The Importance of Social Capital in the Promotion of Community Development and the Enhancement of Local Health System

Journal of Health Management
13(1) 15–38

SAGE Publications
Los Angeles, London,
New Delhi, Singapore,
Washington DC
DOI: 10.1177/097206341001300102
http://jhm.sagepub.com

Maria Costanza Torri

Abstract

Despite the interest in social capital, the value of this concept for health promotion and inequality reduction has yet to be firmly established. Although it has been suggested that the concept of social capital may be useful for exploring factors within individual and social health and for identifying different approaches to community-based healthcare, the interlinkages between primary healthcare, social capital and community development have yet to be considered in much detail.

The purpose of this article is to analyse, through the examination of a case study from southern India (Tamil Nadu), how far social capital can trigger community participation and an effective process of enhancement of basic health system in rural areas, while conserving local medicinal knowledge. The case study is represented by Gram Mooligai Limited Company (GMLC), an innovative female community enterprise of tribal herb gatherers which commercialises medicinal plants and produces phytomedicines, using their traditional knowledge in ethnomedicine.

Keywords

Social capital, local health system, entrepreneurship, traditional medicine

Maria Constanza Torri is Lecturer and Researcher, Department of Social Sciences, University of Toronto, Scarborough Toronto, Canada. E-mail: mctorri @yahoo.it

Introduction

'Social capital' has been the focus of considerable research since the mid-1990s. Much of this research has explicitly linked social capital with improved health, making the concept of interest to those in health promotion. Hawe and Shiell (2000) emphasise how the concept of social capital has found applications in often already existing initiatives that strengthen 'natural helping networks', build empowerment and community capacity.

Despite all this interest, the value of the social capital concept for health promotion and inequality reduction has yet to be firmly established. For one thing it remains significantly under-theorised (Hawe & Shiell 2000; Meagher 2006): the concept has been criticised as vague and indiscriminate (Mohan & Stokke 2000; Woolcock 1998) and the processes by which social capital develops and is maintained in the health promotion have not been clearly identified (Hayes & Dunn 1998; Porter & Lyon 2006). According to Labonte (1999) and Mort et al. (2003) social capital is merely a repackaging of what health promoters and community organisers have been doing for a long time. For others, it is a new way of looking at social relationships that has the potential to revolutionise thinking about society, with either positive or negative results. These perspectives are made more complicated by an absence of a consistent representation of social capital within the literature, and a failure to link to what community developers and other health promoters do in their actual day-to-day practice.

The salience of social capital debates for health promotion is increasingly underscored as the attention of policymakers turns to the role health promoters can or should play in building social capital to facilitate health promotion. Many scholars (Fukuyama 2000; Light 2004) have commented on the potential 'dark side' of social capital analysing in what circumstances social capital is likely to be a regressive rather than progressive force in terms of empowerment and community development.

We focus our discussion on community development in particular because it, more than any other health promotion strategy, sets itself the task of attending to the restoration and enhancement of extra-familial social relations and community capacity, and because it explicitly seeks to embody and operationalise core philosophical elements of the new

health promotion (namely participation, empowerment and collective action), and is consistently positioned at the core of health promotion practice (Bracht 1990; Green 1990; Sixsmith & Boneham 2002).

The case of the GMLC, an innovative female community enterprise of herb gatherers which commercialises medicinal plants and produces phytomedicines on the basis of traditional knowledge in ethnomedicine, presents an opportunity to analyse the interlinkages between primary health care, social capital and community development, with a special focus on gender.

The purpose of this article is to identify, through the analysis of this case study, how far social capital can trigger community participation and an effective process of enhancement of basic health system in rural areas, while conserving local medicinal knowledge.

Social Capital and Health

Social capital is an increasingly popular concept both in social theory and in healthcare policy.

Notions of participation and promotion of civic life in health policy and implementation have stimulated debate among academics, policy-makers and practitioners about the potential contribution of social capital in reducing health inequalities. The concept of social capital and the potential it offers for using community and civic pathways to promote and improve health has been emphasised by some (Portes & Landolt 2000; Sixsmith and Boneham 2002) as one means of tackling inequalities in health.

It has been suggested that the concept may be useful for exploring factors within individual and social health and in identifying different approaches to community-based healthcare (Cooper et al. 1999). As a result, social capital has been linked to a number of important health-related topics including neighbourhood regeneration, social inclusion and health inequalities (Cattell 2001). However, there is still a need to clarify the exact nature of the relationship between social capital and health.

The research literature reviewed in Cooper et al. (1999) draws attention to the ways in which social capital may affect individuals' health and

health-related behaviour. We use Putnam's (2000) definition of social capital as 'features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit'.

Various authors have posited social capital as a mediating link between socio-economic inequality and health. In particular Lynch et al. (2000) argue that socio-economic inequality affects health because it erodes social capital. Campbell (1999) suggests that social capital can act as a buffer against social-economic disadvantage by reducing the effects of the lack of economic resources.

