A report on women Self Help Groups (SHGs) in Kerala state, India : a public health perspective

A report prepared for FCRSS/IRSC

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There are people who cut down the forests to build a well,
not seeing the connection between the trees and the water.

Malayalam proverb

1.0 Introduction

The Indian desire of *Sarve Santh Niramayaha*, 'let all be free from disease let all be healthy', is a seemingly difficult task for poor and oppressed populations. Although poverty is widely accepted to be a root cause of ill-health (Wagstaff, 2001; 2002), we in public health have often attempted to address illness and disease by implementing, sectoral programs, in the pursuit of 'magic bullet' or uniquely 'health' solutions. These approaches, however, marginalise the multi-factorial and social nature of health production. An alternative approach to improve the health of the poor is to adopt a multi-sectoral approach (Lipson, 1998). Evaluating an intervention in another sector (e.g. rural development, agriculture), from a public health perspective, could illuminate potential intra-sectoral initiatives. Moreover, such an exercise may demonstrate unrecognised health benefits from that sector. Due to the existence of a strong linkage between poverty and health, poverty alleviation schemes (PAS) are a particularly attractive option to explore.

In many low- income countries, over half of the population lives in poverty, which does not include those who are not considered 'poor' but live under impoverished conditions and will suffer from poor health (Leon, Walt, & Gilson, 2001). Women represent about 70% of the poor (UNDP, 1995), and are particularly vulnerable to health problems due to persistent gender inequalities. These inequalities are the result of institutional (e.g. inappropriate health care), household barriers (e.g. unequal distribution of health-related resources), societal norms (e.g. preferences for the male child), as well as interactions between economic class and women's status (Mukhopadhyay, 1998; Sen, Iyer & George, 2002). Consequently, there have been increasing numbers of development interventions geared to not only raising women's access to resources, but also to increase their level of autonomy, and decision-making powers.

This report is a preliminary exploration of the linkages between participation in one type of PAS, micro-credit, and health. Micro-credit is increasingly seen as a contributor to the reduction of poverty in developing countries, by providing the poor the opportunity to engage in productive activities. Micro-credit involves small groups of poor individuals who obtain access to collateral-free loans from financial institutions. These groups begin by collecting fees from members, which are put into a bank for saving. After a specified time (usually around six months), members become eligible for credit and can make a request for a loan. After securing a loan, the member is then required to repay the amount borrowed, with the accumulated interest.

One form of micro-credit, popular in India, is the self-help group (SHG). Promoted by national and state government, and non-governmental organisations (NGOs), SHGs are voluntary groups engaged in collective saving and thrift activities for the purpose of securing credit. The 1990s saw a proliferation of women SHGs across India, particularly in the South (Narayana, 2002). These groups were designed not only as a strategy for poverty alleviation, but also to increase women's access to resources and their power in household decision-making (Sundram, 2001).

During the summer of 2002, I had the opportunity to spend time in the Indian state of Kerala to better understand how SHGs function, to gain a contextual knowledge of the area, and to develop a question for my doctoral research. This report is a result of that trip and is organised in the following manner. First, an overview of the relationship between poverty and health is briefly outlined. Second, experiences with micro-credit schemes in South East Asia, with a particular focus on women, are reviewed. Third, the context of the research and the local SHGs are described. Fourth, the potential links between SHGs and health are explored. The paper concludes with the author's proposed future research question.

2.0 Seeing the connection between poverty and health

The relationship between poverty and health has held the attention of public health researchers and activists throughout history (Rosen, 1993; Waitzkin, 1981). Poverty continues to be of primordial importance, particularly in the developing world (Wagstaff, 2001). This powerful linkage between poverty and health has been characterised as bi-

directional and synergistic (Das Gupta & Chen, 1996; Leon, et al., 2001; Wagstaff, 2002). **First**, poverty exacerbates ill-health. The poor have limited access to health inputs (e.g. nutritious foods, health services, non-toxic environment), and little capacity to convert (e.g. through education) the inputs they do have into health. Therefore, the poor have lower health productivity than non-poor, and consequently limited outputs. This is supported by global studies, which have shown that the poor suffer more from ill-health (Gwatkins et al., 2000).

Second, poor health may lead to impoverishment and downward mobility. Poor health restricts economic growth by reducing the availability of labour, limiting the productivity of workers, creating dependency on others, and wasting resources (Abel-Smith, 1990). A household member who falls ill reduces their capacity to earn income, or perform necessary household tasks, thereby increasing economic vulnerability of the household (Wagstaff, 2001). Moreover, the burden of medical costs is higher for the poor, and in extreme cases, may push families who are just above the poverty line, into destitution (Krishnan, 1999).

The challenge set before us is to break the cycle of ill-health and poverty. While many public health experts have attempted to address poverty within their interventions, it is also possible that poverty alleviation strategies, such as micro-credit, may have a positive impact on health. In order to understand the potential health benefits of participating in micro-credit, these schemes will first be reviewed.

3.0 Micro-credit initiatives

Without land or paid employment, many of the world's poor turn to self-employed activities to generate income. The poor are faced with the challenge of acquiring credit to take loans to engage in various productive activities, without the necessary collateral (e.g. land) required by formal lending institutions. Micro-credit initiatives have become increasingly popular as a way to mobilize poor communities through the provision of loans through specialized financial institutions (Mosely & Hulme, 1998). Small groups are formed, and loans are allocated to members, based on group solidarity instead of formal collateral (Montgomery, 1996). This strategy appeals both to those on the left for it is based on redistribution principles, and to those on the right for it promotes self-

sufficiency and independence of the poor through capitalist activities (Mosely & Hulme, 1998). Micro-credit schemes have been particularly targeted towards poor women, who are often discriminated against not only by institutions, but also within their own households. The provision of loans to women may then serve the dual goals of increasing household wealth and empowering females (Amin, Becker & Bayes, 1998; Kabeer, 2000).

While some have labelled micro-credit as revolutionary and a new paradigm for development, others ponder the real *impacts* of micro-credit. Some have questioned whether or not micro-credit leads to poverty reduction. For example, it has been observed that due to the preference, or need for consumption loans by the poor, members are not gaining productive capacities (Mosley & Hulme, 1998). Furthermore, micro-credit has not succeeded in attracting the poorest members of society, thereby bypassing those most in need. The potential of micro-credit, however, is still being explored, and authors have suggested various changes to improve the effectiveness of micro-credit on poverty alleviation (Matin, Hulme, & Rutherford, 2002; Mosley & Hulme, 1998).

The evidence with respect to the impact on women's status and well-being is mixed. Some studies have found positive results, including female empowerment and decreased violence against women (Amin, Becker, & Bayes, 1998; Hashemi, Schuler & Rile; 1996). Other studies have cited unintended side effects of micro-credit, including increased violence against women, negative peer-pressure linked to loan repayment, and emotional stress of females due to family-related conflicts (Amed & Chowdhury, 2001; Montgomery, 1996; Rahman, 1998). The extent of women's empowerment is also unclear, as some authors have found that these initiatives have led to another form of domination over women, through the development of new hierarchies of power (Rahman, 1998). For example, Rahman stated that 60% of husbands were using loans secured by women. This means that even if household income increases and women are gaining new experiences with financial institutions, they are not acquiring new status or power within the family.

The conflicting results of micro-credit on women's status and well-being, may be attributed, in part, to methodological variations (Kabeer, 2000). Some studies base their

findings purely on statistical evidence, while others rely on qualitative approaches. Kabeer points out that a quantitative survey may determine an average reduction of violence, while ethnographic work may find increased violence within certain households. Differential impacts of credit schemes may also be related to the type of questions being addressed, those studies which have found positive impacts usually focussed on outcomes, while studies finding negative results focussed on processes (Kabeer, 2000). Also, the underlying issues being addressed, such as autonomy and empowerment, are not always measured appropriately. Kabeer promotes a comprehensive approach, which includes the participation of female members in the evaluation process, combined with conceptual clarity and validity of the elements of study.

