# Contents

*Assessing people's perceptions of their neighbourhood and community involvement (Part 1)*

# Project Team

**Alison Walker**
GHS Project Manager
D1/19
Office for National Statistics
1 Drummond Gate
London
SW1V 2QQ
Tel: 020 7533 5303
email: alison.walker@ons.gov.uk

**Melissa Coulthard**
Assistant Social Survey Officer
D1/19
Office For National Statistics
1 Drummond Gate
London
SW1V 2QQ
Tel: 020 7533 5422
email: melissa.coulthard@ons.gov.uk

**Antony Morgan**
Head of Research and Information
Health Development Agency
Trevelyan House
30 Great Peter Street
London
SW1P 2HW
Tel: 020 7413 1895
Fax: 020 7413 2051
email: antony.morgan@hda-online.org.uk

**Caroline Mulvihill**
Research & Development Specialist
Health Development Agency
Trevelyan House
30 Great Peter Street
London
SW1P 2HW
Tel: 020 7413 1836
Fax: 020 7413 2051
email: caroline.mulvihill@hda-online.org.uk

# Introduction and background

## Introduction

This guide has been produced as a practical document to support the growing number of people researching the topic of social capital and social support. The guide is based on a module of questions developed for the General Household Survey (GHS) 2000/2001, and is part of a larger programme of research commissioned by the Health Development Agency to investigate the links between social capital and health.

Data from the 2000/2001 GHS will be used to develop a set of new national indicators relating to the social environment within which the people of Britain live. This document is intended to encourage the collection of a standard set of information on this topic which will allow comparisons to be made between different local studies of social capital and corresponding national indicators. This question set can be used in its entirety, or in parts, to collect data on issues relating to people's views about their local area, civic engagement, reciprocity, local trust, and people's social networks and social support.

Whilst the original context for the research that led to this guide had a health focus, it is hoped that this guide will be useful to a wide spectrum of professionals engaged locally in regeneration, community development and neighbourhood renewal initiatives.

The guide provides detailed information on how to collect information from surveys, and will be most useful to researchers interested in capturing attitudinal data relevant to the measurement of social capital in neighbourhoods.

The publication of this guide is timely, as the report of the Policy Action Team (PAT) 18 (Cabinet Office, 2000a,b) recommends that a set of standard neighbourhood statistics should be pulled together annually, and there should be leadership at national level to identify what these should be. In particular, the PAT 18 report identifies a lack of attitudinal data available for assessing change in deprived communities. This module goes some way towards filling that gap by highlighting ways in which to capture through surveys what residents think of their neighbourhoods.

## Background

The Acheson report on inequalities in health (Acheson *et al*., 1998) recognised that the solutions to major public health problems such as heart disease, cancers, mental health and accidents are complex. The report summarised the substantial evidence that now exists about the importance of the social, economic and environmental determinants of a range of health outcomes, and made a range of recommendations for future policy and strategy development in this country.

Many of these recommendations are now reflected in the wide range of policy initiatives set up by the government to tackle health inequalities, and are outlined in several documents from the Department of Health (DOH, 1999, 2000) and the *National Strategy for Neighbourhood Renewal* (Cabinet Office, 2000).

Recent evidence suggests that social approaches to the organisation and delivery of public health may have considerable potential for health improvement (Gillies, 1998), particularly for those who suffer most disadvantage in society. The evidence base for moving forward in this field is, however, somewhat limited.

The concept of social capital is a relatively new addition to the health field, but has been put forward as one coherent construct that will allow us to progress the debate about the general importance of social approaches to public health. The interest in social capital is typically traced to the work of three main authors: Pierre Bourdieu, James Coleman and Robert Putnam. Each of these authors has defined social capital in different ways.

Bourdieu (1986) defines social capital in terms of social networks and connections. He posits that an individual's contacts with networks result in an accumulation of exchanges, obligations and shared identities that, in turn, provide potential support and access to sources.

Coleman (1988) emphasises the idea that social capital is a resource of social relations between families and communities.

Putnam (1993, 1995) defines social capital as a key characteristic of communities. In his definition, social capital extends beyond being a resource to include people's sense of belonging to their community, community cooperation, reciprocity and trust, and positive attitudes to community institutions that include participation in community activities or civic engagement. It is Putnam's definition that has been most referred to in the health field. While the evidence for links between social capital and health are sparse, Putnam's study of governance and wealth production in Italy found an association between life expectancy and infant mortality.



Despite the lack of clarity about its definition, and the limited evidence of the links between social capital and health, the concept remains an important one and is already being used to inform the development of many community-based projects (HEA, 1999). As Hawe and Shiell (2000) point out, the constructs underlying social capital explicitly recognise that individual health and health behaviour are influenced by social structures. Thus the constructs of social capital have the potential to underpin the development of new theoretical frameworks for understanding health and health behaviour in individuals within a broader and more complex social context.

Gillies (1998) argues that, although not a theory with explanatory power, social capital allows us to examine the process whereby formal and informal social connections operating through a range of different types of networks can act as a buffer against the worst effects of deprivation. It reinforces partnership and participatory approaches to sustainable development, and challenges us to produce a new set of social indicators to capture the benefits of community-based initiatives designed to promote health.

The key indicators of social capital include social relationships, formal and informal social networks, group membership, trust, reciprocity, and community and civic engagement. These indicators offer a new way of thinking about how we develop healthy communities.

Cooper and colleagues, in an analysis of the links between social capital and health (Cooper *et al*., 1999), recommended that future health surveys should include measures of social capital. They comment that quantitative indicators of social capital based on surveys of individuals complement existing aggregate-level analyses of social capital, and allow the distribution of social capital to be analysed based on large and representative samples of the population.

It is with this background that the former Health Education Authority (now the Health Development Agency) set up a programme of research to further explore the relationship between social capital and health, and to seek ways of measuring it.

The GHS social capital module forms part of this larger programme of work. While research relating to both the measurement of social capital and its links to health is ongoing, this document provides a state-of-the-art guide for other researchers on how to capture the levels of social capital that exist in local communities. Further details of other projects in this programme can be found in Appendix 3.

# Background to the social capital module of the General Household Survey

The University of Surrey and the Social Survey Division (SSD) of the Office for National Statistics were commissioned by the Health Development Agency to design a social capital module for inclusion in the 2000/2001 GHS.

## Background to the General Household Survey

The GHS is a multi-purpose, continuous survey, conducted on an annual basis, which collects information on a range of topics from people living in private households in Great Britain. It includes a range of measures of health and health-related behaviours such as smoking and drinking. It also includes detailed information on related topics such as family history, qualifications, economic activity, benefits, income, housing characteristics, and ownership of consumer durables and vehicles. This is an ideal survey in which to include the social capital module, because of its content and large sample size. The report based on the 1998[1] GHS, *Living in Britain*, is available in hard copy (Bridgwood *et al*., 2000), and can be found on the National Statistics website[2]. The report contains the results of the survey, as well as background information and details of the methodology used. A series of articles in Issue No. 46 (2000) of the *Survey Methodology Bulletin*, a journal published by SSD, give some background information to the development of the 2000/2001 GHS.

## The social capital module

The questions for this module were designed with the explicit purpose of measuring social capital and social support. They form part of a well established national survey, and provide a national reference point for those researching this topic at a local level.

This guide presents the full question set developed for the social capital module (page 8), together with notes on the background and application of individual questions, where appropriate. The notes are based on the development work which included cognitive testing (interviews investigating respondents' perceptions of words and phrases) and piloting. The preliminary social capital module was largely based on questions from previous national surveys[3]. Appendix 2 shows the surveys from which the social capital module questions were derived. Additional questions were formulated to cover aspects of social capital not previously explored in UK surveys – such as perceptions of civic trust, social trust, and action to resolve local problems. The cognitive interviewing was carried out by Surrey Social and Market Research during August 1999, through 31 in-depth interviews which looked at people's understanding of the aspects of social capital, as well as other key concepts. The report of this cognitive testing forms a basis for this guide (Earthy *et al*., 1999). The final version of the questionnaire was then piloted by SSD in September 1999, and was further revised. Finally the whole GHS questionnaire, including the social capital module, underwent a full 'dress rehearsal' in November 1999. The field work period for the GHS containing the social capital module was April 2000 to March 2001.

The questions are ordered so the respondent is first asked about the local area (the most distant level), followed by questions about the neighbourhood (an interim level), then finally questions at a personal level. Not only is this a logical structure, but it was also found that respondents appeared more at ease when answering the more sensitive questions last. Definitions of local area and neighbourhood were based on the results of the cognitive analysis.

The social capital module takes approximately 10 to 15 minutes to complete, and interviewers found that the questions were very well received by respondents. When trying to persuade people to take part in the GHS, interviewers found the social capital module to be a good 'selling point'; people like to give their opinion on their local area. The topic is introduced as 'finding out people's views of and involvement in their area and neighbourhood.' In the GHS, the social capital module was used with adults aged 16 or over.

---

Notes

1. The GHS was not carried out in 1999.
2. The National Statistics website is www.statistic.gov.uk. *Living in Britain* can be found in: bookshelf, compendia and references.
3. These included the HEA Health and Lifestyles Survey, the 1998 Health Education and Monitoring Survey, the British Household Panel Survey, and pilot questions for the Health Survey for England 2000.

# Conducting your own survey

## What aspects of social capital do you want to research?

The GHS social capital module investigates five areas of social capital. Three relate to the local community (views about the local area, civic engagement, reciprocity and local trust); and two relate to individuals themselves (social networks, social support). You may choose to investigate some, rather than all of these areas. The following section, 'The questionnaire', shows which specific questions relate to which topic.



## What additional questions will need to be asked?

The social capital questions presented in the following section form a module taken from the main GHS questionnaire, which collects data on a large number of topics including the socio-economic characteristics of the respondents. If you are conducting your own survey you will need to include additional questions to establish characteristics such as age, sex, household size, family type and employment status. Further information on these questions can be found on the ONS website (www.statistics.gov.uk) in the Living in Britain section.

## Method of data collection

The GHS is carried out through face-to-face interviewing, using computer-assisted personal interviewing, run on *BLAISE* software. Further information on the methodology of the GHS can be found in the report *Living in Britain* (Bridgwood *et al*., 2000). The question set can easily be used as an interviewer-administered paper questionnaire or for self completion, although in the latter case the format for questions and signposting may need to be adjusted.

