

## **Subjective Wellbeing: the Tangible and the Intangible.**

### **Lessons from a Women's Mental Health Project in India**

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#### **Abstract**

The paper shares some of the key learnings from an action research in rural Karnataka, India, that integrates mental health interventions within a developmental framework of microcredit self-help groups (SHGs). A qualitative research method, focus group discussion, was used to assess the impact of the SHG and mental health intervention. In addition, women SHG members, who participated in the intervention and those who are yet to participate, were interviewed to understand the meaning of money and happiness in their lives.

While money, and its purchasing power to fulfill basic needs, was the tangible related to happiness; Social capital, in terms of good family and social relationships, and faith in God were the intangibles. Women, who had participated in the mental health intervention, were higher on subjective wellbeing as a result of the emotional and instrumental support they received from group members. Members reported a poor quality of life due to inadequate civic amenities. Policy makers have a responsibility to address these needs.

#### **Introduction**

Subjective wellbeing (SWB) is the emotional and cognitive evaluation of one's life and is often referred to by terms such as happiness, peace, fulfillment and life satisfaction (Diener, Oishi & Lucas, 2003). Subjective wellbeing is determined by a complex interplay of economic and psychosocial factors. While work participation, economic security and purchasing power are necessary for economic wellbeing, social status, dependable social networks and self-efficacy are intrinsic for emotional wellbeing. The context, in terms of living conditions, in which these two dimensions of wellbeing interact, determines the overall quality of life.

There is a clear curvilinear relationship between purchasing power and SWB (Diener et al, 1995). The relationship between money and life satisfaction is stronger at low income levels, mostly because it directly addresses human needs of food and shelter (Biswas-Diener & Diener, 2001; Veenhoven, 1991). Increase in income and possession of consumer goods, beyond what is necessary to meet basic needs, has not been found

to be reliably related to happiness (Diener, 2000; Easterlin, 1995). In what is referred to as the hedonic treadmill, large increases in standards of living have almost no detectable impact on life satisfaction or happiness (Kahneman & Krueger, 2006).

Culture also has direct and indirect effects on SWB. The relation between economic level and life satisfaction is stronger in individualistic cultures, than in collectivistic cultures. Individualistic cultures emphasize freedom of choice and individual's needs, whereas collectivistic cultures emphasize duties and others' needs. Personal happiness is a valued goal in individualistic societies, whereas, in collectivist societies, happiness and life satisfaction are based more on fulfilling normative expectations (Suh et al, 1998). The role of religious beliefs, including acceptance of one's fate and trust in God, also differs across cultures (Diener et al, 1999).

The paper highlights the above mentioned issues by presenting some of the key learnings from an ongoing project that integrates mental health interventions within a developmental framework of microcredit self-help groups<sup>1</sup> (SHGs). The project is designed and implemented by Sampark, Bangalore, India, a registered community based, non-profit, non-governmental organization (NGO) with funding support from the Anuradha Foundation (U.S.A.).

## **Background to the project**

### *The implementing organization*

India accounts for 15 percent of the global population and 27 percent of its 1.3 billion were in the absolute poor in 2001 (Premchander et al, 2009). Sampark has been working for the past 18 years in various parts of India, in the area of poverty alleviation by supporting NGOs, cooperatives and women's self-help and informal groups in income-generating activities, enterprise development and gender-related issues. More recently, in response to local community needs, it has expanded its focus to include health and education. The project described in this paper is located in Koppal, one of the most backward districts in the state of Karnataka in the southern part of India. Koppal is a semi arid, drought prone region with a population of about 1 million spread over 488 villages. Livelihood is mainly dependent on rain-fed agriculture. Poverty is rampant and literacy rates among both men and women are low, ranging from 31% to 57% with an average of 52%. The composite human and gender development index is low (53.09) and many households, especially those belonging to low social status (individuals belonging to scheduled castes and tribes<sup>2</sup>, devadasi women<sup>3</sup> and landless/marginal farmers), live below the poverty line (Premchander et al, 2009). Since 1998, Sampark has been working in 32 villages of Koppal district with the objective of holistic development, it has supported local people's initiatives and strengthened their management capacities in the areas of education, health, vocational skills, micro-credit and micro-enterprise.

