Resilience of HIV/AIDS-affected households in a village in Tanzania: Does social capital help?

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HIV/AIDS morbidity and mortality reduce the ability of households to generate livelihood and cushion other shocks. Social capital is supposed to have the potential to mitigate the impacts of HIV/AIDS and help affected households maintain their resilience, but the extent to which it can do so remains questionable. Drawing from a study in village in the region of Morogoro in Tanzania, this paper investigates the impacts of HIV/AIDS on social capital and its implications for rural livelihoods resilience. The findings reveal that the significance of social capital for helping individuals and households to cope with the shock of HIV/AIDS does not apply in a situation of widespread poverty. Additionally, HIV/AIDS undermines reciprocity by diminishing resources that could have been invested in social relations, while access to social capital is fraught with difficulty due to the stigma surrounding HIV/AIDS. Different from the idealized view that social capital helps households maintain their livelihoods and strengthens their resilience to future shocks and stress, many of the HIV/AIDS-affected households were found unable to cope with HIV/AIDS impacts, because social capital itself is not resilient in a context of high HIV/AIDS prevalence and widespread poverty.

[social capital, resilience, rural livelihood, poverty, AIDS impacts, Tanzania]

Although households use various assets and resources to maintain their livelihoods, there has been increasing attention for the role of social capital in this respect. The importance of social capital for micro- and macro-level economic development and for poverty reduction is much emphasized in the literature (cf. Dhesi 2000). Previous studies have highlighted the relationship between the distribution of social capital and household incomes (Narayan & Pritchett 1999) and the function of social capital as a safety net (Morduch 1999). Studies show that social interaction among neighbours, friends and members of groups and associations, generates social capital and the ability to work together for a common good, which is especially important for the poor (Morduch 1999, Moser 1996). Social cohesion in the community may have an impact on people's health and feelings of safety (Wilkinson 2002).

Social capital is regarded as particularly important as a last resort resource to the poor and vulnerable for its ability to provide a buffer to shocks such as death in the

family. It functions as an informal safety net to ensure survival during periods of insecurity and may compensate for the lack of other types of capital (e.g. labour groups compensating limited human capital in households). Social capital provided by family and close friends ensures assistance and care and creates a sense of well-being. Ferlander (2007) emphasizes the importance of social capital for safeguarding health and overcoming illness. In a situation of high HIV/AIDS prevalence, social capital could facilitate households to respond its impacts. In Tanzania the spread of HIV/AIDS has significant effects on demographic and social and economic structures. The epidemic has struck the economically most active group, namely adults aged 15-49. The average national HIV/AIDS prevalence rate in Tanzania is seven percent, with women having higher prevalence rates (8%) than men (6%) (TACAIDS, NBS & USAID 2005).

Social capital is often seen as a panacea for all kinds of problems affecting societies, which could include AIDS impacts, but this is a questionable claim (Portes 1998, Fine 2001, Portes & Landolt 1996, Putzel 1997). The role of social capital in strengthening the resilience of households and communities in times of HIV/AIDS should be critically assessed. The analysis of social capital in relation to coping mechanisms is important to reveal how it can reduce the sensitivity of households to crises and strengthen the resilience of households affected by HIV/AIDS. Our premise is that HIV/AIDS impacts change the forms and quantity of social capital available to households. Therefore, this paper will address the questions of whether social capital strengthens the resilience of HIV/AIDS-affected households and to what extent social capital itself is resilient towards HIV/AIDS impacts.

This paper will focus on micro- and meso-level social capital. Its emphasis will be on the ability of individuals and households to mobilize resources through social networks, such as kinship networks, friends and neighbours and community groups. It will also pay attention to trust as the cognitive dimension of social capital. The data presented were collected in a village study in Mkamba, Tanzania, during 2004-2005 (cf. Nombo 2007). The paper begins with a discussion of the concepts of social capital and resilience. Then, information about the study area setting and the research process is given. Next, empirical evidence is presented and discussed. The paper ends with a conclusion.

