

# Resilience and AIDS

## Exploring resilience in the case of AIDS among female-headed households in Northern Zambia

Esther S. Wieggers

*AIDS affects all facets of people's livelihoods through illness, death and the subsequent care of orphaned children. While AIDS has negative impacts on the livelihoods of many households, not all affected households experience a loss of livelihood security. Several factors condition people's ability to respond to AIDS impacts. This paper explores the concept of resilience in the context of AIDS-related adversity and suffering. In the paper resilience is seen as the responses that enable households to persist or adapt to the difficulties caused by AIDS. Using case material from Northern Zambia, specific attention will be paid to resource mobilisation and factors that enable resilience. Also, the paper examines some of the methodological implications relating to research on resilience.*

*[resilience, AIDS, social capital, gender, resource mobilization, Zambia]*

Since the first case was reported in 1981, over 25 million people have died of AIDS. Sub-Saharan Africa is the epicentre of the global epidemic with almost 68% of all people living with HIV. Presently, women constitute 61% of infected adults in sub-Saharan Africa and in almost every country, prevalence rates for women are higher than for men, especially among young women (UNAIDS 2007). Underpinning these sex-based differences in prevalence rates are profound gender-based differences in power, social attitudes and vulnerability (Commonwealth Secretariat 2002). Since the 1990s, several studies have examined the socio-economic impacts of AIDS on rural livelihoods and household food security using qualitative and quantitative approaches and data sources. Examples are: Barnett and Blaikie (1992); FAO (2003, 2004); Rugalema (1999); Mutangadura et al. (1999); Topouzis (2000); Yamano and Jayne (2002); and SADC-FANRE VAC (2003). From these studies a generally accepted narrative has emerged about the impacts of AIDS on rural livelihoods and food security that has been widely used to inform and develop policies and programmes. The AIDS-impact narrative postulates the following main effects: a sharp decline in the household labour force, reduced area cultivated, a shift towards less labour-intensive

crops, decreased use of farm inputs, reduced production and productivity, losses in off-farm income, and distress sales of tangible household assets.

In reality, impacts of the epidemic do not conform to a simple narrative but are in fact complex and diverse (Wiegiers 2007). While it is clear that AIDS affects people's livelihoods, not all households across rural sub-Saharan Africa face a similar inevitable and rapid decline in livelihood security as a result of AIDS (Murphy et al. 2005). Several factors condition whether households are able or not to persist or adapt to AIDS impacts, like gender, age and role of who falls ill or dies, the pre-death household asset level, characteristics of adults remaining in household, labour requirements in a livelihood system and the ability to attract new members. This paper explores the concept of resilience to AIDS-related adversity at household level. Using case material, the paper will particularly look at resources mobilised by female heads of households in response to AIDS and the factors that enable or limit their resilience. The paper is based on case study research carried out among female-headed households affected by AIDS in the Northern Province, Zambia, in 2005. The case study research collected narratives from twelve female heads of households, who differed by marital status, age, educational attainment and wealth, and aimed at understanding the resources they mobilised over time when confronted with AIDS and the challenges and opportunities they faced.

## **Resilience**

The concept of resilience is frequently used in ecology and climate change debates. Resilience has various meanings but is often referred to as the ability to withstand external shocks and to recover (Adger 2000). From a livelihoods perspective, resilience means that a livelihood system is able to absorb impacts of perturbations like droughts, diseases, economic fluctuations or political upheaval without resulting in significant changes to its structural features or declines in outputs. In the context of AIDS, resilience has two distinct connotations. From an emotional or psychological dimension, resilience to AIDS means the ability to accept one's status, endure pain, stay positive and see beyond the illness (cf. Kotoh 2008). Looking at resilience to AIDS from a material or economic perspective, it refers to the responses households adopt to avoid the worst impacts of AIDS on their livelihoods or to rebuild their lives faster than normal (Loevinsohn and Gillespie 2003). In this paper, resilience is looked at from a material point of view. Central to resilience is the rate of change. Shocks that are sudden and unanticipated, like AIDS, have much more consequences for people's livelihoods than gradual changes that allow time for people to adapt. Continued change, such as related to infrastructure, communication, and wider economic changes, only gradually alters the context in which people pursue their livelihoods and ultimately reshape rural livelihood systems (Moench 2007).

Closely related to resilience is the concept of resistance. Resistance and resilience both refer to coping with shocks but differ in the sense that resistance refers to the ability to cope without changing its structure or function, whereas resilience means a

livelihood is able to revert back to the original state. Resistance in the context of AIDS refers to one's ability to avoid infection by HIV. Resistance to HIV infection includes avoiding exposure to the virus and escaping infection once exposed, e.g. through better nutrition to strengthen the immune system (Loevinsohn & Gillespie 2003). Resistance to HIV exposure is determined by behaviour and the risk environment. Several causal factors increase the likelihood that individuals engage in unprotected sex. These include gender roles, power asymmetries between men and women, lack of economic empowerment and livelihood opportunities among women, and cultural norms of masculinity and femininity which encourage male infidelity and discourage women to negotiate safe sex. Further, social and economic disempowerment of women and girls exposes them to gender-based violence and sexual exploitation (Gupta 2000). Also, high poverty levels contribute to increased exposure risk through increasing the likelihood of transactional sex to secure food and income.