Women are the focus of Sampark's development activities, especially those belonging to the most vulnerable and disadvantaged sections, who are often excluded from most development activity (Jeyaseelan, 2009). It has helped women to form savings and credit Self Help Groups (SHGs) and has been providing skills training in enterprise development so that they can increase their income generating capacity and supplement their irregular agriculture income. Sampark uses a participatory approach that enables women to become more independent. A group of 15-20 women form a SHG and meet every week to discuss savings and credit issues. The group members decide loan criteria and identify person/activity eligible for loan. SHGs are linked to commercial banks and group solidarity is used as collateral, enabling access to resources much

Women are the focus of Sampark's development activities, especially women belonging to the most vulnerable and disadvantaged sections. Sampark supports the women to form self help groups, access microfinance, start microenterprises, educate their children, and also provides vocational training and placement services. The mental health programme adds value to a well grounded economic support programme.

larger than the group's savings. Further, by developing good relations with government agencies, banks and financial institutions, Sampark has facilitated better credit linkages for these women. This, in turn, has provided them with better access to credit to set up viable business concerns.

A village has about 3-12 SHGs. Groups from 3-4 neighboring villages (about 15-20 groups) form a cluster association that plans, implements and monitors the various activities. Each cluster has five different committees (Administration, finance, income-generating activity, education and health). The SHG selects its leaders who, by rotation, represent the group at the cluster meetings. Cluster leaders take turns to head the various committees. This ensures that all women members have an opportunity to develop their leadership capacity. Till date, Sampark has established 180 SHGs and 10 cluster associations reaching out to about 3500 women in 32 villages in Koppal district (Jeyaseelan, 2009). For more information about Sampark please visit [www.sampark.org](http://www.sampark.org)

While focusing on income generation activities and poverty reduction, the Sampark field staff observed that a number of women reported somatic complaints such as body aches and pains, disturbed sleep, tiredness and a variety of gynecological symptoms. The women were under chronic stress due to poverty and social exclusion and felt helpless and hopeless about their future. Although distressed by their health status, they did not seek formal medical or psychological help for these complaints due to stigma and lack of access to formal services. There are several reports documenting the strong association between poverty and depression in developing countries (Patel

& Kleinman, 2003). To address this concern, the project sought to integrate a coping skills based mental health intervention with the ongoing SHG activity.

### *Action research on mental health*

At the start of the project, the Sampark field staff (three women with undergraduate qualification and considerable development experience) were trained as lay counselors. They were provided training in basic techniques of counseling, coping skills to manage stress and a simple breathing-based relaxation method (Details of the content of training and intervention are provided in Prameela et al 2007). Before introducing the mental health intervention to the SHGs, a health camp is organized at the village level and all members in the community (not just the SHG members) are screened and treated for medical illnesses or referred to the nearest appropriate health facility. The doctors who attend the camp are from the local primary health centre. The SHG members are given a health card which has their identifying information as well as the results of the screening. Children, adults and elderly with physical or mental disability are referred to appropriate services. Persons with serious physical disorder are referred to the nearest government hospital. Majority of women suffer from common illnesses such as anemia due to worm infestation, viral fever, cough and cold, skin diseases and reproductive tract infections and are prescribed treatment by the camp doctors. All medicines are provided by Sampark free of cost at the camps. As of October 2009, 9 camps have been organized and 300 men, 1212 women and 646 children (total N= 2164) have benefited from this service.

The mental health meeting takes place every fortnight after the groups complete their savings and credit activity. Mental health professionals trained the NGO staff who, in turn, provide training to women leaders in order to make the intervention sustainable. The main techniques used in the groups are ventilation, reassurance, problem solving coping and relaxation exercise.

