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Family Health Clinics as a Source of Social Capital

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ABSTRACT

Purpose: To examine the extent to which Family Health Clinics (FHCs) contribute to the formation of social capital among mothers, and determine whether it is influenced by socioeconomic factors. In FHCs, social capital can be gained by relationships between mothers (bonding social capital), by relationships between mothers and FHCs team, or between mothers of different origins/culture (bridging social capital) and health services institutional bodies (linking social capital).
Design: This is a mixed method study. For the quantitative part, data were collected from 673 mothers using a questionnaire. The qualitative part was conducted with six focus groups.
Results: The FHC constitutes a source of social capital in all dimensions. Bridging social capital was most prominent and is formed by interactions between mothers and FHC nurses. The factors that explain the formation of social capital were: mothers' spoken language being Arabic, participation in group training, and lower level of education. The focus groups revealed that participation in group training increased the social capital. Mothers noted that FHC nurses supplied updated information about their children's care. Regarding linking social capital, mothers perceive FHC nurses as mediators between them and the local and national health services.
Conclusions: FHC clinics are a source for gaining social capital. The FHC services should be adapted to mother's needs.
Implications: FHC nurses should try to create conditions for mothers to meet to create bonding social capital, relate to mother's needs for the creation of bridging social capital, and provide culturally adapted care for the formation of linking social capital.

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Introduction

It is generally accepted that a network of social connections contributes to the strength of the individual (Villalonga-Olives, Adams, & Kawachi, 2016). Social capital was defined by Putnam (1995, p. 67) as 'features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit'. It is obvious that when mothers have more interactions with their community, they are able to generate better relationships with other parents and health agents, and to acquire more information about caring for their children. A mother's social capital has been found to influence her children's health such that increasing the mother's social capital can improve their child's health. Furthermore, interventions including community activities, can enhance mother's social capital and reduce disparities in the health of possibly disadvantaged children (Sujarwoto & Tampubolon, 2013). The aim of the present study was to examine the extent to which Family Health Clinics (FHCs) constitute a source of social capital for mothers and determine whether this is influenced by the socioeconomic environment.

Preventive health services for mother and child – Family Health Clinics

FHCs are responsible for health provision and health promotion, and provide preventive health services to healthy clients. They offer basic services for mothers and children as recommended by the World Health Organization (United Nations, 2011). The value of health promotion lies at the core of the services provided by FHCs for mothers and infants (Rosenberg et al., 2013) and it is generally accepted that investment in health during pregnancy and the first years of life can guarantee development and health during adulthood. In Israel, the services provided by these clinics are subsidized by the State because of the perception that they are essential for the proper development of infants and children and that the investment saves on costs in the long-term. Diseases during pregnancy and many childhood diseases can be treated and

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prevented, thus reducing morbidity at a later age (Lassi, Imam, Dean, & Bhutta, 2014; Margolis, 2004).

General health services in Israel are public and are provided according to the National Health Insurance Law (1994), which defines the package of services covered by this law. The preventive services offered focus mainly on mother and child health, and include: a) promotion of physical, intellectual, emotional, and social health, b) disease prevention, c) early disease detection, d) fulfilling the needs of the population for health monitoring, including the provision of vaccines, and screening tests (vision and hearing), e) overseeing the health of pregnant women, and the growth and development of infants and young children (weight, height, hearing, vision, etc.) (Ministry of Health, 2004). The range of services provided by the FHCs is designed to focus mainly on preventive health services. Little attention has been given to the contribution of the FHCs to mothers beyond providing medical services. Specifically, there is little information about their contribution to the social aspects of wellbeing, such as gaining social capital as a result of visiting and participating in activities at the FHCs.

A prominent aspect of the preventive service in Israel is the high level of confidence and satisfaction with the clinics (Neumark, Palti, Donchin, & Ellencweig, 1992; Rosen, Elroy, & Nirel, 2007) and FHC nurses (Rosen et al., 2007) that is expressed by the general population. An estimated 95% of babies in Israel are monitored at a family health clinic (Kagan, Shachaf, Rapaport, Livne, & Madjar, 2017). Further evidence for patient support comes from the high percentage of infants vaccinated. In 2016, 94% of the population in Israel were vaccinated against diphtheria-tetanus-pertussis (WHO-UNICEF, 2017). Although other models of preventive medicine for mothers and children (Freed, DeFriese, Williams, & Behar, 2001; Hemminki & Blondel, 2001; Oldenburg & Owen, 1995; Sarkadi, Gulenc, & Hiscock, 2015) exist worldwide, the preventive services as currently provided in Israel are perceived *by* the Israeli public as professional, friendly, and non-discriminatory.

