Social capital, social movements and global public health: fighting for health-enabling contexts in marginalised settings.

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Abstract

Research linking health and social capital is often cited in relation to global public health policies and programmes that mobilise local community participation in health promotion in marginalised settings. A long-standing criticism of this body of analysis and action is its inadequate attention to the power inequalities that drive poor health, often linked to macro-social forces beyond the reach of local community activism. Supplementing social capital research with attention to more ambitious and wide-ranging forms of health activism tackles this criticism. It puts the reproduction and transformation of health-relevant power inequalities at the heart of social capital research and community mobilisation strategies. We use the South African Treatment Action Campaign as a prototype for expanding understandings of social capital for health promotion. Existing social capital work currently focuses on facilitating community mobilisation to create co-operative bonding and bridging social capital (networks of solidarity within and between marginalised communities respectively), as well as linking social capital (networks uniting marginalised communities and more powerful champions). We call for an expanded focus that takes account of how these co-operative networks may serve as springboards for community involvement in adversarial social movements. In such cases, these networks of solidarity serve as launch pads for various forms of demand and protest where the marginalised and their allies confront power-holders in conflictual struggles over health-relevant social resources. We illustrate this expanded framework with two examples of collective action for mental health: the Movement for Global Mental Health and the UK Mental Health User and Survivor Movement. Both seek to use bonding, bridging and linking networks as the basis for movements to pressurise power-holders to increase access to appropriate psychiatric services, adequate welfare support and social respect and recognition for people living with mental distress.

Keywords: Social capital, Social Movements, Global Public Health, Health-enabling communities, Health inequalities, Social determinants of health, Community participation, Collective Action.

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Introduction

How can we expand the theory of social capital and the associated practice of community mobilisation to take better account of the impact of power inequalities on health in marginalised settings? Much research links health and social capital – understood as peoples' participation in community networks with their associated social norms (Kawachi *et al*., 2008). In global public health, this research often informs the design and evaluation of policies and interventions to promote health-enhancing networks and norms in local (place-based) community settings (Eriksson, 2011; Ogden *et al*., 2014). These seek to facilitate health-promoting behaviours through strengthening participation in pre-existing indigenous community groups e.g. faith-based organisations, sports clubs or women's groups (Gregson et al., 2004), or through creating new externally generated groups. Examples of externally generated groups include local peer education networks for those at risk of particular health challenges (e.g. domestic violence or HIV) and support groups uniting those with a common health condition (e.g. mental distress or breast cancer) (Campbell, Scott *et al*., 2013).

Health-related behaviours refer to any actions that contribute to the promotion of health, or the prevention, care or treatment of ill-health. Our interest in how social capital might improve or limit opportunities for such behaviours is framed by community health psychology. This views community mobilisation (understood as efforts to engage communities in various forms of participation and partnership to improve their health) as a key strategy for increasing the power of marginalised people and groups to behave in ways that optimise their health and well-being (Murray *et al*., 2004;).

Compared to traditional health psychology which focuses on individual decisions as drivers of health behaviours (Conner & Norman, 2005), community health psychology and associated community health promotion approaches assume health-related behaviours are driven by social norms as well as individual decisions, with people being most likely to change high-risk behaviours when they see liked and trusted peers changing theirs (Campbell & Cornish, 2010b). Community group participation is seen to promote the likelihood of such actions through providing “safe social spaces” (Vaughan, 2014:184) for people to share and process potentially sensitive or alien health-related information and engage in critical thinking about individual and social drivers of health-damaging behaviours. Ideally, this leads to dialogue about the possibility of new behavioural norms, and the development of solidarity and confidence as well as feasible plans to action newly formulated health-enhancing behaviours (Vaughan, 2010). Such programmes also seek to build co-operative partnerships between at-risk communities and groups (in public, private or civil society sectors) capable of helping them put new action plans into practice (Aveling & Jovchelovitch, 2014).

