal.

The study shows that one needs to appreciate the process areas of the Convergence Community Action (CCA) to understand the remarkable transformation of a village woman from what was 10 years ago to what she is today. 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. Although most of these are still at the level of perceived needs, they have not been achieved and realised.

Findings also show that health related expenditure is the major cause for indebtedness and dependence on Sahukar. 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[11].

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 some of them have shown interest to join adult education classes. They understood the importance of small family and visit to the health centres. They have attended the government sponsored polio eradication programs and got their children immunised. But the full fledged vaccination is not available in health centres, so the children are not fully immunised.

[11] World Health Organization. 1986. Ottawa Charter for Health Promotion. International Conference on Health Promotion, Ottawa. Geneva.

The question regarding the perception of women on 'what is health' had varied responses. Women have different understanding and perception of health and everyone defined health in the context of their environment and need. The women reported that their health is important. However, data and findings show that despite their knowledge about prevention and awareness of various diseases, majority of them fall sick regularly[12]. It was also found that the health-seeking behaviour of the people is largely determined by many interconnecting factors, such as gender, traditional beliefs, customs and norms, level of education, socio-economic status, and physical factors like distance and lack of transportation, etc.

Although the women reported that there is increase in their knowledge about health and health awareness, it was found that practice and use of this knowledge and information is very low. It was also found that Knowledge-Attitude - Practice (KAP) relationship is not harmonious. They also reported that practically it is not possible for them to follow it because of poor economic condition of the family.

More than one-third of the women reported that they are independent to take decision about their health and visit to the doctors. However, considerable variation was found across blocks regarding decision about visiting doctor or accessing health services[13]. However, it was also found that decision-making and control do not ensure visit to a doctor.

It was also observed that the programme has differential impact in two blocks due to the variation in resource availability and development. Considerable variation was seen across blocks as well as caste groups regarding the women's perception of benefit from the SHG programme[14]. It was found that programme has more impact in Phulwari (Developed block) in comparison to Maner (Less developed). Similarly, across caste groups, it was found that OBC

[12] See, Chapter VII, Table 7.1: Disease pattern and prevalence across block and caste groups.

[13] See, Chapter VII, Table 7.4: Decisions in accessing health services across block and caste groups.

[14] See, Chapter VI, Table 6.4: Benefit of the programme across blocks and caste groups

women more benefited from the programme in comparison to SC women. It appears from the data that the programme has benefited the developed block (Phulwari) as well as developed community (OBC) more than the underdeveloped block of Maner and the disadvantaged community of SCs. This is particularly worth noticing given the fact that the programme is supposed to have special focus on Scheduled Castes women. The differential access by caste groups and by blocks also suggests that the government hospitals are not accessible to the marginalized sections of the population. While the traditionally better-off caste groups such as OBC households were able to utilize the government health services, the same was not true for the SC households who were reluctant to use the government health system[15]. It was also observed that now women are conscious about their rights and are conscious about their self respect and dignity. It was also observed that women leaders who received frequent exposures and opportunity to receive more training, visits, discussions /interactions with others became more vocal and active than those who were not directly involved in such a process. It was observed during the course of the study that the emphasis of the programme was more on empowering and capacity building of women's groups through saving-credit activities rather than focusing on other aspects of empowerment and development.

In summary, the data and findings suggest that there are not enough evidences, supporting the assumption that self-help groups can be used as an effective strategy for women empowerment and improving women's health.

## CONCLUSION

It has been argued by many that women's participation in self-help groups can play a revolutionary role in poverty alleviation and also achieving gender equity by empowering women to not only take economic decisions but also through the group activity inculcating in them qualities of teamwork, leadership skills and building their capacities towards generating higher incomes, being

[15] See, Chapter VII, Table 7.3: Access to health services across block and caste groups (SC and OBC).

independent and so on. Further, it is said that the self-help groups can also be useful platforms to enhance women's health through increased knowledge and awareness on health issues, financial security during health emergencies etc.

