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Social capital and health in Kenya: A multilevel analysis

John Musalia

Department of Sociology, Western Kentucky University, 1906 College Heights Blvd. #11057, Bowling Green, KY 42101, USA

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ABSTRACT

Despite the acknowledgment that social capital is an important predictor of good health and overall well being in wealthy countries, little empirical research has been conducted in developing countries, particularly in Africa, to examine this relationship. This study examines the association between cognitive (trust) and structural (membership in organization) social capital on health at both the individual and contextual levels. Health was measured using answers to a subjective question on physical health and anxiety/worry suffered by individuals within the last 30 days. This study utilized Afrobarometer data collected in Kenya in 2005 to examine this relationship using multilevel logistic statistical modeling.

Upon controlling for socioeconomic and demographic factors, social capital was found to be significantly associated with anxiety/worry and physical health in Kenya. Membership in organizations was associated with increased odds (OR = 1.34, 95%CI: 1.02–1.76) of physical health problems, while individual trust was associated with a 6% (OR = 0.94, 95%CI: 0.90–0.99) reduction in the likelihood of physical health problems. Conversely, generalized trust was associated with a 37% reduction in the odds (OR = 0.63, 95%CI: 0.40–0.99) of anxiety/worry, while individual trust was associated with a 5% reduction (OR = 0.95, 95%CI: 0.90–1.00) of anxiety/worry. With the exception of membership in an organization that exacerbates physical health, both individual level trust and generalized trust were associated with better health outcomes in Kenya. The availability of social organizations at the contextual level was associated with worsening anxiety/worry although the effect size was small. These results show that social capital, particularly trust, is a concept that can apply to different social and cultural contexts and can potentially be harnessed to improve health in settings that suffer from resource poverty.

1. Introduction

The potential impact of social capital on health has spawned an increasing number of studies in disparate disciplines such as sociology, economics, political science, and public health. These studies have linked social capital to a number of health and wellbeing outcomes (for reviews, see De Silva et al., 2005; Kawachi et al., 2008; Murayama et al., 2012; Uphoff et al., 2013). Despite the extensive literature, ambivalence remains on the conceptualization and measurement of the concept (Szreter and Woolcock, 2004). Nonetheless, research has consistently found a positive association between social capital and the health and general well being of individuals (Field, 2008; Helliwell and Putnam, 2004; Kawachi et al., 2007; Murayama et al., 2012; Subramanian et al., 2001).

As social capital involves relationships within the community, an unfortunate reality exists that countries with an underperforming health infrastructure are the least studied, although they are likely to derive the greatest benefit from harnessing the potential of social capital in improving their health. Moreover, these countries, particularly Africa, have a robust associational life. Kenya has a long a history of grassroots organizations used to mobilize resources to meet community needs. Harambee (meaning pull together) is an indigenous Kenyan motto used as a vehicle of mobilization involving collective efforts to meet needs for labor and pooling of other forms of resources, such as money, to undertake projects that benefit the community (Ngau, 1987). Harambee provides an example of how communities build social capital to meet both personal and public needs. Harambee forums are social gatherings that unite individuals thereby providing an avenue to cultivate civility, trust and generalized reciprocity (Fisher, 2001). This type of voluntary action increases the potential for establishing

E-mail address: John.musalia@wku.edu.

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and maintaining effective norms of generalized reciprocity likely to influence health and well being.

As the majority of social capital research has been undertaken in developed countries, a study of less developed countries may provide an interesting contrast to establish whether social capital operates in a similar manner to influence health in communities with different social structures. Less developed countries generally have rudimentary healthcare systems. As such, individuals often turn to friends and relatives to access essential resources to resolve health issues. An understanding of the association between social capital and health is critical particularly when is positive, because policy can enhance the benefits for the community and can advocate for complementary affordable interventions that are socially, culturally, and environmentally sustainable in addressing emerging health issues (Kunitz, 2004; Nobles and Frankenberg, 2009).

This research study targets Kenya, a resource poor country, and provides an opportunity to contrast it with those that have been conducted in wealthy countries. It is intended to fill the existing knowledge gap through an investigation of the utility of the concept of social capital in understanding the health behavior of an African country. First, the relationship is examined between social capital and health. Second, the study adopts a multilevel analysis to delineate individual and contextual influences of social capital on both anxiety/worry and physical health. Third, the study is theoretically driven in measuring the concept of social capital and, fourth, it applies to the entire population of Kenya.

1.1. Social capital

The central idea about social capital is that social networks are valuable assets that individual's can deploy to benefit themselves or their community. Networks enable social cohesion because they enable cooperation with one another, whether they know the others in the network or not. The ensuing cohesion and cooperation enable individuals or communities to have better lives because they feel safe, which in turn improves health outcomes (Field, 2008).