While the public health field has been perhaps the slowest to catch on to the potential use of the concept in improving health and well-being, a growing proportion of this literature focuses on whether social capital has anything to offer public health professionals in their attempt to reduce health inequalities. Challenges to the concept in the literature have included whether or not it is really a new concept or merely a revitalised version of social support (Lynch et al. 2000); accusations that it is being used in policy terms to cheaply replace the need to tackle broader structural issues (Lynch et al. 2000); and cautionary notes to ensure we realise the negative consequences of promoting strong social networks among groups with negative motives. While there is some merit to these challenges, Hoang and Antoncic (2003) suggest social capital offers new insights into the success of community-based multi-disciplinary approaches to health promotion.

Despite recent research showing gender differences in the relationship of health to socio-economic characteristics (Annandale & Hunt 2000; Arber & Khlat 2002), research and thinking about social capital has usually lacked attention to differences in the meaning and relevance of social capital for men and women (Ronsmans & Graham 2006). These gender differences are likely to reflect structural inequalities such as the gender pay gap and the gendered division of labour (Hickey & Mohan 2004). Muntaner et al. (2000) notes that 'there are important differences in the type of activity undertaken by women and men' in relation to social capital.

Much of the literature on social capital has discussed the influence of the community context on individuals' health (Macintyre et al. 1993). In this article the view is taken that social capital can be properties of both the individual and the larger community and that these are not

mutually exclusive and are partially fungible. A first and popular component attribute of social capital is a description of the social network in which social capital is found. The type of network is usually of interest.

The types range from membership in the informal (e.g., family, friend and neighbour networks) to the formal (e.g., farming associations) network. Previous authors have partitioned the features of these networks into the physical [e.g., network size, homogeneity, horizontality, verticality (Ardichvili et al. 2003; Bowles & Gintins 2002; George & Zahra 2002; Silvey & Elmhirst 2003)] and affective characteristics [e.g., social cohesion, feelings of solidarity (Hayton & Zahra 2002; Hickey & Mohan 2004)]. The frequency of participation is not the only consideration. The level of involvement (e.g., as a group leader as opposed to a passive subscription payer) may also alter the amount of advantage obtainable from the network (Putnam 1995).

This perspective of networks of individuals interacting with environments has the power to explain an array of collective outcomes beyond that explained by aggregated individual health outcomes. Some studies have shown the powerful health effects of social connectedness (Hoang & Antoncic 2003). The mechanisms by which this social capital is beneficial to health are not clearly delineated, but social networks are believed to promote better health education, better access to health services, informal caring, and enforcing or changing societal norms that impact on public health (e.g., smoking, sanitation and sexual practices) (Johannisson et al. 2002).

Much work remains to be done in accounting for the mechanisms underlying the alleged health-community and entrepreneurship link (Campbell 2000). There has been a great deal of interest in the last two decades in the relationship between absolute income, income inequality and health outcomes. A number of studies have sought to explore whether individuals exposed to significant income inequalities suffer adverse health outcomes independent of the established effect of absolute income on health (Lochner et al. 2001; Mellor & Milyo 2001; Pathmanathan et al. 2003).

Mellor and Milyo (2001) pay particular attention to methodological issues in the measurement of inequality and health outcomes. They point out that there is a well-established concave relationship between inequality and health so that higher levels of income produce diminishing returns in terms of health outcomes.

These studies though do not analyse the interlinkages between income inequality, health and social capital, being focused on the first two elements. This article aims to bridge this gap by analysing a community-based enterprise active in the field of traditional medicine which involves tribal communities in India. The objective of this article is therefore to analyse at what extent this initiative has been able to reduce at the same time the income inequality among these rural communities and to foster the local health system, putting a special focus on the role of social capital in this process.

The Case Study

GMCL, created in 2001, is a community-based enterprise which supplies medicinal herbs to Indian pharmaceutical enterprises. GMCL, which plays an intermediary role between the final market and the gatherers and farmers living in rural areas, also sells *ayurvedic* medicines manufactured by local communities under the brand of 'Village Herbs'. With a turnover of $180,000 in 2008, GMCL is contributing an average $90 annually to the livelihoods of roughly 1,300 families in the southern states of Karnataka and Tamil Nadu.

GMCL, which has been designed with the objective of developing participatory management for rural poor, has been promoted by a group of Indian NGOs, more in particular by Foundation for the Revitalisation of Local Health Traditions (FRLHT) and Covenant Centre for Development (CCD). The shareholding of the company is represented by female cultivators and gatherers of medicinal plants who formed 72 local groups called *Sanghas*[1]. These groups are present in 80 villages in Karnataka and Tamil Nadu.

The elected board of directors is constituted of both managers and representatives of *Sanghas* who are elected among the members of the *Sanghas*. GMCL has the main functions of liaising, selling medicinal herbs and negotiating with the pharmaceutical sector and expanding the market share for the final product.

CCD plays the role of facilitator and action catalyst, its role involving an organisational dimension (facilitating the constitution of *Sanghas* and

their coordination), and a communication dimension (facilitating the flux of information between the different levels of the organisation).

