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DEVELOPMENT OF SELF-HELP GROUP TO PROMOTE FAMILY PLANNING AWARENESS AND ADOPTION

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Abstract

Funding agencies and government organizations are increasingly using women-led self-help groups (SHGs) as platforms for implementing development initiatives. However, there remains limited evidence on whether SHGs serve as effective and equitable channels for delivering health or livelihood interventions. In the present study community self-help group was created to encourage, educate and reassure the use of family planning methods between females of selected areas of Greater Noida UP. Out of 40 women, 5 were taken as a sample by using total enumeration sampling technique. Structured knowledge questionnaire was used to collect the data. The intervention led to a consistent and statistically significant improvement in participants' knowledge scores, rising from a mean of 14.4 in Post-Test 1 to 29.8 by Post-Test 6 (p=0.000). The steady increase and decreasing standard deviation reflect both enhanced understanding and uniform knowledge retention among the Community Self-Help Group members. The progressive increase in scores highlights the effectiveness of stepwise teaching and the power of community-based self-help groups in enhancing awareness and empowering rural women.

Key Words: Self-help group, Family planning methods, awareness.

INTRODUCTION

Self-help groups are small organisations with ten to twenty members that were established for social or economic reasons. It can be characterised as a self-governing, peer-controlled information group of individuals with similar socioeconomic backgrounds who want to work together to achieve a common goal.[1]

Self-Help Groups (SHGs) have become a revolutionary movement in emerging nations like India. These organisations at the grassroots are based on the ideas of self-sufficiency, mutual aid, and group empowerment. The idea is to empower people to take control of their own financial, social, and personal development, particularly those from marginalised groups.[2]

Providing women with access to quality healthcare, especially regarding their reproductive health, may improve their general well-being and empower them to make informed decisions about their life and physical health. SHGs' participatory aspects enable females to participate in community events and create networks of support. SHGs often give women with training in a variety of areas, including health related decisions, how to motivate others, and leadership.[3]

Women-only self-help groups have been shown to provide a valuable support system for women and girls, helping them build social networks, increase awareness of their rights to safe and healthy relationships, achieve financial independence, and strengthen their ability to make informed reproductive and family planning decisions.[4]

LITERATURE REVIEW

Ragini Kulkarni et.al has conducted a study titled "Assessing the potential of self-help group women for improving reproductive health of women in a tribal block of Maharashtra, India"2022. The study aimed to assess

the impact of involving Self-Help Groups (SHGs) in improving reproductive health-seeking behaviour and service utilization among tribal women in Nasik district, Maharashtra. Conducted over 18 months in two tribal blocks (Kalvan and Surgana), the intervention included training SHG women to conduct health education sessions and refer women with reproductive health problems to public facilities, with incentives provided for their efforts. Following the intervention, 65% of referred women availed reproductive health services. There was a significant improvement in service-seeking behaviour in the intervention block compared to the control block (χ^2=9.06, P<0.002). The study concluded that SHGs can effectively enhance reproductive health awareness and service use among tribal women. This community-based model is feasible and scalable without adding pressure on existing health staff.[5]

Somen Saha, Peter Annear, Swati Pathak has conducted a study titled "The effect of Self-Help Groups on access to maternal health services: Evidence from rural India" 2013. In order to determine the effect of SHG presence on maternal health service uptake, researcher examined the complete dataset from the third national District Level Household Survey from 601 districts in India. The existence of a SHG in the community was the main predictive variable. Institutional birth, colostrum feeding for newborns, familiarity with family planning techniques, and usage of family planning were the outcome variables. They adjusted for respondent wealth, education, health messages heard or seen, access to medical services, and the presence of a local health and sanitation committee. According to stepwise logistic regression, respondents from SHG-affiliated villages were 19% more likely to have given birth in an institution, 8% more likely to have fed newborns colostrum, and more likely to be aware of and make use of family planning services and products. These findings are substantial when individual and village-level heterogeneities are taken into account, and they are in line with previous research showing that women's involvement in SHGs generates social capital that affects health outcomes.[6]

