Evaluating Community Health Projects: the role of Social Capital

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Declaration:

This dissertation represents original work by the author and has not been submitted in any other form to another university. Where use has been made of the work of others it has been duly acknowledged and referenced in the text.

The research for this dissertation was performed whilst I was a student in the School of Development Studies at the University of Natal, Durban. Research was undertaken under the supervision of Dr. Cathy Campbell at the London School of Economics during 1998.

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Contents

Chapter One: Introduction

1.1 Motivation, the objectives and the scope of this dissertation:

In this dissertation, the following issues will be explored:

- the potential relevance of social capital as a *framework* for investigating the community-level networks and relationships that might determine the success or failure of sexual health promotion programmes with a community outreach emphasis
- the potential usefulness of social capital as a tool for *evaluating* such programs

In essence, the aim of this study is to speculate how levels of social capital affect and determine the outcomes of health projects, specifically HIV / sexual health projects, through analysing the results of a survey which sought to measure (amongst other things) possible links between social capital and health.

As discussed above, the hypothesis is that there is a positive relationship between high levels of social capital and sexual health. If such a relationship can be found, it will be argued that building social capital might be an important activity for those interested in improving sexual health. This relationship will be examined using data collected from the Carletonville HIV Management Programme's Pilot Survey. One section of a long questionnaire contains questions relating to perceived levels of social capital in peoples' communities, and their responses to these questions have been linked to their STD(sexually transmitted diseases)/HIV status (as measured through blood and urine samples). (*DFID Proposal*, Williams, B, 1997).

The dissertation, utilising data from a secondary source, assesses social capital as an analytical tool for understanding social development programme implementation, and in many cases, failure. Investigating the issue by analysing current literature will hopefully give further insight into where there should be future research, and into what the strengths, as well as the weaknesses of the concept are. There has been much criticism of

social capital since Putnam's (1993) usage of it, however, not much of this criticism has resulted in any tangible, pragmatic approaches. Like all fledgling concepts, social capital needs polishing and refinement, as well as practical methods of implementation of the tool and measurement of the outcomes. Pointing in particular to gaps in the literature where social capital and sexual health are concerned, this dissertation is more of an introductory text highlighting the need for resources to be applied to the area.

1.2 Chapter Outline:

- **Chapter Two: Contextualisation & Research Problem & Methodology**
  This chapter contextualises the dissertation within the data collected in the Carletonville project. It looks at the background to the project, what it comprises, what its origins and aims are, its methodologies, and how social capital can be of use in the evaluation of the project. It sets the scene for the collection of data in the pilot survey, and discusses the downfalls of conventional HIV management programmes, which tend to be biomedical in nature. It thus serves to justify further study of the links between social capital and sexual health.

  What is then discussed is the methodology used in writing this dissertation, namely the analysis of secondary data from the Carletonville HIV Management Programme, and written material on social capital ranging from Putnam's initial work to more current, critical writing on the topic. A brief consideration of problems associated with using secondary data is also given.

- **Chapter Three: Literature Review - Theoretical Framework**
  This chapter gives an overview of the literature (some of it referred to in Chapter Two), looking at the origins of the concept, the subsequent criticisms thereof, as well as discussing gaps in the literature. It considers the literature in terms of its relevance to the Carletonville HIV Management Programme, with the central aim being an assessment of the usefulness of social capital in the implementation and understanding

of social capital and sexual health on the one hand, and social development on the other. Key issues which relate not only to the Carletonville Programme but to social capital as a theory in itself, will also be identified.

- **Chapter Four: Results**

  Chapter Four gives a basic overview of the results obtained in the Carletonville HIV Management Programmes' pilot survey (hereafter 'The Pilot Survey'). Results from those questions in the survey which relate to sexual health and social capital are presented statistically for further, more qualitative analysis. Below each set of data, issues for discussion in Chapter Five are introduced.

- **Chapter Five: Discussion**

  Chapter Five focusses on the issues which were highlighted by the social capital questions in The Pilot Survey. The data points to relationships, which in some cases are strong, and in others, weak. The purpose of this chapter is to elaborate on these relationships and investigate whether the links are actually meaningful. A preliminary investigation of why these relationships occur is also presented.

- **Chapter Six: Conclusion**

  The concluding chapter will draw together all the aspects of the study, assessing the concept of social capital, the existing literature and what the gaps are, as well as the usefulness of social capital as an analytical tool in the field of social development. Development theory needs conceptual frameworks which allow the measurement of community level changes that the projects seek to bring about, through their emphasis on participation, empowerment and representation. Social Capital would be only one of a series of tools used to evaluate community development and progress. It potentially offers a framework which allows for community-level assessment that takes into account the importance of inter-personal relationships and networks. Sexual health will be examined in terms of its broader impact on social development, and hence in effect what is being examined is the relationship between social capital and social

development. While it is clearly ambitious to offer policy recommendations from a pilot survey, what will be suggested is future areas for research to allow for policy improvements and adjustments.

Chapter Two: Research Methodology and Contextualisation

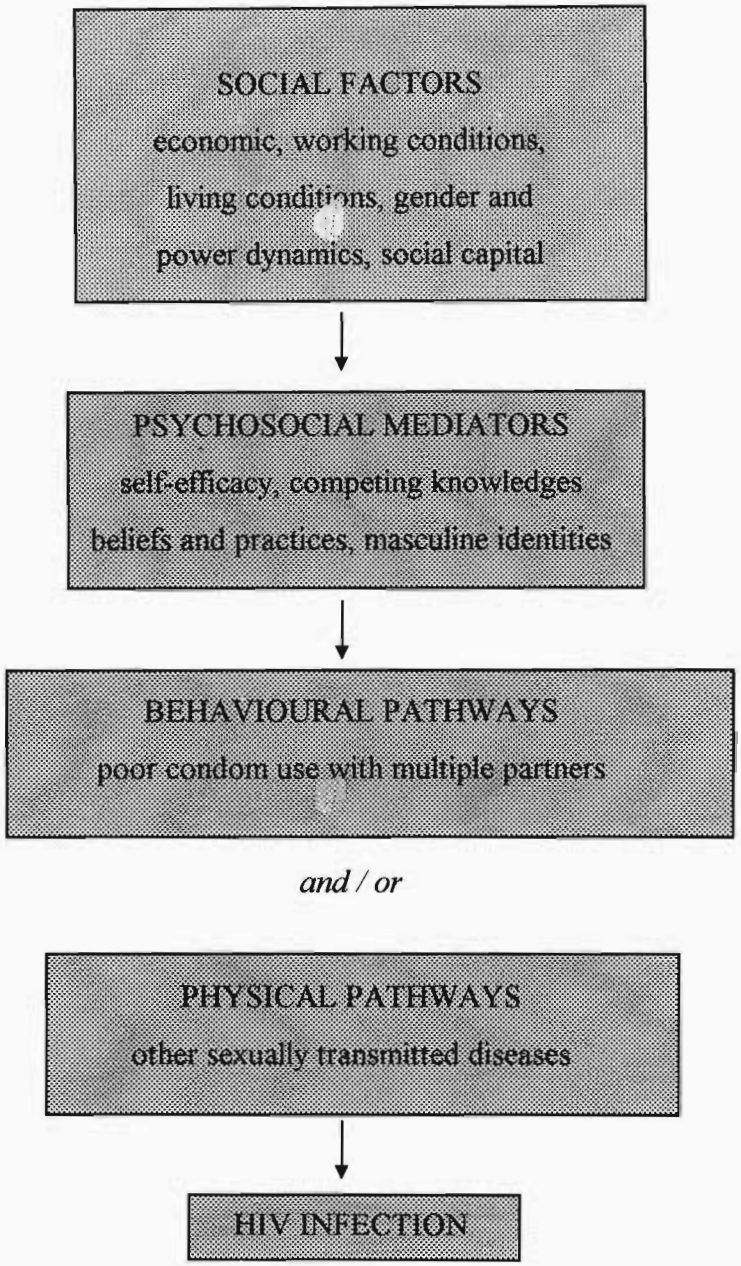
2.1 Introduction:

The data used in this dissertation are secondary data, obtained from The Pilot Survey, carried out by the Carletonville HIV Management Programme. The aim of this chapter is to outline this programme, and to give some background information on, and present an historical account of the project and its origins. The survey questionnaire will be discussed, as will the motivations behind the initial programme. The funding proposal which was submitted to DFID (Department for International Development) (who are the major funders) will also be outlined. The chapter then goes on to discuss my methodology, as well as issues associated with using secondary data.

2.2 HIV/ AIDS as a development problem

Klouda (1995:467) argues that 'HIV is not a cause in its own right, but a strong marker for action and concern in development'. It is crucial therefore to see this programme within the context of HIV as a development issue, rather than one which is only related to health. It has been the failure to accept HIV as a development issue which has rendered previous HIV management programmes unsuccessful.

The diagram on the next page, adapted from Campbell and Williams (1998a) depicts the relationship between the social context and HIV infection in the context of the South African mining industry:


SOCIAL FACTORS
economic, working conditions,
living conditions, gender and
power dynamics, social capital
PSYCHOSOCIAL MEDIATORS
self-efficacy, competing knowledges
beliefs and practices, masculine identities
BEHAVIOURAL PATHWAYS
poor condom use with multiple partners
and / or
PHYSICAL PATHWAYS
other sexually transmitted diseases
HIV INFECTION

2.3 The Carletonville HIV Management Programme

2.3.1 The Objectives of and Rationale Behind The Carletonville HIV Management Programme

The aim of the management programme is to reduce levels of HIV and STD transmission in Carletonville, South Africa. In essence its aim is to generate community level processes that will promote sexual health through the facilitation and promotion of peer education programmes. Its objectives are:

- to reduce sexually transmitted diseases, thereby reducing the risk of HIV transmission (given that one is more likely to get HIV if one has another STD
- to create community based condom distribution and outreach programmes with an emphasis on grassroots participation to promote condom use
- and to encourage maximum stakeholder participation. This will be achieved through the promotion of alliances between the relevant people, allowing the creation of an enabling environment.

Campbell and Williams (1998e) discuss HIV in the gold mining industry, pointing to the failure of biomedical and behavioural prevention programmes, introduced both by management and trade unions. They illustrate the complexity of HIV transmission through examining the community within which mine workers contract HIV and other sexually transmitted diseases. Mine workers live in single sex hostels, they are exposed to dangers on a daily basis, and there is little intimacy or social support. They are therefore often fatalistic and despondent, and this has immobilised the efficacy of management-led, biomedical and behavioural programmes. It is their daily lives which shapes their social identity, and informs their risk behaviour. In a context where the threat of death is an everyday reality, and there is little opportunity to share feelings of anxiety, loneliness or grief, an action which may have a consequence in years to come is not given a second thought. It is this relationship between sexual behavior and the psychosocial context

within which it happens, which seems so obvious, that needs to be tackled and changed if peoples' behaviours are to be altered in a way that has far-reaching and positive effects. What is therefore necessary is an examination of how society operates, and how individuals that make up the wider community within which the miners live, interact and relate to one another. This has direct implications for HIV transmission.

Campbell (1998c) also examined HIV transmission amongst sex workers who live and work in settlements around the mine. They are therefore part of the mining community, and the outreach programmes of the Carletonville HIV Management Programme will be aimed at them as well. What Campbell has noted, through extensive life history collection, is that women's social and sexual identities, which shape their behaviour, need to be reshaped through the promotion of health enabling communities. Their behaviour, as with the miners, is also found to be tied up with their social identity. The root cause of their feelings of inadequacy and helplessness are different - both are related to poverty and to power relations, however, the miners feel helpless largely because of conditions on the mine, whereas the sex workers are rendered powerless because of the gender dynamics, particularly in the area of sex work where despite having a certain degree of control over their lives they are objectified, abused and limited in terms of how much say they have over the sexual act itself. If a woman refuses to have unprotected sexual intercourse, there are ten other woman desperate enough for the money, who will concede. Yet, despite the different causes of low self esteem and self-efficacy, the effect is the same, and the end result is that risk behaviour is accentuated.

As part of an ongoing evaluation strategy, The Pilot Survey aimed to assess a range of biomedical, behavioural and community level factors believed to influence HIV transmission. In relation to community level processes it aimed to asses what aspects of the community should be promoted in terms of their being beneficial to the programme. Social capital was used as a framework for understanding community level networks and relationships, and the results will be used to shape the future emphasis of the programme.

The programme is an acknowledgment of the failure of biomedical and behavioural approaches to HIV management. Campbell and Williams (1998b) stress that there is a growing awareness, or at least a recognition that there needs to be an awareness, of the role that society, culture and the economy play in HIV transmission. Campbell and Williams add to this growing body of literature by suggesting that people's sexual identity, which is shaped by psycho-social processes, will impact on levels of HIV, and on sexual behaviour. Therefore an analysis of how this identity is created is crucial, to provide insight into how these behaviours can be modified.

Gillies (1996) discusses the growth in programmes which are community based and are based on participatory health promotion models. The underlying goal of such projects is to create enabling environments to allow for positive behaviour changes. It is these types of projects which need to be implemented if they are to succeed in changing the way people view themselves, and their levels of self-efficacy and empowerment, as it is these constructs of sexual identity which ultimately determine how people will behave sexually. The Carletonville Programme recognises this validity of such projects, and therefore aims to implement a programme along these lines. This is a huge step away from traditional management programmes which are aimed solely at changing behaviours through top-down education programmes and condom distribution. Furthermore, such programmes would use biomedical and behavioural outcomes[1] to measure and analyse the success of a health initiative, rather than attempting to understand the complexity of the environment within which sexual behaviours are formed.