The findings show that in the context of Bihar, SHGs have only succeeded, to an extent, in playing an economic role by increasing saving and credit facilities but have failed as far as enhancing women's empowerment is concerned. Many studies have shown that control over the resources and income generated through the women still remains with men. However, the data and findings of the study do not support this[16].

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.

The field survey raises therefore many issues on how much SHGs can be used in improving women's health. Women's health is very much dependent on existing gender relations, access to health care among the poor, income and quality of life of the poor. It was also found that the SHGs programmes are functioning in a vacuum without addressing these contextual issues. Therefore, SHGs are not and cannot be able to have a significant effect on women's health. For improving women's health, it is essential to involve the entire community and sensitise men on issues of gender equity. Further, issues of decentralisation, availability of health facilities that are accessible and available also need to be addressed.

[16] Seventy six percent of women reported that they have control on their income. Although variation across caste groups was marginal, the variation across blocks was clearly indicative of the fact that in the developed block (Phulwari) women had greater say in controlling income compared to women in less developed block (Maner). (See, Chapter VI, Table 6.9: Control on income across blocks and caste groups).

The findings also suggest that the link between SHGs activity and its impact on empowerment which gets reflected on women's health behaviour is not linear. While SHG activity does appear to have led to some level of increased empowerment, it is also clear from the previous chapters[17] that this empowerment is not necessarily reflected in their awareness about their health needs. While women did show greater awareness about their perceived needs as well as increased benefit on account of housing and employment, it was not very clear on their perception of benefit with regard to health. In terms of empowerment being translated in health awareness and health practices, there is no clear evidence of it being channelled as a result of group activity of the SHG. Needless to say, empowerment in the context of health needs much more effort on part of the government to develop infrastructure for functional health services and facilities than economic empowerment of women. Without which it is not possible to improve women's health through micro-credit and self-help group programmes.

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. Secondly, most of the SHG programmes are imposed on women by NGOs, Government and other agencies. Although the women or beneficiaries are benefited by the programme, it never got acceptance as a concept which was the major reason behind unsustainable nature of the programmes.

In summary, the data and findings of the study do not support very strongly the assumption that women's empowerment (particularly economic empowerment through micro-credit programmes) has its impact on women's health. However, there may be indirect impacts on health and positive health

[17] See the data and finding Chapter VI and VII.

spin-off can be expected from self-help groups, provided functional health services and facilities are available for all. By denying these basic infrastructures, facilities and enabling social, cultural and economic environment, it is not possible to empower women economically and socially. Thus, there is a need to promote overall development of women by contextualising the programmes according to women's need. The thesis concludes that it is the government's, the international donor community's and the World Bank's euphoria that SHGs can be used as strategy or tool for enhancing women's empowerment and eradicating poverty as well as improving health.

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# APPENDIX

# INTERVIEW SCHEDULE

# स्वयं सहायता समूह एवं महिलाओं के स्वास्थ्य और सशक्तिकरण में उनकी भूमिका : पटना जिले की स्थिति का अध्ययन

(महिला स्वंय सहायता समूह के सदस्यों के लिए साक्षात्कार सूची)

अनंत कुमार

सामाजिक औषधि व सामुदायिक स्वास्थ्य केन्द्र
सामाजिक विज्ञान संकाय
जवाहर लाल नेहरु विश्वविघालय
नई दिल्ली –११००६७
भारत

साक्षात्कार/सर्वे संख्याः ..... दिनांकः .....

