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Health, Community and Development: Towards a Social Psychology of Participation[1]

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ABSTRACT

The concept of 'community participation' plays a central role in policies and interventions seeking to reduce health inequalities. This paper seeks to contribute to debates about the role of participation in health by suggesting how social psychological concepts can add to the theorisation of participation. It criticises traditional concepts of development and introduces some of the challenges that are present for development and community theorists in conditions of rapid globalisation. The paper proceeds to demarcate the space which a social psychology of participation occupies within the terrain of existing research into the health-society interface. The concepts of empowerment and social capital are identified as important starting points to address the relative lack of social psychological attention to community-level determinants of health. It is suggested that social identities, social representations and power are crucial elements for constructing a social psychology of participation. The paper concludes by highlighting the vital link that should exist between the development of theory and practical interventions. Paulo Freire's notion of conscientisation is a guiding notion throughout the paper.

INTRODUCTION

The poorest people in the world are also the ones with poorest health. Despite years of concerted action by the WHO and other international agencies we are nowhere nearer to achieving the ambitious goals laid out in the "Health for All by the Year 2000" initiative. Poverty and other forms of social exclusion continue to be key determinants of health inequalities both between countries and within countries in the north and the south. It has been suggested that community participation could playa key role in policies and interventions seeking to reduce health inequalities. In this paper we seek to contribute to debates about the role of participation in health by suggesting how social psychological concepts can add to the theorisation of participation. In particular, we shall highlight the way in which the concepts of social identity, social representations and power--as well as Freire's concept of conscientisationm--form key starting points for the development of a 'social psychology of participation'.

The pathways whereby inequalities impact on health are many and complex. Apart from the direct effects of socio-economic deprivation on health, members of marginalised groups often lack the material and/or symbolic resources to deal with health-damaging stress. Social exclusion undermines peoples' access to health-related knowledge. It also impacts on the value that people place on local health-related knowledge and skills, where these are not consistent with mainstream approaches to health and healing. People who lack the power to shape their life course in significant ways are less likely to believe that they can take control of their health, and thus less likely to engage in health-promoting behaviours (Bandura, 1996).

Those concerned to reverse the trend of health inequalities pit their energies at various levels. Some work at the level of governments, some at the level of nongovernmental organisations. Some seek to promote partnerships between the public and the private sectors. Others work to formulate and implement health-promoting social policies at the global, national, regional or local levels. Some work directly in the areas of health. In the current climate of 'joined up thinking', others work to create alliances between health activists and representatives of social sectors which impact on health in more indirect ways, such as welfare, housing, transport, womens' issues, education and employment.

Each of these levels of struggle forms an essential backdrop for our interest in community development and participation as one of the strategies for addressing health inequalities. Within the area of health promotion, in particular, recent years have seen "a paradigm drift" away from biomedical and behaviourally oriented interventions and policies towards a community development perspective (Beeker *et al.*, 1998). This perspective is driven by the insight that it is only through the participation and representation of grassroots communities in planning and implementing health programs that such programs are likely to have an impact.

There are various forms of participation that are important for health. These can impact directly or indirectly on health. Firstly, there is growing recognition of the need to involve local community groupings in strategic and operational decisions about health service design and delivery. This is deemed crucial for addressing issues such as differential access, cultural differences, racism, and communication difficulties which are often believed to undermine the level of health service provision received by marginalised groups (Dept. Health, 1999). Secondly, it is argued that local community groups should participate in designing and implementing grassroots initiatives to promote healthy behaviours, given that people are far more likely to change their behaviour if they see that liked and trusted peers are changing theirs (Dube and Wilson, 1996). Thirdly, more indirectly but equally importantly, there is a growing recognition of the influence of local community/neighbourhood conditions on health, with studies emphasising that social cohesion and strong local networks benefit health in a range of indirect ways (Baum, 1999a). In this regard, health promoters are increasingly becoming involved in general 'community strengthening' programmes, which seek to create 'health-enabling communities',

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characterised by trust, mutual support and high levels of involvement in local community projects of mutual interest.

Yet, despite the growing emphasis on participation amongst those concerned with health inequalities much remains to be learned about the processes and mechanisms whereby participation and representation have a positive impact on health and community development. Partly this gap can be explained by the difficulties associated with theorising practical interventions. Too often there has been a lack of communication between practitioners on the ground and theoreticians in universities. This communication, however, is vital. Another reason is the resilience of the biomedical model, which has managed to persist in practice, despite the participatory rhetoric that has characterised international declarations and policy documents, more particularly in the wake of Alma Ata in 1977. The individualism of the biomedical model has conveniently served to mask the contribution of economical and political inequalities to patterns of ill health.

We can identify at least three reasons why it is important to develop a theoretically grounded social psychology of participation. Firstly, it is theoretically important because attention to the concept of participation can illuminate the relationship between individual and society, which is the central problem of social psychology. Secondly, it is pragmatically important for health policy and intervention in the light of some evidence that participation leads to improved health outcomes. Thirdly, it is politically important insofar as it addresses broader issues related to democracy and citizenship, which need a social psychological dimension in order to be properly understood.