Vulnerability is the flipside of resilience and attempts to describe the proneness of people, households and communities to an acute fall in the level of certain variables or livelihood outcomes (Ellis 2003). In the context of AIDS, vulnerability refers to the likelihood of AIDS having a negative impact on food security or other livelihood outcomes (Barnett & Whiteside 2002; Loevinsohn & Gillespie 2003). Vulnerability to AIDS-related adversity encompasses the inability to cope, disruption to livelihoods, and loss of livelihood security. Coping strategies are temporary responses that individuals, households and communities adopt in order to avert a negative effect. In the AIDS literature, coping strategies aim at maintaining or improving household food security, raising and supplementing income, and alleviating the loss of labour (Mutanagadura et al. 1999). Ultimately, coping strategies are adopted to sustain the economic viability of a household and to avert its disintegration (Sauerborn et al. 1996).

The level of resilience to AIDS impacts differs among households and is influenced by several factors. These include the livelihood system, the available production options, the resource endowment at the onset of the crisis, and households' capability to exploit these (Davies 1996). Gender is another important factor determining differences in the capacity to persist or adapt (Moser 1996). In particular women are vulnerable to AIDS impacts because of their limited access to assets and low levels of education and economic status.

The actual level of resilience is difficult to measure in absolute terms and can only be studied through proxy indicators and in retrospect. Because different factors contribute to resilience, no single proxy indicator can capture the totality of resilience (Carpenter & Brock 2004). A variety of different indicators are thus needed to adequately represent resilience to AIDS impacts, such as stability in livelihood assets and outcome and the capacity and level of interest in change or adapting to a new situation. The capacity and interest of individuals in changing with circumstances relates to an individual's financial, social, and emotional flexibility (Marshall et al. 2007). Flexibility in this context refers to people's ability to make use of other livelihood options and can be restrained by attitude and lack of necessary or transferable skills (Gramling & Freudenberg 1992, Marshall et al. 2007). Further, people's resilience to changing circumstances is determined by their ability to learn new skills and reorganize their

livelihood and is often a function of innovation, creativity, experimentation, learning, and planning (Marshall et al. 2007). Judgements on resilience to AIDS impacts are often made by comparing quantitative snapshots of the household asset-base and their livelihood strategies before and after the death of a core adult member. The so-called 'before and after scenario' fails to show the dynamic process of household responses to resist AIDS impacts. Responding to livelihood challenges caused by AIDS is a dynamic process whereby households mobilise different resources simultaneously and repeatedly. This cannot be understood by taking a snapshot but requires a longitudinal approach to capture the process.

Caution should be applied when using the term resilience in the context of AIDS, because resilience might be deceptive. Several household surveys undertaken in the mid-1990s (see World Bank 1997, Ainsworth et al. 1998) indicated various degrees of household resilience and recovery of consumption levels following an AIDS death in the household. Also De Waal et al. (2005) in their paper on Tanzania reason that traditional rural African coping strategies can mitigate some of the worst effects of AIDS in the short-term in cases where households are not facing multiple shocks, and depending on a range of factors. The factors include: sex, age and position of the ill or deceased person, the economic status of the household, the production system and its labour requirements, availability of formal and informal sources of support, and livelihood opportunities. Barnett and Whiteside (2002), however, have suggested that traditional impact research such as the World Bank Kagera study painted a more positive picture of households' coping ability as they did not include dissolved households – i.e. households that were not able to cope with the AIDS effects – nor were in-depth discussions held with individuals using detailed ethnographic and case study approaches as done by Rugalema (1999). Further, households might appear resilient to a crisis for a certain period of time by selling off assets and calling upon claims through reciprocal relations, but once they have exhausted most of their assets, their ability to survive as a household suddenly collapses (Swift 1989; Sauerborn et al. 1996). Furthermore, Yamano and Jayne (2004) based on their work in Kenya show that households that experienced a prime-aged adult may not recover for years.

## **Exploring resilience: Cases from Northern Zambia**

### ***Case 1: Emily<sup>1</sup>***

Emily<sup>2</sup> was born 28 years ago in a patrilineal family in Mpika district, Northern Zambia, and is relatively well off. She completed secondary school and got accepted at a nursing school when she was 19 years old. At that time, she started a relationship with John, 35 years and a truck driver from Lusaka who operated between Lusaka and Dar es Salam. Emily only completed one term at the nursing school, as she had to leave school because of pregnancy. She married John who had paid about six cattle as bride wealth (*lobola*). She moved to Lusaka and had four children, presently aged nine, six, four and two years. In Lusaka, Emily started a small saloon shop where she

sold hair products, which her husband brought from Tanzania. Emily also started selling potatoes to local restaurants in her native area to increase her income and be less dependent on John's income for purchasing supplies for her shop. Both her family and family-in-law cultivated her potatoes in return for monthly remittances and her sister was paid for marketing the potatoes. In October 2003 her husband became sick.

