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Social capital and well-being among marginalized young Malaysians

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Abstract

According to social capital theory, the quality of social networks is equally important as the size of the networks. The quality of a social network very much depends on trust and its reciprocity among members. If the shared information is trustworthy, then the group members could generate more resources to combat stress and enhance the well-being of all members of the same network. The objective of this paper was to test the role of health behavior as a mediator of the interaction between generalized social capital (GSC) and subjective well-being (SWB) among young Malaysians. In total, 3,558 youths aged 15–25 years who lived in marginalized communities were recruited for this research using stratified and clustering sampling. The results from the descriptive analysis showed that respondents displayed moderate GSC, health behavior, and SWB scores. Pearson's correlation analysis showed that the relationship between the GSC and SWB of respondents in this study was significant. These findings suggested that the practice of social capital toward people in general would contribute to a higher level of SWB. The results from the regression analysis suggested that health behavior acts as a partial mediator between the interaction of GSC and SWB, which means that the SWB of the youths is influenced by both GSC and health behavior. These findings imply the need to promote activities that could strengthen the elements of trust and their reciprocity toward people in general, as well as promoting health behavior among marginalized young people. Future research could examine programs that promote social capital toward the general population and health behavior that strengthens the SWB of young Malaysians.

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Introduction

Marginalization refers to the exclusion of a group of people because of geographical factors (Jenson, 2000). Schnittker (2004) suggested some characteristics of marginalized people, with one being that marginalized people have a low socioeconomic status (SES)—low education attainment,

technology advancement, job opportunity, employment rate, and monthly income (Jenson, 2000). Therefore, they cannot afford to purchase goods and services, which may promote good health, such as vitamins, supplements, or joining a fitness program. In addition, they tend to consume tobacco, eat cheap and unhealthy food (fast food and junk food), have a poor diet, and do not exercise (Schnittker, 2004). Because of their unhealthy lifestyle, they are more prone to diseases, such as cholera, skin disease, diabetes mellitus, obesity, and hypertension (Schnittker, 2004). In other words, they suffer from diseases that would directly affect their well-being as a whole. They tend to be less satisfied with their life, less happy, and more stressed since their resources are limited (Baum, Garofalo, & Yali, 1999). In addition, Shim, Xiao, Barber, and Lyons (2009) proposed that having a low income and few job opportunities could lead to depression, distress, and poor interpersonal relationships.

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Since marginalization can negatively affect the well-being of the marginalized people, it is important to understand them, identify their problems, and suggest solutions to reduce the impact of marginalization. Hyypää and Maki (2003) found that social capital, self-rated health, and well-being are closely related. However, in their research, they did not establish a pathway of how the positive effect of social capital could lead to increased well-being and improved health. Thus, following their concluding remarks, this research attempted to test the theoretical model that explains how health-related patterns of social capital could influence well-being. This idea is demonstrated in Figure 1. In this model, the social connections established through health behavior could increase the SWB levels. In other words, people who actively participate in social activities based on health themes could have better well-being. In conclusion, this model suggests that health-promoting behavior mediates the relationship between social capital and well-being.

This study focused on marginalized youth since they are the human capital of the next generation. Well-being refers to a dynamic process that helps an individual make sense of and evaluate the quality of his or her lifestyle. It includes a sense of vitality and meaningful and engaging activities which make them feel competent and autonomous. There are numerous components of well-being, such as mental well-being, spiritual well-being, financial well-being, psychological well-being, and subjective well-being (SWB). In the current study, the researchers focused on SWB. SWB takes into account the self-reported assessment of an individual's well-being. The main components of SWB include life satisfaction, happiness, and psychological well-being. SWB is measured by simply asking people about their happiness. It allows people to decide how good their life is without someone else determining their well-being (Dolan, Layard, & Metcalfe, 2011). Factors that predict SWB are standard of living, health, achievements, quality of relationships, safety, community, and sense of security (Cummins, Eckersley, Pallant, Van Vugt, & Misajon, 2003; Dolan, Peasgood, & White, 2008).