## Face-to-face interviews

The following section gives background information on each question and advice on how to code answers, much of which will be useful for the interviewer, and for providing notes to accompany a self-completion document. It is important that interviewers know how to ask the questions, so that different individuals ask the same question in the same way. This reduces interviewer bias, which occurs if the presence of the interviewer affects the answers given by the respondent. Nearly all the questions within the social capital module are opinion questions. These questions are indicated by an asterisk [*] in the questionnaire. Within the SSD there are strict interviewer guidelines on how these types of questions should be asked. The question should be asked exactly as it appears. If the respondent wants the question explained, the interviewer should say that it means what the respondent thinks it means, and should repeat the question once, as it is written. Interviewers should not try to probe 'don't know' or unsatisfactory answers. Opinions of others present during the interview should be discouraged.

Different techniques are used for asking the questions. In some cases the interviewer reads out the answer categories (called a running prompt); in others the respondent selects an answer from a prompt card.

A glossary of research terms is listed in Appendix 3.

## Analysing the data

This document gives a brief outline of the way the data can be analysed, giving examples from other surveys. A second booklet in this series will give a detailed account of the way in which the data from the GHS module have been grouped and analysed.

# The questionnaire

*Including the full question set, with notes*

This section presents the complete set of questions from the GHS social capital module. The questions are presented in the order in which they appear in the module. Although they are mainly grouped within the five main topics, there was some adjustment to ease the flow of the interview. The table below shows which questions relate to which topic.

## General notes about the questions

Additional information is given for most questions, and can be found in a shaded box following the relevant question. This includes remarks about the development of the question, notes for interviewers, and other comments on use.

The following conventions apply:

- Within the questions, words in capital letters are instructions to the interviewer.
- If a section of the question is in brackets then it is optional. It is up to the interviewer to judge whether it is appropriate to ask.
- The asterisk [*] indicates an opinion question.
- Variable names as used in the GHS module are shown by each question number. These are included for two reasons. The variable names uniquely identify the GHS social capital data to be stored in the data archive; data will be available from the end of 2001.[1] It may also be useful for researchers who wish to compare local data with the GHS data if they use equivalent variable names.

All the show cards are listed in Appendix 4.



Notes

1. The reference data archive can be found at The Data Archive, University of Essex, Wivenhoe Park, Colchester, Essex CO4 3SQ. Tel: 01206 872 001, Fax: 01206 872 003, email: archive@essex .ac.uk.

*The five main topics and related questions*

| Topic | Question numbers |
|---|---|
| *View of local area*<br>This topic looks at the physical environment in which people live, the facilities in their area and whether they feel safe in the area. People's feelings about their physical environment can relate to each of the other aspects of social capital. | 1–17, 24–32, 34 |
| *Civic engagement*<br>This looks at people's role in their community, and whether they feel they can influence events within the community. Indicators of civic engagement and trust of civil institutions and processes are central to Putnam's understanding of social capital. It is measuring the amount of self-empowerment and control that people think they have, and their involvement with the community. | 18–23, 33 |
| *Reciprocity and local trust*<br>This section looks at how many local people respondents know and trust, and whether people would do favours for them, or *vice versa*. Trust of the stranger is a central dimension of Putnam's concept of social capital. | 35–39 |
| *Social networks*<br>This section looks at how often respondents see or speak to relatives, friends or neighbours, and how many close friends or relatives live nearby. Social networks are seen as an important aspect of social capital, as the number and types of exchanges between people within the network, and shared identities that develop, can influence the amount of support an individual has, as well as giving access to other sources of help. | 40–46 |
| *Social support*<br>This section looks at how many people the respondent could turn to if they needed help – ranging from practical to financial to emotional support. This section also asks who they would turn to for help. The degree of individual support a person has can influence health outcomes and health behaviour. | 47–54 |

## The questions on social capital

### *Questions 1–17 examine 'view of local area'*

This topic looks at the physical environment in which people live, the facilities in their area, and whether they feel safe in the area. People's feelings about their physical environment can relate to each of the other aspects of social capital.

***1**. AskNow*
*IS THIS SECTION BEING ASKED NOW OR LATER*

'AskNow' allows the interviewer to ask this section now or later. This is useful in the GHS as only one person is asked the social capital module, whereas concurrent interviewing occurs in all other sections. It may therefore be more convenient for this section to be left to the end. In a 'stand-alone' survey this will not be required.

***2**. Areaintr*
*Now I would like to ask you some questions about your local area. (By area I mean within about a 15–20 minute walk or a 5–10 minute drive from your home.)*

Cognitive testing found that this definition of an area was the one that respondents could closely relate to, in terms of easy access to local shops and facilities. A car-based definition caters for those who rarely walk, as well as allowing for variations in walking speeds. The area that respondents define as their local area may be unevenly shaped. Pilot interviewers reported that this definition of area worked well in towns, but not in rural areas. The definition is therefore in brackets, indicating that it should be read out at the interviewer's discretion. It should always be read out in urban areas, but within rural areas the definition may seem inappropriate. The interviewer should refer back to this definition of area as appropriate. It should be noted that although social capital is mainly defined as an 'area' classification, this module collects data at an individual level. The pilot found that some respondents living in the same area used different definitions of the area, and had different opinions about their neighbourhood. This is acceptable, as the questions are based on opinion, and a paragraph was included in the interviewers' instructions to explain this.

***3**. Arealive*
*How long have you lived in this area?*
*CODE YEARS*
*IF LESS THAN 1 CODE AS 0*
*0..97*

Question 3 is designed to find out how long the respondent has lived in the area, as defined in the preamble. So if someone has lived at their current address for 5 years, but previously lived two streets away for 3 years, they are coded as 8 years. If the answer is less than 1 year, than they are coded as 0.

*Ask if have lived in the area for less than a year*
*(Arealive = 0)*

***4**. Areamth*
*How many months have you lived in this area?*
*0..11*

Question 4 is only asked of those who have lived in the area for less than a year.

***5**. Enjyliv*
*[*] Would you say this is an area you enjoy living in?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know* | *3* |

The following questions (Q6–13) ask about the facilities in the local area. The answer categories shown on the card include 'don't know or have no experience', which is usually excluded as an explicit response. It was felt it was important to include as some respondents would genuinely have no idea, for example someone without children may not know about the facilities provided for young people.

Many of the questions below were not originally included, but were added as they were mentioned by respondents during the cognitive testing. For example those on leisure facilities and rubbish collection.

The original response categories asked people to rate services compared with what they would 'expect' (e.g. 'better than expected'). However, respondents found these questions hard to answer, and the responses they gave depended on whether they had low or high expectations of the services.

Appendix 2 lists the show cards.

***6**. Locserv*
*[*] Thinking generally about what you expect of local services, how would you rate the following:*

***7**. Leisyou*
*[*] Social & leisure facilities for people like yourself*
*SHOW CARD A*

| | |
|---|---|
| *Very Good* | *1* |
| *Good* | *2* |
| *Average* | *3* |
| *Poor* | *4* |
| *Very Poor* | *5* |
| *Don't know or have had no experience* | *6* |

In Q7 the emphasis is on the social and leisure services the respondent wishes to use. This question originally referred only to leisure facilities, which respondents took to mean sporting amenities only. The question was revised by using the term 'social and leisure facilities'.

Where younger respondents are being asked these questions, Q9 on facilities for teenagers may seem repetitious, but will give information about how teenagers and older respondents rate more general local facilities, as well as those facilities specifically designed for young people.

***8**. Leiskids*
*[*] Facilities for young children up to the age of 12*
*SHOW CARD A*

***9**. Leisteen [*] Facilities for teenagers (aged 13 to 17)*
*SHOW CARD A*

Q8 and Q9 were originally one question asked about young children, without specifying an age range. However, respondents commented on facilities for children in a range of ages, and differentiated the quality of services for different age groups. For this reason the question was split into two.

***10**. Bins*
*[*] Rubbish collection*
*SHOW CARD A*

***11**. LocHlth*
*[*] Local health services (e.g. your GP or the local hospital)*
*SHOW CARD A*

A hospital should be considered local if it serves the local area, even if it is not physically within a 15–20 minute walk or a 5–10 minute drive.

If a respondent has difficulty in answering the question because they have differing views on their GP and on their hospital, the interviewer can refer them back to the preamble to these questions which asks what they think 'generally' of local services.

***12**. Schools*
*[*] Local schools, colleges and adult education*
*SHOW CARD A*



This question originally asked about 'education service', but the pilot interview found that respondents were unsure what the term meant. Universities are not of interest because they are not considered 'local' in the same way as schools or colleges.

***13**. Police*
*[*] Local police service*
*SHOW CARD A*

***14**. Transprt*
*What is your main form of transport?*

| | |
|---|---|
| *Car/motorcycle/moped* | *1* |
| *Public transport (buses and trains)* | *2* |
| *Cycling* | *3* |
| *Walking* | *4* |
| *Other* | *5* |
| *Never goes out* | *6* |

The cognitive interviewing found that respondents felt transport was crucial to the quality and quantity of their social networks, and therefore it was considered important to include a question on the form of transport that is predominantly used. The ordering of this question (before the public transport question) also gives some indication of how qualified the respondent is to judge the efficiency of public transport in terms of their reliance on it.

This question is trying to obtain the *main* form of transport used by the respondent.If respondents ask for a reference period, the interviewer should suggest 'in a typical week'.

The code 'car/motorcycle/moped' includes lifts from other people, including lifts from ring-and-ride schemes, and taxis. The code 'public transport (buses and trains)' includes trams and underground trains.

***15**. Loctrans*

*[*] Would you say this area has good local transport for where you want to get to?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know* | *3* |

Respondents often felt that public transport was good if you wanted to go to certain specific destinations, but not so good for other destinations. The question was thus designed to accommodate varied responses.

***16**. Walkday*

*[*] How safe do you feel walking alone in this area during daytime?*

*Do you feel …*

*RUNNING PROMPT*

| | |
|---|---|
| *Very safe* | *1* |
| *Fairly safe* | *2* |
| *A bit unsafe* | *3* |
| *Very unsafe* | *4* |
| *Or do you never go out alone during daytime?* | *5* |

***17**. Walkdark*

*[*] How safe do you feel walking alone in this area after dark?*

*Do you feel …*

*RUNNING PROMPT*

| | |
|---|---|
| *Very safe* | *1* |
| *Fairly safe* | *2* |
| *A bit unsafe* | *3* |
| *Very unsafe* | *4* |
| *Or do you never go out alone after dark?* | *5* |

Question testing showed that respondents had a clear understanding of what was meant by 'safe': they understood it as safety from physical attacks.

