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Social capital and health : contextualising health promotion within local community networks

SOCIAL CAPITAL AND HEALTH: CONTEXTUALISING HEALTH PROMOTION WITHIN LOCAL COMMUNITY NETWORKS[1]

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> On the one hand, millions of dollars are committed to alleviating ill-health through individual intervention. Meanwhile we ignore what our everyday experience tells us, *i.e.* the way we organise our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health.
> (Lomas, 1998, p. 1181)

This chapter examines the potential contribution of the concept of social capital to our understandings of the social determinants of health, and to current debates in the design and evaluation of health promotional intervention and policy. Historically, information-based health education has been the preferred method of health promotion in many countries and contexts. However much research points to the limitations of health education, which is believed to change at best the behaviour of one in four, generally the more affluent and better educated (Gillies, 1998). This is because health related behaviours (such as smoking, diet, condom use and exercise) are determined not only by conscious rational choice by individuals, on the basis of good information - as traditional health educational approaches assumed - but also by the extent to which broader contextual factors support the performance of such behaviours. Against this background

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the challenge for health promoters is two-fold. Firstly they need to develop policies and interventions that promote social and community contexts which enable and support health-enhancing behaviours. Secondly there is a need for the development of measurable indicators of what constitutes a health-enabling community – to assist in the planning and evaluation of such policies and interventions.

However, our understandings of what constitutes a 'health-enabling community' are still in their infancy. Recently much enthusiasm has been generated around the hypothesis that levels of health might be better in communities characterised by high levels of social capital. Such discussions have tended to draw on Putnam's (1993) definition of social capital, where social capital is defined as the social or community cohesion resulting from the existence of *local horizontal community networks* in the voluntary, state and personal spheres, and the density of networking between these spheres*;* high levels of *civic engagement/ participation* in these local networks; a positive *local identity* and a sense of solidarity and equality with other community members; and norms of *trust* and *reciprocal help, support and co-operation* (see Chapter 1 for an account of Putnam's work). Unless otherwise specified, it is Putnam's notion of social capital that forms the context for this chapter.

High levels of social capital have been found to be associated with a range of positive political and economic outcomes in contexts as diverse as Italy (Putnam, 1993) and Tanzania (Narayan and Pritchett, 1997). Most of the social capital research in the Putnam (1993) tradition falls within the disciplinary boundaries of economics and political science. More recently a range of authors (such as Baum, 1999; Gillies 1998, Kawachi *et al* 1997, Lomas 1998 and Wilkinson 1996) have suggested that social capital might also be associated with positive health outcomes, and argued that Putnam's ideas might usefully be imported into the field of health promotion. If support could be found for this hypothesis, the implication would be that health promoters should put less energy into health education and the provision of information about health risks, and more energy into developing programmes and policies that enhance levels of social capital in low health communities.

The concept of social capital has generated much enthusiasm in health promotion circles, but also many criticisms, with even its most enthusiastic supporters pointing to its shortcomings. Baum (1999) warns that in its present state of development the concept is vague, slippery and poorly specified, and in danger of 'meaning all things to all people' on both the right and the left of the political spectrum. As such it urgently needs clarification. Gillies (1998) emphasises that social capital is a descriptive construct rather than an explanatory theory, and that much work remains to be done in accounting for the mechanisms underlying the alleged health-community link. Other less sympathetic critics argue that those who seek to import social capital into the field of health promotion research are simply reinventing the wheel – and that most of the so-called insights the concept would allegedly bring to health promotion are already well established in both research and practice in this field (Labonte, 1999).

The most strongly articulated criticism is that the concept of social capital has been so enthusiastically grasped -- by health professionals ranging from local and national government representatives to overseas development agencies – because it points towards a convenient justification for a retreat from expensive welfare spending. Cynical critics point out that despite the abundance of strong research linking material deprivation and health inequalities (such as Gordon *et al*, 1999), social capital proponents prefer to place their emphasis on the as yet only hypothesised link between health and social capital. Critics suggest that social capital is popular because its implications for policy (for example that ordinary people should be encouraged to participate in the local civic community in the interests of improving community levels of health) are cheaper than the goal of reducing income inequalities. They also argue that such thinking potentially incorporates an element of victim-blaming -- implying that that poor people are unhealthy because they do not devote enough energy to participation in community activities (Muntaner and Lynch, 1999).