Campbell and Williams (1998b) argue that while there has been progress made in the implementation of community-based interventions, this progress has yet to be matched by adequate changes to evaluation methods. Indicators need to be developed to evaluate the psycho-social and community level factors which inform behaviour, which in turn

[1] A study looking at behavioural outcomes would examine reported behaviour, knowledge, attitudes, and perceptions (KABP studies). The biomedical approach would involve examining HIV and STD scores.

determine how 'enabling' an environment can be. Sexual behaviour is informed by the following psycho-social and community level factors:

- social identity, which is shaped by peoples working and living conditions, cultural environment, their gender, and the community
- perceptions of self efficacy, which is also influenced by the above factors,
- and the extent to which the community is enabling, and supports, or discourages, particular behaviours.

Campbell (1998c) argues that social capital promotes self efficacy, which in turn allows for an empowered social identity. If people feel valuable, and therefore that their health is worth preserving, they are likely to behave in ways that are more healthy. A good example of this would be empowering women through women's groups, such as single women's support groups, burial societies and rotating credit funds (Wilson, 1995) which in turn enables them to take control over contraception, and to insist on, or at least broach the subject of, condom use.

The link between social capital, HIV/AIDS, and social identity is more easily understood if HIV is recognised as being a complex issue, which is determined by a complex interplay of the issues outlined above. Understanding it purely in biomedical or behavioural terms blurs this complexity, and therefore impedes effective action.

The duration of the project is three years, and the bulk of its funding is from the Department for International Development (DFID). The contribution DFID has made will be managed by the Epidemiology Research Unit (ERU). The ERU will also play a role in the facilitation of public, union and private sector participation (Williams, 1997).

What needs to be stressed is that the evaluation programme (whose function is to evaluate the success of the management programme, as part of an ongoing evaluation procedure) is utilising a multi-method approach, of which The Pilot Survey is just one aspect. The data collected in the Pilot Survey will be backed up by numerous other data collection methods

and methods of analysis. However, what is being considered here is only the initial data from The Pilot Survey. The evaluation consists of the following aspects - as detailed by Campbell and Williams (1998b):

- Biomedical surveys
- Behavioural surveys
- STD (sexually transmitted diseases) monitoring
- Epidemiological modelling
- Ethnographic interviews and focus groups
- Participant observation
- Operational evaluation

The evaluation consists of outcome and process evaluation (Campbell and Williams, 1998b). The outcome evaluation tends to be quantitative in nature, while the process evaluation is more qualitative. Process evaluation looks at the 'how' as opposed to the 'if'. The HIV Management Programme aims to evaluate why and how they had the outcomes they did, and this includes assessing levels of community trust of the programme, levels of communication, resource availability, and the organisational context within which the programme took place.

What they are stressing is the importance of ascertaining why the programme had the results it did through tracking the processes whereby HIV transmission is or is not reduced, and not just presenting a set of before and after *outcome* results that could have no future use for other programmes. Historically, presentation of results has focused only on the outcome at an individual level, such as individual behaviour, reported condom use, knowledge and disease states, and has not considered why the programme produced the results it did. Analysing process as well as outcome also allows for a move away from the individual to an analysis which includes the community. While recognising the uniqueness of every situation, cognisance of the potential of the programme to provide lessons, examples, ideas and policies, is given.

Campbell and Williams (1998b) then go on to argue that as well as process and outcome evaluation, what needs to be developed is a theoretical framework with which the broad range of community *processes* which shape and determine the success of the programme can be evaluated. It is here, they argue, that *social capital* can be used as a theoretical tool.

There are three main components to the project: condom promotion and peer education, and STD care and stakeholder management. The first phase of the project involves 92 000 gold miners and an estimated 240 000 community members in the surrounding areas (*ibid.*).

The following provides a description of the project's long- and short-term goals, as well as the rationale behind the project, and how it differs from previous well-meaning yet largely unsuccessful programmes.

The project framework includes a series of long-term, biomedical level goals, as well as short-term behavioural level goals. It also has output- and activity-related goals, which refer to process rather than end-product goals. The short-term goals for the first two years include syndromic STD management, training and follow-up support, a target of 75% of all miners and surrounding community members attending peer education activities, and a decrease in the number of sexual partners and the incidence of non-condom use.

The long-term goals, which are biomedical in nature are a lower prevalence of sexually transmitted infections, and a lower rate of change in the prevalence of HIV compared to comparison sites. The lowered rate they are aiming for is 33% (Williams, 1997). The output and activities goals are related to programme management and project development respectively. Output aims include 100 000 miners and members of the community receiving syndromic STD management, training of health care personnel from

200 health centres, 5000 community education and condom promotion meetings to be held within two years, and 5 million condoms to be distributed within the same time frame.

2.3.2 The Survey Questionnaire

The questionnaire was designed to cover eight broad topics. they are as follows:

1. Identification[2]
2. background characteristics & migrancy
3. marriage
4. sexual relations
5. STDs and health issues
6. perceptions about AIDS
7. risk perception, behaviour change and attitudes to persons with HIV/AIDS
8. condom use

The questionnaire is a slight modification of the UNAIDS Multisite questionnaire, which was extensively used by The World Health Organisation in Africa. It also used the work of Narayan and Pritchett (1997), and Kawachi (1997) to extend the questions asked to the survey more appropriate for an exploration of social capital. It picked up the questions used by Narayan and Pritchett's examination of associational membership, and by Kawachi et al in their discussion on the role of trust and reciprocity.

What is evident from these areas of investigation outlined above is that the questionnaire covered a broad and detailed area of investigation. For the purposes of this dissertation, only questions relating to social capital are relevant, and these questions fell within section two, on background characteristics and migrancy. The questions asked were:

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[2] Although participation is anonymous, informants are identified by number in order to link the results of the biomedical tests and the questionnaire responses

- Are there any groups, clubs or associations which people in Carletonville can belong to? (a number of options were given for example - women's group, stokvel, church group, burial society)
- which ones are you a member of?
- how would you rate the way each group you belong to functions? (G = good, B = bad, A = average
- Generally speaking, would you say that most people can be trusted or would you say that you have to be careful when dealing with other people?
- Generally speaking would you say that most of the time people try to be helpful to others, or would you say that people mostly look after themselves
- did you vote in the last national elections?

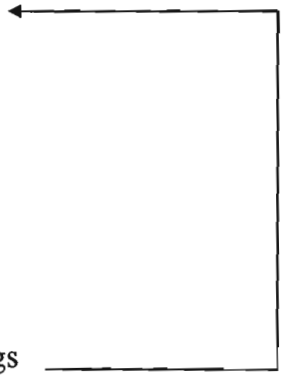
The questions tried to get an idea of what the levels of trust, civic cooperation and reciprocity were like in the questionnaire area. These were asked in an attempt to ascertain levels of social capital, using Putnam's (1993) indicators. The rational behind these questions was to then compare these results with the overall findings on sexual well-being in the area to determine whether there is a link between social capital and health. This in turn would allow an investigation of possible enabling environments which would influence the outcome of health programmes. The aim of this dissertation is to take these basic findings, which are reported as quantitative data, and to analyse these relationships. The questionnaire lays the foundations for such a study, but is too broad to provide a specific interpretation of social capital in the study area.

2.4 Research Methodology

2.4.1 Steps in the Research Process

Giddens (1993) identifies the following steps in a research project:

1. define the problem
2. review the literature
3. formulate hypothesis
4. select a research design
5. carry out research
6. interpret results
7. report the research findings



which prompts further research

This was a useful guideline to use in terms of deciding how to structure the research project.

- The *problem* was *defined* initially as examining the importance of social capital in attaining sexual health. The broader issue of social capital and social development has also been introduced, however, the scope of the project is too limited to be able to offer any more than a preliminary discussion of these links.
- The *literature* on social capital was *reviewed*, in Chapter Three, to identify key issues, strengths of the concept, as well as critiques of social capital as a theory. What was useful was that through this analysis it became clear where the gaps lie, and therefore where future research needs to focus. As argued by Boyle (1997) the purpose of the literature review is not to cite everything ever written on the topic, but to examine and show understanding of the articles and arguments which have been influential in the field. What also need to be shown is that the most up-to-date literature has been consulted.

- The *hypothesis formulated* is that there is a positive link between high levels of social capital and high levels of sexual health.
- The *research design* chosen was the utilisation of secondary data collected from The Pilot Survey - the use of which was the evaluation of the Carletonville HIV Management Programme.
- The *results* of The Pilot Survey were *analysed* in terms of current social capital theory, as identified in Chapter Three. The data had already been statistically analysed, and a social analysis was added.
- The *research findings* were *reported* in the format of a discussion chapter, Chapter Five, which elaborated on the findings and the social analysis thereof, and also picked up on the key issues identified in the literature.

2.4.2 Other relevant issues in methodology

One of the main functions of sociological research is to determine cause and effect. What was examined in this dissertation was the relationship between sexual health and social capital, and in essence what was being explored was the question of causality - do higher levels of social capital lead to enhanced sexual health, or would it be coincidental if areas were identified as being rich in social capital and having higher levels of sexual health.

Obviously the best way to determine the significance of relationships is through statistical analysis, which points to causality. However, statistics do not tell us about the quality or nature of relationships, nor do they give us enough detail to foster an understanding of the complex interplay of the different factors examined. An understanding of why, and not just what, is crucial to inform future research and policy, and to provide insight into why people behave as they do. Utilising quantitative and qualitative data together (such as those collected through in-depth household interviews), is a useful tool when exploring issues of causality. These relationships can then be explored and understood through a sociological analysis.

While I am not going to elaborate on this issue, Barnes (1979) discusses the question of ethics in research. What has to be considered, and what was taken into consideration in The Pilot Survey, is that questions about sexual health and behaviour are highly personal and often contentious, and at all times respect of peoples' privacy and right to anonymity is crucial. Questioning people on their sexual lives and their sexual identities brings with it a series of issues such as non-disclosure, and misreporting, which have to be taken into account when analyzing all data. The use of in-depth discussion groups, or one-to-one interviews which are conducted through repeated visits can go some way to overcoming these problems, as what is vital is that trust be built. A range of additional methods will be used by the ERU to supplement survey findings (in progress).

Fotheringham (1997) discusses the use of statistical or numerical data in a dissertation. His discussion was a useful starting point for understanding measures produced by statistical analysis. A useful caveat discussed in his article is that care must be taken in case of the identification of *spurious relationships*. This is of particular relevance to The Pilot Survey because of the complex nature of the relationships explored within the communities. What has been acknowledged therefore is that there is clearly a lot more to sexual health, and to social development, than levels of social capital, but that social capital could be a *significant* variable in this relationship.

2.4.3 The Use of Secondary Data:

What will be examined is the problems with, as well as the benefits of, using a secondary data source. Secondary data can be statistics collected such as those collected through a census, it can be diaries written by individuals, newspapers, or television extracts. While much data is 'secondary' in nature, in terms of it often having been collected by a third party, the distinction lies in how much influence the researcher has had in shaping the project, its aims and its objectives.

While many researchers do not themselves collect data, and often commission others to do the collection, it would be primary in so far as it was collected using questions and research tools as identified by the researcher. Once one no longer has any influence over how data is collected, and one uses only the end product, it becomes secondary.

Clark (1997) states that linkages which have been statistically identified can be used as a secondary data source, and these linkages or relationships can be used as a *starting point* for a discussion.

He states that secondary data has the following advantages:

- it exists (and so is cheaper and quicker to obtain than primary data)
- it is usually of proven quality and reliability

the *weaknesses* are identified as follows:

- its inflexibility (it cannot be customised it to one's needs)
- its quality is unverifiable since it is not replicable

(Clark, 1997:59)

2.5 Conclusion:

In the first part of this chapter I discussed the Carletonville HIV Management Programme to set the scene for The Pilot Survey results as used in this dissertation. Issues such as the background to the Programme, research design, objectives, duration and funding were discussed. In the second part of the chapter, my methodology was explored, in terms of how the dissertation was formulated, and what texts were referred to as basic guidelines for writing up, and for using secondary data.

Chapter Three follows, with a discussion of literature reviewed, and forms the basis of my theoretical argument.

Chapter Three: Literature Review - Theoretical Framework

'Social capital, while not all things to all people, is many things to many people' (Narayan and Pritchett, 1996:2)

3.1 Introduction:

The aim of this dissertation, through assessing the results of Carletonville HIV Management Programmes' Pilot Survey, is to focus on Putnam's definition of social capital to determine whether it can help to conceptualise and measure some of the processes that community development seeks to set in motion. Within the realm of social development, there is much discussion around, and promotion of, participation, representation, empowerment. However, there has not been enough theorising about what implementing these concepts entails, and about how their effects might be measured.

Chapter Two included criticism on conventional biomedical and behavioural approaches to HIV prevention. Using the traditional approach, HIV has been tackled through providing people with information about the importance of condom use, and through informing people about STDs. However, what has been argued is that HIV is a complex problem, which is determined by a number of psycho-social and community level factors.

Social identity, perceived self-efficacy, and how supportive and enabling a community is will all impact on a person's risk behaviour. It has also been argued that social capital potentially offers a framework for understanding the types of communities which may be health enabling, promoting healthy behaviours. Social capital was defined as reciprocal social support, civic engagement and local identity. It is believed that if social capital can improve people's sense of empowerment and self-worth, for example through women's support groups, they will be more likely to use, or insist on the use of, condoms.

