



**Introduction to Sociomedical Sciences
PH-P6700
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Oct.23 Social Capital, Intentional Communities, and Resistance: Pressing the Limits of Structure
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Teaching Goals

Introduce and explore the concept of “social capital” (from its earliest use by Jane Jacobs as an attribute of neighborhoods to recent assessments of its role in health promotion), review critical appraisals of the term, and describe an example of a neighborhood-based intervention (Family to Family) in Harlem.

Required Reading

S. James, A. Schulz and J. van Olphen, Social capital, poverty, and community health: An exploration of linkages, in S. Saegert, J. P. Thompson and M. R. Warren (Eds.), *Social Capital and Poor Communities*. New York: Russell Sage Foundation, 2001, pp. 165-188.

R.E. Fullilove, L. Green, L. & M.T. Fullilove, The Family-to-Family program: A structural intervention with implications for the prevention of HIV/AIDS and other community epidemics. *AIDS* 14 (suppl. 1): S63-S67, 2000.

Chapter 7

Social Capital, Poverty, and Community Health: An Exploration of Linkages

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This chapter explores the degree to which the overall health of communities depends, at least in part, on reliable access to social capital among their residents. As discussed in chapter 1 by Mark Warren, Phillip Thompson, and Susan Saegert, social theorists (for example, Bourdieu 1987; Coleman 1988, 1990; Putnam 1993) have generally defined social capital as resources that inhere in social relationships. These resources include mutual trust, a sense of reciprocal obligation, and civic participation aimed at benefiting the group or community as a whole. As such, social capital is construed to be a property of groups or communities, not of individuals. Thus defined, social capital bears a strong resemblance to a number of other theoretical constructs (such as social integration, social support, and community capacity) that have been used with great success by public health researchers for many years. We examine the overlap between social capital and these analogous constructs in setting the stage for our review of the emerging literature on the relationship between social capital and the public's health. Following the review, we present a conceptual model outlining our own perspective on the pathways through which social capital may influence, directly and indirectly, the health of poor, inner-city U.S. communities. We illustrate several key points of our model through a case study of an ongoing, community-based, public health intervention in Detroit, Michigan. The chapter concludes with several policy recommendations designed to foster sustainable progress in building the capacity of poor communities to solve public health problems.

SOCIAL CAPITAL AS A CONSTRUCT IN PUBLIC HEALTH

The field of public health has a long-standing interest in the impact of socio-environmental factors on health (Yen and Syme 1999). Research dating back to 1854 has examined patterns of social behavior and social organization and their implications for understanding the differential distribution of diseases across communities (Snow 1936). Despite the fact that scientific paradigms and research methods emphasizing the individual as the unit of analysis have come to dominate public

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health in recent decades (Pearce 1996), a subset of researchers and practitioners continues to focus on the impact of community structures, broadly conceived, on the public's health. The latter emphasis includes the location and quality of housing (Saegert and Winkel 1998); patterns of residential segregation by race (Polednak 1996; Wallace 1990; Collins and Williams 1999; Fullilove 1998); membership in social networks and related perceptions of social support (House, Umberson, and Landis 1988; Heaney and Israel 1997); community and political participation (Wandersman et al. 1987; LaVeist 1992; Israel et al. 1994; Eng and Parker 1994; Goodman et al. 1998); and relative equity in gaining access to community-level economic resources (Wilkinson 1996; Kennedy, Kawachi, and Prothrow-Stith 1996; Kaplan et al. 1996; Lynch et al. 1998).

These aspects of the social environment are interconnected in complex ways. For example, the physical structure of communities shapes, and is shaped by, patterns of social interaction among residents. Those patterns, in turn, are strongly influenced by the economic resources of residents (Wallace 1990; Fullilove 1998) and by cultural values linked to race or ethnicity (James 1993; Lomas 1998). Over the years a substantial body of evidence has emerged attesting to the impact of these features of the social environment on the health of both individuals and communities (Cassel 1976; House et al. 1988; Wolf and Bruhn 1993; Aday 1994; Cohen et al. 1997; Israel et al. 1998). Importantly, this impact does not appear to be disease-specific; rather, the evidence suggests that it shapes a community's overall risk for being at risk (Link and Phelan 1995).

The growing interest in the relationship between access to social capital and community health (for example, Wilkinson 1997; Kawachi et al. 1997; Kennedy et al. 1996; Lomas 1998) is a potentially important elaboration on the ancient public health thesis that the manner in which social relationships are structured in a given society is a powerful determinant of the health status of all members in that society (Cassel 1976; Link and Phelan 1995). To paraphrase Bob Edwards and Michael Foley (1997), however, the question is, to what extent does the concept of social capital yield a distinctive analytic payoff above and beyond the analogous constructs used in public health for many years?

Despite unresolved theoretical and measurement challenges, the construct of social capital appeals to many public health researchers because of its potential to integrate complex, community-level economic and social processes in ways that could help explain variations in the general health status of communities across time and place (Wilkinson 1997; Kawachi et al. 1997). However, the construct's full research and policy potential can be realized only through its greater theoretical specification (see Warren, Thompson, and Saegert, this volume) and through improved operational measures for specific applications, including applications in public health.

To date, only a few empirical studies (Kawachi et al. 1997; Kennedy et al. 1997, 1998) have directly investigated the relationship between social capital, as defined here, and public health outcomes. Ichiro Kawachi, Bruce Kennedy, and their colleagues, the group that has pioneered this empirical work, have operationalized the construct in keeping with the framework provided by James Coleman (1990) and

Robert Putnam (1993). That is, they have emphasized mutual respect, social trust, and group membership (equating the last of these with civic engagement) as the key dimensions of social capital. Importantly, none of the potentially negative aspects of social capital, including its instrumental relationship to the abuse of social power (see Portes and Landolt 1996), have been investigated thus far, an issue we discuss in more detail later in the chapter.

Constructs like group membership, mutual respect, and trust appear to share much in common with constructs like social integration, social cohesion, and social support, all well-established predictors in the public health literature of both physical and mental health outcomes (House et al. 1988; Aday 1994; Heaney and Israel 1997). Indeed, the *positive* contributions to health made by social integration and social support are said to rival in strength the *detrimental* contributions of several well-established biomedical risk factors like cigarette smoking, obesity, elevated blood pressure, and physical inactivity (House et al. 1988). The mechanisms responsible for these "protective effects" are not well understood, but it is likely that several pathways are involved. In addition to buffering individuals against the harmful effects of daily stressors, for example, group membership (and related access to social support) could foster a sense of meaning and coherence for individuals, facilitate access to material aid or emotional comfort at critical moments, or promote adherence to healthy lifestyles (House et al. 1988). Hence, the health benefits derived from social integration probably result from the *cumulative* contributions of these varied, complementary pathways (see Cohen and Syme 1985).

Although public health researchers have not entirely neglected the theoretical relationships between social capital (group membership, mutual respect, and trust) and social power, neither have they satisfactorily addressed them. Kawachi and his colleagues (1997) and Kennedy and his colleagues (1998), for example, equate social capital with social cohesion and, evoking an hypothesis first formulated by Clifford Shaw and Henry McKay (1942), argue that

inequality and the concentration of poor economic conditions lead to social disorganization through the breakdown of social cohesion and normlessness. It is hypothesized that communities lacking in social cohesion (social capital) are less effective in exerting informal means of social control through establishing and maintaining norms to reduce violence compared to communities with higher levels of social capital. (Kennedy et al. 1998, 8)

Temporarily setting aside the equation of concentrated economic poverty with social disorganization—itsself an empirical question—this excerpt explicitly connects social capital (defined as social cohesion) with the mobilization and enforcement of community norms. In doing so, it emphasizes one form of social power—that exerted *within* communities by some individuals, or groups, over others. The role of power differentials *between* communities in producing and maintaining social inequalities in health, however, is not addressed. Thus, articulating the multiple pathways through which differentials in social power between communities are related to the distribution of health problems both within and between communi-

ties is, we believe, a largely unrecognized issue among researchers who are actively investigating the utility of the social capital construct for public health.