In response to such criticisms, it has been argued that rather than seeing a focus on social capital as a means of displacing attention from the strong evidence for the impact of

poverty on health, a focus on social capital could contribute to much-needed research into the mediating mechanisms whereby material deprivation impacts on health. Empirical research into the health-social capital link is still in its infancy. However, a preliminary analysis of existing health survey data in England (Cooper *et al*, 1999) suggests that while material living conditions and socio-economic position remain stronger predictors of adverse health than various indicators of social capital, people living in materially deprived circumstances are more likely to live in communities that are low in social capital. Furthermore, the same study suggests that the statistical relationship between material deprivation and poor health is weakened by controlling for variation in neighbourhood social capital. Against the background of similarly suggestive evidence for possible links between income, social capital and health inequalities in Australia, Baum (1999) points to the work of Bordieu (1986) – with his emphasis on the role played by different forms of capital in the reproduction of unequal power relations – as a useful starting point for urgently needed research into the role that social capital might play in mediating between material deprivation and poor health.

Along similar lines, Gillies *et al* (1996) emphasise that the primary cause of health inequalities is poverty and that the economic regeneration of deprived communities is essential for reducing such inequalities. However they qualify this claim with their argument that since that one of the effects of poverty is to undermine community networks and relationships, *economic regeneration* must be accompanied by *social regeneration* (*i.e.* projects to enhance social capital) if they are to have optimal success in improving health.

In the light of the controversies that the concept has generated, the remainder of this chapter examines the role the concept of social capital might play in developing actionable understandings of what constitutes a 'health-enabling community' – a community context that enables or supports health-enhancing behaviour. The first section locates the concept within the context of current debates in the practical fields of health promotion and public health. The next section seeks to illustrate how social capital fills an important gap in existing academic understandings of the health-society interface. The

third section refers to existing preliminary research seeking to link health and social capital. The fourth section examines recent research into the appropriateness of Putnam's conceptualisation of social capital as a tool for characterising local community life in real-world social settings in England. The fifth section raises the potential negative effects of 'anti-social capital' on health. The chapter concludes by highlighting the urgent need for further research if social capital is to serve as a useful conceptual tool for health promotion.

1. Social capital and current debates in the practice of health promotion and public health

This section outlines the potential role the concept of social capital could play in addressing a number of currently unresolved issues in the applied fields of health education and public health. Each of these areas is considered in turn. Within the area of health education, the limited successes of didactic information-based methods (such as posters, school lessons and television programmes) has led to a "paradigm drift" away from the provision of health-related information by experts to a passive target audience towards a community development perspective (Beeker *et al*, 1998, p. 831). Such approaches involve the participation and representation of local people in health promotional interventions. They have gone hand in hand with the proliferation of non-governmental organisations which aim to empower members of groups particularly vulnerable to health problems, working at the local level in projects which aim for 'community ownership' as their highest goal.[2]

Despite the fact that the concepts of community-level 'participation' and 'representation' have become virtual articles of faith in health promotion circles, little is known about the psycho-social and community-level processes whereby participation and representation have their alleged benefits. This gap severely restricts the extent to which the benefits of

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[2] This move towards participatory community-based approaches to health promotion has been formally articulated in a range of internationally subscribed declarations of intent, spearheaded by the World Health Organisation, including the Alma-Ata Declaration of 1978, the Ottawa Charter of 1986 and the Jakarta Declaration of 1997.

successful programmes can be documented and disseminated, and to which lessons can be learned from less successful programmes (Milburn, 1995).

Drawing on the social psychological concepts of social identity and perceived self-efficacy/ empowerment, participatory health promotion programmes succeed to the extent that they facilitate two inter-locking processes. Firstly they succeed to the extent to which they facilitate opportunities for people to make collective decisions to change their behaviour in negotiation with liked and trusted peers. Health-related behaviour is shaped by collectively negotiated social identities, rather than by factual information about health risks as traditional health education programmes assumed (Stockdale, 1995). Secondly they succeed to the extent that they increase the sense of perceived self-efficacy and confidence (or 'empowerment') experienced by target group members. This occurs as the result of peoples' participation in programme planning and implementation - given that people are most likely to take control of their health if they feel they are in control of other aspects of their lives (Bandura 1996).

It is hypothesised that both of these processes are facilitated within community contexts characterised by a rich tapestry of trusted and valued social networks. Such networks would provide opportunities for the collective re-negotiation of peer identities which are believed to influence health-related behavioural norms. Furthermore high levels of participation in effective horizontal networks are likely to maximise general levels of perceived self-efficacy amongst community members. The concept of social capital emphasises the positive value of high levels of civic participation in dense horizontal local networks. As such it provides a potentially useful starting point for conceptualising those features of community that serve to enable and support the identity and empowerment processes that are most likely to facilitate health-enhancing behaviour change.

