# Northumbria Research Link

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**Locality, loneliness and lifestyle: a qualitative study of factors influencing women's health perceptions.**

## Abstract

The contribution of women to the achievement of global public health targets cannot be underestimated. It is well evidenced that within families, women are a key influence on the health and wellbeing of their children and partners. However geographical differences in women's health inequalities persist and research focusing specifically on women's perceptions of locality factors influencing their own health and wellbeing is scarce. This paper presents an interpretive, qualitative research study undertaken in 2011 with a group of women living in one locality in the North East of England in the United Kingdom (UK) which aimed to better understand their health and wellbeing perceptions and locality influences on it. Fifteen women participated in two focus groups and six individual, semi-structured interviews. Thematic analysis yielded four key themes: health and wellbeing perceptions; mental resilience; low income and choice; and influence of place. The influence of women's geographical location in relation to amenities and services and loneliness were recurring factors in the discussion, each influencing lifestyle. It was evident that women in their local context were themselves assets through which their own physical and mental health could be improved. However women's perceptions of protective factors and their influences on health and well being varied. Connecting with women in the context of their immediate living circumstances and understanding their perceptions as individuals, are important first steps in

the process of gaining consensus and mobilising their assets to collectively build healthy local communities.

## What is already known:

- Women's health and wellbeing research has largely focused on specific health conditions such as breast cancer.

- Women's life roles tend to be multiple and subject to several constraints such as geographical location

- Women's self-rated health and wellbeing is associated with the geographical "ward" they live in.

## What this paper adds:

- The loneliness women experience can impact on lifestyle factors affecting their health and wellbeing.

- Women's social circumstances and local environment can operate together to influence their perceived mental and physical health and wellbeing, both positively and negatively, however women's perceptions of influences varied.

- In taking a community asset based approach, Health Networks and other agencies need to acknowledge complexity, taking time to understand the perceptions and living circumstances of individual local women as a foundation for gaining consensus on priorities and working together more effectively.

## Introduction and Background

The significance of women in achieving the aspirations of public health policy should not be underestimated. Women can significantly influence the achievement of targets set to reduce health inequalities for children, young people and other family members who rely on their support (Miranda, 2011). To feel a sense of coherence and resilience, people need to harness "general resistance resources" (Antonovsky, 1987) including: self-esteem; knowledge; healthy behaviour; social and cultural capital (Lindström and Eriksson, 2006). Asset based approaches also focus on identifying the protective factors and positive assets within individuals and communities aiming to mobilise these in an empowering way (Friedli 2013). This is an alternative to deficit models where problems and limitations are a starting point for community decision making (Brooks and Kendall 2013). Blaxter (2004) suggests some women view health as a resource which individuals have the capacity and responsibility to develop, however other women consider it to be outside of individual control. Morgan (2014 p.4) suggests such "positive paradigms for wellbeing", a principle of the asset model, should be prioritised. However asset theory has been criticised for potentially deflecting attention from more embedded societal issues such as unemployment, poverty and discrimination (Friedli 2013). Others argue both asset and deficit approaches are needed to effectively address inequalities in health and other aspects of society (Brooks and Kendall 2013).

How individual women and communities understand and value health, potentially impacts on their health seeking behaviour and health outcome. Findings from a survey of 9003 women concluded women tended to define health in terms of their relationships with others which varied over the life course. Social economic circumstances and psycho-social environments were identified as more significant determinants of health than healthy behaviours (Blaxter, 1990). For participants in a qualitative study in a middle class town in Ontario, Canada, health meant not being ill and healthiness was defined as a sense of wellbeing (Litva and Eyles, 1994). Several research studies consider the validity of self-rated health and the complex and interdependent nature of perceptions of health and wellbeing determinants

(Idler and Benyamini, 1997). For example Davidson *et al* (1991) developed the concept of lay epidemiology, exploring lay understandings of risks for coronary heart disease. Lay epidemiology was used in a breast cancer study in Chicago USA African American communities (Salant and Gehlert, 2008). Focus groups undertaken with 224 participants explored survival rate disparities compared with the general American population. Community understanding about disease and social context on the behaviour of women, were identified as key factors. Similarly, Dibsdall *et al*. (2002) explored perceptions of women with low income of the links between food choice and health; again a key theme was the participants' social world. Harvey's (2007) meta-synthesis considered health and wellbeing of rural Australian women, identifying themes of: isolation; belonging; coping with adversity; and rural identity. Tensions were identified between societal expectations of these rural women and their health experience. Despite perceptions that women coped well with adversity there was little understanding of:

*'the complex ways in which health and wellbeing are shaped by a range of individual, social, economic, cultural and geographical factors'* (Harvey, 2007 p.10).