Methodology

The field research was carried out in Tamil Nadu (Dindugal, Virudhanagar and Ramanad districts) between June and August 2007. The research is based on a sample of 22 households of *Sanghas* farmers and of sales representatives, elected on the basis of age, marital status and economic conditions. The number of people interviewed amounted to 42 women aged 21–55 years. The data obtained from the interviews have been complemented by group interviews consisting of 10 participants each, selected among the members of the *Sanghas* not previously interviewed.

The methods of data collection involved the use of key informant interviews with the members of GMCL, FRLHT and CCD and with local leaders of *Sanghas.*

Participant observation at the different levels of GMCL structure and in depth interviews with a selected number of villagers, have also been used to collect field data. The villagers have been selected by using the snowball technique. In order to reduce the risk associated with this sampling technique, this sample has been matched with a sample of villagers randomly selected. In order to assure the data confidentiality, the names of the interviewees have been changed or omitted.

The Sanghas

The *Sanghas* are grassroots organisations composed of 20 villagers whose activity consists of harvesting, cleaning, drying and weighting the medicinal herbs. The *Sanghas* also promote microcredit and capacity-building in basic health issues to its members who are mostly marginal farmers and belong to the scheduled tribes.

The socio-demographic profile of the *Sanghas* shows that almost the totality of their members belongs to the age group of 30–45 years and has a family size ranging from 3 to 5 members.

The quantity produced or collected by every member is decided on collective base inside the *Sangha*. The *Sanghas* send the samples of the materials to be collected to the buyer through the GMCL. When the buyer accepts the sample, GMCL places orders to the *Sanghas* specifying quantity, quality, packing style required and transportation modalities.

The organisational structure of GMCL is unique in many ways. Methods of work are rather diverse and flexible: according to the preference of its members, in some groups medicinal plants are cultivated collectively, in others this is done individually.

The Network Structure of GMCL

GMCL is characterised by a network structure at external and internal levels. This network is formed by different organisations including seeral NGOs, think tanks and research centres, as well as local village organisations (*Kalasams* and *Mahakalasams*).

External Network

The organisation who has played a particularly important role in the development and success of the GMCL model is the FRLHT.

The Role of FRLHT

Ethnomedicine capacity is originated by the interactions between the scientists of the FRLHT, the members of CCD and the villagers, in particular the folk-healers. This involved research and action and consisted in the documentation, research and conservation of medicinal plants and in the dissemination and increase of awareness among the villagers on traditional practices and uses of ethnomedicine.

Another step in the process of ethnomedicine capacity creation is represented by the processes of standardisation[2] of extracts of plants developed by FRLHT in conjunction with the folk-healers using modern techniques and models; currently the golden scientific standard being that of randomised clinical trials. The latter are being reassessed and

'indigenised' in their offshoring (Osborne et al. 2004), yet still following strict scientific standards.

In reference to its final products (e.g., the phytomedicines produced), GMCL is able to follow Quality Control (QC) parameters. Currently, there is no organisation or government body in India that certifies that a product is 'labeled correctly'. Without proper QC, there is no assurance that the herb contained in the product is the same as what is stated on its outside label. With the identification of plants by laboratory analysis carried out in conjunction with the FRLHT, the consumer can be sure that the right plant is used.

There are various certification systems that can be applied to different stages of the production of *ayurvedic* preparations. The World Health Organisation (WHO) has prescribed Good Manufacturing Practices (GMP) as an indicator for certified products: GMP could be applied to the processing and production of *ayurvedic* formulations.

Through the support of FRLHT, GMCL is able to follow GMP to ensure that medicinal products are consistently produced and their quality standards are maintained. This can represent an important advantage of GMCL when compared to other enterprises in the herbal sector. As we have seen, the Indian *ayurvedic* market is characterised by a large number of small companies and other unlicensed manufacturing units. Quality control cannot be assured for these enterprises. Currently, only a few manufacturers in India adhere to complete QC and GMP, including microscopic, physical, chemical and biological analysis.

The natural next step of this process of knowledge acquisition through documentation and research has been the sharing of such knowledge with the immediate concerned groups, that is to say the local villages and their local institutions (*Kalasams and Mahakalasams*). FRLHT currently specialises in developing need-based training courses and educational events that serve as supportive means in the process of conservation and revitalisation of Indian Medical Heritage. In the purpose of educating villagers and increasing their knowledge of medicinal plants and traditional health practices, a Medicinal Plants Conservation Park (MPCP) has been developed by CCD in Madurai district in a campus named Sevayoor.[3] The park consists of an Ethnomedicine Forest (EMF) spread over 33 acres with a collection of over 500 plant species.