The importance of this point is underscored by noting that a variety of theoretically similar constructs that are widely used in public health research and practice explicitly address the issue of community power differentials. Examples of such constructs include community competence (Cottrell 1976; Eng and Parker 1994; Iscoe 1974), community capacity (Parker and Eng 1995; Thomas, Israel, and Steuart 1985; Clark and McLeroy 1995; Goodman et al. 1998), and community empowerment (Israel et al. 1994; Schulz et al. 1995; Zimmerman and Rappaport 1988; Wallerstein 1992; Wallerstein and Bernstein 1994; Patrick and Wickizer 1995). Each emphasizes the importance of a community's ability to identify collective concerns related to the health of residents and a corollary ability to mobilize resources to address those concerns effectively. Moreover, in varying degrees, the literature based on each of these constructs recognizes that while social norms in communities are often beneficial, they frequently reinforce ideologies that result in positive harm to individuals because of their race, gender, social class, or sexual orientation (Israel et al. 1994; Goodman et al. 1998). Finally, not only do the theoretical frameworks for these analogous constructs give explicit attention to the different meaning that the exercise of social power can assume, depending on the social, political, or economic context, but they also underscore the important mediating role of community organizations in amplifying or diminishing the effects of between-group differentials in social power on individuals' health and well-being (Berger and Neuhaus 1977).

We have three major concerns about how the construct of social capital has been conceptualized so far in public health. First, the functional definition of social capital as "whatever facilitates individual and collective actions" makes it difficult to separate what social capital *is* from what it *does* (Edwards and Foley 1997; Cohen 1996). Specifically, when defining the construct, it seems important to distinguish the group connections within which social capital inheres from the actual resources (social, economic, political) that these connections may contain. This point has relevance to the earlier quote (Kennedy et al. 1998, 8) regarding the alleged breakdown of social networks and resulting social disorganization in poor communities. Social networks in poor communities may be quite strong, but these networks may also have an under-supply of certain critical resources (such as political power) that could be mobilized to deal with a range of threats to community health, such as substandard housing, neighborhood violence, and a lack of jobs. In sum, social capital that involves real access to political power may be crucial when poor communities confront problems whose roots lie in institutional arrangements that go beyond the immediate geographical boundaries of the community itself (Stack 1974, 1996; Kaplan and Lynch 1997; Portes and Landolt 1996; Parker et al. 1998; Israel et al. 1994).

Second, it is important to be both critical and wary of conceptualizations of social capital as an unmitigated "good." A substantial literature suggests that social groups often go to considerable lengths to define preconditions for group membership. Individuals who belong to excluded categories may fall outside the "moral boundaries" established by the excluding group—resulting in acts motivated, for example, by racism, sexism, or homophobia (Cohen 1996; Cohen 1985; Frankenberg

1993; Almaguer 1994; Ferber 1998; Israel et al. 1994). It is clear, then, that the public health implications of access to social capital vary considerably, depending on who is mobilizing the social capital, and for what purposes (Kaplan and Lynch 1997; Portes and Landolt 1996; Foley and Edwards 1997).

A final observation follows closely on the preceding two. Although social capital inheres within social relationships and therefore is clearly linked to the structure of those relationships, an analysis of structural features alone is insufficient for understanding social capital as a construct and how it relates to community health. As Edwards and Foley (1997, 671) point out: "It is precisely [the] sociocultural component of social capital that provides the context within which it acquires meaning and becomes available to individuals or groups in a way that can facilitate individual or collective action not otherwise possible." A conceptual framework for understanding the conditions under which social capital can be effectively mobilized must therefore include an analysis of the systems of meaning, as well as the structures within which social capital is embedded and enacted (Warren, Thompson, and Saegert, this volume).

SOCIAL CAPITAL AND COMMUNITY HEALTH: THE EVIDENCE

In this section, we review the published evidence concerning the relationship between social capital and infant and adult mortality. Data on these health outcomes are widely regarded as key indicators of the overall health of communities; they have the added advantages of being routinely collected and easily aggregated at the level of cities or states. Our review includes U.S. studies that explicitly address health and social capital, the latter measured as the presence or absence of mutual respect, trust, and group membership (that is, the Coleman-Putnam perspective). In addition, we discuss studies that deal with how equitably economic and political resources are distributed among communities and with racial segregation and health, both of which we argued earlier are fundamentally linked to the construct of social capital. The literature on the positive effects of social integration on the health of individuals is both clear and convincing (House et al. 1988; Heaney and Israel 1997). Social capital, viewed at the geopolitical level (for example, cities and states), permits an examination of analogous protective effects that may operate at the community level.

Table 7.1 summarizes the characteristics and key findings of studies dealing with the respect-trust-group membership dimensions of social capital. Studies on income inequality are included in this table as well, since several authors (Kawachi et al. 1997; Wilkinson 1997) suggest that reduced social capital (equated here with reductions in social cohesion) could be both a cause and an effect of increasing income inequality. We begin with a study by Kennedy and his colleagues (1997) on the association between "collective (dis)respect" toward black Americans and state-level variations in all causes of mortality.

"Collective respect" displayed by one group toward another qualifies as a dimension of social capital because, as Kennedy and his colleagues (1997, 208) note, "a lack

TABLE 7.1 / U.S. Studies of Social Capital and Mortality: Disrespect, Trust, and Income Inequality

Authors	Study Design	Sample	Construct	Findings
Kennedy et al. 1997	Ecological; cross-sectional	39 states	Collective disrespect (percentage saying blacks are poor because they are less smart or motivated)	Higher disrespect associated with higher mortality for both blacks and whites, independent of poverty rates
Kennedy et al. 1996	Ecological; cross-sectional	50 states	Income inequality (Robin Hood Index ^a scores)	Higher income inequality associated with higher adult and infant mortality across states
Kaplan et al. 1996	Ecological; cross-sectional and longitudinal	50 states	Income inequality (percentage of total household income in each state received by poorest 50 percent of households)	Higher income inequality associated with higher mortality and smaller declines in mortality over time; inequality associated with low investments in human capital
Lynch et al. 1998	Ecological; cross-sectional	283 metropolitan areas	Income inequality (percentage of total household income received by richest 10 percent of households versus poorest 50 percent and 90 percent) ^b	Higher income inequality associated with higher adult and infant mortality, independent of per capita income
Kawachi et al. 1997	Ecological; cross-sectional	39 states	Income inequality (Robin Hood Index ^a scores); social capital (trust; group membership; perceived fairness and helpfulness)	Higher scores on social capital associated with lower state-level mortality; income inequality effects operate through social capital

Source: Authors' compilation based on data from cited works.

^aThe proportion of aggregate household income that must be redistributed from households above the mean to those below the mean in order to achieve perfect income equality.

^bAdditional indices, all showing associations in the expected direction, included the Gini coefficient, the Atkinson Deprivation Index, and the Theil Entropy Index.

of respect (that is, disrespect) is usually accompanied by a breakdown of social trust between members or groups within society, and a consequent disinvestment in social capital. Poor health status arises in such societies because the community fails to invest in, and assume responsibility for, the collective well-being of its members."¹ Collective disrespect toward black Americans ranges from negative media stereotyping, absence of representation in important spheres of public life, recurring exposure to prejudicial attitudes or even physical violence, and internalized oppression (that is, diminished self-respect among blacks as a consequence of the foregoing).

Archival data from the General Social Survey (GSS), a national representative survey of non-institutionalized, English-speaking adults conducted periodically by the National Opinion Research Center, were used to measure collective disrespect toward blacks. Respondents were asked to answer yes or no to each of four possible reasons why blacks have worse jobs, lower income, and poorer housing than whites: (1) racial discrimination, (2) less in-born ability to learn, (3) a decreased chance to gain the education it takes to get out of poverty, or (4) a lack of sufficient willpower and motivation. Responses to these questions over the five-year period 1986 to 1990 were averaged. For each state, the percentage of respondents who answered each question in the affirmative was calculated. Data from thirty-nine states were used because, "by chance, people residing in some of the less populous states were not picked up by the sampling scheme" (Kennedy et al. 1997, 209). Age-adjusted total mortality rates for 1990 constituted the dependent variable.