Much of the evidence of the impacts of micro-credit in South East Asia, has arisen from Bangladesh, where the micro-credit 'movement' originated (Yunus, 1999). In particular, studies have focussed on the larger and well-known schemes such as the Grameen Bank. There is, however, a diversity of initiatives across the continent. In India the importance of the Self Help Group (SHG) is expected to grow rapidly; NABARD (1999) predicts that by the year 2008, at least one third of the rural population will be covered by one million SHGs (Sivramkrishna & Panigrahi, 2001). Prior to detailing SHGs, we will first examine the context, which is extremely crucial in understanding the dynamics of social organisation, socio-economic conditions, and the health needs of the population. Our focus, therefore, turns to a small *panchayat* (village) called Kottathara, located in Wayanad, one of the most rural and 'backward' districts in the Indian state of Kerala.

4.0 Context of study

4.1 Kerala

While Kerala lies within the countours of India, one must understand the specificities of the state, which varies tremendoulsy from other areas of the country. Kerala is located on the South Western tip of India. One is first struck by the greenness of the state, full of coconut groves, paddy fields, coffee plantations, and forests. Kerala is home to 32 million people, whose livelihoods depend largely on agriculture. The density of the population is very high, even by Indian standards (for this figure and other basic statistics of the state refer to Table 1). But instead of aggregating in a few mega-cities

found elsewhere in India (e.g. Bombay), the population is spread out. It is often difficult to differentiate urban and rural areas, and it has been suggested that Kerala is essentially 'rurban' (Ramachandran, 1996). The typical 'urban bias' with greater access to public services in urban areas, seen elsewhere in low-income countries is not present in Kerala. This is attributed both to the dispersal patterns of the population and the directive public policies towards rural development.

When travelling in Kerala, one of the most notable observations is the number of people seen reading newspapers. Kerala has been declared fully literate and although the state language is only spoken in Kerala, Malayalam newspapers are the most frequently read newspaper in the country. The most prevalent religion in Kerala is Hinduism, although there are also significant populations who practice Islam, Christianity, and Jainism. There are also Scheduled Castes and Scheduled Tribes.[1]

Table 1. Basic information for Kerala, 2001

Capital	Thiruvananthapuram (Trivandrum)
Language	Malayalam
Land area	39, 000 sq km
Population, 2001	31, 838, 619
Population density, 2001	819 per sq km
Literacy rates, 2001	90.92

Sources : Government of India, 2001; Ramachandran, 1996

[1] In India, a caste system has been in place since before British rule. This system is a hierarchial social classing assigned at birth, with scheduled castes (SC) and other backward castes (OBC) having lower social standing than the higher castes. In Kerala, the caste system exists, but is less severe than other parts of India. The Scheduled Tribes (ST), who fall outside of the caste system, continue to suffer from material deprivation, lack of social opportunities, and cultural oppression.

4.1.1 Poverty in Kerala

Kerala is considered economically poor. Table 2 compares GDP of the state with several Asian countries, illustrating that although Kerala's GDP is higher than India's[2] the state's economy is much lower compared to other Asian countries. But Kerala has achieved success in poverty reduction over the past thirty years. Table 3 illustrates the large proportion of Kerala's population falling under the poverty line during the 1970s and 1980s; rates higher than the overall Indian average. Within that 10 span Kerala succeeded in reducing poverty by 36%. This is particularly impressive as the economy was growing very slowly at the time (Kannan, 1999). The growth rate of per capita GDP grew an average 2.3% per year in Kerala during the 1980s, and this number increased to 5.1% during the 1990s, but it was during the first period that poverty was greatly reduced. Recent poverty analysis suggests that poverty is less severe in Kerala compared to other areas in India (Table 4). This reduction in poverty can be attributed to various factors, centred on public action, state intervention, and an educated population (Kannan, 1999).

Table 2. Comparison of GDP per capita of Kerala and several Asian countries

GDP per capita	Kerala	India	Sri Lanka	Thailand	Indon-esia	China
PPP	1618	1348	3277	7104	3740	2604
US	398*	317	646	2461	897	420

Source : Kannan, 1999

*This includes remittances from abroad.

[2] Note that the higher GDP of Kerala is due to the inclusion of remittances from citizens of Kerala who work abroad, particularly in the Gulf region. Other estimates which do not include remittances may indicate that Kerala's GDP is in fact lower than India's.

Table 3. Proportion of persons below the poverty line in India and Kerala

Year	Rural		Urban		Rural and urban	
	Kerala	India	Kerala	India	Kerala	India
1970-71	69.0	57.3	62.4	45.9	68.0	55.0
1983	47.2	49.0	47.8	38.3	47.3	46.5
1987-80	44.0	44.9	44.5	36.5	44.1	42.7

Source : EPW Foundation (1993), cited in Ramachandran, 1996.

Table 4. Estimates of rural poverty in Kerala and India, 1993-94

	Head-count ratio[ac] (%)	Poverty-gap index[bd]	Average Household expenditure, per capita, 1999-2000[e]	Gini coefficient of per-capita expenditure[e]
Kerala	19	3.9	810	30.1
India	33	7	589	28.6

a From Deaton and Tarozzi (2000), cited in Drèze and Sen (2002).

b From unpublished data by Angus Deaton, cited in Drèze and Sen (2002).

c The head-count ratio is the proportion of the population below the poverty line.

d The poverty-gap index is the difference between a person's expenditure and the poverty line.

e From Drèze and Sen (2002).

Poverty, however, remains in Kerala. For example, even though Kerala is an agricultural state, more than half of rural households do not own land (63%), compared to only 36% of landless households in India (Dreze & Sen, 2002). There is little industry (both large scale and small to medium size enterprises) and material production, which contributes to a persistent unemployment crisis[3] (Ramachandran, 1996). Kerala's economy depends on mixed farming based on 10 main crops : paddy, tapioca, banana, rubber, coffee, cardamom, areca nut, cashew, pepper, and coconut. During the 1970s and 1980s, agriculture production stagnated and has not recovered. Kerala is a food deficient state and requires 50% of its grains to be imported to feed the population (Ramachandran, 1996). In sum, the overall economy of Kerala can be characterised as

[3] Unemployment in Kerala, is considered higher than any other Indian state.During the late 1980s, 14.1% of men in urban areas and 12.5% of men in rural areas were unemployed. These rates jump even higher for women whose rates are 33.8% in urban areas and 25% in rural areas. There is also a high rate of educated unemployed.

insufficient production and high unemployment rates, but that absolute poverty seen elsewhere in India and other poor countries, is not prevalent.

4.1.2 Health in Kerala

Kerala has sparked great interest world-wide, due to high social and equitable development in the face of limited economic growth. Table 5 presents data on demographic, education, and health indicators for Kerala compared to India. While having a relatively low GNP, Kerala has achieved life expectancies comparable to industrialised countries. From a gender perspective, women in Kerala have made impressive gains in health and education, particularly when compared to other parts of the country. The female to male ratio is 1,058 per 1, 000 compared to all of India, which is only 933[4] (GOI, 2001). The gender gap in literacy rates is much smaller in Kerala, compared to other regions in India. Education of women has been linked to the low fertility rates, which together are key indications of the emancipation of women (Dreze and Sen, 2002). Infant mortality rates stand impressive at one fifth of India's rates.

