

Mobilizing Social Capital in a World with AIDS

Report and Recommendations

30 March 2009 – 1 April 2009 | Schloss Leopoldskron | Salzburg, Austria

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Catherine Campbell is a professor of Social Psychology, Director of the Master of Science in Health, Community and Development and Director of the MPhil/PhD Program at the London School of Economics. She presented in Panel I on key issues concerning social capital and HIV/AIDS and in Panel IV on the possibilities and challenges for strengthening community responses to AIDS.

Alexis Close is pursuing a graduate degree in International Development and Social Change at Clark University. She was a program assistant for the workshop.

Brandon Cohen is currently a Social Change Fellow completing a graduate degree in International Development and Social Change at Clark University. He was a program assistant for the workshop.

Usa Duongsaa is a lecturer at the Faculty of Education, Chiang Mai University, and coordinator of the AIDS Education Programme (AEP) in Thailand and serves as a Board member for the Asian HIV/AIDS Reduction Foundation. She was a discussant on Panel I.

William F. Fisher is the Director of International Development, Community, and Environment at Clark University, Professor of International Development and Social Change, and Research Professor at the George Perkins Marsh Institute in Massachusetts. He is co-convenor of the aids2031 Social Drivers Working group. He was a co-convenor of the workshop and served as a moderator for Panel IV and a plenary session.

Eduard Grebe is a researcher in the University of Cape Town's AIDS and Society Research Unit and where he is currently enrolled in the Masters of Commerce program. He presented during Panel III on the emergence of effective AIDS-response coalitions.

Geeta Rao Gupta is the president of the International Center for Research on Women (ICRW), a position she has held since 1997. With extensive experience in the field of women and HIV/AIDS, she is an expert on issues related to AIDS prevention and women's vulnerability to HIV. She is co-convenor of the aids2031 Social Drivers Working Group. She presented "Reflections on Day One" to launch the second day's discussions.

Mike Isbell is an independent consultant specializing in public health policy, strategic advocacy planning, and health-related communications and is a senior advisor for the aids2031 project.

Daniel Kim is a Research Associate in the Department of Society, Human Development, and Health at the Harvard School of Public Health. He presented during Panel I on findings derived from a systematic review of empirical studies linking social capital to physical health outcomes.

Sudirman Nasir is a lecturer and researcher in the Faculty of Public Health, Hasanuddin University in Makassar, Indonesia, is also currently a PhD candidate at the School of Population Health at the University of Melbourne, Australia. He presented during Panel II on culture, local constructions of masculinity and HIV-risk practices among young male intravenous drug users (IDU) in a slum area in Makassar, Indonesia.

Cheikh Niang is a Professor of Social Anthropology and Research Methods at Cheikh Anta Diop University, Dakar, Senegal, is coordinator of the West African Office of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) Program in Partnership with the Human Science Research Council, South Africa and the Tropical Institute of Community Health, Kenya. He presented during Panel I and was a discussant on Panel II.

Willis Odek is a scholar/practitioner with ten years experience in HIV/AIDS livelihoods and health research and programming, and has an MS in Demography and Health from the University of London. He is presently a PhD candidate at the University of Aberdeen, UK. He presented during Panel IV on the effects of micro-enterprise services on HIV-risk behavior among female sex workers in Kenya's urban slums.

Jeffrey O'Malley is Director of the HIV/AIDS Group in the United Nations Development Programme's Bureau for Development Policy. He has 25 years experience in public health and development, including almost 20 years of international leadership on HIV/AIDS. He was the moderator for Panel III.

Paul Pronyk is an infectious disease/public health physician from South Africa and the Research Director and HIV/AIDS Technical Advisor for the Millennium Villages Project (MVP)—a partnership between the Earth Institute, Columbia University and the United Nations Development Program. He was a discussant for Panel III.

Rachel Sullivan Robinson is an Assistant Professor in the School of International Service at American University in Washington, D.C. She presented during Panel III on the distribution and impacts of HIV/AIDS NGOs in Sub-Saharan Africa.

Fiona Samuels is a Research Fellow in the Poverty and Public Policy Group at the Overseas Development Institute (ODI), holds a PhD in Social Anthropology from the University of Sussex and has more than 15 years experience in the fields of rural development and public health. She presented during Panel IV on the role of social capital in preventing the spread of HIV in Andhra Pradesh, India.

Abhay Shukla is a physician and a public health specialist focusing on primary health care issues, health rights, and community action and advocacy. He currently serves as the Senior Programme Coordinator of SATHI-CEHAT, an organization in Maharashtra, India devoted to training and advocacy on health rights. He was a discussant for Panel I.

Morten Skovdal is the Founder and Managing Director of World Voices Positive (WVP) Kenya, an NGO operating in Western Kenya providing support to over 750 orphans and their communities. Currently he is pursuing a PhD at the London School of Economics. He presented during Panel IV on the role of social capital in strengthening the resilience of orphans and vulnerable children in western Kenya.

Lucy Stackpool-Moore is the HIV Officer for Stigma with the International Planned Parenthood Federation (IPPF) Central Office in London, where she oversees multi-country research and advocacy about HIV and human rights at international, regional and national levels. She presented during Panel II on *The People Living with HIV Stigma Index*, a tool for building the capacities of people living with HIV and for informing policy and practice to address HIV stigma and discrimination.

Barbara Thomas-Slayer is a Research Professor in the Department of International Development, Community and Environment at Clark University, where she focuses on participatory approaches to development, the changing roles of community institutions and organizations, and rural livelihoods. She was a co-convenor of the workshop and the moderator for Panel I and a plenary session.

Michael Woolcock is Professor of Social Science and Development Policy, and Research Director of the Brooks World Poverty Institute at the University of Manchester. On leave from the Development Research Group at the World Bank, he is co-founder of the World Bank's Justice for the Poor program and has written extensively on the application of social capital theory to development research and practice. He presented during Panel I on the definitions and uses of social capital.

Two invited participants who were, unfortunately, unable to attend at the last minute are **Roberts Kabeba Muriisa**, Head of the Department, Acting Dean, and Lecturer in the Faculty of Development Studies, Mbarara University of Science and Technology, Uganda, who carries out research on social capital and the role of NGOs in alleviating the impact of HIV/AIDS; and **Lambert Wesler**, a Haitian physician, who has been associated with Partners in Health in Haiti for 13 years with the Haitian Ministry of Health for 7 years.

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I. Executive Summary

The aids2031 initiative is a consortium of partners who are examining what the international community has learned about the AIDS response, what we have done effectively, and what we should and can do differently now to change the face of the pandemic in 2031, 50 years after the HIV virus was first identified. Among the institutions involved in aids2031 are UNAIDS, the International Center for Research on Women (ICRW), Imperial College of the United Kingdom, Brookings Institute, Communications for Social Change, the Nelson Mandela Foundation, the Gates Foundation, and Clark University, host of the coordinating unit.

In March 2009, aids2031 and Clark University hosted a workshop for 23 invited scholars and practitioners to examine the specific social drivers related to the terms “social capital,” “culture,” and “religion” that are shaping the nature, locale, and momentum of the HIV/AIDS pandemic. Participants from 12 different countries, representing a wide variety of disciplines with a great variety of experience, shared insights, expertise, research findings, and analysis in relation to social capital and HIV/AIDS. Twelve papers presented in four different panels served as the basis for discussions that ranged widely over the three days. Papers provided 1) broad conceptualization of HIV/AIDS, examining the key issues in linking social capital, health and HIV/AIDS; 2) examination of the ways in which culture and religion shape and are shaped by the AIDS pandemic; 3) assessment of new political configurations that can enhance capabilities for coping with HIV and AIDS; and 4) analysis of specific actions, programs and policies that can address the prevention or treatment of HIV and AIDS.

Discussions in small groups and in plenary sessions covered a wide range of topics raised in the panels. Critical themes that emerged from the workshop and demand both action and further exploration are: 1) To engage social capital as researchers and as practitioners in ways that enable us to provide evidence regarding its effectiveness in reducing HIV vulnerability and its potential as a useful metric to help us understand and strengthen HIV/AIDS interventions. 2) To recognize the power hierarchies that shape the HIV/AIDS agenda and to find new strategies for addressing those hierarchies through such approaches as building effective AIDS-response coalitions or developing community health care monitoring systems; 3) to address the conceptual and practical dilemma of “AIDS exceptionalism” versus “Whole Health Systems”; and 4) To provide the rationale for a new research paradigm that incorporates rigorous social science data to complement biomedical research that is based on randomized controlled trials. These themes call for new strategic approaches for interventions that will effectively decrease vulnerabilities and create AIDS-resilient communities and health enabling environments.

Based upon the presentations and discussion at the workshop, we make the following eight recommendations:

1. Re-conceptualize the HIV/AIDS problem.
2. Focus on the community as well as the individual.
3. Focus on upstream vulnerabilities and the ways to strengthen social capital to address them.
4. Create and strengthen AIDS-response coalitions and strategic alliances at international, national, regional, and local levels.
5. Transform power relations in order to shift resources to poor and marginalized people.
6. Work at multiple levels to develop new strategic approaches to HIV and AIDS interventions.
7. Create capacities for sustained leadership.
8. Use social capital as an indicator for understanding vulnerability, and as a metric for understanding and strengthening HIV/AIDS interventions.

Perhaps Geeta Rao Gupta summarized the essence of the workshop most effectively in the reflections she presented on the second day of the conference. She indicated that key challenges exist, such as sustaining leadership or facilitating social capital in the face of traditional collectivities with strong and inequitable hierarchies. Large issues remain: for example, AIDS exceptionalism or creating accountability. Social capital is both a resource and an outcome, and it is only one ingredient in any complex socio-economic situation. Those of us in attendance at the workshop benefited from two concepts put forward by participants. The first, *nit nittay garabam*, a Wolof phrase, reminds us that people are the best medicine. The second is *ubuntu*: Loosely translated, it means, "I am because we are." Health and well-being come directly from social connections. Both concepts touched all of us in our endeavor to reflect clearly and imaginatively on mobilizing social capital in a world with AIDS.