There are many exaggerated claims being made about social capital. Many of these claims are simply wrong. Social capital is not the solution to all development problems, nor is it the route to democracy and community ownership of development. Others are premature insofar as the concept is still far too poorly specified at this stage. In this dissertation our goals for social capital are modest, viz., that the concept could be developed into a useful evaluative tool alongside others. This is a controversial concept, and there are many criticisms of it - it is necessary to attempt to specify the use to which it will be put.

As discussed in the introductory chapter, what will be considered is the possible links between social capital and sexual health in terms of our hypothesis that social capital might form a useful tool for measuring the ongoing effect of community development programmes.

In this section an overview of the current debates around social capital, as well as an examination of the origins of the concept will be presented. Criticisms of the concept, and of Putnam specifically will be explored. Case studies of social capital will be reviewed to give an idea of where social capital as a concept is in use, and more importantly, where there are gaps in the literature.

In this review the way in which the concept of social capital has been taken up by research in the field of:

- development in general
- and health in particular

is examined

It is argued that while much more work needs to be done before the concept can sustain some of the more grandiose claims made on its behalf, it could play a more modest role in helping with small, clearly defined tasks in terms of starting to pin down some of the community level networks and relationships that might enable or support those healthy behaviours that health development projects seek to promote.

3.2 Putnam's definition of social capital

Putnam introduces the concept of social capital in relation to his study of modern Italy, a study whose origins date back to 1970. He refers to social capital as 'features of social organisation, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions' (Putnam, 167:1993). Putnam's study of Italy found that the North, which is richer in horizontal rather than vertical ties, is historically far more likely to have governments and markets which are more effective. This is because, argues Putnam, less effort is spent on transaction costs, and different social and civil networks overlap, allowing for more efficient monitoring of, and therefore promotion of effective, governance. Vertical relations on the other hand, as found in the South, involve low levels of trust, and levels of state accountability to civil society would be significantly lower. Relations, rather than being accountable, would be patron-client type relations, which in turn allow for more corruption, and less control over the state and the market (1993).

Voluntary associations and effective governance were found to be connected, and Putnam uses the example of rotating credit associations to illustrate how spontaneous cooperation is facilitated by social capital. An illustration of this link is the finding that the more associations were joined, the faster and more efficiently health care claims were reimbursed. Putnam suggests two reasons for this, the first being that there would be more monitoring of government provision of public goods, and secondly that the government itself would be more embedded in social networks (1993). Putnam found this enhanced level of civic interaction in the North, dating back to the 11th century, to be relatively stable, even during times of war and pestilence. The non-civic cooperation in the South was equally stable and established (1993:181). These differences can be traced back to distinct and enduring traditions, which determined the divergent paths of the regions.

Coleman (1988) examined the theory of human action, examining how and why people behave as they do, and referred to networks and qualities of social structure that are critical resources for human action. He showed how in the United States of America, student's results were better in communities where social networks were more dense,

and this environment allowed for support and more effective disciplining of the students. Coleman (1988) was also an early proponent of the theory that enhanced levels of social capital would lead to greater levels of other forms of capital, such as human or person made. His work examined the ways that individuals within a network would exercise sanctions as a way of maintaining crucial reciprocal activities (1988).

Coleman's work preceded that of Putnam, and Putnam picked up on Coleman's links between trust, social networks and more effective social action in his studies on civic traditions and regional development in North and South Italy.

Putnam (1993: 171) elaborates on two features or bases of social capital: networks of civic engagement and norms of reciprocity. Each concept will be explored in turn.

Norms of Reciprocity:

Putnam states that norms that can 'undergird social trust evolve because they lower transaction costs and facilitate cooperation. The most important of these norms is reciprocity' (1993:172). Norms arise when there are externalities arising from people's actions, such as non-cooperation in a village meeting. It is understandable why norms of reciprocity are crucial, particularly in areas where resources (both tangible and intangible) are limited.

Once social capital is set in motion, in daily interactions involving sharing of resources - physical and non-material or labour resources - it is understood and accepted implicitly that should these transactions not be reciprocated, they would cease to operate. If one depends on these very transactions for daily survival then it is unlikely that one is not going to reciprocate. You 'spend' in order to create or produce further resources to draw on, whether now or at a later stage.

Putnam (*ibid.*) states that there are two forms of reciprocity: balanced or specific, when there is a simultaneous exchange of an item of the same value, and generalized or diffuse, when there is a continuing relationship of exchange. This latter type involves an implicit assumption that a transaction now will be compensated for at some stage: 'All men distrust one forgetful of a benef[illegible]' (*ibid.*). This component of social capital is,

according to Putnam, a highly productive feature (productive in the sense that the more that is spent the more is created, even if it is created to be utilised at a later stage). It is common in communities which have managed to overcome harsh difficulties, for example in the northern communal republics of medieval Italy.

Networks of Civic Engagement:

Putnam (1993:173) states that all societies are characterised by a number of different networks of communication and exchange, both formal and informal. These can be either horizontal or vertical in nature, linking equal or unequal agents respectively. Most networks are a mix of both types. Networks of civic engagement are a vital part of social capital, and the denser the networks the more likely it is that people are going to cooperate for mutual benefit. These networks foster sturdy norms of reciprocity, the norms being reinforced by the network of relationships established. As the networks also facilitate communication, and provide, through drawing on the past, a culturally-defined template for future action, the norms are strengthened (1993:174).

Social capital is likened to other forms of capital in that it serves as a type of collateral for borrowers (*ibid.*), with however, as Putnam contends, the crucial difference that it is available to those who have no access to ordinary, more common forms of capital. It is also a 'capital' in the sense that the more capital expenditure takes place, the more is created, as with physical and human capital. Activities such as mutual aid practices are themselves an investment into the stock of capital. An extension of this idea of spending to create more is that if it is not used, it will become depleted. Thus, to create trust and reciprocity one has to draw on existing ties and networks. Another distinguishing feature of social capital, states Putnam (1993:170) is that unlike conventional capital, social capital is a public rather than a private good.

It is, however, the use of the term 'capital', and the likening of it to other forms of capital that has created much criticism and debate around the concept (Budlender and Dube, 1998).[1]

[1] An analysis of these criticisms follows later in this section.

3.3 Social Capital as a conceptual tool

3.3.1 Social Capital in the development field

This section will consider the relationship between social capital and development. Arrow (cited in Putnam, 1993:171) states, in a somewhat reductionist manner, that 'much of the economic backwardness in the world can be explained by the lack of mutual confidence'. While this does generalise in some sense the nuances of third world poverty, thereby obscuring the importance that locality plays in determining social development, it exemplifies utilising an understanding of the role of trust and cooperation - in other words, social capital - in aiding development (development here is referred to in the broad sense of both social and economic development, as it is argued that both are necessary and desirable if long-term poverty is to be eradicated).

Narayan and Pritchett (1997), outlining the mechanisms by which social capital affects development outcomes, state that pure non-cooperative action would lead to inferior outcomes, which is an interesting way of assessing social capital, i.e., in terms of examining situations with no social capital at all. They argue that social capital has the following effects:

- social capital affects public sector efficacy, as illustrated by Putnam (1993) when comparing North and South Italy
- it allows for cooperative action in terms of development planning and implementation and problem solving
- this allows for a diffusion of innovations
- less imperfect information will be passed on
- it creates an informal insurance which allows households to pursue risky activities which may have higher returns in the long run

Putterman (1995) questions whether there are any cultural preconditions for development. What he is trying to ascertain in his study of rural Tanzania is the link, if any, between cultural behaviours and economic development. He argues that the causality in the argument has been reversed, and that culture precedes economic

growth and development. This is also what Putnam argues, pointing to the circularity (as opposed to a linear relationship), of social capital and development.

Previously it has been presumed that once economic development has been initiated, people start to change patterns of behaviour, such as fertility choice, the assumption being that traditional societies will change their actions as and when they develop, and that all societies are equally receptive to development. Thus, argues Putterman, they have development potential. He stresses that it is essential to go beyond what he refers to as 'dichotomous notions of traditional and modern' to an understanding and a dialogue of varieties of social organisations (1995:5). This is also what Institutional Economics is trying to do.

Putterman discusses human capital in a broad sense, talking about cultural inventories, attitudes, knowledge and behavioural repertoires. He argues that 'social capital accumulates over long periods, adapting and permitting adaptation to new environments and technologies' (1995:7). The social organisation, which is dynamic, determines development capacity rather than potential. His notion of development capacity, which by definition is changeable and fluid, being determined by social capital, is what Campbell and Williams (1998c) refer to as *enabling environments*. Their article, discussing HIV prevalence among the miners in Carletonville examines why sexual health programs, based on changing peoples sexual behaviours, have thus far failed. They argue that what is needed for programmes to succeed is an environment which enables significant changes in sexual identity and subsequently behaviours.

It is argued that rather than trying to persuade people to change their behaviours, and using what is seen as logical reasoning to rationalise such demands, environments need to be created which enable behaviours to change. It is here that social capital has a potentially crucial role to play. It plays a vital part in repairing the social fabric of a community and enhancing its development capacity. What needs to be examined is if and how these environments can be created or enhanced, and if so, will they have a positive effect on social development programmes?

Bebbington et al (1997) also examine the link between social capital and development. They have found in their case studies of Bolivia and Mexico that development programmes often broke down or failed because of a lack of communication and because of distrust. Relationships tended not to be collaborative. They also found that levels of trust were related to the history of the community. This echoes Putnam's (1993) findings in Italy.

They assessed the relationship between rural peoples organisations - which would count as a form of social capital, and their relationship to social development. While they conclude that social capital is important for development, and that it is a prerequisite for successful programmes, they do acknowledge conceptual problems which need to be addressed (*ibid.)*.

Bebbington et al (1997) also discuss how social capital can influence other forms of capital - namely human made capital, natural capital and human capital (Serageldin and Steer, 1994, cited in Bebbington et al, 1997). They cite examples of social capital increasing market efficiency and therefore increasing the stock of human made capital. Sanctions, enhanced by social capital can also determine how human and natural capital is utilised (1997:9). It is argued in the present dissertation that all four forms of capital - human, human made, natural and social, are vital components of development. While there is criticism regarding the comparison of social capital to the other forms of capital associated with development (for example, Dasgupta, 1997), it is, however, useful to acknowledge a relationship between social, human, physical and environmental capital. While they may not be the same in economic terms, there is arguably a connection between levels of social capital on the one hand and levels of physical, human and environmental on the other. The main aspect of social capital which prevents it from being categorised alongside other forms of capital is the absence of appropriate and reliable measures. While qualitative studies of institutions can provide an idea of how social capital works and what comprises social capital in

different settings, it is very difficult to quantify[2]. This is clearly a vital area for future research.

As Dasgupta argues, it is necessary to assess whether or not social capital has potential to enhance our understanding of institutions in society which will protect human well-being (Dasgupta, 1997).

Perhaps one of the more common examples of the use of social capital in case study work is that of Moser's (1998) 'Asset Vulnerability Framework'. What she argues is that it is necessary to assess the sum total of peoples resources, not just there tangible, traditionally measured goods that determine peoples wealth, but their access to information, support and help from and within their local communities.

Thus, she states, one can be wealthy financially but poor socially, with a very low endowment of social capital because one is not linked into social networks, and one can be very poor with no money, yet have access to, and be part of, vast social networks which allow survival. By the same token, it can be levels of social capital which determine vulnerability and security, in that in a disaster situation, should all one's physical capital be lost, one would still have reserves of social capital on which to draw. Thus social capital determines security or vulnerability in the long and short term (1998). Moser focuses on the notion of enabling environments, a theme used in Campbell and Williams (1998c) when assessing how to enhance the effectiveness of social health programmes.

Beall (1997) argues that in Bangalore, India, solid waste management (SWM) has picked up on social capital, and on the current global trend towards decentralisation of development responsibility as an organising principal. Individuals hold the ultimate responsibility for environmental protection, and civic engagement is key. Community based organisations are encouraged to take control of SWM, which involves the collection, transportation and disposal of the waste.

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[2] Quantifying the relationship between social capital and sexual health has been undertaken by

What Beall examines in this paper is whether or not social capital is actually valuable, or indeed desirable. It has been argued by many theorists that social capital is to be promoted and created if development is to succeed (see Putnam, 1993; Evans, 1996; Narayan and Pritchett, 1997; Gillies, 1997), however, argues Beall, her study of SWM in Bangalore has shown that what is on the surface a positive and mutually beneficial set of relations and networks can often be beset by a number of problems. These problems include lack of representativity, clientelism, unequal access to and exclusionary forms of social capital, and anti-social capital. They relate to issues of *power*. She concludes that community organisation cannot be taken as an indicator of the impact of, or potential for the impact of citizen participation (1997:959). These critiques of social capital, at least of the form of social capital as found in Bangalore, will be explored in greater detail in section 3.4.

3.3.2 In the health field

In terms of the relationship between successful community health programs and social capital, a literature review undertaken by Health 2000 (*Health 2000 Social Capital Update*) has found 'repeated anecdotal examples providing circumstantial evidence of the association between levels of social capital, manifested by its specific constructs, and the effectiveness of collaborative effort undertaken to promote health' (*ibid.*). Gillies cites studies in the United States which have found (i) significant links between social trust and deaths from stroke, as well as (ii) an outreach programme for HIV patients in New York which resulted in more effective information dissemination (Gillies, 1997). According to Health 2000, it is crucial that this link be considered by the funders and organisers of public health actions, if these are to succeed.