Social capital: bridging, bonding and linking

As already discussed, Putnam (1993) referred to social capital as "a complete set of characteristics of a social organization such as trust norms and social networks that can improve and rationalize the functioning of an organization or community by accelerating coordinated actions" (Putnam, 1993, p. 167). It is possible that Putnam's greatest contribution to the issue of social capital lies in the distinction between two types of social capital: bridging and bonding (Putnam, 2000).

Bridging social capital is what allows the horizontal connections between individuals and between community organizations, which may be dissimilar (or heterogeneous) with respect to socioeconomic or other characteristics (Villalonga-Olives et al., 2016). In contrast, bonding social capital is based on horizontal relationships between members of homogeneous social groups where it strengthens cooperation between individuals and families and promotes their willingness to help community residents and develop joint initiatives (Sajuria, VanHeerde-Hudson, Hudson, Dasandi, & Theocharis, 2015).

Szreter and Woolcock (2004) referred to social capital in the context of the characteristics of the social structure and resources that bond its members. However, their contribution to the field lies in adding the dimension of linking social capital. This type of social capital is based on vertical relationships between heterogeneous individuals and organizations within and outside the community. The interacting parties may differ with respect to availability as well as the access to economic and political resources and influence (Macke & Dilly, 2010; Poortinga, 2012).

Social capital and sociodemographic variables

An individual's social capital is influenced by personal characteristics such as age, sex, marital status, income, education, and place of residence. For example, people with more connections in the neighborhood have greater social capital (Babaei, Ahmad, & Gill, 2012; Cattell, 2001). Other studies have reported that higher education and high levels of income are related to greater social capital (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Nieminen et al., 2008). Lower social capital was associated more with housewives than with working women in Teheran (Baheiraei, Bakouei, Mohammadi, Majdzadeh, & Hosseni, 2016) and with minority groups, generally with a low socioeconomic level (Lewis, DiGiacomo, Luckett, Davidson, & Currow, 2013). Among immigrants (generally considered a weaker population with low social capital), participation in community activities was associated with an increase in social capital (Hou, Lin, & Zhang, 2017).

Social capital and health

There is ample evidence in the literature for a positive relationship between social capital and many aspects of health (Eriksson, Hochwälder, Carlsund, & Sellström, 2012; Gilbert, Quinn, Goodman, Butler, & Wallace, 2013; Murayama, Fujiwara, & Kawachi, 2012; Nieminen et al., 2013; Sujarwoto & Tampubolon, 2013). The social capital of individuals and communities was reported to promote health specifically by: promoting engagement in health behavior, improving accessibility to diverse health services, and providing important information on health practices (Gilbert et al., 2013; Nieminen et al., 2013; Story, 2014; Sujarwoto & Tampubolon, 2013). For example, the social capital of immigrants in China was related to the utilization of community health services (Hou et al., 2017) while an increase in social capital was related to the performance of mammography in South Korea (Lee & Kim, 2015) and to screening for cancer among African Americans (Hollard & Sene, 2016).

Studies have examined the relationships between social capital and maternal and child health, with an emphasis on how the social capital of the mother contributes to the health of her child in terms of infant mortality rates, nutrition, and physical and mental health (Curtis, Dooley, & Phipps, 2004; Harpham, De Silva, & Tuan, 2006). A study in India found that women living in communities with bridging social capital attended more follow-up medical visits, and were more likely to have immunized children (Story, 2014). Mother and child health programs and services are also valued in relation to their contribution to social capital (Bertoia & Matheson, 2006; Scott, 2000; Sujarwoto & Tampubolon, 2011). However, in the Israeli context, the interaction between health and social capital has scarcely been addressed. The few studies performed in Israel have focused mainly on adult populations with certain diseases, or on differences between the Jewish and Arab populations (Baron-Epel, Weinstein, Haviv-Mesika, Garty-Sandalon, & Green, 2008; Soskolne & Manor, 2010).