Table 5. Selected health and education indicators for Kerala and India

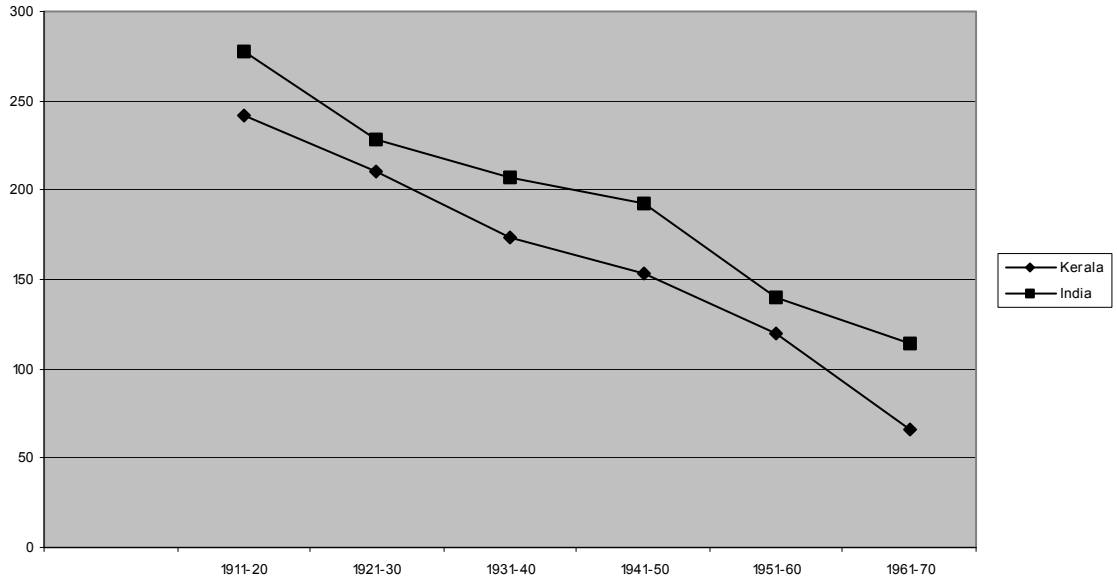
	Adult literacy rate (+15 years) %		Life Expectancy at birth years		Crude Death Rate*	Infant Mortality Rate*	Total Fertility Rate
	Male	Female	Male	Female			
Kerala	83	93	76	70	6	14	1.8
India	44	72	64	62	9	71	3.1

*Crude death rates and infant mortality rates are per 1,000, and female to male ratio is the number of women per 100 men.
Data source : Dreze and Sen (2002)

[4] Females are biologically stronger, and typically should outnumber men in any society. A score of less than 1000 indicates what Amartya Sen (Sen, 2002) refers to as « missing women », for they did not survive due to gender inequalities limiting female opportunities, subjection to male violence, and general subordination.

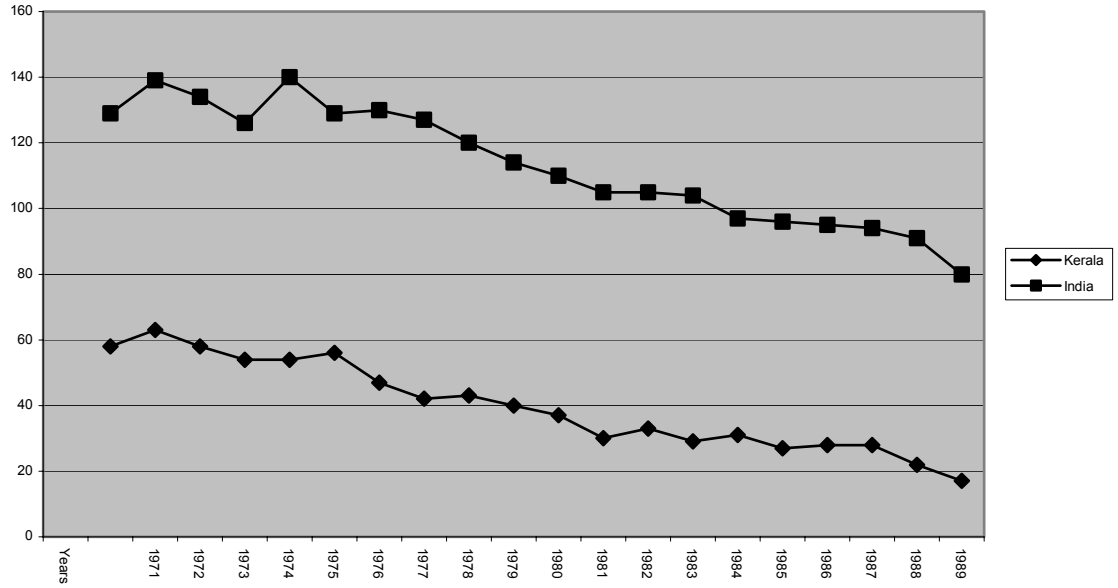
The low infant mortality rate of the state was the result of a historical process over the past eighty odd years (Figures 1 and 2). These figures indicate that while infant mortality rates were also declining in India, the process happened much more rapidly in Kerala. According to T.N. Krishnan (1991), the reduction of infant mortality can be divided into three separate periods (Ramachandran, 1996). First, there was a rapid reduction following the formation of Kerala in 1956, until the mid 1960s. Second, there was a slowing down during the 1960s, until the third period during the late 1970s and 1980s when the rates decreased rapidly. According to Krishnan, the first period corresponds with control of infectious diseases, the second period was a levelling off after the first period, and the third period was associated with improved maternal services. There are, however, various historical, political, and social reasons for reductions in infant mortality rates, and overall health and social development in Kerala.

Figure 1. Declining infant mortality rate in Kerala and India, 1911-1970



Data source : Ramachandran (1996).

Figure 2. Declining infant mortality rate in Kerala and India, 1971-1990



Data source : Ramachandran (1996).

Following Kerala's formation in 1956[5], Kerala became the first region in the world to elect a communist government. Under the leadership of E.M.S. Namboodiripad, a leading social theorist from Malabar, Kerala would go on to have Communist-led majority governments, intermingled with Congress-major governments, greatly impacting on the social development of Kerala (Ramachandran, 1996). Governments were dedicated to redistributive public policies and land reform, while also having an educated and politically active civil society (Heller, 1996; Radcliffe, 1978). Education has played a large role in both reducing poverty and improving health status of the population (Kannan, 1999). Kerala is considered to have the greatest access to health care services among the states, with a public health facility located in close approximation to urban and rural populations (Krishnan, 1999). People in Kerala are generally known to be more 'health conscious' than other Indians, due to their high literacy rates and established hygienic practices (Krishnan, 1999). The emancipation of women has occurred due to the influence of Indian leaders during the colonial period, social and religious reform movements during the 20th century, and traditional matriarchal family

[5] This involved merging areas of Malayalam speakers, which included the erstwhile states of Tranvacore and Cochin, with Malabar, previously under British rule.

systems (Arun, 1999). Overall, it has been argued that Kerala has followed 'support-led' development, which emphasised principles of social development and redistribution through public action (Drèze & Sen, 1998). Kerala's social and health achievements, therefore, were obtained due to multiple reinforcing factors, illustrating the complexity and uniqueness of this state.

While Kerala has made rapid gains in the reduction of poverty and improved health status of the population, problems persist. **First**, while mortality is quite low in Kerala, the population continues to suffer from chronic disorders and conditions related to occupational or environmental hazards. One study found the morbidity rates per 1000 population for acute and chronic diseases was 121.86 and 114.98, respectively (Kunhikannan & Aravindan, 2000).

Second, Kerala is not a homogenous state. Health, social and income inequalities exist, which are often hidden within the aggregate data. Similar to national figures hiding inequalities (e.g. rural-urban divide, inter-provincial disparities), there are many communities (particularly among mountainous areas and fisher folk) with extremely poor health status, and who lack access to quality health care. These communities often have large tribal/low caste populations, who are India's poorest and most marginalised people. Table 6 presents the disparities in literacy rates between scheduled tribes (ST), scheduled castes (SC) and the general population, including gender and spatial inequalities. A study performed in 1985 found infant mortality rates in one fishing community to be as high as 123 per 1000, due to insufficient food, unhygienic practices and lack of access to appropriate medical care (Kumary, 1991, cited in Ramachandran, 1996). Tribal colonies in the northern district of Wayanad, had 28 young men die from hunger between July and December of 1993 (Deshabhinmani, 1993, cited in Ramachandran, 1996). The inability to reach these vulnerable populations is seen as a social failure in Kerala (Ramachandran, 1996).