However, community mobilisation often fails to achieve sustained or generalised improvements in health behaviour or health status amongst people in difficult settings (Cornish, 2014). This is especially so where people are marginalised through varying combinations of material deprivation, lack of symbolic respect and recognition (due to gender, ethnicity and other forms of discrimination) and other forms of social precarity limiting their ability to action newly negotiated decisions to engage in healthier behaviours (Campbell & Cornish, 2010; CSDH, 2008). A long-standing criticism of the practice of community mobilisation and associated social capital scholarship is its inadequate attention to the macro-social power inequalities that drive poor health, often lying beyond the reach of local community efforts (Wakefield & Poland, 2006). Calls have long been made for greater attention to how unequal macro-social contexts limit the role of local social capital in health promotion, and how public health interventions might address these limitations (Muntaner and Lynch, 1999).

Scholars have also long criticised the use of the concept of social capital to inform public health interventions in the ‘partnerships’ mould. These facilitate norms of cooperation between unequal interest groups, masking the way in which ill-health is driven by these groups’ conflicting needs and interests (Moore *et al*., 2006). More adversarial strategies may often be necessary to improve opportunities for health in unequal settings. This position aligns us with “critical” approaches within community health psychology (also called ‘emancipatory’ perspectives). We distinguish these from “accomodationist” approaches that assume marginalised groups can achieve significant and sustainable health gains by cooperating with, rather than challenging, relevant power-holders (Campbell & Murray, 2004:187).

In line with our commitment to an emphasis on the role of power inequalities in framing health, this paper moves beyond Kawachi et al.’s (2008) relatively neutral definition of social capital cited above (in terms of network participation and associated norms) that has influenced much global public health research in low and middle income countries (LMIC’s) to date. Instead, this paper is informed by Bourdieu’s (1986) more critical and power-focused understanding of social capital in terms of the unequally distributed resources associated with peoples’ participation in varyingly advantageous social networks in unequal social settings. We view social capital as mediating between social inequalities and individual health in varyingly positive and negative ways through enabling or limiting peoples’ access to those material, symbolic and/or psychological assets that might support them in behaving in health-enhancing ways.

In the context of our interest in global public health promotion in highly marginalised communities, we will draw on Szreter & Woolcock’s (2004) distinction between three types of social capital. We will view bonding social capital as networks of solidarity uniting people *within* marginalised communities; bridging social capital as networks uniting groups of people (more or less equal in terms of power and status) across marginalised communities; and linking social capital as networks linking marginalised people to more powerful champions.

The aim of our paper is to challenge social capital researchers and community health activists to supplement their work through exploring how bonding, bridging and linking networks may sometimes serve as springboards for participation in conflictual social movements that use various forms of protest or confrontation to demand access to health-relevant resources in conditions of social inequality.

The paper is informed by a review of the literature on the role of community mobilisation and social capital in the practice of global public health promotion. We will argue that our proposed expansion in focus provides a productive frame for extending the theory and practice of social capital and community mobilisation to bring the unequal distribution of power to the heart of analysis and action for health-supporting social change. The remainder of the paper has three sections. Firstly we position our argument for expanding the concept of social capital in the context of the evolution of behaviour change approaches in public health research and practice.

Secondly we provide illustrative examples of varyingly successful health initiatives that have mobilised highly marginalised communities in programmes of activism to challenge health-damaging social relations. We are guided by Flyvberg's (2001) phronetic social science, which advocates examining real-world cases to expand our thinking about the workings of power and possibility of social change. Finally we map out some empirical, conceptual and methodological pointers for future research.

Social capital and health promotion

We provide a brief overview of strategies in global public health promotion (ranging from social cognition to peer education to community mobilisation approaches) to justify our call for expanding the focus of both the practice of community mobilisation and the associated theory of social capital in the health field.