Involving individuals and connecting them to their communities are also key principles of an asset based approach to community development (Morgan, 2014). In addition, social capital theory (Putnam, 2000) suggests that building bridges between communities and individuals encourages the sharing of resources, potentially contributing to positive wellbeing.

In the defined geographical area in the North East (NE) of England, United Kingdom (UK), in which this study was based, health measures show a gradual general improvement in health in all population groups. However rates of improvement in life expectancy have been slower for women than men. Locally defined inequalities persist between political "wards"; relatively small geographical areas defined as a ward for the purpose of political voting and local authority administration. Compared with England as a whole, more people in this NE area identify themselves as having poor health and long term health conditions (Office for

National Statistics, Census 2001); consistent with UK national health outcome statistics (Department of Health and APHO, 2010).

In this area, former District Councils geographical areas had an average population of 70,000 (Office for National Statistics, 2010a) and ward populations range from 2,000 to 5,500 within those areas. In 2010 the Health and Wellbeing Partnership established five non NHS, local Health Networks, to improve health inequalities. Health Networks build on the work of local organisations, using community development, asset based approaches to inform health improvement work (Foot and Hopkins 2010; Morgan 2014). Census data analysis for England and Wales indicated men's self-rated health data correlated with the level of the large District Council area in which they live (Wiggins *et al.* 2002). However women's self-rated health data correlated more with the ward level, a much smaller locality area:

*'...living in a poor ward and/or ward where there is a preponderance of young families increases the risk of poor health over and above a woman's characteristics.'* (Wiggins *et al.* 2002 p.834).

To inform the Health Network's aim of effectively reducing inequalities for women in the study locality, a better understanding of what influences their perceptions of health and wellbeing was needed. Therefore this study aimed to: appreciate how local women view their health and wellbeing; explore their perceptions of local influences on their health and wellbeing; and to identify the implications of this insight for the work of a local Health Network.

## Methods

The study was qualitative, framed within an interpretive paradigm (Hughes and Sharrock, 1997), informed by critical theory. Harbermas' theory of communicative action underpins Critical Theory, identifying language as common ground for mutual understanding (How,

2003). It suggests all research is value laden and that studies of language should openly acknowledge motivation and values in the context of the analysis (Morrow, 1994). The study received ethical approval from the Northumbria University Research Ethics Committee.

*Sample*

A single political ward in a small town in the North East of England (NE) was selected for the study because of its poor health outcomes and the prevalence of low income families living there. In this area unemployment, income deprivation, child poverty and the numbers of older people living in deprivation were all significantly worse than the England average (Office for National Statistics, 2010b).

A Voluntary Community Sector Organisation (VCSO) supporting the study provided a list of women who had had previous contact with the organisation as potential participants. The women were given an information sheet, contact form and stamped addressed envelope to provide the researcher with contact details. Twenty women agreed to be contacted by telephone. In order to facilitate purposive sampling (Bryman, 2008), potential participants were asked to self-rate their health on a five point scale (Very good, good, fair, bad, very bad). Drawing on that information, fifteen women were finally included in the study. The women were aged between twenty and seventy years old; most were mothers and most were currently in a relationship. Some were active in community groups, but most were not. All were either unemployed, employed in low paid work or retired.

