A Literature Review of the Impact of Social Capital on the spread of HIV/AIDS in Rural Communities

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Introduction
HIV/AIDS is becoming an important issue within rural communities and it is becoming increasingly important to identify preventive approaches and support mechanisms for those affected by HIV and/or AIDS.\(^1\) HIV and AIDS are present in rural\(^2\) Canada and the rates of infection are increasing (Health Canada, 2004). Rural communities are at a disadvantage when it comes to containing the spread of HIV. It has been documented in the literature that factors such as geographic isolation, limited access to resources, lack of tolerance for diversity, and lack of privacy, are barriers to dealing with the growing problem of HIV/AIDS in rural communities (Weaver, 1999; Conway et al., 1992; Sullivan, 1991; Rounds, 1988). Thus, rural communities need attention.

Rural communities are traditionally high in social capital (Reimer, 2002). Therefore, social capital may play an important role in the ability of rural communities to develop and maintain programs of HIV prevention and AIDS support. HIV prevention is not effective by simply providing information to people (Fullilove et al., 2000); instead the spread of the infection is intimately connected to social and cultural norms and behaviour. It is for this reason that social capital has become a key focus of our attention since the concept addresses these social relations and the capacity for action that is required to deal with the pandemic.

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\(^2\) Since definitions of rural vary, in this paper rural is defined as a “population living in towns and municipalities (CSDs) outside of the commuting zone of larger urban centres” (du Plessis et al., 2001:12).
In order to explore the relationship between social capital and HIV/AIDS in rural Canada we begin with a review of the literature. Although the initial focus of this review was on rural Canadian communities, due to the limited literature studies examining HIV/AIDS in rural communities, studies undertaken outside of Canada were included. First, we define social capital, followed by an exploration of the literature for information on the role of social capital in HIV prevention and support. This section is divided into literature that claims social capital is an asset for HIV prevention and AIDS support and literature that argue the contrary—that social capital is an obstacle for HIV prevention and AIDS support. Next we present literature that claims that social capital is both an asset as well as an obstacle to HIV/AIDS. We conclude by arguing that the relationship between social capital and HIV/AIDS is highly complex and requires further theoretical and empirical work.

**Definitions of Social Capital**

Social capital is defined differently in the literature. The three most cited definitions are by Putnam (2000), Coleman (1990) and Bourdieu (1986). Putnam and his colleagues emphasize trust and social networks in their definition of social capital (Putnam, 2000; Kawachi et al, 1997). While Coleman (1990) defines social capital as productive, relational, and multiple. He argues that social capitals “consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure” (1990: 302). The third most cited definition of social capital in the literature by Bourdieu who understands social capital as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized
relationships of mutual acquaintance and recognition – or in other words to membership of a group” (1986: 79).³

The definition of social capital used in this paper is based on Reimer (2002) who argues:

“social capital is one type of asset or resource that can be used to achieve valued outcomes. As capital, it is a part of production that is reinvested into future production. As social capital it refers to social forms as reflected in organizations, collective activities, networks, and relationships. From this point of view, social capital is a relational, as opposed to an individual characteristic” (Reimer, 2002: 2).

Reimer’s (2002; Geepu Nau Tiepoh & Reimer, 2004) definition allows for complex understandings and effects of social capital. He defines social capital as based in four types of social relations—market, bureaucratic, associative, and communal—that symbolize the ways relationships are organized and managed in order to accomplish goals. Market relations are based in economics and bureaucratic relations are “based on a rationalized division of labour and the structuring of authority through general principles and rules” (Reimer, 2002: 4). Associative relations are present in voluntary associations and informal organizations and communal relations are based on shared identities.⁴ These four types of relations are not mutually exclusive and often all are present at the same time, with varying effects.

