Original Research Article

Women's Rural Livelihood Programme and Mental Health: A Case Study of JEEViKA in Bihar

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ABSTRACT

Background: Numerous anti-poverty programs across developing countries target women for the dual purpose of improving the financial status of the family as well as inducing women's empowerment in general. A significant amount of literature documented the empirical linkage between socio-economic status and women's empowerment. However, the impact of anti-poverty or developmental programs on women's mental health remains a less investigated subject. This study attempts to document the effect of a women's rural livelihood program, JEEViKA, on women's mental health in one of India's poorest states.
Methodology: A group of 100 rural women working with JEEViKA was randomly sampled, and an equal number of non-Self-Help Group (SHG) rural women's groups were also considered as the reference group. The non-SHG women had not worked with JEEViKA or any SHGs. A personal data sheet and the Verma and Verma's (1989) PGI General Well-being Scale in Hindi were administered to measure the subjects' mental health.
Result: The result obtained in the present study revealed that there exist variations in mental health scores among JEEViKA and non-SHG women. However, the majority of the JEEViKA women fall under the category of good and excellent mental health than their non-SHG counterparts. Moreover, the JEEViKA women are significantly higher in mental health than their non-SHG counterparts.
Conclusion: Result shows that financial inclusion has a meaningful impact on women's mental health.

Keywords: SHG, JEEViKA, Bihar and Rural Women.

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INTRODUCTION

The study was designed to capture the mental health status of rural women working in the field of JEEViKA and compare them with a group of non-SHG women in Bihar. In a cross-country comparison, Choudhary [1] finds that Indian women feel depressed for 31.9 years compared to 18.8 years in China and 22.7 years in the USA during their life span. The WHO [2] statistics suggest that, in India, the burden of depression is higher in females than males, which puts Indian women as a more depressed group. The high figures for depression seem to go along with the prevalence of suicides, as India registers the highest number of estimated suicides worldwide [2]. Indeed, as per the recent report by the National Crime Records Bureau [3], suicide happens to be the top reason for unnatural death among Indian women. Over half of them were married, and three-quarters were among the poorest class in India. Women in rural India have always experienced a growing incidence of common mental disorders and often have little or no recourse to treatment or support. The additional stressors that COVID-19 has introduced, such as constant worry of infection and loss of income and livelihoods, are likely to exacerbate this situation further. Arrietal and others [4] provide evidence of factors associated with mental health, including shocks to non-farm

livelihoods, women's access to self-help groups, and household food insecurity by using cross-sectional data from a pre-pandemic survey of rural women across five states.

Bihar, one of the major states in terms of area and population, undoubtedly intends to play a meaningful role in reaching the developmental goal. The Bihar's Government launched the Bihar Rural Livelihoods Project in 2006 with the support of the central government, and the World Bank. The project aimed to provide rural households with innovative, scalable, and sustainable models for improved livelihood opportunities, such as rice intensification and backyard poultry. The project targeted women from poor rural households and selected the target areas for the project via poverty and social assessment, which analysed poverty levels, social vulnerability, the potential for improvement in livelihoods, and social capital. At the initial stage six districts were selected Gaya, Khagaria, Madhubani, Muzaffarpur, Nalanda, and Purnia; the programme has since been scaled out in all 38 districts of Bihar. It leads different interventions through 7.20 lakh Self Help Groups (SHGs), 46,197 village organizations, and 653 Cluster Level Federations, one of the significant being microfinance intervention. The Bihar Rural Livelihoods Promotion Society (BRLPS), also known as JEEViKA, was established to implement the Bihar Rural Livelihoods Project, which aimed to increase the socio-economic empowerment of poor rural households in Bihar. The project planned to do so by promoting the establishment of community groups with sufficient capacity to productively engage with formal financial institutions, existing market systems, and public programmes to improve their livelihoods, health, education, and asset creation.

The Self-Help Group (SHG) is a homogenous group formed by 10-20 members of poor households having similar aims, objectives, and aspirations. The SHGs are formed under the principle of self-help to promote individuals through collective actions in augmenting income, gaining more accessible access to credit and other resources, and increasing their bargaining power. The SHGs may be formed either by male or female members or both. The SHG is a voluntary association of the poor who come together to improve their socio-economic conditions.

A significant amount of literature documented the empirical linkage between socio-economic status and women's empowerment. However, the impact of anti-poverty or developmental programs on empowering women remains a less investigated subject. Empowering women is seen as one of the central issues in sustainable development for many nations worldwide. There is a large body of research on the impacts of microfinance services on economic outcomes [5].

A range of positive psychosocial impacts has been claimed for SHGs. For example, studies in India have found that members show increased autonomy, political awareness, and empowerment [6], awareness of local social issues [7], more outstanding participation in household decision-making [8-9], self-confidence and self-esteem [10-13]. However, several systematic mixed methodology studies worldwide have found more modest evidence. Anderson's [14] study of medium to higher-quality evidence from South Asia and Sub-Saharan Africa found a positive impact on perceptions of control of decision-making and emotional self-efficacy. Brody et al. [15] found evidence in South Asia for a positive impact on household decision-making, mutual support and solidarity, political participation and networking to engage local authorities, women's mobility, women's control over family planning, and community respect. The qualitative but not quantitative investigation found evidence for psychological empowerment, such as self-confidence. The discrepancy was interpreted as a result of cognitive biases or the inadequacy of quantitative measures.

