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From Financial Support to Health Promotion: Exploring the Role of Self-Help Groups in Women's Well-being in Rural Karnataka

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Abstract

Self-Help Groups (SHGs) have emerged as a significant institutional mechanism for women's socio-economic empowerment in India. While the financial impact of SHGs is widely documented, their role in promoting health awareness and improving health behaviours among rural women remains underexplored. Our current work examines the experiences of 20 SHG members from rural Karnataka to assess the multidimensional impact of SHG participation on health awareness, healthcare access, financial stability, and personal empowerment. Data were collected through in-depth interviews and thematic case study analysis. Findings reveal that SHGs have been predominantly effective as financial safety nets, significantly enhancing members' confidence and decision-making capacity. However, their role in systematic health education particularly in areas such as menstrual hygiene,

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nutrition, and preventive healthcare remains limited and inconsistent across groups. Notable exceptions exist where SHGs actively integrate health-related programs, yielding demonstrably better health outcomes. The study concludes that strengthening health-focused interventions within SHG frameworks, through collaboration with ASHA workers, local governance bodies, and health departments, could substantially amplify their contribution to women's holistic well-being.

Keywords: Self-Help Groups (SHGs), Women's Empowerment, Health Awareness, Menstrual Hygiene, Rural Karnataka, Financial Inclusion, Qualitative Research

1. Introduction

Self-Help Groups (SHGs) represent one of the most far-reaching grassroots institutional innovations in rural development in India. Brought to scale through the National Rural Livelihoods Mission (NRLM) and its state-level counterparts, SHGs have mobilised millions of women into collectives that pool savings, extend credit, and create social capital at the rural level. India currently has over 12 million SHGs, with Karnataka being among the leading states in terms of group formation and federation (NABARD, 2023; MoRD, 2022).

The existing literature on SHGs and its outcomes, most of the time, concentrated on economic outcomes such as access to microcredit, income generation, and poverty reduction. However, women's well-being is a multidimensional construct encompassing physical health, mental health, reproductive health, and social agency. The question of whether SHGs by virtue of regular female congregation, also serve as effective conduits for health knowledge and behaviour change remains empirically contested.

Rural Karnataka presents a compelling research setting. Despite high SHG density, significant disparities in women's health indicators persist. District-level data point to ongoing gaps in menstrual hygiene management, anaemia, institutional delivery rates, and awareness of government health entitlements (Karnataka Health Department, 2022). If SHGs can be

leveraged as platforms for health communication and behaviour change, their potential impact could be transformative given their reach and embeddedness in community life.

The present study was motivated by a simple question: do women who participate in SHGs experience improved health awareness and practices? Using in-depth qualitative case studies of 20 SHG members from rural Karnataka, we sought to understand the realities of SHG participation and its overall impact on women's well-being.

This article proceeds as follows: Section 2 reviews the existing literature on SHGs and health outcomes. Section 3 describes the methodology. Section 4 presents findings through thematic analysis. Section 5 synthesises key patterns and implications. Section 6 concludes with recommendations.

2. Literature Review

2.1 SHGs and Women's Empowerment: A Broad Overview

Self-Help Groups in India originated in the 1990s under the NABARD-SHG Bank Linkage Programme and have since been institutionalised as a core pillar of rural development policy. The transformational premise of SHGs extends beyond credit: by gathering women into regular, structured collectives, they create social spaces that can challenge patriarchal norms and nurture agency (Datta, 2015; Kabeer, 2012).

Research consistently demonstrates that SHG membership is positively associated with financial autonomy, increased household bargaining power, and greater participation in local governance (Swain & Wallentin, 2009; Garikipati, 2008). Kannan and Pillai (2020) found that long-term SHG members in Kerala reported significantly higher decision-making authority across domains including health, education, and household expenditure.

2.2 SHGs and Health Outcomes

The interface between SHGs and health has attracted growing scholarly attention. Desai and Joshi (2014) conducted a large-scale study in Maharashtra and found that SHG

membership was associated with increased likelihood of institutional delivery, antenatal care utilization, and use of contraception. The mechanisms they identified included peer-to-peer information sharing, SHG-facilitated access to Accredited Social Health Activist (ASHA) workers, and microfinance-enabled healthcare expenditure.