The present study builds upon a recent report (Webber, Reidy, Ansari, Stevens, & Morris, 2015) that improving social connections can increase social capital, and that this increased social capital is related to better health outcomes. In addition, there were indications that a mother's social capital can affect the health outcomes of her children. As the FHCs, which are spread throughout the country, provide services to almost 100% of mothers and children, and are trusted by most mothers, the present study was designed to examine the extent to which the FHC services and FHC nurses constitute a factor that helps mothers who visit them create social capital.

Hypothesis

The hypotheses of the study are:

1. Family health clinics contribute more to the creation of social capital of mothers with below average incomes than to those with a higher income.
2. Family health clinics contribute more to the creation of social capital of mothers with lower levels of education than to those with higher education.
3. Family health clinics contribute more to the creation of social capital of Arabic speaking mothers than to Hebrew speaking mothers.

Methods

Sample

The quantitative part of the research was conducted in FHCs located across the country. Sample size was calculated using sample size calculator according to margin of error 4.4%, confidence level of 95% and population size. The calculation yielded a sample of 494 participants, and the actual sample included 673 mothers. Sampling of the clinics was carried out according to a quota method, with the criteria: location of clinic (north, center and south), population type (urban, rural, Jewish and Arab), and the socio-economic level of the locality (high, medium and low). The mothers within each FHC were chosen by the nurses at the clinics by a deliberate judicial method according to criteria of education, income, and religion. Altogether, 673 mothers aged 25–50, who came to the FHCs for their child's care had completed the questionnaire.

In addition, some 60 mothers participated in the qualitative part of the research, with about 10 mothers in each focus group. The focus groups were conducted in three Israeli Jewish and three Israeli Arab localities. The mothers who took part in the focus groups were invited to participate by the head nurses of the FHCs. The mothers in the focus groups did not complete the questionnaire. To determine the locations of the focus groups, the FHCs were categorized according to the religion and socioeconomic status of the mothers who use their services. Members of the Arab population mainly belong to one of three religions: Muslim, Christian, and Druze and most live in villages in the north of the country. In contrast, members of the Jewish population differ on the level of religiosity from ultra-orthodox to secular Jews and most live in cities spread throughout the country. Accordingly, three focus groups took place in the Arab communities with different religious and socio economic status: 1. A group of Muslim mothers living in a lower socioeconomic village in the center of the country (Focus group 1), 2. A group of Druze, Christian, and Muslim mothers living in a middle socioeconomic class village in the north of the country (Focus group 2), and 3. A group of Christian and a Muslim mothers living in a middle-class village in the north of the country (Focus group 3). In the Jewish sector, the groups were: 1. A group of secular mothers with a high socioeconomic status in the north of the country (Focus group 4), 2. a secular group from a middle socioeconomic status in the south of the country (Focus group 5), and 3. a community of ultra-Orthodox mothers of low socioeconomic status living in the center of the country (Focus group 6). The mothers who participated in the focus groups were between 25 and 38 years of age. All had secondary education and some were academic.

Data collection

The quantitative data were collected using a questionnaire composed of two parts:

Demographic data included: age, education level, marital status, number of children, country of birth, mother's spoken language (Hebrew or Arabic), and family income. Other questions related to the characteristics of the present visit at the FHC: visiting the clinics by a predetermined appointment, the place in the family of the child to be examined, and whether the mother was offered group training.

Acquisition of social capital: This part of the questionnaire was constructed for the present study and designed to address bonding and bridging social capital as described by Putnam (2000). The scoring was based on a scale developed and validated by Williams (2006) for measuring acquisition online and offline social capital, and linking social capital as described by Szreter and Woolcock (2004). The overall objective was to assess the contribution of services provided by the FHCs to the acquisition of social capital. The specific services queried were selected according to 1. a qualitative study conducted by two of the researchers in 2009 (focus groups of nurses, FHC head nurses, and regional nurse supervisors), and 2. the procedure for preventative treatment of infants and toddlers at FHCs (Ministry of Health, 2004). The final questionnaire was reviewed and approved by five expert nurses including two head nurses, and three regional nurse supervisors. The final version included items approved by all judges. Before distribution of the questionnaire, a pretest was conducted with 30 mothers who were requested to comment on the clarity of the questionnaire. The pretest enabled us to check the questionnaire reliability by Cronbach's alpha and the construct validity using confirmatory factor analysis.