■ II. Background

From March 29 to April 1, 2009, aids2031 and Clark University hosted a small workshop for invited scholars and practitioners to examine how factors like social capital, culture and religion are shaping and are shaped by the nature, locale, and momentum of the HIV and AIDS pandemic. Social capital has been widely acknowledged and discussed among researchers and policymakers alike. Recently, however, critiques have highlighted the need to re-conceptualize our understanding of social capital and to emphasize its potentially empowering aspects for improving the quality of life for marginalized groups. Members of the Social Drivers Group who sponsored the workshop hoped that it would help identify a conceptual approach to social capital, culture and religion that would be relevant to policies and programs addressing AIDS in the context of the turbulence, instabilities, and environments of risk shaping the lives of individuals and groups in marginalized communities.

The goal of the workshop was to elicit innovative thinking and break new ground for ways to address complex social and political obstacles to the successful prevention of HIV and AIDS. Its specific purpose was to examine existing data and analyses in order to develop recommendations for a long-term sustainable response to AIDS that addresses the social, political, and economic factors shaping risk and vulnerability. Invited participants had the opportunity to contribute to cutting-edge analyses of the ways in which cultural attitudes and practices, religious beliefs and institutions, and diverse forms of social capital have affected and will affect the pathways taken by AIDS in various parts of the world.

In order to convene this conference, the Social Drivers Working Group of aids2031 and Clark University circulated a call for abstracts in September 2008. A panel of working group members reviewed the responses, selected approximately 15 abstracts that were highly relevant and innovative on the topic of AIDS in relation to social capital, culture and religion, and invited the authors to submit papers for presentation at the workshop. The working group panel reviewed the papers and organized them by themes into four panels, with three to four people comprising each workshop panel. In addition to the paper presenters, the workshop included HIV/AIDS activists and organizational professionals, making a total of 25 invited participants. Each panel had a moderator from among the other participants, as well as one or two discussants to analyze the themes raised during the course of the panel.

■ **III. Summary of Panel Sessions and Issues Presented at the Workshop**

The workshop was divided into panel presentations and response sessions, followed by breakout groups and plenary sessions. Panel presentations and responses dominated the first day, as well as half of the second day. The later part of the workshop was loosely structured around small group discussions that then reported back to the plenary session for a broad discussion of the issues arising. Following is a summary of the panel presentations.

≡ **Panel I: *What are the key issues linking social capital, health, and HIV/AIDS?***

Barbara Thomas-Slayter moderated this panel; Presenters included Michael Woolcock, Cheikh Niang, Daniel Kim and Catherine Campbell; the discussants were Abhay Shukla and Usa Duongsa. Woolcock began with a discussion of social capital, arguing that social capital is an “essentially contested term,” wherein finding an explicit definition is less important than how the term is applied. Social capital is customarily analyzed in terms of bridging and bonding, that is, social capital within and between groups of people. Woolcock discussed a third term, “linking social capital,” which connects groups of people across power hierarchies.

Cheikh Niang raised a series of compelling questions for consideration by the workshop participants. Niang wanted those present to analyze the discourse that was controlling the way most researchers and practitioners conceptualize the problem of HIV/AIDS. Niang asked if we should take a Western or a non-Western approach to the HIV/AIDS pandemic and asked whose definition of health would be the basis of our approach. He urged that we regard “health” not as a medical product, but rather as a human one, and noted that we should broaden our understanding of health to include social capital.

Daniel Kim gave a presentation on the different kinds of research that had been carried out regarding health and social capital. Most of the research so far has concentrated on general health outcomes rather than specific disease outcomes, and only a few studies actually examined the connections between social capital and HIV/AIDS. Societies that are more egalitarian show the weakest links between health outcomes and social capital. This may be because social safety nets are already in place for the given population.

Finally, Catherine Campbell presented on conceptualizing social capital as both an integral part of and a means of creating “AIDS-resilient communities.” Five features that AIDS-resilient communities have are:

- the knowledge and skills to prevent the disease and a means of translating this information into action in their own lives;
- social spaces for dialogue and critical thinking, so that people can collectively renegotiate individual and social norms that negatively impact the health and well-being of the community;
- a sense of agency, ownership and responsibility about the response to the epidemic;
- a sense of solidarity and common purpose that allows people to work together despite potentially competing interests and to tackle the problem collectively;
- access to bridging social capital that allows people the ability to connect with and access resources from outside communities or organizations that can support them in their efforts against the epidemic.

In response to the panelists, the first discussant, Abhay Shukla, cautioned that social capital is but one part of a complex social-economic-political system. It is not a magic bullet, but one factor among many that must be considered when we discuss the HIV/AIDS epidemic. Shukla argued that we must do more to confront and overturn power hierarchies. Linking social capital, unlike bonding or bridging, does deal with power, but in a non-confrontational way that does not transform power hierarchies. Social capital is about being able to access resources through formal and informal networks while social change may involve a radical transformation and redistribution of networks and resources. Shukla also cautioned that mobilizing social capital may require the creation of new collectives because traditional ones can be inequitable. In fact, social capital can have negative impacts. For example, in India the caste system creates very strong bonding social capital. It provides support to members, but prevents bridging across groups. New collectives need to be created that use the traditional spirit but are based fundamentally on empowerment and equity. Finally, these new collectives and organizations should combine issues like improving health with radical social, economic and political change. Public health systems are most often top-down systems managed and financed by national and state governments. He urged that communities should use social capital to fight for ownership, whereby the system and its agenda become accountable to the community.

The second discussant, Usa Duongsaa, emphasized the strengths of local communities. She argued that HIV/AIDS experts should facilitate rather than directly control policy and planning. Building the capacity of a community to mobilize people and resources around the epidemic may take some outside help. Development workers come into communities with good intentions, but they often treat community members as inferior and as people who have problems, rather than as holistic human beings with strengths as well as weaknesses or needs. Such attitudes can destroy the self-esteem of people and may prevent them from being able to help themselves. The ways in which outsiders and experts respond to HIV/AIDS may be more difficult to change than local community responses. We need to see HIV/AIDS as one problem among many, in order to help communities identify the links among various issues, and to facilitate the mobilization of people and ideas.

Panel II: *How are factors like social capital, culture, and religion shaping and being shaped by the AIDS pandemic?*

The second panel session, moderated by Judith Auerbach, addressed the question: “How are factors like social capital, culture, and religion shaping and being shaped by the AIDS pandemic?” In the first presentation, Constance Ambasa-Shisanya discussed how culture can be a double-edged sword in that it can help or hinder the adoption of HIV prevention practices. Many people (68 percent) in her study of the Luo in Kenya’s Nyanza Province were aware that certain cultural practices, like polygamy, predispose women and girls to HIV infection, and that marriage can be a risk factor. Ambasa-Shisanya also noted that culture influences which prevention methodologies are more acceptable than others. For instance, within the communities Ambasa-Shisanya researched, condoms were more acceptable than faithfulness as a method for prevention of HIV. However, the use of condoms is a male-controlled practice and the introduction of condoms into a sexual relationship can be interpreted as distrust and thus may lead to violence. She did find that membership in HIV/AIDS widow-support groups was associated with increased uptake of prevention practices. In sum, Ambasa-Shisanya focused on ways that interventions to prevent HIV transmission can be designed so that they are appropriate to local cultural values, channels of communications and patterns of learning.

The second panelist, Sudirman Nasir, discussed culture, local constructs of masculinity and HIV-risk practices among young male Intravenous Drug Users (IDUs) in a slum setting in Indonesia. Nasir’s research reveals that HIV risk is the result of the interplay of complex social, economic, and political factors, including underemployment, boredom, the search for respect, survival and constructs of masculinity, among other factors. In the setting of his study, the young men were interested in having a sense of belonging and in being respected by their social group, as well as in sharing the benefits of group membership. They were not as concerned or worried about becoming infected with HIV. These groups or gangs represent social capital, but the concerns that gang members hold paramount can have negative health impacts. Nasir argued that rather than focusing on individual risk reduction, interventions should be community based and should impact the structural factors that create vulnerability and risk.

The final panelist of the session, Lucy Stackpool-Moore, discussed her involvement in *The People Living with HIV Stigma Index* project, research that resulted from a partnership between the International Planned Parenthood Federation, two networks of people living with HIV, and the Joint United Nations Programme on HIV/AIDS. Research findings and follow-up case studies are being used to advocate for evidence-based policy and practice that is grounded in the real experiences and perspectives of people living with HIV. To date, 128 people have been trained in seven regional workshops conducted in 2008-2009 and involving more than 90 organizations in 69 countries. The project explores how the process of measuring HIV-related stigma and discrimination—a research and advocacy initiative that builds the capacity of people living with HIV to drive the research—can catalyze the realization of human rights and can generate momentum for change for the individual as well as for the wider environment.

As a discussant, Cheikh Niang first talked about culture and attitudes in Senegal that led to recent homophobic violence and the incarceration of several men accused of violating a state law forbidding homosexuality. He then discussed cross-cultural interpretations of important concepts related to HIV/AIDS, drawing on notions of stigma from Stackpool-Moore, notions of community from Nasir, and gendered constructions of sexual behavior from Ambasa-Shisanya. Social change can come about over time by adapting new concepts so that they can be understood and used with customary or traditional symbols or practices, modifying them in the process.



Panel III: Are there new political configurations that can enhance ways of coping with HIV and AIDS?