³ There are arguments emerging in the literature that Bourdieu’s definition of social capital is stronger because it allows for theoretical and empirical analyses of power, unlike Putnam’s definition (Baum, 2000; Hawe & Shiell, 2000)
⁴ For a detailed explanation of the four types of relations see Tiepoh & Reimer, 2004
Additionally, Reimer (2002) makes a distinction between the availability and use of social capital. This feature is important because a form of social capital may be present in a community, but it may not be used. This becomes an important distinction when looking at HIV/AIDS in rural communities. For example, HIV prevention information may be available in community centres or medical offices, but such information may not be taken and used by people because of lack of anonymity. Or, HIV testing may be available, but people may not get tested because they know the person who will take their blood sample. This distinction between the availability and use of social capital is essential when assessing the social capital of a community in order to design and implement effective HIV prevention programs.

This multi-dimensional, relational approach to social capital allows for an exploration of how HIV/AIDS impacts rural communities. It is recognized that different relations and contexts affect social capital, and that these relationships are not uni-directional. In other words, contexts and relations affect social capital and forms of social capital affect relations and contexts. Recognizing and assessing a community’s different forms of social capital is important when designing and implementing HIV prevention and AIDS support programs and policies. Thus, Reimer’s definition provides for complex understandings and measurements of social capital that can be used to assess HIV/AIDS in rural communities.

**Social Capital and HIV/AIDS**

This brings us to the question: Is there any evidence in the literature about the role of
social capital in prevention of HIV infection and support of people with AIDS?

There are many articles exploring the relationship between social capital and health, yet there is a lack of research into the relationship between social capital and HIV/AIDS. Due to this gap in the literature, studies that link social capital and health are included in this literature review. Such studies are relevant because HIV/AIDS is a health issue. In the literature there is a tension surrounding whether social capital is an asset or an obstacle in the prevention of HIV and AIDS support. These two positions are outlined below.

**Social Capital as an Asset**

There is a large body of literature on the positive effects of social capital on health (Gilbert & Walker, 2002; Fullilove, 2000; Kawachi et al., 1999; 1997; Lomas, 1998). Social capital, in the forms of social networks, trust, community participation, has become recognized as an asset and a determinant of health (van Kemenade, 2003a; Putnam, 2000). Specifically, social capital is seen to affect health positively in a variety of ways, such as prompting health-related behaviours (i.e., encouraging healthy behaviours and discouraging unhealthy behaviours) and promoting access to services and support (Kawachi et al., 1999). Because of this recent focus on the relationship between social capital and health indicators of social capital being developed in order to assess and improve the health and well-being of citizens (van Kemenade, 2003a; 2003b; Reimer 2002).
There is a body of social capital literature that focuses upon the relationship between socio-economic status and health. In much of this literature social capital is defined and measured as participation in larger society (i.e., voluntary, religious, social, sport organizations) and is seen as an asset for health (Berkman et al., 2000; Putnam, 2000; Kawachi et al., 1999; 1997). For example, Kawachi et al. (1997) found that income inequalities (disparities between high and low incomes) results in less investment in social capital which in turn affects mortality. They argue that “income inequality leads to increased mortality via disinvestment in social capital” (Kawachi et al., 1997: 1491). In other words, low social capital is perceived as a factor for increased rates of morbidity. Consequently, this literature argues that high levels of social capital are necessary for communities to be healthy. This literature can be easily related to HIV/AIDS since poverty is also related to increased rates of HIV (Thomas & Thomas, 1999). Therefore, this literature suggests that a community’s social capital can be used as a tool to prevent HIV “by enhancing the skills of people in the community and providing them with opportunities and resources to care and advocate for one another” (Thomas & Thomas, 1999: 1082).

However, we question this direct, linear relationship between poverty, low levels of social capital, and increased mortality. This argument is based on an understanding and measurement of social capital as individual’s participation in social, religious, sport, academic, and political organizations (Putnam 2000; Kawachi et al., 1999; 1997). This does not take into account different types of social capital that are not based within organizational membership or the distinction between the availability and use of social
capital (Reimer, 2002). In areas where many people experience low levels of income there may be different types of social relations, networks and capital other than participation in groups. For example, there may be higher levels of availability and use of associative and communal capital (remember these are the relations that are based on common interests and shared identities, respectively). For example, people may exchange services such as babysitting in exchange house repairs when they have less disposable income. This is an example of the some of the complexities of social capital, which are often overlooked in the literature.