The remainder of this paper is organised in three sections. The first one locates the problem of community participation within the context of development. We criticise traditional conceptions of development and introduce some of the challenges that are present for development theorists and community workers in conditions of rapid globalisation. We then proceed to demarcate the space which a social psychology of participation occupies within the terrain of existing research *into* the health-society interface. We identify the concepts of empowerment and social capital as important starting points to address the relative lack of social psychological attention to community-level determinants of health. In the third section we introduce what we believe are crucial elements for constructing a social psychology of participation. Social identities, social representations and power are the conceptual tools that guide our efforts. We conclude by highlighting the vital link that should exist between the development of theory and practical interventions. Paulo Freire's notion of conscientisation (Freire, 1970; 1973) is a guiding notion throughout the paper.

PARTICIPATION AND DEVELOPMENT IN CONTEXT

In the last four decades or so, the two dominant conceptions of development were modernisation, the traditional model of technology transfer associated with the political right, and dependency, the model associated with the political left (Hobart, 1993). Despite their differences, both strands shared the underlying assumption that development was an issue of 'catching up', and that eventually less developed contexts would achieve the stage of more developed ones. Developed societies stood as 'the model' to be followed, which, coupled with a strong emphasis on the ideology of progress, determined the aspirations and goals of development interventions. It is now widely acknowledged that development interventions in less developed countries are not just a matter of transferring information and technological 'fixes' from more developed contexts. This top-down approach to development has failed to recognise local resources and the problems involved in the cultural and material differences between contexts (Apffel-Marglin & Marglin, 1990). It has also become clear that the developed world is far from being free of the problems that are found in less developed circumstances.

Transformations imposed by conditions of late modernity and globalisation take the problem of development today far beyond the traditional north-south divide and uncover the importance of understanding each context in its own right. Although it would be a mistake, and indeed undesirable, to neglect the enormous disparities between countries of the north and countries of the south, globalisation has taken the problem of inequalities and development to a different level of complexity. With a few exceptions around the globe, the presence of poverty transcends the traditional boundary of Third World locations. There are pockets of poverty and wealth in most countries today[2]

As globalisation institutes new co-existences between wealth and poverty and threatens traditional communities and ways of life, the recognition of local contexts emerges as one of the key tasks in development programs (Atte, 1992). Without paying attention to local realities and trying hard to understand and integrate local systems of knowledge, community development interventions remain partial. The tendency to undermine local knowledge has been traditionally founded on the belief that development agents 'know best'. Health promoters and educators saw the knowledges they conveyed as the desirable ones, and were inclined to overlook the implicit assumptions embedded in this conception, namely, that there is a hierarchy of know 1edges-their knowledge was the 'best', and local knowledge was considered to be 'ignorance'. These hidden assumptions, commonly found in health promotion interventions, give ample support to Foucault's description of subjugated and dominant knowledges (Foucault, 1980). They can also explain the mistrust and resistance with which local people tend to receive outside workers.

Development initiatives which recognise local representations and ways of life are, on the other hand, more likely to be relevant and to generate sustainable and successful interventions (Atte, 1992; Brokensha, Warren and Werner, 1980). There are a number of lessons to be learned from the *experience of context* and the way this experience produces knowledge,

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[2] In the context of development debates. poverty remains the key form of social exclusion in countries of the South. Abrahamson (J 995) correctly points to the need to recognise other forms of socia] exclusion besides poverty, particularly in the context of countries of the North. The interface between social exclusion and health goes far beyond the problem of poverty, to include issues such as ethnicity. gender and sexual orientation, amongst others.

expertise and practices which emerge from, and at the same time respond to, the concrete conditions under which a group of people live. In the case of less developed communities there exists a long tradition of coping and inventing resources to counterbalance the chronic absence of information, state support and welfare. Community and development workers now recognise that peripheral communities have developed strategies of survival based on their cultural traditions and local knowledge to respond to the urgent needs they usually face.

In the field of health, networks of solidarity based in neighbourhood conviviality and kinship relations have been central to provide care and social support (Seabrook, 1986; Stacey, 1986). In the same manner, local knowledge has a great deal to offer. It equips local people with impressive arrangements to cope with the everyday and a vast stock of resources to make the best of it. These resources are expressive of both cultural traditions, handed down across generations and linked to the identity of a community, and the pragmatics of everyday life, where the dynamics of poverty and exclusion produces its own responses to alleviate hardship. The recognition of this portfolio of assets (Moser, 1998) is crucial to establish productive alliances between local communities and development workers. As the communication between different worlds and ways of life increases and as more dominant worldviews meet peripheral ones, it becomes crucial to establish dialogues between local understandings and the outside researchers, development workers and scientific practices that penetrate local communities (Agrawal, 1995).

The role of local knowledges in community development is a complex issue, however. There will be occasions where local understandings can be detrimental to the well being of local populations. Community and development workers will be familiar with situations where local communities express discourses and practices which are at variance with health. In our own work in Brazil, for example, we have to engage with mothers who use 'cachaça' (a cheap and highly alcoholic drink) in their babies' bottles. While this is a highly adaptive practice, which serves to quieten, comfort, and warm up babies while their mothers are earning a living, it also produces alarming levels of alcoholism in infants under the age of five (Unicef, 1988). From our perspective as social psychologists, we know that alcoholism can seriously compromise not only the health of these children but also their general life prospects.