Jeffrey O'Malley, the moderator, opened Panel III by reminding us of the complexities of institutional efforts to enhance coping capabilities. The first panelist, Eduard Grebe, focused on "AIDS-Response Coalitions" and the mobilization of AIDS leadership. He discussed the factors that cause coalitions to emerge and whether or not AIDS-response coalitions can be facilitated by outsiders. He asked, "Under what conditions and by which processes do effective AIDS-response coalitions emerge?" In addition, Grebe inquired about the nature of the leadership required to mobilize successful AIDS-response coalitions, ones that combine strategic alliances with a sense of solidarity and common purpose. He drew on the experience of two well-known AIDS organizations, The AIDS Support Organization (TASO) from Uganda and the Treatment Action Campaign (TAC) from South Africa. Both had charismatic leaders, but they arose out of very different structural and institutional factors that shaped the approaches of each organization. Grebe argued that coalitions arise from pre-existing networks and relationships of trust. Coalitions are dependent on funding, and donors are thus an important part of the equation. Grebe pointed out that donor politics can broker or inhibit successful AIDS-response coalitions. In sum, he explored the ways these organizations go about resolving the complex collective action problems of coalition-building for policy formulation and implementation.

The second panelist of the third session, Rachel Sullivan Robinson, discussed the differential distribution of HIV/AIDS-related organizations in Sub-Saharan Africa. Some countries appear organizationally "rich" and Robinson's research studied why this occurs and what impact NGOs appear to have on the epidemic. Her data suggest that the number of HIV/AIDS-related NGOs in Sub-Saharan Africa has increased in direct relation to increases in the amount of foreign funding available in a given country. Countries with more NGOs that target HIV/AIDS and that have had these organizations for longer periods of time experienced greater declines in HIV prevalence between 2001 and 2007. Robinson also discussed how the whims of donors had a huge impact on the sustainability of NGOs. She cautioned that NGOs are, like other small businesses, prone to failure and are not automatically representative of the needs and concerns of civil society. Despite the apparent dependence of HIV/AIDS-oriented NGOs on the presence of foreign funding, Robinson's data suggest that these NGOs do have beneficial impacts on mitigating the HIV epidemic in Africa.

The first discussant, Paul Pronyk, recognized the importance of measurement, as noted by Robinson, but stressed the difficulties of handling complexity and dealing with the "confounders." He argued that scientists are getting better and better at understanding small elements, but are failing with the big challenges that require a discourse for a multi-disciplinary framework. He introduced the term *ubuntu*, which means, "I am because we are" and suggested that we need programs that do not focus exclusively on the vulnerable but that intervene in the cycle of vulnerability, thereby reducing it. Addressing the health and well-being of the whole simultaneously shifts the curve, having a beneficial effect not only on HIV/AIDS but on other health concerns as well.

The second discussant, Judith Auerbach, identified two contextual lenses as a translator: communicating between the social sciences and the biomedical world; and translating science to practitioners, activists and policy makers. She suggested approaching social capital discussions with a sense of audience and proposed that "rigor" in methodologies was an extremely important aspect of the undertaking. She emphasized the structural factors in which social capital is embedded and noted that these factors are context-dependent, evolutionary, and historical. It is essential for analysts to query which of them can and should be changed, in what ways, by whom, in order to have what

effect, and when. Responding to Eduard Grebe's paper, she contemplated the tensions between structure and agency and the central role of trust in building social capital and strengthening effective partnerships and coalitions.

(Roberts Kabeba Muriisa was also scheduled to participate on this panel. His paper, *Building Social Capital in Uganda: the Role of NGOs in Alleviating HIV/AIDS Challenges in Uganda*, is available in the workshop proceedings.)

Panel IV: What specific actions can be identified for their effectiveness in addressing the prevention or treatment of HIV and AIDS? What works?

Panel IV, moderated by William F. Fisher, focused on actual programs and projects that participants had been associated with as researchers, founders, or organizers.

The first panelist, Morton Skovdal, discussed the role of social capital in strengthening the resilience of orphans and vulnerable children in western Kenya. Skovdal argued that social capital should be viewed as a process and not an outcome. His project supported community-based capital cash transfers (CCCT), which were intended to organize communities around issues concerning AIDS orphans and vulnerable children. He also argued that children should not be viewed as passive victims of the epidemic, but as people actively participating in community life. His research revealed that many children were effectively creating the identity of caregiver that allowed them to access certain resources and relationships in the community. Skovdal concluded that there were a number of social processes that enhance children's resilience and social capital. Successful projects must understand and be able to utilize these processes. In sum, finding effective ways to build and draw on social capital as a process of civic engagement and participation is a value central to Skovdal's analysis.

The second panelist, Willis Odek, addressed an overarching question concerning the intersection between financial vulnerability and HIV risk behavior among female sex workers (FSW). His research focuses on a program that targeted female sex workers in Nairobi's urban slums with micro-enterprise services. The study was a collaborative initiative of the University of Nairobi and the University of Manitoba in Canada. The program had three parts: to provide education to FSW, to provide sensitivity training to health care workers, and to create opportunities for micro-enterprise, through credit provision, business training and savings programs. The results showed that business success or amount of credit received did have a modestly positive impact on women's decisions to reduce HIV-risk behavior by reducing number of sexual partners and improving condom use. However, it was most effective with older women, who were perhaps ready to leave behind their roles as FSW. Odek suggested that strategies for livelihood programs suitable for younger women should be pursued as there was difficulty retaining young women in the program.

The third panelist, Fiona Samuels, studied the role of social capital in preventing the spread of HIV in Andhra Pradesh, India. The Frontiers Prevention Program (FPP) funded by the Bill and Melinda Gates Foundation and managed by the International HIV/AIDS Alliance, targets marginalized groups like female sex workers, men who have sex with men, and people living with HIV/AIDS. It focuses on empowerment through individually focused health promotion, sexual health services and resources, community mobilization, structural and environmental interventions, and capacity strengthening of local NGOs. This program measures the increase of social capital, in the form of trust levels among key populations, as a central outcome. Samuels discussed the importance of the role of outreach workers to the success of the program. One component of the program is to create a safe environment for participants to access health care free from stigmatization. Drop-in centers provide a space

for the creation of a community of traditionally marginalized people. Peer networks, self-confidence, a sense of belonging, and awareness and negotiation skills were all reported to have increased and strengthened as a result of the program. The bonding social capital is strong amongst this group, but bridging and linking social capital are weak. Social, political and economic conditions remain largely unchanged by the program.

The final panelist, Catherine Campbell, presented a comparison of two projects: one she considered a “failed” project in Entabeni, South Africa and the other, Sonagachi, a more successful project in India. The Entabeni project encountered many problems, including lack of successful partnerships with public sector actors, church leadership or local leadership. The local chief participated in program activities, but he seemed to undermine the long-term goals of the project. Involvement of youth and men was weak. Young people felt unappreciated, were overlooked for paying positions in the project, and, instead, were expected to volunteer their labor. Either men were paid, or they did not participate. Campbell argues that the local constructions of masculinity are at odds with HIV prevention messages. Getting stipends for the women volunteers proved impossible and resulted in many women dropping out because they were discouraged. Men dominated the leadership positions of the program and heavily resisted women’s attempts to gain recognition or accountability. Campbell reiterated the challenge of creating conditions where the poor have voice and where relevant social groups are willing to listen.

Paul Pronyk, serving as discussant for Panel IV, identified common themes of the projects presented in the papers, indicating that they challenged prevailing approaches to social capital, addressed immediate needs as an entry point, and were locally generated and peer-led. All offered structural interventions working upstream largely with groups and populations rather than with individuals. He noted the challenges faced by each of the settings and identified the general challenges to structural interventions. Pronyk placed HIV/AIDS in a historical context, comparing it with epidemics at other times of social transition, such as the fall of the Roman Empire (Black Death) or the industrial revolution (TB and cholera). And he provided us with a compelling image accompanied by two questions: How do we take the handle off the pump? How might social capital help us?

■ IV. Major Themes Emerging for Further Exploration

During the last part of the second day and for much of the third day, participants were divided into breakout sessions to discuss concepts, recommendations and next steps. In the plenary sessions that followed the breakout discussions, each group presented its findings. This section summarizes themes emerging in the breakout and plenary sessions, many of which echo, amplify or reinforce key points made by the panelists and discussants. The groups recognized that culture and context matter tremendously in understanding social capital, and that social capital has both instrumental and value dimensions. Given that HIV/AIDS has an inherently social basis, addressing prevention, treatment and care requires social analysis and benefits from wide engagement of social capital. Following is an introduction of four of the key themes that were discussed over the course of the workshop. These themes call for new strategic approaches for interventions that will effectively decrease vulnerabilities and create AIDS-resilient communities and health-enabling environments.

≡ 1. Social Capital and Communities

The discussion of social capital assumes interventions that focus on communities and groups, not on individuals. Workshop participants recognized at the outset that conceptualizing “social capital” is complicated and that there are many different ways the term can be used. In fact, we briefly discussed the impacts of HIV/AIDS on social cohesion, the cultural construction of empathy, and the spiritual basis of social capital. Participants accepted social capital as a “contested term,” discussing it in light of three widely recognized forms—bonding, bridging, and linking—and the challenge of exploring the relationship of these forms of social capital to increasing effectiveness in HIV/AIDS policies and programs.

The term “community” also emerged as one that was difficult to pin down during the discussions. The definition of what constitutes a community may be different for each particular situation, and the term may also be considered one that is “essentially contested.” In this same vein, it is important that the value of communities not be continuously reified. The discussion revealed numerous ways in which communities can be the source of practices and social norms that reinforce the stigmatization and marginalization of certain populations. This, in turn, can lead to increased vulnerability to HIV infection and poor health in general. The variety of examples discussed illustrated convincingly that social capital is obviously different in different places. Skovdal discussed the role of social capital in strengthening the resilience of orphans, whereas Nasir discussed the dark side of social capital, examining how culture and local constructions of masculinity can increase vulnerability among young male drug users. Other examples demonstrated that mobilizing social capital cannot necessarily be based on existing traditional collectives. It may be that a spirit of collectivism will have to be used to facilitate new equitable and democratic organizations.

The participants recognized that if we regard social capital as involving elements of participation in social groups, perception of solidarity, and taking part in collective action, we can begin to measure whether it is effective in reducing HIV vulnerability. In so doing, the participants felt that social capital could be a useful metric to help us understand and strengthen HIV/AIDS interventions.