Community health psychology rejects the individual-social dualism of individual-focused social cognition approaches to health promotion (Campbell & Cornish, 2010). These target the individual as locus of behaviour change, viewing society as a static backdrop to individual-focused behaviour change interventions (Conner & Norman, 2005). In contrast, community health psychologists assume the individual is 'always-already-social', with individual health-relevant behaviours irrevocably linked to social contexts. They argue that behaviour change programmes should go beyond persuading individuals to adopt healthy behaviours, also creating "health-enabling social contexts" (Tawil *et al*., 1995:1299), by which they mean social environments that enable and support the possibility of health-relevant behaviour change. Rooted in Iscoe's work on 'competent communities' (1974), such thinking has informed conceptualisations of ‘HIV-competent communities’ (Campbell, Scott *et al*., 2013), and ‘community mental health competencies’ (Burgess and Matthias, 2017). These refer to communities where members work collaboratively to promote and engage in actions that advance health (both their own and the health of other community members) and that optimise their access to, and optimal use of, services for prevention, care and treatment of ill-health.

One strand of social capital work linked to public health and social development programmes in low income countries has focused on the health benefits of participation in indigenous community networks (e.g. youth groups, sports clubs) (Gilgen *et al*., 2001; Gregson *et al*., 2004), and on participation in community-level interventions set up by NGOs to promote health. Work on social capital and NGO-generated community participation is generally aligned with local-level health promotion strategies e.g. peer education, community conversations and community mobilisation (Campbell & Cornish, 2010; Campbell, Scott *et al*., 2013). As opposed to social cognition’s focus on the individual, peer education targets peer groups as the locus of change. Peer norms are viewed as determinants of health-damaging behaviours (e.g. needle sharing, heavy drinking) with people more likely to change these behaviours when liked and trusted peers change theirs. Programmes train members of hard-to-reach groups (e.g. precarious youth, homeless people) in health information and participatory teaching skills. They are sent back to peer communities to facilitate health-promoting revision of peer norms in informal settings, using ‘*bonding*’ social capital (networks composed of strong within-group relationships) (Szreter & Woolcock, 2004) as pathways to change.

Whilst peer education is method of choice with hard-to-reach groups worldwide, behaviour change outcomes are often disappointing (Kim & Free, 2009). This has increased interest in community mobilisation approaches, which cast their nets wider than peer groups, viewing the entire geographical community within which peer groups are located as target of change (Cornish, 2014). They acknowledge that communities include groups with different, often contradictory, identities and interests that impact health programmes in contradictory ways (Cornish & Ghosh, 2007). Such programmes use different strategies to mobilise differently motivated groups around common and mutually beneficial health goals. Examples include Indian programmes targeting sex workers, brothel owners and police departments in sexual health projects promoting condom use (Cornish & Ghosh, 2007). Such efforts facilitate '*bridging*' social capital as the pathway to health, understood as co-operative relationships between different groups of relatively similar social status (Szreter and Woolcock, 2004).

Beyond local communities

In global public health, community health psychologists seeking to facilitate health-competent communities commonly draw on Freire (1973) to map out the psychosocial pathways between community participation and health (Vaughan, 2010). They characterise health-competent communities as psychosocial contexts where people share knowledge about health risks and engage in dialogue and critical thinking about the social drivers of high-risk behaviours and poor health. Critical thinking leads marginalised people to develop understandings of how ill-health is fuelled by social injustices, rather than individual shortcomings or bad luck. The resulting sense of common fate generates community solidarity and motivation to reformulate health-damaging norms. In addition to these goals, accepted by most accomodationist community health psychologists, Freire (1973) also adds a more radical goal arising from this new solidarity and confidence: people's engagement in collective action to challenge and resist the inequalities that place their health at risk.

Freire's radical agenda for social change via collective action is generally neutered in practice however (Nolas, 2014). Whilst often clothed in emancipatory rhetoric about tackling social determinants of health, most global public health programmes do not go beyond using peer education or community mobilisation to increase peoples' awareness of health risks and the importance of prevention, care and treatment services (Vaughan, 2014). A minority of more ambitious programmes *do* go beyond promoting awareness and health service access, increasing awareness of social roots of ill-health through critical thinking using e.g. 'community conversations' (Nhamo *et al*., 2010). However, they pay little attention to mobilising people to resist the wider contexts that make it difficult for them to action such awareness, benefit from services, or fight for social change (Rolston, 2016). Even where poor communities make collective decisions to change behaviours or challenge unhelpful social relations, external social obstacles (e.g. poor harvests, political instability, gender norms) often prevent them from implementing these (Nhamo *et al*., 2010). Such experiences suggest community health practitioners and associated social capital researchers pay more explicit and systematic attention to structural barriers to health-related agency, developing strategies through which marginalised people might engage in social change activism to tackle these.

