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Role of self-help groups on reproductive autonomy of women

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Abstract
Background: Women's autonomy in reproductive health decision making is extremely important for better Maternal and Child Health outcomes and an indicator of Women empowerment. Poverty and anti-autonomy believes deny women's control over their lives. Investment in education, health, and women empowerment is necessary to improve women's reproductive autonomy. Self Help Groups (SHGs) are being seen as the main stay for poverty alleviation by micro credit system, empowering women economically and socially. It tries to remove the limitations emerging due to poor socio economic status thereby enhancing social security in form of better educational attainment and improved reproductive and child health outcomes which is intrinsically valuable for women and instrumental for the welfare of humankind.
Objectives: To assess the level of participation of women in SHG activities, the level of reproductive autonomy of SHG women and to associate it with selected demographic variables.
Methods: A descriptive study was conducted among 44 SHG women by using convenient sampling technique at Coimbatore. An interview schedule was used to collect data regarding the socio demographic variables, participation of women in SHG activities and changes in reproductive autonomy of the SHG women. The collected data was analyzed using descriptive statistics.
Results: Results reveal that 39% of women are between 25-29 years of age; 39% of women and their spouses have education until high school level; 73% of women are employed and from nuclear family; and 32% of women have 2 children; 75% of women show increased reproductive autonomy after joining SHG. There is a significant correlation between the reproductive autonomy of women and their age, number of years in the group, group size, and frequency of meeting attended at 0.05 level of significance.
Conclusion: The study reveals that participation in SHG activities improves the reproductive autonomy of women.

Keywords: reproductive, women, maternal, child health

Introduction

Women's autonomy in reproductive health decision making is extremely important for better maternal and child health outcomes, and it is also an indicator of women's empowerment. However, the age old traditions and patriarchic natured society still keep the women in dark, not allowing them to expose their real strength and capacity. Across all countries women and men differ in their ability to make effective choices in a range of spheres, with women typically at a disadvantage. The major outcomes of women's ability are their control over resources, ability to move freely, decision making over family formation, freedom from the risk of violence and ability to have a voice in society and influence policy. (World Development Report 2012).

Women are bearers of children, with no right to decide if, when and how many to have. The notion of son preference further dehumanizes women to machines, which have to produce children until the desired number of sons is reached (Pitre and Bhagyashree, 2004). The decision-making on birth spacing depends on the power and authority enjoyed by the individual. In the metros like Delhi where the woman has succeeded to some extent to exercise her rights, the decision-making is shared between the couple. In rural context, most of the women state that the decision-making powers are vested in the hands of the husband. In the case of some others, the mother-in-law is at times given so much power that she is almost the sole decision maker (USAID, 2003).

As former UN Secretary General Kofi Annan stated, Gender equality is more than a goal in itself. It is a precondition for meeting the challenge of reducing poverty, promoting sustainable development and building good governance. The economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behaviour in the community and also an important factor in seeking health care. Inequalities in health in a society are the outcome of unfair distribution of power between different groups within that society. This is why economic development and changes in the health care system by themselves have not been able to enhance the health status of marginalized groups to the extent desired.

A strategy is now being used together with economic development and health sector reforms, as a strategy for reducing persistent disparities in health and quality of life which is termed as women empowerment. (Kar et.al). It is believed that in the process of empowerment itself, a group or community would tackle the underlying social, structural and economic conditions that have impact on its health. As a result, it helps to gain more control over their life. The process of organizing women for collective bargaining and improving their capacity to receive essential basic services in terms of education, health, training, etc. is one of the strategies adopted for empowering women in India (Ila Patel, 1998).

Self Help Group (SHG) is a method of organising the poor people and the marginalized to come together to solve their individual problems. SHGs are being seen as the main stay for poverty alleviation in emerging market. The SHG movement was started in India with the pro active policy support from the National Bank for Agricultural and Rural Development (NABARD) and Reserve Bank of India (RBI) with the launch of a pilot SHG- bank linkage programme in the year 1992 with a modest target of linking 500 SHGs in the country as a whole. Over the years, this intervention received overwhelming response and met with resounding success catapulting it into a movement which now boasts of about 69 lakh SHGs as on 31st March 2010.Of these 90% were women groups, covering more than 6 crore households and about 30 crore people in the country.

The important objective of SHG is to organize women for self reliance at both individual and community levels to empower them both economically and in terms of decision making abilities. The former tries to remove the constraints and limitations emerging due to the poor socio economic status, thereby enhancing and achieving social security in the form of better maternal and child health care, educational attainments and improved housing conditions. Women Empowerment primarily nurtures their economically remunerative activities significant for their autonomy, promoting their decision-making authority that in turn positively influences reproductive choice as Women's reproductive autonomy is intrinsically valuable for women and also instrumentally valuable for the welfare of humankind (Purdy, 2006). The proposed research intends to study the role of Self Help Groups on reproductive autonomy of women which is an important indicator of women empowerment.

Statement of the Problem

Role of self-help groups on reproductive autonomy of women at Coimbatore

Objectives

- To assess the level of participation of women in SHG activities.
- To assess the level of reproductive autonomy of SHG women.
- To associate the reproductive autonomy of SHG women with selected demographic variables and participation of women in SHG activities

Methodology

A descriptive study was conducted among 44 SHG women **(**women who is a member of Self Help Group between the age of 20-35 years, having one or more children and not undergone permanent family planning) by using convenient sampling technique in Coimbatore district of Tamil Nadu. An interview schedule was used to collect data regarding the socio demographic variables, participation of women in SHG activities and changes in reproductive autonomy of the SHG women. The collected data was analyzed using descriptive statistics.