## महिला स्वंय सहायता समूह के सदस्यों के साक्षात्कार सूची

**साक्षात्कारकर्ताः** सर्वे/साक्षात्कार में अपना समय देने के लिए आपको धन्यवाद। स्वंय सहायता समूह की सदस्या होने के नाते, महिलाओं के स्वास्थ्य व सशक्तिकरण में उसकी भूमिका के अध्ययन के लिए आपके विचार व अनुभव महत्व पूर्ण हैं। इस साक्षात्कार में आपकी पृष्ठभूमि, स्वंय सहायता समूह के सदस्या के तौर पर आपके अनुभव, विचार, एवं आपके स्वास्थ्य में स्वंय सहायता समूह की भूमिका व सशक्तिकरण के बारे में प्रश्न हैं। कुछ प्रश्नों के लिए मैं आपके सामने उतर सूची पढ़ूँगा और उनमें से जो उतर आप ठीक समझे उसे बताने को कहूँगा। कुछ प्रश्नों के उत्तर के लिए विस्तृत चर्चा की आवश्यकता होगी। मै आशा करता हुँ कि आप इन प्रश्नों का स्पष्ट उतर दे सकेंगी। इस सर्वे के दौरान हुऐ प्रश्नोत्तर में आपके विचारो की अहमियत हैं न की अपके परिचय की। आपका नाम व व्यक्तिगत जानकारी तथा पहचान किसी को नहीं बताई जाएगी। हम आपसे ध्यानपूर्वक प्रत्येक प्रश्न पर विचार करने व जितना हो सके उतना उतर देने का आग्रह करते हैं।

वे प्रश्न जिसके उत्तर में आपको कठिनाई हो या आप असहज अनुभव करे, मुझे बताऐं, हम उस प्रश्न को छोड देगे।

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**अध्ययन क्षेत्र (Study Area)**

राज्यः बिहार जिलाः पटना प्रखण्डः _____

पंचायतः _____ गॉवः _____ समूह का नामः _____

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**उतरदाता (लाभार्थी) का व्यक्तिगत विवरण (Personal details of the respondent /beneficiary)**

नामः .....

पति का नामः .....

आयुः .....वर्ष

लिंगः १. पुरुष २. स्त्री

धर्मः १. हिन्दू २. मुस्लिम ३. अन्य (उल्लेख करे )

वैवाहिक स्थितिः १. विवाहित २. अविवाहित ३. विधवा ४. तलाकशुदा ५. अन्य (उल्लेख करे) .....

जातिः १. सामान्य २. अनुसूचित जाति ३. अनुसूचित जन जाति ४. अन्य पिछडे वर्ग अन्य (उल्लेख करे ) .....

शैक्षिक योग्यताः १. निरक्षर २. साक्षर ३. कक्षा ५ तक ४. कक्षा १० तक ५. कक्षा १२ तक

बी. पी. एल. (गरीबी रेखा से नीचे) की स्थितिः १. बी. पी. एल. सूची में शामिल २. लाल कार्ड धारक

व्यवसायः १. छोटे किसान (१ एकड़ से कम) २. पट्टे या बटाई पर खेती ३. खेतिहर मजदूर ४. व्यापार ५. अन्य (उल्लेख करे) .....

वार्षिक आयः

१. १०००० तक
२. १००००१–२००००
३. २००००१–३००००
४. ३००००१–४००००
५. ४००००१–५००००
६. ५००००० से अधिक

(१). आपके घर के कुल सदस्यों की संख्या _____ ७ वर्ष से कम उम्र के सदस्यों की संख्या _____

(२). कृषि भूमि पर स्वामित्व (बीघे में ) _____

(३). पटटे पर ली गई कृषि भूमि (बीघे में ) _____

(४). पटटे पर दी गई कृषि भूमि (बीघे में ) _____

(५). एक वर्ष में आप कितनी फसल उगाते हैं? (अ) एक (ब) दो (स) तीन

**महिला सशक्तिकरण योजना**

(६). आपने किसी महिला सशक्तिकरण योजना/महिला स्वंय सहायता समूह/महिला समिति के बारे में सुना हैं?

(अ) हॉ (ब) नहीं

यदि हॉ तो कृपया नाम बताऐं।

(अ)_____ (ब)_____ (स) _____

(७). इनमें से किस योजना ने आपकी आवश्यकताऐं सबसे अधिक पूरी की ?