A fortnightly health meeting is then added on to the weekly savings meetings of the SHGs. On an average, the groups comprise of 12 to 16 members. Each group is facilitated by one of the field staff. The introductory module comprises of general health and hygiene information and introduces the concept of mind-body relationship. Women are then encouraged to share their problems and help each other in generating alternative solutions or perspectives to the problem and ways of coping with it. Each session concludes with the practice of a breathing-based relaxation exercise. After ten such sessions, each group identifies two leaders from among their members who will function as facilitators for the health meetings. Training is then organized for these group leaders. The groups continue to meet on a fortnightly or monthly basis with ongoing support and supervision from the field staff. Till date, more than 72 SHGs have integrated the mental health intervention

with their micro credit activity. The program is ongoing and by the end of 2010, Sampark would have introduced the mental health intervention to a total of 114 SHGs and trained a total of 228 women as group facilitators. In all, approximately 1570 women would have benefitted from participating in the intervention.

The main learnings of the project period are summarized below.

1. The overwhelmingly positive response to the program and interventions indicates that there is a strong felt need, and that women have barriers to seek and access formal help. Since the intervention is embedded in a group based approach it does not identify or stigmatize a person with a problem as "mentally ill". Cluster leaders are demanding that the intervention be introduced in their groups as well.

The intervention is embedded in a group based approach that does not identify or stigmatize a person with a problem as "mentally ill".
2. The initial health screening camp helps to identify women with medical illness as well as those with serious mental illness who are then referred for appropriate medical/psychiatric intervention. The common medical problems affecting the women are severe anemia, primarily due to worm infestations and reproductive health problems, similar to other community surveys in India (Patel et al, 2007).
3. The counseling sessions highlight that the main source of distress is due to interpersonal problems, mostly within the family (spouse, parents, in laws, children and other relatives). Poverty and lack of economic stability are another source of concern. Often financial requirements are to fulfill social obligations, such as education or marriage of an offspring. Social barriers of exclusion are another frequent theme expressed by widows, devadasi women and women belonging to the lower and scheduled castes.
4. Through ventilation and the use of problem focused coping, generated by mutual discussion, the women are able to support and help each other to cope with their problems.
5. The breathing based relaxation technique is very popular and, despite both physical and time constraints, the women practice it regularly. It has resulted in improved sleep quality and has been effective in reducing bodily aches and pains and physical fatigue.
6. After the initial ten sessions conducted by the counselor, each SHG has continued the sessions, either on a fortnightly or monthly basis. Often the health meeting is held after the discussion of credit and savings. The women are able to clearly separate the function and activity of the two.

## **The present study**

The present study uses qualitative research methods to achieve the following objectives: 1. To assess the impact of the mental health intervention by interviewing SHG members who have participated in the intervention and those who have not and 2. To understand the meaning of money and happiness in their lives.

### *Method*

#### *Tools*

1. Two Focus Group Discussions (FGDs) were conducted in last week of October, 2009. Focus Group Discussion is a qualitative research technique used to elicit information. FGDs generate data through interaction among the participants. In responding to each other, participants reveal more of their own frame of reference on the subject of study and are less influenced by interaction with the researcher. The strong social context of the group offers an opportunity to see how ideas and language emerge in a more naturalistic setting (Finch & Lewis, 2004).

The FGDs lasted for about 2 hours. All participants were economically compensated for their time (loss of wages incurred as a result of being unable to go to one shift of labor). They were provided tea and snacks during the discussion. The specific issues raised in the FGD were:

- i) The impact of the savings and credit activity
  - ii) The impact of the mental health intervention
  - iii) The meaning of money and happiness and the role of money in happiness.
2. The participants were individually asked to rate their overall satisfaction with life by responding to the question "All things considered, at this point in time, how happy and satisfied are you with your life". They found it difficult to respond on a scale of 0 to 100 (although a Rupee comprises of 100 paisa) and opted to rate in quarters of a rupee (a four point rating). A single global question has been the most frequent method used to assess subjective wellbeing (Kahneman & Krueger,2006; Steel & Ones,2002)

#### *Sample*

The first FGD was conducted in Kolor village and comprised of 21 participants, aged 20 to 65 years, from 10 SHGS (Group1). These women had participated in SHG activity for a period of 2 to 8 years and had also integrated the coping skills intervention along with their savings and credit meetings. The second FGD was conducted in Madinur village and had 16 participants, aged 20 to 65 years, from 7 SHGs (Group2). These women had

participated in SHG activity for a period of 2 to 4 years, but had not yet initiated the mental health intervention.

