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The experience of social determinants of health within a Southern European Maltese culture

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ABSTRACT

This study contributes to international research on geographies of health and wellbeing in Mediterranean cultures. The paper draws upon evidence from qualitative research in three localities in Malta, a country where previous research on this topic is quite limited. Through in-depth interviews with people from some of the most disadvantaged and socially marginalised groups in Maltese society, this research illustrates how psychosocial health and wellbeing of the inhabitants within this Mediterranean region are strongly influenced by wider social determinants, particularly the powerful dynamics of social norms involving roles of extended family, traditional attitudes towards marriage as an institution, family honour, gender roles and religious beliefs and practices. This research explores how these social determinants of health within a Maltese context are complex and contingent on personal and local socio-geographical conditions, so that while for some individuals they are beneficial for health and wellbeing, for others the effects are detrimental. The discussion considers how to interpret the 'Mediterranean model' of social determinants of health in light of the experiences of this group of inhabitants.

1. Introduction

This paper examines how social and cultural processes operate as 'wider social determinants' of health (WHO, 2008) in parts of Malta and how they influence health of individuals. The 'wider social determinants' of particular interest in this paper include processes involving social norms linked to familial, economic, political and institutional structures, which are often beyond the individual's control (McKeown, 1979; Evans et al., 1994; Marmot and Wilkinson, 2006). These wider determinants are likely to operate variably across Maltese society, and this paper will focus on selected settings to show how their impacts on individual health are contingent on attributes of individuals and the places where they live. This paper therefore contributes to international research in health geography that demonstrates how wider social determinants are mediated by local neighbourhood conditions and may impact variably on different groups of people. It has been argued that health determinants can be interpreted as operating in a *relational* manner that depends on the variable interaction between diverse individual and environmental attributes in different temporal and spatial settings (Macintyre et al., 1993; Pickett and Pearl, 2001; Cummins et al., 2007; Curtis, 2010; Gattrell and Elliot, 2015).

A large body of theoretical and empirical research has focussed on the social determinants of health and neighbourhood processes within Northern European and North American contexts (Macintyre et al., 1993; Pickett and Pearl, 2001; Curtis, 2010; Gattrell and Elliot, 2015). The World Health Organisation defines the social determinants of health as 'the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life' (WHO, 2015 p.1). Moreover, social determinants are influenced by social norms; generally accepted behaviours, recognized by common customs, procedures and rules and form basis for arbitration in social relations (Baron, 2004). Such norms help to build social cohesion (Hechter and Opp, 2004), and may help to prevent deviant behaviour (Horne, 2004). Norms are encouraged by mechanisms including sense of guilt, and social penalties causing shame, exclusion and punishment, operating in the social networks to which people belong (Foley and Edwards, 1998; Leavitt and Saegert, 1990; Hammond and Axelrod, 2006). This paper is situated in the literature (summarised below) suggesting that important social determinants of health in Southern European ('Mediterranean') cultural contexts today may be distinctive because of the persistence of particular social and cultural processes prevailing in these societies that influence social norms.

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The attributes of what are referred to in the literature as 'Mediterranean' cultures have been explored in settings outside Southern Europe where migrant groups have 'reproduced' the kinds of social relationships found in their countries of origin. This literature tends to focus on how features of 'Mediterranean cultures may offer resilience to economic disadvantage. In North American multi-cultural societies, culturally specific social norms and behaviours originating from other societies are observed to buffer ill-health effects caused by poverty and deprivation. Literature emphasising the 'Mediterranean model' (e.g. Egolf et al., 1992; Gans, 1962) explain how Mediterranean cultural factors offer resilience to deprived circumstances. Italian migrants in the American village of Roseto were relatively resilient to ill-health effects of their materially deprived neighbourhoods and this was attributed to the social dynamics and strong bonds arising from familial social capital, social cohesion and social support (Egolf et al., 1992). Gans (1962) found that residents in a disadvantaged neighbourhood in Boston who retained their Italian culture enjoyed strong bonds and social structure. Thus, familial support networks in Mediterranean cultures are an important source of resilience to adversity (Gilliom, 2001).

A large international literature points to socioeconomic position and inequality as significant determinants of health and wellbeing. Inequality of socioeconomic status is related to psychosocial risk factors that affect health outcomes (Wilkinson, 1999, 2005; Wilkinson and Pickett, 2006). An unhealthy sense of disadvantage may be associated with perceived failure to achieve the socioeconomic norms expected for the group which one belongs to. However, research also suggests that processes determining social inequality in the Mediterranean region differ in some respects from those of Northern Europe (Viazzo, 2003). Viazzo (2003) overviews research on the 'Mediterranean model', since it was first proposed by Laslett (1972), and emphasises that in Southern Europe, nuptiality, household composition and the role of the family as a welfare agency differ from those observed today in Northern Europe and some other parts of the world. Other studies of 'Mediterranean' societies also show that economic wealth alone is not the only attribute influencing social rank, since individual social position is determined by a complex set of social norms, involving various factors including: kinship and family; honour reputation and moral respectability; culturally determined gender roles; and religious adherence (Campbell, 1966; Peristiany, 1966; Pitt-Rivers, 1966; Stirling, 1966; Davis, 1969; Cutileiro, 1971). We summarize here some of the literature on the links between these processes and wellbeing.