METHODOLOGY

The quantitative approach was used in this study. In this study researcher has create a community self-help group to educate encourage and re-observe the community people regarding adoption of family planning methods. Researcher has created a community self-help group by using six sigma DMAIC cycle.
The sample consisted of 05 women with more than two children, selected through total enumeration sampling technique. The study was caried out in Dhankaur village, Greater Noida. Total 40 participants were taken for collection of data by using interview technique. Data was collected regarding use of family planning methods and their barriers.
Out of 40 participants only 5 participants have voluntarily participated in this group activity. Researcher has taken interview from these 5 participants about adoption of family planning methods. Based on the interview data, the researcher concluded that there is a lack of awareness about family planning methods and a need to establish a community self-help group to educate and motivate women on adopting these methods.

RESULTS

The main study was conducted among five women residents from Dhankaur village in Greater Noida, Uttar Pradesh, who had more than two children each. Section 1 highlights the demographic characteristics of these participants. The findings revealed variations in age, educational background, occupation, family structure, and socioeconomic status. Most of the women belonged to lower- or middle-income families and lived in joint family setups. Their educational levels ranged from primary to secondary schooling, and the majority were homemakers engaged in household and community activities.
Section 2 presents the representation of the level of knowledge among members of the Community Self Help Group (CSHG). The analysis indicated differences in their understanding of maternal and child health practices, reproductive health, and family welfare measures. The mean difference in knowledge scores among the CSHG participants demonstrated varying levels of awareness, suggesting that while some women possessed moderate knowledge, others required additional information and reinforcement through community-based educational programs.

SECTION – 1 Demographic Variables of study participants

Table 1 Frequency and Percentage Distribution of Demographic variables of women with more than 2 children

SR. NO.	DEMOGRAPHIC VARIABLES	FREQUENCY	PERCENTAGE
1	**Number of children**		
	1. 3	4	80.0
	2. 4	0	0.0
	3. 5 and more	1	20.0

2	**Span of marriage**		
	1. 3 years	2	40.0
	2. 4 years	0	0.0
	3. 5 years and more	3	60.0
3	**Monthly Income**		
	1. Up to 10,000	1	20.0
	2. 10,001-20,000	2	40.0
	3. Above 20001	2	40.0
4	**Age**		
	1. 21-28	3	60.0
	2. 29-36	1	20.0
	3. 36+	1	20.0
5	**Gender**		
	1. Male	0	0.0
	2. Female	5	100.0
6	**Educational status of participant**		
	1. Primary	3	60.0
	2. Secondary	1	20.0
	3. Graduate	1	20.0
	4. Above graduate	0	0.0
7	**Educational status of spouse**		
	1. Primary	1	20.0
	2. Secondary	4	80.0
	3. Graduate	0	0.0
	4. Above graduate	0	0.0
8	**Employment status of participant**		
	1. Labour work/farmer	0	0.0
	2. Home maker	5	100.0
	3. Govt. employee	0	0.0
	4. Private Employee	0	0.0
9	**Employment status of spouse**		
	1. Labour work/farmer	5	100.0
	2. Home Maker	0	0.0
	3. Govt. employee	0	0.0
	4. Private Employee	0	0.0
10	**Religion**		
	1. Hindu	5	100.0
	2. Muslim	0	0.0
11	**Residence**		
	1. Rural	5	100.0
	2. Urban	0	0.0
12	**Gender of children**		
	1. Male	2	40.0
	2. Female	0	0.0
	3. Both	3	60.0
13.1	**Do you know about family planning methods? If yes, mention the media.**		
	1. Yes	4	80.0
	2. No	1	20.0
13.2	**Media**		
	1. Asha-worker	0	0.0
	2. Friends	1	20.0
	3. Hospital	1	20.0

	4. Spouse	1	20.0
	5. TV	1	20.0
	6. NA	1	20.0
14.1	**Types of family planning methods used, if yes, mention the name.**		
	1.Yes	3	60.0
	2. No	2	40.0
14.2	**Name of family planning method used**		
	1. Copper-T	1	20.0
	2. Condom	3	60.0
	3. Male condom & Copper-T	1	20.0
	4. NIL	0	0.0

The table 1 comprised five women residents of Dhankaur village in Greater Noida, Uttar Pradesh, each having more than two children. The demographic profile revealed diverse characteristics across several variables. Regarding the number of children, four participants (80%) had three children, while one woman (20%) had five or more. None had exactly four children. The span of marriage varied, with two participants (40%) married for up to three years, and three participants (60%) reporting a duration of five years or more.