## *Questions 18–23 examine 'civic engagement'*

Indicators of civic engagement and trust of civic institutions and processes are central to Putnam's understanding of social capital. Cognitive research found that these concepts were the most difficult to operationalise in the form of survey questions. This difficulty stemmed from two issues: (i) trying to measure a community-level resource by means of individual-level questions; and (ii) the rarity of civic engagement, or even understanding of such processes, among those interviewed.

It is recommended that the questions relating to civic engagement are placed immediately following those concerned with views of the local area, so that respondents could relate to these in terms of the same area.

***18**. Informed*

*[*] Thinking of the same local area ……*

*Would you say that you are well informed about local affairs?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know* | *3* |

***19**. Influenc*

*[*] Do you feel you can influence decisions that affect your area?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know* | *3* |

***20**. Lserv*

*To what extent do you agree or disagree with the following statements?*

*[*] By working together, people in my neighbourhood can influence decisions that affect the neighbourhood.*

*SHOW CARD B*

| | |
|---|---|
| *Strongly agree* | *1* |
| *Agree* | *2* |
| *Neither agree nor disagree* | *3* |
| *Disagree* | *4* |
| *Strongly disagree* | *5* |
| *Don't have an opinion* | *6* |

***21**. LocNews*

*[*] Local newspapers are a reliable source of information about local issues.*

*SHOW CARD B*

After the cognitive testing, the category 'don't have an opinion' was added to Q20 and Q21, as some respondents stated that they neither agreed nor disagreed where, on probing, it was found they did not have enough knowledge on which to base an opinion.

***22**. Involved*

*Have you been involved in any local organisation over the past 3 years?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |

*Ask if have been involved in a local organisation (Involved = 1)*

***23**. Active*
*In the past 3 years, have you had any responsibilities in this (these) organisation(s), such as being a committee member, raising funds, organising events or doing administrative or clerical work?*

| | |
|---|---|
| *Yes.....* | *1* |
| *No.....* | *2* |

The main interest from these two questions (Q22 and Q23) is whether respondents are *actively* involved in *local* organisations.

Local organisations could include

- parent/teacher associations
- school associations
- religious organisations such as churches, mosques or temples
- residents' or tenants' associations
- neighbourhood watch
- support groups
- local branches of national organisations such as Oxfam or the Salvation Army.

However, it would exclude just being a member of a sport or social club.

Active involvement would include responsibilities such as

- taking minutes
- being a committee member
- organising events
- raising funds by collecting money
- delivering and picking up donation envelopes
- working in a charity shop.

However, it would exclude just attending meetings.

## *Questions 24–32 examine 'view of local area'*

*Still thinking about the same area, can you tell me how much of a problem these things are.*

***24**. Traffic*
*[*] The speed or volume of road traffic*
*SHOW CARD C*

| | |
|---|---|
| *Very big problem.....* | *1* |
| *Fairly big problem.....* | *2* |
| *Minor problem.....* | *3* |
| *Not at all a problem .....* | *4* |
| *It happens but is not a problem.....* | *5* |
| *Don't know.....* | *6* |

***25**. Parking*
*[*] Parking in residential streets*
*SHOW CARD C*

***26**. Carcrime*
*[*] Car crime (e.g. damage, theft and joyriding).*
*SHOW CARD C*

***27**. Rubbish*
*[*] Rubbish and litter lying around*
*SHOW CARD C*

***28**. DogMess*
*[*] Dog mess*
*SHOW CARD C*

***29**. Graffiti*
*[*] Graffiti or vandalism*
*SHOW CARD C*

***30**. NoiseNbr*
*[*] Level of noise*
*SHOW CARD C*

***31**. Teenager*
*[*] Teenagers hanging around on the streets*
*SHOW CARD C*

***32**. Alcdrug*
*[*] Alcohol or drug use*
*SHOW CARD C*

After cognitive testing, 'it happens but is not a problem' was added to the response categories of the above questions (Q24–Q32), as it was found that some examples were not defined as problems by respondents, even when they occurred in their area. The questions on traffic, parking, car crime and dog mess were not on the original list, but were added as they were mentioned as problems by respondents. Problems associated with alcohol and drug use (Q32) could include people hanging round the streets drunk or affected by drugs, syringes littering the streets, or people openly buying or selling drugs.

## *Question 33 examines 'civic engagement'*

***33**. LocAct*
*In the past 3 years, have you taken any of the following actions in an attempt to solve a local problem?*

*CODE ALL THAT APPLY*
*SHOW CARD D*

| | |
|---|---|
| *Written to local newspaper.....* | *1* |
| *Contacted the appropriate organisation to deal with the problem, e.g. the council.....* | *2* |
| *Contacted a local councillor or MP.....* | *3* |
| *Attended a protest meeting or joined an action group.....* | *4* |
| *SPONTANEOUS* | |
| *Thought about it, but did not do it.....* | *5* |
| *None of these.....* | *6* |

The emphasis in this question is taking action about a *local* issue. For example, 'contacted a local councillor or MP' would include writing to an MP about a local issue such as plans to close the accident and emergency unit of the local hospital, but excludes writing to an MP about a national issue.

In cognitive testing, many respondents said they considered taking action but had not actually taken it, and therefore this was added as a spontaneous response category.

The GHS question also included 'or considered taking' in the question wording. Future use of this question would not include this.

## *Question 34 examines 'view of local area'*

***34**. Victim*
*Have you personally been a victim of any of the following crimes in the past 12 months?*
*CODE ALL THAT APPLY*
*SHOW CARD E*

| | |
|---|---|
| *Theft or break-in to house or flat.....* | *1* |
| *Theft or break-in to car parked in the area.....* | *2* |
| *Personal experience of theft or mugging in the area.....* | *3* |
| *Physical attack in the area (i.e. hit or kicked in a way that hurt you).....* | *4* |
| *Racist attack in the area (either verbal or physical).....* | *5* |
| *None of these.....* | *6* |

The response categories for Q34 make it clear that the question is referring to the local area.

As this question might be sensitive for some respondents, a show card is used, so the respondent only has to read out a number.

## *Questions 35–39 examine 'reciprocity and local trust'*

Trust of strangers is a central dimension of Putnam's conception of social capital. In cognitive tests it was found that respondents were generally unable or unwilling to answer questions concerning trust of others in relation to an area that extended beyond their immediate neighbourhood, or when applied to people the respondent did not know personally. Therefore the next set of questions asks respondents to think about their neighbourhood: that is, the street or the respondent's part of the street, the block of flats, or whatever the respondent thinks of as their immediate area.

*Now I would like to ask you a few questions about your more immediate neighbourhood (by which I mean your street or block).*

***35**. KnowNbr*
*[*] Would you say that you know….*
*RUNNING PROMPT*

| | |
|---|---|
| *Most of the people in your neighbourhood.....* | *1* |
| *Many of the people in your neighbourhood.....* | *2* |
| *A few of the people in your neighbourhood....* | *3* |
| *Or that you do not know people in your neighbourhood?.....* | *4* |

Cognitive testing found that the term 'know' was consistently understood as applying to neighbours whom the respondent knew by sight, which flat or house they lived in, and well enough to have something of a conversation with. Knowing the neighbour's name was not a necessary requirement of knowing the person.

***36**. TrustNbr*
*[*] Would you say that you trust…*
*RUNNING PROMPT*

| | |
|---|---|
| *Most of the people in your neighbourhood.....* | *1* |
| *Many of the people in your neighbourhood.....* | *2* |
| *A few of the people in your neighbourhood.....* | *3* |
| *Or that you do not trust people in your neighbourhood?.....* | *4* |

Respondents tended to say that they trusted those neighbours they knew, but also described with some pride how they avoided getting to know people they did not instinctively trust. In this way trust was presented as an indication of the respondent's own lack of gullibility and their

shrewdness in judging character, as much as an objective assessment of the trustworthiness of their neighbours. Further probing suggested that such trust was fairly superficial and often centred on a belief that a neighbour would not 'take liberties'. When respondents were asked how many of their neighbours they would trust in specific situations (such as lending tools, keeping an eye on the children for a short period, or being given the keys to the respondent's home when away), responses tended to be far more selective. Yet, as responses to questions about social support demonstrated, most respondents relied on family or friends rather than neighbours for practical assistance, so failure to trust a neighbour with keys might only mean the lack of need to put a neighbour in that position. It also related to concerns to preserve boundaries and protect privacy.

***37**. Neighlk*
*[*] Would you say this neighbourhood is a place where neighbours look out for each other?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know* | *3* |

This question originally used the term 'look after each other', but cognitive testing found that this proved difficult for respondents to define.

***38**. Favdone*
*In the past 6 months, have you done a favour for a neighbour?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *SPONTANEOUS* | |
| *Just moved into the area* | *3* |

***39**. Favrecd*
*And, in the past 6 months, have any of your neighbours done a favour for you?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *SPONTANEOUS* | |
| *Just moved into the area* | *3* |

Example of favours are

- taking in post
- watering plants
- lending tools or garden equipment
- carrying things upstairs
- feeding pets when neighbours go on holiday
- shopping.

If people have just moved into the area, interviewers can probe to see if the respondent has done or received a favour since they moved into the area. It may be that neighbours have helped then when they were actually moving in. Where such respondents are genuinely unable to answer, use the spontaneous code 'Just moved into the area'.

## *Questions 40–46 examine 'social networks'*



The following two sections on 'social networks' and 'social support' investigate measures of social capital relating to individuals.

The section on social networks attempts to address the quality of contact (conceptualised as 'closeness'), as well as frequency.

***40**. Phonerel*
*The next few questions are about how often you see or speak to your relatives and friends.*

*Not counting the people you live with, how often do you do any of the following? Please choose your answer from the card.*

*Speak to relatives on the phone…*
*SHOW CARD F*

| | |
|---|---|
| *Every day* | *1* |
| *5 or 6 days a week* | *2* |
| *3 or 4 days a week* | *3* |
| *Once or twice a week* | *4* |
| *Once or twice a month* | *5* |
| *Once every couple of months* | *6* |
| *Once or twice a year* | *7* |
| *Not at all in last 12 months* | *8* |

***41**. Seerel*
*See relatives…*
*SHOW CARD F*

***42**. Phonefri*
*Speak to friends on the phone…*
*SHOW CARD F*

***43**. Seefrnd*
*See friends…*
*SHOW CARD F*

***44**. Spkneigh*
*Speak to neighbours…*
*SHOW CARD F*

Q40 to Q44 are about relatives or friends living outside the respondent's household. Interviewers may need to probe to ensure that respondents are not counting the same people twice; someone may be a friend and a neighbour, but should only be coded once.

Work colleagues should be counted as friends only if the respondent sees them outside working hours and outside the working premises. Similarly, if a student sees other students only at classes or lectures, they should not be included as a friends.