Conceptual framework

Social capital

The concept of social capital gained prominence by the writings of James Coleman (1988, 1990) and Robert Putnam (1993). There is no set and commonly agreed upon definition of social capital but it is broadly agreed that social norms and social networks are part of it. Generally, two forms of social capital are distinguished: structural and cognitive social capital. The first refers to the networks and social structures in which people are embedded, the second to contents, such as trust, shared beliefs, norms of obligation and reciprocity. The latter are more subjective and intangible,

hence more difficult to observe (Uphoff & Wijayaratna 2000). Putnam (1993) defined social capital in terms of the existence of horizontal social groups such as associations, clubs and voluntary agencies that bring individuals together to pursue one or more objectives in which they have a common interest. Coleman's (1990) definition of social capital also covers vertical linkages and relations among groups. Other definitions include formalized relations and structures of macro-institutions, such as political regime or the legal and judicial systems (cf. Berger-Schmitt 2000). Corresponding to these different scopes of the definitions, a distinction between three levels of manifestation of social capital can be made: interpersonal relations, such as between family, friends and neighbours; intermediary associations and organizations such as clubs, forms, political parties; and macro-level of societal institutions, including government, the political regime, the rule of law and the judiciary system. The three levels are complementary and mutually re-enforcing, and together they may maximize the socio-economic impacts of social capital (Grootaert & Bastelaer 2002).

In the literature a further distinction is made between bonding, bridging and linking social capital. Putman (2000) describes bonding relationships as those in relatively homogenous groups. Bonding social capital strengthens the social ties within a particular group. It enables individuals and households to meet their daily needs and overcome difficulties. Bridging capital refers to relations between heterogeneous groups. It strengthens ties across such groups, which is more important for 'getting ahead'. Woolcock (2000) identified a third type of social capital, linking social capital, which refers to connections with people in positions of power and is characterized by relations between those within a hierarchy but at different levels. Linking social capital enables one to gain access to resources, ideas and information from formal institutions beyond the own community. All three types of social capital are important in helping households cope and become resilient to AIDS impacts.

Portes (1998) argues that social capital is a relational concept; it exists only as far as it is shared. He observed that whereas economic capital is in people's bank accounts and human capital is inside their heads, social capital is inhered in the structure of their relationship. When people share a sense of identity, hold similar values, trust each other and reciprocally do things for each other, one can expect a positive impact on individuals and on the community they are living in. Previous research has shown that individuals possessing more social capital are usually also healthier and happier (Rose 1999). A person's access to social capital varies with an array of factors, including personal characteristics such as age, gender and health; family circumstances; education, employment; attitudes and values; characteristics of the area of residence, and so on. Use of social capital in tends to be identified with positive outcomes, but it is not equally accessible to all people. Characteristics of social capital that yield benefits to some have downsides to others. For example, strong internal cohesion between members of a group is associated with exclusion of and intolerance towards non-members.

In this paper, the application of the concept of social capital focuses on activities, social relationships and networks that are part of the everyday life of the individuals and households in the study area (structural bonding and bridging social capital), and

on the norms and values that underlie these relationships and networks and the trust they generate (cognitive social capital).

Livelihood, vulnerability and resilience

The concept of social capital plays an important role in livelihood research. Livelihood is about individuals, households, or groups making a living, attempting to meet their various consumption and economic needs, while coping with uncertainties and responding to new opportunities (De Haan & Zoomers 2005). Though localized, livelihoods are influenced by stress and shocks that result from the interactions between global forces and local contexts and by macro-level policies. Livelihoods can be more or less sustainable. Chambers and Conway (1992: 6) call a livelihood sustainable "when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities, assets and entitlements, while not undermining the natural resource base." Livelihoods that are unable to do so are vulnerable (cf. Scoones 1998). According to Niehof and Price (2001) vulnerable livelihoods cannot cope with stress and shocks without being irreversibly damaged. Wisner et al. (2004) define vulnerability as the characteristics of a person or group that influence their capacity to anticipate, cope with, resist and recover from the impact of natural hazards. Vulnerability, therefore, has to do with the probability of individuals, households or communities to experience a decline of well-being in the future, implying a loss of resilience. The level of vulnerability will increase in direct proportion to reduced levels of resilience. Therefore, resilience defined as the ability to 'bounce back' from stress or shocks becomes a critical factor in livelihood sustainability.