The final questionnaire consisted of 29 items related to the three dimensions of social capital: 1) twelve items were concerned with bonding social capital (e.g., "during my visits to the FHC I received support from other mothers I met"); 2) thirteen items were concerned with bridging social capital (e.g., "I received updated information on my child's treatment from the FHC nurse" and "My visits to the FHC allow me to meet mothers with different backgrounds"); and 3) four items were related to linking social capital (e.g., "The nurse at FHC serves for me as a connection with the health system"). The mothers were requested to indicate their agreement with each item on a six point scale ranging from 1 (completely disagree) to 6 (completely agree). The questionnaire was translated into Arabic using Brislin's method (Brislin, 1970). The Cronbach's alpha of all items was: 0.93, for bonding social capital: 0.93, for bridging social capital: 0.84, and for linking social capital: 0.80.

The qualitative part of the study was conducted by six focus groups with an average of 10 mothers in each group. The focus groups were conducted in three Arab and three Jewish communities as described above in the "sample" section.

After a short introduction and explanation of the aims of the focus groups, the mothers were grouped in pairs and performed four activities. For the first activity, each couple had to prepare three sentences related to bonding social capital, and in the second activity they had to rank five expressions related to bringing social capital in descending order. For the third activity, they were requested to identify four FHC services that they would like to continue to receive and four services they were willing to stop receiving. Finally, in the fourth activity they were requested to identify five indispensable services and three services that require improvement. As a conclusion, the mothers presented to the whole group four services provided at the clinics that contribute to the formation of social capital.

Data analysis

The quantitative analysis of the data collected by the questionnaires was carried out using SPSS version 25. Means, frequencies, and percentages were used as descriptive statistics for personal characteristics. Stepwise multivariable-regressions analyses were performed to predict the gain of the different types of social capital. The variables entered to the models were: age, mother's spoken language (Hebrew/Arabic), education, income level, number of children, location of the child in the family, and participation in group training. The categorical demographic variables were codified as dummy variables.

To analyze the qualitative data, the focus groups were recorded and the material was transcribed by the researchers. Analysis was based on the grounded theory (Strauss & Corbin, 1994). During the process, the results were grouped organized and classified into three principal themes; acquisition of bonding, bridging, and linking social capital from the visits at FHCs. In addition, certain specific topics were identified within the main themes.

Ethical considerations

The study was approved by the ethics committee of the Ministry of Health and received an exemption from signing an informed consent form. Before completing the questionnaires, the mothers received a short explanation regarding the aims of the study and were informed that completion of the questionnaire was entirely voluntary. Return of the completed questionnaire was considered to represent an agreement to participate in the study. In order to preserve the anonymity of the mothers and to make them more confident that their identity would not be revealed, the questionnaires were distributed together with an envelope so that the completed forms could be inserted into a box placed at the entrance of the FHC. In order to preserve confidentiality, the identity of the mothers was specified only by the home locality without any additional socio-demographic details.

Results

A total of 673 mothers aged 25–50 participated in the study.

Demographically, 70% (n = 471) were Jewish, 90% (n = 606) were Israeli born, 95% (n = 639) were married, 48% (n = 323) had an academic education, and 76% (n = 511) reported an average or higher than average income (Table 1). The results of queries concerning the present visit at the FHC indicated that about a third of the mothers came with their first child, almost all came by a scheduled appointment, and about 50% (n = 337) of the mothers were offered group training, see Table 2.

Table 1
Sociodemographic characteristics of the sample (n = 673).

