



What constitutes a health-enabling neighborhood? A grounded theory situational analysis addressing the significance of social capital and gender



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ABSTRACT

Variations in health between neighborhoods are well known and the conceptualization of social capital has contributed to an understanding of how contextual factors influence these differences. Studies show positive health-effects from living in high social capital areas, at least for some population sub-groups. The aim of this qualitative study was to understand what constitutes a 'health-enabling' neighborhood. It follows up results from a social capital survey in northern Sweden indicating that the health effects of living in a high social capital neighborhood is gendered in favor of women. A grounded theory situational analysis of eight focus group discussions – four with men and four with women – illustrated similar and different positions on how neighborhood characteristics influence health. A neighborhood, where people say hi to each other (“hi-factor”) and where support between neighbors exist, were factors perceived as positive for health by all, as was a good location, neighborhood greenness and proximity to essential arenas. Women perceived freedom from demands, feeling safe and city life as additional health enabling factors. For men freedom to do what you want, a sense of belonging, and countryside life were important. To have burdensome neighbors, physical disturbances and a densely living environment were perceived as negative for health in both groups while demands for a well styled home and feeling unsafe were perceived as negative for health among women. Neighborhood social capital, together with other elements in the living environment, has fundamental influence on people's perceived health. Our findings do not confirm that social capital is more important for women than for men but that distinctive form of social capital differ in impact. Investing in physical interventions, such as planning for meeting places, constructing attractive green areas, and making neighborhoods walking-friendly, may increase human interactions that is instrumental for social capital and is likely to have health promoting effects for all.

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Introduction

How does our living environment influence health? Variations in health between people living in small areas or neighborhoods have consistently been observed for at least 150 years (Macintyre & Ellaway, 2003). Despite these observations, until recently there has been little interest in finding contextual explanations to area variations in health. Instead, these geographical health inequalities have been explained by differences in the kind of people who live in

these places, i.e., compositional explanations (Macintyre & Ellaway, 2003). Unhealthy places have been viewed as a result of “unhealthy inhabitants”, rather than a product of an unhealthy physical and social living environment to which people are exposed. The general lack of interest in contextual explanations to health inequalities between areas mirrors a focus on individual risk factors seen within public health and epidemiology since World War II (Lomas, 1998; Macintyre & Ellaway, 2003).

However, during the last decades there has been a renewed interest in the social determinants of health (SDH); the social contexts in where people are “born, grow, work and age” as defined by the WHO Commission on SDH (CSDH, 2008). According to Macintyre, Ellaway, and Cummins (2002), neighborhood environments may influence health through the material infrastructure

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(e.g., quality of air and water, safe playgrounds and recreations areas, welfare services, and transportation) as well as through the *collective social functioning* of the neighborhood (e.g., culture and norms, community integration, community support and the reputation of an area).

The growing research field on social capital and health has further fueled a reintroduction of contextual influences on health. Social capital has multiple meanings and is treated in (at least) two distinct ways in health research (Kawachi, Subramanian, & Kim, 2008). Social capital can be seen as an *individual asset* described as “the ability of actors to secure benefits by virtue of membership in social networks or other social structures” (Portes, 1998, p.6). Individual access to social capital may promote health by means of access to social support, health information and/or health services (Eriksson, 2010). Social capital can also be viewed as a *collective feature* that characterizes areas or neighborhoods by levels of social participation, trust and reciprocity norms (Kawachi & Berkman, 2000; Putnam, 1993, 2000; Szreter & Woolcock, 2004). Putnam (1993) describes social capital as a collective attribute with “features of social organizations, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions (p.167)”.

Collective social capital is believed to influence health by enabling trust and collective action (Eriksson, 2010). A trusting environment is assumed to support health-enhancing behaviors, and ease diffusion of health information and healthy norms (Kim, Subramanian, & Kawachi, 2008). It may also facilitate “collective efficacy” in that community members increase control over their lives and their living environment (Campbell, 2000). This “social cohesion approach” to social capital clearly relates to the debate on contextual influences on health. The Ottawa Charter (WHO, 1986) underlined the importance of “health supportive environments” and “community actions” for health promotion; i.e., environments where people take care of each other and their environment, and set their own priorities and plans to achieve better health. An understanding of what constitutes a health-enabling environment is still to be elucidated (Campbell, 2000). However, the concept of collective social capital has become an attractive potential “conceptual tool” for understanding its components by a focus on neighborhood characteristics such as trust, mutual support and local involvement (Campbell & Gillies, 2001; Campbell & Jovchelovitch, 2000).