(अ). योजना का नामः _____ (ब). पता नही /कह नही सकते

(८). कृपया अपनी प्रमुख जरुरतों / अवश्यकताओ को बताऐं।

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| | | | | | |
|---|---|---|---|---|---|
| (अ). आश्रय/घर | | (ब). वृति/ रोजगार | | (स). कुछ आय अर्जित कर ने वालो की किया कलाप | |
| (द). कुछ काम सीखना | | (इ). सिचाई | | (फ). पेय जल | |
| (ग). स्वच्छता/शौचालय | | (ह). काम के औजार | | (आइ). वृद्धावस्था पेंशन | |

(९). परिवार के समक्ष सबसे महत्वपूर्ण मुददे क्या हैं?

_____

_____

_____

**विशिष्ट योजना (Particular of the scheme)**

(१०). उस योजना का नाम जिसके अर्न्तगत आपने अपनी स्वयं सहायता समूह /समिति बनाई है।_____

(११). आपको योजना का पता कैसे चला ? योजना के लिए आपको किसने सुझाव दिया।

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१. गैर सरकारी संगठन (उल्लेख करे ) २. ग्रामस्तर के कर्यकर्ता/ग्राम सेवक

३. ग्राम सभा/ग्राम पंचायत ४.सहायक परिचारिका र्नस (ए एन एम )

५. अन्य(उल्लेख करे ) _____

(१२). ऐसा क्या था जिसने आपको समूह में शामिल होने के लिए प्रेरित किया।

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१. आय में वृद्धि ३. बैंक ऋण /सरकारी योजनाओं का लाभ उठाना

२. साख की जरुरत ४. अन्य (उल्लेख करे ) _____

(१३). स्वंय सहायता समूह का उद्धेश्य क्या हैं।

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१. आपकी बहुत सारी समस्याओं का सामूहिक समाधान
२. पैसे की बचत
३. समूह के सदस्यों की आर्थिक मदद करना

(१४). क्या आप विश्वास करते है कि

१. स्वंय सहायता समूह ही सर्वोतम सहायता हैं
२. एकता ही शक्ति हैं

(१५). क्या आप अनुभव करती हैं कि इस कार्यकम ने आपको लाभान्वित हुई हैं ?

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१.पूरी तरह लाभकारी २. कुछ हद तक लाभकारी ३. कतई नहीं

(१६). कार्यकम ने किस प्रकार आपको लाभान्वित किया ?

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| संभावित लाभ | १. पूरी तरह से २. कुछ हद तक ३. प्रभावहीन |
|---|---|
| आय में वृद्धि हुई | |
| रोजगार की संभावनाऐं बढी | |
| कुछ लाभ प्रदान करना | |
| परिवार में महत्व बढा | |
| समुदाय में महत्व को बढा | |
| सुरक्षा में वृद्धि /समाजिक आर्थिक खतरो में कमी आई | |
| परिवार में सशक्तिकरण हुआ | |
| समाजिक कियाकलापों में सहभागिता बढी | |
| सम्बन्ध बेहतर बने/अधिक मित्र बनाने में सहायता मिली | |
| जागरुकता का स्तर बढा | |
| व्यक्तिगत स्वास्थ्य में सुधार हुआ | |
| परिवार के स्वास्थ्य में सुधार हुआ | |

**आर्थिक सशक्तिकरण**

(१७). समूह में शामिल होने के पूर्व आपकी वार्षिक आय क्या थी ? रु._____वार्षिक

(१८). समूह में शामिल होने के बाद आपकी वार्षिक आय क्या थी ? रु._____वार्षिक

(१६). कृपया अपने आय के स्रोतो को बताऐं। (स्रोतो में परिवर्तन को इंगित करे )

| आय के स्रोत्र (वार्षिक) | लाभ पाने के पूर्व | लाभ पाने के पश्चात |
|---|---|---|
| अपनी भूमि पर खेती | | |
| बटाई की खेती | | |
| पट्टे की भूमि पर खेती | | |
| खेतिहर मजदूर | | |
| गैरखेतिहर मजदूर | | |
| बागवानी | | |
| व्यापार | | |
| सेवा | | |
| दुग्ध उधोग | | |
| अन्य | | |
| सभी स्रोतो से आय | | |

(२०). कृपया समूह में शमिल होने के बाद की सभी नई भूमि व सम्पतियों का विवरण दें ?