Facilitating a "push from below"? Social capital and social movements.

Some re-distribution of political power, economic wealth and/or social recognition is usually necessary to create contexts that support the health of marginalised groups (CSDH, 2008). Yet rather than calling on power-holders to effect such redistribution, community health programmes usually operate within the parameters of unequal settings. Engaging power-holders generally takes the form of cooperative 'partnerships' between marginalised groupings and more powerful actors and agencies in health ministries, health care settings, development NGOs or international research bodies (Aveling & Jovchelovitch, 2014). These relationships constitute '*linking* social capital' – collaborative relationships between people with very different access to social power and status (Szreter & Woolcock, 2004).

"Power is not conceded without demand" however (Douglass, 1857). Powerful groups seldom re-allocate health-enabling power or resources without assertive demands from marginalised people. Yet vulnerable members of excluded groups seldom have psychological or material capacity to make suitably forceful demands (Campbell, Cornish *et al*., 2010a). Much can be learned from campaigns that have mobilised an effective "push from below", not only mobilising local people to understand the impacts of adverse social settings on their well-being, and to call for better conditions, but also pressurising power holders into heeding these calls (Campbell, Cornish *et al*., 2010:1359). The South African Treatment Action Campaign (TAC) (Robins, 2008) is a good example (Campbell, Cornish *et al*., 2010). It illustrates how small groups of highly marginalised people may be mobilised into more ambitiously networked health-related social movements – providing a productive lens for expanding the scope of community strengthening interventions and how we think about social capital.

The Treatment Action Campaign

The TAC arose when millions were dying of AIDS due to lack of access to life-saving drugs, with the South African President and senior government figures denying the existence of HIV/AIDS. It mobilised predominantly black, unemployed, poorly educated, young HIV-positive women from poor communities across the country (Friedman & Mottiar, 2005). It mobilised small bonding networks of local women through cascades of treatment literacy training (‘train the trainer’ approaches). Rooted in radical Freirian principles, this went beyond simply spreading information about HIV and associated inaction by national government and global pharma. Using programmes of dialogue and critical thinking, it united women in powerful networks of solidarity through their shared HIV-positive status, fear of having an untreatable terminal illness and joint determination to resist national and international political, health and pharmaceutical interests seeking to withhold their right to life (Robins & von Lieres, 2013). Local bonding networks formed the basis for bridging and linking relationships that formed the springboard for an immensely powerful and effective adversarial political force.

The Movement provided funding for transport, bringing together small local groups with similar others from different areas, and providing opportunities for them to share experiences and aspirations in larger networks of bridging social capital. At the same time it integrated this growing band of women into alliances with actors and groups with very different access to material resources and social status all over the world (Grebe, 2011). These included poorly paid local hospital workers, national and global networks with influential leaders, and associated grassroots constituencies, in law, medical science, politics and civil society. These alliances constituted a powerful global linking network of diverse allies committed to working with HIV-positive South

Africans to champion their cause (Heywood, 2009). This network included e.g. the Durban Declaration signed by 5000 international scientists, including 11 Nobel Laureates, published in *Nature* (Commentary, 2000), and powerful international lobbies of gay men living with AIDS.

These powerful bonding, bridging and linking networks constituted a social movement that compelled the SA government to acknowledge the reality of HIV/AIDS and peoples' rights to treatment, and forced international pharmaceutical companies (sheltering behind international patent law) to make life-saving drugs available at affordable prices (Geffen, 2010). Key to these gains were a range of adversarial strategies including mass public protests, using the constitution to claim socio-economic rights, marches, civil disobedience strategies including occupations of government offices, and peaceful mass arrests –underpinned by the grassroots mobilisation outlined above (Mbali, 2013).