Table 6. Literacy among different social groups for Kerala and selected districts, 1991

District/state	Literacy among general population		Literacy of ST/SC population as % of literacy of general population			
	Male	**Female**	**Male-SC**	**Male-ST**	**Female-SC**	**Female-ST**
Kerala	93.62	86.16	78.98	57.40	75.47	50.52
Wayanad	87.59	77.69	80.07	55.13	75.81	47.03
Trivandrum	92.84	85.76	80.75	76.01	79.31	67.61
Malappuram	92.08	84.09	76.80	44.31	74.17	37.45

Source : Government of Kerala, 1993

Third, escalating costs of health care is a problem in Kerala. One study found significant increases in costs within a ten year spand (Table 7). While access to primary health care is a historical attribute of this state, there has been a shift to an ever-expanding private sector over the past twenty years (Table 8). Generally, private care is more expensive than public services. In rural areas of Kerala, hospitalisation would cost about three and a half times more in a private facility (Krishnan, 1999). Rising costs are also associated with ageing populations, a shift from communicable diseases to chronic disease, and a demand for more and better care. A lack of a national health insurance program leaves the poor vulnerable to high health expenditures when faced with illness, often leading poor or near-poor households to destitution. This problem is not new in Kerala, (see Box 1), but appears to be worsening.

Table 7. Kerala's rising medical expenditures (in Rupees) per per capita, per year, for 1987 and 1996.*

Item of Expenditure	1987	1996	% increase
Drug	44.20	232.36	539
Fee	15.60	99.06	535
Other	29.12	167.44	475
Total	88.92	548.86	517

Data source : Kunhikannan & Aravindan, 2000.

*Based on a household survey of several panchayats in Kerala.

Table 8. Growth of modern private medical facilities in Kerala, 1986-95.

	1986	1995	% growth
Institutions with beds	1, 864	1, 958	5.0
Number of beds	49, 030	67, 517	37.7
Institutions without beds	1, 701	2, 339	37.0
Doctors	6, 345	10, 338	63.7
Paramedics	13, 921	25, 256	81.4

Data source : Kutty (2000).

Box 1. The expense of health : Downward mobility in a Pulaya family

During the 1980's, Kalyani, a 35 year old Pulaya lived in a squatter settlement just outside Kerala's capital city, Trivandrum. She was an agricultural worker, and her husband, Mosha was a labourer, who unloaded trucks. He worked hard, but received a reasonable salary of 9-12 rupees per day, which when supplemented by Kalyani's earnings when she was able to find work, enabled Kalyani, Mosha, and their children to get by.

But then their son fell ill and passed away. This tragedy was followed by Mosha becoming sick and requiring hospitalisation. Once he was hospitalised Kalyami had to provide for the family, buy medicine, and supplement the meagre hospital food. She decided to pledge her ration card to a friend, for 150 Rupees. And consequently, the family had to eat less since their rice would now have to be bought at the much higher open market prices. She would now have to pay 150 Rupees to get back her ration card.

Source : Gulati (1984)

Fourth, although women in Kerala have experienced improvements in social development over past decades, persistent gender inequalities remain. Women do not have social, political and economic entitlements that men do (Arun, 1999; Dreze and Sen, 2002). They have limited ownership of and control over land and other resources, and therefore lack collateral needed for access to formal credit with banks (Arun, 1999). Literacy rates, which are unquestionably higher among women in Kerala compared to the rest of India, is often presented as a sign of high social development. However, it has become increasingly clear in Kerala that education alone is insufficient in challenging the subordination of women. Eapen and Kodoth (2002) stress the need to examine non-conventional indicators to assess women's status in this state, such as an alarming rate of gender-based violence, high prevalence of mental illness among Malayalaee women, and increasing rates of the practice of dowry and dowry-related crimes. Furthermore, the ability to influence household decision-making, and in particular to assume 'self-interested' decisions, remains limited (Eapen and Kodoth, 2002).

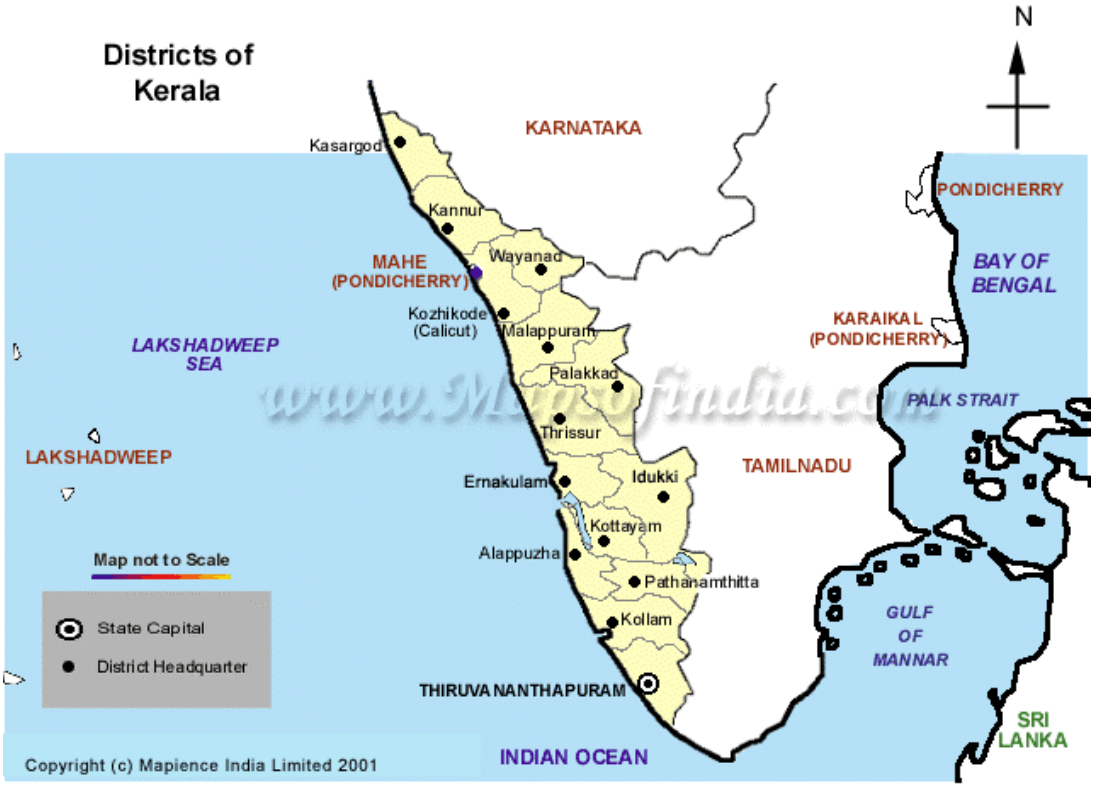
4.2 Study site

4.2.1 Wayanad, 'land of forests'

The research was conducted in Kotthatara panchayat[6], which is located in the district of Wayanad (Map 1). Wayanad is located in northern Kerala on crest of the Western Ghats, a mountainous area. Prior to the formation of Kerala state in 1956, Wayanad was part of the Malabar region. Under the British, Malabar did not benefit from the promotion of education and emancipation of women urged under traditional Indian rule and early missionary influences, and consequently this region has not developed as rapidly as in the other two regions of Travancore and Cochin (Kabir & Krishnan, 1999). Originally populated by tribals and Jains, Wayanad received many migrants from southern Kerala and the neighbouring states of Karnataka and Tamil Nadu, who were attracted to Wayanad's fertile land, and pleasant climate.

[6] Note that panchayat refers both to the administrative unit, or village, and the political body. When we are referring to the political body, *Panchayat* is capitalised and italicised.

Map 1. Districts of Kerala



According to the 1981 census, the main religious groups of Wayanad are : Hindu (50%), Muslim (25%), Christian (25%) and Jain (less than 1%). The proportion of Scheduled Tribes in Wayanad (17%) is the highest in the state (1.1%). There are various Tribal populations, Paniyas, Kurichas, Kurumas, Irulas, and Kattunayakkas. These groups have large variations in terms of socio-economic status and quality of life. For example, the Paniyas are landless, and are the poorest of all Tribes, while the Kurichas own land and are considered to be at a higher level of 'modernisation'. As Table 6 indicates, literacy rates are lower in Wayanad than in Kerala, particularly among Scheduled Castes and Scheduled Tribes. Public health facilities are accessible, but are not as prevalent as in other parts of the state, also traditional health care facilities (Ayurvedic, Homeopathy), including tribal medicine, are available. While geographical access to care is not problematic in Kerala, financial barriers remain (Haddad, Narayana & Mohindra, 2001).

