

Catherine Campbell

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PUTTING SOCIAL CAPITAL IN PERSPECTIVE: A CASE OF UNREALISTIC EXPECTATIONS?

Catherine Campbell³

The concept of social capital has been around for much longer than Putnam's 1993 book, (*Making Democracy Work*) through the work of Coleman, Bourdieu and others (see Baron, Field and Schuller, 2000, for a review). However, certainly in my fields of interest, viz: the areas of health promotion and community development, it was this book of Putnam's that catapulted the concept of 'social capital' to the centre stage of an extraordinary range of research and policy agenda's. In this book, Putnam defines social capital in terms of the community cohesion associated with: the existence of co-operative and accessible *community networks/ organisations*; high levels of *participation* in these; a strong sense of *local identity*; and high levels of *trust, mutual help and support* amongst community members.

The concept is being used to predict and explain a wide range of outcomes, including those as variable as household income in Tanzania and the Philippines, the effectiveness of local government in Italy and the US, and levels of mortality in Russia. The concept has become the darling of a number of influential policy makers, development agencies, and high profile researchers. Shortly after its appearance a leading international journal reviewed Putnam's work, citing it as 'the greatest work of social science since Marx and Pareto'. Few who have read Putnam's book would disagree that this is something of an over-statement. The work relies on unremarkable statistical and methodological techniques, and it is largely descriptive and atheoretical in nature. Outside of its historical context, it seems an unlikely vehicle for all the accolades and attention it has received.

However, in this case, context has been everything. Ron Labonte (1999), Fine (this volume) and many others, have pointed out that the reason why the concept was grasped so enthusiastically was -- in the absence of any theoretical grounding within a broader

³ Department of Social Psychology, LSE

theory of power relations -- it has served as a blank cipher which could be moulded to a range of political agenda's. The concept came as something of a 'gift' to thinkers of the neo-liberal free market persuasion -- who argued that grassroots voluntary organisations and neighbourhood networks should take over many functions (e.g. welfare) previously assigned to governments. Building social capital became a justification for cuts in welfare spending in more affluent countries; and for reduced development aid to less affluent countries. In this regard, the coincidence of some of Putnam's ideas with the rise of Third Way politics - both in the US and the UK - can carry part of the burden of explanation for all the attention the concept has generated.

On the other hand the concept has also appealed to people on the left of the political spectrum. They use it to argue that its only through the building social capital in socially excluded communities that previously marginalised people will ever gain the confidence or power to lobby governments to meet their needs. Thus, building trust, local identity and neighbourhood networks becomes an essential building block in a broader re-distributive political programme.

In my view the concept of social capital has fallen victim to hopelessly unrealistic expectations. I believe that once we tone down our expectations, the concept of social capital is a potentially extremely important and useful concept in particular research and policy contexts, in a far more limited way than people currently suppose.

The first of these unrealistic expectations is that we should work towards developing the concept of social capital into a conceptual tool which might apply across disciplines. I have already emphasised that my interest in social capital lies within the context of a particular set of disciplinary concerns and practical interests - community development and health promotion. In my view, to assume that one could develop a unitary concept which would predict and explain outcomes in spheres as diverse and complex as the economic, the political and the medical -- in the manner of a Grand Theory -- seems to me unduly optimistic and old-fashioned. In my view, the concept's usefulness from one disciplinary context

or one sphere of practical application to another is a matter that must be argued on a case-by-case basis, rather than assumed.

The second unrealistic expectation lies in the desire to develop a concept of social capital that might be used as a research and policy tool across countries and cultures. The current fashion for taking Putnam's dimensions of social capital - developed on the basis of research done in Italy and America - and unproblematically seeking to use it to measure community cohesion for policy and research in contexts ranging from Zimbabwe to Guatemala to England, seems to me an unduly optimistic one.

Thus, for example, recent research in the Gender Institute examined the potential of Putnam's 'social capital' for describing local community life in a town in southeast England (Campbell, Wood and Kelly, 1999). We found that the concept would need to be quite dramatically reworked to apply to small local communities in England. We argued that Putnam's conceptualisation of a 'cohesive community' -- characterised by a sense of common identity and generalised trust between neighbourhood residents -- bore little resemblance to the rapidly changing, dynamic and divided nature of contemporary community life in this particular town. Membership of formal organisations of the type Putnam emphasises, such as Residents' Associations, or church groups, was extremely low, with people's main social networks consisting of informal face-to-face groups of friends and relatives. The notion of generalised trust or a common identity with other relative strangers, simply because they lived in the same neighbourhood, seemed rather bizarre to our interview informants. As one informant said: 'I've had marvellous support from my friends, but its nonsense to suggest that I would rely on Fred Bloggs for help just because he lived across the road.'