Therefore, social capital is defined as the resources derived by individuals as members of a community. The resources are constituted and disbursed through membership in social networks and features of social organizations that include norms and social trust (Portes, 1998, 2000). Social capital consists of cognitive and structural the dimensions (Harpham et al., 2002; Yip et al., 2007). Cognitive aspects of social capital manifest in the form of attitudes such as trust in others and reciprocity among individuals. Structural social capital entails a diverse set of social ties with the capacity to provide access to various resources. Indicators of structural social capital include size (number of social ties and organizations), density (frequency and reciprocity of contacts), and diversity (the social demographic makeup) (Ferlander, 2007; Mitchell and Bossert, 2007; Yip et al., 2007). This study is guided by the cognitive/structural approach to social capital, as this approach makes it possible to incorporate both individual and contextual factors in determining health status of Kenyans (Ferlander, 2007; Mitchell and Bossert, 2007; Yip et al., 2007).

A further development distinguishes two categories of social capital: bonding and bridging (Putnam, 2000; Szreter and Woolcock, 2004; Woolcock, 2001). These concepts are similar to Granovetter (1973) “strong ties” and “weak ties” respectively. Bonding social capital is based upon family and close friends and generally is inward looking and involves those who share particular social outlooks or characteristics (Granovetter, 1973; Lin, 2002; Putnam, 2000; Szreter and Woolcock, 2004; Woolcock, 2001). The issue with bonding social capital is interacting with individuals who basically share the same worldview about health, which makes difficult to change behavior (Fischer, 1982; Granovetter, 1973; Marsden, 1987). As such, this type of networks maintains and enforces the normative structure of the community, which can be harmful to health.

Conversely, bridging social capital consists of those who are different in their social outlook. It generates broader identities and has a much wider reciprocity. Bridging social capital is beneficial, as it provides a different worldview and may yield more information, as well as more confidence in decision making (Granovetter, 1973; Lin, 2002; Putnam, 2000; Szreter and Woolcock, 2004; Woolcock, 2001). Interacting with diverse people likely increases the chances of encountering new and non-redundant information and opinions that might indicate a need to reevaluate an individual's health status.

1.2. Social capital and health

Generally, strong evidence exists suggesting that individuals with more social capital likely have better health and live longer (Field, 2008; Mohnen et al., 2011; Mohnen et al., 2014; Prins et al., 2012; Rözer et al., 2016). Further, evidence shows that those with strong networks have mortality rates half or one third higher than those with weak ties (Kawachi et al., 1997). At the aggregate level, Putnam (2000, 1993) established that social capital positively influences economic and political systems in addition to health behavior. Putnam (1993) attributed the decline of social capital to the many problems experienced by the US. While he found that membership to civic organizations enhances particularized and generalized trust among and between community members in Italy, Herreros (2004), using the World Values Surveys, found membership in associations do not lead to social capital and material wealth. Rather, social trust is positively related to church attendance, education, and income level.

While emphasis is on the positive aspects of social capital, there is a dark side. A review of evidence revealed that, while dense informal networks (bonding/strong ties) are positive for health, this is not necessarily the case in poor communities. Studies in poor communities have shown that the burden of obligations arising from strong bonds is a source of anxiety and distress, particularly among women who usually are the caregivers. Moreover, tightknit communities have been found to exert undue pressure on members to conform to cultural standards that imperil personal freedoms (Ferlander, 2007; LeClere et al., 1998; Myroniuk and Anglewicz, 2015; Story, 2013).

A major criticism of social capital and health studies is that the cause and effect of these studies are similar to the extent that a strong relationship between the two is tautological (Portes, 1998). Despite the shortcomings of the concept of social capital, it retains utility particularly in the context of helping to understand health conditions in developing countries. This study examines social capital from both individual and structural levels, as health is affected by a complex set of factors that could operate at the individual (socioeconomic, demographic, and lifestyle) and structural levels (context, social, cultural, and environmental). Past research has shown that the environment impacts health, although it varies among and within communities (Berkman and Kawachi, 2000; Tampubolon et al., 2013). Community level differences in health may be due to limited opportunity structure and infrastructural resources, as well as to customs, culture, history, degree of integration, social mobility, and norms and values (Berkman and Kawachi, 2000). Thus, social capital provides a theoretical handle with which to investigate the effect of these individual and contextual factors on health.

While the effects of social capital on health have been extensively documented in developed countries, few studies have established this relationship, particularly in Africa. Results from the