Kawachi et al (1997) hypothesise in their study of the United States of America that reduced social cohesion (read social capital) leads to increased income inequalities, and this in turn is related to increased levels of mortality. Social capital was measured in their study by examining associational membership, as well as levels of social trust.

Williams and Campbell (1998) - their data forms the basis of the dissertation.

Causes of mortality examined were as follows: infant mortality, heart disease, malignant neoplasms, cerebrovascular disease and unintentional injuries (1997).

Their data supported this hypothesis, finding for example that states which had higher levels of social mistrust, also had higher levels of age-adjusted rates of total mortality (1997:1494). One contention they make is that social capital is non-excludable, and therein lies its attraction. However, as Beall (1997) has argued, social capital does not necessarily involve the inclusion, in a beneficial manner, of the whole community. Rather, it tends to be about one defined segment of a community, benefiting at the expense of others. Kawachi et al's argument that access to social capital is not restricted is clearly debatable.

Kawachi et al also point out future areas for research, namely on the definition and measurement of social capital, as well as work on urban-rural and other determinants of variations in social capital and its benefits. Furthermore they state, what is urgently required is work on how social capital can be created, arguing that there is a wealth of literature on how it can be destroyed, and that this is not particularly constructive (1997: 1497).

Kawachi et al's (1997) work on mortality and income inequalities was preceded by that of Gillies et al (1996), who looked specifically at AIDS, questioning whether or not it is a disease of poverty. They also acknowledge the failure of conventional approaches to health care, citing condom distribution and persuasion as typical facets of approaches aimed primarily at altering behaviour at the individual level. These have largely failed.

Poverty, they argue, makes people more vulnerable to AIDS. Socio-economic impoverishment has been found to determine HIV prevalence, regardless of injection use and frequency of sexual partners. Community development initiatives which promote social organisation and harmony will therefore have a profound impact on HIV/AIDS prevalence and susceptibility (1996). What is also required is adequate

outcome evaluation measures, which relate to the concept of social capital[3]. This claim, as well as the promotion of peer-led, face-to-face educational techniques, is followed up by Campbell and Williams (1998b), and in the Carletonville HIV Management Programme.

Gillies et al (1996) note that while the relationship between GNP (Gross National Product) per capita and AIDS is not significant in the developed world, it is significant in the developing world. AIDS tends to be associated with extreme poverty, and with affluence. For example, there is a negative association between AIDS prevalence rate and GNP per capita in sub-Saharan Africa. Affluence in parts of Europe and The United States also tends to be associated with HIV/AIDS prevalence. The pandemic is exacerbated by the fact that AIDS weakens the workforce, which in turn heightens the risk of the population as a whole because of the fall in productivity (1996:354).

Gillies et al (1996) discuss the features of poverty render populations vulnerable to AIDS transmission. They cite the following as being central to AIDS prevalence in poor nations, or amongst poor communities within nations:[4]

- Homelessness - which has an impact on sexual behaviour, and increases people's vulnerability in terms of opening up previously closed avenues of sexual culture, people are also more open to abuse, and prostitution is often the only option to survive, and to support drug habits associated with these lifestyles
- Rural to urban migration and industrialisation - this feature of industrialising societies brings with it a number of problems, including those outlined above, i.e., new activities which were not features of rural areas, are undertaken. Prostitution is

[3] Gillies et al (1996) illustrate this need by citing an example of a women's health programme in Gujarat, India which aimed at the overall empowerment of women, as well as having a social health objective. Women were trained as health workers offering knowledge and support services. However, the outcomes were not amenable to evaluation, because of the paucity of existing evaluation techniques. Examining individual as opposed to community level changes is not helpful, and projects such as these have failed to secure financial support because they do not show evidence to prove that they are succeeding with the task at hand (*ibid.*).

[4] Of relevance here would be power, geographical and racial differences, where for example in South Africa, the white population is far less vulnerable than the African population, despite living within a country that is classified as being developing. Thus, living within a developing region does not by default make one more susceptible to HIV/AIDS transmission. A political economy-based

often the only option for women, and is often the most 'lucrative' activity of a range of undesirable activities such as domestic or menial factory work. Male migrants away from their families frequent brothels, and have multiple partners, which in turn makes both themselves and the female migrants more vulnerable. Migration, as is evidenced in South Africa, is also associated with a break down in social ties, and this in turn fuels certain 'undesirable' and unhealthy behaviours. Campbell and Williams (1998a) illustrate this in their examination of HIV in industry, looking specifically at mines in South Africa.

- Systems of labour and production - as discussed above there are few opportunities for women other than prostitution, and the organisation of labour and production - namely the reliance on migration, often from other countries (South African mines using Malawian workers for example) exacerbates the AIDS crisis, and renders entire communities of people vulnerable. This in turn destroys social cohesion.
- Disintegration of neighbourhoods - also associated with urban rather than rural areas, the disintegration of neighbourhoods is related to mass movements of people, for example when a squatter settlement is destroyed, and to other disasters which force people to move on, and communities to break up. If people are constantly moving on, horizontal ties are constantly being broken and having to be built up again. Thus, potential benefits of social capital are diffused. (Gillies et al, 1996:357-360)

Lomas (1998) argues, as do Campbell and Williams (1998a, 1998e), that there has been a disproportionate focus on modification of individuals' risk factors, for example multiple partners, lack of condom use, and non treatment of STDs. However, issues around social systems and their importance in relation to community health have largely been ignored. Lomas found that in the case of heart disease, social support and measures to increase social cohesion had a greater positive impact than did individual approaches. This finding supports the rationale behind the Carletonville HIV Management Programme, illustrating that a creative and multi-pronged approach to health care, including a range of factors from the biomedical and behavioural to the psycho-social, must be acknowledged and incorporated into policy, and extended to

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examination of such regions, in particular of previously colonised areas, would be a useful area for

health care professionals' individual roles and actions, if programmes are to be effective.

AIDS needs to be recognised as being a developmental issue, one which is inextricably linked to income levels. At the community and regional level, AIDS needs to be tackled in a way that takes social networks and relationships into account. If these can be strengthened, and environments created which enhance healthy behaviours, then some of the deleterious effects of poverty can be mitigated. However, if at a macro-scale poverty is not alleviated, then social capital may ultimately fail to flourish, and HIV prevalence rates will increase exponentially.

3.4 Critiques of the concept of social capital

Social capital is becoming increasingly popular in the field of development. Fine (1998) refers to social capital as a chaotic concept. Herein, he argues, lies its popularity. It is clearly a problematic and contentious concept, and while it is useful, there are a number of issues that need to be addressed if it is to be of use to development practitioners.

In terms of ethical considerations, Fine discusses social capital in relation to changing World Bank policy, stating that '(i)n short, as it is being deployed, social capital allows the World Bank to broaden its agenda whilst retaining continuity with most of its practices and prejudices which include the benign neglect of macro-relations of power and preference for favoured NGOs and grassroots movements' (1998:7).

'For those genuinely committed to political economy, whether from a base within economics or otherwise, both the opportunity and the obligation have arisen to develop alternatives to and to oppose social capital and the new consensus before they dominate the development agenda as did the old consensus before them' (Fine, 1998:8).

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future research.

- *Definitional Problems*

There are numerous definitions of social capital and this lends to it not being taken too seriously as an alternative to current development theory. Bebbington et al (1997) note that there has been a distinct failure at reaching a consensus on a definition of the concept of social capital. As pointed out by Fine (1998) it in is the nebulousness of this concept that its attraction lies. Budlender and Dube, in discussing its nebulousness, point out that the concept ranges in meaning from individual, household, community and even institutional relationships. Moser even includes NGO's into the definition (Budlender and Dube, 1998:12).

Another definition of social capital is that of Brown and Ashman (cited in Budlender and Dube, 1998:13): 'joint action by many different actors - grassroots groups, non-governmental organisations (NGO's), private corporations, government agencies - who together have the knowledge and resources required in implementing sustainable projects'. This definition is a more useful one for the purposes of the Carletonville HIV Management programme, and for this dissertation[5]. This is indicative of the problematic nature of the concept of social capital - within quite broad limits, its definition can be adjusted to fit the development context and/or problem at which it is looking.

There has also been much criticism of the use of the term 'capital' to describe what is essentially a set of relationships and networks. In a sense they do represent resources, however, that they are a form of capital is a highly contentious issue, especially amongst economists. Budlender and Dube (1998) argue that Putnam uses the term capital to ensure that economists take a previously ignored aspect of society more seriously. This usefulness of the term capital is also acknowledged by Moser (cited in Budlender and Dube (1998)). However, one has to question whether there is good enough reason for using a concept which denotes a set of criteria which relationships and networks cannot meet.

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[5] What the programme is trying to promote and illustrate is the idea that there needs to be collaboration and community participation and ownership of health projects if they are to be successful.

Following on from this, an interesting issue raised by Budlender (1997b) (cited in Budlender and Dube (1998:12)) is that '(w)here the community becomes capital, are all members of society except total outcasts capitalists?'. The danger is that capital is an all-encompassing word which collapses relationships and networks into one category, ignoring issues of power relations and of control over resources. Furthermore, it suggests that even in a society which is in a state of extreme poverty and deprivation, while they may not have human or other forms of capital, they can still be richly endowed because of (social) capital in the form of a set of rights and obligations (Budlender and Dube, 1998).

- *The Problem of Causality*

The notion of causality in the concept of social capital is also complex. Firstly, it can be a virtuous or a vicious circle. If social capital enables positive behaviour changes and aids social development, it could either increase or reduce stocks of social capital. Putnam (1993) argues that the more it is spent, the more social capital is created. However, it can be more project or goal oriented, and once the specific goal has been attained, social groupings can break down. Thus in a sense the social capital was only a means and not an end.

When theorists criticise social capital in terms of causality though, what they tend to refer to is the issue of what is found first - good governance or high levels of social capital? The critique is that Putnam tends not to be very clear about this in his discussions.

Tendler (1997, cited in Bebbington et al, 1997) states that she has found evidence to suggest that good governance allows levels of social capital to grow, whereas Putnam would argue that it is the social capital that allows for, and promotes the causes of, good governance. If social capital does not exist in any significant form, Putnam would argue that it is unlikely that governance can be effective. However, Putnam does also state clearly that good governance and social capital enhance each other, and

acknowledges that there is circularity in his argument, stating that the 'chicken and egg problem', while there, should not obscure more important issues once the cycle has been set in motion (1993). Thus although good governance is unlikely without social capital, it also promotes social capital once it starts.

- *Creating Social Capital*

Levi argues that a central problem with Putnam's concept and his discussion of social capital is the production and maintenance of social capital (1996:53). Bebbington et al also note this problem, stating that there is little understanding on how to build social capital, and that it is not easily constructable. For example they state that the World Bank suggests building on and investing in local institutions, but in practical terms, how is this to be done? (Bebbington et all, 1997).

Levi questions Putnam's assertion that civic activity is prompted by the expectation that others will also participate, thereby increasing civic activity. Why, she asks, is there this expectation that others will participate and follow the rules, and more importantly what are the mechanisms that maintain such an expectation (*ibid.*)? Budlender and Dube (1998) also discuss the issues surrounding the promotion and 'engineering' of social capital. They claim that, for example, Moser is somewhat unclear on whether it can be created or not. Moser states on the one hand that it cannot be engineered, however she also states that development projects can build and promote social capital (Moser, cited in Budlender and Dube, 1998:12). What is also pertinent here is ethical and practical issues of whether it is advisable to intervene and interfere in social relationships (Budlender and Dube, 1998).

- *Perverse Social Capital and Associational Membership*

Associational membership is often promoted as one of the key features of social capital, one which is to be promoted (see Kawachi et al, 1997). It has been found to enhance social development. However, what needs to be assessed and examined more critically is what types of associations will, for example, promote healthy behaviours. This issue will be picked up on in Chapter Five.

Fine (1998) discusses the notion of perverse social capital, and Levi (1996) talks of unsocial capital. This points to a fundamental problem with social capital - that it is on a continuum, at the other end of which is antisocial capital. For example, a key feature of social capital is associational membership. However, not all associations are good, nor do they necessarily promote well-being, either within or without the group. Furthermore, for every group that exists or every set of ties that are formed, there exists, by definition a set of outsiders, those who do not belong, and those who will not benefit. This aspect of social capital is not given enough consideration.

Budlender and Dube (1998:13) also discuss the notion of antisocial capital, stating that examples abound of communities richly endowed with social capital, however, they argue, these communities are probably as rich in antisocial capital. They are not necessarily more altruistic just because they are poor, nor are they necessarily concerned with the common good. People tend to do things as long as they themselves are not disadvantaged or put out. If it came to a question of one household surviving at the expense of another, obviously there would be little incentive for or likelihood of reciprocity and sharing of resources.

Moser (1998) discusses a critical level beyond which people are too poor and vulnerable to be able to offer assistance, material and non-material, to members of their community. Thus at some stage social capital is not only unviable, it cannot exist in any productive form. If however, what little social capital there is does enable some development, there will obviously be an impetus for more social capital to be created. People have the means with which to achieve an end other than tangible development.

Budlender and Dube (1998) argue that in South Africa people do not necessarily want to be involved in civic associations and community based activities which require their commitment and attendance. It is not the case therefore that all who are in a situation where social capital is needed, and where there is poverty and a lack of development will want to work towards the upliftment of that community. If this is the case, there are obviously policy implications. It is possibly not always appropriate to attempt to include and promote community involvement and participation in development projects. Perhaps initiatives of this type, however politically correct they may currently

be perceived to be, are not always the solution. Budlender and Dube (1998) discuss the danger of romanticising social capital, of promoting it because it is the presumed correct route to be following.