People had no time or interest in participating in community life, once they had paid the mortgage and cooked for the children. Those without jobs lacked the confidence to feel that they had anything to offer the community. As one young man said: 'How could I help the community - I don't even have any GCSEs'. In short, there was little evidence for an actual or latent culture of

community participation that the concept of social capital presupposes.

Unsurprisingly, those community networks and resources that did exist were not equally created, sustained and accessed by everyone. In terms of trust and common identity, our local community of interest was divided by sharp divisions based on generation, gender and housing tenure. These divisions fractured the possibility of a sense of common identity or a belief in the value of co-operation with other community members.

This takes me to the third unrealistic expectation which has crept into many discussions of social capital. This is the expectation that one can meaningfully talk about social capital as the property of geographical communities, without taking account of intra-community differences in the way in which social capital is created, sustained and accessed. This assumption is frequently made in large-scale survey studies which measure aggregate levels of social capital across geographical states or towns or suburbs. A current Gender Institute research project is finding quite dramatic differences in the way in which different groupings create and access social capital within one small local community, based on interviews with residents who identify themselves as Pakistani Kashmiri, African-Caribbean and White English (Campbell and McLean, in press).

Ginny Morrow's important research into social capital amongst children, again in the Gender Institute, points to significant differences in the social capital available to children and adults (Morrow, 1999). Even Morrow, ever sceptical about the concept of social capital, has conceded that in the context of a human rights framework, social capital has served as a useful heuristic device. It has helped her to highlight vast inequalities in the opportunities that children and adults have to participate in decisions regarding their day-to-day lives.

Moving back to health, the concept of social capital is increasingly being mentioned in debates about health inequalities. One increasingly reads or hears of research projects which seek to argue, for example, that social capital is 1.3 or 3.4 times more or

less useful in predicting health inequalities than socio-economic status. In my view, research of this nature is premised on a whole raft of unrealistic expectations. It is extremely problematic to set up social capital and socio-economic status as competing explanatory variables, or indeed to imply that it makes any sense at all to talk of social capital independently of material wealth or deprivation. Here, Bourdieu's (1986) view of the role played by social capital in the process whereby social hierarchies are reproduced (or less commonly transformed) is more interesting than Putnam's. In our current Gender Institute Research Programme on ethnicity, social capital and health inequalities, Carl McLean and myself start from the assumption that it has been conclusively proved that material deprivation and minority ethnic status are key determinants of health inequalities. It is within this context that we seek to examine the way in which various forms of social exclusion undermine people's access to potentially health-enhancing social capital in their local communities.

I think much of the misunderstanding and controversy around social capital in the health arena has arisen as a result of the misplaced attempt to set sc up in competition to SES as an explanatory variable, rather than seeing the two phenomena as inter-dependent. Wallace (1993) makes this point very clearly in his article on the impact of poverty and racism on the fabric of local community life in inner city areas in America, linking this analysis to high levels of HIV amongst poor black Americans. Gillies et al. (1996) make a similar point in their discussion of the mechanisms whereby poverty makes people particularly vulnerable to HIV/AIDS. These colleagues argue that while the first step in addressing this issue is to push for the economic regeneration of deprived communities, economic regeneration must be accompanied by social regeneration (i.e. programmes to repair the damage that poverty and racism have done to social capital in a particular community).

At this early stage of 'social capital's' conceptual development, I would also argue that it is premature to seek to use social capital as a causal variable in epidemiological models. Social capital is a context-specific process and product of particular people and places. Increasingly, cautious souls are pointing to the folly of

attempting to set up such a poorly defined, diffuse and context specific concept as a hard-nosed independent variable.

I use the concept of social capital quite extensively in applied research I am doing into the design and evaluation of community-led participatory HIV prevention programmes in South Africa squatter settlements in the Carletonville region. I also use it in academic research into community life in Luton, England. One common motivation of both research projects is a concern that too much talk about social capital has been generated by academics and policy-makers in ivory towers and offices, with too little effort being made to go out to the local communities that these academics and policy makers are talking about to see what is actually there.

In opposition to this top down approach, myself and colleagues are trying to develop the concept of social capital through active involvement in community development projects, and through micro-qualitative research in traditionally marginalised communities -- many of whom constitute the targets of social capital building exercises.

In both Luton and Carletonville the realities of local community life are far more complex than the concept of social capital can capture. Let me illustrate this with an example from our South African work with commercial sex workers on the gold mines (Campbell, 2000). Women work in conditions of extreme poverty and violence in shack settlements. Death and injury are a daily occurrence - from HIV, violent assaults, tuberculosis, alcohol poisoning and malnutrition. In these very desperate living conditions there is seldom a moment in women's lives where their physical safety and survival does not depend on the support and care of their colleagues. Thus for example women selling sex in the veldt are vulnerable to thieves who lie in wait in the bushes to surprise and rob people having sex. Clients sometimes pull out knives after the sexual transaction is finished and stab women who refuse to give them their money back. In such contexts one's physical survival often depends on having supportive colleagues standing by. At times of illness, death and hunger, the solidarity between women is extremely strong.

