Women's Empowerment Collectives (self-help groups)

Courtney Cabot Venton

Summary

Women's Empowerment Collectives – also known as Self Help Groups (SHGs) - are voluntary groups, typically comprised of 15-25 women who meet every week to save, start small business activities, and grant loans to one another. They have been used in a wide range of contexts, adapted for refugees, caregivers of orphans and vulnerable children, people living with HIV/AIDs, adolescents, as well as layered with maternal, neonatal, child, and sexual and reproductive health support.

Importantly, these groups use a combination of empowerment, collective action and economic strengthening to yield a range of substantial outcomes. A person's social capacities have been shown to be one of the strongest determinants of whether a person is able to escape and remain out of poverty, and a mounting evidence base that layers women's collectives with health messaging has yielded very significant reductions in maternal and neonatal mortality. While the evidence is still nascent, Self Help Groups offer the potential to catalyze and leverage poverty reduction efforts.

Identification of the problem

Strategies to reduce poverty are founded in the notion that poverty arises because of a resource constraint. It therefore follows that providing people with access to resources will reduce poverty. However, a growing evidence base suggests that economic strengthening is only one component of a poverty reduction strategy, and that a person's aspirations and sense of control over outcomes may have a determining effect on their pathway out of poverty. For example, a 2018 USAID evidence review[2] finds that a range of social capacities are some of the strongest determinants of whether a person or household is able to escape and remain out of poverty, including social capital, aspirations, self-efficacy, confidence to adapt, women's empowerment and gender equality. These social capacities are, in turn, variously linked to improved food security, avoidance of negative coping strategies, and ability to recover, as well as longer term outcomes such as greater access to savings and credit, child school enrollment, spending on schooling and agricultural inputs.

This narrative has played out in health investments in developing countries. Maternal and child mortality rates are unacceptably high. About 830 women die from pregnancy- or childbirth-related complications around the world every day, and 99% of all maternal deaths occur in developing countries.[3] Worldwide, the mortality rate in children younger than 5 years is still unacceptably high at 7.7 million to 8.8 million per year, and includes 3.6 million deaths in newborn babies.[4,5] More than half of all maternal deaths occur in Sub-Saharan Africa (SSA)[6], and SSA remains the region with the highest under-five mortality rate in the world. By 2050, an estimated 60 per cent of under-five deaths will occur in SSA.[7]

Most births in African countries occur at home, especially in rural areas. Health investments have taken a strong focus on supply side interventions historically, focusing on ensuring the provision of resources such as the supply of medical equipment, good facilities and trained health workers. However,

[2] USAID, 2018. "Resilience Evidence Forum Report".
[3] https://www.afro.who.int/health-topics/maternal-health
[4] Rajaratnam JK, Marcus JR, Flaxman AD, et al. Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: a systematic analysis of progress towards Millennium Development Goal 4. Lancet 2010; 375: 1988–2008.
[5] Black RE, Cousens S, Johnson HL, et al, for the Child Health Epidemiology Reference Group of WHO and UNICEF. Global, regional, and national causes of child mortality in 2008: a systematic analysis. Lancet 2010; 375: 1969–87.
[6] https://www.afro.who.int/health-topics/maternal-health
[7] United Nations Inter-Agency Group for Child Mortality Estimation (2018). "Levels and Trends in Child Mortality"

supply side interventions need to be complemented by demand side interventions, stimulating people's demand for health services - for example, via women's collectives - to ensure that supply side investments are used by the populations that they are intended to serve.

The proposed solution

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Evidence indicates that participation in women's groups can result in increased aspirations[8], economic[9] and political[10] empowerment, as well as improved governance and service delivery[11]. Women's groups have also been shown to help people cope in a shock or stress. Women's groups layered with health content have seen substantial decreases in maternal and neonatal mortality, as well as significant improvements in health practices.[12] A systematic review of 36 evaluations of women's groups and nutrition outcomes in Asia found promising outcomes on infant and young child feeding practices, and an analysis of the national district level household survey in India found that villages with a Self Help Group present were 19% more likely to have delivered in an institution.[13]

Despite this evidence base, in Africa, almost no trials of community mobilisation through women's groups have been done to assess effects on poverty and health outcomes.

Identification of the costs and benefits

Costs:

- A Tearfund study in Ethiopia estimated costs of GBP 50 per person (2013 GBP) comprised of overall project costs and 2 years of facilitation support to the group (or approximately 100 meetings).
- The average cost of a women's participatory group health intervention is $2.6 per person, ranging from $ 1.1-$4.5 (2016 INT$).[14] This cost is comprised of overall project costs, training of facilitators and facilitation of 20 groups meetings.