The concept of resilience has been utilized mainly in research on the relations between human society and the natural environment, but it has a much broader field of application. Walker et al. (2004: 1) define resilience as "the capacity of a system to absorb disturbance and reorganize while undergoing change so as to still retain essentially the same function, structure, identity, and feedbacks". Resilience is future-oriented and characterizes a system's ability to deal with change. Berkes et al. (2003) identify three central features of resilience as applied to integrated systems of people and their natural environment: the ability of a system to absorb or buffer disturbances and still maintain its core attributes; the ability of the system to self-organize; and the capacity for learning and adaptation in the context of change. In the case of HIV and AIDS, resilience refers to the ability of people to avoid its worst impacts or to recover to an acceptable level of well-being (Loevinsohn & Gillespie 2003). Different aspects of well-being, such as food security, nutrition, health, education or income can be considered in analysing resilience in a context of high HIV/AIDS prevalence. In an operational sense, resilience needs to be considered in a specific context; it requires defining resilience *of* what *to* what (Carpenter et al. 2001). This paper is about the resilience *of* households *and* social capital *to* the shock of HIV/AIDS-induced morbidity and mortality.

For the purpose of further specification and operationalisation, in this paper we will follow Davies (1993) in linking the concepts of vulnerability, sensitivity and resilience.

In her view, vulnerability has two dimensions. First, the dimension of sensitivity: the intensity with which a shock is experienced. The greater the sensitivity of a system, the further the system will need to bounce back. The ability to recover, in the literature now also referred to as 'bounce-back-ability' (Davies 1993), is the dimension of resilience. Hence, the questions to address in this paper can now be reformulated as:

1 How important are bonding and bridging structural social capital and cognitive social capital for the sensitivity of households to the shock of HIV/AIDS?
2 How important are these forms of social capital for the ability of households, or the resilience, to recover from the shock of HIV/AIDS?
3 How sensitive and resilient are these forms of social capital to the shock of HIV/AIDS?

Study area and data collection

Study area

The study was conducted in Mkamba village, in Kilombero district, which is squeezed in between the foot slopes of the mountains of the Udzungwa Mountains National Park and the sugar plantation in the plains. In 2003 the village counted 12,737 inhabitants (Village Report 2003). Its population increases during the sugar cane harvest peak season (May-December), when about 5,000 to 6,000 casual labourers are recruited from other regions. The Mkamba population is increasing rapidly because of migration into the sugar estates. Farming dominates the livelihood of the households in the village with farming plots ranging from two to five acres. Most Mkamba people do not have land near the village but farm on (own or hired) distant plots. Because of this, many villagers are forced to stay in temporary shelters on the farms during the main farming season (December-August). Poor farmers sell their labour for cash to invest in their own farms, which reduces the time they can work on their own plots. According to the Village Report (2003), only 65 percent of the population is food secure or have only seasonal food shortages, the rest is chronically food insecure.

Before the privatisation of the Sugar Company in 1998, many Mkamba households were producing food crops from unutilised company plots. Although legally the land belonged to the Sugar Company, the law was not enforced and people used it for farming. After 1998 the company reclaimed all plots, depriving the villagers of farm land. Those who legally owned plots near the sugar cane plantation could no longer produce other crops than sugar cane, because these would be eaten or damaged by monkeys and vermin hiding in the nearby sugar cane fields. Crops like rice, maize and vegetables thus had to be produced on distant farms, which had a negative impact on household food security in the area. The policies of the Sugar Company after 1998 caused unemployment and increased economic hardship. Many people live in dire conditions. Witchcraft beliefs have proliferated in the area and have destructive effects on interpersonal trust and social relations.

Data collection

The study employed a combination of qualitative and quantitative methods. Qualitative methods used included open-ended interviews with key informants, focus group discussions (FGDs) and in-depth interviews with case studies. Nine FGDs were conducted, involving people who represented different groups in the village. The groups were composed of seven to eight people of varied age. There were mixed as well as separate groups for men and women. Issues discussed included: livelihood, vulnerability, coping with livelihood insecurities, gender differences, social networks and community organisations. The discussions were conducted in Swahili. They were all tape-recorded, transcribed, and translated into English for further analysis.