The frequencies shown on the card were harmonised with those used in other sections of the GHS.

Questions are asked about relatives and friends separately, as research has shown that the two types of contacts are distinct and are likely to be differentially motivated.



*Ask if see or speak to relatives regularly (i.e. at least once every couple of months)*
*(Phonerel = 1–6 or Seerel = 1–6)*

***45**. Closerel*
*Apart from the people you live with, how many relatives that you feel close to live within a 15–20 minute walk or 5–10 minute drive, if any?*

| | |
|---|---|
| *One or two* | *1* |
| *Three or four* | *2* |
| *Five or more* | *3* |
| *None* | *4* |

*Ask if see or speak to friends regularly (i.e. at least once every couple of months)*
*(Phonefri = 1–6 or Seefrnd = 1–6)*

***46**. Closefri*
*How many close friends live within a 15–20 minute walk or 5–10 minute drive, if any?*

| | |
|---|---|
| *One or two* | *1* |
| *Three or four* | *2* |
| *Five or more* | *3* |
| *None* | *4* |

The term 'close to' was understood by all respondents in a similar way, with most describing a quality of relationship that involved trust, and shared interests and outlook. 'Close family' generally implied the nuclear family, although some respondents excluded from this definition relatives who were close kin and/or lived nearby if they were not regarded as being emotionally close. 'Close friendship' was often considered to involve longevity of acquaintance.

Q45 and Q46 are not asked of those respondents who see people very occasionally, in order that only the minimum number of questions are asked of those who have little or no social contact.

## *Questions 47–54 examine 'social support'*

Hypothetical scenarios are used to explore individuals' social support (Q47 to Q52). Cognitive testing found that the strongly preferred response from some respondents was not to ask anyone for help. The questions were revised to ask first if respondents 'could' ask for help and, if so, who 'would' they ask. Answers are chosen from a card which includes 'would prefer not to ask for help' as an option. It was also found that many respondents omitted their spouse or partner when answering these questions, so a prompt card was added with a list of people including 'husband/wife/partner'. The category 'husband/wife/partner' would included ex-husbands, -wives and -partners, and partners not living in the household. The category 'voluntary or other organisation' includes wardens of sheltered housing and social services.

The interviewer may need to probe to ensure that respondents are not counting the same people twice; someone may be a friend and a neighbour, but should only be coded once. If the respondent mentions only one person, the interviewer should probe by asking 'anyone else?'

***47**. Lifts*
*I am going to read a list of situations where people might need help. For each one, could you tell me if you would ask anyone for help?*
*You need a lift to be somewhere urgently. Could you ask anyone for help?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know / It depends* | *3* |

*Ask if could ask for lift or answers don't know/depends*
*(lifts = 1 or 3)*

***48**. Lifthelp*

*Can you look at the card and tell me who you would ask for help?*

*CODE UP TO 3 ANSWERS*

*SHOW CARD G*

| | |
|---|---|
| *Husband/wife/partner* | *1* |
| *Other household member* | *2* |
| *Relative (outside household)* | *3* |
| *Friend* | *4* |
| *Neighbour* | *5* |
| *Voluntary or other organisation* | *6* |
| *Other* | *7* |
| *Would prefer not to ask for help* | *8* |

In Q48 the category 'voluntary or other organisation' would include voluntary or community organisations which transport people, such as

- Help the Aged taking pensioners to luncheon clubs
- Sunshine Coaches transporting children.

***49**. Illbed*

*You are ill in bed and need help at home. Could you ask anyone for help?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know / It depends* | *3* |

'Help at home' means help with domestic tasks such as cooking, cleaning, making a cup of tea.

*Ask if could ask someone for help if ill in bed, or answers don't know/depends*
*(Illbed = 1 or 3)*

***50**. Illhelp*

*Can you look at the card and tell me who you would ask for help?*

*CODE UP TO 3 ANSWERS*

*SHOW CARD G*

***51**. Money*

*You are in financial difficulty and need to borrow £100. Could you ask anyone for help?*

| | |
|---|---|
| *Yes* | *1* |
| *No* | *2* |
| *Don't know / It depends* | *3* |

At the outset of the research it was assumed that the amount of money to be requested would affect the extent to which respondents could ask for help. Respondents were therefore probed about whether their response would vary if the amount was £50, £100, £200 or £500. In practice, the amount appeared to be of secondary importance. The primary factors influencing response were whether the respondent knew anyone who could spare money (even £5 or £10), and the respondent's own willingness to admit to financial need.

Loans from banks or other financial institutions should be excluded.



*Ask if could ask someone for help if in financial difficulty, or answers don't know/depends*
*(Money = 1 or 3)*

***52**. Monyhelp*

*Can you look at the card and tell me who you would ask for help*

*CODE UP TO 3 ANSWERS*

*SHOW CARD G*

***53**. Ncrisis*

*If you had a serious personal crisis, how many people, if any, do you feel you could turn to for comfort and support?*

*RECORD NUMBER 0..15*

*IF MORE THAN 15 CODE AS 15*

This question needs to be dealt with sensitively, as it can be upsetting for people who are socially isolated.

Respondents had no difficulty understanding what was meant by a personal crisis. Examples included bereavement, or a partner leaving.

If respondents have difficulty in giving a number for this and the following question (Q54), the interviewer should ask them to give an estimate.

*Ask if could turn to someone for comfort and support*
*(Ncrisis > 0)*

***54**. NearNcri*

*How many of these people (Does this person) live within a 15–20 minute walk or 5–10 minute drive, if any?*

*RECORD NUMBER 0..15*

*IF MORE THAN 15 CODE AS 15*

# Analysing the data

## Analysis plans for the GHS social capital module

Although it is instructive to look at the answers to the questions individually, the main purpose of the analysis is to group questions together to create summary variables which can be used as indicators of the different aspects of social capital. These indicators can then be analysed with respect to other variables, such as those relating to health.



It is intended that the analysis of the GHS social capital module will produce summary variables for each of the five main aspects of social capital. At the time of this guide's publication, the derivation of these variables had not been finalised. However, a second booklet in this series will give a detailed account of the way the data from the GHS module have been grouped and analysed.

Summary variables are produced by combining the answers to different questions. For example, questions within the module could be given a value, depending on the answer, and then the scores are added together to form an index. Below is a step-by-step guide to show how summary variables can be produced from some of the questions used in the social capital module. These examples are included to give an idea of the ways in which data can be grouped. They are **not** the finalised indices from the GHS social capital module. When you come to analyse the data you will probably want to use the indices that have been created for the GHS module, so that your data can be compared to national data. The second booklet in this series will contain this information.

## Example: To create an index to measure civic engagement

This requires combining the respondent's answers to the relevant questions, to give an overall impression of their degree of civic engagement. The most straightforward method is to give each response a score that can then be added across the questions to give an overall score. The overall scores can then be grouped and categorised into degrees of civic engagement (for example 'low' 'medium' or 'high').

In this example, answers indicating a positive degree of civic engagement are given a positive score, and those indicating a negative degree of civic engagement are given a negative score. The scores range from –2 to +2 for each question. Using a negative to positive range makes the scoring of 'neutral' or 'don't know' answers simpler, as they can be set at zero. Questions that have been omitted by a respondent should be excluded, and some account taken of this in the final score and categorisation.

In general the scores should be equivalent across questions (for example, a very positive response to one question should be scored the same as a very positive response to a different question). The exception to this is where it is known (or considered) that a particular question carries more 'weight' than other questions, in which case the scores can be increased for this question. In this example, all questions are considered to carry equal weight. The table overleaf shows the scores that could be allocated to the responses to each civic engagement question.

*Scores for each civic engagement question*

| Name/ number | Question | Answer code and full answer | Score |
|---|---|---|---|
| Informed (Q18) | Would you say that you are well informed about local affairs? | 1 Yes | +2 |
| | | 2 No | –2 |
| Influence (Q19) | Do you feel you can influence decisions that affect your area? | 3 Don't know | 0 |
| | | –8 Not answered | 0 |
| Lserve (Q20) | [*] By working together, people in my neighbourhood can influence decisions that affect the neighbourhood. | 1 Strongly agree | +2 |
| | | 2 Agree | +1 |
| LocNews (Q21) | [*] Local newspapers are a reliable source of information about local issues. | 3 Neither agree or disagree | 0 |
| | | 4 Disagree | –1 |
| | | 5 Strongly disagree | –2 |
| | | 6 Don't have an opinion | 0 |
| Involved (Q22) | Have you been involved in any local organisation over the past 3 years? | 1 Yes | +2 |
| | | 2 No | –2 |
| Active (Q23) | In the past 3 years, have you had any responsibilities in this (these) organisation(s), such as being a committee member, raising funds, organising events or doing administrative or clerical work? | –8 Not answered | 0 |
| LocAct (Q33) | In the past 3 years, have you taken any of the following actions in an attempt to solve a local problem? | 1–4 Took an action | +2 |
| | | 5 Consider taking an action | 0 |
| | | 6 Did not take, or consider taking an action | –2 |

Thus a respondent who answered as follows:

Q18: yes (+2); Q19: no (–2); Q20: agree (+1); Q21: neither agree or disagree (0); Q22: yes (+2); Q23: no (–2); Q33: took an action (+2)

would have an overall score of:

+2–2+1+0+2–2+2 = +3

In this example the overall scores could range from –14 to +14. These scores would then be grouped, as described earlier, into categories, either by dividing the range of scores (for example –14 to –6; –5 to +5; +6 to +14); or the more likely approach would be to split the scores according to the distribution of respondents and adjust the verbal description accordingly. For example, if the majority of respondents scored less than zero, you may have to describe categories in terms of degrees of lack of civic engagement, rather than the broad general terms of 'low' 'medium' and 'high'.

## Examples from other surveys

For more examples of summary variables that have been used on large-scale surveys, it is worth looking at the appendix to Cooper *et al.* (1999), which lists various summary measures on social support and social capital that have been used by different British surveys.

# References


Acheson, D. *et al*., 1998. *Independent inquiry into inequalities in health – Report*. London: The Stationery Office.

Bourdieu, P., 1986. The forms of capital. *In:* J. Richardson, ed. *Handbook of theory and research for the sociology of education*. New York: Macmillan.

Bridgwood, A. *et al*., 2000. *Living in Britain: results from the General Household Survey*. London: The Stationery Office.

Cabinet Office, 2000a. *National Strategy for Neighbourhood Renewal: Report of the Policy Action Team (PAT) 18: Better Information*. London: The Stationery Office.