१. _____ २. _____

३. _____ ४. _____

(२१). क्या आप कहेंगी कि आप ये चीजें/सम्पतियॉ बिना समूह में शामिल हुऐ खरीद सकती थी ? १. हॉ २. नहीं

(२२). विभिन्न स्रोतों से अर्जित आपकी आय पर किसका नियत्रण हैं?

१. स्वंय २. पति ३.श्वसुर

४. सास ५.पुत्र ६. अन्य (उल्लेख करे ) _____

(२३). धरेलू एवं महत्वपूर्ण बड़े खर्चों का निर्णय कौन लेता है।

१. स्वंय २. पति ३.श्वसुर

४. सास ५.पुत्र ६. अन्य (उल्लेख करे ) _____

(२४). क्या समूह से लाभान्वित होने के बाद निम्नलिखित मदों में आपका खर्च बढा, घटा या उतना ही रहा हैं? (खर्च में परिवर्तन के दिशा )

| वस्तुएं | (१)बढा (२)घटा(३) उतना ही रहा |
|---|---|
| खदया सामग्री | |
| बच्चों की शिक्षा | |
| बच्चों की दवॉए | |
| बीमारी की रोकथाम की दवॉए | |
| स्वस्थ्य | |
| समाजिक पर्व | |
| परिवार के कपड़ें | |
| मकान का रख रखव /मरम्मत | |
| मंनोरजन | |
| सुविध की वस्तुऐं | |
| अन्य _____ | |

(२५). क्या आप सोचती हैं कि समूह में शामिल होने के बाद साहूकार पर आपकी निर्भरता घटी हैं? १. हॉ २. नही

(२६). क्या आप साहूकार से नियमित कर्ज लेती हैं ? १. हॉ २. नही

(२७). साहूकार द्वारा ली जाने वाली ब्याज दर क्या हैं? _____

(२८). साहूकार से कर्ज लेने का उद्धेश्य क्या हैं?

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**परिवार में सामाजिक सशक्तिकरण**

(२६). कृपया निम्न कथनो का उतर दें? क्या आप सहमत है कि स्वंय सहायता समूह के द्धारा पाऐ गये लाभ के कारण परिवार में आपके निर्णय लेने की शक्ति बढ़ी।

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क्या आपमें अधिक आत्मविश्वास पैदा हुआ है ?

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क्या अब आप अधिक सुरक्षित महसूस करती हैं ?

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क्या पिछले एक वर्ष में सम्पतियों की खरीद/ फरोख्त पर आपने अंतिम निर्णय लिया है ?

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क्या बच्चों को उच्चशिक्षा /विधालय भेजने का निर्णय आप लेती हैं ?

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क्या आप बच्चों को समय समय पर टीके लगवाने के लिए कदम उठाती हैं ?

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क्या बच्चों की संख्या/उनके पालन पोषन पर आप अपनी राय रखती हैं ?

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क्या बच्चों के वर /वधू चुनाव में आपकी राय ली जाती हैं ?

क्या आप जब चाहें कही जा सकती हैं ?

क्या आप अतरिक्त आय रखती हैं ?

क्या सार्वजनिक जीवन में आपकी सहभागिता बढी हैं ?

क्या आप भविष्य के लिए बेहतर योजना बना सकती है ?