It has been found that young people's health, especially those in marginalized areas, is declining (Eckersley, 2011). This is because marginalized youths lag in health promoting behavior and exposure to health promoting campaigns. It also indicated that they are more prone to mental illness and obesity-related health problems. The marginalized youths who were the participants in that study have lower self-reported health, happiness, and life satisfaction. Therefore, it can be seen

that health-promoting behavior affects SWB and that marginalized youths' health needs must be taken into account, as their situation becomes worse day-by-day.

Traditionally, people use medication to treat specific illnesses and health problems (Niggemann & Gruber, 2003). However, medication used for one diagnosis may have side effects which trigger other health risks (Niggemann & Gruber, 2003). Therefore, Berkman (1995) suggested treating health problems by perceiving them in a broader context. He stressed the importance of social networking and social support to enhance health behavior. The umbrella term for social networking and social support is social capital. Social capital refers to the connectedness of an individual to other individuals which is developed from trust and reciprocity (Putnam, 1995). He added that social capital facilitates cooperation for mutual benefit and facilitates social ties.

It has been found that social capital enhances health by monitoring, disciplining, advising, and competing. For instance, whenever we feel sick, our family will monitor our medication schedule and advise us on how to use the medication, even if we do not want to do so (Wilkinson, 1996; Young, 1998). To look at how social capital enhances health by discipline and competition, we can observe fitness programs—we join fitness programs and set a daily target to reach. We will feel motivated and competitive whenever we see other members who have already achieved the target. We will push ourselves to do the same thing. In addition, the instructor will monitor our progress; therefore, we will be more disciplined in achieving the target. Hence, it is obvious that social capital enhances health-promoting behavior.

Overall, the current researchers chose two research objectives: 1) to determine if there are significant relationships among the variables of social capital, health behavior; and well-being; and 2) to determine if health behavior acts as a mediator for the relationship between social capital and well-being.

Methodology

Research Design

In this study, a quantitative research method utilizing a survey was used. Stratified and clustering sampling were employed to recruit respondents. This study examined the effect that the independent variable of generalized social capital (GSC) has on the dependent variable of social well-being (SWB). The mediation of health promoting behavior on the

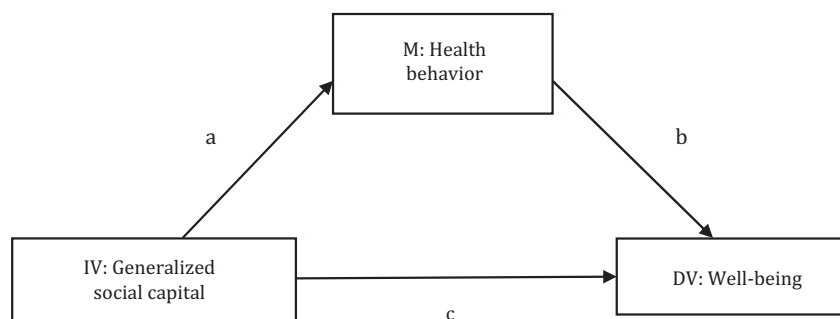


Figure 1 Social capital and subjective well-being mediated by health behavior

interaction of GSC and SWB was also studied. The study was conducted nationwide and encompassed two main zones—east and west Malaysia; west Malaysia consisted of five main zones (north, south, east, west, and central), and east Malaysia consisted of two main zones (Sabah and Sarawak). It was estimated that respondents would need approximately 30–40 minutes to complete the survey. Confidentiality was emphasized and respondents in this study were assured that their identities could not be traced at any point.

Participants

This study used a cross-sectional survey with a quantitative approach to explore the role of health behavior as a mediator of the interaction between GSC and well-being among youth. In this study, 3,558 young Malaysians, aged 15–25 years, living in marginalized communities were surveyed. Of the total number of respondents, 1,758 (49.4%) were Malays, 915 (25.7%) were Chinese, 271 (7.6%) were Indians, and 614 (17.3%) were of Sabah and Sarawak ethnicity.