Nair (2011), studying SHGs in Andhra Pradesh, noted that health outcomes were significantly better in groups that had formal linkages with health systems compared to those that operated purely as financial collectives. This finding underscores the importance of structural integration rather than incidental health discussions. A systematic review by Brody et al. (2017) of 15 studies on SHGs and women's health globally found that SHG participation had a modest but significant positive effect on women's mental health and subjective well-being. The review noted, however, that effects on physical health behaviours were heterogeneous and context dependent.

In Karnataka specifically, studies by Rajasekhar et al. (2013) found that SHG participation improved women's health-seeking behaviour but that menstrual hygiene and nutrition remained largely outside SHG discourse. This aligns with findings from the present study.

2.3 Gaps in the Literature

Despite the above, several gaps remain. First, most studies focus on measurable health outcomes (delivery rates, contraception use) rather than on the processes of health knowledge acquisition and behaviour formation within SHGs. Second, qualitative explorations of how individual women narrate their SHG experience with respect to health are sparse. Third, the role of SHGs in disseminating government health scheme information, a potentially critical function, has received little attention.

The present study attempts to fill these gaps by privileging the voices of SHG members themselves, capturing both the scope and limits of health-related change through SHG participation.

3. Methodology

3.1 Research Design

A qualitative case study design was adopted, appropriate for exploring complex, context-embedded social phenomena (Yin, 2018). The study aimed to generate rich, idiographic understanding rather than statistical generalisation.

3.2 Participant Selection

Purposive sampling was employed to select 20 SHG members from rural villages in Chikkaballapur district of Karnataka. Participants were selected to ensure diversity in age, educational background, occupational status, duration of SHG membership, and geographic location. The sample included homemakers, agricultural workers, teachers, government functionaries, and small business owners, ranging in age from 23 to 54 years. Duration of SHG membership ranged from 1.5 to 25 years.

Table 1: Profile of Research Participants

Participant (Names used here are pseudo)	**Age**	**Occupation**	**SHG Duration**	**Primary Motivation**
Sumithra	33	Housewife	12 years	Financial support
Shanthamma	49	Homemaker	15 years	Financial assistance
Anitha	38	Homemaker	18 years	Financial emergencies
Munilakshmamma	45	Agricultural Worker	10 years	Support system
Manjula	40	Homemaker	8 years	Mutual support

Participant (Names used here are pseudo)	**Age**	**Occupation**	**SHG Duration**	**Primary Motivation**
Lakshminarasamma	38	Non-teaching staff in a school	7 years	Children's education
Vanajakshi	42	Homemaker	18 years	Community dev.
Shantha	40	Homemaker	10 years	Financial/collective support
Chandrakala	36	Homemaker	1.5 years	Loans and savings
Saraswathi V	54	Tailor	25 years	Financial assistance
Nagaveni	42	Teacher	6 years	Loans/emergencies
Gayathri	36	Teacher	N/A	Loans/savings
Munikrishna KG	41	Lab Assistant	8 years	Supportive community
Sujatha	50	Homemaker	16 years	Emergency loans
Devaki	33	Homemaker	10 years	Emergency loans
Parvathamma	40	Sangha Prathinidhi	12 years	Leadership/coordination
Savitri	40	Homemaker	10 years	Emergency loans
S. Anuradha	40	Hotel business	8 years	Savings/loans
Pushpa	45	CRP (NRLM)	25 years	Financial difficulties
Chandana	23	Homemaker	2 years	Future security

Source: Primary fieldwork data (2025)

3.3 Data Collection

Data were collected through in-depth, semi-structured interviews conducted in Kannada and subsequently transcribed and translated into English. The process dived into the understanding of structure and functioning of SHGs, financial activities, household well-being,

health-related discussions within SHGs, access to healthcare services and government health schemes. Apart from that the interview questions dealt with the themes related to health behaviours such as hygiene, nutrition, and menstrual health practices, confidence and decision-making autonomy, and the role of SHGs in fostering social support networks. Interviews were conducted at participants' homes or community settings to encourage open responses and lasted around 45 to 90 minutes.

3.4 Analytical Approach

Data were analysed using inductive thematic analysis following the framework proposed by Braun and Clarke (2006). The process involved: (1) familiarisation with data through repeated reading of transcripts; (2) initial coding; (3) searching for and reviewing themes; (4) defining and naming themes; and (5) producing the final analysis. Both within-case and cross-case analysis were conducted to identify patterns and divergences across participants.

3.5 Ethical Considerations

Informed consent was obtained from all participants. Confidentiality was maintained using pseudo names. Participation was voluntary, and participants were free to withdraw at any stage without consequence.