**समुदाय में समाजिक सहभागिता**

| | |
|---|---|
| मेरे समुदाय में मेरा स्तर बढ़ा है | लाभ १. हॉ २. नही |
| गॉव में मेरे स्तर में सुधार हुआ है | |
| अब पहले के तुलना में अधिक लोग मेरे सम्पर्क में आये हैं | |
| विवाह बजार में स्थिति में सुधार हुआ है | |
| समुदाय में उच्च स्वीकार्यता रखती हैं | |
| पंचायत व अन्य कार्यक्रमों में सहभागिता बढी है | |

(३०). क्या आप किसी संगठन की सदस्य हैं ?(उल्लेख करे )

१. धार्मिक २. जातिगत ३. राजनीतिक दल ४. सांस्कृतिक ५. अन्य (उल्लेख करे )_____

(३१). यदि हॉ तो उस संगठन की सदस्य आप समूह में शामिल होने से पहले या बाद में बनी हैं

१. समूह में शामिल होने के बाद २. समूह में शामिल होने के पहले

**स्वास्थ्य का स्तर**

(३२). आप स्वास्थ्य से क्या समझती हैं ?

(३३). क्या आप सोचती हैं कि आपका स्वास्थ्य महत्वपूर्ण हैं। यदि हॉ तो क्यों ? १. हॉ २. नहीं

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(३४). क्या आप बीमार पड़ती हैं। यदि हॉ तो

शायद ही कभी --------- कई बार ---------- कभी कभी ----------

(३५). किस बिमारी से आप बहुधा परेशान रहती हैं ? (बीमारी का नाम )

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(३६). बीमारी होने पर क्या आप डॉक्टर के पास जाती हैं ? १. हॉ २. नहीं

(३७). यदि हॉ तो आप कहॉ जाती है ?

१. आसपास/गॉव में ही
२. सरकारी अस्पताल /उपकेन्द्र
३. पास के शहर में
४. निजी चिकित्सक के पास

(३८). यदि नहीं तो क्यों

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(३९). आपके परिवार में डॉक्टर के यहॉ जाने/ न जाने का निर्णय कौन लेता हैं ?

१. आप स्वंय
२. आपके पति
३. आपकी सास
४. अपके ससुर
५. अन्य (उल्लेख करे ) _____

(४०). क्या आप उनके निर्णय से संतुष्ट होती हैं ? १. हॉ २. नहीं

यदि हॉ/नहीं तो क्यो ?_____

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(४१). अब मैं यह जानना चहुँगा कि स्वयं सेवी समूह में आपकी सदस्यता आपके निम्नलिखित चींजो के ज्ञान की वृद्धि में किस हद सहायक हैं।

| | १. वृद्धि | २.अपघटन | ३.अपरिवर्तनीय |
|---|---|---|---|
| स्वास्थ्यपरकता व स्वच्छता | | | |
| प्रतिरक्षा के टीके /टीकाकरण | | | |
| गर्भ निरोधक | | | |
| गर्भावस्था के दौरान देखभाल | | | |
| बच्चे के जन्म के उपरान्त अपनी देखभाल | | | |
| शिशु की देखभाल | | | |
| व्यक्तिगत स्वास्थ्य की देखभाल व जरुरतो के प्रति जागरुक | | | |
| उपलब्ध स्वास्थ्य सेवाओं के प्रति जागरुक | | | |

(४२). अब मैं जानना चाहुँगा कि आपकी स्वंय सहायता समूह की सदस्यता ने आपके स्वास्थ्य के प्रति आपके व्यवहार को किस प्रकार प्रभावित किया हैं?

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| | १. वृद्धि | २.अपघटन | ३.अपरिवर्तनीय |
|---|---|---|---|
| प्रथमिक स्वास्थ्य केन्द्रपर जाना | | | |
| निजी डॉक्टर /नसिंग होम में जाना | | | |
| गर्भावस्था के दौरान प्रसव देखभाल | | | |
| गर्भावस्था के दौरान प्रसव के पूर्व देखभाल | | | |
| प्रसोवपरांत देखभाल | | | |

(४३). क्या आप परिवार नियोजन के बारे में जानती हैं ? १. हॉ २. नहीं

(४४). आपकी परिवार नियोजन की सूचनाओं का स्रोत क्या हैं। _____

(४५). आप परिवार नियोजन का कौन सा तरीका सही/सरल मानती है?