As critiques of traditional educational approaches gain wider acceptance within health education circles, there is a shift in discourse. People are speaking less of 'health

education' and 'behaviour change' and more of 'structural interventions' and 'enabling approaches'. Tawil *et al* (1995) define enabling approaches as those that - rather than trying to *persuade* people to change their behaviour - seek instead to create circumstances that *enable* behaviour change to occur. Such approaches focus on the community or social or political factors that facilitate or impede behavioural choice, and they aim to remove structural barriers to health-protective action as well as constructing barriers to risk taking. Tawil *et al* illustrate their argument by discussing the context of HIV transmission through heterosexual sex in developing countries. They argue that enabling approaches should focus on the economic development of at-risk groupings, as well as on development policy. In their view, the crucial issue at stake in HIV-transmission in their countries of interest is the economic powerlessness of many women to protect themselves against HIV-infection in the face of male reluctance to use condoms. They discuss a number of economic and policy strategies aimed at improving women's access to resources and reducing their financial dependence on male partners.

While few would disagree with the substance of Tawil *et al*'s argument, their analysis illustrates a common tendency to polarise health promotion possibilities in terms of micro-social individual behaviour-change mechanisms on the one hand (such as persuading individuals to use condoms), and macro-social structural and economic interventions on the other hand (such as the economic empowerment of women). Concepts such as social capital enhancement, which focus on formal and informal networks at the local community level of analysis, represent an important intermediary stage between the micro-social individual and the macro-social levels favoured in such polarisation's.

Turning away from a focus on health education to consider the broader field of public health, the Health Cities Movement (H.C.M.) has aimed to enhance and build health-promoting networks and practices in a number of cities throughout the world (Kelley and Davies, 1993). The H.C.M. is based on the insight that the promotion of health must include the adaptation and transformation of those social structures that foster ill-health, and that community participation is the most powerful method of attaining this goal. The

Healthy Cities Movement attempts to maximise involvement of a wide range of community representatives in health promotion, backed up by the development of appropriate health policies at both the local and national levels. Accordingly, the movement seeks to foster the development of health-promoting social relations within cities -- including strong local government, broad community ownership, effective committees, strong community participation, inter-sectoral collaboration and political and managerial accountability (see Tsouros, 1990, for a more extensive list).

Advocates of the H.C.M. highlight the lack of appropriate research techniques and concepts to document and evaluate the processes underlying the approach (Hancock, 1993). The H.C.M.'s emphasis on the promotion of citizen participation in strong local community networks resonates strongly with insights from a social capital framework. If hard research evidence could be gathered to demonstrate a link between health and social capital, the concept could form the basis of measurable indicators of some of the processes which the H.C.M. seeks to stimulate. It could also play a key role in the design and evaluation of future public health programmes.

2. Social capital and current debates in the academic study of the health-society interface.

This section locates social capital within the broader context of existing academic research into the health-social relations interface – in the interests of assessing the potential of the concept of social capital to contribute to such understandings. Copious research has highlighted the links between health and social relations at a range of levels of analysis, including the macro-social (e.g. socio-economic status, area of residence, ethnicity, gender), the organisational (e.g. status within organisations), the small group (e.g. social support) and the psycho-social (e.g. empowerment, perceived self-efficacy). However, very little is known about the community level networks and relationships that mediate between these levels. Social capital forms a fruitful starting point for filling the current gap in our understandings of community-level determinants of health (see Figure 1).

INSERT FIGURE 1 AROUND HERE PLEASE (attached to the end of this document)

3. Existing research linking social capital to health

Attention to the concept of social capital in the area of health is relatively recent, and as yet little hard empirical evidence exists linking social capital to health. Here we need to distinguish between research into social capital, and the related research field of social support and social networks where much research has been done (Berkman, 1995). This research has measured social support as a property of individuals. In comparison, social capital is a property of communities. Kawachi *et al* (1997) emphasise the distinction between the individual-level construct of social support and the community-level construct of social capital. They provide an example of a widow, living on her own, and with few friends -- who would qualify as socially isolated using a measure of individual social support. However she would still benefit from residing in a neighbourhood with high levels of social capital -- "in which neighbours organised and mingled at block parties, transported elderly residents to voting booths on election days, made sure the sidewalks were cleaned when it snowed, and so on" (p. 1496).