Open-ended interviews were held with key informants to explore issues such as the village history and major events in the village, people's livelihoods, gender relations, social relations and communal activities, witchcraft, HIV/AIDS, and ways of coping with livelihood insecurities.

For the household survey a sample was drawn from four of the six hamlets in the village, yielding 180 households comprising 903 persons. The interviews were done with household heads, who provided information on household composition, mortality and morbidity experience, livelihood activities, asset ownership, sources of income, household food security, and engagement in mutual exchanges and group activities.

Cases were selected for further in-depth study. Given the fact that social capital of individuals and households may vary according to socio-economic status, asset ownership was one of the three selection criteria for the case studies. The other criteria were HIV/AIDS status (affected – frequent or long AIDS-related illnesses or deaths, or fostering AIDS-orphans – and non-affected) and household headship (male or female). The in-depth interviews with persons in the case households facilitated studying people's own perceptions on and experiences with the dynamics and problems of coping with insecurities in daily life. The cases revealed how households generate and make use of their social capital to cope with prolonged illness, death and food insecurity. Using a checklist, life histories addressed important questions on migration, occupational history, coping mechanisms and mutual help and sharing. All field notes and interview transcripts were recorded in notebooks and later analysed and interpreted. Extracts of the interview transcripts from case studies, comments from key informant interviews and statements made in the FGDs in relation to the issues investigated are presented in this paper.

Empirical evidence

Livelihood and food security impacts of HIV/AIDS

The most direct impact of HIV/AIDS-induced morbidity and mortality on households emanates from the loss of human capital, which consists of ability to work and skills and knowledge that are important in pursuing livelihood activities. Of recorded deaths

in the sample about 65 percent were of individuals at their prime productive age. This affects the livelihood of the households involved, as the people most capable of working die. Forty-five out of the 180 households had 53 ill young adults who were unable to work. About 50 percent of HIV/AIDS-affected households had members who had been sick for more than six months. The effective dependency ratio in HIV/AIDS-affected households is slightly higher than in non-affected households, implying that households affected by HIV/AIDS have a relatively smaller supply of labour than non-affected households and a larger proportion of household members consisting of ill persons, children or elderly persons (Nombo 2007). AIDS-induced illness and deaths remove labour and deplete other productive resources that could have been used in food production and income generation, leading to food and livelihood insecurity. While affected households were found to do their best to respond to the impacts of HIV/AIDS, their ability to do so is severely compromised by the depletion of their resources. In this situation, most of affected households are assumed to rely on their social capital for help. It is questionable to what extent their social capital continues to function as expected in a situation of diminished resources.

Social capital and coping with HIV/AIDS impacts

Kinship networks

Generally, family relationships, households and kinship networks function as a resort of social support for the individuals who belong to them. In the study area, in most cases households provide care in a situation of already stretched resources. HIV/AIDS effects on resources and lack of knowledge on proper HIV/AIDS care, renders households unable to provide adequate care. As Du Preez and Niehof (2008) emphasize, although care giving may be motivated by emotions, resources are needed to carry it out. Women's role in care provision adds to their vulnerability to AIDS impacts. Opportunities for farming and income generation are lost because of the time they spend on care. Lack of time and other productive resources prevent women from investing in social relations, which erodes their social capital.

The evidence provided by case studies shows that there is little assistance by other family members during sickness. This may be because those affected or their caregivers did not inform other family members about the situation, but distance may also play a role; physical care requires proximity. Additionally, relatives living nearby may have the intention to help, but economic constraints may prevent them from doing so. During informal interviews and focus group discussions it became evident that nowadays there is little assistance from kin. The following statements show that despite the importance of kinship economic decline makes it difficult to support affected relatives and that households tend to fall back on their immediate family:

– It is not that the sense of brotherhood is dying but the big problem is poor living and economic conditions for many of the families. Life has become very difficult. Even if your relative is sick, you are unable to assist due to the lack of income.

– Real relatives were there in the past. Nowadays there is no one who can even pay you a visit, very few do that. Your own children are now your relatives.