_____ _____ _____ _____

(४६). क्या आप उनमें से कोई तरीका अपनाती हैं ? १. हॉ २. नहीं

(४७). यदि हॉ तो कौन सा _____

(४८). आपने क्यों /कैसे उस तरीके का प्रयोग करने का निर्णय लिया है ?

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(४९). क्या आपने और आपके पति ने कभी प्रजनन स्वास्थ्य सम्बन्धी मुददो पर चर्चा की हैं ? १. हॉ २. नहीं

(५०). आपके विचार विमर्श का मुख्य विषय /बिन्दु क्या हैं ?

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(५१). कितनी बार आप अपने पति की राय से सहमत होती हैं जिसे आपके पति सही मानते हैं ?

१. हमेशा २. बहुधा ३. कभी कभी ४. कभी नही

(५२). आपकी सहमति /असहमति को कारण

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**स्वंय सहायता समूह के क्रियाकलाप की सूची**

| कम | आकलन हेतू सूचना | १. उत्तम | २. अच्छा | ३. असंतोषजनक | |
|---|---|---|---|---|---|
| १. | समूह का आकार | १५ से २० | १० से १५ | १० से कम | |
| २. | सदस्यों के प्रकार | सिर्फ बहुत गरीब सदस्य | २ या ३ बहुत गरीब सदस्य नहीं | बहुत से गरीब सदस्य नहीं | |
| ३. | बैठको की संख्या | महिने में ४ बैठक | महीने में २ बैठक | महीने में दो से कम बैठक | |
| ४. | बैठको का समय | रात्रि या ६ बजे के बाद | सुबह ७ से ६ बजे के बीच | अन्य समय में | |
| ५. | सदस्यों की उपस्थिति | ६०% से अधिक | ७० से ६०% | ७०% से कम | |
| ६. | सदस्यों की सहभागिता | उच्च स्तर की सहभागिता | मध्य स्तर की सहभागिता | निम्न स्तर की सहभागिता | |
| ७. | समूह में धन एकत्र करना | महीने में चार बार | महीने में तीन बार | महीने में उससे कम बार | |
| ८. | बचत होने वाला धन | पहले से तय | निश्चित नहीं | | |
| ९. | आन्तरिक ऋणों पर व्याज | उद्धेश्य पर निर्भर | २४ से ३६% | ३६% से अधिक | |
| १०. | स्वंय सहायता समूह द्वारा बचत धन का प्रयोग | सदस्यों को ऋण देने के लिए पूरा धन प्रर्युक्त हो | ऋण के लिए कुछ भाग प्रयुक्त | खराब अनुप्रयोग | |
| ११. | ऋणों की वसूली | ६०% से अधिक | ७० से ६०% | ७०% से कम | |
| १२. | पुस्तको का रख रखाव | सभी पुस्तको का नियमित रुपसे रख रखाव | अधिक महत्वपूर्ण पुस्तिकाओं (मसौदे, बचत, ऋणपत्र) | पुस्तको के रख रखाब में अनियमितता | |
| १३. | कुल जमा बचत | ५००० से अधिक | ३०००–५००० | ३००० से कम | |
| १४. | स्वंय सहायता समूह के नियमों का ज्ञान | सभी को ज्ञात | | सभी को ज्ञात नही | |
| १५. | शिक्षा का स्तर | २०% से अधिक सदस्य लिख और पढ़ नही सकते | | २०% से कमसदस्य लिख व पढ़ सके | |
| १६. | सरकारी योजना का ज्ञान | सरकारी योजना के प्रति सभीलोग जागरुक | अधिकतर सदस्य सरकारी योजना के बारे में जानते हैं | कोई नहीं जानता हों | |

**अन्वेषक /जॉचकर्त्ता की टिप्पणी:**



**आपके समय और विचारपूर्ण उत्तरों के लिए धन्यवाद**