The TAC presents a formidable example of the effective mobilisation of social capital networks as basis for a social movement that successfully tackled significant vested interests. These included a national government led by an AIDS-denying president, the economic giant of the pharmaceutical industry, and international legal codes, to create social changes that dramatically increased the survival of millions of marginalised people (Heywood, 2009).

The TAC challenges community mobilisation researchers to expand social capital into a tool for design and evaluation of more ambitious global health programmes. This would extend the field's relatively modest local-level focus through attention to strategies uniting a wider array of participants and non-local allies, with wider geographical reach and influence, than the lens of traditional social capital research and practice. Furthermore the TAC challenges social capital researchers and community health activists to give greater acknowledgement to the fact that conflict will often be as essential to struggles for health as cooperation (Moore *et al*., 2006), .

The TAC's success has inspired new health campaigns, particularly in global mental health where leaders laud it as an inspirational role model (Patel, Collins *et al*., 2011a). Using real-world examples to advance understandings of the workings of power and possibility of social change (Flyvberg, 2001), we use the TAC as a prototypical lens onto two mental health movements. We draw on our characterisation of the TAC not only through its mobilisation of bonding, bridging and linking networks (already well accepted in social capital research and community mobilisation practice). We also take account of its use of these alliances as springboards for adversarial social movements that challenged the power inequalities that often drive ill-health (our proposed extension of social capital thinking and practice).

We examine each mental health Movement's aims, achievements and challenges, before discussing the complexities of its engagement with local communities and the types of questions these throw up for an expanded vision of social capital as a tool for more ambitious public health practice. Given strong mental health service-user/survivor resistance to being 'objects' of judgement by non-user/survivor academics (Cresswell & Spandler, 2013), we draw on user-academics' writing in commenting on challenges facing each movement.

Movement for Global Mental Health (MGMH)

Globally, one in four experience poor mental health each year, 90% not accessing medical care (Patel *et al*., 2011). Launched in a special issue of *The Lancet* in 2007 (Prince *et al*., 2007), the MGMH is a world-wide coalition of mental health professionals, activists, people in distress and families/carers, committed to scaling up psychiatric service access, especially in LMIC's (Patel *et al*., 2011).

Mobilising local communities (in bonding and bridging networks) is a core strategy for increasing treatment and care access, with plans to train 100 000s of local people in LMIC's around the world in basic mental health care and support (Petersen *et al*., 2012). Activities also seek to link local networks with powerful allies in psychiatry and global policy including the World Health Organisation, the World Psychiatric Association and international centres of academic psychiatry (Patel *et al*., 2011).

Co-operative linking networks have played the key role in foregrounding mental health in global policy initiatives. They have also engaged in ambitious global and national advocacy to persuade national governments to scale-up and fund services, international donors to prioritise financial assistance, and national and international stakeholders to increase resources for prevention, treatment, research and monitoring.

Despite significant strides in advocacy and planning, critics argue the Movement now needs to focus more specifically on converting growing awareness of the plight of distressed people, eloquent statements of intent and an expanding evidence-base into essential funding for budgeted action (Mackenzie and Kesner, 2016). Even when international commitments come with some funding, domestic governments must adapt goals to local contexts, integrate implementation into existing health and welfare systems and monitor progress (Mackenzie and Kesner, 2016).

Sunkel (2011), a service-user activist working to strengthen user organisations in Africa and Asia, says practical implementation of Movement goals cannot be achieved without significant bottom-up pressure on national governments from grassroots communities. She calls for empowerment of the mentally ill to increase their capacity to advocate for themselves. She advocates for a more strident and combative engagement between the Movement and foot-dragging LMIC governments who fail to provide even minimal resources for mental health services. She argues for a more *adversarial* tone and aggressive tactics to highlight how power inequalities and lack of political will maintain the treatment gap.