We don't know, however, what the mothers know and undergo: a hard life, in conditions of poverty, usually alone, with minimal material and emotional resources to bring up their children. To establish a constructive dialogue between what "we know" and "they know" is a necessary pre-condition for promoting the health and living conditions of these children. Without exchange of views and perspectives, our attempts to work with these communities will only meet resistance, mistrust and failure.

Thus development interventions in the community can be based on a different assumption: the recognition of different types of knowledge and expertise and the possibility of establishing a dialogue between them with the objective of critical awareness. Here, development interventions are not a matter of transferring knowledge from agents who know better to recipients who are in a state of ignorance, but a joint action between agents who hold different knowledges and pertain to different cultural traditions (or different levels of affluence in the case of community interventions with excluded social groups within the same culture).

Such a conception follows closely Freire's discussion of development projects (1973). While discussing 'extension', which was the word used to describe development projects in the Third World, he makes clear that "the effort required is not one of *extension* but of *conscientização"* (p. 110).[3] The concept of conscientisation is at the core of Freire's pedagogy and it has been central to social psychological work in the community in Brazil and Latin America. Conscientisation is the process whereby critical thinking develops. It contains several stages, starting from 'intransitive thought', where people believe that control over their lives is out of their hands and fate defines their experience. They do not see their own actions as capable of changing their conditions. God or luck are seen as the way out of their often very poor living conditions. 'Semi-transitive thought' is the next stage towards conscientisation. Here people partly believe in themselves as motors of chance and to some degree they try to act in order to produce social change. Their understanding of their situation, however, is still fragmentary, insofar as they fail to connect their particular problems to the larger societal determinants underlying single situations. The final stage, which Freire calls 'critical transitivity' corresponds to the achievement of conscientisation. It refers to a dynamic relationship between critical thought and critical actions triggered by the ability to think holistically and critically about one's condition. This level of consciousness is never given, but always achieved through a social process of learning characterised by dialogical and participatory relationships. A critically transitive thinker feels empowered to think and to act on the conditions that shape her living.

According to Martin-Baró (1994: 18) "the now well accepted concept of the awakening of critical consciousness *(conscientizaci6n)* joins the psychological dimension of personal consciousness with its social and political dimension, and makes manifest the historical dialectic between knowing and doing, between individual growth and community organization, between personal liberation and social transformation". In dialogical communication, actors can develop an appreciation of reality which was not there before: they construct awareness about their conditions of living not only for themselves but also for those who work *with* them. It is this awareness that pushes a community into participating action and, in a dialectical way, reinforces the very existence of their community links.

Freire's considerations are in line with a great deal of recent work on development and community projects (Rappaport,

[3] The Portuguese word *conscientização* is difficult to translate in English and translators of Freire's work frequently use the French *prise de conscience*, or leave the Portuguese word in the middle of the English text, as in the case we quote above. In this paper we use the word conscientisation, the choice of many of Freire's English translators.

1987). The key issues guiding these interventions revolve around the idea of empowering communities to participate both in the construction/consolidation of the relationships that form the community itself, and in larger social arenas where representations and resources are disputed. By participating and consolidating the level of community action, deprived sectors can proclaim/reclaim their interests in the public sphere, reaffirm their identity in relation to other social groups and pressurise channels of decision making and institutional power to respond to their needs. This level of community participation, which is embedded in a struggle over knowledge, identity and resources, becomes central to thinking about health in conditions of poverty and exclusion.

HEALTH AND SOCIAL RELATIONS

While issues of empowerment and participation have long received attention within the fields of community psychology as well as the social psychology and sociology of health, we still lack a social psychological theorisation of these processes. In this section we seek to demarcate the space which a social psychology of participation can occupy within the terrain of existing debates about the society-health interface. Researchers have pointed to an array of variables, which mediate between social relations and health at various levels of analysis. At the *individual* level of analysis much work has been done into physiological pathways between social stresses and health (Wilkinson, 1999). Also at the individual level of analysis, psychological work has been done on concepts such as self-efficacy (Bandura, 1996), sense of coherence (Antonovsky, 1984), and social identity (Stockdale, 1995), all of which have been associated with positive health outcomes. At the *inter-individual* level we have concepts such as social support (Cohen and Syme, 1984), social networks (Berkman, 1995) and perceived relative deprivation (Wilkinson, 1996). Sociologists and epidemiologists have provided ample evidence for links between health and factors at the *macro-social* level of analysis such as ethnicity, social class and gender (Blane *et al.,* 1996; Gordon *et al.,* 1999; Nazroo, 1998).

Many gaps remain in our understandings of *community* level determinants of health, however. In particular, as we will argue below, much work remains to be done in examining the processes whereby community networks and relationships impact on health. There is also need for attention to the mechanisms whereby such community level factors are shaped by broader macro-social relationships, particularly amongst socially excluded groups, who often have the poorest health status. An understanding of these processes is essential if we are to understand the mechanisms through which community participation might serve as a health promotion strategy.