Results showed a significant, positive relationship between age-adjusted total mortality and the proportion of respondents in each state who attributed the economic problems of blacks to lack of motivation or intelligence rather than racial discrimination. Significantly, collective disrespect for blacks was associated with higher mortality rates almost as strongly for whites as it was for blacks.

Several groundbreaking studies on income inequality and community health have been conducted within the past decade, both in Europe (Wilkinson 1996) and in the United States (Kennedy et al. 1996; Kaplan et al. 1996; Kawachi et al. 1997; Lynch et al. 1998). These studies suggest that the wider the gap in income between the poorest and the richest members of a society, the higher the mortality among adults and infants in that society. Thus, gross inequalities in income appear to undermine the health of all members of the society, not just the poorest members.

Table 7.1 summarizes the key characteristics and findings from the five studies of income inequality conducted so far in the United States. The adverse effects of income inequality on overall community health were observed using a variety of approaches to measure income inequality. It should be noted, however, that the study by George Kaplan and his colleagues (1996) is the only one to date to include both a cross-sectional and a longitudinal component. Specifically, in 1980, states with higher levels of income inequality (see table 7.1 for a definition) reported higher age-adjusted total mortality rates. During the period 1980 to 1990, when total mortality rates continued to decline for the country as a whole, states with more income inequality showed significantly smaller declines in mortality. Interestingly, states with higher income inequality invested less in the development of human capital,

as indicated by such measures as spending on education, library books per capita, and the percentage of the state population with health insurance coverage.

Kawachi and his colleagues (1997) examined more directly the hypothesis that income inequality undermines overall community health in part because it undermines the social capital of communities. Again, five-year (1986 to 1990) GSS data from thirty-nine states were averaged to produce measures of social capital. In addition to the number of group memberships per capita (civic engagement), three additional statements were presented to respondents for a yes-or-no answer: (1) most people can be trusted (social trust); (2) most people try to be fair (perceived fairness); and (3) most people try to be helpful (perceived helpfulness). Income inequality was measured by the Robin Hood Index (see table 7.1 for a definition). In general, high scores on the social capital variables were associated with lower age-adjusted total mortality rates, even controlling for the poverty rate in each state. Similarly, high scores on income inequality were also associated with higher mortality, controlling for state-level poverty rates. Subsequently, path analyses determined that the association between income inequality and mortality was almost completely explained by the strong, inverse association ($r = -0.73$) between income inequality and the social trust variable. There was no evidence, however, that income inequality mediated the strong protective association ($r = -0.64$) observed across states between social trust and all cause mortality rates.

The impact of institutionalized racial segregation on overall community health is a relatively new topic in public health research. Like income inequality, however, hyper-segregation of neighborhoods by race and the related underrepresentation of blacks in elected offices at the municipal and state levels have important implications for the kinds of life-enhancing resources to which black communities will be able to gain access. Since the hyper-segregation of neighborhoods by race usually reinforces the economic and political "dis-empowerment" of black communities (Wacquant and Wilson 1989), racial segregation in housing patterns and the underrepresentation of blacks in local elected offices are herein viewed as forms of community disempowerment.

Table 7.2 summarizes the characteristics and key findings from studies investigating community-level variations in infant and adult mortality in relation to residential segregation by race and the proportional representation of blacks on city councils in medium-size to large cities. Residential segregation was measured by the Index of Dissimilarity or by the Isolation Index (see table 7.2 for definitions). Anthony Polednak (1991, 1993) found that black excess infant and adult mortality (as indicated by age-standardized black-white mortality ratios) increased linearly with residential segregation across thirty-eight metropolitan statistical areas (MSAs). These adverse effects on black mortality relative to whites were independent of race-specific poverty rates. A similar study conducted several years later, however, failed to replicate these findings (Polednak 1996).

Thomas LaVeist (1989) found that black-white racial segregation in 176 central cities was associated with higher infant mortality among blacks, but not among whites. Using 1990 U.S. census and vital statistics data, Chiquita Collins and David

TABLE 7.2 / U.S. Studies of Social Capital and Mortality: Community Disempowerment

Authors	Study Design	Sample	Construct	Findings
Polednak 1991, 1993	Ecological; cross-sectional	38 MSAs	Racial residential segregation (Index of Dissimilarity) ^a	Higher segregation scores associated with larger black-white infant and adult mortality ratios, independent of poverty rates
Polednak 1996	Ecological; cross-sectional	38 MSAs	Racial residential segregation ^a	Segregation scores unrelated to infant mortality in both blacks and whites
LaVeist 1989	Ecological; cross-sectional	176 central cities (population 50,000 or more and 10 percent black or higher)	Racial residential segregation ^a	Higher segregation scores associated with higher infant mortality for blacks but not whites, independent of percentage of low-birthweight births, percentage of unwed mothers, and percentage of blacks in poverty
Collins and Williams 1999	Ecological; cross-sectional	107 cities (population 100,000 or more and 10 percent black or higher)	Racial residential segregation; ^a black social isolation (Isolation Index) ^b	Higher mortality observed for both whites and blacks under conditions of high residential segregation and high black social isolation
LaVeist 1992	Ecological; cross-sectional	176 central cities (population 50,000 or more and 10 percent black or higher)	Relative black political power ^c	Relative black political power associated with lower post-neonatal mortality ^d for blacks, independent of percentage of low-birthweight births; no association for whites

Source: Authors' compilation based on data from cited works.

^aThe proportion of a racial group (blacks, for instance) who would have to change neighborhoods in order to achieve an even racial distribution across neighborhoods in a given city.

^bThe probability that a randomly drawn black person in a city interacts with a nonblack person.

^cThe proportion of black city council members divided by the proportion of blacks in the voting-age population.

^dDeath of an infant between one and twelve months old.

Williams (1999) reported higher age-adjusted total mortality for *both* blacks and whites in cities with high levels of residential segregation as well as high levels of black social isolation. In other words, in urban areas where blacks and whites had little contact, mortality rates for both groups were elevated.

Finally, in a study of 176 central cities, LaVeist (1992) investigated the association between infant mortality among blacks and whites and the numerical representation of blacks on city councils in relation to the black voting-age population. LaVeist termed this ratio "relative Black political power." As scores for this variable increased from below 1.0 (indicating underrepresentation) to 1.0 or higher (proportional, or more, representation), post-neonatal mortality among blacks decreased in linear fashion. In this study, post-neonatal mortality rates among whites had no association with black political representation. Interestingly, while relative black political power was positively associated with municipal expenditures on public infrastructure (street repairs, public safety, and so on), differences in such expenditures did not explain the observed protective association. LaVeist speculated that a relatively high level of community organization may have been responsible for both the political success of certain black communities and their lower post-neonatal mortality rates. If true, this would underscore the potential importance of neighborhood levels of social capital in achieving a range of desirable outcomes in poor urban communities.

Collectively, the studies summarized in tables 7.1 and 7.2 strongly suggest that an equitable sharing of societal resources—social, economic, and political—translates into a lower burden of mortality for all members of the community. Even so, this body of research is characterized by a number of limitations, the first of which concerns the study designs. With only one exception (Kaplan et al. 1996), all of the studies employed cross-sectional designs, leaving unanswered the question of whether high mortality rates (especially among working-age adults) precede or follow high levels of inequality in access to community resources. Though limited by small numbers, data from the longitudinal component of the study by Kaplan and his colleagues (1996) suggest that high state-level inequality does in fact precede high state mortality. Studies using larger databases are needed, but this interpretation of the temporal relationship involved is clearly consistent with findings from a large number of longitudinal studies among *individuals* that provide convincing evidence that chronic economic and social deprivation are linked to early mortality in adults (Williams and Collins 1995; Link and Phelan 1995).