Internal Network

GMCL model is rooted into the village network structure already existing at the local level in the form of *Kalasams* and *Mahakalasams,* that are village microcredit organisations previously created with the support of CCD. This integration between the newly established village organisations (*Sanghas*) and the previous ones increases the synergy between them and represents a distinctive element of GMCL model. The link between *Kalasam* and GMCL is evident since the constitution of this community-based enterprise. In the phase which preceded the constitution of GMCL, CCD along with *Mahakalasam*, mobilised the share capital necessary for the creation of the enterprise and carried out market surveys and groundwork studies regarding the local medicinal plants sector.

The social exchanges within the *Sanghas* and these village organisations allow a transfer of information and knowledge (Ong & Collier 2007) and increase the social capital (Onyx & Bullen 2000). Two-third of the members of the *Sanghas* interviewed emphasised how the existence of previous village organisations has allowed them to benefit from different village-centred services present in the village such as credit, training, and so on. However, one may wonder to which extent the social stratification present in the villages, which is linked to caste belonging and socio-economic background of the villages, may hinder the full access to these services provided to the different members of the local organisations.

Results and Discussion

The Impact of the Initiative in the Rural Livelihoods

The increase of revenues was the most important result of the initiative of GMCL which has been highlighted by 26 out of 42 villagers interviewed, in particular by the women with a large size of the family. The interviewees emphasised how GMCL has allowed them to obtain higher prices than those offered by local traders and are able to reduce the transaction costs involved in the presence of middlemen. The increase of selling price for the gatherers was on average 30 per cent, being higher in villages located close to tourist resort and lower in remote villages.

The villagers interviewed also emphasised a reduction of the expenditures for medicines, as a consequence of the GMCL activity. A sales representative explains:

> We can prepare our own medication from plants that grow in our backyard. You mentioned about piles (hemorrhoid) if we go outside it will cost ₹2000 but if we prepare our own medicine (some of the names of herbs are mentioned) with butter milk we can save around ₹500.

In some cases, depending on the willingness of women of being involved in GMCL activity and investing some initial money in the purchase of medicines, GMCL has been able to enhance local entrepreneurship and employment. A leader from Umlalli explains: 'Our venture helps create job opportunities for women. We want to ensure that the local profit is used locally'.

Social Outcomes and the Promotion of Gender Active Agency and the Local Health System through Capacity-Building

Organisational theory and empirical evidence support the notion that knowledge is socially constructed. A process of mobilisation and collective action develops a shared cognitive system and shared memories. These forms of organisational cognition, which call for the understanding of events, open the opportunity for social interpretation as well as the development of relatively dense interpersonal networks for sharing and evaluating the information, thus creating effective learning systems. In the approach followed by GMCL, there is a clear focus upon understanding the experiences of the villagers in their everyday life and on rendering those experiences collectively by taking part in the same activities related to knowledge of medicinal plants. This element—sharing knowledge on the uses associated with medical plant—has been emphasised by one-third of the participants. In this respect, a middle-aged woman belonging to a *Sangha* stated:

> I am a member of this *Sangha*. This gave me the possibility to meet other women and talk about the medicinal plants we gather and use on daily basis

> for our family and our children. This is very important since we can exchange information among us and learn more of the medicinal uses of the different plants, especially from the older women.

A woman from Minitankulam village affirms:

> It is good to be a member of the Sangha. This helped me to meet other women of the village. We share our problems and we support each other. If someone is in need, or if I am in need, I know that I can rely on them and they know that they can rely on me. This is mutual.

The herbs gatherers and the sales representatives, who are generally landless or marginal farmers, have experienced an improvement of their social status, although the process has not always been easy as a woman recalls: 'my husband told me to stay at home and look after the housework, instead of going and gossiping. If I was late in cooking his dinner after a meeting, I was beaten.'

Social recognition has gradually given way to respect in most villages and the changes are most visible in the public domain. A sales representative called Rajeshvari affirms: 'Further, earlier I was just some person. But now, people recognize me as Rajeshvari who can treat diseases. I have also improved my knowledge regarding diseases because I have to educate the public'.

A woman from Perunguri who is a selling representative in her village affirms that since the time she has successfully established her petty shop to sale GMCL products, her reputation inside the community has increased and she is often invited to give speeches about *Ayurveda* and traditional remedies in the local schools and in the panchayat.

Nevertheless, the initiative of GMCL has not been able to produce a tangible change in the traditional culture and family values. To the question whether they preferred male dominance in the family and society, half of the women interviewed answered in an affirmative way. Although social and gender dominant structure appear hard to be modified, progressive improvements can be identified in the capacity of women to actively participate in decision-making processes and benefit from positive outcomes in terms of revenue and social recognition at community and family level.

The Impact of the Initiative on Collective Action, Social Capital and Learning Processes

In the GMCL case study social learning through capacity-building developed in the network has also been an effective strategy to bridge the entrepreneurs' technical and managerial capabilities of the villagers and enhance their self-confidence. The data show that the degree of success varies from village to village depending on the type of training and the number of training sessions attended. Classes and discussions at the community level, organised by resource persons and field workers directly to *Sanghas* members, have helped to raise their levels of information, awareness and knowledge.