Research Instrument

This study focused on the level of generalized trust—an individual belief at the core of social capital—and its relation to well-being. Studies have found a close correlation between generalized trust in surveys and actual behavior as observed in experiments (Fehr & Fischbacher, 2003; Glaeser, Laibson, Scheinkman, & Soutter, 2000). GSC was measured using three variables: a) level of generalized trust of people; b) tendency to accept help from people (for example, lending a phone during an emergency); and c) tendency to help people in need (for example, giving directions). All three variables were presented in a five-point Likert scale response format: “never, rarely, sometimes, usually, and always,” with rating scores ranging from 1 to 5, respectively.

Health behavior was measured using an adapted version of the Adolescent Health Promotion Scale (AHPs) (Chen, Wang, Yang, & Liou, 2003) which is considered valid and reliable. The AHPs that the study used comprised 22 items assessing five dimensions of behavior: (1) social support (such as speaking to and sharing feelings with others, discussing personal problems with others, keeping in touch with relatives); (2) life-appreciation (such as making an effort to feel happy and content, degree of positive thinking, recognition of personal strengths and weaknesses and their acceptance); (3) health responsibility (making an effort to moderate body weight and search for health information); (4) stress-management (making an effort to monitor emotional changes and making an effort to determine the source of each stress that occurs); and (5) exercise behavior (such as exercising rigorously for 30 minutes at least three times per week, performing daily stretching exercises). The instrument used to measure the frequency of reported behavior was a self-reporting Likert scale with a five-point response format: “never, rarely, sometimes, usually, and, always,” with rating scores ranging from 1 to 5, respectively. The validity and reliability of the original AHPs were assessed with a sample of 1,128 Taiwanese adolescents and deemed satisfactory. Factor

analysis yielded a six-factor instrument that explained 51.14 percent of the variance in the 40 items. Cronbach’s alpha reliability coefficients were .93 for the total scale; alpha coefficients for the subscales ranged from .75 to .88.

Well-being was measured using an adapted version from the Office for National Statistics (ONS) (Tinkler & Hicks, 2011). The ONS questionnaire was used to capture what people think about their well-being by asking participants how they had felt over the previous four weeks in relation to four items used to measure aspects of mental well-being (such as satisfaction with life, feeling happy, feeling restless, and things you do in your life that are worthwhile), with respondents self-reporting on a Likert scale with a five-point response format: “never, rarely, sometimes, usually, and always,” with rating scores ranging from 1 to 5, respectively.

Data Analysis

The data were analyzed using the IBM SPSS Statistics version 22 software (IBM, Armonk, NY, USA). The mediation analysis in this study broadly follows the approach outlined by Baron and Kenny (1986). In the first step, a simple correlation analysis was run to determine if there were significant correlations among GSC, health behavior, and SWB. Second, a model was constructed in which SWB was regressed on health behavior (Model 1). Third, a model (Model 2) was constructed in which well-being was regressed on GSC while controlling the health behavior effect which should reveal whether health behaviors mediate the association between GSC and well-being.

Results

Demographics

In total, 3,558 marginalized youth participated in this study; male respondents slightly outnumbered female respondents (Table 1). The results showed that the majority of respondents identified themselves as ethnic Malays (49.5%), and most of the respondents had obtained a secondary level of education (65.7%).

Table 1 Demographic profiles of the respondents.

	(n = 3,558)	
	Marginalized	
	Frequency	%
Gender		
Male	1,947	54.7
Female	1,611	45.3
Ethnicity		
Malay	1,758	49.4
Chinese	915	25.7
Indian	217	7.6
Indigenous Sarawak and Sabah	614	17.3
Level of education		
Primary school	287	8.1
Secondary school	2,336	65.7
High school	935	26.3

Correlation and regression analyses of generalized social capital, health behavior, and subjective well-being

Table 2 shows that GSC was moderately higher among marginalized young people, which means that marginalized young people were able to build trust and reciprocity in people in general. In other words, they could behave well in the general settings of society. However, they did not feel that they were comfortable enough to interact with most people they meet on a daily basis.