Second, the ecological measures of social capital are relatively crude. To a large degree, this crudeness is due to the newness of public health research on social capital per se and the exclusive reliance so far on state-level survey data that were collected for other purposes. Nevertheless, exploiting the full research potential of the social capital construct will require the development of improved measures, including measures that can be used with economically and culturally diverse populations (Kreuter et al. 1998; Goodman et al. 1998). In addition, more attention needs to be given to the theoretical and empirical relationship between social capital and social power. Social connections may exist in poor communities in abundance, but the resources that inhere in these connections may not be easily translated into social

power. Again, LaVeist's (1992) work and recent theoretical distinctions between the "bonding" and "bridging" features of social capital (see Warren, Thompson, and Saegert, this volume) underscore the importance of this distinction.

Third, it is not clear how high levels of social capital at the community level actually work to promote health among all members in the community. It could operate by imposing limits on income inequality (Wilkinson 1997; Kawachi et al. 1997), on interpersonal and institutional expressions of racism (Kennedy et al. 1997; LaVeist 1992; Polednak 1996; Collins and Williams 1999), or on social policies that lead to progressive disinvestments in human capital—education, jobs, health care, and so on (Kaplan et al. 1996, Kaplan and Lynch 1997). It is possible, of course, that all of these explanatory pathways are involved to some extent, analogous to the health-enhancing effects of high levels of social integration at the individual level (House et al. 1988).

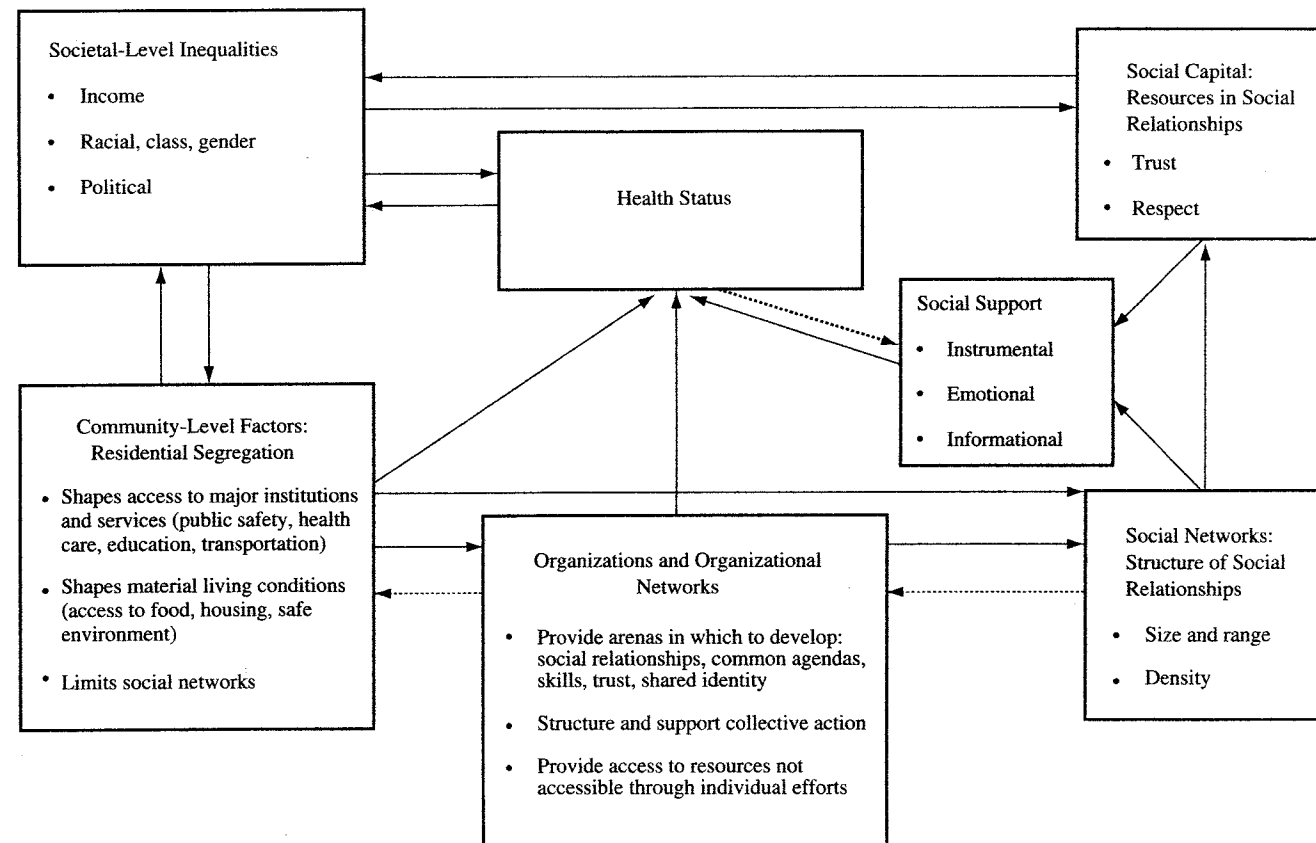
Fourth, it is not clear at what level of community social capital processes exert their influence on health: is it the country as a whole, the state, the city, or the neighborhood? The available evidence suggests that important effects may occur at each of these levels. But even if this is so, how one intervenes in these processes to promote health in communities depends on the level of community that is under discussion. Public health policy interventions target social capital processes (specifically, structural inequalities) that function primarily at the state or national level. On the other hand, interventions designed to strengthen social networks or increase the frequency of positive contact among different social networks target social capital processes that operate primarily at the level of the neighborhood or the city. Each type of intervention has an important contribution to make, and the contribution of each is undoubtedly strengthened, or weakened, depending on how well it interfaces with other social processes operating at different levels of the overall social system.

In concluding this section, we return to the question raised by Edwards and Foley (1997) concerning the extent to which the concept of social capital yields a distinct analytic payoff in public health above and beyond analogous, pre-existing constructs. Based on our review of the emerging evidence, we conclude that the explanatory potential of the social capital construct for public health research and policymaking resides less in its theoretical uniqueness than in its potential to reveal hidden linkages among the various domains of public health research that focus on the origins of social and economic inequality in America and the multiple pathways through which that inequality undermines the public's health. We believe this to be a potentially important theoretical contribution. In the following section, we present a conceptual model that specifies some of these potential linkages and pathways.

SOCIAL CAPITAL AND COMMUNITY HEALTH: A CONCEPTUAL MODEL

Our conceptual model (figure 7.1) elaborates on recent conceptualizations of social capital within the field of public health and attempts to address some of the shortcomings noted earlier in this chapter. First, it distinguishes conceptually between

FIGURE 7.1 / Social Capital and Community Health: A Conceptual Model



Source: Authors' configuration.

the structure of group relationships and the resources that might be mobilized within those relationships. Second, it specifies pathways through which the social, economic, and political context may influence social capital and health. Third, the model suggests the importance of including the sociocultural as well as structural factors that influence social relationships and the resources that can be mobilized within them. Fourth, the model specifies multiple pathways through which social relationships may influence health status and emphasizes the synergistic effects of these multiple pathways and their cumulative effects on health. And finally, the model represents social capital as both a dependent and an independent variable; that is, it delineates factors that presumably contribute to the building of social capital as well as the putative effects of social capital on health.

Beginning in the upper left corner of the model, societal-level inequalities such as income inequalities both reflect and exacerbate the social distance between population subgroups. These distances have direct effects on social networks and the resources within them, shown on the right side of the model. Furthermore, we suggest that societal-level inequalities also operate through class- or race-based residential segregation (lower left corner of the model), which influences social networks by physically separating groups and limiting the resources available to them. The effects of race-based residential segregation on social relationships are also mediated through community organizations, as shown in the lower center of the model. Importantly, each component of the model has a direct link to health status.

We have suggested that the construct of social capital would benefit by distinguishing conceptually between the group relationships within which social capital inheres and the resources that can be mobilized within these relationships. The model thus distinguishes between three characteristics of social relationships: social networks as the *structure* of social relationships; social support as one *resource* that can be mobilized through these networks; and *interactional characteristics* of social relationships, such as reciprocity, trust, and stability (see Israel 1982). Until now, research on social capital and health has emphasized measures such as reciprocity and trust, giving little or no attention to the ways in which these dimensions are shaped by network structure.