Today, most of the population is dependent on agriculture, for which the main crops are coffee and paddy. Other key crops include pepper, rubber, cardamom, tea, ginger, banana, and lemon grass. Irrespective of Wayanad's environmental attractiveness, the district remains one of the most 'backward' areas in Kerala. It is considered a 'rural' state with no major industry. Based on the 1991 census, the percentage of the population in Wayanad employed in the workforce is 39%, predominantly as cultivators and agricultural labourers. Wayanad has an alarmingly high proportion of the population who is not employed, including many educated unemployed. There was a 46% increase in individuals seeking employment between 1986 and 1993. Consequently, this has led to migration, particularly of men to neighbouring states and the Gulf region.

4.2.1 Kottathara panchayat

Some basic data on Kotthathara Panchayat is presented in Table 9. Kotthathara is located 20 km from the district's headquarters, Kalpetta. It is a multi-religious, multi-caste village. Tribal populations in the panchayat are predominantly Paniyas and Kurichas. There is a total of 87 tribal colonies, and close to five thousand Scheduled Tribes.

Table 9. Kotthatara : Basic statistics, 2001

Land area	31.75 sq km
Population	14,494
Females	7246
Males	7248
Population density	465.5 per sq km
Number of households	2730

Source : Panchayat Development Report 2002

This village is further divided into 10 sections, called wards. Each ward elects a representative, which forms the local government, Kotthathara Grama Panchayat[7]. The

[7] Panchayat literatlly means 'council of five elders'.

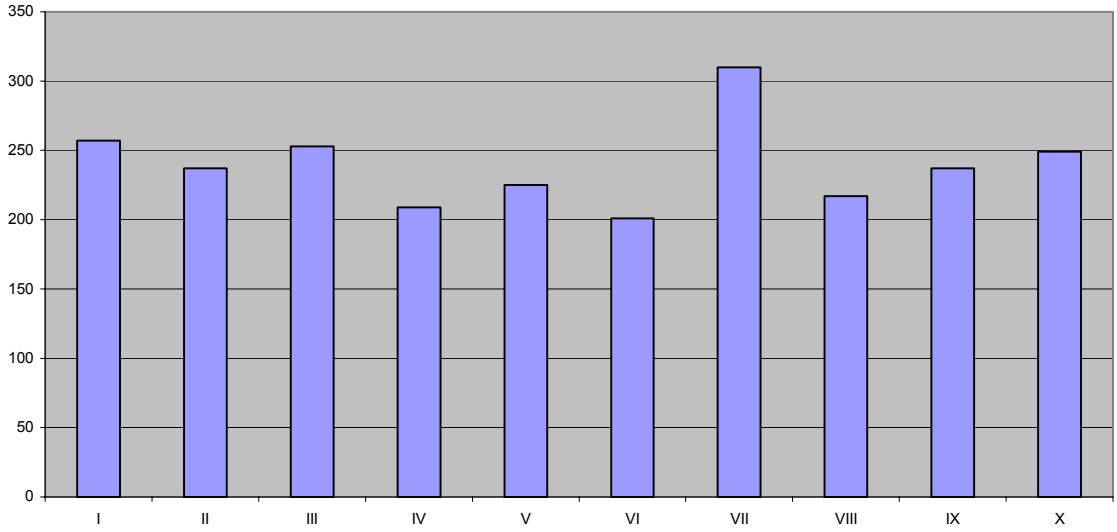
Grama Panchayat is the lowest of three levels of India's local government system [8]. The governing body of this *Panchayat* are in their third year of a five-year term, and represent various political parties and social groups, with only one full time position occupied by the President (s*arpanch*). The mandatory representation of women (one-third) and scheduled tribes is present[9]. *Panchayat* members are responsible for giving sanctions for the implementation of various programs, which are processed by the *Panchayat* office consisting of permanent staff members employed by the State[10].

Development programs for Kotthatara are especially targeted towards those families who fall below the poverty line (BPL). In 2002, there were 2395 families considered to be BPL, the distribution of BPL families by ward are shown in Figure 3. Precise poverty estimates in a population is a difficult task, and therefore the number of families considered BPL in the graph should be interpreted with caution. BPL families are defined according to national regulations, which is based on a set of specific criteria[11].

There is one primary health centre (PHC) in the panchayat, and seven sub-centres. These sub-centres were the product of the World Bank's India Population Project, which focuses on health education for maternal and child health and family planning. There is a lack of health statistics data, particularly disaggregated information (gender, social group). The main health problems, which were reported to the PHC during the past year, are presented in Table 10.

[8] The three tiered panchayat system includes Grama, Taluk, and Zilla.
[9] This representation, however, does not necessarily equate with dispersion of power. There appears to be an imbalance in power in that the ruling party political party, the Communist Party of India (Marxist) or CPI(M)[9] controls decision-making. Community members also suggested that women and tribal representations were artificial. Elsewhere in India, it has been noted that women often merely represent their husbands view, and do not have equal political power as males.
[10] 1 secretary, 1 head clerk, 2 upper division clerks, 3 lower division clerks, 1 pound keeper, and 1 office helper.
[11] The criteria include income, housing, assets, area of land, and were developed based on 97 surveys implemented by the central government. Several states, including Kerala, find this criteria does not effectively discriminates between poor and non-poor, and are currently planning surveys to determine a new definition of BPL.

Figure 3. Number of BPL families, by ward, in Kotthatara for 2002



Data source : Kottathara Development Report, 2002

Table. 10 Health problems reported to PHC, 2002

Health problem	Number of cases
Digestive-related	579
Malnutrition and anaemia	213
Blood pressure	29
Lung problems	5813
Skin diseases	31
Other	3077

Data source : Kottathara Development Report, 2002

5.0 Women Self Help Groups (SHGs)[12]

In India, women Self Help Groups (SHGs) were initiated by NABARD (National Bank of Agriculture and Rural Development), with the support of local NGOs. These groups were followed by the implementation of two other forms of SHG programs, *Swarnajayanti Gram Swarozgar Yojana* (SGSY), launched by the Ministry of Rural Development, and *Kudumbasree*, sponsored by local self-government institutions or *Panchayats*.

Here I focus exclusively on women groups, which has been the main thrust of the SHG movement[13]. SHGs are generally defined as 'homogenous' groups, for the members tend to be similar in terms of socio-economic status, and live in close approximation to each other[14]. A group generally has ten to twenty members. The women meet weekly on a rotational basis at each other's homes. Groups begin their meetings with a prayer, proceed to business affairs, and conclude by tea and socialising. During each meeting they will make their weekly contribution of ten rupees[15]. The funds are collected and deposited in the bank by the group's president and secretary, who also carefully record all transactions and minutes from their meetings in notebooks. These positions are rotated each year, distributing power and sharing responsibilities among members. Each member will also have a passbook, where they record their personal transactions. SHGs follow a predetermined set of rules, delineated by the group, for loan distribution and repayment. After an initial savings period, SHGs are able to begin taking loans.

There are two different types of loans and associated interest rates. First, the more common loan taken, particularly in the early stages, is from group savings. These are generally small loans[16]. The amount a member qualifies for will depend on individual savings. For every rupee they have saved, they become eligible for 3 or 4 rupees in return. The women will set the interest rates themselves, generally at a high rate (around 24%), to match those rates in the local credit market (e.g. moneylenders), but also as a mechanism to increase group savings. The group may decide once their funds are

[12] The information in this section comes predominantly from discussions with staff at the Centre for Development Studies (particularly Pr. D. Narayana), local NGOs, fieldworkers, and SHGs.
[13] Male NGO-SHGs do exist, many groups emerged through demand, after men witnessed the benefits accrued by their wives and female family members.
[14] Although members may vary on other characteristics such as age and marital status.
[15] This rate could be higher if the SHG chooses to raise the sum.
[16] Loans generally range between 100 to 3,000 Rupees.

substantial and members are taking larger sums as loans that they will reduce the interest rate. A loan may also be acquired through a bank based on credit as an SHG member. For NGO groups, NGOs will provide administrative assistance and technical advice to secure the loans. Financial institutions generally prefer to interact with NGOs than directly with SHGs, and the necessary paper work and interest rates are usually lower for NGOs than for SHGs.