As Budlender and Dube (1998) argue 'it is primarily because they are poor, that these communities are forced to come to communal decisions. In richer communities individuals can make, and afford, their individual decisions in relation, for example, to their water and energy sources. Individuals in poorer communities don't have that luxury, and their neediness combined with lack of alternatives will make the issue more pressing and potentially divisive' (Budlender and Dube, 1998: 16).

Another aspect of promoting associational membership to enhance levels of social capital is that establishing new structures can be problematic. Thus it is advisable to work with existing structures to avoid new contestations of power and control (Budlender and Dube, 1998). However, what must also be stressed is that within established associations there are existing power relations which will impact upon how community activities are carried out, and on how development practitioners relate to and function within communities. This needs to be considered if associations are to be targeted as sites of social capital promotion and therefore as tools development.

Beall's (1997) case study discussed referred to above illustrates clearly how social capital is not appropriate in settings like India, where caste is an over-riding feature, and clientelism and self motivated actions are prevalent. She noted far more cooperation along vertical rather than horizontal lines, in a situation which at first glance would appear to be an ideal site of social capital formation. It would seem obvious that people involved in the same activity of rubbish picking would have a shared and mutual goal from cooperation, even if they were competing. However there is clearly a lot more to social network formation than mutual necessity. Rather, promotion of self interest, and attainment of self identified targets, inextricably linked to power relations, is widespread.

- *The importance of Location:*

What needs to be considered when evaluating the Pilot Survey, and when extrapolating to other development programmes, is that the transferability of social capital to sub-Saharan Africa, or to any other geographic region, is debatable. Much work that has taken place has been in first world settings (such as Putnam's, 1993, work in Italy), and there is no reason why it should be an appropriate concept for other communities.

Bebbington et al (1997) caution that regional context must be taken into account when assessing the potential benefit of social capital by examining 'success stories'. It is necessary to acknowledge that social capital is spatially as well as temporally determined, and that this limits its transferability as a tool. Different geographical, cultural and social environments will most certainly determine the ability of social capital to have an effect on development outcomes, and indeed on the ability or potential for social capital to be developed. Pieterse (1997, cited in Budlender and Dube, 1998) states that 'each locality and community will have to be dealt with differently and on their own terms. There can be no grand plans'. This caveat is in keeping with the post modern move away from meta-theory such as Gunder Frank's Dependency Theory[6], or classical Marxism, towards theory which takes the specificities of each locality into account, and most importantly looks at issues of power, gender and race as well as class. Institutional economics goes some way towards answering these short-falls. While social capital is potentially an answer to inadequate meta-theory which does not take these nuances into account, it clearly also holds the potential danger of obscuring what is individual and specific within communities, by providing a solution which is not necessarily appropriate.

3.5 Evaluation of the critiques

Much of the fuzziness around the concept is due to the fact that theorists, while promoting or criticising its potential as a conceptual tool, are not readily providing the reader with an adequate description of what it is they expect it to do, and of how they themselves understand the concept.

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[6] For an edited version of Gunder Frank's Dependency Theory see Gunder Frank (1966), reprinted in Corbridge, S (ed) (1995)

There is much criticism surrounding the definition of social capital. This can obscure the fact that social capital has much to offer, despite the proliferation of definitions and applications. Its flexibility is not necessarily a negative feature, and it should be acknowledged rather that social capital is a way of thinking and evaluating community development, rather than being a wholesale theory for eradicating poverty. Ethical problems with the concept are not particularly relevant to many theorists' application of this tool, because rather than being proponents of 'World Bank' policy, as is argued for example by Fine (1998), many are merely trying to address an impasse in development theory - a gap waiting to be filled. There is a lack of understanding of how communities operate, and of how to evaluate outcomes which are stated in programme objectives. Using social capital as a starting point allows an in-depth understanding of individual communities, because it can organise our thinking in terms of the psycho-social processes which inform behaviour, allowing for a greater understanding of how communities function. Offering a critique of a theory, which is in essence nothing other than a tool amongst an array of potential tools, without offering suitable alternatives is neither constructive, nor theoretically sound. Like any other tool, depending on who uses it and for what objectives, its outcome and relevance will vary. While it may be adopted by neo-liberals in an attempt to reform state involvement in development, it also has a potentially vital role to play in more appropriate and politically sound development projects.

3.6 How my dissertation takes account of these critiques, what gaps it seeks to fill

Despite the reference above to numerous anecdotal accounts of the relationship between social capital and health, and in spite of all that has been written on the topic, there is little concrete evidence of this relationship, and the effects thereof. What is absent is any form of robust critical consideration of the relationship between the two. Putnam (1993) writes on the relationship between social capital on the one hand, and economic growth and governance on the other. Woolcock ((1998:193-96) cited in Fine, 1998:4) states that social capital has been applied to the following fields:

(dys)functional families, schooling, community life, work and organisation, democracy and governance, collective action, and intangible assets[7]

The majority of critical writing on social capital has been to do with its role in the economy. Dasgupta (1997) has written about social capital and economic development, looking at it in terms of institutional economics. Institutional economics studies the various institutions, such as the community associations, and networks and relationships, both vertical and horizontal, that comprise society. Social capital would thus be a feature of institutions in society. Fine (1998) has examined social capital in terms of its adoption and promotion by the World Bank, and assesses it as a successor to previous Bank policies. Thus, the focus tends to be predominantly economic. Apart from the work cited in the case study section above, there is not much other work on health and social capital.

There are thus major gaps in critical literature on social capital in health, and a concomitant need to build a platform for discussion around social capital and health, through examining the usefulness of social capital in evaluating health programmes. This dissertation aims to make a modest contribution to that project. Areas beyond the scope of this dissertation are pointed out for future research and consideration, the most pertinent being how to create and promote social capital, how best to evaluate it, and the effect of power relations, in particular gender[8] and class, on social capital.

3.7 Key Issues Identified:

The following issues have been identified from the literature, and will be used in Chapter Five as a rough framework for analysing social capital as identified and analysed in The Pilot Survey.

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[7] Fine does not give detail of how the concept was applied, nor of how it was defined. The seven fields were identified only in a footnote in Woolcock's article.

[8] Another very interesting issue, also beyond the scope of this dissertation is the effect of programmes aimed at promoting social capital on women's lives, where the burden of power inequalities and poverty is already taking its toll.

- *Incremental development & New Realism*[9]

  Devas and Rakodi (1993) introduced the concept of new realism, whereby the limitations of development projects are acknowledged, and goals are scaled down to a more realistic and manageable size. World poverty cannot be solved through one programme, however one project can succeed in attaining social development goals at a local or micro level.

- *Exclusionary development*

  Care needs to be taken when formulating policy to take into account all of those who will be included, as well as those who will be potentially excluded. For example, extra attention needs to be paid when organising communities in terms of enlisting women as well as men - in a way that is constructive and not just involving a further demand on women's time - in grassroots organisation of a project. Furthermore what needs to be acknowledged is that development, and social capital are exclusionary by definition, and that some will always be excluded from the process. An awareness of this can help lessen the potential negative consequences.

- *Participation & empowerment*

  Development projects increasingly have participation and empowerment as their goal. However, what needs to be examined further is what exactly these concepts mean in practical terms, and more importantly how can they be measured?

- *Flexibility*

  In a post-modern light, what is being stressed is that meta-theory is to be avoided, and that concepts which take spatial and temporal differences into account are far more useful. This will ultimately involve the development of new methodologies which can help in understanding nuanced contexts.

- *Assets*

  Moser's (1998) concept of assets is useful in terms of pointing to the range of tangible and intangible (i.e. social capital) assets which people draw on in their day to day survival. Assessing someone's poverty only in terms of their capital is neither useful, nor accurate.

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[9] New Realism is a useful concept introduced by Devas and Rakodi in Devas, N & Rakodi, C (eds.) (1993) *Managing Fast Growing cities: New Approaches to Urban Planning and Management in the Developing World*, London: Longman.

3.8 Conclusion:

As Budlender argues, social capital is one of a number of new development theories or concepts which have emerged because of the limits of existing theories in understanding how society works at a local level (1998:1). Social capital is limited in terms of practical implementation: how can it be enforced, how can it be produced or manufactured, how can it be measured?

A number of issues have been raised regarding the concept in its present state. There are the ethical concerns such as the inappropriateness of passing the burden onto communities, and in particular women, where governments should be providing services (Fine's (1998) critiques of this World Bank type approach are relevant here). Finally there are theoretical concerns related to the use of the word capital and whether social capital can be considered to be a form of capital such as physical or human, which, the more is spent, the more is created. Other theoretical criticisms centre around the nebulousness of the concept, and of its constructs, such as the lack of a clear definition of trust (Levi 1996). Another much discussed aspect of social capital is the question of causality.

Because it is a problematic concept, what I have aimed to do in this chapter is illustrate its weaknesses and its strengths, and thereby identify the aspects of the concept which will be useful in the task at hand. Despite all the criticism that social capital has attracted it must clearly not be written off completely. Its use as an analytical tool for understanding how communities are functioning, and why some programmes work and others do not is, in this dissertation, undisputed. Furthermore, it is a useful practical tool and should be promoted to enable future programmes to succeed where they have failed in the past. The critique above should serve as a caveat rather than as a dismissal of the concept. As with any theory, in particular a development theory, it provides a springboard for future action, and for future research, and the very fact that it has created such debate and subsequent research and theoretical consideration is validation of its usefulness.

It is by no means an answer to all local level problems, nor is it claimed to be the appropriate alternative to state-led development initiatives. Rather what it is, or at least what it is becoming in subsequent usage, is a recognition that there is a failure of governments to provide local services and to stimulate development effectively, and until these delivery problems can be overcome, there clearly needs to be a way of enabling community level initiatives to step in where government development agencies are failing.

The aim of this dissertation is to examine the issues around community development, through examining the community level processes and networks that constitute what is being called social capital. It aims to assess whether social capital is a useful tool for understanding why programmes have in the past failed to have an impact on levels of HIV in Carletonville. It looks at both the previous, management initiated and controlled, and the subsequent initiative which has been implemented by the ERU which has centred around community involvement and management of the programme, in an attempt to see whether sexual health is related to levels of social capital. The Carletonville HIV Management Programme will use social capital as one of its analytical tools throughout the duration of the programme. What this dissertation will do is to take one segment of this research, still in its preliminary stages, and assess, in light of the debates around the concept, the usefulness of social capital as an analytical tool.

Chapter Four: Results[1]

4.1 Aims of this Dissertation vis-à-vis those of The Pilot Survey

The aims of this dissertation are linked to those of the social capital section of The Pilot Survey. As discussed in Chapter One, the Introduction, the aims of the dissertation are to assess the usefulness of social capital primarily as an evaluatory tool in process and outcome evaluation[2]. While specifically considering the relationship - if any - between social capital and sexual health, through the use of The Pilot Survey's results, it is hoped that this dissertation will point to areas for future research around broader social developmental issues.

The Research Questions:

According to Campbell and Williams (1998b) a lot has been written in quite a vague way about the positive effects of community cohesion, civic engagement on health, but little work has been done in relation to

(a) operationalising what is meant by community cohesion and participation or

(b) providing hard evidence for possible relationships between community cohesion and health.

In The Pilot Survey the problem is addressed (a) through the use of Putnam's concept of social capital as the research tool, operationalising it in terms of measures of trust, helpfulness and civic engagement. In addressing issue (b), they seek to investigate whether or not there is any hard evidence for an association between these three dimensions of social capital and sexual health (measured in terms of HIV status).

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[1] The data, and research questions, in this section are taken entirely from The Pilot Survey. I have therefore not included individual references after each set of data produced. They have been statistically analysed by The ERU, and I have added a sociological analysis - pointing to areas for discussion. Chapter Five elaborates on these issues, linking them to issues identified in chapter three, the theoretical chapter

[2] Outcome evaluation looks at changes in social capital over the three year life of the project through quantitative survey questions. Process evaluation will give a qualitative account of why the outcome did or did not happen, through qualitative interviews and other data sources. The Pilot Survey 'tests' the questions that will be used in the three yearly surveys

The issues investigated in terms of social capital were:

1. Is there an association between the three dimensions of social capital, viz.: civic engagement (associations joined), trust and helpfulness?

2. Is there any significant association between HIV status and each of the three dimensions of social capital (associations joined, trust and helpfulness)?

3. Can one make blanket generalisations about 'associational memberships' in relation to health? Or do different associations have different impacts on HIV status?

4. Do gender or housing type mediate the impact of any of the above-mentioned dimensions of social capital on HIV status?

4.2 Background to the Carletonville Survey

This section leads on from the introductory discussion on The Carletonville Programme in Chapter Two. The survey was conducted by Progressus, an organisation that specialises in large surveys for research purposes. It was commissioned by the Epidemiology Research Unit (ERU) as part of the evaluation of the Carletonville project.

The on-going collection of survey material has two aims: firstly to evaluate the impact of the project, and secondly to inform the intervention throughout its three year life. Three surveys will be conducted - the pilot survey reported on in this study, a baseline survey (completed in August 1998) and an end of intervention survey (late 2000).

In August 1997 a demographic survey was carried out by ERU and Progressus in order to establish the basic demography of the population (gender, age, housing type, income). Based on this survey, the study site was divided into five sampling areas: council, private, informal and site and service, mine hostels and hotspots.