One reason for the dearth of empirical research linking social capital to health is that at the early stage of its conceptual development, the task of developing instruments to measure social capital in the context of health is still in its infancy. Much work remains to be done in this regard (see Morgan, 1999; Onyx and Bullen, 1997 and Kreuter, 1997 for discussion of measurement issues in the context of health promotion in England, Australia and the United States respectively)

Within discussions of social capital and health, the most frequently cited empirical research is Wilkinson's (1996) analysis of the link between health and comparative income distribution between countries, and Kawachi and colleagues' work on comparative income distribution between regions within the U.S. (Kawachi and Kennedy, 1999) and Russia (Kennedy, Kawachi and Brainerd, 1998). The concept of

social capital serves as a major explanatory construct in Wilkinson's (1996) book, *Unhealthy societies: the afflictions of inequality*. Wilkinson examines the relationship between health (as measured by mortality statistics) and social inequalities, arguing that in the developed world it is not the richest countries that have the best health, but those with the smallest income differences. Drawing on a rich and diverse array of research from a variety of disciplines, Wilkinson suggests that the concept of social capital might serve as a potential explanation for his findings that relative income levels have a greater impact on health than absolute income levels. He suggests that egalitarian societies are more socially cohesive, with the public arena serving as a source of supportive and health-promoting social networks rather than a source of stress, conflict and ill-health. On the other hand, social inequality increases social instability, crime rates and violence, and undermines the likelihood of densely overlapping horizontal social networks, imposing a burden which reduces the health and well-being of the whole society.

Wilkinson suggests that his claims about the health-enhancing benefits of social capital presuppose a particular level of economic affluence, and that these principles are only likely to hold in countries that have achieved the level of wealth necessary to make the 'epidemiological transition' (where the main causes of death have changed from infectious diseases to degenerative diseases, and where there is a shift from direct material pathways to disease, to a more complex pattern which includes psychosocial pathways). The extent to which social capital might constitute a positive social resource in developing countries or in conditions of extreme poverty is currently a source of much research and debate (e.g. Campbell and Mzaidume, 1999, Gillies *et al*, 1996, Moser, 1998).

Kawachi *et al* (1997) seek to provide hard statistical support for Wilkinson's preliminary arguments about the role of social capital – through their study of the correlation between mortality, social capital and income inequality in 39 US states. Their statistical analysis isolates social capital (measured in terms of levels of trust of fellow citizens, and the extent of membership in voluntary groupings) as a causative variable in this relationship, arguing that income inequality exerts its negative effect on health through the social

capital variable. Although further studies are clearly needed to test the validity of this causal model, it does provide suggestive support for a link between health and social capital.

Lomas (1998) hails current interest in Putnam's notion of social capital as a welcome antidote to the individualistic focus of much research and practice in the field of public health. He compares the potential of six progressively less individualised and more community-focused interventions to prevent death from heart disease. These range from measures geared towards: the rescue of sick individuals (at the most individualised end of the continuum); routine medical care; improved access to care; traditional public health approaches; increased social and family support services; and measures to improve social cohesion (the most community-focused end of the continuum). Lomas uses the terms 'social capital' and 'social cohesion' interchangeably in his study. He finds that measures to increase social support and measures to increase social cohesion fare well against more traditional individualised medical care approaches.

A plethora of other small-scale specialised studies provide evidence for links between a variety of measures of social cohesiveness and a range of health-related outcomes, such as resistance to the common cold (Cohen *et al*, 1997) and satisfaction with health care services (Ahern *et al*, 1996). However, despite the excellent quality of many such studies of health and community cohesion, they work with a piecemeal variety of conceptualisations and measures of what constitutes positive community resources. As a result of this, there is a lack of conceptual coherence when one attempts to integrate their findings, and any cumulative impact these studies might have is severely diluted. In particular, Kawachi, Kennedy and Wilkinson (1999) emphasise that although they themselves often use the concepts of 'social capital' and 'social cohesion' interchangeably in their own research, these terms do not mean the same thing, and urgent work needs to be done in distinguishing between them.[3]

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[3] "It is important to note that social capital and social cohesion are not the same thing. In a well known example, gangs may provide social capital to their members without contributing to the level of social cohesion in a community." (Kawachi, Kennedy and Wilkinson, 1999, p. 730) The issue of anti-social capital is taken up in section 5 of this chapter.