Studies from several countries, such as the US (Kim, Subramanian, & Kawachi, 2006), Sweden (Engström, Mattsson, Järleborg, & Hallqvist, 2008; Eriksson, Ng, Weinehall, & Emmelin, 2011; Sundquist & Yang, 2007), UK (Snelgrove, Pikhart, & Stafford, 2009) and the Netherlands (Mohnen, Groenewegen, Völker, & Flap, 2011), show a positive effect on health from living in a high social capital area. However, studies also indicate that these positive associations are not valid for all population sub-groups, but differ by ethnicity (Engström et al., 2008; Kim et al., 2006) and gender (Eriksson et al., 2011; Kavanagh, Bentley, Turrell, Broom, & Subramanian, 2006; Stafford, Cummins, Macintyre, Ellaway, & Marmot, 2005).

In a previous cross-sectional study from the Umeå region of Sweden, we investigated the association between collective social capital and self-rated health for men and women (Eriksson et al., 2011). We used two different measures of collective social capital; one conventional (using aggregated measures of trust and participation), and one neighborhood-related (using aggregated measures of neighborhood perceptions such as whether neighbors talk to each other, care for each other, are willing to help each other, and whether one is expected to be involved in issues that concern the neighborhood). The results showed a positive effect of living in a high social capital neighborhood on health for women, but not men. When controlling for socio-demographic factors and access to

individual social capital, this association was significant for women when the neighborhood-related measure was applied. A place-related measure might thus provide a clearer picture of the health effects of collective social capital and health as Poortinga (2006) also suggests. In line with other studies (Kavanagh et al., 2006; Stafford et al., 2005), we found the health effects of living in a high social capital neighborhood might be gender-related in favor of women. If this is true, one might discuss why women would receive greater benefit from living in a neighborhood where it is common that neighbors talk to each other and care for and support each other, and where one is expected to be involved in issues that concern the neighborhood. One hypothesis is that the benefit is due to actual time spent in the living environment; women may spend more time there due to gendered expectations that they are mainly responsible for domestic life. Another hypothesis is that the living environment is equally important for men’s health, but by factors not related to neighborhood-specific social capital. Further, Stephens (2008) in her qualitative study from New Zealand found that social connections and social capital are not necessarily located in neighborhoods, but spread in the broader social environment. However, there might also be a gender pattern in the importance of geographically close versus more distant social connections. However, in order to come up with new and unexplored explanations for possible gender-related health effects of neighborhood social capital, there is a need for additional in-depth qualitative studies. These findings may shed new light on how neighborhood social capital, along with other aspects of the living environment, influences health for men and women (Dudwick, Kathleen, Nyhan Jones, & Woolcock, 2006; Harpham, Grant, & Thomas, 2002).

In this study, we sought to qualitatively follow-up the gendered results from the Umeå region cross-sectional survey mentioned above. Our overall aim was to contribute to an understanding of what constitutes a ‘health-enabling’ living environment. We specifically wanted to explore how social capital and other aspects of the neighborhood may influence health for men and women.

Methods

Overall study design

This is a grounded theory situational analysis (Clarke, 2005) that builds on data from focus group discussions (FGD) as well as memos and logs made by the researchers. Clarke’s development of grounded theory builds further on Strauss’s pragmatism, as opposed to Glaser’s traditional or classic grounded theory (Bryant & Charmaz, 2007). Blumer (1969), cited in Clarke (2005), recognizes the use of sensitizing concepts to indicate tracks to follow, without allowing these concepts to dominate or steer the analysis. Focus group discussions were the main source of information since they are a good way to capture a broad range of aspects of how people think and reason about a focused theme, i.e., the living environment and its relationship to health (Barbour & Kitzinger, 1999). We used the collective components of social capital, i.e., networks, reciprocity norms, trust, and collective efficacy as sensitizing concepts to design the discussion guide, to develop the statements used in the focus group discussions, as well as to analyze the data. The primary focus of the analysis was the ‘health-enabling environment’ and situational and positional analytical maps were developed to understand the most salient features (Clarke, 2005).

The study setting

The study was conducted in the municipality of Umeå, which also formed the basis for the cross-sectional survey referred to

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