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# Participation, Health and the Development of Community Resources in Southern Brazil[1]

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**Abstract**

*This article seeks to contribute to the debate about participation and health by presenting a framework for psychosocial interventions in primary health care. It highlights the social psychological dimensions of participation and the role it plays in improving conditions of living and thus health. The Freirean concepts of dialogue, recognition and conscientization, combined with understanding of local knowledge are suggested as guiding notions for psychosocial interventions seeking to enhance community participation and develop the local level. The article discusses the challenges as well as the potential gains experienced in the process of participation presented. It concludes by reaffirming the importance of participation and empowerment in health interventions struggling against health inequalities and seeking health for all.*

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The process of participation has firmly entered the vocabulary of health research and acquired mainstream connotation as international agencies and funding bodies incorporate the concept in their programmatic documents and rediscover the need to involve local peoples in the process of improving health and health care delivery. Indeed since it was first institutionalized by the WHO at Alma-Ata in 1978, a firm consensus about the importance of participation has emerged. Both the WHO and the World Bank have continuously produced documents highlighting the importance of participation and encouraging the implementation of participatory processes (Kahssay & Oakley, 1999; World Bank, 1996). This has been corroborated by growing evidence that health outcomes are positively affected by community participation, social capital and social cohesiveness (Baum, 1999; Campbell, 1999; Kawachi & Kennedy, 1997; Lomas, 1998; Wilkinson, 1996, 1999).

In this article we seek to contribute to the debate about the relations between participation and health by presenting a framework for psychosocial interventions in primary health care focusing on participation, empowerment and community development. Drawing on the participatory experience taking place in Porto Alegre, south of Brazil, and on-going intervention in two communities in the outskirts of the city, we highlight the social psychological dimensions involved in participation and the role it can play in improving conditions of living and thus. health. Our work is located in what southern Brazilians call *vilas:* a geographical context of extreme social exclusion, where small groups of people start to occupy land illegally and gradually constitute themselves as a community demanding resources in sanitation, education, transport and health care delivery. This situation affords a real life laboratory on how poor communities develop themselves as active agents and negotiate resources in the public sphere. It also provides further evidence to the now generally accepted idea that the health of the poor can only be understood in a framework of general conditions of living.

In countries exposed to chronic social inequality such as Brazil, improving these conditions does not happen without pressure from below. Communities living in a situation of extreme deprivation need to organize themselves and develop the various competences required for effective participation in the public sphere if they are to improve conditions of living and thus enhance health. Participation, empowerment and community development, therefore, become key strategies in reducing health inequalities and in incorporating the demands of the poor into health policy.

## Approaches to participation

Clear consensus about the importance of participation in health has not dissipated widespread disagreements about what participation means, why it should be encouraged, how it can be implemented and assessed. Theorists in the field have repeatedly noted that since the concept is open to different meanings and interpretations, its practical implementation can lead to a number of different directions reflecting different interests and projects. Indeed, the generalized acceptance of participation by actors as disparate as the World Bank and various NGOs and social movements in countries of the South poses questions related to what are the principles underlying participation and which interests are at stake when a participatory element is added to a project or policy. One of the dangers of the consensus is to gloss over the very fundamental differences involved in such a contested terrain.

There has been an abundant literature examining the role of, the obstacles to and the complexities of participatory processes in reducing health inequalities and enhancing the health of poor populations (Campbell & 10vchelovitch, 2000; Craig & Mayo, 1995; Dhillon, 1994; Kahssay & Oakley, 1999; Morgan, 1993, 2001; Muller, 1991; Nelson & Wright, 1995; Rahman, 1995; White, 1996). While nuances in the debate should not be overlooked, it is clear that two different, and most of the time conflicting, perspectives on participation can be identified. Morgan (20CH) defines these two perspectives as the utilitarian and empowerment approaches to participation. In the first, participation is seen as means; external agents invite communities to participate in order to legitimate interests and to 'use' local resources to offset costs. The second approach sees participation as a set of empowering practices; it seeks to achieve a real re-balancing of power structures while developing the conscientization and citizenship of socially excluded communities.