Sociodemographic variables		% (n)
Country of birth	Israel	90 (606)
	The Former Soviet Union	7 (47)
	Other	3 (20)
Religion	Jewish	70 (471)
	Muslim	22 (148)
	Christian	1.5 (10)
	Druze	6.5 (44)
Age (average = 31; standard deviation = 0.46)	19–24	10.3 (2)
	25–30	35.5 (239)
	31–36	36.5 (246)
	37–42	16 (108)
	43–50	1.3 (9)
Nationality	Jewish	69.4 (443)
	Arabic	30.6 (230)
Marital status	Single	1.9 (13)
	Married	95.4 (642)
	Divorced/separated	0.7 (5)
	Live in relationship	1.8 (12)
	Widow	0.1 (1)
Education	Full and partial elementary education	2.1 (14)
	Full and partial secondary	29.2 (198)
	Full and partial post secondary	19.4 (131)
	Academic	48.4 (326)
Income	Below average (under 5046$)	24.3 (164)
	Average (=5046$)	37.3 (251)
	Above average (above 5046$)	38.4 (258)

Bonding social capital

The responses to the questionnaire indicated that bonding social capital was created by the relationships between mothers during their visits in the FHC. Analysis of results showed the percentage of mothers who have answered the question and that agreed and completely agreed to questionnaire items. About 50% (n = 333) of the participants agreed that they connected with other mothers during visits to the FHC, although only 30% (n = 205) stated they received support from mothers they met at the clinic, and 35% (n = 226) reported that meeting with other mothers allowed them to share the joys and difficulties of motherhood.

Bridging social capital

Most mothers felt that the FHCs were a source for gaining bridging social capital. Analysis of results showed the percentage of mothers who have answered the question and that agreed and completely agreed to questionnaire items. Almost all participants agreed (94%, n = 617) that the guidance received from the nurse on their children's care was up to date, while 92% (n = 598) of mothers stated that their visits to the FHC made them more aware of their child's developmental stage. Eighty-eight percent (n = 565) of the mothers reported that the guidance they received from the nurses at the FHC matched their perceptions about their children's nutrition and 83% (n = 534) of the participants indicated that they felt free to share their hardships with the nurse at the FHC.

Linking social capital

Analysis of results showed the percentage of mothers who have answered the question and that agreed and completely agreed to questionnaire items. More than half of the mothers (56%, n = 367) felt that their visits to the FHC facilitated their access to various services in the health system (physicians, occupational therapy, and speech

Table 2
Characteristics of the present visit at the Family Health Center (n = 673).

Data of visit in FHC		% (n)
Offered participation in group training	Not offered	50.5 (340)
	Offered but did not participate	30.0 (202)
	Offered and participated	19.4 (131)
Location of child visiting in the FHC in the family	First	33.9 (228)
	Second	27.3 (184)
	Third	21.3 (143)
	Fourth	10.8 (73)
	Fifth or higher	6.6 (45)
Number of children in the family	1	29.7 (200)
	2	30.0 (202)
	3	21.2 (142)
	4	12.0 (81)
	More than 5	7.1 (48)
Arrived by appointment	Yes	97.3 (655)
	No	2.7 (18)

therapist, etc.). Most mothers (77%, n = 505) stated that the FHC nurse was a significant connection with the health system and 54% (n = 351) indicated that their visits to FHC helped them to recognize their social rights as mothers. About half of the mothers (54%, n = 349) felt that the FHCs enabled them to be exposed to and participate in group training (which is a national initiative) on issues such as parenting, preparation for birth, breastfeeding, or child safety.

Multiple stepwise linear regression were performed in order to understand the factors that may explain the acquisition of the three dimensions of social capital and to test research hypotheses. The variables that were introduced into the models included: age, mother's spoken language (Hebrew/Arabic), education, income level, number of children, location of the child in the family, and participation in group training. The results indicated that the mother's spoken language, education, and participation in group training predicted the three dimensions of social capital. That is, the mother's language being Arabic, lower education, and participation in-group training were related to the creation of the three dimensions of social capital at the FHCs. The model explained 27% of the creation of bonding social capital, 31% of bridging social capital, and 30% of the acquisition of linking social capital. These results are presented in Tables 3–5.

Analysis of focus groups data

The results of the focus groups are presented according to the acquisition of the different dimensions of social capital (bonding, bridging and linking).

Bonding social capital

The analysis of the focus groups revealed that although, mothers viewed the FHC as a potential source for bonding social capital, the mothers tended not to generate bonding social capital. This was in spite of a number of responses that might have suggested bonding social capital. One such example was: "After the birth [of my baby] I went through a very difficult period mentally, my body changed and the baby was not sleeping and was crying all the time. They [the nurses] invited us to trainings and at the end of each session I would feel happy. After the training was over, we asked for it to be extended or to participate in another training group with other mothers" (Focus group 3).