## Results

### *The impact of SHG activity*

Women in both groups reported that joining the savings and credit groups had improved their financial position. They now had increased income generating capacity that, in turn, had led to economic security and stability. Majority of women in group 1 (18/21, 85%) had initially taken small loans of Rs. 100 to Rs. 500 (\$2 to \$10) to meet basic needs such as food or clothing. They then moved to larger loans of about Rs. 5000 to Rs. 50,000 (\$100 to \$ 1000) to start a small business or improve the returns on their land.

The savings and credit activities have helped the women to use savings to fulfill their consumption needs. Some have also been able to use savings and loans for children's education, social needs, and a few for improving their economic activities and incomes.

They were able to easily avail of loans for children's education and to celebrate marriages or religious festivals. In group 2, less number of women (6/16, 40%) had started their own enterprise, but had taken loans to meet personal expenses like repairs for the house, illness and marriage of daughter etc. Overall, however, members in group 2 were still using their savings to fulfill basic needs of food, clothing and shelter, while members of group 1 had started making investments for a better future. However, members in both groups stated that they could now easily access loans at lower rate of interest and had stopped being indebted to the local money lender who charged a much higher rates of interest.

The SHG women reported that good creditworthiness and ability to contribute financially, had earned them the respect of their spouse and other family members (especially in-laws) who now consulted them when making family decisions. In addition, now that each one of them operated a bank account, they were treated with respect by community members and bank officials. Many of the women stated that they had visited a bank for the first time, after joining the group. Their communication skills had improved and they were confident of interacting with government and other officials.

Participation in the cluster committees had improved their managerial skills. They were involved in the planning, implementation and monitoring of development interventions in diverse areas such as children's education, savings and credit, health, skill training and enterprise promotion for youth and women. They were now more aware of their rights and were better able to avail of government social and welfare schemes.

### *The impact of mental health intervention*

As only the members of Group 1 had participated in the mental health intervention, this question was raised for discussion with them. The members stated that the health screening camp had enabled those with medical illness to seek help and had overcome their fear of visiting a medical doctor. Also the free medications had helped them immensely. However, for most it was reassuring that their complaints did not indicate any serious problem.

All the women in group 1 reported that their health had improved after the group counseling was introduced. The relaxation exercise had improved their sleep quality and they were able to carry out their daily household chores and go to work without feeling tired. They no longer complained of aches and pains. They now realized that their somatic complaints were actually a manifestation of their distress. However, the most salient benefit was that of sharing their problems in the group. They felt unburdened and the group member's care and concern had made them feel that they were not alone and could face any situation. They were no longer distressed or worried, and felt happy and confident. Members had reached out to help each other financially and emotionally, and broken many social barriers in doing so. For example, to tide over dire economic circumstances, a woman had been encouraged to start her own business by the group members, much against the family's wishes. Another member was supported when she decided to find a groom for her daughter who had been widowed at a young age. Although caste barriers still existed, the group members were slowly breaking them down. Group 1 had also succeeded in closing an illicit wine store in their village.

Women who had participated in the mental health intervention reported that sharing their problems helped them feel "lighter" and unburdened and they had received both emotional support (understanding and reassurance) and instrumental support (money to start a business, finding suitable marriage alliances for a widowed daughter etc.) from group members. Overall, their general health had improved considerably and they no longer felt helpless or hopeless.