*Procedures for focus groups and interviews*

Two focus groups and six individual interviews were undertaken in 2011.  Focus groups provide a permissive environment, which encourage participants' expression of a range of diverse opinions and are potentially empowering (Krugeger & Casey, 2000; Morgan, 1993). Group interaction generates data, providing an effective research method for examining

topics which are previously unlikely to have been thought about in detail by participants or are habit ridden (Morgan and Krueger, 1993). The first focus group included four women with long term health conditions who shared experiences about health and treatment. Whilst their ill health was acknowledged important and valued in the discussion, it proved difficult to focus on health and wellbeing as a positive concept. As a consequence the decision was made to purposively select and invite women to the second focus group who had rated their health good or very good. The second focus group was held with five women at a community venue and participants travelling expenses were paid. Although both focus groups had a relatively small number of participants, between six and eight being the optimum number (Kuzel,1992), they provided a breadth of perspective and enabled full participation. Six individual semi-structure interviews were also undertaken with women who expressed preference for interview, in a private room in the community venue.  The interview process provided a space for reflections to be shared (Holstein and Gubrium, 2011). None of the women interviewed participated in a focus group.

The discussion was facilitated by a topic guide in both focus groups and interviews. The guide was sufficiently broad and fluid to allow new issues to emerge through dialogue, whilst ensuring relevance to the research question. Prompts for discussion included: how the women would describe health and wellbeing to others; things that can help women stay healthy and well; and any perceived gender differences in health and wellbeing. Focus groups and interviews were digitally recorded, facilitating accurate data analysis (Bryman, 2008).

Participants provided written consent prior to participation. Consent was sought for recording and transcription of discussions. Participants were assured all data would be anonymised. They were also reminded that they could leave any time and have their contribution removed from transcripts. Participants were advised that they should not divulge information which they did not feel comfortable sharing.

*Data Analysis*

Recordings were transcribed and analysed line by line for concepts and themes relevant to the research question. Data analysis was informed by discourse analysis in the form of critical language study (Fairclough, 2001) which conceptualizes a person's language as a form of social practice, discourse. Fairclough explicitly links the study of discourse to critical theory. Three stages of analysis were undertaken; description, interpretation and explanation. This enabled scrutiny of: speech in the focus groups; context of participants' lives; structural influences on their lived experiences and power relations. Discourse analysis also identified interrelationship between primary discourse topics, stemming from the topic guide and researchers interest, and secondary topics arising from participants (Krzyzanowski, 2008). Interviews were analysed through a process of "co-texting"; locating themes in text and establishing links between them. An exploration of "intertextuality" enabled consideration of other voices in the text, introduced as reported speech by participants, and socio-political and situational issues of relevance (Abell and Myers, 2008).

Using different qualitative data collection methods provides an alternate way in which cases are seen and improves the rigor of the analysis (Stake, 2005). Data analysis was undertaken by one researcher which may be perceived as a limitation of the approach (Denzin, 2009). However examples of raw data and emerging themes were discussed with another researcher at each stage of analysis in order to limit single researcher influence on data interpretation. In addition, to further enhance the credibility of the analysis (Halcomb and Davidson, 2006), focus group and interview recordings were listened to in full post analysis to ensure findings fitted with the initial context of the discussion and perceptions of participants.

# Findings

Thematic analysis resulted in four key themes: health and wellbeing perceptions; mental resilience; low income and choice; and influence of place. Each will be discussed in turn, supported by verbatim quotes from participants. Quotes from interview participants are labelled (P1-6), focus group participants are labelled (FG: R1-9).

*Health and wellbeing perceptions*

Determinants of physical health were explained early in interviews in terms of lifestyle choices around; food, exercise and smoking. Participants were aware that food consumption, exercise, moderate alcohol consumption and not smoking contributed to better physical health; reflecting dominant public health messages. Physical activity levels varied and could be transient because: people tired of specific activities; put off taking part; or lacked peer support. Different types of physical activity were pursued at different stages of the life course. Some participants defined being healthy by focusing on their knowledge and behaviour in relation to food and exercise. However they recognized that a range of influences affected their ability to act on knowledge and advice. These included: professional advice and relationships; the media; and social and personal circumstances:

> '…normally keeping fit and eating well, not that I do that very often, but I do know that I should be keeping fit and healthy. (P5)
>
> '…he [GP] told me what to do and that's what I did, lost weight…I have the proverbial 5 a day… I grill instead of fry… I go to the gym twice a week hopefully 3 times a week…Its just what they tell you in books and on the television really that's what I do' (P6)