Cabinet Office, 2000b. *The National Strategy for Neighbourhood Renewal*. London: The Stationery Office.

Coleman, J., 1988. Social capital in the creation of human capital. *American Journal of Sociology*, 94 (supplement), S95–S120.

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

DOH, 1999. *Saving lives: our healthier nation.* London: The Stationery Office/Department of Health.
DOH, 2000. *The National Plan: London*. London: Department of Health.

Earthy, S., Maltby, S., Arber, S. and Cooper, H., 1999. *Cognitive interviewing for development of GHS social capital module*. Guildford: Surrey Social and Market Research.

Gillies, P., 1998. The effectiveness of partnerships and alliances for health promotion. *Health Promotion International*, 13 (2).

Hawe, P. and Shiell, A., 2000. Social capital and health promotion: a review. *Social Science and Medicine*, 51, 871–885.

HEA, 1999. *Social action for health: hopes, expectations and progress.* Report of a seminar held on 15 November, 1999. London: Health Education Authority.

Putnam, R., 1993. The prosperous community: social capital and public life. *The American Prospect*, 13, 1–8.

Putnam, R., 1995. *Making democracy work. Civic Traditions in modern Italy*. New Jersey: Princeton University Press.

# Appendix 1 Surveys used in the development of the GHS social capital module

The following table lists the questions used in the GHS social capital module showing which survey the questions were originally taken from. These included the pilot questions for the Health Survey for England 2000 (HSE 2000); the 1998 Health Education and Monitoring Survey (HEMS); the Health Education Authority's Health and Lifestyles Survey (HEA HALS); and the British Household Panel Survey (BHPS).

| | | Surveys used in the development of the GHS social capital module | | | |
|---|---|---|---|---|---|
| **Question** | | **HSE2000 Pilot questions** | **HEMS** | **HEA HALS** | **BHPS** |
| ***3.*** | *Arealive* | + | + | + | |
| ***4.*** | *Areamth* | | | | |
| ***5.*** | *Enjyliv* | + | + | + | + (different wording) |
| ***6.*** | *Locserv* | | | | |
| ***7.*** | *Leisyou* | + | + | + | |
| ***8.*** | *Leiskids* | + (similar) | + (age not specified) | | + (age not specified) |
| ***9.*** | *Leisteen* | | | | |
| ***10.*** | *Bins* | | | | |
| ***11.*** | *Lochlth* | | | | |
| ***12.*** | *Schools* | | | | |
| ***13.*** | *Police* | | | | |
| ***14.*** | *Transprt* | | | | |
| ***15.*** | *Loctrans* | + (similar) | +(similar) | +(similar) | |
| ***16.*** | *Walkday* | | Φ | | |
| ***17.*** | *Walkdark* | + | | | + |
| ***18.*** | *Informed* | | + (different response categories) | | |
| ***19.*** | *Influenc* | | | | |
| ***20.*** | *Lserv* | | | | |
| ***21.*** | *LocNews* | | | | |
| ***22.*** | *Involved* | Φ (gives list of activities) | Φ (gives list of activities) | | Φ (gives list of activities) |
| ***23.*** | *Active* | | | | |
| ***24.*** | *Traffic* | | | Φ (asks in relation to risk to health) | |
| ***25.*** | *Parking* | | | | |
| ***26.*** | *Carcrime* | | | | |
| ***27.*** | *Rubbish* | + | Φ (asks in relation to risk to health) | Φ (asks in relation to risk to health) | |
| ***28.*** | *DogMess* | | | | |
| ***29.*** | *Graffiti* | + (similar) | + (similar) | Φ (only vandalism) (asks in relation to risk to health) | Φ |
| ***30.*** | *NoiseNbr* | | Φ | Φ (asks in relation to risk to health) | |
| ***31.*** | *Teenager* | + | | | Φ |
| ***32.*** | *Alcdrug* | | | | |
| ***33.*** | *LocAct* | | | | |

Key:
+ = question is identical or very similar
Φ = survey covers a similar topic, but the questions asked are different

**Appendix 1 continued**

| Question | | Surveys used in the development of the GHS social capital module | | | |
|---|---|---|---|---|---|
| | | **HSE2000 Pilot questions** | **HEMS** | **HEA HALS** | **BHPS** |
| ***34***. | *Victim* | | | | |
| ***35***. | *KnowNbr* | | | | |
| ***36***. | *TrustNbr* | | Φ | | |
| ***37***. | *Neighlk* | + | + (reworded) | + (reworded) | |
| ***38***. | *Favdone* | | | | |
| ***39***. | *Favrecd* | | | | |
| ***40***. | *Phonerel* | Φ | Φ | Φ | |
| ***41***. | *Seerel* | Φ | Φ | Φ | Φ |
| ***42***. | *Phonefri* | Φ | Φ | Φ | |
| ***43***. | *Seefrnd* | Φ | Φ | Φ | Φ |
| ***44***. | *Spkneigh* | Φ | Φ | Φ | + (similar, fewer response categories) |
| ***45***. | *Closerel* | | | | |
| ***46***. | *Closefri* | | | | |
| ***47***. | *Lifts* | | | | |
| ***48***. | *Lifthelp* | | | | |
| ***49***. | *Illbed* | | | | |
| ***50***. | *Illhelp* | | | | |
| ***51***. | *Money* | | | | * |
| ***52***. | *Monyhelp* | | | | |
| ***53***. | *Ncrisis* | | + | | |
| ***54***. | *NearNcri* | | | | |

Key:
+ = question is identical or very similar
Φ = survey covers a similar topic, but the questions asked are different

# Appendix 2 Show cards used in the GHS social capital module

A

1 Very good
2 Good
3 Average
4 Poor
5 Very poor
6 Don't know or have had no experience

B

1 Strongly agree
2 Agree
3 Neither agree or disagree
4 Disagree
5 Strongly disagree
6 Don't have an opinion

C

1 Very big problem
2 Fairly big problem
3 Minor problem
4 Not at all a problem
5 It happens but is not a problem

D

1 Written to local newspaper
2 Contacted the appropriate organisation to deal with the problem, e.g. the council
3 Contacted a local councillor or MP
4 Attended a protest meeting or joined an action group
5 None of these

E

1 Theft or break-in to house or flat
2 Theft or break-in to car parked in the area
3 Personal experience of theft or mugging in the area
4 Physical attack in the area (i.e. hit or kicked in a way that hurt you)
5 Racist attack in the area (either verbal or physical)
6 None of these

F

1 Every day
2 5 or 6 days a week
3 3 or 4 days a week
4 Once or twice a week
5 Once or twice a month
6 Once every couple of months
7 Once or twice a year
8 Not at all in the last 12 months

G

1 Husband/wife/partner
2 Other household member
3 Relative outside the household
4 Friend
5 Neighbour
6 Voluntary or other organisation
7 Other
8 Would prefer not to ask for help

# Appendix 3 Summaries of projects in the HDA social capital programme

## Exploring the relationship between social capital and health using quantitative studies: the General Household Survey 2000/2001 module

### *Contact*

22 **Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
email: antony.morgan@hda-online.org.uk

### *Principal partners*

**Alison Walker**
GHS Project Manager
D1/ 19
Office for National Statistics
1 Drummond Gate
London SW1V 2QQ

**Sara Arber**
Department of Sociology
School of Human Sciences
University of Surrey
Guildford
Surrey GU2 7XH

### *Duration*

July 1999–March 2002

### *Background*

The HDA has signalled a commitment to tackling inequalities in health. A number of qualitative studies are currently investigating the links between health and social capital, to inform the development of interventions to tackle the broader determinants of health. This body of qualitative work, however, must be complemented by robust quantitative analyses. These analyses must aim to identify the links between social capital and longer-term health outcomes.

The HDA has therefore commissioned a programme of work to:

- more extensively test the component elements of social capital and health in large surveys already conducted in the UK
- devise new surveys or studies in order to test the link between social capital and health and health behaviour in the UK.

This project is one of a number commissioned in this area.

### *Aims*

To develop empirically, evidence of links between social capital and a range of health outcomes, through the analysis of existing data sets and the development of new ones

### *Objectives*

- to carry out a review of existing cross-sectional surveys to assess their potential for analysing data related to any of the constructs of social capital and health measures; surveys identified will ideally have data on a wide range of health outcomes, health-related behaviours and other measures of social support
- to develop a social capital module which could be added to existing longitudinal studies and, if this is not possible, to set up new studies
- to explore the potential for setting up a social capital module which could be used in future cross-sectional and/or panel health surveys
- to gather the data, perform univariate and multivariate analyses and publish the data
- to investigate the role of social capital in the impact of new government health and education initiatives.

### *Description*

The work done over the life of the project will include:

- a review of existing cross-sectional surveys and assessment of their potential for analysing data in relation to the range of constructs of social capital and health
- a 10–15 minute module of questions on social capital will be developed and included in the 2000/1 GHS; the module will be administered to one randomly selected adult aged 16 or over in each responding household
- detailed multivariate analysis of the social capital module will be undertaken, creating a range of further indicators of social capital and examining their relationship with a range of health measures
- further analysis of the social capital module will be undertaken, to provide a health policy analysis of the impact of new government health and education initiatives; in addition, comparisons will be drawn with earlier work to examine changes over time.

### *Proposed outputs*

- A report to the HDA on the review of the various cross-sectional surveys on social capital, discussing the available questions on the various elements of the social capital construct.
- A 60-page report from ONS on the social capital module: this report will be published by the HDA in spring 2001.
- A 120-page publishable report from the University of Surrey on the multivariate analysis of the social capital module.

# Exploring the relationship between social capital and health using quantitative studies: the British Household Panel Survey

## *Contact*

**Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
email: antony.morgan@hda-online.org.uk

## *Principal partners*

**David Pevalin**
**David Rose**
**Richard Berthoud**
Institute of Social and Economic Research
University of Essex
Wivenhoe Park
Colchester CO4 3SQ

## *Duration*

July 1999–August 2001

## *Background*

The HDA has signalled a commitment to tackling inequalities in health. A number of qualitative studies are currently investigating the links between health and social capital, to inform the development of interventions to tackle the broader determinants of health. This body of qualitative work, however, must be complemented by robust quantitative analyses. These analyses must aim to identify the links between social capital and longer-term health outcomes.

The HDA has therefore commissioned a programme of work to:

- more extensively test the component elements of social capital and health in large surveys already conducted in the UK
- devise new surveys or studies in order to test the link between social capital and health and health behaviour in the UK.

This project is one of a number commissioned in this area.

## *Aims*

To empirically test for evidence of links between social capital and a range of health outcomes, through the analysis of data from the British Household Panel Survey (BHPS).