The Impact of Social Capital and the Local Health System

The *Sangha*, being a grassroot organisation, encourages the women to come together, to analyse their issues and problems and to fulfil their needs in a participative approach. As a local association, the *Sanghas* form a privileged place for information and knowledge sharing and for the strengthening of social linkages among the members. The practice of holding regular group meetings is found to build better understanding, forge solidarity, and develop qualities of self help and mutual help among the members. The findings suggest that social cohesion takes different forms in different *Sanghas*; in some places there are dense networks of relationships between local women and high levels of trust and attachment to groups and neighbourhood, while in some others the social cohesion is lower. This can be possibly explained, as we will emphasise later on in the article, by the different composition of the members of the *Sanghas* in terms of socio-economic background and age.

The revitalisation of the knowledge in traditional medicine has been achieved by combining the entrepreneurial activities with a variety of training programmes for the members of the *Sanghas* organised by CCD and FRLHT. These initiatives constitute an important moment of interaction between the fieldworkers of FRLHT and CCD with the villagers and the folk-healers.[4] The approach followed by these two NGOs mainly consisted of an alternation of research and action, which had as a result

the documentation, research and conservation of medicinal plants and their related knowledge.

These studies have been instrumental to realise the importance of venturing into the sector of medicinal plants in order to enhance local livelihoods and health system through the constitution of GMCL. The interaction with folk-healers and the other members of the communities is done through the organisation of workshops and meetings organised in the villages. Such occasions help to build up a series of relationships between the scientists, the NGO's field officers and the communities they are working with. About 200 practitioners have participated to document over 700 practices in traditional medicine.

Another important result of this enhancement in capacity-building has been an increased awareness among the women interviewed of the importance of using medicinal plants inside their families and with their children.

The majority of the women interviewed affirmed that their activity is socially useful to enhance the community health system.

Following the training that the members of the *Sangha* have received, these women are able to play an important role vis-à-vis the other women of the community by giving advice regarding basic health problems. In this respect, a member of the *Sangha* from the village of Ramanand declares:

> There are several women that told me they didn't dare asking for an advice to the doctor as they feel intimidated by him but with me it is different. There are also some women who have no money or time to travel to the clinic. The closest clinic is 15 km from our village. They cannot go alone but they have to be accompanied by their husband or a male member of the family…. But since I have stated selling the medicines, they can come to visit me and I can help them.

Lessons Learnt

In the section below some key features that emerge from the case study in order to promote successful innovation and learning processes and enhancement of innovation capacity in a local network have been identified.

The Importance of Linking Local Actors at Several Levels in Local Health Initiatives

The importance of the rural network as an instrument to enhance the performance of the organisations has been already emphasised in literature. Some authors have underlined the capacity of a network to have an increased and diversified set of resources available and to be more responsive to the external environment and the changes it undergoes.

The GMCL model can provide a valuable lesson as it shows the importance of adopting a multi-layered network structure in local health initiatives which involves a diversity of stakeholders in a community-based organisation. One of the interesting aspects of this case study has been the way this programme has built up a variety of partnerships and networks outside and at the village level, somewhat creating new 'global assemblages', to borrow a concept introduced by Ong and Collier (2007). These have occurred in a variety of ways and across different types of stakeholders' groups. For example, in the field, village community organisations such as *Kalasams*, *Mahakalasams* and *Sanghas*, NGOs and training centres now have extensive cross-linkages that are both formal and informal.

Another strength and peculiarity of GMCL model, which could be adopted in other network structures operating in similar rural contexts, is its capacity to create synergies not just with outsider organisations but also to be embedded within the village network organisation structure. Community assemblies have been one of the most important mechanisms available for community planning, for dealing with power imbalances and conflict, for achieving accountability, and for strengthening local organisations (Onyx & Bullen 2000). This multi-dimensional interaction and cooperation between endogenous and exogenous organisations can be valuable in reinforcing their linkages with mainstream institutions, enhancing their opportunities and innovation and in funding better and more effective ways of supporting local resources and skills.

Nevertheless, despite the success of this model to create synergies with internal and external organisations, the network up to the present has not been able to liaise with local health services. The latter remain merely focused on an approach based on allopathic medicine and are

very reticent to intercultural practices, especially in rural areas. This incapacity to sensitise local authorities on the importance of an integrated approach in health and to promote the links with external stakeholders represents one of the weak points of the organisation structure of this community-based health model.

The Importance of Promoting Capacity-Building and Human Capital Development in Health

The training organised by FRLHT and CCD at network structure has been a prerequisite for the creation and diffusion of ethnomedicine capacity and its enhancement. On the occasion of programmes such as local healers' conventions and village botanists' workshops, local communities in village learned new skills of identification, herbarium preparation and new uses of medicinal plants. This has helped them in recognition and valorisation of the local knowledge relevant to medicinal plants' use and conservation. The final result has been the shift from a form of individual knowledge, mainly possessed by the folk-healers, towards a form of collective knowledge, more diffused at community level.