The health promotion research literature provides two useful starting points for filling these gaps in our understandings of the community-level determinants of health: the concepts of empowerment and social capital. Much work has been done on the concept of empowerment (Rappaport, 1987), conceptualised as a community-level construct impacting on health. Drawing heavily on the ideas of Freire, this work starts with the assumption that powerlessness or a "lack of control over destiny" severely undermines the health of people in chronically marginalised or demanding situations. Peoples' ability to cope with such stresses depends on their access to political, economic or psychological resources. Many people in low income countries, or those living in conditions of high relative deprivation in high income countries, do not have access to such resources. They are thus particularly susceptible to the negative health effects of their life stresses (Wallerstein, 1992). In addition to being more susceptible to stress, disempowered people, who have little control over important aspects of their lives, are less likely to feel that they can take control over their health, and are thus less likely to engage in health-enhancing behaviours. Within this context, empowerment, the process whereby people gain control in their own lives in the context of participating with others to change their social and political realities, is posited as a health-enhancing strategy (Rappaport, 1987). Here again, we can identify the centrality of Freire's notion of conscientisation.

Research studies have sought to make links between empowerment at the individual, community and organizational levels (Israel *et al.,* 1994). It has been argued, however, that in practice, research examining the impact of interventions and policies aimed at promoting empowerment has often tended to focus on outcomes at the individual, psychological, behavioural and biomedical levels, with inadequate attention to community-based processes and community-level outcomes (Labonte, 1994). As an antidote to such criticisms, there has been an upsurge of work describing those features of community that serve as preconditions for successful community empowerment. Phenomena such as 'sense of community' (McMillan and Chavis, 1986), 'community competence' (Eng and Parker, 1994) and 'collective efficacy' (Sampson *et al.,* 1997) have each been cited as features of community most likely to enhance the health of their members either directly through promoting the likelihood of health-enhancing behaviours, or indirectly through serving to buffer the effects of stress. The concept of 'community capacity' has also generated much interest. In their definition of community capacity for successful health promotion, Goodman *et al.* (1998) emphasise the importance of leadership, citizen participation, skills, resources, social and inter-organisational networks, sense of community, understanding of community history, community power, community values and critical reflection.

Despite the excellent quality of many such studies of community-level determinants of health, there is a lack of conceptual coherence when one attempts to pull together these findings, and the cumulative impact they might otherwise have had, is severely diluted. We argue that one reason for this fragmentation lies in the theoretical paucity of this area of interest. Researchers offer a variety of descriptions of surface level aspects of community-but much scope remains for the development of theoretical frameworks seeking to explain the underlying social psychological mechanisms whereby community empowerment impacts on health.

Recently, much attention has been given to the possibility that the concept of ' social capital' might provide an integrative framework for conceptualising those features of community most likely to enable and support health-enhancing behaviours (Campbell, Wood and Kelly, 1999; Kawachi *et al.,* 1997; Lomas, 1998). Putnam (1993) defines social capital as the

community cohesion resulting from four features of community: (i) the existence of a dense range of local community organisations and networks; (ii) high levels of civic engagement or participation in these community networks; (iii) a strong and positive local identity and a sense of solidarity and equality with other community members; and (iv) generalised norms of trust and reciprocal help and support between community members, whether or not they are personally known to one another. It has been argued that people are more likely to be healthy in communities characterised by high levels of social capital (Gillies, 1998).

Along these lines, it has been noted that an important determinant of the success of participatory health promotional interventions is the extent to which they mobilise or create social capital (Kreuter, 1997). Social capital is considered to be important for health promotion for two reasons. Firstly, communities that are rich in social capital are said to provide a supportive context within which people can collectively re-negotiate social identities in ways that promote the increased likelihood of health enhancing behaviours. This emphasis on social identity is important given that health enhancing behaviours are determined more by collectively shaped social identities than by individual rational choice, as assumed in traditional information-based health education. Secondly residents of communities with high levels of social capital are most likely to have high levels of perceived control over their everyday lives. This is important for health, given that people who feel in control of their lives in general are more likely to take control of their health, through health-enhancing behaviours, or through the speedy and appropriate accessing of health services (Campbell, 2000). These points resonate with insights from the work on empowerment and are also directly linked to the concept of conscientisation.

The notion of social capital has taken strong hold in the discourse of leading international development agencies, and the task of building or enhancing local social capital is increasingly regarded as a key dimension of a wide range of health-promoting development initiatives in disadvantaged settings. However, much work remains to be done if social capital is to be a useful conceptual tool for the design and evaluation of health promotional programmes aiming to reduce health inequalities.

In particular, the concept has been criticised for its failure to engage with the way in which various forms of social exclusion undermine stocks of social capital in marginalised communities (Wallace, 1993). While Putnam's conceptualisation of social capital is the one most frequently cited in health promotion circles, critical social scientists have expressed concern that a focus on community-level determinants of health could serve to displace attention from the well established links between health, poverty and racism (Muntaner and Lynch, 1999). Such critics argue that Bourdieu's (1986) concept of social capital might be a more appropriate starting point for understanding health inequalities, with its emphasis on the role played by different forms of capital in the reproduction of unequal power relations (Baum, 1999b).

The concept of social capital has generated a great deal of controversy and criticism, with much of this discussion posed as a polarised argument about the possible relative benefits of community-level (i.e. social capital) and macro-social (e.g. racism, poverty) explanations of health. In our view neither community-level nor macro-social determinants of health can be understood without reference to the other. Community-level factors will often playa key role in mediating between social disadvantage and health. Thus, for example, poverty is clearly a primary cause of health inequalities-and the economic regeneration of deprived communities is essential for reducing such inequalities. However, if one of the effects of poverty is to undermine health-enhancing community networks and relationships, *economic regeneration* must be accompanied by *social regeneration* (i.e. projects to enhance social capital) if it is to have optimal success in improving health (Gi1lies *et at.*, 1996).