≡ 2. Power and Politics

A recurrent theme over the three days concerned various elements of inequality, power, and the politics of everyday life. Participants were cognizant of the importance of analyzing power with respect to social capital. Who controls the agenda both for individual projects and for the international effort against the epidemic? The participants identified many ways in which outsider agendas serve to preempt or undermine indigenous responses to the epidemic and thus serve to destroy social capital rather than create or build it. All parts of an intervention should mutually reinforce the long-term goals of strengthening social capital and decreasing vulnerability. Concerns about power, justice and fairness in access to health care and rights regarding health took many forms. At one level there was a call for re-conceptualizing (Cheikh Niang and Paul Pronyk) what we mean by health and how we visualize health. At another there was recognition of the need for strategic alliances, for AIDS-response coalitions that are effective in mobilizing around AIDS issues, as noted by Eduard Grebe and Jeff O'Malley. At yet another level, there was concern for marginalized people and communities (Abhay Shukla, Catherine Campbell, Usa Duongsaa, among others) and ways to shift resources for improved health to them. Discussion returned often to the notion of fostering "AIDS-resilient communities" that could, among other things, begin to shift power relations. One means of accomplishing this objective and at the same time fostering linking social capital is to create systems for community monitoring of projects. Such systems would allow communities to hold NGOs and donors more accountable and would begin to transform power hierarchies. There was widespread agreement among the participants, with valuable points contributed by Geeta Rao Gupta, Mike Isbell and others, that issues of power and fair distribution of social and material resources needed to be addressed, not only in relation to HIV/AIDS, but also vis-à-vis other health rights.

≡ 3. AIDS Exceptionalism vs. Whole Health Systems

Workshop participants also questioned whether a long-term view of the HIV/AIDS epidemic might make it necessary to move beyond the idea of "AIDS exceptionalism." When the disease was first discovered, it was logical for health systems and governments to respond with an emergency mentality. However, as more research has been done and as the epidemic has become entrenched in certain areas and populations, it may be time to think more about general health outcomes rather than just specific disease outcomes. One idea, perhaps best articulated by Jeffrey O'Malley and Paul Pronyk, is to use HIV/AIDS as an entry point into improving whole health systems. The resources and expertise that go toward building infrastructure and improving service provision for HIV/AIDS-related programs should be usable by the whole health system in a community or country, a position put forth by Abhay Shukla and affirmed by others. Otherwise, these efforts will serve to fragment health systems, resulting in long-term detrimental effects.

In thinking about AIDS exceptionalism and "whole health systems," it is useful to return to Cheikh Niang's call for an epistemological shift in how we regard AIDS and the very meaning of health and healthy communities. Niang offered a Wolof phrase, *nit nittay garabam*, as a conceptualization of what it means to be healthy: people are the best medicine, and health and well-being reside in supportive social connections. Paul Pronyk offered a similar concept commonly used in South Africa, *ubuntu*, which loosely translates as "I am because we are."

≡ 4. Research Paradigms

Finally, a major problem faced by social science researchers, advocates for structural interventions, and activists for mobilizing social capital concerns the question of evidence. This problem was identified and explored throughout the workshop with care by several participants and with special attention from Judith Auerbach and Jeffrey O'Malley. The dominant paradigm in HIV/AIDS research and programming is biomedicine, which takes a very technical and quantitative approach to understanding health and disease. The standard for biomedical research is the randomized control trial (RCT), which can decisively tell researchers if a variable does or does not have an effect. However, RCT does not tell researchers *why* a certain variable works or not. If we wish to translate interventions into different contexts or to scale them up, knowing why they work will help implementation. Interventions that work under controlled research conditions may not have an effect in chaotic, real-world settings. Social science, on the other hand, using such methods as longitudinal ethnographic studies, can elucidate the operation of complex social processes in particular settings. Social scientists have for years argued for the importance of rigorous qualitative research methodologies, but the data produced by these methods have had inadequate influence on policymakers. In any case, as O'Malley points out, rigorous data are needed and evidence must be made actionable. It can be difficult to know what aspects of change caused by an AIDS intervention can be attributable to social phenomena such as social capital.

■ V. Recommendations

≡ 1. Re-conceptualize the HIV/AIDS Problem

Participants in this workshop argue that a new lens can help reframe and shape responses to the AIDS pandemic in the 21st century. A “social capital” lens helps to introduce culture, context, power relations, the distribution of social and natural resources, vulnerability, and marginalization in the context of the HIV/AIDS pandemic and will increase the likelihood of meeting our objectives, not only as researchers and professionals, but as global citizens, of building AIDS-resilient communities and health-enabling environments.

What else is involved in such a paradigm shift? Taking issue with the notion of AIDS exceptionalism is central to this agenda. Is AIDS different from other health problems or pandemics? To date, it has been regarded as such. Participants in this workshop suggest that it is time to consider HIV and AIDS as part of a larger set of health, development, rights and social justice concerns. These issues are very much at the forefront of efforts to create a paradigm shift. Nevertheless, there are concerns about the implications of taking a long-term view of the AIDS epidemic and moving beyond AIDS exceptionalism. We must get the right mix of “exceptional approach” and systems thinking. A new approach must be strategic.

An epistemological reframing of the HIV/AIDS problem must recognize the relevance and dynamism of culture and context. Identifying culture and context as central to a reframing of AIDS responses is diametrically opposed to the conventional treatment of AIDS through large-scale organizations and programs designed from the top down, more or less in a one-size-fits all mode. Such an emphasis would assure more local control of programs and policies, and presumably, also, of funding. Too often the donors call the shots, offering top down, “foreign” solutions that will not work in non-Western communities. Local authorities, local power structures, and local community organizations are all an important part of recognizing the relevance of local contexts. These might vary from the potential of women’s organizations in Southern Africa willing and able to work effectively with orphans in the community to young men in an urban community in Makassar, Indonesia for whom “social capital” is fundamentally a negative influence in regard to HIV prevention.

In particular, regarding the relevance of context, participants in the workshop were persuaded that a more Afro-centric approach would be useful in dealing with AIDS across Africa. Even though “culture” has been recognized in the Millennium Development Goals as pivotal in preventing HIV infections, there is still little effort to address and incorporate local mores. Culture and local forms of social capital may either encourage or hinder the adoption of HIV measures for prevention. Finding ways to engage elders or other community leaders may facilitate the adoption of safe practices and would be one way to acknowledge and involve the local community. In many parts of Africa, participants noted strongly, it would not be possible to engage in programs in a local community—in

any way whatsoever—without the approval and blessings of the local chief. In sum, local culture matters, and a reframing of the HIV and AIDS pandemic must take this into account.

These concerns bring us full circle to a consideration of social capital as a missing link that is crucial to reaching across power structures to gain rights and resources for vulnerable populations. What does such a redefinition mean for AIDS policies and programs? It means a philosophic and practical shift to creating space and support for dialogue and action. It shifts the emphasis from blueprint to improvisation. It focuses on those policies and programs that can shape not just individual choices but the structural conditions shaping group behavior, as well as individual choices. This is a very different underlying philosophy from the one that suggests there are answers arising from the HIV/AIDS research world and they simply need to be implemented appropriately.

2. Focus on the community, as well as the individual

Our focus on social capital leads us to look at the community, rather than the individual. Such a focus acknowledges the centrality of networks and a capacity for collective action in dealing with health concerns, particularly a communicable disease such as AIDS. There needs to be a common understanding of the nature of the disease and the most effective ways to prevent and treat it and to care for the ill. This approach can enable policies and programs to address AIDS in the context of the turbulence, instabilities, and environments of risk shaping the lives of individuals and groups in marginalized and HIV-vulnerable communities. In this way, we shall be better able to support and mobilize social capital so that it can help address the complex social and political obstacles to the successful prevention of HIV and AIDS.

This recommendation also involves unpacking the term “community” and recognizing that communities have both positive and negative attributes. The actualization of a “community” differs according to the situation, and, like the term “social capital,” it may be considered a dynamic entity and an essentially contested term. Communities may be geographic, but they can also be constructed around interests, age groups, religion, gender, profession, or many other categories.

Social capital manifests itself differently in different places and can serve both beneficial and harmful objectives. It is possible for a community to reinforce the stigmatization and marginalization of certain populations, increasing their insecurities and vulnerabilities. This, in turn, can lead to increased vulnerability to HIV infection and poor health in general. On the other hand, communities can serve as a mechanism of support and provide resources and knowledge to decrease vulnerability. Campbell discussed the Sonagachi Project in West Bengal in which marginalized women led a peer education program that was successful in reducing HIV, and also in using HIV as a springboard for wider social development of women.

Some of the case material demonstrated that mobilizing social capital cannot necessarily be based on existing traditional collectives, particularly if they are characterized by principles that are not egalitarian. In such instances, perhaps a spirit of collectivism can be used to facilitate new equitable and democratic organizations. Re-conceptualizing and planning around social capital, communities, and HIV/AIDS inevitably means that we must engage other concepts as well, including those such as justice, rights, fairness, and equity.



3. Focus on upstream vulnerabilities and the ways to strengthen social capital to address them

Participants urged strategic attention to key differences between downstream approaches targeting specific populations affected by HIV and AIDS and upstream approaches addressing the conditions that have contributed to the spread of HIV and AIDS. They also stressed the difficulties of doing so, and the numerous ways in which roadblocks are configured to perpetuate hierarchies and inequalities. An intervention emphasizing the root causes of vulnerability will find upstream approaches and seek transparency and participation in addressing them.

There is ample evidence to suggest that HIV and AIDS attack not just individuals in the hardest hit developing countries but the social networks or fabrics of which individuals are a part. These social networks, which provided keys to survival in the pre-AIDS period, are now under tremendous stress. In fact, many are crumbling in the face of the pandemic. That is, traditional forms of social capital have been damaged and a complex web of vulnerabilities has been created by the HIV/AIDS pandemic. Many researchers suggest that there is a role for reviving effective traditional networks, transforming them in ways that will make them effective, or creating new ones that develop a sense of joint responsibility, create new forms of public discourse, build alliances and stress mutual interests across generations, genders, households and communities in the struggle against HIV and AIDS.