We envision these three aspects of social relationships as an interrelated system with, for example, the structure of social relationships influencing the mobilization of resources within and across those networks, and influenced by the interactional characteristics of those relationships.

Disentangling these dimensions would permit us to examine the interplay between them as well as their distinct contributions to health. For example, some evidence suggests that dense social networks (groups whose members are in close geographic proximity) may be effective in maintaining health when emotional support is needed. Under conditions of social change or transformation, however, social networks that are larger, more diffuse, and characterized by less intensive ties may be more adaptive, since they facilitate outreach and the exchange of a wider range of information (Heaney and Israel 1997; Heying 1997; Wilson 1998). Thus, different kinds of network structures may be more or less effective in mobilizing different kinds of resources within various social contexts.

Our model also suggests that societal-level factors, such as political and economic systems, influence the shape of social networks and the resources that can be mobilized within them. In addition to the direct effects illustrated by the arrow at the top of the model, the lower left of the model depicts effects on social networks mediated through race-based residential segregation. For example, the combined forces of income inequalities and racism result in race-based residential segregation and concentrated poverty (Massey and Fisher 2000), circumscribing the range of resources that can be mobilized within social networks and decreasing their flexibility in responding to the social environment.

The model locates organizations as mediating structures between broad social and community characteristics and social networks. In addition to structuring relationships through the organization of work and civic participation, they play a central role in the mobilization of resources (Berger and Neuhaus 1977; Israel et al. 1994; Goodman et al. 1998; McCarthy and Zald 1977; Schwartz and Paul 1992; Minkoff 1995). Organizations provide opportunities to develop and strengthen social ties, develop a sense of shared identity, define common goals, pool resources, and develop skills and a sense of shared power as they work toward collective goals (Berger and Neuhaus 1977; Israel et al. 1994). Economic, political, and social inequality, combined with the concentration of poverty tied to race-based residential segregation, contributes to the exodus of businesses and health and social service providers from economically marginalized communities. These processes have clear and substantial impacts on community life (Wilson 1987). Nevertheless, economically impoverished communities retain other associations and assets that provide arenas for the development and mobilization of social networks toward common goals (Kretzman and McKnight 1993; Israel et al. 1994; Parker et al. 1998).

In addition to the pathways through which societal inequalities influence social networks and the resources available within them, these inequalities compound each other. For example, communities experiencing concentrated poverty also tend to experience political marginalization (Cohen and Dawson 1993), which effectively reduces their ability to influence local, state, and national policies related to the distribution of social and economic resources.

Collectives (social movements, communities, identity groups) are founded on relationships defined as meaningful by the individuals who are part of them. These relationships form the foundation for the mobilization of resources within and between groups (Steuart 1978; Friedman and McAdam 1992; Morris 1984; Snow, Zurcher, and Eklund-Olson 1980; McMillan and Chavis 1986; Heaney and Israel 1997; Eng and Parker 1994; Israel et al. 1994, 1998). Group boundaries and the meanings of group membership are associated with relationships between groups and the distribution of resources within and between groups. Thus, the symbolic meanings associated with race and ethnicity in the United States influence, and are influenced by, social policies that in turn contribute to political, economic, and social inequalities. These sociocultural processes influence the resources available to create or resist social change processes, with profound implications for the health of group members (Israel et al. 1994; Goodman et al. 1998). Finally, the model suggests reciprocal pathways through which health status may influence the size and

resilience of social networks. For example, as the health and stamina of individuals in poor communities deteriorate owing to sustained high-effort coping with social or economic adversity (Geronimus 1992; James 1994), the social resources that can be mobilized to address community problems are correspondingly reduced (House et al. 1988; Heaney and Israel 1997).

The multiple pathways described in our conceptual model suggest many potential avenues to influence the structure of social relationships, the resources that inhere within them, and their impact on community health. In the next section, we describe a public health intervention case study illustrating some of the key dimensions of our conceptual model.

BUILDING COMMUNITY CAPACITY AND SOCIAL CAPITAL TO PROMOTE HEALTH: A CASE STUDY

In this section, we present a case study of an ongoing, community-based, public health intervention on the East Side of Detroit, one of the most economically distressed areas in the city. Although improving the general health status of the community is the ultimate goal, increasing community empowerment and capacity by strengthening and expanding existing social networks is considered a prerequisite for attaining this goal (Israel et al. 1998; Parker et al. 1998; Schulz et al. 2000).

Background

In 1990, Detroit reported a population of 1,027,974 (U.S. Bureau of the Census 1990), 76 percent of which was African American. This makes Detroit the largest African American-majority city in the United States. Many of the African Americans who migrated to Detroit from the 1940s through the 1960s in search of jobs settled on the East Side, which historically had been known as the gateway to the city for successive groups of immigrants (Parker et al. 1998). Following World War II, the city began to experience a steady outflow of whites to the suburbs, a trend that was greatly accelerated after the 1967 civil unrest (Babson 1986). By 1990, Detroit was one of the most racially segregated cities in the country (Sugrue 1996; Massey and Denton 1993), and also one of the most impoverished: 29 percent of all families with children lived below the poverty line (U.S. Bureau of the Census 1990).

In keeping with its high percentage of families in poverty, Detroit's infant mortality rate in 1990 was 20.45 per 1,000, more than double the rate for the country as a whole (U.S. Bureau of the Census 1990). Moreover, a recent study contrasting all-cause mortality rates in selected low-income urban and rural areas of the United States found that death rates for young adults in Detroit (especially African Americans) were among the very highest in the country (Geronimus et al. 1996).

These statistics do not, however, provide a complete portrait of the city of Detroit. Many neighborhoods in the city, including the East Side, have assets that bode well for public health interventions designed to build community capacity and social capital. For example, Detroit has a strong history of union and neighborhood

organizing, and African Americans have made strong contributions to both. Block clubs have been an important feature of neighborhood life in Detroit since the 1950s. Moreover, unlike many other large metropolitan areas, close to 75 percent of Detroit's population lives in single-family dwellings, 53 percent of which are owner-occupied (Parker et al. 1998). Others (for example, Saegert and Winkel 1998) have noted that higher rates of resident homeownership are associated with improved property maintenance and less residential mobility, environmental attributes that strengthen a sense of community. Collectively, these varied community assets provide a solid basis on which to launch "capacity-building" public health interventions in neighborhoods on the East Side.

The Intervention

The intervention builds on epidemiological studies linking poor health among residents of impoverished communities to structured racial, economic, and political inequalities (Williams and Collins 1995; LaVeist 1992). As highlighted in our conceptual model, the cumulative effects of these various forms of social inequality on individuals are presumed to be mediated by the layers of social networks in which those individuals are embedded (Bronfenbrenner 1979; Israel 1982; Gottlieb and McLeroy 1994; Parker et al. 1998; Schulz et al. 1998). If collective action at the community level is a precondition for reducing these various forms of structured inequality, then building community capacity for social change logically must become a major focus of public health interventions (Steuart 1993; Israel et al. 1994; Fisher 1995; Parker et al. 1998).

The East Side Detroit Village Health Worker Partnership involves about forty community residents acting as village health workers (VHWs) and a steering committee made up of representatives from ten institutions: the Detroit Health Department, Friends of Parkside, the Henry Ford Health System, the Butzel Family Center, the Warren-Conner Development Coalition, Mack Alive!, the Island View Development Coalition, the Kettering Butzel Health Initiative, the East Side Parish Nurse Network, and the School of Public Health at the University of Michigan. Two VHWs also serve on the steering committee as voting members. The steering committee is thus a forum for building and extending social networks among representatives from the constituent organizations and for identifying and mobilizing resources that can be used to address the problems identified by community residents.