People also noted that care and support are provided in a context of reciprocity. The problem with AIDS is that it creates a care demand among young adults who will never be able to reciprocate to their parents and other family members. HIV/AIDS-related stigma may also hamper care from relatives, as was reported during the focus group discussion with youths on HIV/AIDS issues.

Friends and neighbours

Neighbours and friends are an important source of support in the study area because most of the households come from outside the area; relatives who could have assumed the responsibility to help live elsewhere. However, people had mixed views about the help of neighbours and friends. Some respondents reported positive incidences where households in need received food and money from friends and neighbours, despite the fact that poverty is a problem for the majority of the people in the village. Lending money for medical expenses was also reported. However, others held more negative views on the assistance by friends and neighbours, saying that it was not as before and that many people keep to themselves and do not bother about what is happening next door. The following statements could be recorded:

– Who is there to give you food and money these days? Everyone has to fend for her or his own family.
– Even if you have friends it is just on the mouth. We cannot help each other because our situations are the same. Now who is to help the other?

The statements show that in fact support from neighbours and friends is not readily available and that in a situation of widespread poverty, it is difficult to cope with problems that affect the majority of the villagers simultaneously.

The willingness to act in a way that will benefit others is based on trust or the expectation of being treated fairly in the future. It could be deduced from qualitative data that if people are indifferent to the problems and significant events of others, they are unlikely to be assisted when faced with problems. HIV/AIDS impacts affect relationships with neighbours and friends. Since continuous social interaction is based on give and take, if a person is affected s/he is not likely to be able to maintain this exchange. One participant in a focus group discussion said explicitly: “No one will be willing to assist someone from January to December knowing that this person will not be able to reciprocate”. Inability to reciprocate and prolonged need for assistance are likely to discourage people from helping relatives with AIDS. Because of HIV/AIDS impacts, affected households in most cases are left with few resources which make reciprocating in tangible terms difficult. The vulnerability of AIDS-affected households increases after exhausting the resources they could use for investing in social relations. Gillies (1998) notes that when a certain point of economic crisis or hardship is reached, reciprocity between households breaks down. Mobilization of resources

within the social network becomes difficult, not only because of prolonged illnesses but also because of HIV/AIDS-related stigma.

Membership in groups

At community level, local groups are the manifestation of social capital. Members of these groups do not belong to each other's immediate circle of close contacts that informal social capital is made up of. In Mkamba there is an organization for sugarcane out-growers, to which a saving-and-credit association is linked, that provides loans to sugarcane out-growers. Other people in the community can also get loans from this group if they can meet the membership and loan application conditions, which is rarely the case. There are also women groups, formed to provide help in times of death and during festivals. Other groups include burial groups, made up of people from the same ethnic group or neighbourhood, and religious groups which mostly offer moral and spiritual support to their members. All groups have specific rules of membership and reciprocity in terms of entrance fees, annual contributions, stipulated in bylaws. They are governed by balanced reciprocity, meaning that all members who contribute according to the rules can expect to benefit equally from the group.

Generally, members in all groups claim the right to be assisted regardless of their health situation. However, HIV/AIDS-related deaths and illnesses put pressure on group resources, even though these groups do not specifically address the needs of HIV/AIDS-affected households. Members are entitled to (substantial) assistance for funerals and (only once) for hospitalization of an immediate family member. Home care is not considered eligible for group assistance. Most members feel they cannot give special attention to those affected, as their needs are beyond the capacity of the group to attend to. One group member said:

> Bearing in mind our economic hardship, we cannot deceive ourselves that we can be able to give full support to those affected. Their demands are so many and our group cannot mobilize enough resources to attend to all.

Moreover, the secrecy surrounding HIV/AIDS limits assistance those affected could obtain from their group as most of the affected individuals do not disclose their status to fellow group members for fear of stigmatization and exclusion.

Many people who are not a member of a group think that the conditions for membership discriminate against the poor. As one woman said:

> I am making rice buns everyday, which gets me about TShs. 500 to 1,000 profit per day depending on how good the day is, and on average my daily food expenses are about TShs. 1,500. The profit I make cannot even feed my family. I know the arrangement is good but where will I get money for weekly contributions? Getting money for my daily food is already a problem, so how will it be possible to pay the contribution?