The claim that social capital has any role to play in our understandings of the community-level determinants of health is a controversial one. Labonte (1999) argues that community level determinants of health have already been well researched and investigated, and that social capital adds nothing new to a long tradition of interest in this area. Related concepts include, amongst others, community empowerment (Shiell and Hawe, 1996), sense of community (McMillan and Chavis, 1986), community competence (Eng and Parker, 1994), community capacity (Goodman *et al*, 1998) and collective efficacy (Sampson *et al*, 1997). Each of these concepts has been linked to health both within health promotional research and practice. In particular, since the classic work of Freire (1970), a large health promotion literature has postulated 'empowerment' as the mechanism through which successful community-based health promotion has its effects (Israel *et al*, 1994; Schultz, 1995). Health-enhancing empowerment is generally agreed to derive from participation in and representation on those community and political structures which shape peoples' lives. This focus on empowerment is consistent with a large social psychological literature on the health-promoting effects of self-efficacy (e.g. Bandura, 1996). However little consensus exists regarding exactly what is meant by the 'empowerment' of local people, or which community networks and relationships are most likely to promote this 'empowerment' -- despite the fact that this is the key goal of most community-based health promotion programmes. Rissel (1994) argues that the field of health promotion undoubtedly has much to gain from better understandings of the process of empowerment. However he suggests that at its present state of conceptual development, the use of the concept of empowerment is hampered by "the lack of a clear theoretical underpinning, distortion of the concept by different users and measurement ambiguities" (p. 39).

There is an urgent need for energies to be pooled in the establishment and definition of consensual definitions of what constitutes health-enhancing community resources. Otherwise work in this field will continue to be undermined by the fragmentary array of conceptual tools used from one study to the next. It is argued here that the concept of social capital – which resonates with the insights of the fragmentary range of concepts

cited above – is particularly suitable for such a task. At a pragmatic level, the concept is particularly suitable because of the unprecedented amount of ground it appears to have captured in contemporary political discourse. At this particular moment in history there is an unusual degree of sympathy for concepts such as 'community' and 'participation', and a heavy emphasis on the importance of 'the local'. Partly as a result of this, social capital has captured more research and political interest than has been the case with any of the piecemeal community-level concepts referred to above. Furthermore, the concept holds particular promise for health researchers and practitioners because of its inter-disciplinary nature – in a context of growing emphasis on the complex array of determinants of health. These include features of the local environment as diverse as housing, transport, air quality, the reputation of an area and the quality of policing (Macintyre and Ellaway, 1999). Many such factors lie outside the conventional scope of a biomedical conceptualisation of health or of the traditional scope of public health departments. In the current general climate of 'joined up thinking' increasing attempts are being made to dissolve boundaries both between traditionally separate academic disciplines (such as political science and economics and medical sociology), as well as across traditionally separate sectors of local and national government (such as housing and transport and health). Within such a context, a multi-disciplinary concept such as social capital could serve as a useful bridging tool both for academics and practitioners in the field of health promotion.

4. To what extent is Putnam's conceptualisation of social capital applicable to small local communities in England?

On-going attempts to develop the notion of social capital for use by health-promoters in England currently take two forms. The first is reanalysis of existing health surveys, most of which were developed before the concept of social capital became current, but included questions which are now being pulled together as composite proxy measures of social capital. Thus for example, Cooper *et al* (1999) create social capital scales by pulling together existing survey questions such as 'involvement in community activities', 'availability of facilities for young children', 'personal experience of theft, mugging,

break-in or other crime' and various social support measures. A variety of further large-scale studies of this nature are currently in progress.

As an antidote to this 'top-down' large-scale quantitative research, a number of studies are using micro-social 'bottom-up' qualitative research methods to explore social capital at the level of small local communities. In a recent study, this author and colleagues conducted micro-qualitative exploratory research into social capital in two wards (administrative districts) in the town of Luton, England. We did this in the interests of examining the suitability of Putnam's conceptualisation of social capital as a tool for characterising local community life in England (Campbell, Wood and Kelly, 1999). We justify our choice of a micro-qualitative approach in line with our view that too much thinking and writing about social capital and its potential as a resource for improving health (or governance or economic performance for that matter) has been done in a top-down way by researchers, politicians and policy-makers. Such actors often make unproblematised assumptions about the existence of such resources at the small local community level.

In the field of health and social services, historical experience of 'care in the community' policies suggests that these policies made intellectual and political sense. Despite this, many of them were less than successful because they rested on a series of over-optimistic and untested assumptions. In particular they over-estimated the extent to which supportive community networks existed in local communities, and the extent to which these networks were capable of providing adequate care and support for previously institutionalised people (Barnes, 1997). We argue that if, by the same token, health promoters are going to work at enhancing social capital or community cohesion in order to advance their goals, they need to have clear understandings of what resources exist in local communities as the basis for their policies and interventions.