The first substantive undertaking of the steering committee was to build a sense of common purpose and mutual trust (Parker et al. 1998). In-depth interviews with key community informants and focused discussion among members of the steering committee contributed to an improved understanding of both the challenges and the resources available to families on the East Side. Themes identified through these processes were incorporated into a household survey instrument. The instrument was used to assess the prevalence of selected problems and their baseline association with self-perceived health among a random sample of East Side women with child-rearing responsibility (Schulz et al. 1998). Consistent with the literature on social integration and health (House et al. 1988; Heaney and Israel 1997), results

from this baseline survey indicated that women who had limited contact with neighbors, or who were not involved in block clubs, reported higher levels of stress and symptoms of depression than more socially integrated women (James et al. 1998).

The VHWs involved with the project are residents of the East Side. Most were asked to participate in the partnership on the basis of their identification by community members or organizations as people who were considered trustworthy and competent problem solvers. Many have histories in local organizing, while others are firmly embedded in social networks in which they play key roles in providing instrumental and emotional support to other members. The partnership is grounded in the lay health adviser models that have been used successfully in developing countries and in rural areas of the United States (Steuart 1993; Eng, Hatch, and Callan 1985; Eng and Young 1992). The East Side intervention is one of relatively few efforts to implement this model in a large urban area (Parker et al. 1998).

Owing to their leadership roles within existing local social networks, lay health advisers can intervene (or alternatively, help to organize interventions) at multiple levels (Eng and Young 1992). These levels are analogous to those described in our conceptual model of social capital. Specifically, these advisers may strengthen and extend social networks as well as mobilize resources within networks for the benefit of individuals or groups (for example, by relaying information to individuals or providing instrumental support for network members). Collectively, they may act at the organizational level (for example, on the steering committee) to mobilize the acquisition of new resources, or the transfer of existing ones from participating institutions to community residents. Finally, they may work toward broad-scale community change by mobilizing community residents and community-based organizations to promote positive change in the surrounding community or in the broader social system, in ways that promote community health and well-being.

In addition to the overall structure of the intervention and its links to aspects of our conceptual model, there are important conceptual issues related to the process of enhancing community capacity for change. The Village Health Worker Partnership is grounded in a theoretical model that emphasizes the development of partnerships between multiple actors, each bringing unique perspectives and resources to the table (Israel et al. 1998). This model emphasizes the power differentials among all participants in the process: it recognizes that community capacity involves effective management of both internal social power processes and differential power relationships with external organizations and communities. Today there is considerable dialogue within public health and related fields regarding power differentials between researchers and community members, but less attention has been given to differentials in power and resources within communities, as conditioned, for example, by gender, social class, or race. If they do not explicitly pay attention to the social power differentials among their members, partnerships—including public health partnerships—may simply reproduce existing social inequalities.

These power differentials may be addressed at multiple levels. The active participation and influence of community members in the process of establishing the goals, framing the specific agenda and assessing the results of the intervention, is essential if the goal of community capacity building is to be realized (Hatch et al.

1993; Israel et al. 1998). In the East Side Village Health Worker Partnership, attention to these processes is guided by principles arrived at through discussion and consensus among community members, organizational representatives, and academic partners (Schulz et al. 1998). Corollary changes in the relationships between funding agencies in the health arena, both public and private, and the communities that will be affected by the funding are also urgently needed.

None of the goals of the East Side Village Health Worker Partnership will be easy to achieve. There are major challenges at every level, from the time constraints on VHWs to the need to avoid reproducing unequal power relationships within decisionmaking structures of the partnership, to the search for effective pathways to engage the structural inequalities that lie at the root of the social, economic, and health problems in the community. These are formidable challenges, but the participants are fully committed to the principle that building sustainable community capacity (and increasing social capital) must incorporate a partnership approach that engages community members, community-based organizations, and other institutions in the process of addressing the institutional structures that reinforce racial and economic inequalities.

POLICY IMPLICATIONS AND RECOMMENDATIONS

Enlightened public policy plays a critical role in addressing the societal-level factors and institutional structures that reinforce racial and economic inequalities. In this section, we discuss two levels at which public policy can foster the development of social capital in poor communities. First, governmental agencies and foundations can support social capital development through funding initiatives that build community capacity to promote health. Second, progressive legislation that counters the cumulative impact of poverty and racism on the health of communities should be developed and enforced.

Funding agencies and organizations can facilitate the production and development of social capital in communities by addressing the pathways of influence reflected in our conceptual model. Economic development within communities should undergird all promising community-based initiatives in order to address the societal-level factors that impede the development of social capital. In addition, activities supported by funding agencies could increase community capacity if forums were convened in which the skills and leadership of local residents were strengthened, as well as the relationships and commitment of local residents and others to the community. Community-based health initiatives should also recognize the critical role of mediating organizations, as noted earlier, in building social capital and fostering connections between residents and organizations, both inside and outside the community. Initiatives that actively incorporate community-based organizations as crucibles for the development and mobilization of social capital should be encouraged. Finally, funding decisions should be made only after a realistic appraisal of the length of time the community development process takes and the resources it requires.

Social policies that address the disproportionate burden of health-compromising factors in economically impoverished communities would complement these efforts. Specific attention should be directed to the excessive burden of health problems borne by low-income women, many of whom are raising children as single heads of households. Since they are overrepresented in the low-wage labor force, policies related to child care, parental leave, and the general conditions under which women labor are needed in order to improve their overall health (Geronimus 1992).

Finally, a number of our policy recommendations would directly address the broad societal-level risk factors that influence both social capital and the health of community residents. Along with others (for example, Link and Phelan 1995), we argue that health disparities between subgroups of the population cannot be reduced without addressing the fundamental social processes that accelerate the deterioration of community health. Policies that would moderate the wide disparities in income and wealth (for example, ensuring a living wage, capping wage differentials within organizations, or attending to corporate taxation loopholes) and facilitate the political participation of groups with modest economic resources are worthy of special consideration. Finally, policies that curtail residential segregation by race would facilitate wealth accumulation by working-class families while increasing the potential for social networks to become more racially diverse. All of these recommendations would make a substantial contribution to building social capital and improving the public's health within and across U.S. communities.

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NOTE

1. We read this use of the word "community" as referring to a social and political system that fails to invest equitably in the well-being of all of its members. This interpretation is in contrast to a specific, identifiable community that runs the risk of "community-blaming," analogous to "victim-blaming" in reference to individuals.

REFERENCES

- Aday, LuAnne. 1994. "Health Status of Vulnerable Populations." *Annual Review of Public Health* 15: 487-509.
- Almaguer, Tomas. 1994. *Racial Fault Lines: The Historical Origins of White Supremacy in California*. Berkeley: University of California Press.
- Babson, Steve. 1986. *Working Detroit: The Making of a Union Town*. Detroit: Wayne State University Press.
- Berger, Peter, and Richard Neuhaus. 1977. *To Empower People: The Role of Mediating Structures in Public Policy*. Washington, D.C.: American Enterprise Institute for Public Policy Research.