This survey had a major shortcoming, namely the high refusal rate amongst people in private housing, which means that there may have been significant biases amongst this group of people (e.g. people who refused might have been at higher or lower risk for HIV - or been quite representative - it is not possible to say which). Secondly on some of the mines, problems arose in particular because of a strike which coincided with the survey and made working very difficult. For this reason only 229 of 750 planned interviews of miners were conducted. This sample of 229 people was drawn randomly, however it must be borne in mind that it is a bit on the small side.

This shortcoming will be addressed in the survey proper which is currently being conducted. In the meantime, it is believed that despite these limitations the data still provide interesting preliminary insights into factors likely to facilitate HIV transmission in Carletonville – but these findings will need to be confirmed in the analysis of the August 1998 baseline, and future surveys, which will also be conducted by the ERU.

4.3 Social Capital questions in the survey

This dissertation focuses on the results of The Pilot Survey's 'social capital' questions. Social capital was conceptualised in terms of four components: perceptions of trust, perceptions of helpfulness, associational membership and voting.

In designing the survey there were constraints in terms of the number of social capital questions that could be put in – given that the overall survey needed to measure a range of things - a biomedical component (with blood and urine tests for HIV, syphilis, gonorrhoea and chlamydia) as well as a 'social science' component (a slightly adapted version of the UNAIDS multi-site HIV survey, which had sections on background characteristics; sexual relationships and sexual networking with both regular and non-regular partners; knowledge/perceptions of HIV and attitudes to those with HIV, condom use and reported behaviour change; and experiences of STDs).

Putnam (1993) has defined social capital in terms of trust, helpfulness and civic engagement. Kawachi's (1997) study on social capital, income inequality and mortality, focuses only on trust and helpfulness. This is the source of the trust and

helpfulness questions used in the Pilot Survey (see Chapter Two). Narayan and Pritchett's (1997) study on household income and social capital in rural Tanzania focuses on civic engagement through examining associational membership. They look at how levels of social capital have positive effects on levels of household income in Tanzania, and they quantify social capital by looking at and identifying key associations and organisations. The Church was shown to play a very important role in people's lives. Their questions were also adapted for the survey (see Chapter Two).

Initially voting was going to be used as a second measure of civic engagement (in addition to associational membership) because that is one of the measures that Putnam uses in his questionnaire. However voting was abandoned because, probably due to the excitement of the first election, levels of voting were over 75% in all of the housing types examined.

4.4 Survey Sample

Prior to the study, a demographic survey was carried out, establishing the number of people per housing unit in different socio-economic areas. These areas were classified as: private housing, council housing, site and service areas, and squatter areas. Having determined the mean number of people per housing unit in each of these housing types, and the total population of people in each area, people were sampled so that the total number of people in sample in each area was proportional to the population of that area.

Ordnance survey maps were used to choose houses at random, and all of the people in each house were included in the sample. If no one was present after three visits, or if more than two people refused to participate, the next house was chosen. People were sampled in this way until the requisite number of people was obtained in each area. The sample is therefore stratified on housing type and clustered in houses with the number sampled in each stratum proportional to the population of that stratum.

- The sample size was 1484

- Housing breakdown: Council 302, Private 190, Informal 716, Mines 229, Hotspots 47
- Gender breakdown: Men 658 Women 826

Different housing types: *council, private, informal* – were all in the township of Khutsong.
Mine hostels were on Goldfields, Anglo and *3rd mining house premises*.
Hotspots - 5 squatter camps adjacent to various mine hostels, close to the perimeters of mine boundaries.

In this dissertation we will look at the relationship between various dimensions of social capital on the one hand, and HIV status on the other hand – and how this relationship varies according to gender and housing type.

The ERU has a particular interest in different housing types given that STD and HIV prevention services (clinics, mobile clinics and so on) are organised on an area-to-area basis. Thus housing type was chosen here as a planning of services tool. However Crankshaw (*pers. comm.*) suggests that housing type can also be used as a rough proxy measure of socio-economic status. The earlier demographic survey conducted in Carletonville in 1997 suggested that average income per dependent was R330 a month in private housing, R170 amongst miners in mining hostels, and R133 in both council and informal settlements.

4.5 Levels of HIV in the Sample

24% of the sample were HIV positive (36% of the women, and 20% of the men). Other STDs (which we will not consider in this dissertation) identified were: Syphilis (7% men, 14% women); chlamydia (5% men, 7% women); gonorrhea (6% men, 8% women).

There was no significant difference in HIV levels in the different housing types averaged over men and women.

There was no significant difference in HIV rates for men in different housing types (men in private housing 19.4%, council 1?.%, informal 19%), but women in private houses were at significantly lower risk of HIV infection (19.5%) than women in council (34%) or informal housing (39%). The protective effect of private housing on women's HIV status was not significantly confounded by employment or educational status.

The age range of the sample was 13-60 years. In this dissertation we cannot take account of age, because the original statistical analysis does not do so. This shortcoming, given that age plays a key role in HIV transmission, will be rectified in analyses of the results of future surveys. It is clear, however, that research that looks at the interaction of age and social capital needs to be done.

4.6 Research Findings

4.6.1 is there an association between civic engagement, helpfulness and trust

This question was explored using the Pearson Product Moment Correlation test. The findings were as follows:

- Trust and helpfulness are positively correlated ($r = 0.39$, $p < 0.05$*)
- There is a very weak but significant positive correlation between helpfulness and number of associations joined ($r = 0.06$, $p < 0.05$*). Too weak to take too seriously.
- Association between trust and number of associations joined is not significant ($r = 0.01$, not significant)

These findings are not particularly interesting except that they do point to a correlation between helpfulness and trust. As we will see below, there was no

significant correlation between trust and HIV status, and in the conclusion it will be argued that far more work needs to be done into the concept of trust in developing country contexts to explore why this concept (so central to the notion of social capital in countries in the North, Putnam's (1993) work being a prime example of this) has played so little role in the results of The Pilot Survey.

4.6.2 is there a significant association between HIV status and any of the three dimensions of social capital (trust, helpfulness, associations joined)?

The data discussed in 4.6.2 were analysed using the Chi Square Test.

4.6.2.1 Is there a relationship between trust and HIV status

Descriptive statistics:

- Across the whole sample the percentage of people who believed that others could be trusted was 24%
- This finding was not affected by gender (irrespective of HIV status) (23% of men were trusting, 25% of women were trusting)
- There were no differences in trust levels across housing types (irrespective of HIV status)

Analysis of variance:

- No significant association between trust and HIV status ($p = 0.53$, not significant).
- The association remains insignificant even after taking gender differences or housing types into account.

The insignificant relationship that was found between trust and HIV status is contrary to the hypothesis. There are two possible reasons for this, either (a) that the concept of trust is not as important as Putnam's (1993) definition of social capital would suggest, or else that (b) the measure of trust that was used in the survey is too crude. This point will be taken up in the discussion chapter, Chapter Five.

4.6.2.2 Helpfulness and HIV Status

Descriptive Statistics:

- Across the whole sample, 41% believed that people are helpful.
- There were no gender differences in this finding (irrespective of HIV status): 41% of men saw others as helpful, 40% of women saw others as helpful.
- There was a significant variation ($p < 0.008^{**}$) in helpfulness among housing types – insofar as levels of helpfulness were highest in the hotspots (55%), followed by private housing (49%). In the council housing and mine hostels levels of helpfulness were 43%, and in informal housing levels were 37%.

Analysis of variance:

- There is a significant association between helpfulness and HIV status ($p = 0.034^{*}$) Amongst those who say that other people are helpful, the prevalence of HIV is 26%. Amongst those who say that other people are not helpful, the prevalence of HIV is 31%.
- This association exists consistently across all housing types ($p = 0.048^{*}$). There is no significant interaction between helpfulness and housing types in relation to HIV.
- This association exists consistently across both genders ($p = 0.03^{*}$). There is no significant interaction between helpfulness and housing types in relation to HIV.

What can be said from the above is that the relationship between helpfulness and HIV is the same across housing types, and for both genders. This will be returned to in Chapter Five.

The significant correlation between perceived helpfulness and positive sexual health (measured in terms of HIV status), confirms the hypothesis that sexual health and some aspects of social capital - namely perceived helpfulness - are positively related. Clearly this is the *tentative* finding of a pilot survey, and this finding will be followed

up in the next three Carletonville surveys. The level of statistical significance that was shown points to this as an important issue for future research. Chapter Five deals with this issue in greater depth.

4.6.2.3 Associations Joined and HIV Status

Descriptive statistics:

- Across the whole sample, the average number of associations joined was 1.67 per person.
- Average number of associations joined by men were 1.81 and average number of associations joined by women were 1.56. This is a significant difference (p = 0.0004*** significant at the 1% level).
- According to housing types, the average number of associations was as follows: council housing (1.66), private housing (2), informal housing (1.61), mine hostels (2.06), hotspots (1.06).

It is interesting to note that the most marginalised group of people - in the hotspots (predominantly commercial sex workers and petty criminals) belong to the smallest number of formal organisations, whereas the most privileged members of the sample, namely those in private housing, and the mine workers amongst whom levels of employment are obviously 100%, belonged to the most organisations.

Although levels of formal organisation membership were highest amongst men, this does not necessarily mean that men access more sources of social capital. Rather, as Campbell (1998d) shows, women tend to draw more on the support of informal organisations. The neglect of women's major source of social capital is a severe shortcoming of the pilot survey. This has been corrected in the baseline survey, which includes a number of questions about informal support networks in areas such as

assistance with childcare / household tasks, borrowing and lending money and advice / emotional support.[3]

4.6.2.3.1. The interaction between HIV and Associations Joined

The variable 'associations joined' was composed by combining all those who belonged in one or more organisation (23% of the overall sample), and comparing them to those who did not have any organisational membership (76% of the overall sample). There was a significant relationship between sexual health and absolute numbers of organisations joined ('none' vs. 'one or more'), with membership of one or more organisation serving to protect people from HIV infection.

- No associational membership: 33.6% HIV positive
- One or more associational membership: 27.6% HIV p = 0.027 * (significant at the 5% level)

The number of associations joined did not have any significant impact on HIV status. HIV levels did not vary amongst those belonging to one (28% of the overall sample), two (24% of the overall sample), or three-or-more (25% of the overall sample) associations.

This finding supports the hypothesis. Associational membership is the most important component of Putnam's notion of social capital. According to Putnam it is high levels of civic engagement in voluntary organisations that leads to high levels of trust, helpfulness and local identity - in other words those community relationships which are hypothesised to lead to health enhancing behaviours. Narayan and Pritchett (1997) also identify and explore associational membership as a vital component of social capital, and they argue, of a household's survival.

4.6.2.3.2. Interaction between HIV : Associations Joined : Gender

[3] There is much interesting work to be done on the important role that groups such as informal mother and toddlers groups, and assistance with child care and child minding, play in determining the overall health of mothers.

The 'protective' effect of organisational membership did not vary significantly between women and men (p = 0.49).

4.6.2.3.3 Relationship Between HIV, Gender and Particular Associations

What at first looked like a straightforward relationship between 'associations joined' and HIV became more complicated once the effects of various types of associations were examined.

Church membership

Statistical analysis of the relationship between church membership and HIV supported the expectation that church membership would be associated with significantly lower levels of HIV in both women and men.

Church members: 26.9% HIV
Non church members: 31.9%
p = 0.028 * (significant at 5% level)

Church membership had a slightly increased protective effect for women compared to men (significant at the 10% level).

Women church members (31.9%), Non church members (42.6%)
Men church members (18.9%), Non church members (21.5%)
p = 0.077† (significant at the 10% level)

The effect of church membership also varied between housing types.

In the council, private and informal housing sectors church membership was associated with reduced HIV prevalence. In mine hostels and hotspots church membership had no effect on HIV status. This could be because of the dire situation of mine hostels

and hotspots, where church membership could arguably not be enough to mitigate prevalent sexual attitudes and practices.

Church members in council, private and informal housing (26% HIV positive)
Non-members in these housing types (34% HIV positive)
p = 0.0029** (significant at the 1% level).

Church members in mine hostels (21.3%)
Non church members in mine hostels (22.3%)
p = 0.87 (non-significant)

Church members in hotspots (68.7% HIV+)
Non church members in hotspots (67.7%)
p = 0.94 (non-significant)

Sports groupings

Belonging to a sports grouping also significantly decreased peoples' chances of being HIV positive (there was no interaction between sports group membership and gender[4]).

Sports group members (23.4%)
Sports group non members (29.7%)
p = 0.026* (significant at the 5% level).

Stokvel membership

The relationship between stokvel membership and HIV was more complex and puzzling (particularly in the light of the large development literature that extols the benefits of stokvel membership).

[4] Male sports group members (16.2%), non members (22.2%). Female sports group members (30.6%), non-members (37.1%)

In every housing type other than private housing (viz.: council, informal, mine hostel and hotspots), belonging to a stokvel was associated with a significant *increase* in HIV status.

Non-private housing types, stokvel members (47% HIV)
Non-private housing types, non stokvel members (28.8%)
$p = 0.037$* (significant at the 5% level)

The only exception to this odd result lay in the private housing areas. Here stokvel membership was associated with reduced HIV prevalence.