The training programmes organised by FRLHT helped local villagers in recognising and giving value to their local knowledge of medicinal plants. This has resulted in an increased capacity to study, document and monitor traditional knowledge on medicinal plants and their use, make an inventory of medicinal plants and local biodiversity through biodiversity registers, and so on. Twenty seven members of the *Sanghas* highlighted how their active participation in the GMCL initiative helped them to improve their knowledge of local plants and their medicinal uses. Almost majority of them (30) affirmed to have experienced a positive shift in the perceptions of traditional medicine by attributing an increased importance to it. These positive outcomes have been repeatedly emphasised by 37 villagers interviewed in Sevayoor who saw in the training activities an important means to put into value their local resources and their ethnobotanical knowledge.

The Importance of Fostering Knowledge Sharing and Learning Processes

In the GMCL case study social learning through capacity-building developed in the network has also been an effective strategy to bridge the entrepreneurs' technical and managerial capabilities of the villagers and enhance their self-confidence. Classes and discussions at the community level, organised by resource persons and field workers directly to *Sanghas* members, have helped to raise their levels of information, awareness and knowledge. As the field data show it, the degree of success varies from village to village and depends on the type of training, number of training sessions attended and also the quality of training. The fact that these village organisations, such as *Sanghas* are created on the basis of collectively owned social endowment facilitates the creation of solidarity among community members and receptivity to collective action.

Social linkages can become the basis for a new enterprise; but, conversely, the presence of an enterprise can strengthen or create these social ties. The limited number of members and the homogeneity of their background have helped minimise conflicts and discriminatory practices and allowed to enhance the social capital within these local organisations.

The fact that these village organisations, such as *Sanghas* are created on the basis of collectively owned social endowment facilitates the creation of solidarity among community members and receptivity to collective action.

Having emphasised this positive aspect, the interviews also highlighted how low caste and social status may inhibit entry into group entrepreneurial occupations and can thus reduce the importance of social capital in terms of health. This socio-cultural constraint prevents an increase in the participation of women in GMCL activity, and limits their empowerment in health. As among these village communities the herb gathering activity is associated with low caste and tribal background, it represents a social stigma. It is clear here how the link between social capital and equity in health needs is to be taken into account as an important factor capable of reducing the access to health to the members of

the local groups. Social inequalities between groups may also be in part attributable to the social networks to which individuals belong (Bourdieu 1997).

The interviews also show that some members, particularly the young ones, have trouble in actively participating in this process of knowledge sharing with the older members—an aspect which undermines the creation of social capital inside the groups. A young woman explains:

> Since I have been a member of this *Sangha*, I have learned a great deal about medicinal plants and their importance by talking with other women of this association. However, some older women sometimes protect their knowledge and do not share it with all the members on equal basis.

The question of religious differences represents another delicate issue. A leader of a *Sangha* noted that she found it difficult to involve women from Muslim families because of their lack of control over finances, movement or time management.

In a context where women's autonomy and physical mobility are generally restricted by gender inequalities within the family, differences in economic roles and power, son preference, oppressive cultural traditions, and the lack of encouragement is further penalising the women's participation in village organisations such as the *Sanghas*.

Inequalities and Social Capital

Inequalities in health are well-documented and evidence suggests that the attributes of places may influence health over and above any effects of individual risk factors.

Various authors have posited social capital as a mediating link between socio-economic inequality and health. In particular, Wilkinson (1996) argues that socio-economic inequality affects health because it erodes social capital. On the other hand, Campbell (1999) suggests that social capital can act as a buffer against social-economic disadvantage by reducing the effects of the lack of economic resources. In the case study analysed, we can see how there is an evident link between

socio-economic conditions and health. The interviewees have highlighted how the increase in their revenues obtained by taking part in the commercial activities in the *Sangha* has allowed them to have access to phytomedicines and thus to improve their health. The GMCL case study also highlights that the prevalence of poor self-rated health was higher in *Sanghas* with less participation in organised activities, less integration and lower levels of trust and attachment.

Further Issues of Future Research

A key problem in measuring social capital for areas (of any size) is that the concept refers to community norms, which cannot be directly observed. Many studies have measured the extent to which individuals are engaged in voluntary and associational activities of various kinds, and/or the extent to which citizens exhibit 'trust' or and/or participate in the political system (Lochner et al. 1999; Veenstra & Lomas 1999; Veenstra 2002). There have been some interesting attempts at 'systematic social observation' of behavioural norms but these could not easily be generalised beyond small areas without vast resources.

In the study of social capital in networks it is necessary to further understand and assess the psychosocial processes and outcomes of planned initiatives such as the ones analysed in the GMCL case study. This can include an analysis of the different degrees of friendship network and social support inside the community-based health organisations.

There is a need of more data to analyse the interlinkages between social capital and health in grassroots organisations which are using a network approach such as GMCL. This will help shed light on the relationships between attributes, for example, between norms and network characteristics and between levels of external resources and network characteristics. In other words, norms specifically related to the treatment of others, the non-material external resource of members' willingness to help others in the group, and the consequence of support received by members of the group from others in that group could be seen as potentially and theoretically linked.