Initial discussion of family relationships focused on health supporting aspects of family relationships; described as providing a sense of purpose, happiness and social support. These were clearly viewed as assets or protective by participants. Although individual family relationships were usually portrayed positively participants also identified the importance of avoiding loneliness, which they associated with staying indoors. Causes of loneliness

included a range of family situations: being at home with young children; adult children leaving home and bereavement; family thus perceived less as an asset and more as a health inhibitor. Loneliness impacted on mental health, which ranged from low mood to illness requiring acute care; women addressed mental health issues by finding a sense of purpose in local activities including: hobbies, employment, volunteering and socialising:

> *'… loneliness is a bad thing for making you ill, cos my son when he left home that was me by myself…I was really, really suicidal rock bottom depressed because of loneliness, I couldn't cope with having nothing to do I was unemployed at the time…it was only when I got back into employment that I picked myself back up again.'* (FG: R1)

> *'… when we go out and socialize even if we are in a group you've got to be able to help someone who maybe can't help themselves.'* (FG: R4)

Women reflected upon how they use lay knowledge to inform decision making around life choices. Participants reflected on life choices made by older women and used these observations to inform how they might approach older age:

> *'well I look at the two ways of life that they both have and I think well I want to still be like my mum… she's the one that's going out and enjoying herself…I don't want to just end up with wanting to sit in and watch telly all day.'* (P4)

Participants had experienced the effects on mental health of unhappy marriages, which included husbands dependent on alcohol and in some cases violent. Women learned from these negative experiences, using knowledge as an asset to make decisions about suitability of future partners:

> *'…he was a womanizer, he was an alcoholic…I divorced him and in fact…[I] was in psychiatric care because I just couldn't take any more…I sort of was a depressing person after that because he made me like that.* (P1)

### *Mental resilience*

Mental resilience appeared to underpin health and wellbeing seeking behaviour. How women are feeling about themselves and their circumstances appeared a more powerful determinant of health and wellbeing seeking behaviour than knowledge.

The benefits of a healthy diet were well understood and many participants ate well. Food was a complex issue for others. Women were well informed but shared insights about difficulties maintaining a healthy weight. Participants' lay knowledge developed from family and work experience suggested awareness of the health risks of being overweight, including developing diabetes. However some participants had not addressed being overweight either because of low resilience or a lack of belief it was making them unhealthy:

> *'…I did get down to target weight at weight watchers and then I moved far away…and the support I had wasn't there and I just kind of spiralled back to eating to make myself feel better.'* (P5)

> *'…when we hit our 30's …you knew you were getting bigger and putting weight on but you didn't feel poorly so you didn't do anything, it didn't slow you down you know.'* (P4)

Some participants had stopped smoking however some were current smokers. Smoking was linked by the women to mental wellbeing, particularly their mental state and stressful life events. They were aware of the risks, but dependence on smoking was linked to coping with family life pressures and stressful life events:

> *' I have always wanted to stop* [smoking] *but then there's always something that has come up and I can't…I feel really guilty about that…I can see what happens to people what do smoke.. it's been a very stressful few weeks.'* (FG: R5)

> *'well I had an unhappy first marriage for 27 years and I think when you've got pressure like that and 2 children to bring up…it's not a good time* [to stop smoking]*…'* (P6)

One participant had mobilised a range of assets to stop smoking despite being bereaved because she knew from personal experience about smoking related disease:

> *'…my* [second] *husband had never smoked in his life but never asked me to stop smoking bless him and I knew it was bad for me because my mother had emphysema and she was dying of it and it was a load of little things I think probably went into it...I'm in the right state of mind I'm going to do it...'* (P6)

Reflecting on family relationships, participants suggested they had learned from difficult experiences in taking positive future directions.