### *The meaning of money and happiness*

Members in both groups stated that money was necessary to meet basic needs: food, clothing, shelter, education of children and health related expenses. Both groups expressed that desires were a source of unhappiness and there is no end to desire. So one must desire within limits, and be contented with what one has. When specifically asked as to when a person will be satisfied, a member put it very eloquently when she stated "only when we eat we say enough, otherwise man never says no to anything!" When persuaded to look beyond their present circumstances and list out things that they aspire for, members in group 1 stated that their "wish list" comprised of a

television(TV) and mobile phone, followed by a mixer, fan, chair, cot and own house. Jewelry and better clothes would be last. Only two of the younger members expressed that they would like to possess a two-wheeler vehicle (a scooter). In group 2, the women stated that they do not aspire for things that they know are beyond their purchasing power. They debated whether possessing a TV was a good thing. Majority of them were of the opinion, that having a TV in the house would be a major source of distraction and prevent children from doing well in their studies. They concluded that a TV should be purchased only after the children have grown up!

Women made a distinction between wants and needs, and felt that it was important to limit desires. They related happiness not only to sufficiency of money and limited wants, but more importantly, to good social relationships, within both the immediate family and the neighborhood, having children and faith in God.

Participants in both groups stated that happiness is derived from children doing well, harmonious family relationships, good relationship with neighbor and neighbor's happiness. Interpersonal goodwill, the trust and support of family and friends is what makes one really happy, they said. In Group 2, the members stated that having children was a source of happiness, even if one had only one meal a day. Rich people without children are unhappy. This reflected an emphasis on social capital as against financial capital alone. "Happiness is not derived from the mere possession of wealth". One of the members said "Politicians are rich people who enjoy a comfortable life, but they are not necessarily happy; they are afraid of losing their position any time!". The others laughed and said that the wealthy live in fear of losing their wealth, so they don't sleep well, they do not trust others and have interpersonal problems with family and friends. They opined "Money will come and go; one should not get too attached to it". They stated the example of the recent floods<sup>4</sup> in their region, which treated rich and poor alike. Being rich makes it more difficult to face the unexpected challenges that life throws. Money is necessary, but happiness comes from contentment and being at peace with oneself.

Belief in God and a spiritual/philosophical outlook was the substrate on which everything rested. They said "everything begins and ends with God, so his presence is everywhere like the air we breathe." Without Him, nothing works, nothing good can happen without his blessing.

When asked what would be required at the community level to improve the standard of living, the members stated that better civic amenities were required to enjoy a good quality of life (QOL). They wanted better roads with transport services, electricity, water and sanitation, schools with good teachers and hospitals with adequate health care facilities. When asked if they would like to move to the cities for a better QOL, only two

members (both under 25 years) stated that they would like to do so. The rest stated that there was a difference between a good, comfortable life and being happy, and although they did not enjoy all the comforts of a life in the city, they preferred to be where they belonged.

*Overall rating of happiness and life satisfaction*

In response to the single global question, "All things considered, at this point in time, how happy and satisfied are you with your life", the results are presented in table 1.

**Table 1: Rating of Happiness by Members of SHGs**

Happiness Rating	Group 1(N=21)		Group 2 (N=16)		Remarks
	f	%	f	%	
25%	0	0	03	19	One member in Group 2 had lost her father to cancer and her mother had recently undergone surgery for breast cancer. The other two, were very poor and from the SC community.
50%	13	62	10	63	
75%	04	19	01	06	
100%	04	19	01	06	Except one member who was < 25 years, all the others were above 60 years.
Average group rating		65%		47%	

Majority of the participants in both groups rated themselves at the half way mark of 50%. The ratings indicate that Group I that has participated in the mental health intervention is, on the average, higher on wellbeing, than Group II that has only participated in the savings and credit activity.

**Discussion**

The experience of combining income generation activity with the reduction of psychological distress through a group based self help approach has been both challenging and rewarding. The process of capacity building using the SHG model has increased rural women's ability to generate income. This has led to increased involvement and participation in decision making processes both within and outside of

the family. The women felt more confident as they had an economic safety net to fall back on in times of need. Several studies have documented the efficacy of the SHG model as a poverty alleviation strategy (Mohindra, Haddad & Narayana, 2008, Premchander et al, 2009).