Conclusion

This article analysed an innovative and holistic approach for the promotion of traditional health knowledge system and social capital through a community-based entrepreneurship initiative. The reduction of dependence vis-à-vis Western health services, the improvement of community access to health and market resources, and an increased social role for marginalised members of the rural society represent the main positive outcomes of this initiative.

The GMCL case study provides further evidence that social capital has the potential to underpin the development of new frameworks in order to understand health and health behaviour in individuals, within a broad and complex social context.

The peculiar organisational structure of GMCL, based on grassroots organisations which involve the community in the overall governance, has been instrumental to achieve these positive outcomes. This helped to foster the social capital in health at community level and the learning of their social skills, thus maximising the impact and community outreach in terms of knowledge sharing in ethnomedicine.

However, it needs to be highlighted that social capital, although effective in improving local basic health of the rural communities, has also its limits as the issue of rural health needs to be addressed both at macro and micro levels, making a special effort to bring the poorest of the population, women included, to the centre of the health policies.

Grassroots initiatives, such as the one analysed in this article, cannot fully replace the role of the government in the delivery of basic services for the local population. The health status of Indians, especially of rural women, is still a cause for grave concern (Suneetha & Chandrakanth 2006; WHO 2007). The failure of India's public health system to deliver basic health services and infrastructures to the poor requires serious rethinking of its institutional design and the structure of incentives that health service providers in the system face.

Further research is necessary in order to examine other organisational forms as the outcomes of similar initiatives possibly existing in the field still remain highly undocumented. Community initiatives such as GMCL should be encouraged and sustained through innovative policies

and actions that entice change and institutional innovation in order to revitalise traditional health systems and reinforce the links between culture, conservation and socio-economic development of local communities.

Notes

1. S*angha* is a Sanskrit word that can be translated roughly as 'association', 'assembly', 'company' or 'community' with common goal, vision or purpose.
2. In herbal medicine standardisation refers to providing processed plant material that meets a specified concentration of a specific 'marker' (that is to say a substance used as an indicator of a biologic state) constituent.
3. Sevayoor in Tamil means 'place of service'. This place was named such, also because of the long-standing inspiration of the founding team of CCD to build a rural community centre, where local resources and traditional skills will give the solutions to all the needs of the community, as well as the neighbourhood.
4. It needs to be noted here that this implies a new social organisation, in a sense 'commodifying' health by detaching 'plant knowledge' from both the role of the healer and a more complex therapeutic healing system beyond plants.

References

Annandale, E. & K. Hunt (eds) (2000). *Gender inequalities in health*. Buckingham: Open University Press.

Arber, S. & M. Khlat (2002). Special issue: Social and economic patterning of women's health in a changing world. *Social Science and Medicine*, 54(5), 643–848.

Ardichvili, A., R. Cardoza & S. Ray (2003). A theory of entrepreneurial opportunity identification and development. *Journal of Business Venturing*, 18(1), 105–23.

Bourdieu, P. (1997). The forms of capital. In A.H. Halsey, H. Lauder, P. Brown & A. Stuart-Wells (eds) *Education, culture, economy, and society* (pp. 123–34). Oxford: Oxford University Press.

Bowles, S. & H. Gintins (2002). Social capital and community governance. *The Economic Journal*, 112(483), 419–36.

Bracht, N. (ed.) (1990). *Health promotion at the community level*. Newbury Park, CA: Sage.

Campbell, C. (1999). *Social capital and health*. London: Health Education Authority.

——— (2000). Social capital and health: Contextualising health promotion within local community networks. In S. Baron, J. Field & T. Schuller (eds) *Social capital: Critical perspectives*. Oxford: Oxford University Press.

Cattell, V. (2001). Poor people, poor places, and poor health: The mediating role of social networks and social capital. *Social Science and Medicine*, 52(10), 1501–16.

Cooper, H., S. Arber, L. Fee & J. Ginn (1999). *The influence of social support and social capital on health. A review and analysis of British data*. London: Health Education Authority.

Fukuyama, F. (2000). Social capital. In L.E. Harrison & P. Samuel (eds) *Culture matters: How human values shape human progress* (pp. 98–111). New York: Basic Books.

George, G. & A.S. Zahra (2002). National culture and entrepreneurship: A review of behavioral research. *Entrepreneurship Theory and Practice*, 26(3), 33–49.

Green, L.W. (1990). *Community health*. Toronto, ON:Times Mirror/Mosby College Publishing.

Hayes, M. & J. Dunn (1998). *Population health in Canada: A systematic review*. Canadian policy research network study. Ottawa: Renouf Publishing.

Hawe, P. & A. Shiell (2000). Social capital and health promotion: A review. *Social Science & Medicine*, 51(3), 871–85.

Hickey, S. & G. Mohan (2004). *Participation: From tyranny to transformation? Exploring new approaches to participation in development*. London: Zed Books.