In terms of socioeconomic status, one woman (20%) reported a monthly income of up to ₹10,000, while two participants (40%) had a family income between ₹10,001 and ₹20,000. 40% had an income exceeding ₹20,000, indicating that most participants belonged to a lower or lower-middle income group. The age distribution showed that three participants (60%) were between 21 and 28 years old, one (20%) was aged 29–36 years, and one (20%) was above 36 years. All participants (100%) were female, as the study focused exclusively on women with more than two children.

Educational attainment among the participants indicated that three women (60%) had completed primary education, one (20%) had attained secondary education, and one (20%) was a graduate. None had education beyond graduation. Conversely, the educational level of their spouses showed that one spouse (20%) had studied up to primary level, while the remaining four (80%) had completed secondary education.

Regarding employment, all participants (100%) were homemakers with no formal employment, whereas all their spouses (100%) were engaged in manual or agricultural work such as daily labor or farming. This points to a rural, agrarian lifestyle with women primarily involved in domestic duties. Religiously, all participants (100%) identified as Hindu, and all resided in rural areas, confirming the study's community setting.

Analysis of family composition revealed that two women (40%) had only male children, while three (60%) had both male and female children. No participant reported having only female children. Awareness about family planning was reasonably high, with four women (80%) having some knowledge of family planning methods and one (20%) lacking any awareness. Among those who were aware, the sources of information were varied each medium contributing 20% respectively—including friends, hospitals, spouses, and television. None reported learning from ASHA workers, indicating limited community health outreach.

Regarding the practice of family planning, three women (60%) reported using some form of contraception, while two (40%) did not use any. Among the users, the most common method was the male condom (used by 60%), followed by Copper-T (20%), and a combination of both methods in one case (20%). None reported other modern contraceptive methods.

Overall, the findings suggest that the women were predominantly young, rural homemakers with limited education and financial resources. While awareness of family planning was moderate, utilization of contraceptive methods was inconsistent, reflecting gaps in health education and access to maternal-child health services.

SECTION:2 Representation of level of knowledge among CSHG
Table 2. Mean, Standard deviation and t test of pre-interventional and post-interventional knowledge level among Community Self Help Group

(n=05)

	Mean ± SD	T value	df	P value
PRE-TEST	7.80 ± 1.48	12.944	4	0.000*
POST- TEST 1	14.4 ± 1.34			
POST- TEST 2	20.6± 2.50	-10.660	4	0.000*
POST- TEST 3	25.6±2.30	-13.494	4	0.000*

POST- TEST 4	29.2± 2.50	-15.989	4	0.000*
POST- TEST 5	29.4±1.79	-19.869	4	0.000*
POST- TEST 6	29.8±0.44	-31.113	4	0.000*

Table 2 presents the mean, standard deviation, and t-test values comparing the pre-intervention and multiple post-intervention knowledge levels among the Community Self Help Group members (n=5). The data clearly demonstrate a consistent and statistically significant improvement in knowledge following successive educational interventions.

In the pre-test, the mean knowledge score was 7.80 with a standard deviation of 1.48, indicating a relatively low baseline understanding of the subject matter among the participants. This low score reflects pre-existing gaps in awareness and knowledge regarding the targeted health concepts addressed through the intervention sessions.

Following the first intervention (Post-Test 1), the mean knowledge score increased notably to 14.4 with a standard deviation of 1.34. This substantial rise in the mean score indicates that the initial educational session had an immediate positive impact on the participants' understanding. By Post-Test 2, the mean knowledge further improved to 20.6 (SD=2.50), representing a progressive gain in knowledge and retention following repeated reinforcement.

From Post-Test 3 onward, the upward trend continued, with mean scores of 25.6 (SD=2.30), 29.2 (SD=2.50), 29.4 (SD=1.79), and finally 29.8 (SD=0.44) recorded up to Post-Test 6. This pattern reflects both improved comprehension and sustained retention of knowledge among the Community Self Help Group across the duration of the intervention program. The steady reduction in standard deviation values by the last session indicates a narrowing gap in knowledge among participants, implying that most members achieved a uniform level of understanding by the end of the intervention.