## *Objectives*

- To develop empirical measures of social capital and health available from the BHPS data and quantitatively to explore the relationships between them.
- Data from the BHPS meet the objectives laid out by the HDA in that a wide range of health outcomes, health-related behaviours and measures of social support are available. Other established factors related to health are included in the data and the BHPS can be merged with community level statistics.

## *Description*

The work done over the life of the project will include the following:

- derive specific research questions from the literature on social capital and health, bounded by the limitations of the data available from the BHPS
- explicitly construct reasonable measures or proxies for social capital
- develop the longitudinal health indicators in the BHPS
- explore the quantitative relationships between the measures of social capital and health while taking into account other health-related factors.

## *Proposed outputs*

- Three interim progress reports during stage 1 of the project (not for publication).
- A final report in July 2001 covering the whole project (publishable).

# Investigating the links between a range of social indicators and health using quantitative studies: using the Whitehall II study and the Health Survey for England

## *Contact*

**Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
Email: antony.morgan@hda-online.org.uk



## *Principal researchers*

**Mai Stafford**
**Michael Marmot**
**Richard Wilkinson**
**Mel Bartley**
**Robert Erens**
Department of Epidemiology and Public Health
University College London
1–19 Torrington Place
London WC1E 6BT

## *Duration*

June 1999–March 2002

## *Background*

Studies of the causes of disease have tended to focus on the characteristics of individuals and individual behaviour. Recently, interest in the role of the wider social environment has been renewed. Empirical research suggests that social capital is related to health, and recent government initiatives appear to be based on the theory that greater community involvement will improve health. However, few studies have investigated the association between social capital and health in communities in a quantitative way.

There is no universally accepted definition of social capital, although Putnam's definition of 'features of social organisations that facilitate action and cooperation for mutual benefit' is often cited. This study will describe levels of social capital within the local community and investigate their association with a range of health outcomes.

## *Aims and objectives*

The aims of this study are:

- to collect comprehensive, quantitative measures of social capital in a range of areas throughout England
- to investigate the biological and behavioural mechanisms by which social capital influences health
- to determine whether social capital in the area adds anything to the social support available to an individual
- to investigate whether effects of social capital are independent of, or interact with, levels of material deprivation in the area.

## *Study design*

A community survey will be administered in a range of deprived, affluent, inner-city, suburban and rural wards throughout England. The survey will include questions on residents' perceptions of various constructs of social capital (social trust, social cohesion, networks), and of the facilities and services in their area. For each ward, responses will be aggregated to form a 'ward social trust index', a 'ward social cohesion index', and so on.

A wide range of health outcomes and determinants of health are already available in two ongoing studies, the Health Survey for England (HSE) and the Whitehall II study. Physical, biological and mental health outcomes and health-related behaviours have been collected, along with data on social supports and detailed socio-demographic characteristics.

The community survey will be sent to a random sample of people living in the same wards as the HSE or Whitehall II participants for whom we have existing health data. The community survey will not include HSE or Whitehall II participants, but will be used to provide contextual information for these participants. Aggregated measures of social capital will be linked to the existing health data. As measures of social capital will be reported by a different group of people from those reporting their health status, the association between social capital and health can be investigated without problems of positive or negative affect bias.

Multi-level analysis will be used to determine whether the association between social capital and health is independent of the individual characteristics of residents, and whether the effects of social capital on health vary according to the socio-economic status of the area or the individual.

The community survey will also be administered in the Camden and Islington Health Action Zone in order to investigate the role of social capital in the impact of new government health initiatives.

## *Intended outputs*

The results from this research should lead to a better understanding of the context in which people live and how the material and social characteristics of their local area may be health-enhancing or health-damaging. They should indicate the appropriate level for intervention, be it at the individual level, at the level of local government, or even at national government level.

# Exploring the relationship between social capital and health using quantitative studies: social capital, place and health

## *Contact*

**Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
email: antony.morgan@hda-online.org.uk

## *Principal partners*

**John Mohan, Kelvyn Jones, Liz Twigg, Steve Barnard**
Portsmouth University
Department of Geography
Buckingham Building
Lion Terrace
Portsmouth PO1 3HE

## *Duration*

October 1999–September 2001

## *Background*

The HDA has signalled a commitment to tackling inequalities in health. A number of qualitative studies are currently investigating the links between health and social capital, to inform the development of interventions to tackle the broader determinants of health. This body of qualitative work, however, must be complemented by robust quantitative analyses. These analyses must aim to identify the links between social capital and longer-term health outcomes.

The HDA has therefore commissioned a programme of work to:

- more extensively test the component elements of social capital and health in large surveys already conducted in the UK
- devise new surveys or studies in order to test the link between social capital and health and health behaviour in the UK.

This project is one of a number commissioned in this area.

## *Aims*

To assess the links between social capital, place and health through multivariate and multi-level analyses of individual and area measures of mortality, morbidity and social capital.

## *Objectives*

- To develop empirical measures of social capital for small areas; one of the weaknesses of current measures of social capital is that they are often constructed at a large spatial scale. We will draw on measures of civic participation and social capital available in national survey data sets.
- Having developed these measures, we aim to link them to individual and area measures of health status and mortality at various scales.



## *Description*

The work done over the life of the project will include the following:

- critical evaluation of existing measures of social capital, focusing particularly on the spatial scale of measurement
- construction of reasonable proxies for social capital, through (i) detailed small-area analyses of the distribution of blood donors (as a measure of altruistic participation) and (ii) synthetic estimates of social capital constructed at ward level through regression-based techniques
- multivariate ecological analyses of links between these measures and patterns of mortality and morbidity, controlling for comparative levels of deprivation
- multi-level modelling of individual and area effects of social capital on health using our measures and the various individual and area characteristics measured in the Health and Lifestyle Survey (HALS).

## *Proposed outputs*

- Three interim progress reports (not for publication) covering derivation of new indicators of social capital, multivariate analyses of relationships between our small-area measures and health indicators, and multi-level analyses.
- Set of derived indicators for wards in England, to be made available to other interested researchers.
- A final report in September 2001 covering the whole project (publishable).

# An examination of the potential to identify an instrument reflecting measurable attributes of social capital

## *Contact*

**Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
email: antony.morgan@hda-online.org.uk

## *Principal partners*



**Sarah Cowley, Jenny Billings, Angus Forbes, Peter Griffiths, Sarah Hean, Jill Maben, Trevor Murrells**
King's College London
Florence Nightingale School of Nursing and Midwifery
James Clerk Maxwell Building
57 Waterloo Road
London SE1 8WA

## *Duration*

March 2000–March 2001

## *Background*

Social capital refers to features of social organisation, such as networks, norms and trust, that facilitate coordination and cooperation for mutual benefit (Putnam, 1993). The construct has explanatory potential and possible utility as a resource capable of ameliorating the worst effects of inequalities in health. The use of the construct has been hampered, however, by several factors, which include a lack of conceptual clarity or agreement about the theoretical basis and constituent parts of social capital and, associated with this, an inability to measure the extent to which social capital is a unitary concept or reflected in an environment that is conducive to positive health.

## *Aims and objectives*

The aim of the project is to develop and test a survey tool that will measure clearly defined attributes of social capital that can be used by individuals as a personal resource, by:

- the completion of a concept analysis: this process identifies the defining characteristics of social capital, as reflected and used in existing research and literature – particularly important as a lack of specificity and conceptual clarity can hinder selection of the most appropriate and meaningful criteria for measurement; a key feature of this study is the concentration on concept clarification before progressing to instrument development
- identifying cross-sectional surveys that are regularly undertaken and survey instruments used (or potentially used) widely in research
- isolating measurable attributes within the concept of social capital in the literature, critically comparing definitions and meanings found, and then mapping these findings across from the literature review to the survey/research instruments
- exploring the structure of the concept both theoretically and empirically
- using the information from the literature and survey instrumentation to develop, validate and pilot a survey tool with the potential to measure attributes embedded in the concept of social capital, establishing whether the survey tool reflects a relationship between social capital and health
- clarifying definitions and developing/locating more fitting instrumentation to measure the extent to which social capital is reflected in an environment that is conducive to positive health; in this study, particular attention will be paid to clarifying pathways (if any) between health as a personal resource and social capital, which is a community resource.

## *Study design/project description*

The project will proceed in two phases. The first involves concept clarification and the compilation of an initial survey instrument. The second phase involves pilot applications of the instrument so as to begin establishing validity and reliability, and to identify scales onto which similar items may load, based on common themes that they address.

The first phase of the project will have identified a bank of potential items, which may be useful in measuring social capital. The degree to which those items interrelate (as calculated by factor analysis and reliability calculations), and their appropriateness in measuring social capital, need to be ascertained. This will be achieved through two pilot procedures:

- an initial pilot of the instrument will be conducted with 50 members of both ancillary and academic staff from the School of Nursing and Midwifery, King's College London: a face-to-face application of the instrument will be achieved, and a stratified sample will be selected based on gender, age and job grade
- in the final pilot procedure two areas have been chosen within the urban area of London, the boroughs of Newham and Chelsea/Westminster, as examples of one deprived and one affluent community; the Jarman census data will be utilised so as to ensure identification of truly deprived and affluent streets/zones/individuals within these areas; a postal application of the questionnaire will be conducted; a sample of 1,000 subjects will be selected at random from the electoral role, and post stratification procedures applied in terms of age, gender and socio-economic status.

Factor analysis of items will be conducted in the final pilot to ascertain or confirm the identity of scales of items, and a final measure of internal reliability calculated.

## *Intended outputs*

The primary output of the project will be a report of the development and operational characteristics of the tool, both theoretically based and empirically tested. We would anticipate this report be prepared in a format which could serve as a manual for other researchers wishing to utilise the tool. We will seek advice from the HDA as to the most useful format for dissemination in the light of developments in this and other projects.

# Exploring the relationship between social capital and health using quantitative studies: the contribution of social and emotional well-being in childhood and adulthood to social capital and health

## *Contact*

**Antony Morgan**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1895
email: antony.morgan@hda-online.org.uk

## *Principal partners*

**Sarah Stewart-Brown**
Director
Health Services Research Unit
Department of Public Health
Institute of Health Sciences
Old Road, Headington
Oxford OX3 7LF

## *Duration*

July 1999–March 2002

## *Introduction*

This project will identify completed studies and data sets with the potential for relevant secondary analyses that contribute to the development of current knowledge about the impact of social capital on health. The studies will be appraised and qualitative synthesis undertaken. The data sets will be acquired and relevant analyses completed and described. A report will be written for the HDA covering both the systematic review and the secondary analyses, and papers will be submitted for publication in peer-reviewed journals. The project focuses on longitudinal rather than cross-sectional studies as these provide more powerful evidence of causality, and there appear to be a sufficient number of such studies reported in the published literature. It covers studies of social and emotional well-being, arguing that these attributes underpin social capital. It also covers studies of children and adults, arguing that the social capital available to children (determined to a large part by their parents) plays a key role in determining social and emotional well-being in adulthood. It focuses on measures collected at the level of the individual, as these capture both objective and subjective aspects of social capital.