He started getting sick in October 2003 with TB. He also had other symptoms like swollen lymph nodes and sores in the mouth... People were supporting us and visited us... I knew about AIDS at that time but we did not talk about it due to our culture. I took him to the hospital and he started TB treatment. He was hospitalised for three weeks... Both his and my family cared for him. Because I had a small baby, I was not allowed to sleep at the hospital, so my uncle and the elder brother of my husband were taking turns to sleep at the hospital and my mother and his cousin were taking care of him during the day, including my elder brother. Once he came home, we cared for him: his relatives, my relatives and I... I did not have to sell anything or use my savings as he had a medical insurance from the company he worked for that covered all the hospital and medical bills... Because of his sickness, I failed to supervise the shop; therefore I employed a woman because I knew this was the only source of income I had... His family continued to help with cultivating potatoes. It is a big family, they split; some could go to the field and some could help me to look after the sick... I was forced to close the shop for a month; there were no supplies since my husband used to bring the products for the shop... I had to look for somebody trustful who could bring me products for my shop. Luckily enough my brother-in-law had a friend who used to go to South Africa to get items for his business so he arranged that his friend would also bring products for my shop. After two months the shop picked up again.

In September 2004 he died. Since he was working, the company where he worked assisted in buying a coffin and gave us money to buy food. They also supported with transport. We did not sell any assets as everything was taken care of... In November [2004] we left for Mpika; the company where my husband worked transported us. Since I was alone, I wanted to stay with my family and in-laws as they could help me with the children. I left the shop to my sister to run it and she banks the money. With the benefit shares I was given by the company I built my own house... I am happy looking after my family without problems. I live with my niece. She assists in cleaning the house, washing plates, cooking food and looking after my children. I am the one who buys her clothes and she eats in my house... I still continue with my business of potatoes. I have increased the area from two hectare to three hectare so that I get more money. The relatives now cultivate potatoes, maize and millet for me and I support them by buying clothes for them... As the children have continued that Lusaka life and want tea, biscuits and a variety of food, I have acquired a plot to build a house for rent to earn extra money. This money can help my children, even in future if I die.

The above case provides an example of resilience to AIDS impact. Following Loevinsohn and Gillespie (2003), resilience to AIDS impact is seriously under-reported and thus innovative and resilient responses may not have come to light. In the case of

Emily, it's not innovation that contributed to her ability to respond. Emily's strengths are her economic independence, which she gained before her husband's illness, her available resources in terms of financial means, the good relationships with her family and relatives, and her capability to use those resources to overcome the impact and to invest. Emily is also receiving ARV treatment. In 2003, Zambia planned to have 100,000 people on ARV treatment at subsidised rate by the end of 2005, as part of the WHO and UNAIDS supported 'Three by Five' initiative, which aimed at providing ARVs to three million people in developing countries by the end of 2005. During the time of the interview, Emily would have to pay K 40,000 (USD 9) a month for the drugs and K30,000 (USD 6) a month for hospital fees for CD4 count tests, totalling an equivalent of USD 15 a month. This amount is too much for many of the poor in rural areas who live on less than one dollar a day and does not include the monthly transport for a round trip to the district or provincial hospital, which often is located far from their village. Also, the costs of buying sufficient and nutrient rich foods needed to tolerate the highly toxic drugs have to be added to this amount.

### ***Case 2: Janet***

Janet, the head of the household, comes from a patrilineal ethnic group, is 37 years old, and has no education. At a young age she got married to Joe, who worked as a game ranger in a National Park. She has three boys (18, 12 and 4 years) and three girls (16, 14 and 8 years). At the time her husband worked at the national park, Janet cultivated maize and reared chickens. She used to sell some of it at the local market to raise extra income. When Janet was 28 years, her husband joined the police and was transferred to another location. Janet did not join him but was sent to Joe's village to look after his sick mother. In his new position, Joe left Janet to marry another woman. He had taken all their belongings and until now does not provide any support to Janet and their children. With financial help from Joe's younger brother, Janet moved back to her grandmother's village in 2001 and rented a room. She started to cultivate cassava and sell groundnuts, bananas and roasted cassava along the roadside. She also started to go out with truck drivers for money in order to support her children. Her oldest child Felix, aged 18, became sick 17 months prior to the interview.

My son Felix, upon completing junior high school in 2002, was selected for senior high school. He stayed with his father's young brother. The wife of the uncle was mistreating him and thus he decided to stay with a girl who was working at a bar... He started complaining of chest pains in October [2003]. He was suffering from a cough; the cough made him thin and eventually he was diagnosed as having TB... Well, it's AIDS, I felt shy to mention it last time [first interview session], but I had him tested... I brought him back to Mpika. He stays with me and I am taking care of him, but when I run out of money then my other children look after their brother while I am away looking for money. I need quick money, so the easiest thing to do is prostitution. I know it's bad, but I use condoms and I tell them that its condoms or nothing and they obey. To me, this is the best way [to earn money]; it's fast and easy.

