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SOCIAL CAPITAL AND HEALTH OUTCOME IN NIGER STATE, NIGERIA

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ABSTRACT

Quality of life is directly influenced by the quality of social relationships. Social Capital, a reflection of the cohesiveness of social networks, is considered a significant determinant of health outcomes. Social capital has been described as an empirically elusive concept, yet has also been heralded as the glue that holds communities together. While there has been much debate about its definition. Social capital can be understood as a network of social relations which are characterized by norms of trust and reciprocity and which lead to outcome of mutual benefits. Social capital stands for the ability of actors to secure benefits by virtue of membership in social networks or other social structures. Social capital as relationship in three dimensions that is bonding, bridging and linking social capital. Bonding social capital is a relationship that we have with people who are like us and typically refers to those among member of families and ethnic groups. Bridging social capital refers to those relationships we have with people who are from a different social –economic situation from a different generation or a different ethnicity. While linking social capital is a relationship people have with those in power. Linking social capital enables individuals and community groups to leverage resources, ideas and information from formal institutions beyond the immediate community radios. Thus, health status is critical to both human and economic productivity. Stemming from this, investments have been made to improve health. "On the one hand, millions of dollars are committed to alleviating ill-health through individual intervention. Meanwhile, we ignore what our everyday experience tells us, i.e. the way we organize our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health". Using a set of household data generated from the administration of structured questionnaires to 520 respondents, only 479

were returned and found useful for analysis. This paper investigates the impact of social capital on health outcome in Niger State, Nigeria, using a multi-regression analysis method. The result obtained shows that social capital is positively related to health outcome in the Niger State, thus, fulfilling our a-priori expectations that the more social capital formation by both the people and the Government of the study area, the more they find themselves out of ill-health. The results notwithstanding, policy measures that would continue to make social capital relevant to improve health outcome were suggested.

Keywords: Social Capital, Health Outcome, Niger State, Nigeria

INTRODUCTION

In the last decade, social capital has gained momentum, it has entered the mainstream of social science discourse and it is also a popular focus for policy discussion. Social capital has gained popularity among policy makers, politicians and researchers. Furthermore, there is a strong thrust from the general community to use social capital as a way not only to describe but also to understand community health status. However, the definition and content of social capital remains relatively unfamiliar to the general public. This is hardly surprising as there is no single, universal definition for social capital. Even among the politicians and scholars who use the term, there is confusion about what social capital exactly encompasses. In broad terms, social capital can be understood as networks of social relations that are characterized by norms of trust and reciprocity and that lead to outcomes of mutual benefit. It deals with an important set of resources inherent in relationships, networks, associations and norms (Szreter and Woolcock 2004). Some scholars consider social capital to be one of the most important concepts to emerge in the past decade (Halpern 2005), whereas some express doubts that the concept tries to explain too much with too little (Lynch et al. 2000), and others criticize the concept for including virtually all the socioeconomic aspects of society repackaged in a new guise (Pearce and Davey Smith 2003, Stone and Hudges 2002, Woolcock 2001). In any case, it is difficult to ignore social capital, as it remains an intuitively useful concept.

The key concern is the presence of health inequalities. Even in the richest countries the social hill in health runs through the society, and people who are poor have substantially shorter life expectancies and more illnesses than the rich. However, in order to solve the problem of health inequalities a vital issue is to focus on the social environment in order to generate new understanding (Marmot 1998). Recently, scholars in health and policy research have suggested that the notion of social capital can go a long a long way in tackling the disparities in health status. (Kushner and Sterk 2005, Kawachi and Kennedy 1999). To date, numerous studies suggested that social capital may be a determinant of health status. This assumption is based on its associations with total mortality (Wilkinson et al. 1998, Kennedy et al. 2010, Blomgren et al. 2004), cardiovascular mortality (Sundquist, Lindström et al. 2004, Ali et al. 2006), self-rated health (Kawachi et al. 1999), mental health (Mitchell and LaGory 2002, Sundquist, Johansson et al. 2004) and health-related behaviors (Lindström et al. 2001, Kouvonen et al. 2008).

Conceptual Framework for Social Capital

Since the introduction of the aggregated theories that made the foundation for what is now refers to social capital, many researchers have come up with a variety of definitions of the term social capital. However, a collective basic things that runs through them includes the key components

of trust, reciprocity, cooperation, and civic involvement, from which social capital result. These elements raise the development of a civic community that is able to address public issues collectively, as a community of citizens rather than a collection of private individuals (Borgida, et al. 2002).