Private housing, stokvel members (6%)
Private housing, non stokvel members (20%)
$p = 0.099$† (significant at the 10% level)

This is possibly related to the negative features of a stokvel, which often involve those associated with shebeens, such as heavy drinking. While those who were in private housing possibly had their protective effect, those in informal and non-private housing could be more susceptible to taking part in risk activities. Once money is received from a stokvel, there is often a party held and it is in these situations that women could put themselves at risk.

Other groupings

Taken on their own, membership/ non-membership of the other associations were not associated with variations in HIV prevalence. The other associations identified, and the relationships found were: political parties ($p = 0.29$); trade union membership ($p = 0.63$); burial societies ($p = 0.63$); youth groups ($p = 0.62$ calculated only on the 15 - 30 year old informants); residents associations ($p = 0.50$).

The significance of these findings is that it was possibly the stokvels, churches and sports groupings that had the most impact on peoples' lives overall, and not just on levels of sexual health.

4.7 Summary of findings

To summarise then, what was found was that there was no significant relationship between the three aspects of social capital as identified by Putnam (1993) viz. trust, associational membership and helpfulness, the exception being the relationship between trust and helpfulness. Furthermore, what showed up was that there was no significant relationship between sexual health and trust, which was contrary to the hypothesis of The Pilot Survey, which, extrapolating from studies such as Putnam's, carried out in the North, expected there to be a significant, positive relationship.

What was shown is that there is a high level of significance between associations joined and HIV status. This finding was in keeping with our hypothesis. While the precise *number* of associations joined was not relevant to the health status of people, the type, and whether or not one joined at all, was:

- there is a significant relationship between absolute numbers of association membership ('none' vs. 'one or more') and HIV status, which exists irrespective of gender or housing type

- belonging to one, two, or three-or-more organisations does not make any difference

- it is necessary to disaggregate notion of 'associational membership' - different associations have different effects - church and sports group members appear to be at lower risk. As discussed, the findings regarding stokvels are puzzling and further research needs to clarify these odd results. What needs to be understood is what behaviours other than those directly relating to the saving of money, are associated with stokvel membership and gatherings. Other groupings such as political parties did not seem to have an effect either way.

- findings relating to stokvels and private housing suggest that socio-economic status might mediate the relationship between certain associational memberships and sexual health. Private housing has been seen to have a protective effect on women, and this too could play a role in this finding.
- other findings suggest that gender might be an important mediator between certain associational memberships and sexual health.

4.8 Conclusions

This dissertation began by defining social capital in terms of three dimensions: associations joined, trust and helpfulness. In the statistical analysis, trust has shown no relationship to HIV status. However both number of associations joined, as well as the perceptions of other people as helpful, have been associated with improved sexual health. Furthermore, there is a positive correlation between associations joined and helpfulness.

This is only a pilot survey, so the claims that can be made with any certainty are limited, however, on the basis of the findings above the following is speculated:

- the findings provide tentative confirmation of the hypothesis that associations joined, and helpfulness are associated with better sexual health
- the findings have failed to confirm the hypothesis that trust is associated with better sexual health (levels of trust in the sample were very low overall, and while there was a correlation between perceived trust and perceived helpfulness, there was no link between trust and HIV status) - since trust plays such a central role in Putnam's definition, this is an area where more research needs to be done

What can tentatively be argued is that the potential implication of these data are that development projects concerned with improving sexual health should seek to encourage membership of at least one organisation amongst target audience members What is crucial here, as discussed in Chapter Three, is that the type of organisation might be relevant here (see the discussion regarding unsocial and perverse social capital)

- it is tentatively suggested that organisational membership is associated with health-enhancing higher levels of perceived helpfulness
-more research needs to be done on where trust fits in here, if at all.

This survey has highlighted the gendered nature of social capital[5]. It is not an homogenous resource equally accessed by all members of the community. It has been shown that men belong to more formal associations than women. It has however been speculated that women belong to more informal groupings. The effects of certain organisations (e.g. the church) have varyingly protective effects on men and women.

Chapter Five goes on to discuss these findings. The first section of Chapter Five deals with issues of social development and participation, as these are crucial features of any development programme. The second section examines the findings introduced above in light of these overall development goals, in terms of the role social capital plays in promoting participatory, enabling environments, as well as in light of the issues identified in the literature review chapter, Chapter Three.

[5] This is also a crucial area for future research, as hardly anything has been done on the gendered access to social capital as a resource. Issues of power are vital when exploring the potential impact of social capital on social development programmes, and gender relationships are one of the most pertinent relationships involving power inequalities.

Chapter Five: Discussion

5.1 Introduction:

This chapter outlines the findings of The Pilot Survey, and discusses them in terms of what these results mean for future research and development policy. The relationship between social capital and development is examined. The findings will be considered in relation to the hypothesis, as well as in relation to the current literature. What will be explored is how the results have differed from what was expected. Tentative suggestions will be suggested for future research, pointing to methodological and theoretical issues which require attention.

As discussed in Chapter Three, my analysis of the literature identifies five main theoretical issues. These are personally identified development criteria and are not necessarily the goals of The Pilot Survey, however they are, for me, a link between the aims of The Pilot Survey, and the overall aim of this dissertation - which is to try to understand social capital as an evaluation tool. They have not been covered by the data collected in The Pilot Survey, however, I outline them below as they form part of my broader framework of understanding social capital, and the process of social development.

These five areas are:

- *Incremental development & New Realism* - I am asserting that social capital is a recognition that development takes place at a community level, and can be successful in terms of attaining small and manageable goals. The notion of New Realism, as discussed by Devas & Rakodi (1993: 100) emphasises the importance of recognising what development programmes can and cannot achieve. No one is arguing that social capital is the solution to all development problems, but rather that it is a tool which is useful in terms of analysing the types of environments in which community level development is likely to succeed. If these environments can be understood, then hopefully resources can be channeled into promoting their

emergence.

- *Exclusionary development* - this is the notion that, by definition, all development projects will exclude some people. Viewed from the perspective of those sectors of the population whom it does not include, much social capital is anti-social.
- This exclusion may harm them directly, through for example the selfish use of non-renewable resources, or it may harm them indirectly simply by not including them in the benefits of development. While some argue that the benefit of social capital is that those who do not participate may still benefit, for example if a street committee manages to get new street lighting installed, the opposite must be kept in mind that some forms of social capital can exclude The notion of exclusionary development is not exclusive to social capital, and is a pitfall of all development programmes. While it cannot be avoided, awareness of potential exclusionary practices need to be kept in mind.
- *Participation & empowerment* -Increasingly, development programmes have as their goal, or at least as part of their means of achieving their goal, participation and empowerment[1]. What needs to be assessed, however, when analysing any development programme is what level of participation and empowerment is actually taking place. This is of particular relevance to projects which involve the participation of women. Many projects, while relying heavily on the labour of women, could not be said to be in the control of those women.
- *Flexibility* - flexibility is required in terms of how groups of people, and people's survival strategies are 'labelled' and analysed.
- What is vital is that all forms of activity be taken into consideration when determining whether a community has social capital endowments. In development programmes, methodologies are often used which are incapable of capturing subtle and nuanced differences. Diversity of experiences and situations has to be acknowledged and catered for in the formulation of research projects. If theory is not appropriate to the particular social setting, then alternative theories need to be explored. Communities, and the social processes which are played out within those communities,[2] exist within space and time,[3] and these factors must be taken into

[1] For a discussion on intersectoral problem solving and community participation in development see Brown and Ashman (1996)

[2] See Donovan (1988) for an examination of research methodologies used in understanding the United

consideration when assessing the usefulness of a theoretical tool. This caveat is in line with the current shift away from meta theory[4].

- *Assets* - a key feature of a development programme is to assess a community's assets, which goes beyond measuring their economic assets to an understanding of all the forms of capital and resources to which people have access.

The above points are key criteria which I have identified to consider in terms of development planning and policy formulation. I have considered these criteria throughout my discussion of The Pilot Survey findings, as a way of linking their data to my own development objectives. They are distinct from the key research questions outlined by the Pilot survey, as discussed in Chapter Four, and are more of a guiding framework for my understanding and interpretation of the results.

5.2 Social Development and Community Participation

AIDS is a development problem and not merely a behavioral or biomedical one. This is being acknowledged, and theorists such as Cornwell (1984, 1988), Campbell (1998c), Gillies ((1997a) and Gillies et al (1996) discuss the importance of a broader approach to understanding the context and causes of all forms of illness. It therefore needs to be addressed through community development programs such as the Carletonville program. While there is much written on the importance of participation and representation in development projects, and this will be discussed further on, little is known about what type of community contexts participation and representation are trying to create. Gillies (1997) and Kreuter, Lezin and Koplan (1997) have suggested that social capital describes the kinds of health-enabling community contexts that development projects try to create.

Kingdom's Black population's experience of illness. To understand why and how people act, argues Donovan, and therefore not to label them as irrational, it is necessary to understand the context within which they act

[3] See Asthana (1996) for a discussion on the importance of locality in determining women's health and women's empowerment

[4] Kabeer (1996) discusses the importance of assessing household poverty through different lenses, because of gender differences that exist within household groupings. What she points to is the importance of developing more participatory methods of evaluation and assessment, which can take these nuances and power relations into account.

Thus, to inform future policy, a better understanding of social capital and its relationship to the outcomes of development projects, and the community level processes that occur, is crucial. The Carletonville development project, which seeks to produce positive health outcomes, is a useful case study within which this relationship can be explored. (Campbell and Williams, 1998b)

Before the results of the pilot survey are discussed, a discussion on social development and participation is required, particularly because there is a move to seeing public health problems as development problems - i.e., to be served through social development. As mentioned above, social development programs, while having development as their core goal, also have participation and empowerment as process and outcome goals. Thus participation is both a means and an end.

What is problematic is that key words such as participation have become standard currency in development rhetoric, yet there is often very little explanation or discussion about what exactly is meant by this, or what the purpose of it is. What needs to be explored therefore is the role of participation and empowerment in development, as well as means of promoting and measuring these aims within a more substantial and structured framework in future.

Midgley (1995) states that most advocates of social development place an emphasis on community- or government-based forms of intervention. What is being promoted, argues Midgley, is the notion that people should take initiative and come up with creative solutions to development issues. Communities need to participate and cooperate to promote development goals. Communitarian approaches, such as these, are increasingly popular. As Midgley argues, they differ from collectivism, as they do not call for joint or communal ownership of land, but do require collaboration on projects, and joint ownership of processes[5]. There is an acceptance that communities are equipped to carry out development projects more effectively than the state.

[5] For a discussion on communitariansim, populism and collectivism see Midgley, J (1995), Chambers, R (1983) and Thomas, D and D Potter in Allen, T, and A Thomas (eds.) (1992)

Thus, while not asserting that welfarism is wrong, there has been a recognition that other types of interventions, aside from state-led projects, can be more successful in terms of achieving development goals. This does not mean that the state should not be providing resources, but that communities are possibly better at managing these resources. The idea is that people can participate more effectively, and become self-reliant (Midgley, 1995).

This type of ideology must however be seen as falling on a continuum, where on the one extreme is an individualistic approach where the state is not seen as responsible at all, in the middle is communitariansim, and on the other, where the state is seen as the sole provider and responsible party in development. As Thomas and Potter (in Allen and Thomas (eds.), 1992) argue, the state can either be the primary agent for development, an enabling agent, or an obstacle for development. Very few projects can be slotted into one category, as they all have differing levels of participation and resource management and provision.

In terms of social capital, this is an issue which has attracted a lot of criticism, because of the assertion that it is calling for a shift from welfarism to a laissez faire, liberal approach. However, as has been argued in previous chapters, promoting social capital is a recognition that community-led initiatives tend to have far more success in terms of development than do state-led, top down projects which do not take local level relationships, networks and nuances into account. As Curtis (in Nelson and Wright (eds.) 1997) argues, it is not that communities should be responsible for their own betterment, but that states have thus far failed to provide. It is all very well to promote welfarism, but history has shown that it has yet to succeed in any substantial form. Curtis argues that while thinking has evolved to allow for community development programs, policy has yet to catch up. This is a crucial point - what is being examined here is what types of environments are most suited to community development, in particular public health, and therefore, what should future policies aim at promoting to ensure the success of future programs.

As its name suggests, social development has as its goal more than economic

development and growth. It wishes to foster the development of society as a whole. This is arguably not possible without participation and empowerment. The list of human needs which are to be satisfied if social development is to be deemed successful goes beyond the material and includes political and social aspects (Thomas and Potter in Allen and Thomas (eds.) (1992).

Karl (1995) outlines the following levels of participation and empowerment, which she has adapted from UNICEF (1993). While this is related specifically to women, it is a useful framework for analyzing participation in development projects by all previously disempowered individuals.

1. Welfare - this is the provision of welfare services, and does not address or consider the underlying structural issues. It is apolitical.
2. Access - involving the equality of access to resources, which comes about through a recognition that they have been denied access to resources such as education, and take steps to overcome this
3. Conscientization - a recognition that problems stem from structural and institutional discrimination
4. Participation - mobilization and organization, allowing for active participation and increased representation
5. Control - the ultimate level of equality, with people taking control over their lives and their resources

The above framework is useful in terms of assessing and evaluating where it is that projects fall into, and at what level there needs to be intervention to promote further empowerment and participation - to enable 'ownership' of the development process. Curtis (in Nelson and Wright (eds.) 1997) argues that the notion of community development is often used to describe all sorts of development initiatives which are not always empowering, or successful. These usually involve some form of assisted self-help projects such as building one's own house with bricks made by oneself, or deciding where a new classroom should be built. These are not really community led initiatives, and often fit into the first two categories of Karl's framework. As Karl

argues, it has been shown that when communities are educated about and involved in the development projects' aims and plans, and they see themselves as beneficiaries of the projects, holistic development is far more likely to succeed. This is relevant in terms of the aims of the Carletonville project's pilot survey, which sought to address how sexual health programs could be implemented more effectively. Peer education, community involvement, decision making and participation are all key features of a successful program, and social capital augments, and allows for these processes by strengthening dissemination of information, strengthening of community ties, building of community identities, and easing the burden of poverty.