One convenient approach to studying SHG impact is examining how membership duration relates to psychosocial well-being. For example, Desai and Joshi [16] examined the effects of two years of exposure to bank-linked women's SHGs. They found SHG members to exhibit greater personal autonomy through increased participation in household decisions and greater involvement in civic activities but no significant increase in income. Sahu [17] also compared women with at least three or more years of SHG membership v non-members and found greater total empowerment for SHG members (13.2% v 1%), more significant gains in economic security, physical mobility, political participation, self-confidence, public interaction, though not of autonomy in decision making over childbirth.

Kumar [18] conducted a study on Bihar to estimate the causal impact of JEEViKA on mental health using data on a sample of 2300 SHG women from matched pairs of 66 high-exposure and low-exposure JEEViKA villages. The results suggest that mental health improves with increasing age and among socially backward

communities in high-exposure JEEViKA villages. JEEViKA, through its operations of creating self-sustaining community-based organizations, is indeed trying to build social capital. The federated structure of SHG, utilize the networks, norms, and trust, and such a process of building social capital has been found to improve one's capability, health, and well-being [19-21].

Hypothesis of the Study

The following hypothesis were framed for empirical investigation-

- Women working with JEEViKA will experience good mental health than non-SHG women.
- There will be a significant difference between the JEEViKA women and non-SHG women in terms of their average scores on mental health.

METHODOLOGY

Sample: A multistage sample design (MSD) has been adopted for the selection of units. Since the study is designed to capture the mental health status among rural women working with JEEViKA and compare them with a group of rural non-SHG women in Bihar. There are different types of SHG programmes running in India as well as Bihar. Therefore, two districts of Bihar were randomly included in the sample frame. A group of 100 rural women working with JEEViKA was sampled, and an equal number of non-SHG rural women's groups were also considered as the reference group. The non-SHG women consisted of those who had not working with JEEViKA or any SHGs. The sample of the study was chosen by the method of simple random technique. All the respondents were 25-35 years of age and inhabitants of rural areas. The respondents came from families lacking literacy and education with poor socio-economic backgrounds.

Tools used: Following tools were used for the collection of responses:

- **Personal Data Sheet (PDS):** The researcher developed it, which includes respondents' personal, familial and socio-economic characteristics.
- **PGI General Well-being Scale:** The PGI General Well-being Scale developed by Verma and Verma [22] in Hindi was administered to measure the subjects' mental health. The test consisted of 20 items. Each item that was checked as 'yes' was awarded a score of one. The administration and scoring hardly take 5-6 minutes per subject. Thus, the total score one individual could obtain ranges from 0 to 20. High scores on the scale showed more excellent positive mental health among subjects and vice-versa. Reliability was measured by KR 20 formula and was found to be 0.98. Validity was also found to be 0.49. The scale showed a significant relationship with therapeutic intervention.

RESULTS

From the inspection of table1, it appears that 37 per cent and 57 per cent of JEEViKA women fall under the good and excellent mental health category. Whereas 34 per cent and 55 per cent of non-SHG women's group were fall under the poor and average mental health category. Thus, economic deprivation is one crucial source or cause of poor mental health among rural women. Previous studies [1-3] also confirms that the burden of poor mental health is higher among disadvantaged Indian class.

Table 1: Distribution of scores on mental health of JEEViKA and Non-SHG groups

Group	Frequency distribution of scores (in Percent)					Total
	Extremely poor	Poor	Average	Good	Extremely good	
JEEViKA	0	0	6	37	57	100
Non-SHG	0	34	55	11	0	100

A perusal of table 2 revealed that JEEViKA women are significantly superior in average mental health scores compared to the non-SHG women. However, both the groups differ significantly between themselves in terms of average mental health score ($t=5.02/p<0.01$). The results are in complete accord with the earlier findings [16-18], which have clearly delineated that mental health improves with significant increase in income and economic participation.

Table 2: Comparison of scores on mental health of JEEViKA and Non-SHG women

Group	N	Mean	SD	SE of Mean	t-ratio	F-value
JEEViKA	100	16.41	2.336	.234	5.02 (p<.01)	1.65 (NS)
Non-SHG	100	10.79	10.953	1.095		

CONCLUSION

The results obtained in the present study revealed that there exist variations in mental health scores among JEEViKA and non-SHG women. The majority of the JEEViKA women fall under the category of good and extremely good mental health than their non-SHG counterparts. The JEEViKA women are significantly higher in mental health than their non-SHG counterparts. This shows that financial inclusion and socio-economic status link with women empowerment vis-à-vis women's mental health. The study does not claim to present a complete picture of women's mental health, because the study was conducted among rural women of Bihar. However, the results indicate financial inclusion has a strong positive impact on mental health.

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