People's economic situation influences their social interaction and group membership, as the cases of Mr Mlogola and Hawa (below) show, and affects their coping abili-

ties. The cases demonstrate the higher returns of social capital for the wealthy and the greater barriers for the poor. They also show the importance of having cash available for participation in groups. Poor and HIV/AIDS-affected households have problems making ends meet, leaving little to invest in groups. Non-poor, food-secure households seem to be able to diversify their memberships in groups and other informal networks, which helps them in times of need. The case of Hawa shows that even an individual in an HIV/AIDS-affected household can become a member of a group and benefit from it, provided the household is relatively well-off.

Bwana Mlogola: poor, HIV/AIDS-affected, non-group member

Mr Mlogola, 36 years old, came to Mkamba in 2001 to find a job. He worked as a seasonal labourer with the Sugar Company but later decided to settle in the village. He is married with one child. The family lives in a poor rented room and depends on odd jobs to make their living, but the man is often unable to work because of frequent bouts of illness. Sometimes his wife works on their landlady's plot and gets some food in return. They can hardly meet their food needs and medical expenses.

Bwana Mlogola knows about the groups in the village and appreciates their benefits, but he cannot join because he cannot pay the required contributions. He knows that there is a Wahehe group, the ethnic group he belongs to, but he cannot become a member. The entrance fee (TShs. 3,000) and annual contributions (TShs. 10,000) are too expensive for him. He would also not be able to attend to the group meetings due to lack of time or illness. He attends one of the Protestant churches in the village for spiritual and emotional support. The couple does not receive any practical and material support from their Church. He would not mind telling people about their health status but his wife is worried of the treatment she is going to get once people they know they are infected. She is scared of being laughed at, stigmatized and isolated by other community members. He says: "Once people know that you are affected they will not even give you a loan because they know you are soon going to die".

Hawa: HIV/AIDS-affected, coping sustainably with AIDS impacts

Hawa (38) is married as a second wife to a famous businessman in the area. She is living with other two relatives who came to seek help from her. She is a successful farmer who hires labour to work in her farm and can harvest up to 1,000 bags of rice per season. She stocks and sells the rice during off-season. She also has a hardware shop in the village. Her father is a popular politician in the district. She has been treated in Dar es Salaam for her skin condition. When she was seriously ill, her father hired a car and took her to Ifakara Hospital and later to the Aga Khan Hospital in Dar es Salaam. She did not tell me that she has AIDS but people told me she is currently on antiretroviral treatment. Hawa gets care from the relatives she is living with. Despite her condition, she is involved in many women organizations in the district and in the village and is a leader of one of them.

Despite the fact that female-headed households were found to have more informal social capital than male-headed households, who are more often involved in formal groups, both types of social capital do not seem to offer substantial help to reduce the impacts of AIDS. Moreover, groups place personal obligations on members that may be difficult to meet, especially for poor and HIV/AIDS-affected households. Some of the non-group members interviewed said they were once in a group, but that they had insufficient income and time to meet group conditions:

> It is difficult to get time to go for meetings and have money to contribute to the group, when you have to attend most of the things in your household; you have to fend for your own household first.

Community groups that help to establish beneficial relationships for their members exclude those who do not have the means to participate. This means that those most in need are left out.

Trust

Trust is built in continual interactions embedded in social relations and exchanges. People will help each other if they trust each other and if they believe that others will help them in the future if need be. At face value, relationships in the village seemed to be harmonious. However, further probing revealed a different picture. Lack of interpersonal trust proved to curtail social networks and reciprocal relations in the village. When respondents and key informants were asked if villagers trust each other, many responded negatively. Lack of trust manifests itself in various ways. Lack of social support from relatives, friends and neighbours is partly explained by lack of interpersonal trust in the village, which people attribute to economic hardship, witchcraft accusations, and ethnic diversity.

Witchcraft suspicion and accusations indicate deteriorating trust among neighbours and friends, such that people are not willing to help one another. This was stated by a villager as follows:

> Even if I know my neighbours do not have food, I cannot provide them with food assistance for fear of being accused of witchcraft in case any member of that household gets sick. I don't want to be harassed and be taken to the 'salon' for shaving [witchcraft-cleansing ceremony].