Kawachi, Kennedy, and Glass (1999) opines that social capital consists of social organization characteristics that facilitate collective actions. Hawe and Sheill (2000), stated that social capital is not "one thing." It has relational, materials. And political aspects as well as positive or negative effects. It can refer to both dense and loose networks and it takes on a different form depending on whether one is concerned with the individual, immediate group membership, or the interaction between social institutions. Hancock (1999) comes up, with another definition that social capital constitutes the glue that hold communities together. It has both an informal aspect, related to social to social networks, and a more formal aspect, related to our social development programs.

In a broader ecological perspective, social capital is not merely concerned with individuals having a multitude of relationships, but with quality relationships that are rooted in features of social organization. The end goal, of social capital is not just tom produce trust, reciprocity, and civic involvement as a stagnant endpoint. These characteristics are cornerstones of a dynamic and circular process that continually accrues positive dividends for individuals and communities. Social capital does not depreciate with use like physical assets, rather it undergoes a multiplier effect whereby the more it is used the larger it becomes (Hawe & Shiell, 2000). It typically produces dividends from the initial investment that was made, and reciprocity is generally a by-product of the transaction. Social capital cannot accrue to individual unless he or she interact with others (Macinko & Starfield, 2001).

Social Capital and Health Outcome

A wide variety of studies have underscored the benefit of high levels of social capital. A study by Seeman (1996), indicated that, based on available data, social integration is generally associated with better health, and quality of relationships influence the extent of health benefits. Seeman (1996), noted that "clearly, individual's networks of social relationships represent dynamic and complex social systems that effect health outcome." Social capital relates directly to levels of social cohesion in a community, and the strength of social networks, social ties and social support among its members can determine individual and community self-determination. These factors are potent ammunition in the battle to develop healthy environments based on individuals' ability to work together to combat a sense of shared powerlessness and helplessness. According to Hancock (1999), "a nation's health is a nation's wealth." The health of the members of a society is indeed a form of capital valuable to the society at large. Healthy individuals are able to contribute to the establishment of healthy communities, healthy economies and robust political system. In addition, scholars have long noted an association between social relationships and individual health status. Lynch (1977) identified dialogue as an elixir that sustains our lives. Furthermore, reciprocal relations, sharing, and caring communication with others involve processes that go beyond what scientific instruments can measure.

Health is the product of multiple levels of influence including, biological makeup, individual behaviors, and the context within which people live, the social environment. A multilevel approach to health requires taking into consideration social capital as a characteristics of social environment and thus a potential determinant of health. Socially isolated individuals are less psychologically and physically healthy, and are more likely to suffer morbidities and mortalities than more socially integrated individuals (House, Landis & Umberson, 1988). Humans seems to have an innate understanding that there is a link between loneliness or isolation and deleterious physical effects. Putman, (2000), traced the consequences of varying levels of social capital and it was found that none was importance of social connectedness so well in the case of health and well-being. This insight has been reflected in public health research on virtually all aspects of physical and mental health (Berkman & Glass, 2000; Hernderson & Whiteford, 2003), and through both epidemiological and qualitative studies (Baum & Ziersch, 2005). It is evidence that, the size of one's social network or degree of "connectedness" is inversely related to high-risk health behaviors. Kawachi et al. (1999), found that states with low social capital had higher numbers of residents who reported their health status as being only fair or poor. This findings are typical and replicated in multiple other studies. Studies have also showed strong correlations between lack of social ties and poor post-stroke and post-heart attack recovery, increased mental disorders and lowered immune function (Berkman & Glass, 2000). Availability of social support and access to information that comes from network connections are necessary for survival and health.

The degree to which an individual is connected to and embedded within the networks of a community is vital to his or her health and well-being, as well as to the health and vitality of the community. Individuals who lack social support and social ties live in a situation that is not conducive to optimal health. Obviously, these factors cannot all be isolated for experimental purposes to produce conclusive evidence of causation. However, a wealth of studies on the topic has nonetheless identified a significant impact of social capital on individual health outcome in Niger State, Nigeria. However, this study ought to look at the impact of social capital on individual health outcome in Niger state, Nigeria.

STUDY AREA AND METHODOLOGY

Study Area

This study was conducted in Niger State of Nigeria, Niger State is one of the State in the Northern part of Nigeria, specifically, North central region. The State located in an area of about 150 Kilometer from Abuja, the Federal Capital of Nigeria and on Latitude 8o22'N and 11o30'N and Longitude 3o30'N and 7o20'E.

Data Source

The study used both secondary and primary data for regression analysis. The variables considered for the study are the social capital indicators which comprises (interpersonal trust, civic responsibility, and social networks).