There was a clear difference, however, between Group 1 which had received the mental health intervention and Group 2 which had only participated in the SHG activity. The women in Group 1 formed a more cohesive group and had been able to support each other. The level of trust and kinship that they felt for each other was palpable in the way they communicated with each other during the FGD. They sat in a close circle, there was much camaraderie in their exchanges and they were optimistic about the future. In Group 2, although the economic activities were slowly gaining momentum, meeting the daily needs of life and living was still a struggle. The group members showed an interpersonal distance, reflected even in the way they sat, in twos and threes, rather than in a closed circle. There was a sense of helplessness and hopelessness reflected in their inability to “dream” about the future. They expressed an eagerness to initiate the health meetings in their groups.

The integration of the mental health intervention with SHG activity in Group 1 has clearly led to increase in individual self efficacy as well as social capital. Interpersonal trust and reciprocity within social networks is said to be key to the strengthening of social capital (clearly evident in the group) and social capital, in turn, is linked to enhanced wellbeing (Poortinga, 2006; Putnam, 1995).

On the individual rating of happiness, majority of the women in both groups rated themselves at the 50% mark. Across nation studies have indicated that, on a scale of 0-100, western populations average scores tend to be around 75 and that of non-western populations around 70, with scores of 50 and above being seen as on the positive side (Cummins, 2007, Diener, 2000). Several researchers have commented that, while the poor are lower on wellbeing measures than people who are economically better off, they are not miserable. The FGDs clearly brought out that while it is difficult to maintain a positive outlook in the face of negative life circumstances, poor people are not necessarily unhappy. Studies carried out in people living in adverse circumstances have also found levels of satisfaction that were higher than expected (Biswas-Diener & Diener, 2001).

The difference in the average ratings of happiness between Group 1 and 2 (65% vs. 47%) and the larger number of women in Group 1 reporting high levels of happiness and life satisfaction (38% vs. 12%) indicates that participation in the mental health intervention had made a positive difference in the lives of women in Group 1. By the women's accounts, it had helped to reduce their psychological distress and strengthened their trust and belief in the support provided by the SHG network.

Three women in Group 2 gave individual ratings of 25%. Scores below 50 indicate that the individual is at high risk for depression (Cummins, (2007). Although, the mental health intervention will be introduced shortly in Group 2, three women in Group 2 were clearly depressed and needed immediate individual help. Two of them were going through a financial crisis and belonged to a very disadvantaged section of society. One of them stated that a "farmer's life is fraught with misery and only death will bring relief", clearly indicating the possibility of suicidal ideation. The third, a young, unmarried girl, was shouldering the responsibility of the entire family. She had lost her father to cancer, her mother had undergone surgery for breast cancer and was on anti cancer treatment, and she had two siblings to educate. Other studies have indicated that, while SHG participation may improve access to health care, it may not be sufficient to address the mental health concerns of poor women (Ahmed, Chowdhury & Bhuiya, 2001; Mohindra, Haddad & Narayana, 2008). High rates of emotional stress and depression are associated with poverty especially in developing countries (Mohindra, Haddad & Narayana, 2008; Patel et al, 2007; Patel & Kleinman, 2003) and somatic symptoms are the idioms of distress (Pereira et al, 2007; Raguram et al, 1996). This psychological morbidity often goes undetected in general health care and is inappropriately treated with unnecessary medication (Linden et al, 1999; Patel et al, 2001). Thus, psychological distress poses a major economic burden on poor women and impacts on their livelihoods.

However, despite their poor economic status, these women put comparatively less emphasis on the role of money in contributing to happiness and wellbeing. The tangibles were those that met daily needs. Although living in a State whose capital, Bangalore, is seeing rapid economic growth, these women did not seem drawn to or attracted by the lure of wealth. It was the intangibles that accounted for their apparent satisfaction with life. A sense of contentment with what they had achieved, limited wants and an unshakable faith in a superior power (God). It was also interesting to note that the members placed greater emphasis on the happiness of others around them, even though they had so little themselves. This is in keeping with the collectivistic orientation that makes wellbeing of others central to one's own wellbeing. Other studies carried out in India have also demonstrated that the negative impact of poverty is to some extent mitigated by the presence of strong social relationships and faith in God (Biswas-Diener & Diener, 2001).