I did not receive any support, not even from my own relatives. My family has abandoned me because I have no money to give to them. The truth is, my relatives wanted my husband and me to sit and solve our problems. I totally refused. They told me Joe is also responsible for the children, and what I am doing, going out with men, is not a solution to solve the problems. I was angry and insulted them, and then they told me to solve my own problem. That is why they do not provide any support and why I am always on the road and at nightclubs to look for money. But I have some good neighbours. They help me when I am in need. They help me to look after Felix and my children when I am away and feed them as well as look after my house. In return, I buy sugar and salt for them and when possible give them some money. But when Felix is critically ill, I do not go away nor cultivate... I cultivate cassava, about a quarter of a hectare, which I can manage... Money is always scarce and we usually suffer a lot. This time, my two girls went to look for money at night in bars. They know if they do not look for money, then we will have nothing to eat and nothing to pay the school... They started after Felix's sickness, when I could not afford buying nice clothes for them. It is rather difficult to talk to them since they always point a finger at me. I know it is risky, but I have no option; I have to let them go and look for money... I cannot stop them since they bring money, pay for their school fees, and buy school requirements. Life continues; they will finish school and support me with their sick brother... Also, I get help from the Catholics because of Felix. I get food; some maize or rice once every three months. I also regularly get credit from the church and buy things to sell like ground nuts or cassava, and sell it, get money, return the credit, and buy what ever is required for the home. My son is also registered with the home-based care agents. Every month they bring him some soya beans powder, cooking oil and some ground nuts.

Janet's narrative illustrates a household with limited options to adjust to multiple livelihood shocks. In this case, Janet became *de jure* head of household after her husband deserted her and left her to look after their six children without any assets and financial means. Her situation is worsened when her oldest son becomes chronically ill with AIDS. Not only does her son's sickness entail high medical and time costs, he was also completing high school education and thus embodied the hope of a future source of financial support for his mother. In contrast to the previous case, Janet's way of responding to these shocks is limited by her resource endowment at the onset of the crisis. She has no strong social network on which she can lay claims. Janet is cut off from her extended family following a fight about her husband and her reliance on sex work to support her children. Her neighbours are her only source of social support. They help with looking after her children in return for some food and money. Furthermore, she has no valuable assets or savings she could cash in. As for many other poor women, economic vulnerability and lack of income earning opportunities lead to reliance on transactional sex as a strategy to sustain their families (Heise et al. 1995). Especially women who are left with dependent children and who are not supported by remittances have few other options to fall back on.



### *Case 3: Julia*

Julia is a 30 year-old widow who attained upper primary education. She got married to Paul when she was 15 years old. Julia and Paul are part of a patrilineal system with patrilocal residence, but they lived with Julia's mother for personal reasons. Julia has four children, three girls and a boy, now aged 13, 10, 8 and 5. When her husband was still alive, their livelihood depended mainly on cultivating cassava, millet, maize and vegetables. They sold cassava and vegetables at the local market and received bi-monthly remittances from Julia's brother, about K200,000 (USD 43)<sup>3</sup>. They also sold charcoal, local chickens and sometimes beer. Julia's husband was sick for about 22 months and Julia had been a widow for almost five years at the time of the interview.

In August 1998, my husband became sick; he was on and off... In February in 1999, he became worse; he had a terrible rash on his whole body and he was referred to the Kasama general hospital. He was diagnosed with TB and was put on treatment. After finishing the course he was sent home... In taking care of my husband during his sickness my family helped as well as the church members. They supplied us with food at the hospital and my relatives took care of the children. We cared for him for a long time: two years. When he was at the hospital, I used to care for him at night and during the day either a church member or a relative would assist with taking care of him... We had to buy medicines for him, so I sold a knitting kit. I also asked for assistance from family and friends; they assisted. My uncle sent me money for food after selling an animal; K300,000 [USD 64]. Aunt Joyce gave me K 50,000 [USD 11] and friends assisted me for two months with K100,000 [USD 21] per month.

In December 1999, my husband became seriously ill again and I was advised by people to try the Chilonga hospital... I sold an old bicycle frame so that I could have money to buy food during our stay in Chilonga hospital. I also used my savings to buy medicine and food for my husband, K50,000 [USD 11]. The community members and neighbours helped twice in that month to prepare the fields for the next season. I had to reduce the cropping area because of labour problems and as money had run out since taking care of a sick person is not that easy. Also, the sale of vegetables was affected, since there was no continuous supply to continue selling. My mother and the church members helped me to understand that life is not easy since my husband is sick, but that I have to be strong since I have children to look after... My husband was in Chilonga hospital for about four months... During the period my husband was seriously ill, the community used to supply me with cassava mealie since it was the only meal that my husband could eat... My children Patricia and John were doing piece works and they were being paid in money or in food. Their performance at school was affected as they were missing classes in order to finish the work. Their grades were bad. I also started to do casual work on other people's fields to earn money to buy food, as I could not manage to maintain the family with no money. I was spending a lot of money on the patient as he was demanding good food... We sold our chickens to send my cousin to inform my husband's relatives about his sickness. But none of my husband relatives came to my aid, and my brother who was assisting us [with remittances] could not continue as he got married and he could no longer afford it.