A number of theorists have described the utilitarian approach by different terms; these might change but the substance remains the same. In his typology of participation Pretty (1995) identifies five forms of participation that fit in this group: manipulative participation, passive participation, participation by consultation, participation for material incentives and functional participation. They all exclude participants from decision making while using them instrumentally for legitimating projects. In a similar vein, White notes: *'sharing through participation does not necessarily mean sharing in power'* (1996, p. 6, emphasis in the original). She refers to nominal and instrumental interests at the basis of participatory processes that are concerned solely with legitimation, efficiency, cost and means. A technocratic impetus is clearly identifiable in the utilitarian approach; criticisms of Kahssay and Oakley's paper for the WHO point precisely to its technocratic emphasis on the institutionalization of participatory thinking at district levels in national ministries of health in detriment of empowerment of citizens and civil society's participation.

The empowerment of local communities and the creation of social change to improve health outcomes are at the centre of what is referred to as the empowerment approach. Also called people-centred development (Escobar, 1995) this perspective unashamedly links participation to political change and resists the tendency to focus on the operationalization and measurement of participation (Guijt & Shah, 1998). Rather, the trend here is to adjust participation to specific local, cultural and political contexts with the clear goal of empowering. Closely linked to the agenda of collective social movements, participation for empowerment is essential because it can lead to awareness and the subsequent dismantling of the political, social and economic structures that encourage growing inequalities between the rich and the poor. This is notably the case in countries of the South where the initial emancipatory principles of participation developed (Chambers, 1995; Kalinsky, Arnie, & Rossie, 1993; Ugalde, 1985). In this approach, participation is political, seeks social change and transformation in power relations. In this sense it is a site of conflict where different interests and projects clash and compete in public arenas (White, 1996). But it is also, as Muller argues, a local reaction to desperate conditions of living, a survival strategy for marginalized people (Muller, 1991).

These two approaches to participation provide the backdrop against which most participatory experiences take place. It would be incorrect to establish an over-sharp divide between them. Sometimes elements of one slide into the other and vice versa. In real settings participation is messy, takes time and escapes neat definitions. This, however, does not lead to eclecticism and peaceful co-existence between the models. As Morgan concluded in her comprehensive review of community participation in health, 'disagreements about participation persist, to a large extend rehearsing and reiterating the original schisms between empowerment and utilitarian models' (2001, p.229).

In the next section we describe the wider context of participation in the city of Porto Alegre. We outline the process of participatory budgeting in the city, how it relates to the development of community resources at both individual and community level and the social psychological dimensions of the process. We suggest that the empowering character of the Porto Alegre experience rests in the real changes it has introduced in the power structures of the city's budget definition and in its wider re-structuring of the: relations between individuals, communities and the socio-political sphere.

## The experience of participation in Porto Alegre

Porto Alegre is the capital city of the state of Rio Grande do Sui, situated in the extreme south of Brazil. It is the largest city of the region with a population of 1.3 million people. Since 1989, it has been governed by a coalition of parties lead by the Workers Party (PT). In 2001 PT won its fourth consecutive election in the city and consecrated itself as the first political party to achieve such string of electoral victories in Brazil. Social indicators in Porto Alegre show a clear improvement in sanitation, housing, health and education over the last 12 years and the implementation of participatory budgeting *(orçamento participativo* or OP from now on) as the main government policy for defining where to allocate investments has become internationally renowned. The World Bank has distributed informative material about the OP throughout Latin America and UNESCO has it in its MOST *Best Practices* databank[2].

The OP is a process of decision making that gives power over public resource allocation to forums elected at open neighbourhood-level meetings and at open thematic meetings. The themes are transport, health and social security, education and culture, economic development and fiscal policy and city organization and urban development. At these levels participants discuss and decide which investments are most important to them locally and for the city as a whole and delegate to representatives the task of taking further the views of their community. These representatives elect a Municipal Budget Council whose job is to finalize with local government officials the final budget proposal and present it to the city legislative council for approval. The process has expanded considerably over time gaining power over an increasing number of policy arenas, major capital investments and even personnel issues.

Coupled with the OP forums most city departments have also formalized special participatory councils in areas such as housing, transport, health and education. Participation in these councils is open to any citizen; there are no requirements of technical qualification or nomination by local government. In the health area, for instance, there is a Municipal Health Council with members elected by Local Councils, which correspond to the neighbourhood areas that form the regions of the participatory budget. In the same manner of OP open assemblies, these Local Councils are open structures where local citizens discuss and decide over health issues for their area.