The t-values obtained (ranging from 12.944 to -31.113) and the consistently significant p-values (p=0.000) across all comparisons confirm that these differences were statistically highly significant. This signifies that the educational intervention was highly effective in enhancing knowledge levels among the CSHG members over time.

Overall, these findings suggest that structured, repeated educational interventions led to substantial and sustained improvement in the knowledge levels of the group. The gradual rise in scores across post-tests demonstrates the success of the stepwise teaching process and highlights the value of community-based participatory approaches in improving awareness and empowering rural women through self-help group initiatives.
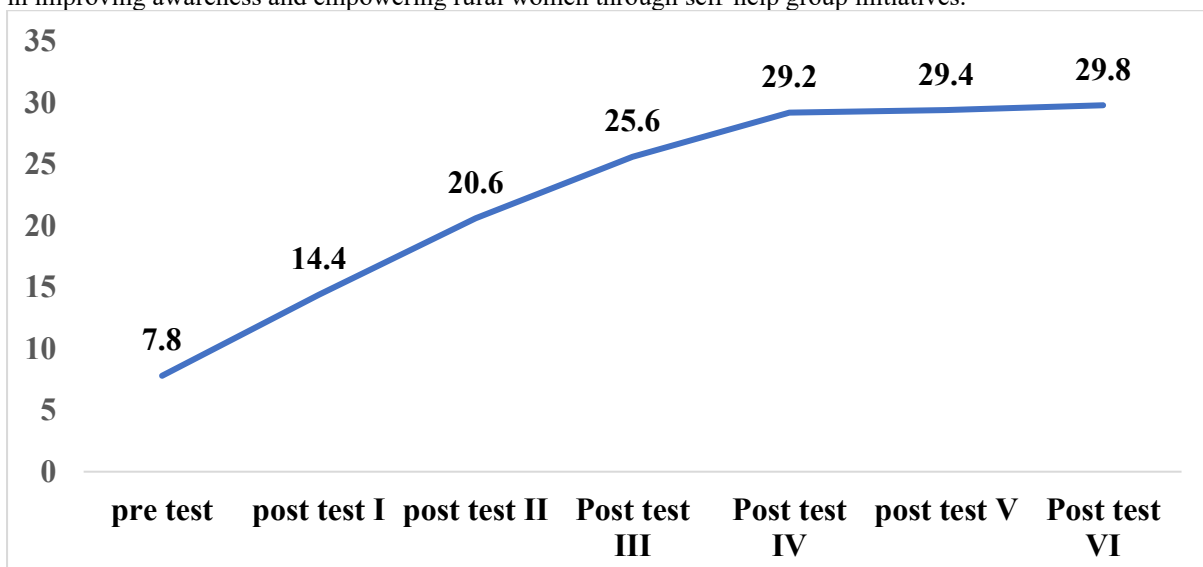
Figure No. 1. *Mean knowledge score of community self-help group during pre-test, post-test 1, post-test 2, post-test-3, post-test-4, post-test-5 and post-test 6*

DISCUSSION:

The study findings reveal a significant and progressive increase in knowledge levels among Community Self Help Group (CSHG) members following repeated educational interventions. This aligns with broader evidence that women-led SHGs serve as effective platforms for disseminating health information and improving reproductive health awareness in rural India. For example, Saha et al. (2013) reported that villages with SHGs had significantly higher knowledge and utilization of family planning services, suggesting that participation in SHGs enhances women's access to health information and positively influences health behaviours. Similarly, Kulkarni et al. (2025) showed that training SHG women to conduct health education sessions improved reproductive health-seeking behaviour and service uptake among tribal women, highlighting the feasibility and impact of community-based SHG interventions.

The statistically significant increase in mean knowledge scores at each post-test stage in the present study demonstrates the effectiveness of stepwise, reinforced educational interventions. This is consistent with findings from other educational intervention studies, which emphasize the importance of ongoing reinforcement to sustain knowledge improvement, bolster understanding, and translate into behavioral change. Moreover, the reduction in standard deviation values towards the last post-test indicates that knowledge gains were consolidated across all participants, reflecting uniform comprehension a hallmark of successful group-based health education.