Data was collected through structured questionnaire administered among the heads of households in Niger State between the month of December 2016 and April 2017. A stratified sampling method was used in selecting the respondents, a multistage sample design was used to

collect cross sectional data from households in the study area. The first stage was to identify the sample areas which comprise twenty five (25) local government areas, which was divided into three (3) senatorial district. In the state, two local government area was randomly selected from each of the senatorial district based on the proximity, ecological, socio-cultural, language speaking, and economic variations. This was necessary for equal representation of the study area. The second stage identified the number of household and population in each study area, while the third stage of the sampling involve random selection of eighty five point five (86.5) approximately eighty seven (87) households in each of the selected study areas. In all a total sample of about five hundred and nineteen (519) or five hundred and twenty two (522) heads of households were randomly selected to respond to the questions in the questionnaires. Out of which only 479 questionnaires were suitable for the analysis of this study.

MODELS SPECIFICATION

In determining the influence of social capital on health outcome in Niger State, Nigeria, an econometrics model was built around the indicators of social capital and health status, as the main objective of this paper. The model are thus used in estimating the impact of these indicators on health outcome in Niger State, Nigeria.

The indicators that were taking into consideration are: (interpersonal trust, civic responsibility and community volunteerism).
Having stated this, the model is thus formulated as: Houti = *f* (Soc, Cap.)…….. (1) With Soc. Cap. = *f* (int.tr, civ.res, com.vol.)…….. (2)

When equation (2) is substituted into equation (1) it then becomes Houti = *f* (int.tr, civ.res, com.vol.)…….. (3)

When transformed into a multiple linear relationship, the model thus become InHouti = Inβo + β1int.tr + β2civ.res + β3com.vol + U …….. (4)
Where

InHouti = Log of health outcome in Minna proxies by individual health status.
Int. tr. = Interpersonal trust among the people of Niger State
civ.res = Civic responsibility of individual in the study area.
Com.Vol. = Community Volunteer activities by members in the study area.
β_o, β_1, β_2 & β_3 = Estimation parameter associated with the influence of the indicators of social capital on poverty reduction in Minna Metropolis
U = Disturbance term.

Drawing from the model, our a-priori expectation of the expected pattern of behavior of the independent variables (int.tr, civ.res, com.vol.) on the dependent variable (Hout) are int.tr > O, civ.act > O, com vol > O.

RESULT AND DISCUSSION

The results of the multiple regression analysis conducted at 5% percent level of significance are presented in table 1 below.

Table 1: Regression results of social capital and poverty in Minna Metropolis.

Explanatory Variables	Coefficient and t-value
Intercept (t)	7.42(3.52)
Int.tr (t)	3.82 (2.15)
civ.act(t)	4.62 (1.07)
com. vol.(t)	0.74 (4.28)
R^2	0.72
F	7.05

Significant at 5% Per cent Level of Significance

Looking at the model, it is shows that the model is of good fit because it has an R^2 of 0.72. This shows that 72% variation in the dependent variables (Health status) is explained by the explanatory variables (social capital) while error term taken care of the remaining 28% which are variables in the study that cannot be included in the model because of certain qualitative feature. At 5% level of significance, the F-statistics show that the model is useful in determining if any significant relationships exist between health status and social capital in Niger State, Nigeria as the computed F-statistic which is 7.05 is greater than the tabulated F-statistic value at 1.75. In terms of the individual independent variables the coefficient and the associated t-values of social capital is related to health status in Niger State, Nigeria which fulfilled our expectation. An indication that social capital has contributed to the health status in Niger State. Reasons established for this could be linked to the following:

i. That people in the study have recognized the important social capital as a tool for health status
ii. That people can be trusted in the study area.
iii. That, even the people and Government in the area are performing their civic role in a way that it leads to the improvement in the health status of the citizen in the areas.
iv. That people in the area are engaged in community volunteerism in which activities that can improve health status of individual in that area.

CONCLUSION AND RECOMMENDATIONS

A relationship can be beneficial to health just as it can be unhealthy, it requires knowledge of the difference and commitment to produce a change. In order to connect with others and generate greater levels of social capital, it is first necessary that individuals have the ability to know themselves and prioritize their values, reflected in lifestyle choices, as it relates to health.

However, an empirical study of the impact of social capital on health outcome in Niger State was carried out using a structured questionnaire in collecting the data among the head of households and regression analysis. The findings show that social capital has significant impact on health status in Niger State, Nigeria. This outcome notwithstanding, individuals, government and policy makers in Niger State still need to take into consideration the following measures that would likely improve the flow and effective utilization of social capital, which in turn would further improve the health status of head of households in Niger State, Nigeria.

i. Niger State government and individual head of households in the study area should recognized the important of social capital.

ii. Interpersonal trust among the head of households in the study area should be prioritized, this will go a long way in improving the health status of the head of household, because with trust, one can engaged in any activities/ transaction without any written agreement.
iii. Niger State Government and head of households in the study area should sincerely perform their civic role in a way that it will improve the health status in the area.
v. Head of household in the study area should engage in community volunteerism, in which activities can be of assistant and a better health outcome among the people of the study area.

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