Focusing on upstream vulnerabilities is an important first step in reviving social networks and creating AIDS-resilient communities. Communities need knowledge, skills and access to resources. Engaging local social capital is an important component of building AIDS-resilient communities, but it is unlikely to be sufficient without the resources necessary and without appropriate and effective linkages to the national and international setting. Resources, whether in the form of cash transfers as discussed by Skovdal, opportunities for micro-enterprise as noted by Odek, honoraria for tasks performed by community health workers, or other options can facilitate participation and programmatic action.

Examining and transforming structural concerns is also central to a focus on upstream vulnerabilities. The agenda is incomplete without conscious attention to the broad picture. For example, patriarchal systems that empower senior males to the disadvantage of women and youth make it difficult for women to negotiate sexual relationships and for male youth to gain respect within the traditional setting. These outcomes can make both women and youth especially vulnerable to the HIV pandemic. They are part of the context that must be addressed for effective policy and programs. In another example, research in Indonesia revealed the ways in which local culture and social capital can have a negative effect on efforts to manage HIV/AIDS. In this setting, social capital comes from participation in gangs and from reciprocal relationships around drug use and sharing of supplies and needles. The local perception of esteem and masculinity is abetted by socio-economic deprivation and is linked to risky drug use and sexual practices. This analysis emphasizes the structural and cultural conditions that hinder safe practices; it is also wary of an over-emphasis on the behavior of individuals in programs addressing HIV/AIDS. Attention to the local culture would suggest a need for new norms and new policies to reduce socio-economic deprivation and to discourage risky drug use and unsafe sexual practices.



4. Create and strengthen AIDS-response coalitions and strategic alliances at international, national, regional and local levels

An effective HIV and AIDS response requires cooperative collective action on the part of a wide range of actors at various levels of society. Coalitions are associations of groups and organizations working to resolve specific problems that are beyond the capacity of any individual member to solve. Coalitions bring together groups or institutions that may have varied and divergent long-term goals that they are willing to set aside for some intermediate, common, collective goals. How do they go about resolving the complex collective action problems of coalition-building for policy formulation and implementation? These are overarching questions, but they lead to some specific strategies for consideration:

- Finding ways to identify and mobilize internal community champions.
- Involving international agencies and NGOs in ways that foster partnership and shared responsibility.
- Engaging civil society organizations involved in participatory planning and enabling them to become partners in the process.
- Understanding and mobilizing the formal, semi-formal and informal networks, all of which are valuable in mobilizing resources to build social movements and influence public policy.
- Grappling with the complexities of political culture and understanding how it differs from one context to another.
- Knowing the issues for which international alliances and coalitions are essential.

Astute leadership is required to mobilize successful AIDS-response coalitions that combine strategic alliances with a sense of solidarity and common purpose. In an exploration of The AIDS Support Organization (TASO) in Uganda, and the Treatment Action Campaign (TAC) in South Africa, Grebe demonstrates that these organizations have faced similar challenges such as the transition from charismatic leadership to formal professionalized management, but have handled them in substantially different ways.¹ (See Annex 2 for a discussion of these two organizations and strategic alliance formation.) These differences are shaped not only by their leaders, but also by the constraints imposed and opportunities provided by their differing environments. He argues that the clearest and most important insight emerging from his research is that the development of AIDS-response coalitions is highly context-dependent.²

Included among potential participants in coalitions are the media, donors, academics, and other non-state actors. Moreover, the state itself is complex with different elements that can form alliances. Funders can be very powerful and influential in shaping alliances. They can establish funding patterns that are broadly consultative and egalitarian or highly vertical and centralized. The relations between national leaders and funding agencies can be critical in this mix for building strategic alliances. In sum, donors, programmers, and leaders of NGOs working on HIV and AIDS need to be savvy about their objectives and the opportunities for meeting them through shared efforts with like-minded organizations.

1 Grebe (2009:11)

2 Grebe (2009:12)

≡ 5. Transform power relations in order to shift resources to poor and marginalized people

If communities, context, and culture are to receive greater emphasis in a paradigm shift around HIV/AIDS prevention and treatment, then it would follow that there would be a major redistribution of resources (social and material) based on structural changes in HIV/AIDS planning and programs. Moreover, attention to the quality of relationships between those with differential access to power is essential if efforts to assist or transform the situation of the ill, the poor, or the socially excluded is to occur.

Throughout the presentations, discussion, and analysis, it was evident that social position characterized by attributes related to class, religion, ethnicity, gender, and caste were important elements permitting or preventing access to health care and to HIV and AIDS interventions. In many instances, income disparities are widening and aggravating social difference. Moreover, in some parts of the world there are extreme forms of social inequity. Namibia, for example, has been described as “one country, two worlds” with a small affluent white population, a large black population living in abject poverty, and prosperous foreign-owned mining companies. Other countries have deep-rooted social and economic structures that reproduce poverty and perpetuate inequality. In India, for example, as Abhay Shukla noted, issues of access and power relations at the community level, related to all the attributes noted above, are central to the fair and equitable development and delivery of health care systems. Discussion of many cases, including Indonesia, Kenya, Senegal, and South Africa, among others revealed illustrations of crosscutting exclusion. These were paramount in workshop reflections on the scope and possibilities for HIV and AIDS interventions and the necessity for addressing inequitable power relations.

Moreover, in each of the cases presented there was an undercurrent of tension around gender relations—male rights in regard to women, impacts of polygamy, constraints of poverty leading women to choose sex work to earn a living. In addition, the norms whereby senior males have power over women are commonplace in Africa, as Campbell’s analysis of Entabeni, Ambasa-Shisanya’s of Kenya and Niang’s of Senegal attest. Similar observations were made in regard to other parts of the world. Local definitions of patriarchy abound!

Thus, the various elements of inequality, power, and the politics of everyday life are relevant to problematizing power relations and analyzing power with respect to social capital. Analyzing power leads to questions about agenda-setting. Who determines how HIV and AIDS funds will be allocated and what trajectories they will pursue? Sometimes, even often, outsider agendas serve to preempt or undermine indigenous responses to the epidemic and thus serve to destroy social capital rather than create or build it. All parts of an intervention should mutually reinforce the long-term goals of strengthening social capital and decreasing vulnerability.

Reframing AIDS from a social capital perspective moves away from a blueprint approach to much greater improvisation based on context and culture, upstream vulnerabilities and structural concerns. It has transformational potential in regard to power relations.

≡ 6. Work at multiple levels to develop new strategic approaches to HIV and AIDS interventions

An important recommendation for an effective strategy vis-à-vis HIV and AIDS is to build capacity to combine approaches and to work at multiple levels. Vulnerability to HIV and AIDS is a complex and multifaceted issue that requires thoughtful and well-targeted packages of interventions and simultaneous programs. Approaches might be loosely categorized as overarching strategies, those pertaining to community level concerns, and those suitable for national or regional implementation. Following are some illustrations of possible actions identified for each category.

Discussing the community level, participants observed that the history of HIV/AIDS interventions is one of top down, and often externally imposed programs. Workshop participants recommended attention to community involvement and to participatory approaches at the local level. Community input should be sought for establishing research and programmatic priorities. One important strategy is to engage communities in monitoring AIDS programs, thereby encouraging accountability to community members. Creative use of community support can build resilience in community members, leading to the establishment of AIDS-resilient communities. Others emphasized the importance of mobilizing and engaging marginalized and vulnerable groups.

Considering national and regional levels, there was much interest in analysis of AIDS-response coalitions and how they might be constructed for effective advocacy and action around HIV and AIDS interventions. Suggestions focused on capacities for creating strategic alliances, building a sense of solidarity and common purpose, and fostering cooperative collective action. An important step is to build effective alliances between national level AIDS NGOs and international donors. Combined strategies at multiple levels can link states, non-governmental organizations, community-based organizations and civil society. AIDS- response coalitions can then position themselves to move the agenda and address power structures at national and international levels. Their energies can be harnessed to address structural vulnerabilities to the HIV pandemic.

Working at multiple levels to develop new strategic approaches at the community level and across national and international scales is a critical element in a newly emerging paradigm shift. In the context of a conceptual reframing, a significant overarching objective would be to build knowledge and advocacy around HIV/AIDS, poverty, and social dysfunction that have shaped and continue to shape upstream vulnerabilities. Within a transformed HIV and AIDS framework, this understanding could be linked to a broad rights agenda, to other health issues, and to social justice. It would contribute to building AIDS-resilient communities and creating a healthier environment for all.

≡ 7. Create capacities for sustained leadership

It is incumbent upon those involved in the aids2031 initiative not only to seize opportunities to strengthen leadership for AIDS policy, program and research agendas, but also to exercise leadership themselves. Two broad policy initiatives found enthusiastic support during the workshop and could be undertaken under the leadership of aids2031. They are:

- Use the current, more open political environment in the U.S. to re-think the donor AIDS response in a public forum; and
- Frame an international discussion for AIDS, rights and development beyond 2015 and the Millennium Development Goals.

Several more-specific methods for building and sustaining leadership include:

- Create mechanisms for dialogue that are context specific, encouraging leaders to emerge in multiple settings.
- Build a dialectical relationship between indigenous responses and outside interventions so that both can strengthen leadership and effective social capital regarding HIV and AIDS.

AIDS professionals, including the donor community, can mobilize social capital as a vital component of combined responses to the epidemic. If social capital is deliberately engaged as a framework for understanding vulnerability, it can be a valuable element in harnessing the strength of people and communities. In this regard, funding becomes a central issue. Long-term capacity building requires sustained funding. Community-based organizations, NGOs and governments all require support. Priorities should be clearly determined for financial allocations, preferably through decentralized mechanisms, and recipients should be held accountable for the outcomes. Accountability should go in two directions—to the people in a bottom-up structure, and to the donors. Attention to funding, structured mechanisms for the use of funds, and mechanisms for accountability should go a long way toward strengthening leadership in and around the HIV and AIDS agenda.