Our Luton study involved in-depth interviews and focus groups with 85 residents, and sought to explore their experiences of social capital in their local communities. On the basis of our data analysis, we conclude that those resources that do exist in local

communities might be fewer, and take a different form, than is commonly assumed by social capital advocates. Our study highlights a number of ways in which Putnam's notion of social capital needs to be developed in order to serve as a useful conceptual tool for health promoters in local communities in England.

Firstly we query the appropriateness of Putnam's highly essentialist notion of a cohesive civic community characterised by generalised levels of trust and identity. We argue that this is a romanticised and inaccurate starting point for characterising contemporary community life in the early 21st century. Informants gave an account of local community life as characterised by high levels of mobility, instability and plurality. Under such conditions the likelihood of widespread community cohesiveness was low. Those community-level relationships of local identity and trust that did exist in our communities of interest were present in a far more restricted form than Putnam's definition of social capital would suggest. They were generally limited to small exclusive face-to-face groups of people (friends, relative and/or neighbours) who were personally known to one another, and they excluded community residents who fell outside one's personal acquaintance. This is in strong contrast to Putnam's concept of generalised levels of trust, which includes trust of community members one is not personally acquainted with.

Secondly we query the extent to which Putnam's emphasis on organisational membership is a useful way of characterising local English community life. Putnam's (1993, 1995) research findings draw on research conducted in very different conditions of local communities in Italy and America. In these contexts, civic engagement -- characterised in terms of high levels of citizen involvement in voluntary associations such as choral societies, literary societies and bowling leagues – is a key component of social capital. Voluntary organisations of this kind played little or no role in the lives of the Luton informants. Peoples' major community networks took the form of the small-scale exclusive informal networks of friends and neighbours referred to above, which Putnam does not take account of at all in his account of social capital. Most informants in our Luton study said that the multiple demands of day-to-day contemporary life (in particular the demands of making a living in a context where employment was often hard to come

by and badly paid, as well as the multi-faceted demands of caring for a family) meant that they had little time, energy or interest in involvement in voluntary organisations or in community affairs (see Higgins, 1999 for similar findings in grassroots communities in Canada). Furthermore people emphasised that they had little faith in the power of ordinary people to exert any influence over any aspect of local or national government, and thus took no interest in these. Interviews suggested that informants were guided by a strongly individualistic outlook, which was counter to the more collectivist and community-oriented culture which forms a building block of Putnam's concept of social capital.

Thirdly, in our comparison of stocks of social capital in their two Luton wards, one of which was characterised by higher levels of health than the other, we hypothesise that certain dimensions of Putnam's social capital might be more health-enhancing than others. In particular we argue that levels of trust, civic engagement and "perceived citizen power" might be more important for health than a strong local identity, or numerous council-provided community facilities. We also suggest that certain network types (diverse and geographically dispersed networks) might be more health-enhancing than others (narrow, local and inward-looking networks). This is within the context of our more general point that sources of social capital often cross the boundaries of geographically defined communities.

Finally we emphasise that social capital is not a homogenous resource that is equally created, sustained and accessed by all members of a particular community. People are embedded in local networks in different degrees and in different ways. Our pilot study data highlight age- and gender-related differences in peoples' perceptions and experiences of community life. In the conclusion to our exploratory study, we hypothesise that income and ethnic differences might also be associated with differences in the forms of social capital available to different identity groups within particular communities (see also Morrow, 1999, for a discussion of social capital in relation to children). Within-community difference is an aspect of social capital which Putnam's work does not take account of – and one that would have definite implications for those

seeking to develop health promotional policies and practices aiming to enhance levels of social capital in local communities.

In short, our study illustrates the way in which Putnam's notion of social capital serves as a useful heuristic device for exploring the existence of grassroots networks and resources in local communities in England. However, much conceptual and empirical refinement remains to be done to tailor the concept into a conceptual tool for planning and evaluating services and policies aimed at promoting health-enabling communities.

5. Anti-social capital?

Another area where conceptual refinement is needed relates to the task of distinguishing between positive and health-enhancing social capital on the one hand, and negative 'anti-social capital' on the other hand (see also Portes and Landolt, 1996; Levi, 1996). Baum (1999) warns that cohesive communities might be characterised by distrust, fear, racism and exclusion of outsiders, and as such may not be healthy for those who are not part of them, or for insiders who disagree with the majority.