Social Capital and Poor Communities

- Bourdieu, Pierre. 1987. "What Makes a Social Class?: On the Theoretical and Practical Existence of Groups." *Berkeley Journal of Sociology* 32: 1-8 (3-4).
- Bronfenbrenner, Urie. 1979. *The Ecology of Human Development*. Cambridge, Mass.: Harvard University Press.
- Cassel, John. 1976. "The Contribution of the Social Environment to Host Resistance." *American Journal of Epidemiology* 104(2): 107-23.
- Clark, Noreen M., and Kenneth R. McLeroy. 1995. "Creating Capacity Through Health Education: What We Know and What We Don't." *Health Education Quarterly* 22(3): 273-89.
- Cohen, Anthony P. 1985. *The Symbolic Construction of Community*. London: Routledge.
- Cohen, Cathy. 1996. "Contested Membership: Black Gay Identities and the Politics of AIDS." In *Queer Theory: Sociology*, edited by Steven Seidman. Oxford: Blackwell.
- Cohen, Cathy, and Michael Dawson. 1993. "Neighborhood Poverty and African-American Politics." *American Political Science Review* 87: 286-302.
- Cohen, Sheldon, William J. Doyle, David P. Skoner, Bruce S. Rabin, and Jack M. Gwaltney. 1997. "Social Ties and Susceptibility to the Common Cold." *Journal of the American Medical Association* 277(24): 1940-44.
- Cohen, Sheldon, and S. Leonard Syme, eds. 1985. *Social Support and Health*. Orlando: Academic Press.
- Coleman, James. 1988. "Social Capital in the Creation of Human Capital." *American Journal of Sociology* 94: S95-120.
- . 1990. *The Foundations of Social Theory*. Cambridge, Mass.: Harvard University Press.
- Collins, Chiquita A., and David R. Williams. 1999. "Segregation and Mortality: The Deadly Effects of Racism?" *Sociological Forum* 14: 495-523.
- Cottrell, Leonard. 1976. "The Competent Community." In *Further Explorations in Social Psychiatry*, edited by Berton H. Kaplan, Robert N. Wilson, and Alexander H. Leighton. New York: Basic Books.
- Edwards, Bob, and Michael W. Foley. 1997. "Social Capital and the Political Economy of Our Discontent." *American Behavioral Scientist* 40(5): 669-78.
- Eng, Eugenia, John Hatch, and Anne Callan. 1985. "Institutionalizing Social Support Through the Church and into the Community." *Health Education Quarterly* 12: 81-92.
- Eng, Eugenia, and Edith Parker. 1994. "Measuring Community Competence in the Mississippi Delta: The Interface Between Program Evaluation and Empowerment." *Health Education Quarterly* 21: 199-219.
- Eng, Eugenia, and R. Young. 1992. "Lay Health Advisors as Community Change Agents." *Family and Community Health* 15: 24-40.
- Ferber, Abby. 1998. *White Man Falling: Race, Gender, and White Supremacy*. New York: Rowman and Littlefield.
- Fisher, Edwin B., Jr. 1995. "The Results of the COMMIT Trial." *American Journal of Public Health* 85: 159-60.
- Foley, Michael W., and Bob Edwards. 1997. "Escape from Politics?: Social Theory and the Social Capital Debate." *American Behavioral Scientist* 40(5): 550-61.
- Frankenberg, Ruth. 1993. *White Women, Race Matters: The Social Construction of Whiteness*. Minneapolis: University of Minnesota Press.
- Friedman, Debra, and Doug McAdam. 1992. "Collective Identity and Activism: Networks, Choices, and the Life of a Social Movement." In *Frontiers in Social Movement Theory*, edited by Aldon D. Morris and Carol M. Mueller. New Haven, Conn.: Yale University Press.
- Fullilove, Mindy T. 1998. "Injury and Anomie: Effect of Violence on an Inner-City Community." *American Journal of Public Health* 88(6): 924-27.
- Geronimus, Arline T. 1992. "The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations." *Ethnicity and Disease* 2: 207-21.

- Geronimus, Arline T., John Bound, Timothy A. Waidmann, Marianne M. Hillemeier, and Patricia B. Burns. 1996. "Excess Mortality Among Blacks and Whites in the United States." *New England Journal of Medicine* 335: 1552-58.
- Goodman, Robert M., Marjorie Speers, Kenneth McLeroy, Stephen Fawcett, Michelle Kegler, Edith Parker, Steven Smith, Terri Sterling, and Nina Wallerstein. 1998. "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement." *Health Education and Behavior* 25(3): 258-78.
- Gottlieb, Neil H., and Kenneth R. McLeroy. 1994. "Social Health." In *Health Promotion in the Workplace*, 2nd ed., edited by Michael P. O'Donnell and Jeffrey S. Harris. Albany, N.Y.: Delmar.
- Hatch, John, Nancy Moss, Ama Saran, Letitia Pressley-Cantrell, and Carol Mallory. 1993. "Community Research: Partnership in Black Communities." *American Journal of Preventive Medicine* 9: 27-31.
- Heaney, Catherine A., and Barbara A. Israel. 1997. "Social Networks and Social Support in Health Education." In *Health Behavior and Health Education: Theory, Research, and Practice*, 2nd ed., edited by Karen Glanz, Frances M. Lewis, and Barbara K. Rimer. San Francisco: Jossey-Bass.
- Heying, Charles H. 1997. "Civic Elites and Corporate Delocalization." *American Behavioral Scientist* 40(5): 657-68.
- House, James S., Debra Umberson, and Karl Landis. 1988. "Structures and Processes of Social Support." *Annual Review of Sociology* 14: 293-318.
- Iscoe, Ira. 1974. "Community Psychology and the Competent Community." *American Psychologist* 29: 607-13.
- Israel, Barbara A. 1982. "Social Networks and Health Status: Linking Theory, Research, and Practice." *Patient Education and Counseling* 4(2): 65-79.
- Israel, Barbara A., Barry Checkoway, Amy Schulz, and Marc Zimmerman. 1994. "Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organizational, and Community Control." *Health Education Quarterly* 21(2): 149-70.
- Israel, Barbara A., Amy J. Schulz, Edith A. Parker, and Adam B. Becker. 1998. "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health." *Annual Review of Public Health* 19: 173-202.
- James, Sherman A. 1993. "Racial and Ethnic Differences in Infant Mortality and Low Birthweight: A Psychosocial Critique." *Annals of Epidemiology* 3: 130-36.
- . 1994. "John Henryism and the Health of African-Americans." *Culture, Medicine, and Psychiatry* 18: 163-82.
- James, Sherman A., Edith A. Parker, Amy J. Schulz, and Barbara A. Israel. 1998. "Community-Based Research on Detroit's East Side: Baseline Correlates of Depression Symptomatology in African-American Women." Paper presented at Conference on Public Health in the Twenty-first Century: Behavioral and Social Science Contributions, Atlanta (May 9).
- Kaplan, George K., and John W. Lynch. 1997. "Editorial: Whither Studies on the Socioeconomic Foundations of Population Health." *American Journal of Public Health* 87(9): 1409-11.
- Kaplan, George K., Elsie R. Pamuk, John W. Lynch, Richard D. Cohen, and Jennifer L. Balfour. 1996. "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways." *British Medical Journal* 312: 999-1003.
- Kawachi, Ichiro, Bruce P. Kennedy, Kimberly Lochner, and Deborah Prothrow-Stith. 1997. "Social Capital, Income Inequality, and Mortality." *American Journal of Public Health* 87: 1491-98.