Older women participants considered their life course and suggested they had gained resilience from aspects of their lives which had gone well in the past, helping them to face current challenges:

> *'…I had been head girl one time…and I say 'you are good you did that you went through* [name] *school everybody looked up to you, don't let yourself get depressed''* (P1)

Painful past experiences such as bereavement, were discussed in the context of moving on in a positive way:

> *'I've lost me husband I can't go out and I'll go anywhere now and I just feel good.'* (P1)

Friendship was perceived as a positive wellbeing influence if it was underpinned by reciprocation; absent friendship reciprocation could be detrimental to wellbeing:

> *'…I have now got a friend…and she won't think twice about doing something for me and to be honest it shocked me at first …the experiences I've had in the past of people who had just basically have been their own needy person...'* (P5)

This again indicates that factors that might be perceived as assets, or protective factors, by some people, are not always viewed in this way by others.

***Low income and choice.***

Data suggested participants understood low income constrained choices affecting their health and well being. Older participants considered themselves comfortable, benefiting from sufficient income; for younger participants money was an issue. Insufficient income impacted on choices about food, physical activity, access to health therapies and facilities offered locally in the Voluntary Community Sector Organisation (VCSO ), which were desirable but unaffordable for many. Women identified the benefits of employment, including: a sense of fulfilment; learning new things; and meeting people. They had coped well with changes in their working lives, including redundancy:

> '… we are on the pension but we are slightly better off than some people…if you haven't the income you are just on your little treadmill.' (P3)

> '…I had worked at [employer] *for 37 years…I was so set up in that… then I got this job within 4 months so again I started learning something new so it kept me mind going...*' (P4)

For working age women, work opportunities and the benefits system were inextricably linked. Types of work fitting with both family commitments and the benefits system meant employment opportunities were limited; although working was considered a fulfilling experience:

> '…I'm on benefits at the moment…it's been more than 2 years now...it's finding a job for 16 hours doing something ...' (P5).

Family relationships could be a source of tension around women's roles affecting, their sense of wellbeing:

> 'My boyfriend said about me, 'don't worry about working too many hours as long as you've got enough that makes you happy', he knows how much I want to go to work ... I think he's quite happy and I'm like, I'm not happy I want to do something.' (FG: R2)

Low income was identified as limiting their access to health promoting opportunities. In addition, women in low paid work could not afford to access unsubsidised activities but were unable to access some free activities available to unemployed people. This suggests that paid work per se is not always viewed as an asset.

### *Influence of place*

Perceptions of local amenities and services linked to health and wellbeing varied. Local green space was used for healthy allotment gardening, cycling and walking, whilst the town centre was seen as unhealthy, run down with local amusement arcades; gambling habits viewed as leading to crime. Clubs and sports facilities were viewed as an asset; providing participants with valued socialising opportunities out of the house:

> *'...to get a few pounds they go and put it in the arcade and then they've spent the rent money and they've spent the shopping money so then if I go and shop lift to get that so then I've developed a gambling problem and just snowballs…'* (FG: R1)

> *'…people say ' it's a terrible town centre' and I say 'the town centre isn't the town it's the people and it's the amenities and I love* [town]…*the amenities we have in* [town] *I think are fantastic.* (P6)

Participants identified potential local improvements included cinema facilities and appropriate activities for young people.

Local services identified as contributing to health and wellbeing included: transport, bus services met local needs; the VCSO; and a range of National Health Services (NHS). The VCSO was valued for support in facilitating participants' access to services and opportunities for training and voluntary work:

> *'…I volunteer at a group there, I think me wellbeing is much better…and I've done a counselling skills course that was very interesting'.* (P2)

Perceptions of the NHS were largely positive. General Practitioner (GP) services were seen as excellent at one local practice, less effective at another. Participant's valued: acute care; effective monitoring of long term conditions; screening services; identifying mental health interventions as helping to counter depression. Participants identified that out of hours primary medical care and counselling services should be improved:

> *'..it takes on average 6 months to get a counselling appointment… obviously 6 months is an awfully long time to wait…'* (P5)

## Discussion

The aims of this study were to: appreciate how local women view their health and wellbeing; explore their perceptions of local influences on their health and wellbeing; and identify the implications of this insight for the work of a local Health Network. Participants evidently had a ready understanding of concepts of health and wellbeing. Individual definitions had a personal emphasis on functional, social or psychosocial perspectives, consistent with Blaxter