8. Use social capital as an indicator for understanding vulnerability and a metric for understanding and strengthening HIV/AIDS interventions

HIV and AIDS professionals should be using social capital as a key marker of program success alongside biomedical and individual behavioral markers. Social capital is clearly a marker of the resilience of a community and, as such, can be a valuable indicator for understanding vulnerability and assessing how we build AIDS-competent communities. Mobilized social capital should, therefore, be regarded as a vital component of combined responses to the epidemic. There remain, however, important questions about how to accomplish this objective. For example, in regard to social capital, how do we make evidence actionable? Who decides what may be evidence?

This workshop, examining social capital as a factor in HIV and AIDS prevention and treatment, clearly supports attention to upstream and community approaches. The cases explored the ways cultural, context, and social, economic and political factors hinder or improve the uptake of HIV/AIDS programs. The evidence presented here demonstrates that qualitative case studies can effectively complement RCT methodologies. Thus, there is broad consensus among workshop participants that a case must be made for understanding bonding, bridging and linking social capital as both an outcome and as a process in addressing the HIV and AIDS pandemic. In fact, linking social capital can provide new opportunities as the missing link that is crucial to reaching across power structures.



VI. Conclusion

The intention in mobilizing social capital is to foster individual resilience and to create both AIDS-resilient communities and health-enabling environments. A consensus emerged at the workshop that, indeed, there are ways we can understand and use social capital effectively in the struggle against HIV/AIDS. Approaches based on the concept of social capital can help the development establishment to think outside the box, to escape the strictures of standardizable interventions that tend to disregard the social aspects critical for success (at least in certain kinds of problems, such as AIDS), and to help fill the policy space with new modalities/interventions that are relationally-intensive and that build/harness bonding, bridging and linking social capital. The participants concluded that social capital gives us a framework to understand vulnerability and to harness the strength of people and communities in more appropriate and sustainable ways. Therefore mobilizing social capital must be a vital component of combination responses to the epidemic. A key to strengthening the AIDS response may lie with what might be called linking social capital. We need to better understand AIDS-response coalitions internationally and learn how to harness AIDS-response coalitions to address vulnerabilities.

Social capital is something that already exists in many communities and in home grown responses—it is something to be harnessed; but it is also something that must be built. So there must be a dialectical relationship between indigenous responses and outside interventions in which both reinforce the harnessing and building of social capital. Perhaps in so doing, we can not only build individual resilience and AIDS-resilient communities, but we can use HIV/AIDS as an entry point to a broader public health, development and rights agenda, and, in the words of one workshop participant, “replace the concept of charity with the concept of justice.”

Annex 1: Creating AIDS-Resilient Communities

Evidence presented at the workshop in the form of varied case studies, as well as the experience of a number of practitioners, provides insights in regard to the effectiveness of various strategic approaches for building AIDS-resilient communities. The evidence also reveals the linkages between HIV and AIDS and social capital from two perspectives: 1) the need for bonding, bridging and linking social capital for addressing HIV and AIDS issues and concerns; and 2) the increased effectiveness with which problems were addressed when strong social capital networks were at work. Following are brief descriptions of three examples of recent or current research that suggest new ways to address HIV and AIDS at the community level.

Frontiers Prevention Program: Empirical evidence from the Frontiers Prevention Program in Andhra Pradesh, India, demonstrated the effectiveness of using peers from the key populations of sex workers, MSM, and people living with AIDS to build trust and decrease risk behaviors.¹ This program involved delivery of a comprehensive package of interventions in 40 sites in Andhra Pradesh. The intention was to reduce HIV incidence in these sites by reducing risk behavior. Interventions included provision of health services and commodities, AIDS care, community mobilization and structural /environmental intervention to create an enabling environment. The research carried out by the Overseas Development Institute and the International HIV/AIDS Alliance concluded that “when comparing end line with baseline data, findings show that social capital amongst respondents has grown over the period of the intervention. Findings also show that uptake of health services and condom use has increased over the time period of the project. These positive findings, as well as findings of reduced STI prevalence rates in Andhra Pradesh are associated with increased social capital and empowerment of key populations, although causal pathways are difficult to demonstrate.”² This carefully executed study of a complex program of mixed interventions could point to the achievements and could assess the positive impact of social capital and its linkages to effective programming. Correlations were clear despite an inability to distill from the research a direct, unilinear, cause-and-effect relationship. Causal pathways between intervention and outcomes are notoriously difficult to elucidate and evaluation frameworks are difficult to standardize and contextualize. They may be unclear and indirect. They don’t easily conform to experimental design. Diffuse benefits take time to accrue. It is hard to change structural conditions!

Two Communities in Western Kenya: A case from Western Kenya speaks to the importance of initiating new forms of organization and participation and of involving youth in efforts to address HIV and AIDS.³ This case explores the role of social capital in strengthening the resilience of orphans and vulnerable children. It emphasizes social capital, not so much as norms and networks, but rather as a process through which people participate in local community life and acquire the ability as individuals and communities to navigate and negotiate social support. The researcher recognizes that social support encourages resiliency and that the link between social capital and improved health is well established. However, most existing research focuses on individuals, as opposed to civic engagement and community activity. In this study, the coping strategies of 48 children were analyzed using multiple methods in two rural communities in Bondo, one of Kenya’s poorest

districts. This is a community with 47.2 percent of the population living in absolute poverty and one of the highest HIV prevalence rates in the country. The author makes an argument that programs targeted to the community rather than to the household help build social support and the resilience and well-being of children affected by AIDS. A qualitative approach using mixed methods, this study provides evidence to indicate that facilitating community-level responses to HIV and AIDS can be an effective way to help both young and old cope with these adversities.

People Living with HIV Stigma: A third case relevant to transforming strategies at the community level for addressing HIV and AIDS is a research initiative to measure stigma in regard to people living with HIV. This research project is one component of a dynamic partnership among the International Planned Parenthood Federation, two networks of people living with HIV (the Global Network of People Living with HIV and the International Community of Women Living with HIV), as well as the Joint United Nations Programme on HIV/AIDS. The primary research tool is, *The People Living with HIV Stigma Index*, a questionnaire that measures stigma and discrimination, covering perceptions of self and internal stigma as well as specific examples of stigma or discrimination in different settings. The research findings and follow-up case studies are being used to advocate for evidence-based policy and practice that is grounded in the real experiences and perspectives of people living with HIV.⁴ To date, 128 people have been trained in seven regional workshops conducted in 2008-2009 involving more than 90 organizations in 69 different countries. This project puts people living with HIV at the center of the research process. It strives to support human rights and to generate social capital both from the process of working with the Stigma Index and from the products that it generates. "This project explores how the process of measuring HIV-related stigma and discrimination—a research and advocacy initiative that builds the capacity of people living with HIV to drive the research—can catalyze the realization of human rights and can generate momentum for change for the individual as well as for the wider environment."⁵

These three examples of recent or current research are indicative of increasing efforts to track the linkages between HIV/AIDS and social capital. They reveal that developing and drawing on social capital can improve the effectiveness of local level policies and programs for the management of HIV/AIDS. They provide empirical evidence demonstrating linkages between effective programs for HIV and AIDS and social capital and suggesting that both knowledge of social capital and capacity to generate and use social capital can help communities design more effective policies and programs. Approaches suitable for community level activities include strategies such as the following:

- Create new forms of community involvement and participation appropriate for the local context.
- Improve accountability through community-level monitoring.
- Focus on achievable steps and small wins.
- Identify and work with marginalized communities.
- Find ways to link formal and informal institutions.
- Determine ways to generate new forms of social capital.
- Mobilize communities to take action on their own terms.
- Find ways to assure that youth are engaged.
- Create capacities for sustaining local leadership.
- Strengthen local-level advocacy networks.

1 Samuels F., Verma R. George C.K. Empowering sex workers, men who have sex with men and people living with HIV : the role of social capital in preventing the spread of HIV in Andhra Pradesh, India. 2009

2 Ibid, p. 12

3 Skovdal M. The role of social capital in strengthening the resilience of children affected by AIDS—A case study from Western Kenya. 2009

4 Stackpool-Moore L., Harrison B., UNAIDS, Mallouris C., Pascal R., Pettitt F. Measuring Stigma—Building the Capacity of Networks of People Living with HIV to Inform Policy and Practice. 2009, p. 5

5 Ibid, p. 8

Annex 2: Aids-Response Coalitions and Strategic Alliances

To achieve long-term success and effectiveness the AIDS response cannot consist of one agent, actor or organization working independently. A key recommendation from the Social Capital workshop is the need to create and strengthen strategic alliances and AIDS-response coalitions. Affected communities, NGOs, national responses, the international community, and donors must work collaboratively toward a common goal in order for programs and policies to make significant long-term strides.

Workshop participants discussed several collaborations in which they were involved or had conducted research. Stackpool-Moore (2009) presented, *The People Living with HIV Stigma Index*, a new research initiative to measure stigma, by and for people living with HIV. It was developed and is the result of partnerships between the International Planned Parenthood Federation (IPPF), two networks of people living with HIV (the Global Network of People Living with HIV and the International Community of Women living with HIV), and The Joint United Nations Programme on HIV/AIDS (UNAIDS). Samuels (2009) presented on the Frontiers Prevention Program (FPP), which is managed by the HIV/AIDS Alliance and funded by the Bill & Melinda Gates Foundation. FPP provides a comprehensive package of services and interventions to key populations in order to empower them to reduce risk behaviors. Finally, Grebe discussed how Uganda's success in creating and implementing one of the most effective AIDS responses has in large part been attributed to its ability to form a broad coalition including civil society, the state and the international community.

Coalitions are associations of groups and organizations working to resolve specific problems that are beyond the capacity of any individual member to solve. Coalitions bring together groups or institutions that may have varied and divergent long-term goals that they are willing to set aside for some intermediate, common, and collective goals. Social capital plays a critical role in creating AIDS-response coalitions and AIDS-response coalitions can aid in the creation of social capital. Bridging social capital is positively related to associations between communities and NGOs; while linking social capital is directly related to associations across power structures, for example, between community groups and the state, donors or international community.