In the same vein, Labonte (1999) expresses concern that concepts such as social capital and participation are dangerously ambiguous. On the one hand, they serve as potential tools for critical social theorists who argue that it is only through grassroots participation in strong community-based organisations that socially excluded people will gain the power to lobby governments to recognise and meet their needs. On the other hand, such concepts have the potential to be 'hijacked' by neoliberal, free market theorists, who argue that grassroots organisations and networks have the power to take over many functions (e.g. welfare) previously assigned to governments. Such arguments can serve as justifications for cuts in welfare spending in more affluent countries of the north, and reduced development aid to poorer countries in the south. Labonte's arguments highlight the vital importance that critical social scientists locate conceptualisations of social capital, participation and community development against the backdrop of wider conceptualisations of power.

While agreeing with the concerns expressed above, it is our view that the concept of social capital could result in a useful framework for conceptualising community level influences on health. It needs further development along two dimensions, however. Firstly, there is a need to theorise the larger power mechanisms that shape and constrain the potential influence of social capital on health. Secondly, there is a need to explicate the social psychological mechanisms whereby social capital and the community participation it entails impact on health. We turn to these issues in the next section.

TOWARDS A SOCIAL PSYCHOLOGY OF PARTICIPATION

Participation is a key notion for social psychologists. Generally absent from the theoretical concerns of the discipline, participation is nonetheless a phenomenon that brings together most of the classical areas of study in social psychology. Participation involves individual and social awareness, as well as a public sphere capable of taking into account the demands of democratically negotiated projects. In this sense, the concept of participation is central in the task of reflecting and theorising community. Indeed, we argue that it *is through participation* that the key constituents of community are enacted. Community and participation are, in this way, intrinsically linked and we need to discuss the two concepts in relation to each other.

There are three key dimensions that need to be unpacked in order to understand the formation of community in

participation. When speaking of community we refer to a group of people who 1) share an **identity** which the community is able to articulate; 2) share a set of **social representations** which organises the worldviews of community members and guides their interpretation of reality and their everyday practices; 3) share the conditions and constraints of access to **power,** both in terms of material resources and symbolic recognition. Participation, as the enactment of these dimensions, is the process whereby community is actualised, negotiated and eventually transformed.

It is through participating that a group of people can develop awareness about its own resources and can engage with significant others in the public arena. These significant others, as we discuss below, can be dominant, oppressive, potential allies, peer communities, and so on. Awareness about its own conditions and identity, acquired in the process of engaging with others and stating a project, takes us back to Freire's conscientisation-the process of constructing critical awareness about oneself and the world. Thus, rather than being a given, which can be measured, community participation is an achievement of social and individual life.

Social identities, social representations and power are the social psychological phenomena which guide our theoretical efforts to think about the act of participation and the development of conscientisation. The first two have been extensively discussed by social psychologists, and the latter has been increasingly incorporated into the discipline through the work of theorists such as Foucault (1980) and Bourdieu (1994).

Participation and social identities

To date, the concept of identity has played a central role in three bodies of literature that are relevant to our interests in community, participation and health. The first relates to debates about the causes of health-related behaviour. In contrast to views that health-related behaviours are determined by individual rational choice, the social identity literature emphasises how actions are shaped and constrained by collectively negotiated social identities (Stockdale, 1995). Thus, for example, using a condom, or visiting a traditional healer, is an act structured by a social identity. Secondly, social identity plays a key role in on-going debates about how to define a community. Many community development projects have been criticised for mechanically locating communities within bounded geographical regions. Alternatively, critics have argued that it cannot necessarily be assumed that people who live in a particular geographical area constitute a community-and that the key component of a community is that its members share a common social identification. Thus it is argued that community development workers should seek to locate their efforts within 'communities of identity' rather than simply assuming the existence of 'communities of place' (Barnes, 1997). Finally the concept of social identity plays a key role in debates regarding the processes whereby unequal power relations are reproduced or transformed. Identities are constructed and reconstructed within a range of structural and symbolic constraints which often place limits on the extent to which people are able to construct images of themselves that adequately reflect their potentialities and interests (Leonard, 1984). However, at particular historical moments, members of socially excluded groupings may indeed come together to construct identities that challenge their marginalised status. In some circumstances, such empowered identities may form the basis of collective action to improve peoples' material life circumstances or to raise the levels of recognition they receive from other social groups. In such a situation, social identities become potent tools for social change.

The notion of conscientisation pulls together these three perspectives on identity. Conscientisation occurs at the moment at which members of a socially excluded grouping are able to 'state' their identity in a way that asserts recognition of their needs and interests, and in a way that demands recognition of these needs and interests by other sectors of society. It is in the act of participating that these processes are enacted and realised in the public sphere, and identity becomes an arena of struggle by disadvantaged groups. In this way, participation is a process that depends upon, and in turn, helps to construct identities. Participating is an action organically linked to the awareness a social group possesses of who it is, what it wants and how it projects itself in a future time horizon in which its identity can be perpetuated, renegotiated and, if desired, changed.