Finally, in June 2000 my husband died and the community assisted with the coffin. Relatives and church members assisted with food for the funeral and my uncle assisted with transport. I did not sell anything after his death... In September, the two older children were taken by the uncle; the elder brother of my husband. This has reduced my problems since I now only take care of Joy and Jean... The relatives of my husband came and got the little property we had: a mattress, a radio and a bicycle. I did not seek any legal advice since they had told me to go to their village as per custom. I refused; I do not like the village and I am at ease here, and staying with in-laws sometimes is a bother. I also wanted to stay with my mother's relatives as they assisted me by comforting me... After the death of my husband, I continued to cultivate cassava as it is less labour intense and no inputs are needed as compared to maize. I hired the church chore to help in the field and paid them with cassava. I sometimes brewed and sold beer, if I got millet... [Since January 2004], I am being helped by the Catholic organisation Tekela with food aid... Also, I am now a member of the farming committee; I joined in [July] 2004. I receive knowledge on vegetable growing and I receive credit... I also became a member of the women's club; they also gave me K100,000 [USD 21] credit in August 2004, to buy manure for my garden and to hire somebody to prepare a vegetable nursery for me...

The narrative of Julia illustrates how women with few resources struggle to avert negative effects and the disintegration of the household following illness and death of the spouse. In this case, the husband had been a registered HIV patient with the local health centre. He had been hospitalised twice for TB and had been sick for a total period of 22 months, thus laying a heavy burden on the household's already constrained resource-base. To manage the stress resulting from her husband's sickness and his death, she mobilised resources through a diverse portfolio of responses. During her husband's sickness, Julia disposed several assets, relied on her kin and friends for financial support, received assistance from community members with food and field preparation, and used her savings. In particular, her social network comprising the extended family and church members proofed a critical asset during her husband's sickness through which she could claim care support, food, childcare as well as much needed emotional support. Various authors have described different stages that households go through to adapt to livelihood shocks. All these broadly imply that, firstly, households place claims on their social network, diversify sources of income or use other reversible mechanisms to manage stress, secondly, households dispose of key assets, thereby undermining the sustainability of the household, and lastly, households dissolve (Corbett 1988; De Waal 1989; Webb et al. 1992; Seeley 1993; Maxwell & Frankenberger 1992; Donahue 1998). In reality, such trajectories are hard to detect. Often, households adopt a diverse range of responses that overlap, are repeated in time, mobilised simultaneously, and concentrated around major stressors such as hospitalisation (Wiegiers 2007). Moser (1998) points out the complexity in determining the sequence of response strategies because of the interrelationship between the different assets. For example, the uptake of some of the children by relatives to ease the financial and care burden on the widow can by the same token reduce the household labour force.

Julia's case illustrates how timing of livelihood stresses and additional shocks undermine a household's capability to respond to livelihood stress. Julia's husband was hospitalised twice: the first time coincided with the so-called hunger period, during which households normally have to make ends meet to purchase food; the second time he was admitted was at the start of the planting season, which resulted in reduced cultivation. Furthermore, the financial support from Julia's brother stopped at the time her husband was in hospital and farm inputs had to be bought.

In Julia's narrative, the year 2004 (three-and-a-half years after her husband's death) is a turning point. Early that year, she benefited from social protection support of a local faith-based organisation. This organisation is part of the Catholic Church in the Northern Province and supports orphans in several communities in the province since early 2003. To each household with orphans that is registered with the faith-based organisation, 20 kg of locally bought maize or rice is provided monthly to supplement the household's own production. In addition, some clothing is given to the children and school fees are paid. Prior to this support, Julia's way of responding to AIDS was mainly aimed at short-term survival. She had moved further into poverty, as she no longer had access to the income she used to earn through selling vegetables and because all her assets were either sold or taken by her relatives. In Julia's case, the assistance she received from the faith-based organisation helped to bridge the households' food and money gap and enabled her to start rebuilding her livelihood. Six months after benefiting from social protection, she joined the local farming committee and women's club, which assisted her to restart her vegetable business through loans and technical support. In Zambia, the civil society is the main provider of social protection for households with orphans, mainly in the form food, money for school fees, clothes and blankets, as the government's social safety net system for vulnerable households is limited and declining in real terms over the last years (PRSP 2002). While in Julia's case, this form of safety net support has helped her to start rebuilding her livelihood, it also may create long-term dependence. Therefore, Devereux and Sabates-Wheeler (2004) argue for a comprehensive social protection programme that should also include interventions that support livelihoods, protect and build assets, and minimise the risk of dependence on external support.