The principal investigators have come together because of a shared interest in the importance of this topic. They come from a range of institutions and cover a range of disciplines. The project will be based in the Health Services Research Unit, a multidisciplinary research group based in the Department of Public Health in Oxford, which has an established track record in epidemiological methods, handling large data sets, systematic reviews, the development of health outcome measures and intervention studies of emotional and social well-being.

The applicant is currently involved in a range of studies relating to emotional and social well-being, including systematic reviews and controlled trials of interventions delivered to groups and communities that aim to promote emotional and social well-being in childhood and adulthood. This project will collate the evidence demonstrating the importance of such interventions for public health in general. It will also prepare the ground for a further project that addresses the development of valid and reliable measures of social and emotional well-being.

## *Aims and objectives*

On the basis of currently identified studies, develop a model that describes:

- the importance of social and emotional well-being as determinants of future physical and mental health
- the critical role of emotional and social well-being in childhood in this process.

Test the validity of the model on the basis of:

- new studies identified in a systematic search of the literature
- further analyses of currently available longitudinal studies.

## *Description*

Systematic search for longitudinal studies in which data have been collected on aspects of social and/or emotional well-being (e.g. social trust, social support, close confounding relationships, self-esteem, self-efficacy, personal autonomy, empathy, resilience, hostility, aggression, parental care, attachment, empowerment) at one point in time, and data on physical and mental health and or health-related lifestyles at another point in time. The search will cover studies in adults and children.

The search will cover electronic databases (such as ERIC, Psychlit, Medline, Cinahl, Social Science Citation Index, Sociofile, Health Star, BIDS, Embase) from 1970 onwards, looking for titles and abstracts of relevant longitudinal studies. The following databases will be searched for relevant grey literature: SIGLE, Dissertation Abstracts, National Research Register, Faculty of Public Health Medicine database of Part II projects. The search will include investigation of websites giving information about relevant studies using the search engines *AltaVista* and *Excite*, and making use of the Social Sciences Information Gateway. The Cochrane Database of Systematic Reviews and the York Database of Abstracts of Reviews of Effectiveness will be searched to identify complementary ongoing reviews. The search strategy and search terms will be defined following preliminary investigation. The details of potentially relevant articles will be downloaded and hard copies of all those that might be relevant obtained. The bibliographies of all obtained papers will be searched for further relevant articles. Inclusion criteria will be defined following preliminary searches. Studies reported in foreign languages will be translated if apparently relevant. Identifying search terms and locating the literature is likely to be more challenging than for a standard systematic review and may require a limited amount of hand searching of journals and contact with research teams undertaking these studies. A broad range of study designs will be included.

The quality of studies will be appraised taking into account factors such as representativeness of the sample, methods of

measuring emotional and social well-being, completeness of follow-up, methods of ascertaining outcomes and adjustment for confounding factors. The strength of the evidence indicating causality will be assessed using accepted criteria such as the strength and consistency of the relationship, adjustment for confounding factors, and dose–response relationship.

Data will be extracted from included studies and a qualitative synthesis undertaken. Where there is sufficient homogeneity in terms of populations studies and outcomes used, it may be possible to undertake a quantitative synthesis. Where studies have been excluded on the grounds of quality or relevance, the reasons will be documented. The results will be tabulated and described.



Data archives in the UK such as that at the Economic and Social Research Council will be contacted to identify longitudinal studies in which relevant variables have been collected, but in which appropriate analyses have not yet been completed. Secondary data analyses will be undertaken on these data sets using quantitative methodology suitable for the data, adjusting for potential confounding factors using multiple or logistic regression techniques. The main confounding factors will be aspects of the economic, physical and social environment such as income, housing, gender and race.

Time and resources permitting, the guardians of other relevant databases, identified from studies found in the systematic search, will be approached. If these are available for secondary analysis by independent research groups they will be obtained and the appropriate secondary analyses will be undertaken.

This is the first part of a two-part project; the second part will form the basis of a subsequent bid for funding to the HDA and other potential funding bodies. The second part will build on the current project and incorporate qualitative interviewing to establish public concepts of social and emotional well-being. It will develop and validate measures of social and emotional well-being that can be used to collect data in self-report questionnaires in both epidemiological and intervention studies. It will pilot different methods of data collection, recognising that questionnaires with personal details may discourage participation in community interventions where there are low levels of literacy and social trust. A range of approaches including financial incentives will be tried.

## *Outcomes*

Results will be disseminated in a report to the HDA and in papers to be submitted to peer-reviewed journals. The details of the study will be publicised in the Health Services Research Unit newsletter, annual report and website. The results of the study will be presented at national and international meetings. The contribution of HDA will be acknowledged in all products of the research.

## Social Capital and Health: A case study analysis of a socially deprived community

### *Contact*

**Catherine Swann**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1903
email: catherine.swann@hda-online.org.uk

### *Principal partners*

**M. Boneham**
**J. Sixsmith**
Department of Health and Social Studies
Bolton Institute
Deane Road
Bolton BL3 5AB

### *Duration*

October 1999–March 2001

### *Background*

The relationship between social capital and health has been under-researched in the British context. Social capital (Putnam, 1993) is defined in terms of social cohesion and sense of community, trust, reciprocity and participation which operates at a community level for the mutual benefit of community members. The contested nature of social capital is apparent (Wall *et al.*, 1998); whilst it may act in a positive and enhancing way to promote health and well-being, it may also act to constrain health experiences and choices (Gillies, 1998). Understanding how social capital and health are related requires a full exploration of the processes that link the two together. Such processes can be identified at both social/community and individual levels.

Individual experiences of life transitions and perceptions of health are contextualised within particular social support and community networks. It is apparent that the experience of life transitions are often associated with higher levels of stress, and the person's efforts to cope with life transitions can involve seeking support from family and friends in the local community. Thus the social/community context provides a medium through which meanings of health and capabilities to cope with stress and ill-health are located.

Past research has suggested that both gender and age strongly influence health experiences. Here it is acknowledged that both gender and age are complex and diverse phenomena: masculinities and femininities can be manifest in very different ways (Mac An Ghaill, 1996), while age categorisations do not always correspond to homogeneous experiences. Indeed, both gender and age can be conceptualised as situational, relational and dynamic such that the situations and relationships within which health problems are experienced can differ tremendously between younger and older men and women.

Current research has identified a number of such differences. In particular, men have a shorter life expectancy while women tend to suffer more in terms of morbidity (Renzetti and Curran, 1995). Men and women can experience different types of health- and stress-related problems (Carroll, 1992) as they age. Men tend to engage in more unhealthy behaviours than women, including increased smoking and drinking (Ogden, 1996). Women, on the other hand, are heavier users of health services and are often the primary source through which healthcare is channelled into family life.

Gender and age are also important issues when understanding the nature of social support networks. Women tend to have larger and more diverse social support networks than men (Cooper *et al*., 1999). In addition, women engage in more reciprocal and confiding relationships which can mediate their experiences of ill-health and stress, although such support networks can change as the person grows older (Scott and Wenger, 1995).



Furthermore, people's relationships with space and place are also highly gendered (Spain, 1992). For example, women experience home and family in very different ways from men, and this experience is subject to change in later life (Sixsmith and Sixsmith, 1991). Gender also influences the experience of living in the community, where women suffer more from living in disadvantaged areas than men (Cooper *et al.,* 1999). It may only be when places are degendered that inequalities can be redressed.

This body of research has revealed many relationships between health, gender, age and the experience of community living. However, it does not clearly address the ways in which community, gender and age provide the context within which social capital relates to health. Thus there is a need to explore as yet under-researched areas such as the nature of young men's health needs and the role of their social support networks. Similarly, there is little known about the social construction of masculinities and femininities in terms of structuring the development and use of social support networks, as well as participation in community and voluntary groups. It is only by research into such areas as these that the processes which underpin the accumulation and maintenance of social capital, and how it is used as a resource, can be fully understood.

### *Aims and objectives*

The study aims to explore the relationship between social capital and health at an individual (psychosocial) level and investigate the ways in which gender and age structure this relationship. Study objectives are to:

- understand the experience of stress and perceived ill-health within the context of the family and local community
- reveal how life transitions relate to stress and perceived ill-health and how social and community support systems mediate that relationship
- explore the roles that trust, reciprocity and shared norms play in creating an inter-linked family and community context within which stress and ill-health are experienced
- examine individuals' motivations for and psychosocial barriers against participation in community-based groups.

Moreover, the research will explore the relationship between

social capital and health at a community (social structural) level. In this respect study objectives are to:

- examine the ways in which identifying (or not) with the local community promotes willingness (or unwillingness) to contribute to community life
- reveal the organisation of community groups in terms of providing a community structure for local participation
- elucidate the ways in which community groups promote local empowerment and shape social attitudes.

Finally, the study will investigate ways in which health intervention programmes can play a role in reducing experience of inequalities in health and well-being, taking into account constructions of masculinities and femininities.



## *Study design*

The present proposal will take a holistic approach, using a case-study methodology in a socially deprived area of Bolton in which people's own experiences of community living, social support and health (in terms of stress and perceived ill-health) will be investigated. The approach will explore processes at both individual and community levels, and will enable both gender and age factors to emerge. The research will employ a multi-methods approach, to include:

- semi-structured interviews
- street interviews
- focus groups
- evaluation of community social structure
- newspaper analysis.

## *Study implications*

The research will contribute to an understanding of the relationship between social capital and health, revealing the ways in which gender and age structure such a relationship. The work has implications for the development of health promotion initiatives and strategies aimed at reducing health inequalities among underprivileged communities.

## References

Carroll, D. (1992). *Health Psychology: Stress, Behaviour and Disease*. London: Farmer Press.

Cooper, H., Arber, S., Fee, L. and Ginn, J. (1999) *The Influence of Social Support and Social Capital on Health*. London: Health Education Authority.

Gillies, P. (1998) The Effectiveness of Alliance and Partnerships for Health Promotion. *Health Promotion International* 13: 1–21.

Mac An Ghaill, M. (1996) *Understanding Masculinities*. Buckingham: Open University Press.