4. Findings and Analysis

4.1 Financial Empowerment: The Primary and Consistent Gain

Across all 20 participants, the most uniformly reported that outcome of SHG participation was financial empowerment. Without exception, members joined their SHGs with financial motivations accessing credit during emergencies, accumulating savings, and reducing dependence on moneylenders or family members for liquidity.

The SHG functioned as a low-cost, socially secure credit mechanism. Loans were availed for diverse purposes: house construction (Manjula, ₹80,000), education (Lakshminarasamma, Nagaveni), medical emergencies (Munilakshmamma, ₹50,000),

marriage ceremonies (Sujatha), and agricultural activities. This financial utility was deeply felt and universally acknowledged:

"During difficult times, the money I contributed becomes accessible. It helped me manage financial stress without going to someone with folded hands." — Munilakshmamma

"I was able to manage my elder daughter's marriage on my own when my husband lost his job. The SHG made it possible." — Sujatha

Financial gains extended to increased personal confidence in money management. Members reported visiting banks independently, understanding loan agreements, and contributing meaningfully to household financial decisions which otherwise previously given to male family members.

4.2 Health Awareness: Heterogeneous and Structurally Inconsistent

The most significant finding in our study for policy recommendation is the marked heterogeneity in health awareness outcomes across SHGs. Three discernible typologies emerge from the data.

Type I SHGs with No Formal Health Integration: Many participants (Sumithra, Anitha, Munilakshmamma, Manjula, Chandrakala, Chandana, Sujatha, Pushpa) reported that health discussions were entirely absent or wholly informal in their SHG meetings. No structured health education was delivered, and members relied on family members, neighbours, or digital platforms for health information. Menstrual hygiene, nutrition, and preventive healthcare remained outside the SHG's functional purview.

Type II SHGs with Partial or Incidental Health Engagement: A second cluster (Shanthamma, Nagaveni, Gayathri, Savitri, S. Anuradha) reported some health-related activity primarily through health card provision (Yashaswini, ABHA, Aarogya Raksha). These offered financial reimbursement for medical expenses. These groups provided material healthcare support without accompanying educational content.

Type III SHGs with Active Health Integration: A smaller but significant group of participants (Lakshminarasamma, Vanajakshi, Shantha, Saraswathi V, Munikrishna KG, Parvathamma, Devaki) reported that SHGs actively incorporated health-related discussions, community health worker linkages, or organised health camps. Members reported Outcomes in this cluster were -improvements in dietary habits, menstrual hygiene practices, and health-seeking behaviour.

The most exemplary model was described by Parvathamma, a Sangha Prathinidhi managing 50 SHGs, in whose groups Non-Communicable Disease (NCD) camps are organised every three months. Apart from that menstrual hygiene is formally discussed, and members receive guidance on the Aarogya Raksha card providing up to ₹75,000 for critical illness.

"Every three months, doctors visit our camps. Blood pressure, sugar etc is checked. If something serious is found, they refer to the hospital. This is how health awareness should work." — Parvathamma

4.3 Menstrual Hygiene: A Persistent Gap

Menstrual hygiene emerged as one of the most consistent gaps across SHG types. Of the 20 participants, only a minority (Saraswathi V, Munikrishna KG, Parvathamma, Shantha) reported gaining menstrual hygiene knowledge through their SHG. The majority attributed their knowledge or indeed lack of updated knowledge to family members, particularly mothers and mothers-in-law.

A particularly noteworthy finding is the role of intergenerational reversal: several participants (Anitha, Manjula) reported that it was their children exposed to school-based health education who introduced them to improved menstrual hygiene practices! Munilakshmamma continues to use cloth during menstruation and reported receiving no information from her SHG to the contrary.

This finding has significant public health implications. SHGs, which meet women regularly and enjoy trust, represent ideal, but currently underutilised, platforms for disseminating accurate menstrual health information.

4.4 Government Health Schemes: Low SHG-Mediated Awareness

Government health schemes like Ayushman Bharat, Yashaswini, ABHA (Ayushman Bharat Health Account) were known to many participants, but the SHG was rarely the channel through which awareness was received. Most participants learned about these schemes through government health officials and ASHA workers. This represents a missed opportunity that is to say SHG meetings, with their regular attendance and trusted social context, could serve as primary communication hubs for scheme awareness.