#### *Case 4: Jane*

The head of the household, Jane, is 30 years old, poor, and is a member of a matrilineal family. She attained upper primary education and got married at the age of 16. Her family disapproved of the marriage. She has two children: a girl aged 12 and a boy of 9. She gave birth to two other children, who both died in infancy. When her last-born died, her husband decided to marry a second wife to have more children. Her husband moved to his second wife's house but continued to cultivate food crops with Jane on their field. They cultivated millet, cassava, maize and potatoes. Jane further burned charcoal, raised chickens, sold potatoes and did casual work on other people's fields. Jane is the vice-chairperson of the local cooperative, from which she purchased improved inputs at subsidised rates. She is also an active member of the

local women's club. Her husband had been sick for 12 months and died around the time of the interview.

My husband was sick; he would complain of body pains. Sometimes he could not even wake up. He developed a loss of appetite and started losing weight due to continuous diarrhoea. His skin looked pale and shiny with scrubs like fish. I cared for him about 40 percent of my time; well it is rather difficult to estimate since he was not staying with me, I was not looking after him the whole time. The other woman was mostly taking care of him since that is where he was staying when he got sick. When my husband was with that woman, I did not assist her because it was her duty to look after him whilst there. She used to look after him and look for food for the patient and the children. I only used to go there sometimes, when he was very sick. At those times, I could not go to the fields... To compensate for this loss, I started to go to the market... I sold sweet potatoes or ground nuts at the market once a week... To buy some food and medicines for my husband, I sold a mattress... I got a loan from the women's club to buy medicine for him... I still grew crops like cassava, millet, maize and beans but I had reduced. I decided to cultivate these because most of them do not need fertiliser. I cannot afford to buy fertiliser on my own. I just cultivate enough for food but this food will not be enough to see us through as I have no husband to do *chitemene* [slash-and-burn], and the labourers I hire will come after doing their own *chitemene* [slash-and-burn] and this delays my planting and affects the yields... I sold a nice cupboard to buy more medicines for my husband... I and the other woman were alternating the responsibility for buying medicines for our husband... She had more things than me, but she never sold anything. She had her relatives who supported her with buying food and medicines for him. My family did not support me because they did not approve of my marriage, as the man is 20 years older than me and his history is not known in our society. Marriage means all in my family and the argument has been why it took him so long to marry. Since he is sick, they are telling me that these are the issues they have been warning me about. I agree with them but I was already in the marriage, so I better stayed...

He died the 3rd of January 2005... After his death, the other wife's relatives assisted with the coffin and transport on the day of burial. My fellow club members assisted me with money and food... After his death, I sold a radio to pay back the loan I got from the club for buying the medicine. The radio was the only valuable asset I had left that I could sell... Now my family receives support from the Catholic Church and my children go to school; the church takes care of all their school requirements. And they assist with inputs; this is how I managed to cultivate maize this year... I also started baking scones, which I learned at the [women's] club to get some extra income. I sell them at schools nearby. I also sell roasted cassava on the street nearby the school. From this I get money to buy some food for my home as well as salt, soap and kerosene...

Now in times of difficulties I brew and sell beer, and sometimes, when I visit the beer hall, men friends assist me with money. In return I go out with them as it is tough to rely only on the small income activities. I have to care for my household. I only go to the beer hall monthly since that is when people have money. So I go at the end of the month and of course we have fun and sex.

The narrative of Jane accounts the ability to respond to AIDS impacts in a polygamous setting. In the case of Jane, the two co-wives experience the impact of the husband's sickness differently. Since the husband is residing with the second wife, she bears most of the burden in caring for the husband. She was responsible for feeding, cleaning up, washing and assisting the patient in the bathroom. While she took care of her husband, the extended family provided support to the second wife with nursing, caring for the two small children, work in the field, food and money. Though Jane would only go to her husband and abandon her fields at times when he was bedridden, she experienced a loss of income as her husband could no longer assist her in the field. She could not rely on her own family to overcome the labour shortages following their arguments over her marriage. As a result, she reduced the area under cultivation and started petty trade to earn income. The loss of her husband's labour contribution is especially impacting Jane's cultivation of food crops. For many households like Jane's that cannot or no longer afford to purchase fertiliser, *chitemene* (slash-and-burn) becomes important for safe-guarding the household's food security. *Chitemene* fields are located far from the homestead and normally used for three to four years, after which a new field is opened up. The clearing of a new field is labour-intensive and involves cutting down trees, chopping the branches, heaping the branches across the field and burning them to provide potash for crops – all tasks normally carried out by men. Female household heads like Jane who, with no presence of adult male members, continue *chitemene* cultivation normally hire male labourers in exchange for beer. However, as Jane indicated, labourers only come after finishing their own fields, which delays the planting.