The mothers noted that even if the purpose of the training was merely to provide guidance, it had helped them feel better. As one mother noted "just coming to the training at the FHC helped me feel better" (Focus group 2). In this way, the mothers felt that the FHC could empower them and they expressed the view that "It's fun to take advantage of resources given for free" (Focus group 1).

The mothers explained that the scheduled appointment system was one of the main reasons for the lack of interaction with other mothers. While the system reduced waiting time and contributed to efficiency, it also prevented mothers from acquiring bonding social capital during their FHC visits. The mothers did not want to cancel or change the schedule appointment system, but expressed interest in creating a framework that would allow them to meet each other. Many mothers expressed the feeling that the baby is the focus of attention at the FHC. One mother stated, "after the birth, the baby is more important than the mother" (Focus group 4). Creating a system that enables mothers to meet could promote their perception that they are still receiving the attention they want and enhance the acquisition of bonding social capital.

Bridging social capital

The analysis of the focus groups in this aspect identified three specific issues: 1) The perception of the FHC nurse as an epistemic authority; 2) the FHC nurse as a significant professional to contact in cases of mental distress; 3) suggestions for improving the services supplied by the FHC to enhance bridging social capital.

The nurse as an epistemic authority. Many mothers described the nurses as knowledgeable experts. One mother stated "the nurse's guidance included updated information on my child's care" with another quotation: "my visits to the FHC made me more aware of my child's development" (Focus group 1). Moreover, although many mothers reported the use of apps and websites as sources of information, they affirmed a preference to receive this information from the FHC nurse (Focus group 4), either in the clinic or through a reliable website/app run by a FHC nurse.

FHC nurses as a significant professional to contact when mentally distressed. A common theme was that the FHCs are an optimal setting for identifying a mother's mental distress. The common claim that "these clinics are an excellent setting for detecting postpartum depression" (Focus group 2) indicates the inherent potential of these clinics for generating bridging social capital. A disadvantage that the mothers noted was that "there is no room or privacy to share their distress with the

Table 3
Multiple linear regression for predicting bonding social capital by sociodemographic variables and variables associated with a visit to a FHC.

Predictive variables	Standardized coefficients Beta	t	B	SE
Number of children in the family	−0.120	1.23	0.199	0.092
Location of child in the family	0.156	1.61	−0.217	0.091
Mother's language	0.355	8.97	0.085***	0.051
Education	−0.135	3.36	−0.179***	0.050
Income	0.043	1.01	0.193	0.057
Participation in group training	0.257	7.03	0.448***	0.053

R squared = 0.27.
*** p ≤ .001.

Table 4
Multiple linear regression for predicting bridging social capital by sociodemographic variables and variables associated with a visit to a FHC.

Predictive variables	Standardized coefficients Beta	t	B	SE
Income	−0.035	0.847	0.046	0.050
participation in group training	0.215	5.98	0.293***	0.045
Education	−0.187	4.76	−0.198***	0.042
Mother's language	0.419	10.77	0.176***	0.043
Mother's age	−0.001	0.030	−0.013	0.007
Location of child in the family	−0.004	0.036	−0.079	0.077
Number of children in the family	−0.022	0.228	0.070	0.077

R squared = 0.304.
*** p ≤ .001.

Table 5
Multiple linear regression for predicting linking social capital by sociodemographic variables and variables associated with a visit to a FHC.

Predictive variables	Standardized coefficients Beta	t	B	SE
Income	−0.001	0.036	0.091	0.053
Participation in group training	0.258	7.15	0.567***	0.049
Education	−0.094	2.36	−0.058***	0.051
Mother's language	0.274	4.37	0.173***	0.048
Location of child in the family	−0.047	0.490	−0.044	0.084
Number of children in the family	0.056	0.58	0.029	0.084

R square = 0.300.
*** p ≤ .001.

nurse because there is not enough time, the FHC is overcrowded" (Focus group 5). In addition, the mothers emphasized that sharing their hardships with the nurse depended on the nurse and the relationship she developed with the mothers (Focus group 5).