Results and Discussion

The data collected were tabulated and analysed using descriptive statistics under four sections as follows:

Section 1: Analysis of Socio demographic data

Table 1: Distribution of socio demographic profile of SHG women

S. No	Variables		No. of Respondents	Percentage %
1.	Age in years	20-24	13	29
		25-29	17	39
		30-34	14	32
2.	Education – Self	Illiterate	14	32
		Primary	07	16
		High School	17	39
		Higher Secondary	04	09
		College	02	04
3.	Education - Spouse	Illiterate	16	36
		Primary	03	07
		High School	17	39
		Higher Secondary	04	09
		College	04	09
4.	Religion Hindu		44	100
5.	Employment – Self	Housewife	02	04
		Daily Wages	10	23
		Monthly Income	32	73
6.	Employment – Spouse	Daily Wages	14	32
		Monthly Income	30	68
7.	Type of Family	Nuclear	32	73
		Joint	12	27
8.	Household Size	Three	13	30
		Four	17	39
		Five	12	27
		Six & Above	02	04
9.	Head of the Family	Husband	42	96
		Father in-law	02	04
10.	Number of Children	One	19	44
		Two	23	52
		Three	02	04
11.	Family Income Per Month (Rs)	8000 – 12000	17	39
		12000 – 16000	21	48
		16000 – 20000	04	09
		20000 and above	02	04

The above table represents the distribution of demographic data of the respondents. 39% of the SHG women were between the age group of 25-29 years and had education till high school level. 39% of their spouses also had education until high school level and all of them were Hindus. 73% of the SHG women and 68% of their spouses worked and had monthly income. 73% of them belong to a nuclear size and 39% had 4 members in the family. In 96% of the family, the head of the family was their husband and 52% of the family had 2 children, 48% of the families had a monthly income between Rs 12,000 – 16, 000.

Section 2: Participation in SHG activities

Table 2: Information on participation in SHG activities

S. No	Activities		No of Respondents	%
1.	Formation of group	0-2 years	12	27
		2-4 years	12	27
		4-6 years	10	23
		6 and above	10	23
2.	Duration of years in the group	0-2 years	12	27
		2-4 years	16	36
		4-6 years	10	23
		6 and above	06	14
3.	Members in the group	13 members	9	20
		15 members	35	80
4.	Group size	Decreased	06	14
		Stable	20	45
		Increased	18	41
5.	Suggestion to join the group	Neighbour	30	68
		Relatives	14	32
6.	Frequency of group meeting	Weekly	42	96
		Monthly	02	04
7.	Members attending the meeting	6-10 members	34	77
		11-15 members	10	23
8.	Reasons for joining the group.	Loan	44	100
9.	Benefits from the group.	Economical support.	44	100
10.	Total no of loans taken.	1-2	22	50
		3-4	06	14
		5-6	16	36
11.	Utilization of loans.	Personal Debts	32	73
		Education of children	04	09
		Building house	08	18
12	Frequency of meeting attended	Weekly	18	41
		Fortnightly	20	46
		Monthly	04	09
		Once in 2 months	02	04
13.	Education of health aspect	Yes	42	96
		No	02	04

The above table deals with information on participation of women in SHG activities. 36% of the women were in the SHG since 2-4 years. 18% of the group had 15 members and in 45% of the groups, the size was stable. In 68% of the women the suggestions for joining the group was given by the neighbours. 96% of the groups meet weekly. All the women mentioned that reason for joining the group and benefits of joining was economic support. About 50% of them have taken between 1-2 loans and 73% of them used it for settling their personal debits. About 46% of them attended the meeting every fortnightly and 96% of the SHG women received education regarding health aspects.

Section 3: Reproductive autonomy of SHG women

Table 3: Frequency distribution on scores of reproductive autonomy of SHG women.

Score	No. of Respondents	%
45-50	5	11
51-55	6	14
56-60	33	75

The above table depicts the changes in the level of reproductive autonomy women after joining SHG. The minimum score was 45 and the maximum score was 60. Thus all the women reported an increased level of reproductive autonomy after joining SHG. Frequency distribution on the scores reveals that 75% of the women scored between 56-60.

Section 4: Association of reproductive autonomy with selected Socio demographic variables and SHG activities

Table 4: Association of Reproductive autonomy with selected Socio demographic variables and SHG activities.

Variables	'r' value
Age	0.345
Household size	0.305
Number of children	0.266
Number of years in the group	0.354
Information on health aspects	0.672

Significant at the 0.05 level.

The above table reveals that there is a positive correlation between reproductive autonomy and age of the women, household size, number of children, number of years in the group and exposure to information on health related aspects.

Conclusion

Self help groups are continuously striving for a better future for women as participants, beneficiaries and decision makers in domestic, social, economic and cultural spheres of life. Women need to be empowered for better health as they are the primary caregivers in almost all families and spend their discretionary money and time with priorities on better health and quality of life for children and family. The study reveals that participation in Self Help Group activities improves the reproductive autonomy of women which provokes them to provide greater health benefits to their children and families.

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