From the groups that I met, loans were generally repaid on time, without major conflict. In order to maintain their finances, many SHGs have integrated flexible and compassionate transactions, distinct from typical banking procedures. For example, when a member is unable to pay one week, the group would pay for her either by drawing on a special pot designated for this purpose, or by members collectively contributing to cover the fee. This member would not be required to repay this fee, but would be expected to contribute the following week. This contradicts other studies, which found that many loans were repaid on the basis of socially damaging peer pressure, which can negatively impact on women (Montgomery, 1996). The lack of negative findings in this case could be related to the specific context, or such experiences may simply not have been voiced due to social desirability.

The funds used to provide loans to members are supposed to be for productive purposes. There is, however, evidence that loans are used for consumption, such as health care[17]and marriages. SHGs may participate in other activities besides savings and credit, such as group micro-entrepreneurship, social activism, and capacity building through various skill trainings organised by NGOs or local government. Further to following their set banking procedures, the women also use the SHG forum as a space for discussion, including voicing personal problems.

There are two main networks of SHGs in Kotthathara, (1) sponsored by RASTA, a local NGO, and (2) sponsored by local government, known hereafter as *Kudrumbrasree*. Each are examined in turn, with some basic information on both networks presented in Table 11.

[17] Due to link between health and economic development, loans for health should be seen as an investment for future production, however, health-related goods are generally viewed by economists as consumption.

Table 11. Basic information of RASTA SHGs and kudumbrasree*in Kotthatara Panchayat

	RASTA SHG	Kudumbrasree
Date of first SHG	1995	2002
Number of groups	74**	136
Number of members	703	1932
Wards covered (10)	9	10
Total savings	2,240,604	10,155,99
Total loans distributed	-	617,780

* Data for RASTA as of February 2003, and for kudumbrasree November 2002. Information pertains to active groups only.
** There are also about 20 male SHGs.
Data source : Records from Kotthtara Panchayat and RASTA.

5.1 RASTA-supported SHGs

RASTA (Rural Agency for Social and Technological Advancement) is an NGO, which has been in operation since 1984. As indicated by their name, RASTA is dedicated to both improving social conditions of rural communities, as well as promoting technological skills. This NGO is particularly dedicated to empowerment of women and environmental issues.

RASTA currently has a two-tiered hierarchal system. At the lowest level are the SHGs. SHGs are then organised into clusters, or local development centres (LDC). Eventually RASTA would like to follow the NABARD model, which strives for SHGs to have organisational autonomy by having a third level, village development centres (VDC). Under this scenario, LDCs are federated, enabling groups to transform into an apex bank, thereby removing the involvement of the NGO.

RASTA's groups are formally linked to several commercial banks through the NGO, but RASTA is performs all administrative tasks. Members are not required to travel to the bank, but will have a fieldworker collect the money directly from their homes. RASTA also ensures that the women understand all banking procedures and technical aspects. However, SHGs must pay additional costs for the administrative role of RASTA, on top of the interest rates required by the bank[18]. RASTA also provides loans, but only at the cluster level. These loans are usually linked to a specific scheme, such as gas loans.

The first RASTA SHG hereafter known as SHG, *kairali*, was formed in 1993 (see Box 2). Initially, RASTA invested significant time and energy in order to convince the community of the value of women participating in SHGs, as it is not inherently evident why women should trust others with their money or should even assume responsibility of money. Moreover, participating in SHGs meant that women would need to spend time away from their households, a luxury which may not be feasible, nor acceptable to family members, particularly husbands. It took approximately three years to set up a small number of SHGs, and another three years to establish 100 groups. At this point, many women came forward to become members, seeing the benefits accrued by other groups. As many as 743 groups were formed, although this number has been reduced to 416 as groups dissolved, with the bulk of them moving to *Kudumbrasree*.

Further to setting up the SHGs, RASTA has promoted additional skill development, through the provision of various trainings (e.g. soap-making, tailoring), and has launched awareness campaigns (e.g. environmental awareness). Thus, the women have developed interests and acquired skills outside the purview of micro-credit.

[18] Interest rates vary according to the financial institution involved. Currently interest rates are 1) NABARD to RASTA at 11.5%, RASTA to SHG at 15%, 2) RMK (a national women's cooperative) to RASTA at 8%, RASTA to SHG at 12%, and the RB Foundation (a Dutch institute) to RASTA at 8%, RASTA to SHG at 15%. The lower rates provided to SHG by RASTA are lower in the case of RMK because the of a specific request from the cooperative.

Box 2. Kotthatara's first SHG

During the early 1990s, local women in the village of Kotthatara began to approach the director of RASTA, affectionately known as *Chechi* (older sister), to ask her to hold on to their money for safekeeping. Chechi obliged the women and began to deposit their money into separate bank accounts. However, as the demand increased, this process became cumbersome. In addition, other women were approaching RASTA to obtain loans. Having viewed the SHG model in operation in other regions of India, RASTA decided to propose to the women that they come together to address their financial needs. In 1993, a group of 11 women gave an initial contribution of 100 rupees, and began to hold meetings every week for which they contributed 10 rupees at each encounter. And *Kairali,* which means 'Kerala', came into being. After a period of six months, members became eligible for a loan up to three times their individual savings, and were expected to repay the loan within 6 months. The interest rate was 24%, which although is quite high, is common practice among SHGs who set the interest rates themselves. Two representatives were in charge of keeping accounts and depositing their savings into a bank. These two representatives changed annually among members.

Almost 10 years later, *Kairali* still exists. There are now 9 members, as 3 have left for various reasons, one found a job, another was not able to save the necessary funds required each week, and the third member was not able to attend the weekly meetings. The group currently has savings of over 3 lakh* rupees. The group has established their credit with the bank, and members no longer need to seek external credit, such as moneylenders. The group also provides invaluable emotional and moral support to each other, and engage in discussions, which interest them.

* One lakh is the equivalent of 100, 000.

Sources : Bhagyalakshmi, personal communication, RASTA documents.

RASTA has developed an evaluation system of the SHGs, through the use of fieldworkers. The fieldworkers provide a link between SHGs and RASTA, they monitor progress, sort out problems and collect data on group activities. This information is related back to RASTA through their monthly meetings and evaluation charts, which the fieldworkers prepare each month, and then is centrally recorded in the RASTA database. SHG fieldworkers also handle disputes within SHGs, as well as problems members may experience with their household or community.

Women of all religious faiths are welcome to join RASTA’s groups, and in many cases a group will have women who are Hindu, Muslim, and Christian. One of these 'mixed'

SHGs composed the opening prayer to cut across all religions, a prayer which is spreading to other groups. There are a greater number of participants from Hindu and Christian faiths. RASTA made special efforts to involve Muslim women in the groups, through holding numerous discussions with Muslim households and community leaders. There is now a cluster of all Muslim SHGs.

RASTA has had little success with involving tribal populations. This may be attributed to various factors. First, Scheduled tribes are the poorest members of society, and lack the capacity to make weekly contributions. Second, tribal societies are culturally distinct, and often are socially excluded from mainstream society. Third, many tribal compounds are geographically isolated and it is difficult for NGOs to frequently visit them due to time and financial constraints.

5.2 Kudumbrasree

Kudumbrasree was initiated by the Left Front political party, under the People's Decentralisation Plan[19]. This program aimed to organise women at the local level with the goal of eliminating absolute poverty in the state by 2007 (Isaac & Franke, 2000). *Kudumbrasree* means "prosperity of the family" and the mission of the program is to reach families through women, and to reach communities through families. The program began in 1996 in urban areas, and then became active in the rural areas in April 1999, although it has only been in operation in Kottathara for one year.