Grebe (2009) defines effective AIDS leadership as the ability to mobilize successful AIDS-response coalitions. He asks, "Under what conditions, and by which processes do effective AIDS-response coalitions emerge?" In an effort to understand the answers to these questions, he analyzes two civil society organizations—The AIDS Support Organization (TASO) in Uganda and the Treatment Action Campaign (TAC) in South Africa. These two organizations play significant roles in their respective countries' AIDS response. Their success is largely attributed to the ability to mobilize coalitions.

TASO was founded in late 1980s in the context of a weak healthcare system, infrastructure and economy as Uganda had just emerged from a period of economic crisis and war. The group initially focused on providing counseling and support and then expanded to providing medical services in response to the state's weak healthcare system. TASO found strong support from the Ugandan government and aid agencies. Today TASO is a professionally run organization and a major provider of medical and social services to people living with HIV and AIDS in Uganda.

TAC was founded in 1998 by seasoned political activists in the context of a strong tradition of protest and a state policy of AIDS denialism in South Africa. The group focused on advocacy and political mobilization, specifically on prices and availability of ARV drugs and other treatments and government policy toward antiretroviral treatment. Given South Africa's relative level of development and advanced healthcare system, there existed sufficient state capacity to implement the policies TAC proposed. TAC remains an activist organization with an informal management structure.

Both TASO and TAC had charismatic leaders who drew on pre-existing networks and relationships of trust to build their organizations and broad coalitions. However, Grebe's most important insight arising from the analysis of these two organizations is that the development of AIDS-response coalitions is context-dependent. TASO and TAC responded to different opportunities as different structural and institutional factors shaped the approaches of each organization.

While donors play an integral part in the AIDS response by providing necessary and needed resources, evidence from the workshop cautioned that donors may help broker or inhibit effective AIDS-response coalitions. For example, donors such as PEPFAR include conditions on their funding, such as requirements not to target sex workers or not to provide reproductive health services that may include abortion. Therefore, AIDS-response coalitions may be more effective if they are not required to follow policies inspired by religious ideology and political considerations of their donors (Grebe 2009). Robinson (2009) also noted that, given their dependence on foreign resources, NGOs may be more inclined to follow the pursuits of their donors than local concerns. These realizations reinforce the need for strategic alliances and AIDS-response coalitions that work cooperatively and collaboratively toward a common goal, putting individual agendas aside.

Muriisa Kabeba (2009) further underscores the importance of creating and building strategic alliances. His research finds that social capital can be mobilized at micro, meso and macro levels and that all the levels are significant in addressing HIV/AIDS in Uganda. Synergy between NGOs, society and the state are critical in determining the levels of social capital for a number of reasons. NGOs work in collaboration with the government in delivering healthcare services. The government can facilitate community participation as it formulates laws and regulations that constrain or are conducive to action. Other examples are abundant. Consequently, investment in and facilitation of strategic alliances and AIDS-response coalitions can enhance social capital, as well as positively affect other HIV/AIDS outcomes.

Annex 3: Abstracts of Papers Prepared and Presented at Mobilizing Social Capital in a World with AIDS

The Contribution of Culture and Social Capital to Adoption of HIV and AIDS Prevention Measures in Kenya

Constance Rose Ambasa-Shisanya, Family Health International

The prevalence of HIV in Kenya has increased from 6.7 percent in 2003 to 7.4 percent in 2008, despite intensified promotion of prevention measures such as condom use, screening for HIV at Voluntary Counseling and Testing centers and circumcision. Culture has been recognized internationally in the Millennium Development Goals as pivotal in preventing HIV infections. The author has attempted to determine, through field research in selected communities in Kenya, how this international concern is played out at the local level in terms of incorporating a cultural dimension into HIV prevention measures and determining how culture influences the adoption of HIV prevention measures. My research was influenced by Social Capital: an understanding that a peoples' culture is full of social resources such as honesty, trust, norms, values, relationships and other networks that facilitate adoption or non-adoption of HIV prevention measures. The results indicate that current HIV prevention measures target the youth—with social capital either promoting or hindering the adoption of HIV prevention measures. Many circumcised boys, for example, bond and become a source of encouragement to peers to adopt HIV prevention measures, such as condom use and screening for HIV in groups. Upon maturation, they marry and abandon HIV prevention measures in pursuit of cultural values, such as children and prestige, leading to unprotected sex with multiple sexual partners. Among the Luo of Nyanza Province, the Council of Elders was initially opposed to adoption of circumcision as an HIV prevention measure. Politicians convinced and sought support from the elders prior to adoption of circumcision as a prevention measure. Therefore, in order to change the face of HIV and enhance adoption of HIV prevention measures, the elderly and mature members of communities should be a new focal point instead of only addressing the youth who are already receptive to change.

Strengthening community responses to AIDS: Possibilities and Challenges

Catherine Campbell, London School of Economics

The context of our work is an interest in shifting the discourse of HIV/AIDS management away from that of 'AIDS interventions' in favor of programs that seek to 'facilitate local community responses.' We believe that programs that resonate with the needs and interests of target communities, and that build on existing local community strengths, are more likely to succeed than those imposed on marginalized communities by outside professionals. Against this background, we propose a conceptualization of social capital that focuses on the psycho-social mediators between bonding and bridging social capital, and the ability of communities to respond effectively to HIV/AIDS—and

we illustrate our conceptual framework with our recent case study of local community responses to AIDS in Manicaland, Zimbabwe. Drawing on the work of Freire, Habermas and Foucault, we outline and illustrate seven psycho-social outcomes of effective bonding and bridging social capital, which we believe are key determinants of community-level AIDS competence. These are: knowledge and skills (related both to AIDS, as well as to community leadership), social spaces for dialogue, critical thinking, a sense of ownership of and responsibility for tackling HIV/AIDS, solidarity, a recognition of local strengths (both individual and collective), and effective partnerships with external agencies. We conclude with a discussion of the implications of our ideas for policy and practice in the fields of HIV/AIDS prevention, care and treatment in poor communities in southern Africa.

***Abstract: The emergence of effective AIDS-response coalitions:
A comparison of Uganda and South Africa***

Eduard Grebe, University of Cape Town

While states must bear the primary responsibility for HIV/AIDS interventions in hyperendemic countries, it is widely recognized that broader partnerships—comprising governments, civil society formations, international NGOs and the donor community—are required for successful responses. While the literature makes frequent references to such partnerships (Nair & Campbell, 2008), these are often ill-defined, and how such partnerships are to be achieved is even less well understood. This comparative study focuses on the role of civil society in the AIDS response in Uganda and South Africa. Both have prominent and vibrant civil society organizations that are seen as world leaders in the AIDS response—The AIDS Support Organization (TASO) and the Treatment Action Campaign (TAC) in Uganda and South Africa, respectively. However, the contexts (political and socio-economic) within which these organizations operate differ significantly, and so do the forms taken by their involvement in the respective national AIDS responses. The Ugandan state has actively promoted and facilitated NGO involvement (Putzel, 2004); whereas the relationship of the South African state with civil society has been characterized by conflict (e.g. Natrass, 2007; Grebe, 2008). This comparative case study therefore includes rich contextual description that takes into account the differences between these organizations and the differing contexts in which they operate. It describes how civil society leadership contributed to the emergence of effective AIDS-response coalitions in both Uganda and, despite an obstructionist state, South Africa. These narratives are related back to the more general theoretical and empirical question of the relationship between civil society and the broader AIDS response in order to highlight lessons that may also apply in other contexts.

Social Capital and Public Health: A Systematic Review of the Literature

Daniel Kim, Harvard School of Public Health

The past decade has witnessed a flourishing public health interest in study of the effects of social capital on physical health. This inquiry has broadened from an emphasis on overall mortality and self-rated health to encompass more specific diagnoses, including HIV/AIDS. A systematic review was conducted of all studies that have examined social capital in relation to physical health, including all-cause mortality, major chronic diseases (e.g., cardiovascular disease), and infectious diseases. While only three studies were identified on the association between social capital and infectious diseases (only one of which was specific to HIV/AIDS), the methodological issues raised for other health outcomes hold utility in future investigations of social capital and HIV/AIDS. This review suggests several points of convergence—for example, more consistent associations between social capital and health in *unequal societies* with weak safety nets compared to *egalitarian countries* with a strong tradition of public goods provision; stronger relations between health and trust compared to associational membership; and stronger associations for social capital at the individual compared to

the collective level. Meanwhile, this review also points to gaps that the next generation of research will need to address, in particular stronger study designs to address questions of causality, and deepen understanding of causal mechanisms.

Building Social Capital in Uganda: The Role of NGOs in Alleviating HIV/AIDS Challenges in Uganda

Roberts Kabeba Muriisa, Mbarara University of Science and Technology

Social capital is one of the most widely discussed and contested concepts in the social sciences. It has received wide attention from development practitioners, policymakers, and academia. Despite its growing importance for analyzing and explaining social economic and political outcomes, there are few or limited studies that have addressed the issues of the process by which social capital is built and its eventual outcomes. As such, there is limited empirical research concerning social capital building and its practice in improving people's health, especially in the context of developing countries. This paper discusses the role of NGOs in mobilizing social capital and its effect on HIV/AIDS challenges. A major finding of the study is that the way individuals and groups are connected and interact with each other are important mechanisms for alleviating HIV/AIDS. In this regard, HIV/AIDS NGOs play a central role in the way individuals, groups and communities and state agencies interact and are vital for people living with HIV/AIDS, especially those who are HIV infected. Drawing lessons from Uganda, the paper argues and concludes that social capital can be mobilized at different levels, i.e. the micro, meso and macro levels, and that all these levels are significant in addressing a social phenomenon such as AIDS.