Hoang, H. & B. Antoncic (2003). Network-based research in entrepreneurship: A critical review. *Journal of Business Venturing*, 1(8), 165–87.

Johannisson, B., M. Ramirez-Pasillas & G. Karlsson (2002). The institutional embeddedness of local inter-firm networks: A leverage for business creation. *Entrepreneurship and Regional Development*, 14(5), 297–315.

Kawachi, I., B. Kennedy, K. Lochner & D. Prothrow-Stith (1997). Social capital, income inequality and mortality. *American Journal of Public Health*, 87(9), 1491–498.

Labonte, R. (1999). Social capital and community development: Practitioner emptor. *Australian and New Zealand Journal of Public Health*, 22(2), 430–33.

Light, I. (2004). The ethnic ownership economy. In C. Stiles & C. Galbraith (eds) *Ethnic entrepreneurship: Structure and process* (pp. 145–56). Amsterdam: Elsevier Science.

Lochner, K., I. Kawachi, R. Brennan & S. Buka (2001). Social capital and neighborhood mortality rates in Chicago. *Social Science and Medicine*, 56(8), 1797–1805.

Lynch et al. (2000). Income inequality and mortality in metropolitan areas of the United States. *American Journal of Public Health*, 8(8), 1074–80.

Lochner, K., I. Kawachi & B.P. Kennedy (1999). Social capital: A guide to its measurement. *Health and Place*, 5(4), 259–70.

Macintyre, S., S. Maciver & A. Sooman (1993). Area, class and health: Should we be focusing on places or people? *Journal of Social Policy*, 22(2), 213–34.

Meagher, K. (2006). Social capital, social liabilities, and political capital: Social networks and informal manufacturing in Nigeria. *African Affairs*, 105(421), 553–82.

Mellor, J. & J. Milyo (2001). Re-examining the evidence of an ecological association between income inequality and health. *Journal of Health Policy, Politics and Law*, 2(6), 487–522.

Mohan, G. & K. Stokke (2000). Participatory development and empowerment: The dangers of localism. *Third World Quarterly*, 2(4), 247–68.

Mort, G.S., J. Weerawardena & K. Carnegie (2003). Social entrepreneurship: Towards conceptualization. *International Journal of Nonprofit and Voluntary Sector Marketing*, 8(1), 76–88.

Muntaner, C., J. Lynch & G. Davey Smith (2000). Social capital and the third way in public health. *Critical Public Health*, 10(2), 107–24.

Ong, A. & S. Collier (2007). Introduction: Global assemblages, anthropological problems, in global assemblages. Technology, politics, and ethics as anthropological problems (pp. 1–21). Oxford: Blackwell Publishing.

Onyx, J. & P. Bullen (2000). Sources of social capital. In I. Winter (ed.) *Social capital and public policy in Australia* (pp. 56–68). Melbourne: Australian Institute of Family Studies.

Osborne, S., A. Williamson & R. Beattie (2004). Community involvement in rural regeneration partnerships: Exploring the rural dimension. *Local Government Studies*, 3(2), 156–81.

Pathmanathan, I., J. Liljestrand & J.M. Martins (2003). Investing in maternal health: Learning from Malaysia and Sri Lanka. *Health, Nutrition, and Population Series*, Washington, DC: The World Bank.

Porter, G. & F. Lyon (2006). Groups as a means or an end? Social capital and the promotion of cooperation in Ghana. *Environment and Planning*, 24(2), 249–62.

Portes, A. & P. Landolt (2000). Social capital: Promise and pitfalls of its role in development. *Journal of Latin American Studies*, 3(2), 529–47.

Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, 6(1), 65–78.

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. NewYork: Simonand Schuster.

Ronsmans, C. & W.J. Graham (2006). Maternal mortality: Who, when, where, and why. *The Lancet*, 3(2), 1189–200.

Silvey, R. & R. Elmhirst (2003). Engendering social capital: Women workers and rural-urban networks in Indonesia's crisis. *World Development*, 3(1), 865–79.

Sixsmith, J. & M. Boneham (2002). Men and masculinities: Accounts of health and social capital. In C. Swann & A. Morgan (eds) Social capital for health: Insights from qualitative research (pp. 84–92). London: Health Development Agency.

Suneetha, M.S. & M.G. Chandrakanth (2006). Establishing a multi-stakeholder value index in medicinal plants–An economic study on selected plants in Kerala and Tamilnadu States of India. *Ecological Economics*, 60(1), 345–58.

Veenstra, G. (2002). Social capital, SES and health: An individual-level analysis. *Social Science and Medicine*, 5(3), 619–29.

Veenstra, G. & J. Lomas (1999). Home is where the governing is: Social capital and regional health governance. *Health and Place*, 5(3), 1–12.

Wilkinson, R.G. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.

Woolcock, M. (1998). Social capital and economic development: Toward a theoretical synthesis and policy framework. *Theory and Society*, 7(2), 151–208.

WHO (2007). World Health Report. Geneva: World Health Organization.