Obviously what needs to be stressed is that community development brings along with it its own set of problems and issues, among which are clientelism, free-riding of individuals who have not assisted in the project but who benefit from it, as well as local power struggles and domination of the project by one group, usually men. Curtis (in Nelson and Wright (eds.) 1997) acknowledges these issues, as do others such as Beall (1997). These issues are critical when considering what benefits are to be attained from organizing and promoting social capital.

While it can be the answer to many problems, it can in itself be exclusionary and/or highly problematic, or as other theorists have defined it, anti-social or perverse, for example Fine (1998). Budlender and Dube (1998) refer to anti-social capital in the South African setting, such as gangsterism in townships, Rubio (1997) discusses perverse social capital in Columbia, in terms of strong dense criminal networks around which activity is organized, and Holland (1998) examines pyramid schemes in Albania, whose failure led to chaos and an ultimate break down in *social* capital[6].

5.3 The Findings of the Carletonville Pilot Survey

The aim of the pilot survey was to establish whether there is any relationship between sexual health (defined in terms of HIV status) and social capital (defined in terms of civic engagement [associations joined], perceived trust and perceived helpfulness).

[6] For a more detailed discussion of the notion of perverse social capital, see Chapter Three

The data suggest that there is a relationship between HIV status and associations joined; and that there is a relationship between HIV status and perceived helpfulness. However, it also shows that there is no relationship between HIV status and trust, which is the cornerstone of Putnam's (1993) work in Italy.

What needs to be explored in future research is whether (a) there actually is no significant relationship between trust and social development - and therefore what can be concluded is that different social settings, in particular developed as opposed to developing regions - will have different aspects of social capital, as defined by Putnam (1993) and others, being the most important variable. The other possibility is that (b) the tools used to determine levels of, and explore the effects of trust were either not adequate, or they were inappropriate to the cultural and social setting of a developing country. It is tentatively argued here that it is most likely a combination of these two factors. One of Campbell's (1998d) goals is to examine the extent to which Putnam's (1993) notion of social capital can be used as a development tool in the UK and in South Africa. Wilkinson (cited in Campbell, 1998d) says that social capital only makes sense in a context where peoples' basic economic needs are met. This issue was discussed in Chapter Three in terms of the transferability of social theory. In terms of the main issues identified in the readings, what needs to be taken into account is the importance of space, of cultural settings, and of difference. While some theories may be applicable across vastly different social settings, others may not be appropriate.

Different aspects of Putnam's (1993) definition of social capital have been used and identified by different theorists, for example, Narayan and Pritchett (1997) pick up on the aspects of associational membership and levels of trust as measures of social capital, while Kawachi et al (1997) focus on trust and perceived helpfulness.

The pilot survey, which conceptualized social capital in terms of perceptions of trust, perceptions of helpfulness, associational membership, and voting[7], showed most

[7]The issue of voting was later abandoned because voting rates were probably unduly high (75%) because of the post-apartheid excitement.

significantly a relationship between associational membership and sexual health, but not between trust and sexual health. However, this does not mean that there is no relationship between trust and sexual health, or in a broader sense, social development. Rather it illustrates the point that more research is required around issues of trust and development, and perhaps different methods are necessary to measure this intangible facet of community life. While associational membership can be quantitatively validated, trust is a far more fluid, complex and nuanced feature, and it also varies over time. Thus while you may trust a neighbour today, if they do something which is deemed inappropriate, you may not trust them tomorrow.

The four main issues to be concentrated on in the analysis of the results are as follows:

1. what association, if any, is there between civic engagement (measured by associations joined), trust and helpfulness (i.e. the different dimensions of social capital)?
2. is there a significant association between these dimensions and levels of HIV?
3. is there a direct and observable relationship between associational membership and HIV status, or health in general?
4. what impact does housing type and gender have on levels of HIV?

Putnam's (1993) much quoted definition of social capital points to networks, norms and trust that facilitate cooperation for mutual benefit. What was therefore examined in The Pilot Survey was whether there was actually a relationship between trust, helpfulness and associational membership. Establishing the existence of this relationship would be vital in terms of trying to understand the effect of, and promoting the creation of, social capital.

What was shown was that the only positive correlation was between helpfulness and trust. What therefore needs to be considered is that despite joining more associations, which in essence is an explicit choice to socialise with people, belonging to a number of associations does not enhance levels of trust and helpfulness. While more relationships are forged, they are not necessarily based on trust or helpfulness, and

even when people are helpful, they are not always trusted. This has implications for future policy in that if, as the findings suggest, associational membership should be promoted, what needs to be examined is that even if there is a positive relationship between associational membership and improved sexual health / decreased HIV status, it possibly does not mend the social fabric on the whole - which itself has a number of ramifications.

While it can only be conjectured at this stage, it is necessary to consider the context within which the research was done. Within contexts of scarce resources it is often a question of the toughest surviving, and the types of relationships formed are often distrustful out of necessity. Such a context is not conducive to the promotion of trust, and to being helpful, or at least not doing all three together. Relationships, while at some level may be helpful, can also be tenuous. As Moser (1998) stresses, there is a level beyond which, for a number of reasons, social capital ceases to exist because people have gone below a base line where it is 'affordable'.

In terms of trust, the data show that there is no significant relationship between trust and HIV status. Even when gender differences and housing type had been considered, the relationship did not alter much. This is interesting because one would assume that trust would allow for more rapid, and more extensive dissemination of information and therefore a potential decrease in HIV transmission. As stated in Chapter Four, this finding is contrary to the hypothesis.

The relationship between helpfulness and HIV status was significant. Helpfulness did not vary much between gender, or across housing types. What was interesting is that the levels of helpfulness were highest in the hotspots, and then in the private housing. Hotspots are not necessarily the poorest communities, and possibly people would help each other out of necessity and a desire for mutual support and protection. In private housing, this would support the earlier assertion that wealth and at least some of the features of social capital are related, and that people will engage on this level only up to a point. People in private housing, while by no means wealthy, are not struggling as much as their neighbours in mine hostels or in informal housing. Mine hostels, while

'paid for' involve their own set of anti-social features, other than the dire poverty of the informal settlement for example, which could easily erode social capital, or any of its components.

The most significant relationship found was between associations joined and HIV status. It was shown that HIV prevalence decreased with an increase in associational membership. While joining an association had an impact on HIV status, the number joined thereafter did not. This could be to do with the types of associations joined, and the fact that not all associations would promote social capital, and indeed could create anti-social capital. It could also point to the characteristics of the *types* of people who join associations in the first place, and the types of behaviours they are likely to exhibit. A longitudinal survey of the same people would produce interesting results in terms of people's status changing with life style changes that lead to joining / leaving associations completely.

It was noted that the most vulnerable or marginalised people tended not to join associations. This links back to the point about levels beyond which people cannot participate, and also to Budlender and Dube's (1998) assertion that people do not always want to take part in community activities.

As Campbell (1998d) argues in her study of communities in Luton, informal relationships and networks are more prevalent amongst women, and the impact of these relationships has not been considered in The Pilot Survey. However, this has been taken into account in terms of future survey design. Organisational membership's protective effect was shown not to vary between genders, however, it is contended here that membership of informal support groups would alter the data quite a bit to show that women would be more 'protected' by belonging to groups, and their HIV status would fall accordingly. Ignoring informal groupings effectively excludes a vast number of women from that part of the survey.

5.4 Conclusion

The link between social capital and health is complex. While the pilot survey did show support for the hypothesis, in terms of links between social capital and health, there needs to be more work done on this issue before it is used to inform policy. Much more research needs to be done. An example which illustrates this well is that rotating credit associations i.e., stokvels have always been presented in a good light, and cited as a perfect example of social capital, however, further research has shown that they are not always as positive, or as simple as they seem on the surface. They can be exclusionary, and beset by a number of internal dynamics which effect how and what their members get out of them. Thus caution needs to be taken when promoting specific forms of social capital to achieve developmental gains.

Social capital is not being promoted as a means of eradicating poverty, it can never do this. It is not an alternative to welfarism, but rather a recognition that at the community level, it has a lot to offer in terms of conceptualising the kinds of community-level relationships and networks that are believed to mediate between development programs and their intended outcomes (in the case of the Carletonville Survey the outcome being health) and in evaluating and implementing community health and social development programs. How it can be used, and where it is and is not appropriate needs to be considered at length in future research, however what the Carletonville Pilot survey showed, and what this dissertation has investigated, is that preliminary findings do show links between health and certain aspects of social capital.

Tentatively what can be said is that development projects should concentrate on promoting associational membership of those types of associations which foster development. Anti-social capital is to be avoided, and thus membership of associations which are not developmental - explicitly or implicitly - should clearly be discouraged. While it is not possible to assert that all associational membership will aid development, or that development is not possible without it, what can be shown from the pilot survey is that there is a relationship between the two.

In terms of the way forward, issues to be considered in future research are where, if at all, trust fits in, and which associations are developmentally sound, and which are not. What needs to be considered is whether (and how) these findings can inform development policy, and funding. Evans (1996b) asserts the need for research into the nature of relationships between the stakeholders - what he refers to as synergy, which will enhance each others' development objectives. Stakeholder relations were examined and targetted in The Carletonville HIV Management Programme. Understanding these relations is no simple matter - Fox (1996), for example, discusses the conditions under which a state can either enhance or block development, because of its own agenda(s). This has to be taken into account when planning stakeholder participation.

As stated before, communities should not be solely responsible for their own betterment, however, on the whole, states, and state-led development have thus far failed to provide. On a global scale, welfarism has yet to succeed in any substantial form. Curtis argues that while thinking has evolved to allow for community development programs, policy has yet to catch up (Curtis, 1997).

The main goal of development is economic growth and regeneration, however, without simultaneous, or arguably prior social regeneration, the impact of economic growth will be distorted in terms of who it benefits and who is disadvantaged. Its results can never be optimised. As poverty has been seen to destroy social capital, it often those very areas which require economic growth that also require most urgently the repairing of their social fabric. As Evans (1996a) argues, social capital will not necessarily promote increased material well-being. However, without it betterment will be exceedingly difficult.

Chapter Six: Conclusion

HIV/AIDS is a complex and multi-faceted disease, and understanding why it is more prevalent amongst certain groups, and more pertinently, how levels of incidence are to be reduced, is a great challenge. Conventional wisdom has sought out issues of sexual behaviour, such as rate of partner change, condom use, and sexual practices, as well as biomedical aspects or features of individuals and groups such as STD status, circumcision, and therefore overall susceptibility. However, what tends to be ignored is the social environment within which these practices take place, and more importantly, the psycho-social forces which shape complex behaviours.

The social, economic, political and psychological context of risk behaviour has to be understood before the implementation of successful health programmes can be attempted. This thesis, while not considering the macro factors of political-economy, has examined the community-level relationships that impact on the success of programmes.

What can be concluded, at least from The Pilot Study, is that if social capital is built by getting communities involved in education programmes for example, and this involvement needs to extend to their management and control of these programmes, then the development goals of increased sexual health and of increased participation and empowerment can increasingly be achieved..

Social capital potentially offers the kinds of participatory and enabling environments sought as a broad development objective. These enabling environments allow for positive behaviour changes, as well as easing the burden of stressful and difficult lives. The feature of social capital, as identified initially by Putnam (1993) which seems to have the most positive effect on sexual health is associational membership. Therefore, I conclude - as does The Pilot Study - that what is necessary to research even further is whether associational membership can be used as a tool for creating an environment which is susceptible to, and allows for, social development. Examining levels and aspects of

associational membership is potentially a useful evaluation tool when examining sexual health programmes. What also needs to be considered is that the other elements of social capital, as identified by Putnam (1993) may also be more relevant in other settings or at different times. Thus while associational membership has shown in this instance to be the most significant factor, trust, cooperation and reciprocity also need to be examined further, possibly using different methodologies.

The use of social capital as a theoretical tool has been illustrated because it allows for the examination of complex community processes. Although social capital has attracted considerable criticism, what much of this criticism tends to ignore is that there is little to offer in social capital's place. While it may be limited in scope, social capital is useful as an analytical tool, and furthermore, it is a useful practical tool for creating enabling environments. Conventional approaches to HIV management have thus far failed, as have many theories aimed at understanding community and individual processes. Social capital potentially offers a solution to both of these problems by providing a tool - and all it is is a *tool* - with which attempts can be made to understand community processes, and thereby introduce programmes which are far more effective and influential. These findings have relevance for all social development programmes, and what they point to is the need for further research to be undertaken to ascertain with greater precision, the nature of the links between social development and social capital.

While it is too early in the study to outline policy implications, what can be said is that the data collected did show significant enough relationships, in particular with reference to associational membership, to point to areas for future funding and resource allocation. What has been discussed in Chapter Five is that conventional research wisdom is failing to assess and evaluate communities in terms of relationships and networks, and issues of diversity, power and change. An analysis of social capital, which is, in essence, an analysis of these relationships and nuanced settings, allows for incorporation into development planning of these features, in a way that is positive and constructive.

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