Most community mobilisation involves training local people to serve as community health workers that administer ‘psychiatric first aid’ in biomedical primary health care systems. Local communities serve as ‘handmaidens of biomedicine’ in task-sharing programmes, rather than equal agents and experts in their own right (Campbell & Burgess, 2012). The Movement’s prioritisation of western biomedicine in engaging with local communities has been criticised for paying inadequate attention to indigenous understandings of health and healing held by many potential beneficiaries (Fernando, 2012). Jain and Jadhav (2009) argue that whilst professionals come with significant expertise in western psychiatry, communities come with expertise about their own lives and cultural understandings of health and healing, including expertise on the limits and potentials of psychotropic drug treatments and the feasibility of human rights interventions in extreme poverty (Read, 2009). Communities also have expertise on the challenges facing ‘task-sharing’ programmes that expect minimally trained and marginalised community health workers to deal with the multi-faceted social problems often driving poor mental health (Petersen, 2012).

United Kingdom Mental Health Service-Users and Survivors Movement (UK-USM)

One in six British adults experiences symptoms of common mental disorder (CMD) weekly; one in five have considered suicide. (Mental Health Foundation, 2016). Two-thirds receiving Employment and Support Allowance (unable to work due to poor health or disability) report mental ill health; 43% have attempted suicide. Members of Black and Minority Ethnic (BME) groups have particularly low treatment rates and high rates of involuntary detention (Mental Health Foundation, 2016). Ninety percent of people experiencing distress have experienced discrimination. Deepening austerity has led to a dramatic increase in mental ill health, and increasingly welfare benefits are linked to assessments of 'fitness to work', often putting the burden of work on people too ill to hold down jobs (Rose, 2018).

Dating to the 1970s, P.Campbell (2013) characterises the UK-USM as a loose coalition of perspectives from radical oppositional 'survivors' seeking to emancipate 'the mad' from psychiatric services and professionals, to 'users' accepting the necessity of psychiatry, and seeking to reform health services through collaboration with service providers. Participants are united through their commitments to the importance of self-help, grounding their work in local small-scale groups and experiences, mutual/peer support, scepticism about professionals, and respect for personal experiences of people in distress (Ibid).

The radical tendency has included anarchistic and oppositional initiatives such as Mad Pride, using picketing, marching and arts/writing to reclaim the stigmatised concept of madness and redefine it in positive ways (Curtis *et al*., 2000). The Hearing Voices Network (2018) emphasises understanding and accepting the emotional meanings of voices, rejecting psychiatric attempts to silence them through medication. Recovery in the Bin (2017) opposes definitions of recovery as a person's ability and/or willingness to behave 'normally', also rejecting the view of recovery as an individual process, when individuals often live in intolerable social and economic settings (Rose, 2018).

Less radical movement members style themselves as 'experts by experience' (Noorani, 2013), working in linking partnerships with health professionals to create services that acknowledge their agency, competence and needs. User involvement in all discussions about services – unthinkable 30 years ago - is now established government policy. Users are routinely active in training mental health professionals, in user-led research challenging unhelpful professional practices (Rose *et al*., 2006) and in media anti-discrimination campaigns.

For prominent user-activists, P.Campbell (2013) and Rose (2018), the Movement's greatest success was its role in creating hundreds of small-scale local support groups across the UK, often with less than 30 members generating vital solidarity amongst otherwise excluded and isolated people (Wallcraft & Bryant, 2003). Yet these bonding networks have often not interfaced with bridging networks of other small user groups or fed into wider linking alliances. Most have lacked financial and management skills, competing with more credible voluntary organisations for funding. Recently, many have discontinued, with dramatic cuts in government funding (Rose, 2018).

Another key achievement has been increased societal awareness of discrimination against users/survivors. Translating this into practice remains a key challenge, however (P.Campbell, 2013). Concrete improvements in services are slow, patchy and stop-start. User involvement in services is often tokenistic. In linking networks between users and professionals, the latter usually have the upper hand (Faulkner, 2018). Decades of activism against compulsion have had little success (Keown *et al*., 2008). Despite user requests for holistic treatments, many services remain dominated by rigid diagnostic categories and drug treatments (Fernando, 2010).