The participatory experience in the city of Porto Alegre has been characterized as impressive in the political science and sociological literatures (Abers, 1998; Alvarez, 1993; Baiocchi, 2001; Fedozzi, 1997; Horn, 1994; Santos, 1998; Utzig, 1996). The complexity and richness of the overall process, whose full cycle takes around 12 months and whose preparation and support activities involve workers in popular education, activists, NGOs, academics, universities and a huge policy community in all thematic areas, cannot be' fully described here[3]. Yet, for us working within its parameters there can be no doubt that it is exceptional for a number of reasons. We identify at least three aspects of the Porto Alegre experience that make it a reference of effective participatory processes that can empower, produce social change and transform existing power relations.

First, and perhaps most importantly, is the fact that the OP has created a new and effective arena of decision making, a new 'public sphere', where ordinary citizens discuss and deliberate about issues which are important to them, The structures of participation guarantee not only informed debate about issues, but also decision making and control over implementation of decisions. Contrary to many utilitarian experiences that 'use' participation as a legitimating tool or involve citizens in participation up to a point leaving the real decision-making process to those in power, the structures of the OP allow for a real redistribution of power in the city.

Second, the development of the OP in the city has been constituted *through* participation. This is important, because the OP did not emerge as a ready-made formula proposed by government officials but was created as an articulation of the institutions of local government, social movements and local neighbourhoods. It started small and grew over the years in a dynamic interaction between ordinary citizens in communities, technical personnel and state. This has afforded a re-socialization of politics and a new interaction between individuals and the state at local level. It has also shown that participation is 'developmental': it is by going through the process of participation that participation is learned and actualized in the public sphere. A recent study looking at group dominance in the structures of the OP showed that participation over time seems to increase participation parity (Baiocchi, 2001). While in the initial years of the OP there were more men and educated people speaking at the meetings, the analysis of participation over time has shown that the main factor affecting verbal expression in meetings is years of participation. People with more years of participatory experience are more likely to speak; there is an upward learning curve in participation as it develops and is co-constructed by social actors. It becomes an asset at the personal, social and political levels.

Third, through effective participation the OP made both itself and shaped a new kind of consciousness whose goal is the consolidation of citizenship and the enrichment of the exercise of citizenship: individuals and communities resignify their relationship with the public sphere as they feel empowered to express views, defend interests and come to meetings that provide real solutions to real problems. Existing knowledge at local level is recognized as a resource; local people know best what they need and can offer imagination and creativity in seeking ways to respond to their needs. In the process of putting existing knowledge into use, the participatory experience also creates *new* knowledge: knowledge about the functions of the state and its limits, about the difficulties of governing and administering scarce resources, about the conflicts and dilemmas of diversity in interests and projects and, above all, new knowledge about what citizens can do, their power to act and the potentialities embedded in their agency. In this sense, the experience of participation empowers by drawing upon existing knowledge and constructing new knowledge. Also, as the indicators for the city of Porto Alegre show (FEE, 2001, 2002), it produces efficiency in public administration and pays off politically.

Finally, and particularly in the context of health inequalities research, it is important to note that the OP process in Porto Alegre has managed to mobilize primarily poor people. As it has been widely noted in the literature it is often the case that middle class and elite groups tend to dominate participatory forums because they are usually better articulated and organized to voice their interests (Jewkes &

[2] http://www.unesco.org/mostlbpcomm.htm
[3] For a detailed description of the OP see http://www.portoalegre-rs.gov.br/OP/index.htm

Murcott, 1998; Lomas & Veenstra, 1995). In Porto Alegre, however, the vast majority of participants were from poor neighbourhoods and as a result the policy benefited and continues to benefit communities lacking basic community infrastructure and public services. Twelve years later, running water and sanitation, public transportation, health clinics in distant areas, schools, paved streets and waste collection have dramatically changed the face of the large urban periphery and hillside *favelas* in the city. However, the chronic array of social problems in Brazil and the displacement of rural populations continue to produce new squatter communities who in their turn pose new challenges to the city.