Kudumbrasree has a three-tiered hierarchal system of organisation. At the lowest level are the neighbourhood groups (NHG), equivalent to the SHG. These groups are then federated at the ward level into Area Development Societies (ADS). The highest level is the Community Development Society (CDS). The CDS is presided by an elected member of the ADS, and includes the *Panchayat* president. In Kottathara there are already 57 groups, clustered into ten ADS. The ease in which the groups were formed may be attributed, in part, to the earlier groundbreaking done by RASTA in setting up their SHGs.

[19] Kerala's People's Planning Campaign is a massive and radical movement for decentralisation which aims to ensure state responsibility, and good governance, in the form of greater transparency and accountability, while concomitantly providing greater powers and resources to local bodies and civil society. (Isaac and Franke, 2000).

The NABARD model used by NGOs, with formal linkages to the bank and the ultimate goal of a federation of SHGs, does not appear to be a shared vision of local government, at least not presently. Unlike NGOs, *Panchayats* channel financial incentives to *Kudumbrasree*. Although all women are able to participate, only those groups who are considered to be below the poverty line (BPL[20]), defined as groups where a minimum of half the members are BPL, are eligible to receive financial incentives. And within the groups only those families who are BPL qualify for benefits.

The *Panchayat* provides *Kudumbrasree* with revolving funds, managed through the ADS. The funds are not in the form of cash, but rather in kind with goats, chickens, and paddy cultivation materials. The ADS will distribute the animals or products to the *Kudumbrasree* groups. They will then collect a percentage of the benefits, such as a number of eggs, or offspring of the goat. At the ADS level, activities include vegetable cultivation (e.g., banana, tapioca, yam), clearing roads, as well as specialized units involved in the production of poppadons, umbrellas, and soap. Some women also participate in community activities such as running preschools, or helping sick people through financial contributions.

At the present there is no systematic monitoring system of *Kudumbrasree*, but an evaluation is in the process of being planned by the *Panchayat* during the spring. Currently, ward level assessments of groups are made at ADS meetings. At this time groups come with their records, clarifications and any doubts they may have. A specific form is filled out, detailing if new members have joined, loan info etc. This information is maintained by the ADS secretary in her home, and forwarded to the panchayat office, where data is compiled.

[20] The identification of the poor, or BPL, is based on several non-income indicators, including inadequater housing, lack of access to sanitatary latrines, lack of access to safe drinking water, having no more than one household member earning wages, inability to take two meals in a day, presence of children below five years of age, presence of an illiterate adult member, presence of alcholic of drug addict, and member of socially disadvantaged group (ST, SC).

6.0 Self Help Groups : Health producers?

The literature has focussed on two main aspects of micro-credit schemes, the ability of the scheme to reduce income poverty, and the impact on female empowerment. There are, however, other potential outcomes of participation in such schemes. Here it is suggested that these schemes may play a role in health production. Based on my field visits, SHG meetings, and informal discussions in Kottathara, I have developed a preliminary framework (Figure 4) on the potential pathway between being an SHG member and producing health. Two main factors are proposed as key elements in health production, female autonomy at the individual level and social solidarity at the group level. These factors were selected over simply outlining straightforward factors such as increased income, due to the interactions between poverty and female sub-ordination.

Female autonomy has been defined as “the capacity to manipulate one’s personal environment” (Dyson & Moore, 1983, p.45). Autonomy is a complex concept, which should be viewed as a process with continuous evolvement, rather than a state (Ghandi & Shah, 1999). In addition autonomy should not only incorporate individual beliefs, desires, and choices, but also the social context in which they are made (Ghandi & Shah, 1999). For example, female autonomy has been found to change over the course of a women’s lifetime in some societies. In India, particularly in the North, women acquire more autonomy as they age and produce sons, and then lose autonomy when they are elderly or widowed (Das Gupta, 1996).

Autonomy is a multidimensional concept. Therefore, I have separated autonomy into three dimensions, economic, social, and political. Economic autonomy represents not only the capacity of a woman to earn income, but also to have command over resources through personal access or control in how the income is spent. Social autonomy is the freedom a woman has to travel outside the domestic household and to engage in social activities. Finally, political autonomy is the capacity of a woman to use her voice either within the household or in public in order to influence decision-making. Economic, social, and political autonomy are inter-linked and capable of reinforcing the other dimensions.

While it is hypothesised that autonomy is a main factor in which health production is assumed, social solidarity is a supporting factor in increasing female autonomy, as well

as a factor in health production at the group level. Social solidarity can increase individual female autonomy through support of and learning from other members. Social solidarity also represents a group level effect, obtained through mutual trust and support of each other. Although not depicted Figure 2, social solidarity may be further characterised as *female* social solidarity, which has specific attributes pertaining to the coming together of women. An SHG may then represent a 'community of women' (Andermahr, Lovell, & Wolkowitz, 1997), where :

> "It is possible to single out networks of women, shadow communities within 'the community', where responsibility for the creation of community and kinship ties and support systems which secure communal social life are often undertaken, and to associate those with women's culture". (pp. 39-40).

If SHGs are indeed 'communities of women', then the feminine nature of social solidarity can be a powerful tool for resisting patriarchal norms in society, providing women opportunities to be unaffected by male presence or influence[21, 22].

Table 12 summarises the factors and mechanisms involved and their hypothesised impact on health and access to health care. Here I attempt to summarise how the factors of female autonomy and social solidarity might be operationalised, concluding the section with an illustrative example.

Access to credit, unsurprisingly, is one of the main rewards of participating in an SHG. While there are cases where husbands assume loans secured by their wives, in general the women find themselves in a new economic position. Women not only gained experience with financial affairs, but they also claimed that their status within the household was raised, as they were seen to be contributing to the welfare of the family. Their opinions became more valuable and their household decision-making powers increased. Greater decision-making powers of women within a household does not only improve gender justice by creating a more equal dispersion of power in a household,

[21] This is not to say that there is no underlying male control of SHG activities. In fact, most of the staff of RASTA are male, as well as *Panchayat* office staff.

there are also specific implications for the health and well-being of the family. There is a large base of literature now that women spend more money on food and health promoting goods for the entire household, than do men, who have a tendency to use money for selfish interests.

Access to credit also decreases the need for women to depend on previous sources of cash, involving more exploitive relationships. Typically villagers will approach moneylenders who are men who lend money to poor individuals, but charge very high interest rate. This is usually perceived as a stressful experience, but often the only option, particularly during crisis situations. Women also have had to depend exclusively on their husbands and male relatives for cash, as men control economic resources in society. By having access to credit from other women in the village, members may potentially have improved emotional well-being through greater independence and less stress.

Generally, women are confined to their households, due to societal norms, and because it is perceived as unnecessary for them to leave their homes. In order to participate in SHG meetings and activities, the women were required to exit their homes, thus opening opportunities to gain social autonomy. Many women now claim they have acquired freedom not only to attend meetings and SHG functions, but also can travel for other purposes. This increases their potential to travel independently to health care facilities for themselves or their children, without the accompaniment of male relatives. The experience of travelling and participating in SHG functions also opened up new ideas and practices to women. Some SHG held meetings on special topics of interest. For example, one group invited a women lawyer and human rights specialist to their group to discuss women's rights. New information can lead to changes in behaviours which are healthier and more empowering. Also, women acquired new skills through various trainings (e.g. umbrella-making, bamboo crafts, etc.). These new skills may not only lead to future income generation activities, but also increase their self-efficacy, which has been linked to improved health and well-being (Bandura, 1989).

[22] This space could be potentially used to benefit or harm group members and their families. The point here is that it is under the control of women.

SHG meetings open up a space for women to not only engage in financial activities, but also as a place of discussion. Through regular meetings, women become more comfortable in sharing their ideas, and learn to speak up for themselves and for each other. In turn, they begin to increase their voice outside of SHGs, in private and public domains creating a political autonomy for themselves. This voice may be used both within the household, to have more control over household decisions, positively impacting on the health of the family, or by participating in public debates and forums, potentially impacting on the formation of public health programs, services, and policies.