The importance local knowledge: participation and social representations

Within social psychology, the theory of social representations has provided an interesting and fertile ground to think about the problem of local knowledge (Jodelet, 1991; Jovchelovitch, 2000; Moscovici, 1981, 1988). Devoted to the understanding of knowledges produced in everyday life, the theory is focused on how a community of people, in communication and practices, comes to construct a shared view of the world. This shared view of the world, which is made of multi-faceted and often oppositional knowledge about surrounding social objects and people, organises and guides the relationship communities have amongst themselves and with others. These knowledges are never detached from the concrete social and historical contexts from which they emerge. On the contrary, they are organically linked to the cultural traditions, the social identities and the material conditions of living of a community. In this sense they are not only lay knowledge 'about something'; they are also expressive of how communities hand down, sustain and negotiate their cultural identities, ways of life and strategies for survival and living. Embedded in this knowledge we find the practical and symbolic resources developed by communities as they engage in the process of living.

However, everyday knowledges are also embedded in ideological mechanisms that conspire to obfuscate and distort the perceptions a group of people possess about their ways of life. As much as it is necessary to recognise the local knowledges expressed in the social representations held by a community, it is also important not to idealise them. No human group is immune to ideological distortions and to the obliteration of critical understandings of the range of dimensions that construct the conditions of their living. As we discussed earlier in this paper, as social psychologists we need to engage with what local knowledge *expresses* and how it impacts on the construction of community participation and of its health practices.

The case of condom use among the mining population in South Africa can elucidate this point. As Campbell (1997) has shown, representations of masculinity serve as a crucial survival strategy in dangerous working conditions. At the same time, these representations see men as risk takers, which undermines the likelihood of condom use and increases levels of HIV infection amongst men and their partners. These representations are adaptive, insofar as they allow men to work and earn a living in conditions where one in forty men is killed, in a work-related accident, in a 20 year career. These same representations, however, increase the chances of HIV infection. Without understanding the double-edged nature of these representations, efforts to increase condom use are unlikely to be successful.

It is the process of participation that forms the on-going arena that allows social representations to be expressed, reaffirmed, and if necessary, renegotiated. Participation involves the process of negotiation of worldviews and projects. It provides a forum for the establishment of dialogues between different representations-as in the case of community workers, governments, development agencies, NGOs, scientists and local populations-and for the clashes between competing representations and projects. It allows the formation of potential alliances between different knowledges as well as the clashes associated with the confrontation of social representations within and between communities. It is here that we need to consider the power differential between communities since not all projects and representations are equally recognised in the public arena (Jovchelovitch, 1997).

Power and participation

While new emphasis on participation expands the scope of decision making and opens up new spheres of debate and legitimation, it also introduces the problem of how local communities appropriate and make sense of the act of participating (Nelson and Wright, 1995). We cannot just suppose that every community will participate in a similar way. The level of knowledge about, and practices related to, participation varies among communities. In this sense, it is not sufficient to say that grassroots participation is central to the construction of communities and improved health outcomes. It is necessary to ask questions about the conditions under which participation is enacted. These questions point to the power differentials between different social actors and to how they may have unequal access to the material and symbolic resources most likely to equip them in forcefully negotiating projects and worldviews in the public sphere.

In this debate it is important to take into account the double edged character of power. On the one hand, we must not lose sight of asymmetries between people and how different social groups hold different levels of power to participate in constructing life projects that meet their needs and interests. The power to act is always limited not only by material inequalities, but also by the recognition others confer on what is done. Participation in conditions where material and symbolic obstacles prevent the possibility of real social change can be a hollow exercise. It legitimises the status quo rather than providing an opportunity for marginalised people to pursue their needs and interests. Our understandings of the mechanisms whereby material and symbolic constraints may impact on a group's potential to participate in ways that enhance their interests and even improve their health are still in their infancy. This is an important area for future research.

On the other hand, conceptualisations of power must allow for the possibility of empowerment. Power is not a phenomenon to be explained only through an intrinsic negativity, but as a space of *possible action*, where social subjects strive to exert their effects. As a space of possibilities, power is not an *a priori* but depends on the contingencies of the various contexts in which it is exercised (Arendt, 1958; Bourdieu, 1994).

As Arendt (1958) has pointed out, power is inextricably linked to that realm where people, in action and speech, participate in the everyday negotiations that bring different representations and identities into dialogue. Power, in this sense, is deeply intertwined with participation. It refers to being capable of: to be able to produce an effect, to construct a reality, to institute a meaning. Whenever a community participates and develops a way of knowing about itself and others, it is, by the same token, instituting itself as such, inviting a future for what it does and indeed, actualising the power it holds to participate in shaping a way of life. Attention to these moments is vital to bring social change into a theory of participation.

In fact, social change through participation can only be properly understood if one understands the ambiguity of power relations and the double-edged nature of power. The dialectic of constraints and possibilities is the motor of social change and as social psychologists, we have a role to play in unpacking the mechanisms implicit in this process.

In the foregoing we have discussed the elements which in our view form the framework for a social psychological theory of participation. We have argued that social identities, social representations and power (both material and symbolic) are the key dimensions for such a framework. It is also important to point out that each of these dimensions is intrinsically related to the other. It is impossible to think about identity and representations without taking into account power relations and vice-versa. These inter-related phenomena are at the basis of participatory processes and play an important role in projects of community development for improving health.