**Developing community participation: diagnosis, intervention, critical reflexivity**

It is within the context of the OP described earlier that we have developed a social psychological approach directed towards participation, empowerment and community development. Theoretically this approach draws on the framework developed by Brandao (1982), Fals Borda (1985) and Freire (1970, 1974, 1975, 1998) in Latin America and the social psychology of knowledge elaborated by Moscovici (1984, 2000). Inspired in particular by the literacy method developed by Freire, we have developed a framework that involves three foci operating both conceptually and empirically: diagnosis, intervention and critical reflexivity. These three dimensions are simultaneous in the process; they are intertwined and depend one on another as each of them presupposes the others to be actualized. Central to an of them is the concept of conscientization and sensitivity to local social representations.

Two communities in the periphery of Porto Alegre have been the specific site where we have been working with the model outlined below. These communities are caned *'vila Pinto'* and *'vila Joana d'Are'*. As with most such communities in Brazil, naming the *vila* is not an accidental process. The names are usually linked to the history and internal culture of these communities and their sources vary from persons who were important in the structuring and struggles of the *vilas* to the syncretism of Afro-Brazilian religiosity. Naming provides identity and outside recognition in the city.

We enter these communities mainly as academic psychologists working within the framework of the participatory budget structures. As we described earlier, the structures of the OP have involved a varied array of social actors. Universities and academic researchers have participated in a range of ways, from researching and systematizing the experience to lending resources and expertise. In our case, it is important to note that in addition to our research interests, we have been actively involved in the movement for health reform in Brazil and in supporting the development of the structures of the participatory budget. The communities know us both as academics and as activists and it is as such that we have interacted and developed our relations over time. This aspect is discussed in more detail under the dimension of intervention.

**Diagnosis**

Diagnosis refers to the vital dimension of approaching a community, getting to know its way of life, the representations and practices it holds and overcoming the strangeness between researchers and local people. The aim of diagnosis is to understand, engage with and map out the local systems of knowledge of the community, the ways in which it conceives of itself and its mode of relation both inside and outside its boundaries. In Brazil as in most developing contexts, there is a large distance between people living in *vilas* and academic researchers due to social and economic differences. This difference needs to be negotiated and dealt with. We do not believe that researchers need to be identical to the population they work with. Difference between researchers and community can be an asset for both interlocutors if the idea of dialogue in theory and practice is taken seriously.

This, however, is not simple. Approaching a peripheral community and understanding its dynamics is a complex task that takes time, demands training and a clear political agenda. It is not only the people in *vilas* who need to accept and understand what the academics are looking for in their milieu. Researchers also need to overcome prejudice, fear of the poor and be prepared to see them as people with needs and anxieties just as they have. As much as this might sound obvious, it is one of the key aspects involved when training students to work with these populations. For a typical psychology student in Brazil, to walk across town and to enter into a *vila,* constitutes a huge symboJic crossing that demands training, supervision and follow-up.

We work through this process informed by the ethos of dialogue and recognition (Freire, 1970, 1974). Both are seen as social practices involving difference in interlocutors. This difference, which is not mild, produces a complex set of difficulties for the communicative process sought in diagnosing the community. One of the most common, and difficult to overcome, obstacle is the 'law of silence'. This code of practice, which operates in most peripheral communities in Brazil, regulates communication with outsiders and the information the community is prepared to offer about itself and its way of life. The law of silence demonstrates clearly that communities are prepared to protect themselves and develop strategies to control contact and identity presentation. This law has been reported throughout Latin America and is a powerful example of the limitations of working only with verbal discourse in such communities. In our experience, silence reveals and speech, at times, can hide.

## Intervention

The second focus of our work is intervention. This dimension makes explicit that we enter the community with a programme. It defines for both researchers and the community that researchers are not neutral. They have an agenda that refers both to the community, to the aims of academic investigation and to commitment with a political project that seeks participation and self-determination for marginalized groups (Briceno-Leon, 1998; Fals Borda & Rahman, 1991; Guareschi, 1996). Behind intervention there is a conviction, which we referred to in the first section of this article, that the health of the poor depends on the political capacity of grassroots to articulate demands and produce pressure from below.