These estimates do not include the cost of the participating women's time.

[8] Sanyal et al. 2015
[9] Field et al.2016; Feigenberg et al.2013; Woolcock and Narayan 2000
[10] Parthasarathy et al. 2017; Prillaman 2018; Datta 2015; Kumar et al. 2019
[11] Casini et al. 2015; Das et al, 2016; Kumar et al. 2019
[12] Kumar, Neha, Samuel Scott, Purnima Menon, Samyuktha Kannan, Kenda Cunningham, Parul Tyagi, Gargi Wable, Kalyani Raghunathan, and Agnes Quisumbing (2018). "Pathways from women's group--based programs to nutrition change in South Asia: A conceptual framework and literature review." Global Food Security
[13] Saha, Somen, Peter Leslie Annear and Swati Pathak (2013). "The effect of Self--Help Groups on access to maternal health services: evidence from rural India." International Journal for Equity in Health 12:36
[14] Pulkki-Brannstrom, A-M, H Haghparast-Bidgoli, N Batura, T Colbourn, L Banda, J Borghi, E Fottrell, S Kim, C Makwenda, A Prost, M Roato, R Sinha, A Costello, J Skordis (2019). "Participatory learning and action cyces with women's groups to prevent neonatal deah in low-resource settings: A multi-country comparison of cost-effectiveness and affordability." Under Review.

Benefits

The evidence base for the impact of these collectives is nascent but highly promising. Only one study estimates BCRs, while several rigorous evaluations have estimated cost effectiveness.

A 2013 cost benefit analysis of Self Help Groups in Ethiopia found that the intervention yielded benefits between $58 and $173 for every dollar spent. The methodology was not based on a quasi-experimental design, and therefore should be viewed with some caution. However, the data used was drawn from 65 Focus Group Discussions (FGDs) with 544 Self Help Group members, and 34 FGDs with 324 non-SHG members (control group). These interviews were used to gather data on income, school attendance, access to low-interest loans and stress sales of livestock.[15]

Rigorous research evaluations in Asia have shown that women's groups can have profound health outcomes. For example, a systematic review of Randomized Control Trials in multiple countries to assess the impact of women's groups on maternal and child mortality in Asia found that participation in women's groups was associated with a 37% reduction in maternal mortality, a 23% reduction in neonatal mortality, and a 9% reduction in still births.[16] A quasi-experimental design in India found that women's Self Help Groups that received additional training around maternal, neonatal and child health found that women's health practices improved, with women more likely to use contraception, practice skin-to-skin care and breastfeed.[17]

Along similar lines, an evaluation of women's groups combined with health education by peer counsellors in Malawi found that, for women's groups, maternal mortality fell by 74% and neonatal mortality by 41%. The cost of women's groups was US$114 per year of life lost (YLL) averted and that of peer counsellors was US$33 per YLL averted, using stratified data from single intervention comparisons.

Implications for scale up

These findings are likely to be highly replicable at scale, and across countries. A single Self Help Group can deliver gains across a wide range of measureable outcomes, including income generation, education, health, livelihoods, and peacebuilding, to name a few. Hence economies of scale are likely to be very high. Further, inherent to the Self Help Group model is a scalable federated structure, represented by Self Help Groups members, that are able to engage at a systems level, with formal legal recognition, the ability to take out large scale loans on behalf of group members, and able to advocate for access to basic services.

Self Help Groups and Women's Empowerment Collectives are numerous and widespread, but have received little visibility or investment. The intervention is already widespread, and may be replicated at scale. Self Help Groups can saturate at 70% of a community population, and replicate organically and virally.

However, the model is also founded in peer support, solidarity, and trust. These core principles are essential for successful Self Help groups, and therefore there is a risk that these groups will fail if they are expanded rapidly or

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with external financial incentives to achieve scale. Rather, a programmatic approach should focus on mapping and investing in the very large ecosystem of Self Help Groups that exist already, and facilitating investments in the systems that can support them to thrive, for example by ensuring that access to markets, health facilities and education are readily available.

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[ii] www.afro.who.int/health-topics/maternal-health

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[v] www.afro.who.int/health-topics/maternal-health

[vi] United Nations Inter-Agency Group for Child Mortality Estimation (2018). "Levels and Trends in Child Mortality"

[vi] Sanyal et al. 2015

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