### **The role of social capital in enhancing resilience**

For the cases presented in this article, social capital is central to their capacity to respond to AIDS. It includes the social networks and local organisations people can call upon, the contributions to these groups and networks, and shared norms of reciprocity and trust that underlie these support networks. Several researchers have highlighted social capital as an important means to cushion livelihood shocks (Seeley 1993; Moser 1996; Sauerborn et al. 1996). According to Cater and May (1997), households employ a range of claims using various distinctive claiming systems, including kinship, friends, the community, the church, faith-based organisations and local community-based organisations. In the presented cases, reciprocity support from kinship was the most important claiming system and involved mainly care and labour assistance. Social capital is a particularly important asset for relieving the burden of caring for people with AIDS. For many poor, the responsibility of caring for the sick falls primarily within the domain of the households and close relatives, and is based on respect and reciprocity (Radstake 2000). This ethics of care in which the household and close relatives are the prime carers of AIDS patients has intensified over the last years due to increasing market forces that have resulted in high user fees for medical care (Baylies 2002a). Caring for the most vulnerable members is a function of the

overall resource allocation and management responsibilities of households and can only be provided if households and the caregivers have adequate caring capacity and recognise the common benefit of care (Niehof 2004a). In the context of AIDS, this is no longer the situation. Members who are bedridden because of AIDS are not able to contribute to the household like they used to do nor can they provide care to others. Moreover, AIDS poses such a heavy burden that many households with sick members do not have the capacity to provide the care that is needed. The care burden on women and other relatives can be somewhat relieved through home-based care support where volunteers, usually predominantly female, assist the affected household with nurturing the patient, advice and counsel, nutritious foods as well as with domestic and productive activities. This community-based care for AIDS patients is often entirely based on community volunteers and thus can only be sustained if the community's resource base is not eroded by the AIDS epidemic (Niehof 2004b).

While reciprocal relationships are a crucial safety net for households in stress and play an important role in increasing resilience (Moser 1998; Mutangadura et al. 1999), it cannot be taken for granted. In reality, social support networks have their limits and should be seen as "safety nets with holes" (Seeley 1993, quoted in Baylies 2002b: 662). Not all households have access to strong networks as they lack the resource base to build up and sustain the network. The extent to which households can cash in claims largely depends on their capacity to build up social capital. Emily's (Case 1) access to strong kinship support is the result of her ability to provide financial assistance to her extended family. The strength of social networks also depends on the overall resource base of those involved and one's place in the network (Baylies 2002b). The strength of social networks is, however, not only a function of assets, but also of family ties (Wiegiers 2007). Disagreements over marriage for example (Cases 2 and 4) can exclude people from their social network. Furthermore, social network support is influenced by the kinship system. Women in matrilocal ethnic groups seem to receive more assistance from their family when faced with chronic illnesses than women in patrilocal systems (Shah et al. 2001). On the other hand, patrilineal societies seem to provide more support to widows compared to matrilineal systems in terms of sharing the burden of childcare. The support to widows in patrilineal groups has, however, to be balanced against the lack of entitlements, widows having to leave their husband's compound upon widowhood, and the risk of property taken by in-laws (Wiegiers 2007). Further detailed research is required to look into the role of kinship system in increasing resilience to AIDS impacts. In addition to the strength of social networks, duration of the support provided is important. While the support Emily (Case 1) receives from her network continues after the death of the husband, for many other women kinship support ceases after the funeral, as they are no longer able to invest in their reciprocal relationships or because the provider can or will no longer do so.

Household's resilience can be improved if they function in a supportive environment that forms a buffer against outside threats as well as provides opportunities to improve coping (Moser 1998). In the absence of state-sponsored welfare programmes, the community, local church and non-governmental form the support environment of many rural households affected by AIDS. In northern Zambia, support provided by

the community is centred on post-harvest food contributions to the most vulnerable and funeral assistance in the form of food, bicycle transport, and childcare. Among the cases, the faith-based organisation and church operating in the communities play an important livelihood-support role by providing food rations and schooling support for orphans. As is illustrated by the case of Julia (Case 3), this safety net helps to close the food and money gap and rebuild livelihood, but can also create long-term dependency on external aid. Also, the local women's clubs are of importance to women's ability to respond to AIDS as members assist each other with food, income-generating activities and small informal loans, as well as emotionally. A third of all the case studies became member of the women's club after the death of their spouse or adult child. Being part of a community-based organisation does not only enhance available resources to widows, it also reduces emotional stress by providing a channel to communicate about the problems and it lessens the isolation and stigma associated with the disease.