Ogden, J. (1996) *Health Psychology: A Textbook*. Buckingham: Open University Press.

Renzetti, C. and Curran, D. (1995) *Women, Men and Society*. Boston: Allyn and Bacon.

Scott, A. and Wenger, G. (1995) Gender and social support networks in later life. pp. 158–172 in: (Arber, S. and Ginn, J., eds.) *Connecting Gender and Ageing.* Buckingham: Open University Press.

Sixsmith, A. and Sixsmith, J. (1991) Transitions in home experience in later life. *Journal of Architectural and Planning Research* 8 (3): 181–191.

Spain, D. (1992) *Gendered Spaces*. Chapel Hill: University of Carolina Press.

Wall, E., Ferrazzi, G. and Schryer, F. (1998) Getting the goods on social capital. *Rural Sociology* 63 (2): 300–320.

# Social capital and health in multi-ethnic communities

## *Contact*

**Catherine Swann**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1903
email: catherine.swann@hda-online.org.uk

## *Principal partners*

**Cathy Campbell**
Gender Institute/Social Psychology Department
**Carl McLean**
Gender Institute
London School of Economics
Houghton Street
London WC2A 2AE

## *Duration*

June 1999–November 2000

## *Background*

Within the health promotion arena there has been a growing emphasis on possible community-level influences on health – in addition to the more traditional focus on the transformation of individual health behaviours.

While there is general agreement that structural factors such as socio-economic inequalities are the most important determinants of health variations, health promotion researchers are increasingly arguing that the impact of such factors may be mediated by a range of community-level factors. Correspondingly, in the arena of health promotional intervention and policy, there is increasing emphasis on the importance of local community participation in health promotional strategies.

However, our understandings of the influence of community-level factors on health, and of the mechanisms underlying the allegedly health promoting outcomes of community participation, are still in their infancy. It is this gap in knowledge that forms the context of the HEA/LSE/Luton and Bedfordshire social capital and health research programme.

## *Social capital and health*

It has recently been suggested that the concept of 'social capital' – derived from research in the areas of political science and economics – has the potential to:

- serve as a conceptual framework for research investigating the impact of community-level networks and relationships on health
- aid in the design of community-level health promotional interventions and policies
- fill gaps in our understandings of the determinants of the success or failure of health promotional interventions (Campbell *et al*., 1999).

These assumptions form the basis of the HDA's commitment to investigate the links between social capital and health, as part of their goal of informing the development of interventions to tackle the broader determinants of health. This investigation takes the form of a range of quantitative and qualitative research projects.

*Pilot study: Social Capital and Health (1998–99)*

The first exploratory study focused on two relatively disadvantaged wards of Luton. Through semi-structured, in-depth interviewing and focus groups, the pilot study provided a micro-qualitative account of people's involvement in a range of social networks.



Those relationships of trust and reciprocity that were found to exist in the communities were located overwhelmingly within informal face-to-face networks of friends, neighbours and relatives, and the study highlighted the minimal role played by other network types in our informants' lives. Furthermore, certain types of these informal networks (diverse and geographically dispersed) appeared to suggest that, potentially, they may be more health-enhancing than others. This suggested that a widening of Putnam's typology of social networks was needed, with more attention paid to the informal.

In the context of the present study, one further recommendation emerged as being of particular interest: that there are strong differences in the way social capital is created, sustained and accessed, and that there is a need for more attention to the interaction of social capital, gender, age, socio-economic status and ethnicity.

*Current research: Social Capital and Health in Multi-Ethnic Communities (1999–2000)*

The current project is again based in Luton, this time in two wards of both high disadvantage and ethnic diversity. In consultation with our local advisory group, three ethnic communities were highlighted for investigation: Pakistani-Kashmiri, African-Caribbean and White English.

Methodology is again micro-qualitative, with 75 3-hour semi-structured interviews (25 from each ethnic group) structured as equally as possible by gender, age, employment status and organisational affiliation.

Analysis will be facilitated via *NUD*IST*, a qualitative software package, and a final report will be submitted by November 2000 to HDA.

## *Aim and policy context*

For those seeking to promote health-enabling communities, it is important to have a realistic understanding of community networks, resources and relationships that exist in their local communities of interest and/or place.

Given the key role that local community/neighbourhood participation is assumed to play in various health promotion

interventions and policies, we need to develop our understanding of:

- what networks exist
- what factors help or widen participation in these
- the potential implications for successful health promotion.

Currently, much attention is being devoted to inequalities in health across ethnic groups. We hope that the concept of social capital can complement existing research on socio-economic influences on health, and contribute to increasing our understanding of health inequalities experienced by British minority ethnic groups, and to designing and evaluating interventions and policies seeking to address them.

## Reference

Campbell, C., Wood, R. and Kelly, M. (1999) *Social Capital and Health*. London: Health Education Authority.

## How older people relate social capital to health

### *Contact*

**Catherine Swann**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1903
email: catherine.swann@hda-online.org.uk

### *Principal partners*

**Mildred Blaxter**
School of Health Policy and Practice
**Fiona Poland**
School of Occupational Therapy and Physiotherapy
University of East Anglia
Elizabeth Fry Building
Norwich NR4 7TJ

### *Duration*

October 1999–March 2001

### *Aims and objectives*

We suggest that a problem arises in the study of social capital and health because, although social capital is usually perceived as a societal characteristic, its components (such as levels of social and civic trust, social cohesiveness and cooperative relationships) usually have to be measured at the individual level. Indicators at the macro-level are currently being operationalised without much information either about their meanings for the respondents of various surveys, or whether other concepts and other indicators are perceived (especially in a life-course perspective) as being more relevant.

The objectives of this study are to derive, from the literature and from a body of specifically focused new interview material, measures of how the concept of social capital is understood, the transitional points at which it has been lost and gained, and how it is associated, in people's minds with health history and health status.

The emphasis is on older age, since it is here that the life course can be reflected upon, and on people in less favourable social circumstances.

### *Study design*

The study consists first of an analysis of the actual questions and measures used for the concept of social capital at the individual level, in the research literature, and how they relate to the community and societal levels. This is followed by an interview study based on a grounded theory method, with the interviews structured to elicit, in a free and open-ended discussion of health history and social history, the respondents' understandings of the different concepts found in the literature.

Respondents will be obtained from a local housing estate in which we have contacts, and from lists of (probably) two general practices, with the collaboration of the practitioners. Analysis and field work will take place concurrently, with a random, small initial group of appropriate respondents followed by a purposive sample of others selected to test developing hypotheses about the dimensions of social capital, how it is gained and lost, and its relationship to individual health. We envisage a total of approximately 45 respondents.

### *Policy context*

The aim is to formalise the expressions of lay perceptions as research tools, although their testing would remain for further research. More immediately, the outcomes for health promotion may be the interpretation of various anomalies in the research literature, and a clearer understanding of the context of perceived social action, negotiation and collaboration as they develop in individual lives.

# Age, social capital and health in East London: generational and life stage influences on the creation, forms and health effects of social capital

## *Contact*

**Catherine Swann**
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 1903
email: catherine.swann@hda-online.org.uk



## *Principal partners*

**Vicky Cattell**
**Rachel Herring**
Department of Public Health and Epidemiology
University College London
1–19 Torrington Place
London WC1E 6BT

## *Duration*

November 1999–March 2001

## *Background*

The current interest in social capital and health can be viewed as the latest stage in the search for a social model in health. Social capital – involving social networks, community participation, perceptions of trust and safety, and reciprocal aid – is a resource produced when people cooperate for mutual benefit. The concept can help us identify conditions which contribute to or detract from the quality of life, and has been used as an aid to understanding the dynamics between poverty, place of residence and poor health. We need to increase our understanding of the complexities of the concept and its effects: factors which influence its creation, the different forms it takes, and the processes by which health can benefit.

Earlier work suggested that local resources and facilities were an important influence on building and developing networks and social capital (Cattell, 2001; Cattell and Evans, 1998). The current research builds on this work by exploring variation by age group. People at different points of the life stage have different needs, may have different opportunities, and may access different kinds of social capital, but influences in earlier life also play a role. Previous work pointed to the role of past opportunities for involvement in clubs and work in influencing current motivation. Questions remain concerning additional influences connected to these 'generational effects'.

## *Aims and objectives*

The overall objectives of the study are to explore the dynamics between social capital, health and age group, and to further explore the utility of social capital as a heuristic tool for understanding processes and patterns of health inequalities. It aims to:

- identify age-related variation in the creation, sources and forms of social capital
- explore processes and mechanisms involved in the relationship between social capital and positive and negative health effects for different age groups
- identify appropriate policy responses with the potential for improving the quality of life of people at the four life stages.

## *Study design*

Set in a housing estate in Hackney, east London, this qualitative study will build on earlier work in the area (Cattell and Evans, 1998). A brief community and health profile of the locality will be compiled and followed by 60 in-depth interviews with residents. The sample will be balanced between teenagers and young adults without children; people with young families; middle-aged residents; and retired residents. Four focus groups will be conducted towards the end of the field work to further explore emerging themes. Data will be analysed using 'grounded theory' methodology.

## *Policy implications*

The research will have implications for government policies designed to tackle social exclusion of neighbourhoods and age groups, and for targeted interventions to reduce health inequalities. At the local level, findings will be of interest to those involved in Health Action Zones, health promotion, regeneration and community development work.

## References

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): 1501–1516.

Cattell, V. and Evans, M. (1998) Neighbourhood images in East London. York: Joseph Rowntree Foundation.

# Appendix 4 Glossary of terms

***BLAISE* software**
BLAISE is an integrated computer program for survey processing in which you can create a questionnaire to be used in computer-assisted interviewing. It allows for complex question routing and checks. The program can also be used in the editing and preparation of data for analysis.

**Cognitive testing**
An approach which pays explicit attention to the mental processes that respondents use to answer questions. In particular it can explore respondents' comprehension of a question, strategies they use to retrieve relevant information from memory, and the decision processes they follow when giving an answer.

**Computer-assisted personal interviewing**
Used in face-to-face and telephone interviewing. The questionnaire is on the computer and some validity checks are done as the answers are entered. Interviewers are routed through the questionnaire by the responses they key in.

**Interview bias**
Occurs when interviewers, by their interviewing style, influence response. Bias can be caused through deviation from the exact wording of the questions, from their predetermined order, from the manipulation of prompt cards, or from the tone of voice.

**Piloting**
Testing of the questionnaire and the survey methodology.

**Variable**
A characteristic that is not the same for all cases and which has more than one category (or value), for example, sex is a variable with the categories male and female.