Finally, the women clearly differentiated happiness and emotional wellbeing from quality of life. They admitted that the lack of civic amenities in their villages had resulted in poor quality of life, but did not diminish the happiness and joy that they felt within themselves. A member put it very well; she said "I am happy when my daughter's marriage takes place, even though the journey to the marriage place may be arduous". The women felt that civic amenities and local infrastructure was something that they had not hitherto paid adequate attention. They would discuss it in their cluster

meetings and then take the matter up with the local Panchayat<sup>5</sup> members. They understood the need to make the government machinery accountable and focus on improving conditions of living in their villages. This would ensure that they and their children could look forward to a better quality of life.

Policy makers must distinguish needs from wants (Veenhoven, 2002). It is imperative that they are directed towards raising the living standards of the poorest segments of the population. Scarce resources must be used to improve health conditions, provide clean drinking water, sanitation systems to dispose waste etc. and provide quality education to build human capital that can form the basis for economic growth, rather than by merely increasing the demand for consumer goods (El-Ghannam, 2002; Kahneman & Krueger, 2006). Countries that are better able to meet people's basic needs, such as for food, clean water and health evidence higher levels of SWB (Diener, 2000). State and local governing bodies need to play a greater role to enhance the economic wellbeing of its citizens and ensure that they have better quality of life.

While the study is limited by the small sample size and the use of qualitative data obtained through self-report, user satisfaction with the mental health intervention and the demand to introduce it in other groups by cluster leaders is indicative that it is of value. The present study demonstrates that at an initial cost of Rs. 587 (\$13) per woman, it was possible to put a mental health intervention in place that addressed women's emotional needs, improved their access to health related information and health services, strengthened their social capital and enhanced their wellbeing. Development interventions need to be integrative so that they address poverty alleviation, strengthen social capital and empower the poor (Fox & Gershman, 2000).

## Conclusion

Micro credit and micro enterprise activities have been instrumental in reaching out to the very poor and marginalized persons, especially women, in developing countries. This has led to increase in income generating capacity and economic security. However, strengthening their social capital and building strong support networks is an important psychological resource that enhances their emotional wellbeing. Empowering the women to make policy makers more responsive to their communities' needs would further improve their quality of life.

Strategies for poverty reduction and increasing of economic capital should be combined with interventions that strengthen social support networks and enhance social capital. The two together contribute to subjective wellbeing. At the same time, policy makers and local government must be made accountable to improve the quality of life of citizens living in the community.

## Notes

1. SHGs are Self-help groups, launched in India by the National Bank for Agriculture and Rural Development (NABARD) with the support of Non-governmental organizations (NGOs). SHGs adopt the position that the poor are agents and that group members themselves should decide loan criteria and identify their own projects and activities (Mohindra, Haddad & Narayana, 2008).

2. Scheduled castes (SC) and scheduled tribes (ST) are vulnerable sections of society and are listed in Schedule XVI of the Indian Constitution. They are entitled to reservations in education and employment in the government sector.

3. Devadasis are women dedicated to the local deity and not allowed to marry, but stay with their parents and have relationships with men outside of marriage.

4. Northern part of Karnataka, was affected floods in the first week of October, 2009.

5. Panchayat is the village governing council

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2. Pangea Foundation, Italy for the development of cluster association from 2006-2009. Pangea Foundation is an international non profit organization that works in close collaboration with local associations intimately familiar with the real needs of the society. Pangea operates in post-emergency situations, and works toward the empowerment of Women through education, instruction on human rights, professional training, health education and micro credit. For more information please visit [www.pangeaonlus.org](http://www.pangeaonlus.org)

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