Successful recognition of detained patients' rights to independent advocacy have led to services increasingly using professional advocates e.g. social workers - with a loss of influence by users, and silencing rather than amplification of their voices (P.Campbell, 2013). Professionals in big national charities now dominate the field. Some are supportive, others are not. Links with government are patchy. Even well-intentioned public sector allies are bound by policies framed by governments sensitive to voter stereotypes of 'the mad' as dangerous or unworthy of support (Chen & Lawrie, 2017). There remains a significant overall lack of political will by government and mental health professionals to take bold steps to action alternatives in a public sphere where stigma, poverty and poor service access and provision remain rife. P.Campbell (2013) calls for the re-politicisation of the Movement, through new networks for channelling user voices, and more bridging alliances with similarly excluded groups such as the disability movement.

Discussion

Our use of the TAC prototype as lens onto two very different mental health movements throws up interesting questions for the expansion of social capital for community mobilisation. Both movements are committed to uniting people in distress and their allies to tackle social inequalities that limit opportunities for health. Yet some of their efforts are hampered by the very inequalities they seek to tackle. Here we focus on only two of the very wide array of challenges showcased in our thumbnail accounts above, which throw light on our particular interest in mobilising highly marginalised people into bonding, bridging and linking networks in difficult settings.

The UK-USM is a national movement in a high-income country, with a history of over 40 years. The MGMH is a global movement that has been targeting LMIC's for over a decade. Each has generated positive outcomes, especially greater recognition of the rights and needs of people suffering mental distress. Yet user/survivor activists in both settings argue these networks have yet to succeed in pushing power-holders to go beyond principled recognition of rights to services and respect, to provide concrete political opportunities and material resources to deliver these.

Sunkel (2011) highlights challenge facing the MGMH to translate rhetorical commitments into action by cash-strapped LMIC governments. P.Campbell (2013) highlights the UK-USM's struggle to ensure recognition of rights translates into adequately resourced services and welfare benefits. Rose (2018) suggests this becomes increasingly urgent as UK government funding cuts and welfare conditionality threatens the very survival of many experiencing mental ill health.

In highlighting implementation gaps, these user-activists indicate shortcomings in forms of social capital mobilised by each movement (here we focus on bonding and bridging in the UK-USM, and linking in the MGMH). They argue these hamper the development of a strong enough 'push from below' to create supportive contexts for social changes necessary to improve conditions of those in distress.

The UK-USM battles to unite diverse participants into bonding and bridging networks of solidarity around clear common demands. Difficulties in accommodating differences over meaning and goals (e.g. between ‘users’ and ‘survivors’) has often prevented a coherent user-survivor voice (P.Campbell, 2013). The movement has often succeeded in mobilising vocal and articulate participants, but often not the most vulnerable and excluded service user/survivors, including young women and people from BME groups (P.Campbell, 2005).

In relation to linking social capital, the MGHM is challenged by how to amplify voices of vulnerable communities in alliances with powerful national and global champions – to achieve a meaningful balance of top-down and bottom-up perspectives. To pressurise national LMIC governments to action principled commitments to mental health Social Development Goals, it must create space for indigenous community voices at all Movement levels (Summerfield, 2012). Currently it tends to mobilise local people as ‘community health workers’ - in biomedical systems whose understandings of health and healing may be very different from theirs. Community members take on these vital roles willingly and enthusiastically. However if senior movement leaders are to action their commitment to the TAC as role model, with its effective strategic use of bottom-up inputs, much work remains to be done in forging grassroots participants into demanding and politicised collectives. Marginalised community worldviews and experiences need greater status in linking networks with psychiatrists, health professionals and other allies (Fernando, 2012).