Although *the role of the family* is important for individual health and wellbeing in most societies, the concept, structure and function of the family varies across different cultures (Bigner, 1989). In the relatively small body of research on this question conducted in the Mediterranean region Fiorillo and Sabatini (2015) emphasise the importance of the extended family as an institution, operating across generations and over a broad family network (Kalmijn and Saraceno, 2008). Adult children provide more support to parents than those in Northern Europe (Daatland and Herlofson, 2003). A comparison of social factors protecting the wellbeing of adolescents living in Spain and England (Morgan et al., 2012) found that those in Spain depended more on direct family support. Ferrera (1996) identifies different types of welfare state, including the 'Southern European' model, influenced by Mediterranean social norms, including a particularly strong reliance on the family as a support mechanism (Tavora, 2012; Trifiletti, 1999). Women are expected to undertake family care rather than paid employment (Lewis et al., 2008). The role of the family is therefore especially important for the individual's health in this socio-cultural setting.

In a typical Mediterranean society, *honour* also emerges as an important factor in the social neighbourhood processes. Honour has been defined as '*...the value of a person in his eyes, but also in the eyes of his society. It is the estimation of his own worth, his claim to pride*' (Pitt-Rivers, 1966, p. 21).' Therefore, one's sense of honour is contingent upon the expected norms within the community one lives in and belongs to. The antithesis of honour may be shame, experienced by those who fall significantly short of the expectations of society. According to Peristiany (1966: p11): *'Honour and shame are the constant preoccupation of individuals in small scale, exclusive societies where face to face, personal, as opposed to anonymous, relations are of paramount importance and where the social personality of the actor is as significant as his office'*. A social process that may be seen as closely related to shame is stigma. Goffman (1963) argues that society is divided into two main categories: those deemed to be 'normal' and the 'deviants'. He defines stigma as a deeply discrediting characteristic that reduces the individual '*from a whole and usual person to a tainted, discounted one*' (Goffman, 1963, p.3). Indeed he argues that stigma can reduce the 'life chances' of people through discrimination followed by feelings of shame. Thus, for example, shame attributed to one person can result in stigmatisation of others in their social group (for example other family members). Major and O'Brien (2005) when examining the effects of stigma, found that it harms mental health, causing anxiety and depression and has effects on physical health such as coronary heart disease and stroke. In this study we examine the operation of concepts of honour, shame and stigma and show that these are frequently linked to social norms dictated by culturally determined gender roles and encouraged by religious institutions.

Regarding *gender roles*, men within a Mediterranean culture claim honour by developing an attitude of aggressive *machismo* (Basham, 1976), while honourable behaviour among women involves submission to male control with quiet modesty. This is complemented by the idea of '*marianismo*', drawn from the idea of Mary, the virgin mother of Jesus, as an ideal of female moral behaviour. Gil and Inoa Vazquez (1997) explain that '*marianismo*' is about sacred duty, self-sacrifice and chastity, as well as maternal values and as the ideal feminine traits (Stevens, 1973; Fisher, 1993). The role of religion is important in developing the notions of appropriate femininity and is related to the Roman Catholic faith. Other aspects of social norms associated with gender also can systematically empower men while disempowering women (Borrell et al., 2014). Therefore, if a woman fails to act according to these social norms and values, she is shamed and at risk of public disgrace which may have implications for psychosocial wellbeing and health related behaviours (Harrington, 1984). These social processes are considered important as health determinants in feminist research on gender in health geography (Kearns, 1995, 1997). Femininities are moulded differently within different countries, regions and local contexts (Massey and Jess, 1995). Gendered identities are constructed according to conditions in particular sites, spaces and networks within the locality (Laurie et al., 1999). Thus gender inequalities are for the most part socially produced and can potentially be ameliorated through changes in the gender order (Annandale and Hunt, 2000).

Several studies from outside Southern Europe (mainly from North America) suggest that *religious institutions* promote supportive social processes and networking, foster psychologically therapeutic practices that help to relieve stress and encourage healthy behaviours (Levin and Preston, 1987; Helliwell and Putnam, 2004; Koenig et al., 2001; Kim and Sobal, 2004; Ellison and Levin, 1998; Kim et al., 2008; Yeary et al., 2012). However, research also identifies aspects of the social processes in religious institutions that may produce more negative effects for some groups in the community (Smilde and May, 2010). It is found that religious organizations may be highly segregated, conservative and even racist and religious adherents may be less tolerant of others with different beliefs (Putnam and Campbell, 2010; Reimer and Park, 2001; Wilcox and Jelen, 1990). Some research from Italy and Spain has also explored how religion and religiosity relate to, for example, resistance to peer pressures encouraging alcohol use among adolescents (Cattelino et al., 2014), psychological health of those facing pressures as they care for sick or disabled relatives (Llancer et al., 2002;

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