In a survey study of the links between social capital and sexual health in the southern African mining community of Carletonville, Williams, Campbell and MacPhail (1999) argue that the impact of varying associational memberships on sexual health is a complex one. While levels of HIV infection were lower amongst members of church groups and sports groups, they were higher amongst members of *stokvels* (savings clubs associated with high levels of alcohol consumption and multiple sexual partners, both of which place people at increased risk of HIV-infection).

In another micro-qualitative study of social capital and sexual health promotion, again in the Carletonville region, Campbell and Mzaidume (1999) examine the contradictions of assuming that strong local networks are necessarily beneficial for health. This work is conducted as part of their process evaluation of a community-led condom promotion programme amongst female commercial sex workers in a deprived shack settlement. On

the one hand, members of their study community expressed a strong sense of local identity. They described their daily community relations as better organised, with higher levels of social control and policing of criminals than other similar communities in the area. However, this organisation was orchestrated by groups of heavily armed gangsters who wielded absolute control over community residents through the threat and use of violence. In order to facilitate the development of a sexual health promotion programme, health development workers had to gain the support and approval of these gangsters who serve as community gate-keepers. The authors discuss the contradictions involved in having to collaborate with a violent and hierarchical group of armed male gangsters in a sexual health promotion programme aiming to empower female sex workers to insist on condom use in the face of reluctant male clients. These findings highlight the way in which social capital might be closely inter-linked with unequal and exploitative power relations – in this case relations between men and women (see also Beall, 1998). The directive by health promotion and development agencies that health workers should seek out latent and existing indigenous sources of social capital as the basis for their work might make theoretical and intuitive sense. However, those charged with implementing these directives frequently become trapped in ambiguities regarding the potentially positive and negative effects of social capital, as well as the potential links between social capital and unequal power relations, which need to be researched and theorised.

Conclusion

In this chapter it has been argued that the concept of social capital fills important gaps in our understandings of the interface between health and social relations. In the applied arena of policy and intervention, concepts such as 'community', 'participation' and 'empowerment' often have the unquestioned status of articles of faith. However, much work remains to be done in developing understandings of the mechanisms whereby community-level interventions and policies wield their effects on health, and in developing ways of measuring the extent to which such interventions or policies succeed or fail. Such understandings are needed for the key tasks of explaining the patchy results of current community-based health promotion programmes, and for documenting and

disseminating the lessons that need to be learned from successful programmes. At the level of academic research, much work has explicated various aspects of the health-social relations interface – at the behavioural, physiological, psycho-social and macro-social levels of analysis. However, much room exists for conceptual development and empirical research into community-level determinants of health, and it is here that the concept of social capital could make an important contribution.

Having argued for the potential importance of the concept however, research into health and social capital is still in its infancy and much work remains to be done. Firstly there is an urgent need for further hard empirical evidence for a health-social capital link in order to move current health-social capital debates beyond the level of conjecture and hypothesis. Much work remains to be done developing measurement tools to facilitate the quest for such hard empirical evidence. There is a need for a two-pronged approach to the development of such tools and such evidence. On the one hand, there is the need for rapid 'top-down' quantitative investigation of existing data sources. Existing health-related survey data often contain items relating to issues such as trust of neighbours, perceived quality of the local area or involvement in community activities which serve as excellent interim measures (see Cooper *et al* 1999, Kawachi *et al* 1996). On the other hand there is an urgent need for micro-qualitative 'bottom up' studies of the forms that social capital takes in particular local communities. Both the Luton and Carletonville micro-qualitative studies referred to above highlight the urgent need for development and refinement of the concept if its relevance is to extend beyond the discourses of academics and politicians. Studies of this nature warn of the need to guard against simplistic and unproblematised assumptions. Thus for example: high levels of civic participation in strong local community networks are not necessarily beneficial for the health of a community. Furthermore it does not necessarily make sense to assume the possibility of cohesive community relationships in the multiply fragmented and mobile communities that characterise life in the early 21st century.

We have already pointed to Gillies' (1998) description of social capital as a descriptive construct rather than an explanatory theory. Levi (1996) has highlighted the poor

explanatory power of the construct of social capital in Putnam's 'home discipline' of political science. She argues that Putnam has, as yet, failed to explicate the mechanisms whereby high levels of involvement in voluntary associations and networks (and the allegedly associated relationships of trust, reciprocal help and support) lead to more effective local government. Ironically while this problem is such an acute one in Putnam's 'home discipline' of political science -- which seeks to link social capital to good government -- this might not be the case when we import the idea of social capital into the area of health promotion. Here a large research literature already provides a range of starting points for developing hypotheses about the pathways between community networks and relations on the one hand, and health on the other. Figure 1 above highlights a range of potential mechanisms at the individual, inter-individual, organisational, community and macro-social levels of analysis which provide a starting point for hypotheses regarding possible mediating mechanisms between health, community-level social capital and broader macro-social relations.