Assistance and support are hindered by fear of witchcraft suspicion and accusation. The association of AIDS with witchcraft gives rise to tension and suspicion between affected households and the community, neighbours and friends, and even between relatives.

Bonds of trust are severely strained both within and beyond the family as a result of HIV/AIDS-related stigmatization and discrimination. For example, a lady who had tuberculosis was not accepted back into the local brew business. "No one will buy beer from me", she said. Such treatment of the afflicted denies them a chance to forge bonds

with people who could be of help, leaving them more vulnerable and sensitive to AIDS impacts. Economic difficulties, caused by HIV/AIDS and other circumstances in the area, lead to decreased interpersonal trust, as the following statement shows:

> I think what causes this mistrust is the bad economic situation. Nowadays our incomes are very low; such that it is difficult to even pay back part of the loan In this case it will be difficult to approach the same person for another loan because this person no longer trusts you. Therefore, the bad economic situation makes people seen as dishonest.

Ethnic diversity is another factor contributing to the decline of interpersonal trust in the study area. People tend not to trust people from other ethnic groups and interact less frequently with them. For example, there were some women groups that did not function because members from a particular ethnic group had isolated themselves from the group, which led to the group's dissolution. Ethnic diversity in Mkamba seems to negatively affect trust and social interaction (Nombo 2007). A comparison with the neighbouring village of Kidatu revealed that somehow Kidatu was better positioned to help people cope with AIDS impacts. The explanation seems to be that in Kidatu the people are rooted in the area. The village is more homogeneous and the people are tied by stronger bonds than is the case in Mkamba.

Discussion

Does social capital reduce sensitivity to HIV/AIDS impacts?

As discussed above, it is found that people's social capital could not provide sufficient support to buffer the crises experienced by most of the HIV/AIDS-affected and other vulnerable households. Increased poverty and deteriorating living conditions among the people in the study area seems to have affected mutual help among relatives, friends and neighbours, and membership in groups. As people are unable to earn enough for their families, they have nothing left for others. People are in an increasingly difficult position to ask for and provide support. As a result, HIV/AIDS-affected households are struggling to make their living, with no or minimum support from their relatives, friends and neighbours, as those are equally affected. The significance of bonding social capital among people with a more or less similar socio-economic status is jeopardized by a widespread crisis because it affects them equally and simultaneously, leaving them all in the same trouble.

Although close ties in groups are necessary to help members cope on a day-to-day basis, they are not very useful in helping the members to get out of their hardships (cf. Putnam 2000). Bridging social capital is necessary to create opportunities to interact with others and access external resources. However, it was found that most of the groups identified in the village have no links with other groups, neither inside nor outside the village. These groups may enable members to 'get by' but lack the connections (bridging social capital) that could help them 'getting ahead'. While strong

intra-group cohesion is positive, lack of inter-group linkages is problematic for a poor community like Mkamba village, because it constrains access to information and financial resources, thereby increasing members' sensitivity to AIDS impacts.

Generation of social capital is impaired if there is no sufficient level of trust. Distrust at the interpersonal level is extended to the community level, affecting the way people could work together to solve their problems. Inability of bonding social capital to provide reliable and sufficient support to those affected and lack of bridging social capital makes households sensitive to AIDS impacts. The weakening of structural and cognitive social capital undermines the capacity of households to respond to the hardships caused by AIDS.

Does social capital strengthen household resilience to HIV/AIDS impacts?

In general, both bonding and bridging social capital in the area were found unable to cushion the effects of AIDS on households and bolster household resilience particularly of poor and/or HIV/AIDS-affected households. It was found that most affected households experienced a decline of social capital because they find it hard to meet the obligations that membership of social networks entails. In a context of widespread poverty households' capacity to respond to AIDS impacts is undermined by weak social capital, thereby intensifying the vulnerability of households and communities to other shocks. Because social capital could not reduce people's sensitivity to AIDS impacts as discussed above, it can also not help them to strengthen their resilience.