Moser (1998) mentions that a community can be regarded an asset that households utilise to offset or manage a livelihood risk, depending on the extent of social capital present within the community. To measure the extent of social capital, she suggests using the number of community-based organisations. While this indicator might give some indication on the community social capital stock, it does not provide insight into whether the support provided is appropriate nor whether it is equitable. Communities are not a unified actor, and although based on values of solidarity and reciprocity, there may also be inequalities in accessing community support (Niehof 2004a). Sauerborn et al. (1996) found that poor households had less access to community support than the better-off ones. Baylies (2002b) mentions that factors such as wealth status and whether you are an in- or outsider contribute to the likelihood of receiving community support. She further mentions that the prevailing power structures within a community may prevent that those impacted by AIDS receive the assistance they need. Thus, one might question the wisdom of supporting community organisations and building upon what already exists when designing AIDS programmes. In recent years, community support has come under strain due to AIDS, poverty and individualisation of society and while in the past, the community provided a stronger safety net, it is now the immediate family that bears most of the burden.

## Conclusions

This paper has explored the concept of resilience in the context of AIDS through the use of case studies. There has been disagreement in the AIDS literature whether resilience is deceptive as often household responses to AIDS impact are more efforts to survive in the very short-term and because households might seem to be resilient in the short-term but this is often at the expense of asset depletion (Swift 1989, Rugalema 1999, Barnett & Whiteside 2002). This article emphasises that while AIDS has negative impacts on the livelihoods of many households, not all affected households experience a similar loss of livelihood security. Equally, not all female-headed households are vulnerable to AIDS impacts, despite their general disadvantage in terms of



entitlements and capabilities, limited access to assets and resources, and heavy work burdens. Some manage to avoid the worst impacts of AIDS on their livelihoods or rebuild their lives faster than normal (Case 1). Some manage to overcome the worst impacts and are able to start rebuilding their livelihood after the spouse's death, however often at expense of dependence on external support (Case 3). Others (Cases 2 and 4) are not able to withstand the stress and resort to transactional sex. Similarly, households that manage to avoid the worst impacts are not necessarily less vulnerable. For example, grandmother-headed households that are doing relatively well after AIDS entered their household owing to the financial support of their off-spring will collapse once the financial support stops, as they have nothing to fall back on.

Looking at the cases, resilience to AIDS-related adversity is neither deceptive nor a reality as it comes with a price in terms of losing assets, heavy reliance on social network, and long-term dependence on external aid. Also, the judgement on whether a household is able to withstand or adapt to AIDS is subjective and depends to a large extent on what proxy indicators are used to measure resilience to AIDS impacts. It further depends on at what time these measurements are made. AIDS has prolonged effects on people's livelihoods and triggers a dynamic process of household responses. Because of its long-term character, it can take years for households to be able to rebuild their livelihoods, as is shown in Case 3. What is particularly important is to understand why certain households are better able to respond than others. Understanding differences in resilience to AIDS impacts exposes factors that underlie people's ability or inability to respond to livelihood shocks and as such has important policy and programme implications. These must be sensitive to differentiation of households and challenge the inequalities that drive AIDS vulnerability. The differences among households in their ability to respond also cautions against blueprint mitigation interventions, as one solution will not fit all the differing needs of affected households. Cases presented in this article showed that household heads differed in their ability to respond to AIDS as a result of their differences in access to endowments and entitlements and capabilities to use these to mobilise resources. Several interrelated factors contributed to resilience, including: a strong resource base and economic independence at the onset of a livelihood crisis, access to strong social support network, access to social protection, access to ARV treatment, and medical insurance through the workplace. In particular, a strong social network is central to the ability to mobilise resources, as is the access to social protection support from faith-based organisations in the form of monthly food rations and school fees. Furthermore, the cases show that the capability to respond is also influenced by marriage systems. In polygamous marriages, the care of the spouse and related medical and food expenses is shared, although likely unequally. The cases also show that while the female heads of households were trying to adapt to a new situation by making use of other livelihood options they are restrained by skills and lack of financial services. Consequently, they diversified into low-profit economic activities such as beer brewing and selling foodstuffs along the roadside or relied on transactional sex.

Finally, this article looked at resilience from a material side and did not address the emotional dimension of resilience. The cases, however, make clear that resilience



is a concept that is neither fully material nor just emotional. The ability to mobilise resources and adapt to new circumstances is not just the outcome of an individual's access to assets but immaterial aspects play a role as well, such as emotional flexibility and the personality of individuals. Strong characters might be able to access more resources or be more inventive in their way of responding to stress and shocks. Further, the ability to accept the situation and manage the emotional stress caused by AIDS and the stigma, discrimination and blaming associated with the disease contribute to the ability to respond to AIDS-related adversities. To better understand resilience in the context of AIDS would thus require a more integrated approach.

## Notes

Esther S. Wiegiers (esther.gerardo@tiscali.nl) has a PhD in Social Science from Wageningen University. Over the past twelve years she has worked as an independent consultant in the areas of rural livelihoods, gender, HIV/AIDS, Avian Influenza and issues of risk management and coping responses.

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- 1 All names used in this article are pseudonyms.
- 2 At the time of the interview (2005), Emily had been widowed for eight months.
- 3 1 USD = 4,660 Kwacha (29/04/05)

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