Table 3 shows the results of the Pearson's correlation analysis which suggested that GSC, health behavior, and well-being are positively correlated at a p value lower than .05. Hence, higher social capital and health behavior levels will report a higher SWB. These results clarify and confirm the predictions of this study with regard to the relationship between GSC and well-being. This satisfies the mediation as suggested by Baron and Kenny (1986) where the independent variable, mediator, and dependent variables correlate with each other. All GSW indicators were associated with young people's well-being. Young people who have a high social capital were more likely to show good health behavior.

Based on the results shown in Table 4, we used a multiple regression analysis which showed that the association between GSC and SWB was still significant after controlling for health behavior (Table 3). This suggested that health behavior acts as a partial mediator. In other words, happiness and satisfaction with life could be determined either by having good GSC or health behavior. Therefore, it is accepted that individual SWB is determined by either having a good GSC or good health behavior.

Table 2 Generalized social capital, health behavior, and subjective well-being statistics

	Mean	SD
Generalized social capital	3.55	0.697
Health behavior	3.73	0.537
Subjective well-being	3.63	0.593

Table 3 Correlation between subjective well-being, generalized social capital, and health behavior

(n = 3,558)			
Variable	Generalized social capital	Health behavior	Subjective well-being
Generalized social capital	-	.272**	.185**
Health behavior	-	-	.469**
Well-being	-	-	-

** $p < .05$

Table 4 Regression between well-being and health behavior (Model 1) and regression between well-being and generalized social capital where health behavior is controlled (Model 2)

	Unstandardized coefficients		Standardized coefficients			95% Confidence interval
	B	SE	Beta	t	Sig.	
Model 1						
Health behavior	.518	.016	.469	31.626	.000**	.486, .550
Model 2						
Generalized social capital	.054	.013	.063	4.095	.000**	.465, .532
Health behavior	.499	.017	.451	29.394	.000**	.028, .079

Note: Dependent variable was subjective well-being.

** $p < .05$

Discussion

The main aim of the current study was to investigate whether health behavior mediates the association between GSC and SWB. From past findings, researchers established that higher levels of SWB could be obtained via building social capital with people in general (Nieminen et al., 2012; Yamaoka, 2008; Yip et al., 2007). When young people trust people in general, they feel happier, and their lives are simpler because they are not wary of other people all the time. Indeed, they would be able to have a higher sense of vitality and meaningful and engaging activities that make them feel competent and autonomous, and, in turn, achieve higher levels of well-being (Dolan et al., 2011).

Next, engagement in health-promoting behavior is the key indicator of young people who have obtained social capital and feel satisfied with life. The multiple regression test results showed that health-promoting behavior acted as a partial mediator in the relationship between GSC and SWB. In other words, young people who built GSC with others did not totally depend on the effect of health-promoting behavior in order to enjoy a higher SWB. However, health-promoting behavior still had a mediating effect between social capital and well-being. Indeed, social capital is essential for young people to form meaningful relationships with others. Once the relationship is made, they may be more motivated to develop healthy behavior with others; for example, information on health care tips and health topic discussions could be shared. In turn, young people could benefit from health-promoting information and activities, and their level of well-being could be increased from the feeling of independence from working towards a healthy lifestyle with people they trust.

In the context of marginalized young Malaysians, especially those living in rural areas, life events typically present a social bonding opportunity due to the collective community way of life generally practiced in rural areas. For example, during a wedding celebration when members of the community come together to prepare the banquet, this presents an opportunity for the appointed local leader to promote healthy eating and cooking with the younger generation, which will increase the sense of well-being among the marginalized young Malaysians.

Conclusion and Recommendation

Engagement in health-promoting behavior is not the only way for marginalized young people who have built social capital with people in general to enjoy a high level of SWB. Young people feel happy about and satisfied with their lives as long as they can build trusting relationships with others in a reciprocated way. Thus, it is important for youth policymakers to study the effect of different types of health-promoting programs and not to limit themselves to considering programs that were formed in social groups. For example, youth development officers could look into health programs that use mobile phone application programs as a source of information and an interactive platform with other users and therefore not restrict themselves to face-to-face health-promoting programs in social settings.

Conflict of Interest

There is no conflict of interest.

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