There has been a long tradition of alliances between health workers and deprived communities in Brazil, which are crystallized in the construction of participatory forums at local, regional and national level. In Porto Alegre, the structures of the OP and the Local Councils of Health afford sites of common practice and experience for academics, students, community leadership and community structures. These sites have been pedagogical and developmental. They teach and help to develop new relationships between holders of different knowledges and status. They produce what we call 'productive alliances' between different people, different levels of expertise and

different social actors, who learn from each other and are put into a position of changing in relation to both themselves and others. Medical doctors, for instance, must listen to community members, who hold effective power on the organization and evaluation of services. While this process has been difficult for doctors, it has contributed a great deal to produce a new sense of self-worth and agency for community participants.

Within this larger context of participatory intervention, we define our work as pychosocial intervention. Dialogical communication, recognition and critical awareness guide the structured intervention in the community. A number of qualitative methodologies ranging from interviews, to group work, to participant observation and filming can be used to enact processes of listening, observing and talking to the community. In our experience individual interviews, group discussion and the use of video to produce films about *vila Pinto* and *vila Joana D'Arc* have permitted to bring to light and to systematize the universe of the community, both at the symbolic and material levels. These techniques allow for identifying the themes, the generative words and the experiences that frame a collaborative understanding of who is the community, how it lives and what it does for shaping its own mode of living. Critical awareness involves realization and problematization of what is taken for granted. That the community itself should see its own agency in defining its predicament is important, as there is a strong tendency in marginal groups to see agency coming only from dominant groups who hold full power to define the community from outside.

Intervention is both the entry point for diagnosis and the medium of critical awareness. As knowledge about the community is systematized and uncovered, it becomes public and the object of reflection and debate. Interviews and group work are themselves moments to talk about and to think about what is being said. Uncovering knowledge of, and about the community means to uncover at once content and critical reflexivity about content, in such a way that content is transformed in the very act of being displayed. This is an important aspect of Freire's methodology, which allows for tuning in the symbolic universe of the community and understanding how, in the process of making sense of its conditions of living, it constructs and renews a discourse about itself. Throughout diagnosis and intervention it is possible to follow what Freire has called the 'investigation of generative themes and the meaningful thematic universe of communities' (Freire, 1972, p. 77).

## Critical reflexivity

Diagnosis and intervention are concomitant to critical reflexivity, the third dimension in which we focus. Critical reflexivity is entangled with the Freirean idea of critical consciousness and provides the guiding principle of psychosocial intervention. In many ways it can be linked to the basic assumption of most critical theory: reality is a field of open possibilities and rather than describing it, the task of knowledge is to identify critically which alternatives can transform it. Critical reflexivity develops in communication and social praxis as social actors engage in the task of translating to interlocutors perceptions, experiences, observations and practices about the everyday (Freire, 1975, 1998; Guareschi & Suzin, 1989; Martfn-Baro, 1998). It leads to conscientization, the process whereby people become aware of the political, socioeconomic and cultural contradictions which shape their lives and who they are. Conscientization and critical awareness are important concepts for the social psychology of community work and empowerment interventions. They point to the issue of personal and social change as well as transformation in knowledges, values and attitudes held by communities.

As much as we value and learn from the knowledge of the communities we work with, we do not think that it should be idealized. We reject the view that all know ledges are equally valid and that local knowledge should always be accepted for what it is. Rather, we suggest that aJl knowledge should be *understood* for what it is, and through communication and dialogue, confronted and challenged. No knowledge system is closed and perfect in itself; knowledge grows out of challenge and critical reflexivity, so does local knowledge.

The concepts of dialogue, recognition and conscientization coupled with the guiding principles of action research cut across the dimensions of diagnosis, intervention and critical reflexivity described earlier. The unifying thread in this framework is attention to the local level, recognition of its potentials and the development of conscientization to achieve empowerment. These direct the conscious effort of establishing a dialogical positioning between researchers and community, where both are participants in a developmental process constructed in the everyday practices of the community. In this process we have found that dialogue, recognition and conscientization, are both enabling and developing out of participation.

### Challenges and contradictions in participation

The structures of the OP described earlier have been gradually developed since 1989. As psychologists working within its parameters we have learned a great deal since; it allowed us to put into practice the model we described earlier and the Freirean concepts that inspired generations of psychologists in Brazil. But it has also led us to confront a number of dilemmas and challenges related to participation and psychosocial work with very *poor* and marginalized communities. Whereas we are convinced that the Porto Alegre experience provides a powerful model for participatory projects, it is important to reflect on the contradictions and difficulties that have permeated the OP and interventions such as ours throughout the city. Most of these difficulties were predominant in the early years, but many remain as continuous obstacles to the process.