Social Capital and Poor Communities

- Kennedy, Bruce P., Ichiro Kawachi, Kimberly Lochner, Camara Jones, and Deborah Prothrow-Stith. 1997. "(Dis)respect and Black Mortality." *Ethnicity and Disease* 7(3): 207-14.
- Kennedy, Bruce P., Ichiro Kawachi, and Deborah Prothrow-Stith. 1996. "Income Distribution and Mortality: Cross-sectional Ecological Study of the Robin Hood Index in the United States." *British Medical Journal* 312: 1004-7.
- Kennedy, Bruce P., Ichiro Kawachi, Deborah Prothrow-Stith, Kimberly Lochner, and Vanita Gupta. 1998. "Social Capital, Income Inequality, and Firearm Violent Crime." *Social Science and Medicine* 47(1): 7-17.
- Kretzman, John, and John McKnight. 1993. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA Publications.
- Kreuter, Marshall. 1998. "Is Social Capital a Mediating Structure for Effective Community-Based Health Promotion?" Working Paper. Atlanta: Health 2000.
- LaVeist, Thomas A. 1989. "Linking Residential Segregation to the Infant-Mortality Disparity in U.S. Cities." *Sociology and Social Research* 73(2): 90-94.
- . 1992. "The Political Empowerment and Health Status of African-Americans: Mapping a New Territory." *American Journal of Sociology* 97(4): 1080-95.
- Link, Bruce G., and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* (extra issue): 80-94.
- Lomas, Jonathan. 1998. "Social Capital and Health: Implications for Public Health and Epidemiology." *Social Science and Medicine* 47(9): 1181-88.
- Lynch, John W., George A. Kaplan, Elsie R. Pamuk, Richard D. Cohen, Katherine E. Heck, Jennifer L. Balfour, and Irene H. Yen. 1998. "Income Inequality and Mortality in Metropolitan Areas of the United States." *American Journal of Public Health* 88(7): 1974-80.
- Massey, Douglas, and Nancy Denton. 1993. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge, Mass.: Harvard University Press.
- Massey, Douglas S., and M. J. Fischer. 2000. "How Segregation Concentrates Poverty." *Ethnic and Racial Studies* 23(4): 670-91.
- McCarthy, John D., and Mayer Zald. 1977. "Resource Mobilization and Social Movements: A Partial Theory." *American Journal of Sociology* 82: 1212-41.
- McMillan, John W., and David M. Chavis. 1986. "Sense of Community: Definitions and Theory." *Journal of Community Psychology* 14: 6-23.
- Minkoff, Debra C. 1995. *Organizing for Equality: The Evolution of Women's and Racial-Ethnic Organizations in America, 1955-1985*. New Brunswick, N.J.: Rutgers University Press.
- Morris, Aldon. 1984. *The Origins of the Civil Rights Movement*. New York: Free Press.
- Parker, Edith A., and Eugenia Eng. 1995. "Conceptualizing Community Problem-solving Capacity: Results of a Grounded Theory Study." Ann Arbor: University of Michigan. Unpublished paper.
- Parker, Edith A., Amy J. Schulz, Barbara A. Israel, and Rose Hollis. 1998. "Detroit's East Side Village Health Worker Partnership: Community-Based Lay Health Advisor Intervention in an Urban Area." *Health Education and Behavior* 25(1): 24-45.
- Patrick, Donald L., and Thomas M. Wickizer. 1995. "Community and Health." In *Society and Health*, edited by Benjamin C. Amick, Sol Levine, Alvin R. Tarlov, and Diana C. Walsh. New York: Oxford University Press.
- Pearce, Neil. 1996. "Traditional Epidemiology, Modern Epidemiology, and Public Health." *American Journal of Public Health* 86: 678-83.
- Polednak, Anthony P. 1991. "Black-White Differences in Infant Mortality in Thirty-eight Standard Metropolitan Areas." *American Journal of Public Health* 81(11): 1, 480-82.
- . 1993. "Poverty, Residential Segregation, and Black/White Mortality Ratios in Urban Areas." *Journal of Health Care for the Poor and Underserved* 4(4): 363-73.

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- . 1996. "Segregation, Discrimination, and Mortality in U.S. Blacks." *Ethnicity and Disease* 6(1-2): 99-108.
- Portes, Alejandro, and Patricia Landolt. 1996. "The Downside of Social Capital." *The American Prospect* 26: 18-22.
- Putnam, Robert D. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, N.J.: Princeton University Press.
- . 1995. "Bowling Alone: America's Declining Social Capital." *Journal of Democracy* 6: 65-78.
- Saegert, Susan, and Gary Winkel. 1998. "Social Capital and the Revitalization of New York City's Distressed Inner-City Housing." *Housing Policy Debate* 9(1): 17-60.
- Schulz, Amy J., Barbara A. Israel, Edith A. Parker, and Adam B. Becker. 2000. "I Started Knocking on Doors in the Community: Women's Participation and Influence in the East Side Village Health Worker Partnership." In *Empowerment of Women and Mothers for Health Promotion*, edited by Snehendu Kar. Thousand Oaks, Calif.: Sage.
- Schulz, Amy J., Barbara A. Israel, Susan Selig, and Irene Bayer. 1998. "Development and Implementation of Guidelines for Community-Based Research." In *Research Strategies for Community Practice*, edited by R. H. MacNair. New York: Haworth Press.
- Schulz, Amy J., Barbara A. Israel, Marc A. Zimmerman, and Barry N. Checkoway. 1995. "Empowerment as a Multi-level Construct: Perceived Control at the Individual, Organizational, and Community Levels." *Health Education Research* 10(3): 309-27.
- Schulz, Amy J., Edith A. Parker, Barbara A. Israel, Adam B. Becker, Barbara J. Maciak, and Rose Hollis. 1998. "Conducting a Participatory Community-Based Survey for a Community Health Intervention on Detroit's East Side." *Journal of Public Health Management and Practice* 4(2): 10-24.
- Schwartz, Michael, and Paul Schuva. 1992. "Resource Mobilization Versus the Mobilization of the People." In *Frontiers in Social Movement Theory*, edited by Aldon D. Morris and Carol McClung Mueller. New Haven, Conn.: Yale University Press.
- Shaw, Clifford, and Henry McKay. 1942. *Juvenile Delinquency and Urban Areas*. Chicago: University of Chicago Press.
- Snow, David A., Louis A. Zurcher, and Steven Eklund-Olson. 1980. "Social Networks and Social Movements: A Microstructural Approach to Differential Recruitment." *American Sociological Review* 45(5): 787-801.
- Snow, John. 1936. *Snow on Cholera*. New York: Commonwealth Fund; London: Oxford University Press.
- Stack, Carol. 1974. *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper and Row.
- . 1996. *Call to Home: African-Americans Reclaim the Rural South*. New York: Basic Books.
- Steuart, Guy W. 1978. "Social and Cultural Perspectives: Community Intervention and Mental Health." Paper presented at the Fourteenth Annual John W. Umstead Series of Distinguished Lectures, Raleigh, N.C.
- . 1993. "Social and Behavioral Change Strategies." *Health Education Quarterly Supplement* 1: S113-35.
- Sugrue, Thomas J. 1996. *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit*. Princeton, N.J.: Princeton University Press.
- Thomas, Rosalind P., Barbara A. Israel, and Guy W. Steuart. 1985. "Cooperative Problem Solving: The Neighborhood Self Help Project." In *Advancing Health Through Education*, edited by Helen P. Cleary, Jefferey M. Kichen, and Phyllis G. Ensor. Palo Alto, Calif.: Mayfield.
- U.S. Bureau of the Census. 1990. *Subcommunity Profiles for the City of Detroit, October 1993: United Community Services of Metropolitan Detroit*. Washington: U.S. Government Printing Office.

Social Capital and Poor Communities

- Wacquant, Loic J. D., and William Julius Wilson. 1989. "The Cost of Racial and Class Exclusion in the Inner City." *Annals of the American Academy of Political and Social Sciences* 501: 8-25.
- Wallace, Robert. 1990. "Urban Desertification, Public Health, and Public Order: Planned Shrinkage, Violent Death, Substance Abuse, and AIDS in the Bronx." *Social Science and Medicine* 31: 801-13.
- Wallerstein, Nina. 1992. "Powerlessness, Empowerment, and Health: Implications for Health Promotion Programs." *American Journal of Health Promotion* 6: 197-205.
- Wallerstein, Nina M., and Edward Bernstein, eds. 1994. "Community Empowerment, Participatory Education, and Health: Part II." *Health Education Quarterly* 21: 279-419.
- Wandersman, Abraham, Paul Florin, Robert Friedmann, and Richard Meier. 1987. "Who Participates, Who Does Not, and Why?: An Analysis of Voluntary Neighborhood Organizations in the United States and Israel." *Sociological Forum* 2(3): 534-55.
- Wilkinson, Richard G. 1996. *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge.
- . 1997. "Comment: Income, Inequality, and Social Cohesion." *American Journal of Public Health* 87: 1504-6.
- Williams, David R., and Chiquita Collins. 1995. "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology* 21: 349-86.
- Wilson, T. D. 1998. "Weak Ties, Strong Ties: Network Principles in Mexican Migration." *Human Organization* 57 (4): 394-403.
- Wilson, William J. 1987. *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy*. Chicago: University of Chicago Press.
- Wolf, Stewart, and J. G. Bruhn. 1993. *The Power of Clan: The Influence of Human Relationships on Heart Disease*. New Brunswick, N.J.: Transaction Publishers.
- Yen, Irene, and S. Leonard Syme. 1999. "The Social Environment and Health: A Discussion of the Epidemiologic Literature." *Annual Review of Public Health* 20: 287-308.
- Zimmerman, Marc A., and Julian Rappaport. 1988. "Citizen Participation, Perceived Control, and Psychological Empowerment." *American Journal of Community Psychology* 16: 725-50.