CONCLUSION

In this paper we have shown how a social psychological dimension can be introduced in issues related to community development, participation and health. We have highlighted how our understandings of development programs can benefit from being attentive to the psychosocial dimensions of local communities. We have also examined the relative lack of attention to community level determinants of health in the existing literature, and pointed to the value of the concepts of empowerment and social capital as potential bridges to a social psychological theory of participation. We have argued that such a theory could fill the gaps in our understandings of the social psychological processes whereby empowerment and social capital impact on health.

We pointed to three key elements towards the development of a social psychology of participation: social identities, social

representations and power. We argued that community participation is the meeting point of these three phenomena. Through participation, a community states and negotiates identities and social representations, which are, in turn, shaped and constrained by the material and symbolic power relations in which they are located. We have suggested that the double-edged nature of power needs to be understood in order for the theory to adequately take account of social change. We may also add that this point is an important one for social psychology in general, given its focus on the relationship between individual and society. As Markova (2000) has correctly pointed out, social change is the arena in which this relationship is most appropriately and most fruitful1y examined.

The final judge of the fruitfulness of the ideas we discussed here must be the extent to which they may be useful in applied contexts. In putting together this paper we have been guided by experiences in our countries of origin, Brazil and South Africa, where debates between theory and practice, social theory and social change, psychology and social justice have long taken place. In developing our arguments Freire's notion of conscientisation was a key reference. It is through the fact that Freire was simultaneously an activist and a theoretician that this concept has been inspirational for community development workers in a range of poor countries and contexts. We are not surprised that it is increasingly informing the debate about participation in countries of the north. As a concept, it keeps alive the vital need to link theory and practice, without undermining either. It also stresses how much can be learned from concrete and practical interventions, where theories are put into use and must show how fertile they are, not only in pointing towards ways of understanding the world, but also in changing it.

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REFERENCES

Abrahamson P. 1995. Social exclusion in Europe: Old wine in new bottles_ *Druzhoslovne Razprave* XI(l9- 20):] 19--136.

Agrawal A. 1995. Dismantling the divide between indigenous and scientific knowledge. *Development and Change* 26: 413-439.

Antonovsky A. 1984. The sense of coherence as a determinant of health. *Advances* 1: 37-50.

Arendt H. 1958. *The Human Condition.* University of Chicago Press: Chicago.

Apffell-Marglin F, & Marglin SA. 1990. *Dominating Knowledge: Development, Culture and Resistance.* Oxford University Press: Oxford.

Atte O. 1992. *Indigenous Local Knowledge as a Key to Local Level Development: Possibilities,Constraints and Planning howes.* Iowa State University: Ames.

Bandura A. 1996. *Self-Efficacy in Changing Societies.* Cambridge University Press: Cambridge.

Barnes M. 1997. *Care, Communities and Citizens.* Longman: London.

Baum F. 1999a. Editorial. Social capital: is it good for your health? Issues for a public health agenda. *Journal of Epidemiology and Community Health* 53: 195-196.

Baum F. 1999b. The role of social capital in health promotion: Australian perspectives. *Health Promotion Journal of Australia* 9: 171-178.

Beeker C, Guenther Gray C, Raj A.] 998. Community empowerment paradigm and the primary prevention of HIV/AIDS. *Social Science and Medicine* 46: 831-842.

Berkman L. 1995. The role of social relations in health promotion. *Psychosomatic Medicine* 57: 245-254.

Blane D, Brunner E, Wilkinson R (eds). 1996. *Health and Social Organization.* Rout]edge: London.

Bourdieu P.]986. The forms of capital. In *Handbook of Theory and Research for the Sociology of Education,* Richardson .1 (ed.). Greenwood: New York; 241 -248.

Bourdieu P. 1994. *Language and ,Symbolic Power.* Polity Press: Cambridge.

Brokensha D, Warren DM, Werner O (eds). 1980. *Indigenous Knowledge Systems and Development.* University Press of America: Lanham.

Campbell C. 1997. Migrancy, masculine identities and AIDS: The psycho-social context of HIV-transmission on the South African gold mines. *Social Science and Medicine* 45: 273 281.

Campbell C, Wood R, Kelly M. 1999. *Social Capital and Health.* Health Education Authority: London.

Campbell C. 2000, in press. Social capital and health: Contextualising health promotion within local community networks. In *Social Capital: Critical Perspective,* Baron S, Field .I, Schuller T (eds). Oxford University Press.

Cohen S, Syme L. 1984. *Social Support and Health.* Academic: Orlando. Department of Health. 1999. *Saving Lives: Our Healthier Nation.* Department of Health: London.

Dube N, Wilson D. 1996. Peer education programmes among HIV-vulnerable communities in southern Africa. In *HIV/AIDS in the South African Mining Industry,* Williams B, Campbell C (eds). ERU: Johannesburg.

Eng E, Parker E. 1994. Measuring community competence in the Mississippi Delta: The interface between programme evaluation and empowennent. *Health Education Quarterly* 21: 199-210.

Foucault M. 1980. *Power/Knowledge.* Pantheon: New York.

Freire P. 1970/1993. *The Pedagogy of the Oppressed.* Penguin: London.

Freire P. 1973. *Education for Critical Consciousness.* Continnum: New York.