Much qualitative and quantitative work remains to be done exploring possible interactions between social capital and broader macro-social factors in perpetuating health inequalities as well as other forms of social exclusion associated with differences in socio-economic position, ethnicity and gender. Our understanding of the role played by social capital in perpetuating unequal power relations is still in its infancy.

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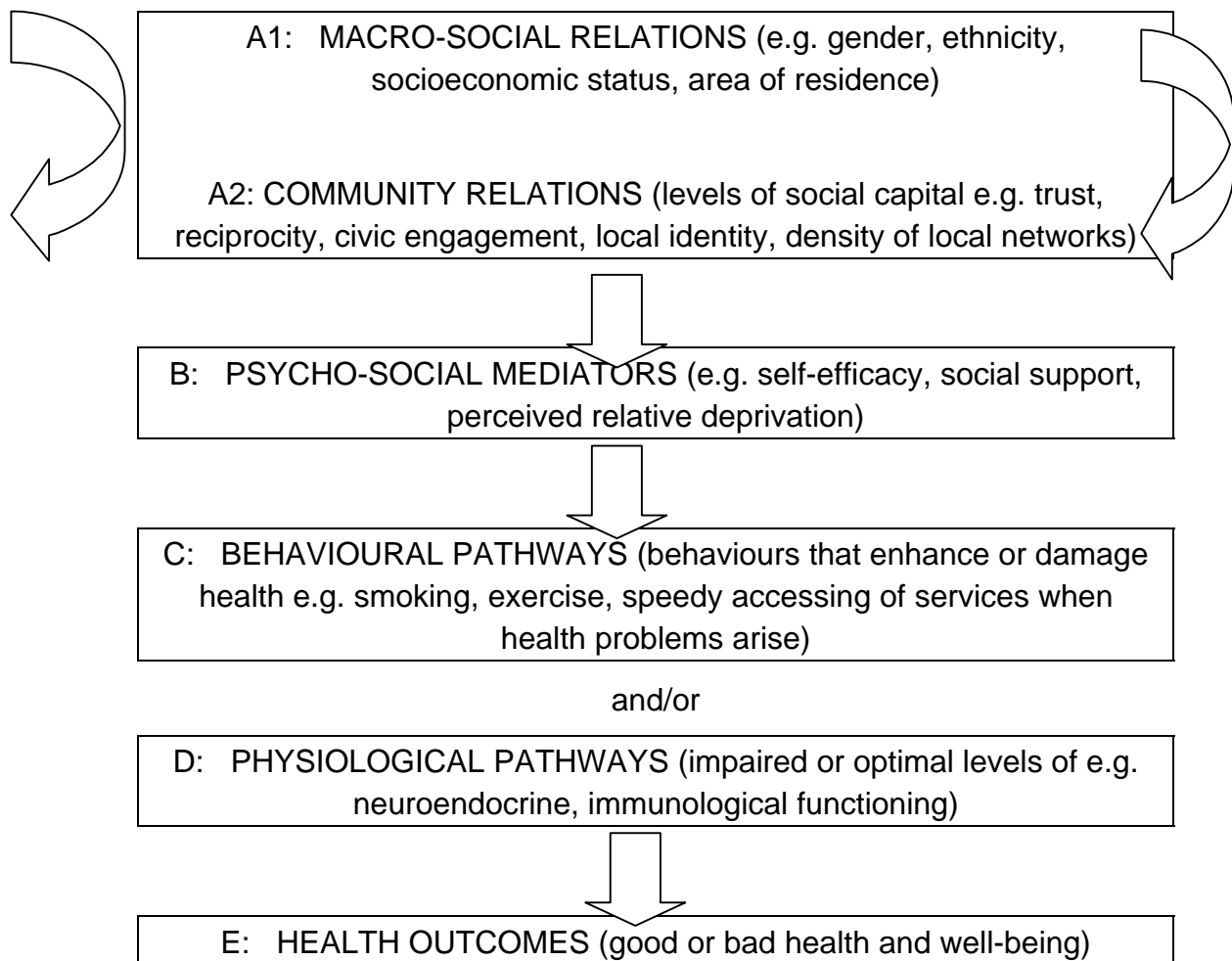
Figure 1: Pathways between social capital and health
(Campbell, Wood and Kelly, 1999 p. 28)