The first and perhaps most important difficulty is the development of a common language about participation between the various actors and stakeholders in the participatory process. Different representations and expectations about participation produced a great deal of miscommunication in OP meetings; for many community participants the meetings were at first a place where they could go and make demands to politicians. The idea of getting involved in a lengthy process where one is invited to discuss what is needed in the city in relation to the resources available and then decide who should have priority of access sounded absurd to many in the initial stages of the OF. On the other hand, for many advocates of the OP there was an expectation that informed participation would occur in the fashion they had idealized. This obviously failed to happen, as the resilience of a political culture mediated by clientelism, favours and reliance on politicians, became clear. Furthermore, communities themselves are not homogenous and different members hold different representations about participation. This variation within and across communities that constitute the participatory forums produces a great deal of communicative difficulties.

Kelly and van Vlaenderen (1996) have pointed to the importance of taking into account the imbalances and power asymmetries that shape communicative processes in participation. These asymmetries have become particularly visible in the interaction between professionals and community members. For instance, in the *vilas* there is reluctance to accept the idea of training members of the

community to become local health agents and participate formally in health teams. This provokes fear that the limited professional medical care they do have will be replaced or disappear altogether. There is a clear preference for professional handling of health care matters despite the wide use and acceptance of alternative and traditional forms of diagnosis and healing. Many health professionals, and especially medical doctors, also tend to recognize specialized medical knowledge as a priority; the consolidation of the power of professionals and bio-medical knowledge is thus shaped from above and from below despite the theoretical intentions of planners and psychologists such as ourselves.

As much as advocates of participation, community and health psychologists among them, would like to see dialogical practices evolve as eventually to undermine the imbalances in power between participants, this remains more an ideal towards which to work than a fully fledged reality. An expression of that is that the most committed community participants, those who become leaders in the neighbourhoods and work hard to enhance participation in meetings and involvement in community activities, are often criticized by their own communities for either becoming too closely connected with the 'doctors' or for being perceived as seeking personal advantages. This shows that active participation from below is still viewed as an unlikely activity by the poor themselves: those who participate do so because they are too close to 'doctors' and are not like ordinary community members any more or because they fall back into traditional politics and want to advance their own interests.

Traditional representations of politics as 'action imposed by the powerful' coupled with representations of the poor as 'passive recipients' permeate these views. They demonstrate that participatory processes depend on cultural and historical determinants that shape how particular locales think and behave in relation to politics and political action. They also express the difficulties embedded in communicative efforts between people who are dramatically different from each other. True dialogue, as Freire remarked, is a difficult and hard to obtain achievement.

## Community participation and community health

Obstacles to, and difficulties in, participation provide further evidence to the complexity of participatory processes, especially in countries where there is a strong tradition of authoritarian politics. These, however, should not prevent a clear appreciation of the importance of participation in both improving health outcomes and the general living conditions of poor and vulnerable populations. Difficulties and unrealized ends do not mean that the process is doomed. Despite problems and contradictions, developing community participation continues to be ethically and practically fundamental to improve the lives of poor communities and achieve better health.

There arc two sets of interrelated outcomes of participation and community development that we would like to highlight here. The first refers to the articulation of the individual, the community and the political levels for enhancing self-esteem, consciousness, social cohesion and trust, all deemed fundamental for improving health. The second refers to capacity for producing pressure from below, which is crucial for effective social change. These two sets of outcomes arc inter-related.

Pressure from below, which appears through participation and community development, is interlaced with self-esteem and the collective action of a community. Self-esteem equips actors to intervene effectively in participatory forums and to take the claims of the community to larger political arenas. These processes, in their turn, enhance the self-esteem of actors in a feedback loop. Individuals who detain higher levels of consciousness are capable of reflecting about the set of factors that frame their everyday life and devise appropriate practices to intervene in these factors. Through participation individuals develop competences for both themselves and their communities to achieve real gains in all areas deemed essential for health. As individuals become vocal and active, they emerge as conscious actors of their own culture.