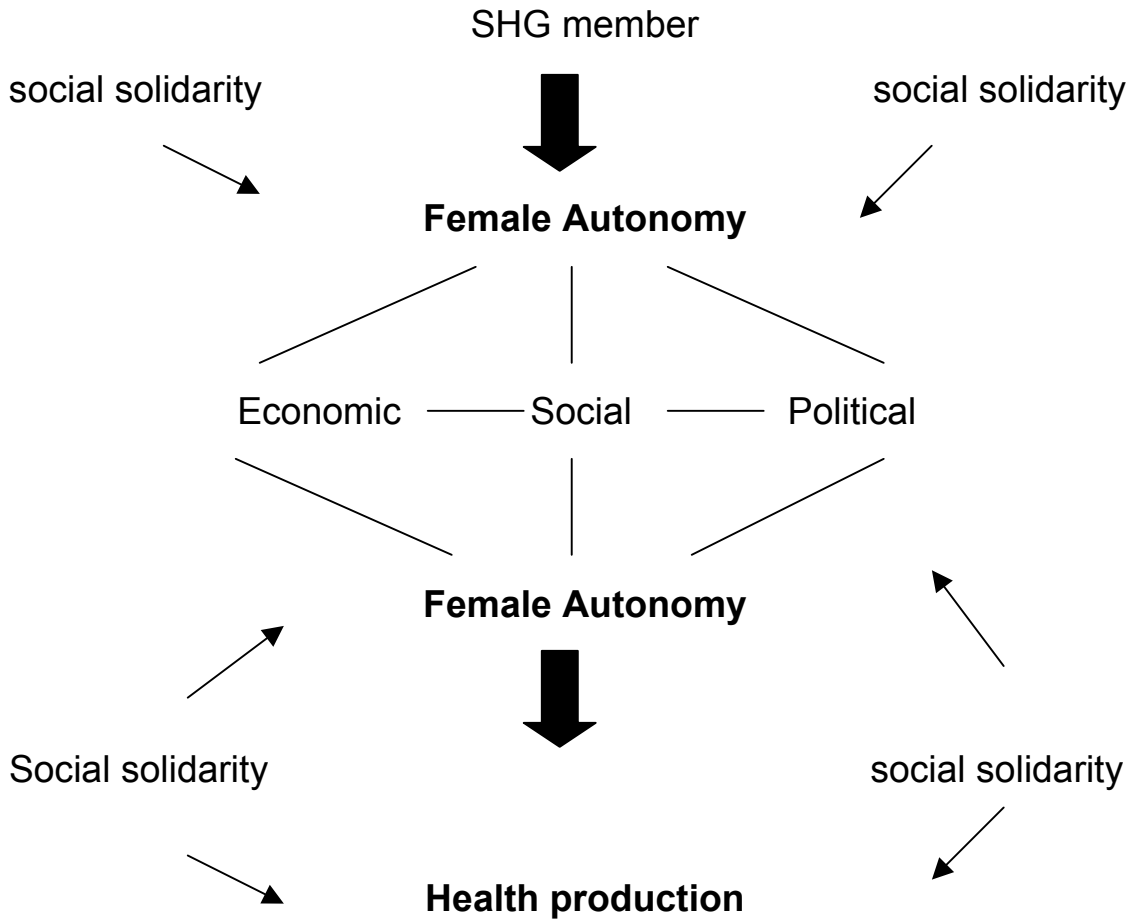
SHGs bring together groups of unrelated women, thereby expanding their social networks outside of the family. This may lead to social support as well as enlarging their range of coping strategies. Women share their problems within group meetings, which are often related to family problems they are unable to discuss within the home. They may also approach members outside of meetings, as they have established various levels of rapport and trust with members The poor are often limited in the range of coping strategies when faced with a crisis or shock in the family, such as an illness or death of a family member. A network of women opens up new possibilities, which are accessible to women. That SHGs are exclusively women creates potential solidarity among women, which is one of the main routes towards decreasing male control and patriarchal attitudes in society.

An example of group and female solidarity can bee seen through a case involving the collective efforts of multiple SHGs to eliminate an illegal alcohol shop. The women were upset that their husbands were coming home drunk, and also that the shop was set up on a main road, where women would have to pass by. The men drinking at the shop displayed rowdy and inappropriate behaviour towards women who has to pass the shop, creating a situation of discomfort and aggravation among the women of the community. Members of numerous SHGs decided together to put an end to this situation, by physically destroying the shop.

Consequently men were coming home sober, and the women felt much safer and more comfortable when passing the shop. The women expressed that such a feat would not have been possible at an individual basis. As one woman put it, *imagine we are sticks, if we are only one stick we can be easily broken, but if we are many sticks, then, it is not*

so easy. Such an example illustrates the creative and radical behaviour that women can take together as a group, even if they are individually oppressed. These actions can both increase female autonomy at the individual level and strengthen solidarity through successfully bringing about purposeful changes in the community. Furthermore, their actions in and of themselves led to the desired goal of social change, which impacted not only on the women members themselves, but others in the community.

Figure 4. Relationship between SHGs and health production



Increased health-related knowledge

Increased access to health care services

Increased household decision-making related to family health

Decreased reliance on men and moneylenders

Extension of social support among non-family persons

Increased range of coping strategies

More appropriate health policies and programs

Community health awareness

Table 12. Summary of potential health producing factors observed among SHG members.

Factor		Examples	Mechanism	Possible impact on health and access to health care.
Autonomy	Economic	Access to credit/cash.	Increase in household decision-making.	Improve household access to food, and health promoting goods.
			Decrease reliance on moneylenders and men.	Improved emotional well-being.
				Reduction in violence against women.
	Social	Greater mobility outside of household, e.g. meetings, trainings, SHG events.	Improve access to health services.	Overall reduction of disease and death, and severity of illness.
			New ideas and practices.	Healthier behaviours.
		Skill acquisition.	Increased self-efficacy.	Improved emotional well-being of women and overall well-being of family.
	Political*	Greater voice.	Increase in household decision-making.	Improve household access to food, and health promoting goods.
			Influence policy-making process and outcomes.	Public health programs, services, and public policies more in tune with female needs and values.
Social solidarity	Group	Network of social support.	Social support/Increased range of coping skills.	Improved emotional well-being.
		Group related activities.	Awareness campaigns, advocacy, etc.	Improved community health : increased knowledge, healthier behaviours.
	Women	Network of social support and space uniquely for women.	Decrease male control, and patriarchal attitudes.	Improved emotional well-being.
				Improved community health.

*Here we defined political in both public and private spheres, and therefore include household politics.

7.0 A question by the way of a conclusion

If exiting poverty requires not only raising income levels, but also achieving good health (Wagstaff, 2002), and poverty remains the main cause of ill-health, comprehensive strategies are required to improve the well-being of poor communities. Exploring interventions aimed at poverty alleviation in terms of their health production potential could increase the effectiveness and efficiency of outcomes in well-being, and overall equity impacts of interventions involving social change. Such understanding may also help to illuminate the causal pathways between poverty and health. My research aims to evaluate SHGs in terms of health and equity, with a special focus on women's well-being, in a particular context. The following research question is proposed : *How does membership in women SHGs aide in the production of health at various levels (individual, household, community), and what are the concomitant implications for social and gender equity in a poor and economically insecure community in Kerala?*

A multi-disciplinary framework will be developed to address the mechanisms and causal pathways for which SHG membership may lead to improved health and distribution of health, based on the large body of work on the determinants of health, considering the particularities of the Kerala context. The framework will integrate Amartya Sen's theory of capabilities, with communitarian, and feminist theories[23] in order to address equity impacts of SHG membership. Both quantitative and qualitative methods will be used in order to capture both health achievements (e.g. standard quality of life indicators), and impacts on capabilities (e.g. increased choices to achieve good health), while taking into account women's needs and values. It is hoped that by evaluating a poverty-alleviation intervention in terms of health and social justice, the roles of and need for uniting poverty and health dimensions in development will be illustrated in practice.

[23] Although not addressed in this report the Indian value on community will be an important aspect of this project, which may impact on the more Western individualistic notion of health and determinants of health. Feminist theories will be explored to assist in addressing the cultural and poverty-driven oppression of women, the relevance of gender justice and a movement towards increasing power of women.

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