Culture, local construct of masculinity and HIV-risk practices among young male IDU in a slum area in Makassar, Indonesia

Sudirman Nasir, Hasanuddin University

This study explored the social context of HIV-risk practices among young male injecting drug users (IDU) in a slum area, commonly named *lorong*, in the city of Makassar, South Sulawesi, Indonesia. HIV-risk practices are defined as risky injecting practices such as the sharing of needles and other injecting equipment and unsafe sexual practices, i.e. having multiple sexual partners and low level of condom use. Employing a qualitative approach, in-depth interviews were conducted with 21 young men (aged between 15 to 29 years) who were recruited in several hang-out spots in the *lorong*, as well as participant observation aimed at documenting the lived experience of young men in this locale. The interviews and participant observation revealed the crucial role of socio-economic deprivation in the *lorong* and the intersection of *Siri* (a local concept of dignity and esteem) and *Rewa* (a local construct of masculinity), as well as participation in gangs that stimulate young men in this area to be engaged in HIV-risk practices. These intersections push many members of the *lorong* to be involved in risky drug use and drug injecting practices as well as unsafe sexual practices that render them vulnerable to HIV infection. Furthermore, risky drug use and unsafe sexual activities that can potentially lead to HIV infection is not an isolated behavior and must be understood in the social context of the *lorong*. I argue that to be more effective, the individualization of risk that characterizes the existing harm-reduction programs in Makassar need to be complemented with wider community-based programs that address socio-economic deprivation in the *lorong*. Additionally, harm-reduction programs in the *lorong* should be cognizant of the cultural and structural constraints hindering young men in this locality to apply safer drug-injecting practices and safer sexual practices.

Effects of Micro-Enterprise Services on HIV Risk Behavior Among Female Sex Workers in Kenya's Urban Slums

Willis Omondi Odek, University of Nairobi; Joanna Busza, Centre for Population Studies, London School of Hygiene and Tropical Medicine; Chester N. Morris, University of Manitoba; John Cleland, Centre for Population Studies, London School of Hygiene and Tropical Medicine; Elizabeth N. Ngugi, University of Nairobi; Alan G. Ferguson, Constella Futures

This study assessed individual-level effects of adding micro-enterprise services to a peer-mediated HIV/AIDS intervention among 227 female sex workers (FSWs) in Kenya. Survey data were collected in May–July 2003 and July–August 2005. Two-thirds of participants had operational businesses by end-line survey. Nearly half reported to have stopped sex work. Self-reported weekly mean number of all sexual partners changed from 3.26 (SD 2.45) at baseline to 1.84 (SD 2.15) at end-line survey ($P < 0.001$). Weekly mean number of casual partners did not change significantly. Weekly mean number of regular partners changed from 1.96 (SD 1.86) to 0.73 (SD 0.98) over the follow-up period ($P < 0.001$). Consistent condom use with regular partners increased by 18.5 percent and remained above 90 percent with casual partners. Micro-enterprise services may empower FSWs by giving them an alternative livelihood when they wish to exit or reduce reliance on sex work. Determinants of successful business operation by FSWs deserve further research.

The Distribution and Impacts of HIV/AIDS NGOs in Sub-Saharan Africa

Rachel Sullivan Robinson, School of International Service at American University, Washington D.C.

Sub-Saharan African countries are differentially resourced in terms of the numbers and types of HIV-related organizations that exist in each country. These organizations are a form of social capital that should be able to mitigate the effects, and spread, of the epidemic, yet very little is systematically known about them. In this paper, I document the variation in HIV-related organizations across all sub-Saharan African countries, as well as examine its causes and effects using a unique data set I have built from information contained in directories of non-governmental organizations (NGOs). I show that while some countries have many NGOs that target HIV/AIDS—for example, Botswana, Cameroon, and Senegal—other countries do not—for example, Angola and Rwanda. Similarly, local organization around HIV/AIDS dates from the 1980s in some countries, such as Cameroon, Nigeria, and Uganda, but did not start until much later in many other countries. Finally, some countries, such as the Central African Republic, Kenya, and Senegal have a plethora of organizations to provide support to people living with HIV/AIDS, while others, such as Tanzania and Zambia, do not. Some of these outcomes result from differential access to financial resources, as I find that foreign aid is an excellent predictor of when and where NGOs come into existence. Countries with more NGOs that target HIV/AIDS and that have had these organizations for longer experienced greater declines in HIV prevalence between 2001 and 2007. Countries with more HIV/AIDS NGOs also do a better job of providing antiretroviral therapy to their populations. Overall, I show that countries have differential capabilities to build and maintain social capital in the form of organizations, which then influences the progression of the epidemic both in terms of changes in HIV prevalence and provision of anti-retroviral therapy. Understanding the causes of the differential distribution of social capital across countries is thus one key to crafting effective responses to the epidemic.

Empowering sex workers and men who have sex with men: the role of social capital in preventing the spread of HIV in Andhra Pradesh, India

Fiona Samuels, Overseas Development Institute/International HIV/AIDS Alliance; Ravi Verma ICRW/ Horizons Program/Population Council; C. K. George, Institute of Health Systems

The Frontiers Prevention Program (FPP) is a prevention program focusing on key populations (KPs), including female sex workers (FSWs) and men who have sex with men (MSM), in Andhra Pradesh, India. The central hypothesis underpinning the FPP is that providing a comprehensive package of services and interventions to KPs will empower them to reduce risk behaviors. For empowerment for prevention to occur, it is necessary to improve KPs' access to services, create an enabling environment free of stigma and discrimination, and build their social capital. Social capital is defined as the ability to obtain support, to count-on or to trust peers, members of NGOs, and/or family members; the ability to participate and belong to groups; and individual confidence and self-esteem. This study explores whether the FPP increased levels of social capital among KPs and if this led to reductions in risk behaviors and changes in knowledge and attitudes.

Methods: Nested within a wider evaluation of the FPP, this study collected qualitative data at 2 points in time: 118 in-depth-interviews (IDIs) in 8 sites at baseline (2004) and 150 IDIs in 5 sites at endline (2006). Respondents were randomly selected with assistance from NGOs and KP informants from sites. Transcripts were analyzed using Atlasti.

Results: The wider FPP evaluation identified improvements in sexual behaviors and STI prevalence. Endline data from this study found higher levels of trust and involvement amongst KPs. Key factors associated with this included: peer outreach workers; provision of quality sexual health services in a friendly stigma-free environment; and drop-in-centers that provide a safe space and foster solidarity between KPs. An increased number of community-based organizations and peer networks were also observed; such informal networks play an increasing role in social capital formation. Involvement with NGOs has increased awareness regarding HIV prevention, access to prevention services and improved negotiation skills, which, in turn, have increased individual confidence and self-esteem.

Conclusions: The positive findings of improved sexual behaviors and reduced STI prevalence are associated with increased social capital and empowerment of KPs, though direct causal pathways are difficult to demonstrate. Building social capital and fostering solidarity amongst KPs increases confidence and strengthens self-esteem. Such processes enable KPs to access and use community and clinic-based health services, ultimately promoting sexual behavior change.

The Role of Social Capital in Strengthening the Resilience of Children Affected by AIDS—A Case Study from Western Kenya

Morten Skovdal, London School of Economics

As the number of orphans increases, various social protection schemes have been developed and implemented as a response. Household and stipend-based cash transfers are being tested and scaled up in many parts of sub-Saharan Africa, undermining community-based responses and with little consideration of Social Capital and its role in strengthening the resilience of orphans and vulnerable children. This may be partly because Social Capital is too often conceptualized statically in terms of networks and norms (e.g. Putnam) or in terms of particular types of power (e.g. Bourdieu). While such conceptualizations are important and contribute to our understanding of the role of Social Capital, I argue there is a need to develop a more process-oriented view of Social Capital. Reflecting on research carried out in Western Kenya, I identify Social Capital as the opportunities that people have to participate in local community life and the ability for individuals

and communities to navigate and negotiate social support. To illustrate this, I present three types of participation that allowed children to cope with adverse circumstances: 1) Resource-generating participation, 2) Support-building participation, and 3) Identity-strengthening participation. The paper concludes that community-based capital cash transfer may be a viable strategy in strengthening the resilience of orphans and vulnerable children.

Measuring Stigma—Building the Capacity of Networks of People Living with HIV to Inform Policy and Practice

Lucy Stackpool-Moore, IPPF; Brianna Harrison, UNAIDS; Christoforos Mallouris, GNP+; Rodrigo Pascal, UNAIDS; and Fiona Pettitt, ICW

Within a framework of human rights and development, this paper explores the potential of The People Living with HIV Stigma Index as a tool for building the social capital of individuals living with HIV, as well as catalyzing a broader momentum for social justice, and improved policies and programs in response to HIV. It is an advocacy and research initiative that is by and for people living with HIV, where the process is just as important as the product. Overall it aims to improve our collective understanding of experiences of stigma, listen to struggles of individuals as they try to achieve their human rights, and document experiences of living with HIV. By putting people living with HIV at the center of the process, it is an actor-oriented approach to human rights in definition and in process, and as such contributes to the realization of rights and generation of social capital through the process of working with the tool, as well as through the products that it generates. To date, evidence on stigma has been largely anecdotal, unsystematically gathered, and difficult to compare across populations, socio-cultural and socio-economic issues, and time. The People Living with HIV Stigma Index enables the deconstruction of that intangible entity—stigma—through documenting the experiences of individuals in a process that is not only nationally grounded and relevant, but also internationally comparable.

Health by association? Social capital, social theory and the political economy of public health

Simon Szreter, University of Cambridge; Michael Woolcock, World Bank

Three perspectives on the efficacy of social capital have been explored in the public health literature. A 'social support' perspective argues that informal networks are central to objective and subjective welfare; an 'inequality' thesis posits that widening economic disparities have eroded citizens' sense of social justice and inclusion, which in turn has led to heightened anxiety and compromised rising life expectancies; a 'political economy' approach sees the primary determinant of poor health outcomes as the socially and politically mediated exclusion from material resources. A more comprehensive but grounded theory of social capital is presented that develops a distinction between bonding, bridging, and linking social capital. It is argued that this framework helps to reconcile these three perspectives, incorporating a broader reading of history, politics, and the empirical evidence regarding the mechanisms connecting types of network structure and state—society relations to public health outcomes.



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