(1990). Participants discussed physical, mental and social aspects of health and wellbeing (World Health Organisation 1948), also acknowledging wider determinants of health. Their private personal commitment to health, or their deliberate non-compliance, was articulated with reference to influential public health messages, encountered in a range of media (Roy, 2007; Seale, 2002); another indication that they were knowledgeable about how lifestyles affect health. Participants' reflections on the aging process included the importance of avoiding loneliness to ensure good health and wellbeing. Never or seldom experiencing loneliness has been suggested as a strong predictor of good self-rated heath (Nummela *et al*. 2010). Participants also identified  that purposeful activities mitigated  loneliness including voluntary and paid work, caring for families and having a social life; consistent with Bryant *et al*. (2001) who identified that health was dependant on having something meaningful to do. Participants also reflected on the support they give to the health and wellbeing of their families and communities. They develop and share understandings of ways of keeping healthy and well benefiting themselves and those around them; for example older participants, with sufficient income, accessed supportive social activities. Robinson and Kirkcaldy (2007) report the importance of personal views in supporting health promoting behaviour. In addition to personal views about health and wellbeing, understanding women's perspectives on factors influencing their personal sense of coherence (Antonovsky, 1987) is also important. Salutogenesis (Antonovsky, 1996) provides an interpretive framework for what women said about health and wellbeing, its determinants and the psychosocial processes they describe in giving their lives a sense of coherence.

The women in this study had different perspectives at different stages of the life-course. Their peers and the older generation were reference groups for their comparison of factors influencing their health. Younger participants reported immediate pressing concerns including family welfare, income and work opportunities. Older participants focused more on wellbeing, sharing information with each other about their own health conditions. Consistent with the theory that a sense of coherence develops as people age (Antonovsky, 1996), they

also reflected on their life experience and reasoned that difficult situations can improve; for some their lives had dramatically improved in middle age.

Social relationships, including families, were identified as important factors influencing health and wellbeing. However family relationships were not always protective factors or assets for health. For example participants linked their capacity to stop smoking with difficult family circumstances. Making the decision to stop smoking was situated within complex personal assessments of the role of smoking in their lives; particularly in relation to stressful situations and difficult family relationships. Others identify the impact of life circumstances on smoking behaviour; the complexity of decisions around smoking (McDermot and Graham, 2006) and the role of smoking as a coping mechanism (Lawlor *et al.* 2003).

Changed family circumstances, including children leaving home and bereavement were often root causes of loneliness. Adaption to change was important in re-engaging with the social world. Getting out of the house was an important milestone in adapting and regaining control of life. Riechstadt *et al*. (2007) found attitudes and adaption to change; feeling secure in stable circumstances; being well and engaging with others are central to good health and wellbeing. Building such resilience within communities is a key to an asset approach to community development (Friedli 2013).

Some participants identified positive health impacts of the locality such as providing opportunities for social activity, through sports and leisure clubs as well as accessible green space. Local health services were also considered by participants to be broadly accessible and relevant to need. Participants reported that local accessible green space had health benefits and as such were positive community assets; consistent with Lee and Maheswaran (2010) and Mitchell *et al.* (2011). However, the local town centre was viewed negatively by others as having limited services and some health damaging businesses. This is consistent with other studies of deprived areas which identified an increase in gambling machines (Wardle *et al.* 2012) and fast food outlets (Cummins *et al.* 2005). These data illustrate the

influence of local geography on women's health (Wiggins *et al.* 2002). Participants also suggested that for local women, access to good work was limited through both availability of employment and family demands limiting opportunity for travel outside of the area. Women are over represented in low paying occupations and lower earning families are more reliant on informal family care (Perrons 2009). In disadvantaged areas women have difficulty finding local flexible employment and effective childcare (Grant 2009). This adds to gender inequalities within communities; women's time often more constrained by caring responsibilities than men (Dahlberg 2007). Furthermore, women are perhaps more likely than men to adapt their paid employment to meet family needs; including finding themselves in a cycle of low-pay, no-pay as they move in and out of poorly paid insecure employment (Shildrick, 2010; Perrons, 2009). The dominance of domestic responsibilities (Miranda, 2011) explains why women's lives are bound by small geographical areas (Wiggins *et al.* 2002).