The capacity of communities for effective participation generates gains at the personal, community and political levels. It not only empowers individuals and the community, but also poses to the institutional structures of the state the need to incorporate and take into account the insights and demands coming from grassroots movements. The development of new relations between social movements and state is crucial for consolidating participatory experiences that interfere, unsettle and transform state structures so as to incorporate citizenship participation. A rich associational life is important for the health of democracies, but government policy on participation does matter. Rather than seeing the participation of the poor running in parallel and detached from the institutions of the state, we would suggest that it also needs to be channelled towards vertical structures where it can shake power relations and put social capital resources into use to demand real gains in the public sphere.

The consolidation of spaces of dialogue between grassroots and institutional actors also offers possibilities for establishing and developing alliances between the knowledges of social movements, outside experts and state institutions. As we discussed earlier this is not an easy process. In the health field in particular the emphasis on biomedical knowledge has been clearly singled out as an impediment to participation (Morgan, 2001). This, however, does not erase the pedagogical nature of participatory processes for all those involved. In the wider context of the OP in Porto Alegre, 12 years of co-existence and a strong social movement for health reform have produced a strong alliance between experts and communities. Experts designing and implementing projects in deprived areas found themselves discussing plans and waiting for decisions from ordinary community members, most of whom with little or no formal education. In the health field, medical doctors, nurses, psychologists and social workers regularly met in the assemblies of the Local Health Councils to listen and to respond to the often-biting criticisms and challenges of local people. These encounters educate both community members and experts, who in the process of taking into account the role and position of the other must re-think their own position. Dialogical structures such as these, feed back into both grassroots and local government producing new articulations between civil society and state.

In these processes we identify the connection between political, institutional and social psychological categories. Effective political processes, the construction of participation and the action of social actors to reduce inequalities are highly complex phenomena that cannot be understood without social psychological categories. As noted before (Campbell & Jovchelovitch, 2000) identity, local knowledge and power are key dimensions for understanding the social psychology of participation. These are related to social capital and empowerment, without which communities remain detached from the political sphere. Underlying the social movement of deprived communities there is both a politics and a psychology of recognition, where otherwise socially excluded subjects come into the public arena to state who they are, what they know and what they want. To speak and to be present in participatory forums is a way of saying 'look at us, listen to what we have to say and pay attention to how we want to develop our projects'. This redefines the very nature of the public sphere and the making of public policies as it introduces a dialogue between self and other that is historically undermined by

chronic poverty and social exclusion. It also shows that demands for, and the construction of, redistributive policies are entangled with recognition policies.

## Conclusion

In this article we have sought to contribute to debates about the relations between participation and health by presenting the participatory experience occurring in the city of Porto Alegre and outlining a framework for psychosocial intervention directed towards participation, empowerment and community development. We have described the main elements of this programme, namely, diagnosis, intervention and critical reflexivity and highlighted the main assumptions of Freire's pedagogy underlying it. The concepts of dialogue, recognition and conscientization guide attention to, and understanding of, the local level. We have pointed to the challenges experienced in the process of participation as well as to the benefits and potential gains that can be derived from it, illustrating our discussion with examples coming from the two communities where we work.

Despite its openness as a concept that can accommodate disparate approaches, we are convinced that community participation continues to be a key strategy for reducing health inequalities and improving the health of poor populations. In countries of the South, where poverty continues to be the single most important cause of ill health, developing and sustaining participation for empowerment remains a necessary, if complex, task. Years of participatory projects in developing contexts have showed again and again that for the poor, health continues to be a set of coordinated intersectoral actions involving basic infra-structure such as sanitation, electricity, waste collection and disposal, housing, education, transport, security and leisure. In our experience this conception of health does not emerge as an abstract notion constructed by experts. This knowledge about health and illness is *lived:* it is in the experience of life each day, as social actors who live in conditions of extreme deprivation face concrete lack of resources and develop strategies for living through and improving their situation.

Participation for empowerment is one such a strategy. It aJlows individuals and communities to develop a new consciousness about their conditions of living and construct strategies for improving them. It re-shapes the relationship between individuals, community and the political arena, empowering, developing citizenship and forging spaces for the presence of grassroots in the institutional structures of the state. It helps to emancipate deprived communities and to improve living conditions for the poor. This makes participation central in the struggle against health inequalities, and furthering our understanding of its multiple and complex dimensions should be part of any programme seeking health for all.

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