In relation to political strategy, confrontational protests rooted in first-hand experiences of hardship and suffering by innocent people may be powerful motors of political protest, placing a movement on the “moral high ground”, generating vital national and global support (Friedman & Mottiar, 2004:17). In relation to effective service development, peoples’ responses to health interventions are filtered through indigenous understandings of health and healing. Neglect of these potentially limits the likelihood that people will access and use prevention, care and treatment services in the most effective way (Jain & Jadhav, 2009). Inequalities between communities and more powerful ‘partners’ (e.g. psychiatrists) in linking social capital mobilised by health movements highlight the irony that linking networks may often be hampered by the very health-damaging inequalities movements seek to tackle.

Compared to our mental health examples, it was relatively easy for the TAC to generate solidarity across bonding, bridging and linking networks because it had a clearly definable, single endpoint (access to life-saving treatment by people with AIDS) associated with implementable strategies. The uncontroversial nature of this goal was capable of uniting diverse movement participants at every level from micro-local to global. The challenges facing mental health movements in uniting diverse participants and potential allies are more complex. The goals of tackling growing levels of mental distress, lack of services in conditions of extreme deprivation, and stigmatisation of the mentally ill are embedded in material, symbolic and relational dynamics that defy clear ‘once and for all’ solutions. Much work remains in teasing out conditions where TAC-style success can be duplicated in relation to more complex and long-term health movement goals.

Conclusion

Our mental health movements highlight important empirical questions for our proposed expansion of social capital. Both seek to mobilise bonding, bridging and linking social capital as springboards to tackle social inequalities that undermine mental health in marginalised groups. Yet, amongst its many challenges, the UK-USM has often battled to create bonding and bridging social capital uniting people who share common experiences of mental distress, services and welfare regimes – but remain divided by inter-sectional power differences and ideological divides. The MGMH grapples to build linking social capital that provides equal spaces for voices of allies with different world-views and access to social power, privilege and status. Applying the TAC lens to these movements highlights the need for specific attention to the conditions that make success possible in some contexts, not others.

We conclude with brief pointers for conceptual and methodological development. Conceptually, our proposed expansion responds to long-standing calls for more holistic frameworks in public health research (Marks, 1996). Our interest in integrating attention to *community-level* social capital and social movements fighting to create *macro-social* contexts that enable and support *individual-level* behaviour change, responds to calls for public health research that integrates individual, community and macro-social levels of analysis, rather than the single-level research studies that are most common (Saegert & Carpiano, 2017).

This integration also offers theoretical enrichment. With notable exceptions, research on social capital for global public health tends to be empirical. Viewing social capital as a potential springboard to adversarial social movements fighting for social changes that enable better health, allies the field with rich bodies of multi-disciplinary social theory on collective action and social movements. This offers great potential for deepening existing analysis and action in global public health: social psychology on identity and solidarity in collective action (Kinvall & Kapellos, 2014); social anthropology on movements as makers and carriers of meaning and culture (Salman & Assies, 2007); sociology on resource mobilisation, political opportunity structures and identities as movement drivers (Snow *et al*., 2018). The applied fields of public policy (Hankivsky & Jordan-Zachery, 2018) and development studies (Cornwall,

2011) also provide rich insights around engaging diverse groups in collaborative social development.

Methodologically, we advocate qualitative case studies of varyingly successful health movements as the next step for the research direction we advocate. Qualitative approaches are not always popular in the world of ‘evidence-based policy and practice’, which favours quantitative standardised measurements of programme inputs, pathways and outputs (Cornish, 2014). Given the improvisational, context-specific process of mobilising communities into complex alliances (Eyben, 2005), however, it would be difficult to aim for generalisable statements about ‘what works’ at this stage. In the first instance, open-ended unstructured case studies are most likely to capture the complex and context-specific dynamics of community participation for social change in public health initiatives in marginalised settings.

Our proposed expansion of social capital research offers exciting opportunities for making the concept more ‘fit for purpose’ for an expanded practice of global public health. It puts the concept of social capital at the heart of new arena for scholar-activists. This arena opens new spaces of engagement for researchers, public health professionals, policy-makers and activists – with shared commitments to engaging marginalised communities in more ambitious, adversarial and wide-ranging forms of activism for health-enabling social change.

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