When some participants explained that they buy the cheapest food and cannot afford to access health promoting opportunities, they identified links between social position and health. An individual's position in relation to wider determinants of health is determined by their social position (Graham, 2004). Furthermore for women living in socioeconomically deprived neighbourhoods, a relationship between perceived social control and biomarkers for stress is suggested (Barrington *et al*. 2014). Lloyd *et al*. (2011) identified challenges in food shopping for people living on restricted incomes. Older participants explained they had sufficient income to do things they enjoyed, leading to more fulfilled lives. Perceived adequate income has a strong correlation with self-rated health (Nummela *et al.* 2010). Whilst more affluent people do not always make healthy choices; they have more choices, more routes open to health and often greater social control. Income is clearly viewed by participants as an asset for heath.

Brooks and Kendall (2013) suggest that understanding and mobilising assets stemming from the interaction between individuals and community is important to inform community developments. However, even in the small geographical area of this study, the availability of assets as protective factors is complex; as is the perception of risk associated with various aspects of the women's lives. In implementing an asset based approach this complexity needs to be acknowledged in finding ways to build new types of relationships with communities and to find new ways of establishing consensus priorities for working together (Durie and Wyatt 2013). Valuing and building on the perspectives of individual women adds more complexity than focusing on women as a community group.  However focusing on improving relationships between service providers and communities of women, may result in inaccurate assumptions about individuals and neglect to capitalise on their available assets.

In addition to community challenges there is also complexity in the multi-professional service provision available to support asset based community development (Morgan 2014). Health Networks were implemented in the study locality to bring together people and services working in communities to improve health inequalities. An asset based approach which acknowledges complexity (Durie and Wyatt 2013), is likely to be of use to the Health Networks. Given the individual experience of women's lives there is a need for any approach taken to focus at the level of individual assets and the interaction between individuals and their social situation and locality.

Local authorities faced with budget pressures are reducing preventative services (Reeder, 2014). This retrenchment is particularly detrimental to women who depend on very local services and work opportunities. When women are vulnerable they would benefit from access to supportive local opportunities, to assist them in setting the direction for their lives. Community led interventions to provide support to those individuals who remain isolated should be considered, including interventions offering low level support such as peer support groups (Hill and Westrip, 2010).  However, a more robust evidence of the efficacy of asset

approaches taken is needed to avoid unintentional negative consequences on other aspects of inequality in communities (Morgan, 2014; Brooks and Kendall, 2013).

## Conclusion

It is clear from the findings of this study that individual women experienced health in the context of their locality in different ways. The influence of their understanding of health and how this interacts with their aspects of their lives is complex, influenced by age, family and other factors impacting on their everyday lives; including resources available in their locality. Although the findings in this study are from a small sample in one ward they are likely to be transferable to other similar community contexts to inform understanding of women's perspectives in similar circumstances.

Taking a life course perspective, an asset based approach has the potential to capitalise on the assets and protective factors available to women at different ages in their lives.  For example, the health benefits of avoiding loneliness through social participation are important to acknowledge, as is the influence of locality on health, wellbeing and women's decision making.  Local interventions to build mental resilience as an asset and promote women's health should be developed in holistic and sustainable ways to support the different dimensions of wellbeing. If the aspirations of domestic and global health policy are to be achieved, the position of women as an asset in building healthy local communities should not be under estimated.

However, in planning community support and development, even at a very local level, Health Networks and other agencies cannot assume that the women who live there agree on which aspects of their living circumstances are protective assets or health limiting. Early engagement with the women in the community to get to know them as individuals is therefore important. Whilst understanding an individual woman's sense of coherence (Antonovsky 1987) in an asset based approach to community development is useful

approach for this work, a collective, community, sense of coherence across groups of women cannot be assumed.  However, this in depth study of one group of women showed that whilst they had some different perceptions there was also consensus on the importance to health and wellbeing of: avoiding loneliness; having access to diverse very local services; needing sufficient income; and the protective value of friendship based on reciprocation. This consensus has provided the local Health Network with a foundation for improved asset based working with women in the study locality.

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