Resilience of social capital to HIV/AIDS impacts: safety nets with holes

This study has found that there is a decline of mutual help in the village and among kin. Families and households are confronted with increasing poverty and other socio-economic changes, such that individuals can no longer count on their relatives and friends for support. Additionally, informal support systems, previously effective even in resource-poor environments, are weakened under the strain of contracting resources as a result of HIV/AIDS. HIV/AIDS impacts on households can be so severe that investing in social relations becomes impossible. Mobilizing resources from social networks is especially difficult in case of prolonged illness and when the affliction has a stigmatizing character. Moreover, a key principle in the assistance provided by kin and friends is reciprocity, while HIV/AIDS destabilizes reciprocity by stripping households of resources. When people are no longer able – for whatever reason – to contribute as expected, they run the risk of losing their access to the social support provided by the informal networks. Beuchelt et al. (2005) say that mutuality is the main motivation for mutual help, and when not guaranteed or anticipated, support is limited. Our findings seem to prove them right, implying that moral principles of solidarity and mutual help – also between kin – break down in a situation of shared hardship, leading to depletion of social capital. Lack of resources to invest in social networks and groups make individuals and households unable to generate and use social capital that could help them become resilient to AIDS impacts and other shocks and stress. Generation of social

capital is also undermined by deteriorating trust among relatives, friends and neighbours. Distrust makes it difficult for people to help each other and work together, and, consequently, renders them unable to generate social capital. As suggested by (Moser 1998), the permanence of social capital cannot be taken for granted.

Conclusion

Life for the people in the study area is marked by uncertainty and challenges. In the absence of strong social networks and social safety nets, communities are faced with huge problems in finding solutions to meet their challenges. Most of the responses of households to AIDS impacts were found to be short-term and erosive. Coping strategies that are pursued because of a lack of alternatives may involve running down productive assets, often irreversibly, and leave people poorer, more sensitive and less resilient than they were before. HIV/AIDS-affected households are left with fewer options to diversify their sources of livelihoods and their coping responses were found to be at the expense of their resilience to future shocks. Such households are likely to be caught in a fatal spiral of decreasing resilience and increasing sensitivity. Unless assisted, they will fall apart, leaving destitute individuals.

Social capital is of little help in such circumstances, because – as with other kinds of capitals – it is not equally available to all. Social networks generate exclusion alongside solidarity, which is why they cannot be seen as a panacea to all social and economic problems in communities. Poor households and most of the HIV/AIDS-affected households have limited social capital because they are unable to invest in it and also because of the stigma attached to their status. While it is generally assumed that HIV/AIDS-affected households cope by relying on their social networks, our findings show that their social networks have weakened and do not provide sufficient and reliable support to sustain their livelihoods. Most of the affected households in the study area belong to the category that has weak safety nets, fitting the description of Donahue et al. (2001: 9) as 'falling through' the vulnerability threshold. Because of the households' depletion of resources and inability to build and maintain their social capital, many are unable to cope with AIDS impacts and become resilient. However, the few households that are better endowed with bonding *and* bridging social capital are likely to be resilient.

The results also show that social capital itself is not immune to the impacts of AIDS; it is eroded as people are not able to invest in generating and maintaining it. The continuing economic crisis in the area has caused people to invest less in social capital. As individuals and households struggle to make ends meet, they have little resources left for mutual exchanges. Therefore, social capital itself is not resilient to AIDS impacts. Similarly, concluding from research in Malawi, Mtika (2001) suggests that when the spread of AIDS reaches a certain threshold level, social capital endowments become unfavourable and reciprocity is undermined, thereby weakening community ability to recover from its consequences.

The finding of this study that ethnic diversity hampers building trust corroborates the results of a large-scale investigation into diversity and community in relation to

immigration by Robert Putnam. Putnam (2007: 149) concludes: "[Ethnic] diversity seems to trigger *not* in-group/out-group division, but anomie or social isolation" (italics in the original). In Mkamba this is reflected in the proliferation of witchcraft accusations. Increasing social isolation and anomie make people in Mkamba more sensitive to HIV/AIDS impacts and decreases their resilience. Hence, villages like Mkamba can be called 'communities in distress' (Nombo 2007). Therefore, there is a need to strengthen the asset base of households in such villages, to enable them to increase their resilience to AIDS impacts.

Note

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