Self-help groups empower women not only by improving knowledge but also by fostering social support, leadership skills, and decision-making autonomy relevant to reproductive health. Economic and social empowerment through SHGs helps overcome barriers to family planning adoption, such as lack of awareness or limited access to services, which was evident in this study's demographic context of predominantly rural homemakers with moderate socioeconomic status.

In **summary**, the study corroborates existing literature that structured educational interventions delivered through women's self-help groups significantly enhance reproductive health knowledge. Such community participatory approaches are promising strategies for empowering women, promoting family planning, and ultimately improving maternal and child health outcomes in marginalized rural settings

Strength
1. Study provides a direct understanding of participants' personal experiences, beliefs, and challenges related to family planning methods.
2. The study creates a community self-help group and that group member teaches, train and encourage women regarding family planning methods.

Limitations
1. Males were not interested to participate.
2. With only 5 participants, the study's findings may not be representative of the broader population, limiting the generalizability of the results.
3. After the formation of the Self-Help Group, the intervention is limited to training, with no subsequent actions or continued support provided.

CONCLUSION:

Study concluded that community self-help group raising awareness of the proper application of these family planning techniques and it is necessary to encourage couples and their kids to have healthy lives.

REFERENCES

1.   Pandey, R. (n.d.). Role of self-help groups (SHGs) in women education and entrepreneurship development. Homesciencejournal.com. Retrieved November 3, 2025, from https://www.homesciencejournal.com/archives/2023/vol9issue3/PartC/9-3-26-338.pdf
2.   Self-Help Groups (SHGs) in India. (2025, August 20). NEXT IAS Blog; NEXT IAS - Made Easy Learnings Pvt. Ltd. https://www.nextias.com/blog/self-help-groups-shgs/
3.   Kumar, N., & Kaur, N. (n.d.). Impact of self-help group for woman empowerment in India. NeuroQuantology: An Interdisciplinary Journal of Neuroscience and Quantum Physics. https://doi.org/10.48047/NQ.2022.20.22.NQ10521
4.   Uysal, J., Johns, N. E., Undie, C.-C., Liambila, W., Pearson, E., Reed, E., & Silverman, J. G. (2025). Women's self-help group participation and discussion of reproductive coercion: Associations with past experiences of violence among family planning clients in Kenya. PLOS Global Public Health, 5(9), e0004087. https://doi.org/10.1371/journal.pgph.0004087
5.   Kulkarni, R., Chauhan, S., Joshi, B., Balsaraf, K., Chaudhari, R., Donde, G., & Juneja, K. (2022). Assessing the potential of self-help group women for improving reproductive health of women in a tribal block of Maharashtra, India. The Indian Journal of Medical Research, 156(2), 191–197. https://doi.org/10.4103/ijmr.IJMR_1827_20

6.   Saha, S., Annear, P. L., & Pathak, S. (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. https://doi.org/10.1186/1475-9276-12-36

7.   Saha, S., Annear, P., & Pathak, S. (2013). The effect of Self-Help Groups on access to maternal health services: Evidence from rural India. *PLoS ONE*, 8(7), e68112. https://doi.org/10.1371/journal.pone.0068112

8.   Kulkarni, R., et al. (2025). Assessing the potential of self-help group women for improving reproductive health of women in a tribal block of Maharashtra, India. *Indian Journal of Medical Research*, 161(3), 327-336.

9.   Impact of educational interventions on knowledge and level of retention among community participants. (2024). *International Journal of Community Medicine and Public Health*, 11(6), 2321-2327.

10.   Effectiveness of multimethod, community-based educational interventions to improve maternal and child health knowledge and practices. (2024). *BMC Public Health*, 24, 987. https://doi.org/10.1186/s12889-024-10987-x

11.   Role of Self-Help Groups in women empowerment and health. (2023). *International Journal of Current Microbiology and Applied Sciences*, 12(5), 344-356.

12.   Integrating health and nutrition messages into Self-Help Groups in India: an evaluation of outcomes and scalability. (2023). *Population Council*.