Exceptions were notable. In Lakshminarasamma's SHG, the ABHA card was actively promoted, enabling members to access significantly reduced or free treatment. Vanajakshi similarly reported SHG-facilitated awareness of the Yashaswini card.

4.5 Confidence, Autonomy, and Social Support

Across all participants, regardless of SHG type, a consistent and strongly felt outcome was the enhancement of personal confidence and autonomy. Women who described themselves as previously hesitant, unable to speak in public, dependent on husbands for financial decisions, articulated transformative changes in self-perception.

"I have learned to coordinate with others, speak confidently, visit the bank independently. Before the SHG, I could not do this." — Lakshminarasamma BL

"I used to stay in the house. Now I am active, independent. I manage finances, I travel for meetings." — Parvathamma

Social support was another consistent theme. SHG solidarity extended beyond formal meetings, with members supporting each other during illness, family crises, and personal difficulties. This social capital, constitutes an important dimension of well-being.

5. Discussion

The findings of this study confirm and extend the existing literature on SHGs in several important ways. First, they corroborate the robust evidence on SHGs as mechanisms of financial empowerment and social capital formation (Swain & Wallentin, 2009; Kabeer, 2012). The financial security from SHGs provide not merely material but it translates into relational power, reduced vulnerability, and enhanced agency all foundational to well-being.

Second, the study contributes a fine-grained typology of SHG health engagement that moves beyond the binary of 'health-aware' versus 'health-unaware' groups. The three-type classification no integration, partial material support, and active integration has practical utility for programme design, helping identify where and how interventions can most effectively be targeted.

Third, the consistent gap in menstrual hygiene education across most SHGs is a finding that demands policy attention. Menstrual health is a core dimension of women's reproductive health and dignity. The fact that intergenerational learning from children to mothers has been more effective than institutional SHG programming underscores a systemic failure that structured programming could readily address.

The role of catalytic individuals such as Parvathamma in this study in transforming SHG functioning merits attention. Her experience demonstrates that the gap between a financially oriented SHG and a comprehensive well-being platform is not insurmountable rather it requires leadership, institutional linkages, and deliberate design.

Finally, the study highlights that financial empowerment and health empowerment, while related, are not automatically co-produced. A woman can gain significant financial autonomy through SHG participation without any corresponding improvement in health literacy or behaviour. Policy frameworks that treat SHGs primarily as microfinance instruments risk forgoing their considerable latent potential as health promotion platforms.

6. Conclusion and Recommendations

This study explored the experiences of 20 Self-Help Group (SHG) members in rural Karnataka to understand the role of SHGs in promoting women's well-being, particularly in relation to financial empowerment and health awareness. The findings reveal that SHGs have emerged as important instruments of financial inclusion, enabling women to access credit, build savings, strengthen decision-making capacity and social connectedness. These benefits contribute in enhancing women's overall well-being and agency within their households and communities.

However, the study also demonstrates that the positive effects of SHG participation do not automatically extend to health empowerment. Few SHGs actively facilitated health awareness through health camps, linkages with ASHA workers. But discussions on preventive healthcare, such initiatives were neither systematic nor uniformly available across groups. Because of this, awareness regarding menstrual hygiene, nutrition, preventive healthcare, and government health schemes remained uneven among participants.

Our findings suggest that SHGs possess substantial untapped potential as community-based platforms for health promotion. Their regular meetings, trusted social networks, and extensive outreach provide an ideal institutional mechanism for disseminating health information and encouraging positive health behaviours among rural women. Incorporating structured health interventions within existing SHG frameworks can generate benefits that extend beyond economic empowerment and contribute to holistic well-being.

Based on our findings, the study recommends: (i) integrating structured health education modules into SHG meetings; (ii) strengthening collaborations between SHGs, ASHA workers, Primary Health Centres, and local governance institutions; (iii) training SHG leaders and Sangha Prathinidhis in basic health communication; (iv) organising regular health

camps and screenings at the cluster level; and (v) incorporating health-related indicators into SHG monitoring and evaluation systems.

In conclusion, SHGs have already demonstrated their effectiveness as vehicles of financial empowerment. With appropriate institutional support and health-focused interventions, they can evolve into powerful grassroots platforms for advancing women's health, well-being, and social empowerment. Harnessing this potential is essential not only for improving rural health outcomes but also for achieving inclusive and sustainable development.

Conflict of Interest: The corresponding author, on behalf of second author, confirms that there are no conflicts of interest to disclose.

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