On the other hand there is consensus amongst sex workers that certain situations justify the total suspension of such trust and support. One such situation is the area of competition for clients, where it is not unusual for a woman to physically attack or even kill a colleague who 'steals' her regular client. Another such situation is when a woman is drunk. People repeatedly spoke of the importance of drinking as a survival strategy in harsh and bleak living conditions. It was accepted that when a woman was drunk she might harm another colleague, and there would be no hard feelings afterwards. Thus for example, several women in our study explained that their faces were scarred after drunken fights with friends, where women would break their beer bottles to use as weapons. When we expressed surprise that women continued to be friends with their attackers they were puzzled at our question, saying 'She was drunk when she did it, why would I blame her?'

How could a situation such as this one be encapsulated in a discrete measure of community level trust or reciprocity according to Putnam's dimensions? Is this a situation where levels of trust are high? Or low? Sometimes sex worker networks constitute positive social capital. At other times the very same networks are a source of the injury, even death, of their members. The notion of developing survey measures which seek to measure generalised levels of trust -- or the existence of supportive co-operative community networks -- as static context-free variables seems a flawed one.

Comparisons between the Luton and South African findings suggest that social capital is a resource that emerges in particular contexts in particular situations - generally in times of stress or crisis. When stress or crisis is absent, so is social capital. However, in life threatening conditions, communities may overcome tremendous barriers to work together in an atmosphere of trust and reciprocity to achieve common goals. In South Africa in the context of the HIV epidemic, against enormous odds, sex workers have generated trusted, easily accessible and often highly effective community networks (Campbell and Mzaidume, in press). They have mobilised people in voluntary groupings aimed at

preventing new HIV infections, offered support to those already infected, and facilitated people's access to medical facilities. In comparison to this, research in Luton suggested that local people were very doubtful about the possibility of deriving benefit from community-oriented actions or co-operative enterprises -- and had no interest in engaging in these (Campbell, Wood and Kelly, 1999).

In my view, our Luton findings point to the folly of our enterprise of searching for social capital out of any particular context. In our South African shack settlements, where levels of HIV are over 70%, sex workers have been able to generate very high levels of social capital in a very short time. In Luton, attempts to promote people's involvement in community development projects -- such as Neighbourhood Watches or grassroots anti-poverty forums, had left community development workers and grassroots local activists feeling tired and demoralised. Yet I have no doubt that if there was a large HIV epidemic in Luton, which threatened to kill 70% of the local population, people would pull together very co-operatively. Voluntary organisations would flourish - despite the low levels of general social capital we found in our Luton study which was conducted in non-crisis conditions. It's in particular situations of stress, need or crisis that social capital is generated.

It's against the background of all these qualifications and proviso's that I argue that social capital can often be a useful concept. In South Africa, we are using social capital as one modest but essential tool in a much broader study which seeks to locate the success or failure of our community led participatory programmes - which seek to prevent HIV transmission - within the broader context of poverty, government mismanagement and lack of political will on the part of powerful social actors to address the problem.

In my joint research with Carl McLean, we are looking at the role played by social capital in perpetuating social inequalities in England, again in Luton, with particular reference to ethnically determined health inequalities. Here too we feel that the concept of social capital has a vital role to play. Several key government policy documents, concerned with health inequalities, have emphasised the key importance of forming partnerships between

socially excluded communities and the government in addressing health inequalities (Dept Health, 199a, 199b; Social Exclusion Unit, 2000). The starting point of our Luton ethnicity research is our belief that forms of social exclusion -- such as minority ethnic status -- might impact negatively on the stocks of social capital available to minority ethnic group members -- in a way that undermines the likelihood that they will participate in health related or community strengthening projects. We are seeking to develop our argument that unless government 'consultation and partnership' policies take account of factors which undermine the likelihood of local participation by socially excluded groups, so-called community partnership exercises could actually serve to exacerbate health inequalities rather than reducing them.

This is the way in which we are seeking to use the concept of social capital to direct our attention to the frequently neglected community level of analysis within health promotion. In my view, if we tone down our unrealistically high expectations of social capital as a multi-disciplinary Grand Theory, the concept does have the potential to serve as a modest starting point for research seeking to conceptualise the community level of analysis in particular situations. In my research it has provided a useful starting point for two endeavours. The first is that of disentangling the role that community level factors may sometimes play in conjunction with a wide range of other micro- and macro- social factors in enabling and constraining marginalised people's participation in collaborative projects. The second endeavour is to examine how - in other situations, often situations of crisis, and even in the most disrupted and violent communities - social capital may indeed serve as the valuable community resource which Putnam argues it to be.

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