Ultraorthodox mothers claimed that although the FHC could offer support, they typically did not feel free to share their distress with the nurse, "because the nurses are not Ultraorthodox themselves, I don't feel I can share my hardships with them" (Focus group 6). It is important to note that in certain communities like the Ethiopian community, there is a linguistic mediator who translates the encounters between the mothers and nurses in the FHC (Focus group 6). When mental distress is identified, the mother is immediately supported, thus demonstrating the importance of cultural sensitivity for gaining bridging social capital. Under the right conditions, the FHC nurse can supply bridging social capital by providing reliable information and mental support.

As a specific way to improve bridging social capital, mothers appreciated the FHC nurse home visit after the first labor and expressed interest in adding home visits after subsequent births (Focus group 5). Another issue raised was the need for more group guidance, workshops, and enrichment activities on topics as breastfeeding, parenthood, parity, and returning to work (Focus group 2). Mothers also expressed a desire for the nurse to build them personalized plans, for example for their baby's nutrition (Focus group 1).

Linking social capital. The analysis of the focus groups presents a discouraging picture of the ability of the FHCs to contribute to linking social capital. As mothers stated "we don't feel that the FHC helps the accessibility to services because they must be referred by a physician [not by the FHC nurse]" (Focus group 4). Many mothers were unaware that the health promotion programs offered by the clinics were on a national level. Mothers claimed that many clinics did not offer the films, produced by the Ministry of Health as part of a national initiative designed to raise awareness to specific issues such as postpartum depression (Focus group 2). In addition, the fact that the film is only in Hebrew, was difficult for mothers for whom Hebrew is not their spoken language (Focus group 2). Another issue raised was not receiving information regarding their rights as mothers such as the right to work an hour less a day, (nicknamed "breastfeeding hour") (Focus group 5). The results showed that mothers would like to receive direct referrals to other health services directly from the FHC nurse, without the need to approach their physician. Others were interested in expanding the FHC services to include physical therapy, nutrition consulting and so forth. An exception to these sentiments were expressed by mothers living in Arab villages who felt that the FHC nurse provided linking social capital because "the nurse at the FHC is their contact with the health system" (Focus group 3). This observation constitutes further evidence for the cultural aspect of providing these services at the FHC clinics.

Discussion

The study results show that FHCs can be a source for building all three dimensions of social capital. Mothers who benefitted most from their visits at the FHCs, by gaining more social capital, were those with lower level education, those who speak Arabic, and those who participated in training groups. In addition, the themes identified in the focus groups show that the mothers perceived the FHCs to be very important and felt that their visits help them to acquire social capital. For example, they expressed a desire to participate in further group training for acquisition of bonding social capital (evidenced by a quote from Focus group number 3). As for bridging social capital, the mothers felt that the FHCs are an excellent setting to receive accurate information from the nurses and to detect postpartum depression. The contribution of the FHCs to gaining linking social capital was most appreciated by Arab mothers. This may be a result of bridging the language barrier, as the FHC nurses speak Arabic while other health services are often provided only in Hebrew.

Although, the concept of social capital is mainly derived from studies in developed countries (Hollard & Sene, 2016), it was surprising that there was no connection in our study between the level of income and gaining of social capital. The literature shows that social capital is high in people with higher incomes (Nieminen et al., 2008), while deprivation might reduce the participation in social activities, leading to despair that can affect social capital (Cattell, 2001). The nature of the FHC clinics might be expected to enhance the gain of social capital specifically in lower income mothers. It is possible that our results are due to the fact that the study sample was quite homogenous with respect to household income. The majority (76%) of mothers reported average to high family income, a value compatible with the Israeli Central Bureau of Statistics (2017) report. The possibility that because people with low education level tend to earn less, the effect of income was reflected via education, was not supported by the multicollinearity test among variables.

Education is a strong personal resource that correlates strongly with social capital of the individual (Huang, van den Brink, & Groot, 2009). Education also facilitates the ability of individuals to create links between themselves and with organizations at the local or national level (Helliwell & Putnam, 2007). As expected, mother's education was related to gaining social capital in the FHCs. Interestingly, the FHCs had a higher contribution to bonding, bridging and linking social capital to mothers with a lower rather than a higher level of education. According to the literature (Nieminen et al., 2008), this finding can be explained by the fact that the more educated the mother is, the more accessible resources she has apart from those provided by the FHC.