Gillies P. 1998. The effectiveness of alliances and partnerships for health promotion. *Health*

Promotion International 13: 1 - 21.
Gillies P, Tolley K, Wolstenholme .1.1996. Is AIDS a disease of poverty? *AIDS Care* 8: 35] 363.
Goodman R, Speers M, McLeroy K, Fawcett S, Kegler M, Parker E, Smith S, Sterling T, Wallerstein N. 1998. Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behaviour* 25: 258-278.
Gordon D, Shaw M, Dorling D, Davey Smith G. 1999. *Inequalities in Health: The Evidence Presented to the Independent Enquiry into Inequalities in Health.* Policy Press: Bristol.
Hobart M (ed.). 1993. *An Anthropological Critique of Development:The Growth of Ignorance.* Routledge: London.
Israel B, Checkoway B, Schu]z A, Zimmerman M. 1994. Health education and community empowerment: Conceptualising and measuring perceptions of individual, organisational and community control. *Health Education Quarterly* 21: 149-170.
Jodelet D. 1991. *Madness and Social Representations.* Harvester/Wheatsheaf: London.
Jovchelovitch S. 1997. Peripheral communities and the transformation of social representations:Queries on power and recognition. *Social Psychological Review* 1(1): 16-26.
Jovchelovitch S. 2000. Socia! representations, public life and socia! construction. In *Social Representations: Introductions and Explorations,* Deaux K, Philogene G (eds). Blackwell Publishers: Oxford.
Kawachi I, Kennedy B, Lochner K, Prothrow-Stith D. 1997. Social capital, income inequality and mortality. *American Journal of Public Health* 87: 1491- 1498.
Kreuter M. 1997. National Level Assessment of Community Health Promotion Using Indicators of Social Capital. WHO/EURO Working Group Report. CDC: Atlanta.
Labonte R. 1994. Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly* 21: 253-268.
Labonte R. 1999. Social capital and community development: Practitioner emptor. *Australia and New Zealand Journal of Public Health* 23: 430-433.
Leonard P. 1984. *Personality and Ideology: Towards a materialist understanding of the individual.* Blackwell: Oxford.
Lomas J. 1998. Social capital and health: implications for public health and epidemiology. *Social Science and Medicine* 47: 1181-1188.
Markova I. 2000. *Psychology and Social Change.* LSE Seminar Series. McMillan D, Chavis D. 1986. Sense of community: a definition and theory. *Journal of Community Psychology* 14: 6-23.
Martin-Bar6 I. 1994. *Writings for a Liberation Psychology.* Harvard University Press: Cambridge, MA.
Moscovici S. 1981. On social representations. In *Social Cognition: Perspectives on Everyday Knowledge,* Forgas JP (ed.). Academic Press: London.
Moscovici S. 1988. Notes towards a description of social representations. *European Journal of Social Psychology* 18: 211-250.
Moser C. 1998. The asset vulnerability framework: reassessing urban poverty reduction strategies. *World Development* 26(1): 1-19.
Muntaner C, Lynch J. 1999. Income inequality, social cohesion and class relations: a critique of Wilkinson's neo-Durkheimian research program. *International.1ournal of Health Services* 29(1): 59-81.
Nazroo J. 1998. Genetic, cultural and socio-economic vulnerability? Explaining ethnic inequalities in health. *Sociology of Health and Illness* 20: 710_ 750.
Nelson N, Wright S (eds). 1995. *Power and Participatory Development: Theory and Practice.* Intermediate Technology Publications: London.
Putnam R. 1993. *Making Democracy Work.* Princeton University Press: New Jersey.
Rappaport J. 1987. Terms of empowerment/exemplars of prevention: toward a theory for community psychology. *American Journal of Community Psychology* 15: 121-148.
Sampson R, Raudenbush S, Earls F. 1997. Neighbourhoods and violent crime: a multilevel study of collective efficacy. *Science* 277: 9 J 8-924.
Seabrook J. 1986. The unprivileged: A hundred years of their ideas about health and illness. In *Concepts of Health, Illness and Disease: A Comparative Perspective,* Currer C, Stacey M (eds). Berg: New York.
Stacey M. 1986. Concepts of health and illness and the division of labour in health. In *Concepts of Health, Illness and Disease: A Comparative Perspective,* Currer C, Stacey M (eds). Berg: New York.
Stockdale J. 1995. The self and media messages: match or mismatch? In *Representations of Health, Illness and Handicap,* Marková I**,** Farr R (eds). Harwood: London; 31-48.
UNICEF. 1988. *Perfil estatistico de crianças e mães no Brasil: Sistema de acompanhamento da situação sócio-econômica de crianças e adolescents-1981-1983-1986.* Fundaçao IBGE/UNICEF: Rio de Janeiro.
Wallace R. 1993. Social disintegration and the spread of AIDS II: meltdown of socio-geographic structure in urban minority neighbourhoods. *Social Science and Medicine* 37: 887-896.
Wallerstein N. 1992. Powerlessness, empowerment and health: implications for health promotion programmes. *American Journal of Health Promotion* 6: 197-205.
Wilkinson R. 1996. *Unhealthy Societies: The Afflictions of Inequality.* Routledge: London.
Wilkinson R. 1999. Health, hierarchy and social anxiety. *Annals of the New York Academy of Sciences* 896: 48-63.