With respect to Hebrew and Arabic speaking mothers, the results indicated a higher contribution by the FHCs to building the three dimensions of social capital of Arabic speaking mothers. This finding can be explained by the fact that Arabs typically live in villages that may be located far from the big cities where the larger health facilities are located. The FHC clinics are also located in these distant villages, and the nurses present usually speak Arabic. Hence, the FHCs constitute an important resource for this population. In many cases, the FHC nurse represents the only health system contact available to these mothers (Gottlieb, Belmaker, Bilenko, & Davidovitch, 2011). The FHCs therefore become meeting places for Arab mothers (Adams-Stockler, 1983), with the result that they may feel comfortable sharing and consulting with the nurse on matters beyond the scope of the clinics. As already discussed, the fact that most FHC nurses in the Arab villages speak Arabic is a big advantage to this population and probably constitutes a source for gaining social capital.

Of the three dimensions of social capital, the study results showed that the FHCs contribute particularly and most prominently to the bridging social capital, built through interactions between the mothers and the FHC nurses. In contrast to the effort required to contact welfare offices or other institutions, the FHC nurses actively reach out to their clients, inviting the mothers to share their hardships and distresses. In this context, the mothers in the focus groups expressed a wish that the FHC nurses could refer them directly to other health services thus serving as a source for linking social capital.

Notably, despite the vast amount of information available on the Internet and social networks, mothers reported that face-to-face meetings with the FHC nurse were of great importance in the child's development follow up. Moreover, in the focus groups the mothers expressed their appreciation for the up to date information they received from the FHC nurse showing that they perceive her as an epistemic authority. It is worth noting the significance of FHCs in increasing social capital by means of parental group training that enables mothers to interact with each other, as well as with the nurses.

In conclusion, the findings of our study revealed that the FHCs contribute to the social capital of mothers, especially for Arabic speaking,

and less educated mothers and that group training is an important means for gaining social capital.

Study limitations

The first limitation is related to the small number of focus groups. Although we managed to conduct focus groups with variety of populations with the emergence of thematic areas pertaining to social capital, and the analysis could identify important themes, increasing the number of focus groups could have contributed to a better representation of mothers in the qualitative part of the study. The mothers who participated in the focus groups requested not to be identified. Hence, there is no exact and particular information about each mother regarding their socio-demographic background apart from their place of residence and religion.

Implications and recommendations

It is generally accepted that promoting efforts to increase a mother's social capital affects her children's health. The present study results indicated that group training is an important means by which social capital can be acquired. The FHC nurse presents an attentive ear for mothers to share their distress – specifically for the disadvantaged populations where she may be the only health professional available. In addition, the FHC nurses are well placed to detect domestic violence or postpartum depression. As demonstrated by the findings, nurses can be influential with enhancing the social capital of mothers, the children, and the entire family. Interestingly, it was the mothers' request that the postnatal treatment should include both mother and baby/child.

Pediatric and family nurses can initiate activities for mothers that include training on specific subjects that are important for children's development and growth. Providing information and enabling mothers to meet and interact with one other will promote the mother's social capital, which in turn will enhance their children's health. In addition, pediatric and family nurses can create conditions for mothers to meet to enhance the formation of bonding social capital, and be responsive to mother's needs to increase the creation of bridging social capital, as well as providing culturally adapted care for the formation of linking social capital.

The difference in the gaining of social capital between the Hebrew speaking (Jewish) and Arabic speaking (Arab) mothers implies that future studies should try to learn more about the different needs of the two populations in Israel. In addition, disadvantaged populations such as Bedouin and “asylum seekers” mothers should be included in such studies.

Conclusions

Social capital is an important resource for mother. FHC clinics are an important source for gaining social capital. The FHC services should be adapted to mother's needs. Identifying services that contribute to the formation of social capital is essential.

Conflict of interest

The authors declare no conflict of interest.

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CRediT authorship contribution statement

Anabel Lifszyc-Friedlander: Conceptualization, Data curation, Formal analysis, Investigation, Validation, Writing - original draft, Methodology, Writing - review & editing. **Mira Honovich:** Data curation, Project administration, Resources, Supervision, Writing - review & editing. **Ilana Stolerman:** Data curation, Project administration, Resources, Writing - review & editing. **Batya Madjar:** Data curation, Project administration, Resources, Writing - review & editing. **Sivia Barnoy:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing - original draft.

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