Therefore there are limitations to studies that define social capital as strictly an asset to health, especially if the indicators of social capital focus on individuals and do not address social contexts effectively. Such studies result in a limited understanding of social capital and its effect on health and HIV/AIDS.

These complexities will be outlined further in the following section which presents literature that argues that social capital can act an obstacle to HIV prevention and AIDS support.

**Social Capital as an Obstacle**

Two challenges facing rural communities are geographic isolation and lack of privacy, which can also be characteristics of communities with high levels of social capital. Thus
it is imperative to look beyond social capital as only an asset and consider instances where social capital is an obstacle for HIV prevention and AIDS support.

There is not a positive, causal relationship between social capital and health. Instead, exclusion and distrust can be characteristics of communities with high levels of social capital (Baum, 1999). Thus, social capital can be an obstacle for people who are not a part of the majority, such as persons with HIV, homosexuals, and drug users (Baum, 1999; Rounds, 1988). This is often overlooked in the literature. For example, Campbell et al. (2002) argue that frequent church attendance results in positive social capital, yet the authors do not consider certain religious values that resist sexuality education, the availability of condoms, and homosexuality. People with HIV may be seen as immoral and deserving of the infection, unlike someone who has cancer because traditional values and beliefs about AIDS (Carwein et al., 1993; Smith et al., 1990). This can create social capital that has negative effects for certain people (i.e., homosexuals) are excluded from membership (Smith et al., 1990).

Tight-knit communities with high levels of social capital can also have another feature—lack of privacy and anonymity. This can also be an obstacle in HIV prevention and treatment (Silvestre et al., 2002; Carwein et al., 1993; Smith et al., 1990; Rounds, 1988). People may not want to be tested for HIV because they know the person who does the testing, or because other people may see them in the medical facility. For example, women in Mill’s (2000) research in rural Alberta wanted, and tried, to keep their HIV diagnosis private, yet many experienced a rapid spread of the news of their diagnosis
through their communities. Therefore, lack of privacy and anonymity in rural communities can affect an individual’s decision to be tested for HIV, or to attend HIV/AIDS prevention and educational programs, if they exist. If facilities and/or programs are present, a community can be perceived has having sufficient HIV prevention and AIDS support programs. Yet it is imperative to evaluate whether people use these services. This is an example of why Reimer’s (2002) distinction between the availability and use of social capital is important and useful.

Additionally, close networks are often defined as social capital, yet this is another way in which social capital can facilitate the spread of HIV. For example, Gilbert & Walker (2002), in a South African study, argue that transport infrastructure is a factor that affects the spread of HIV. Well-kept roads linking rural communities to larger ones (which can be considered a form of social capital) allow for rapid movement of the virus since circular migration between rural and urban areas is common (Conway et al., 1992; DePoy & Bolduc, 1992). The prevalence of HIV infection is higher in urban centres than in smaller, more isolated communities, therefore by improving the transportation between these areas can facilitate an increase in HIV infection rates in rural communities.

**The Complexities of Social Capital and HIV/AIDS**

Campbell et al. (2002) is an example of a study that addresses the complexity of the relationship between social capital and HIV/AIDS, despite using associational indicators.
Following Putnam (2000), they measured social capital as memberships to a variety of associations such as churches, youth groups, sports clubs, women’s groups, and stokvels (savings clubs that have social meetings). They found that church membership is a form of positive social capital for men in that those who were a part of a church are less likely to engage in casual sex, thereby decreasing their risk of HIV infection. Thus, this form of social capital was an asset for HIV prevention for men. Likewise, women who were members of sports and youth clubs were less likely have HIV infection and more likely to use condoms. Yet, membership in stokvels increases both women and men’s risk for HIV infection, therefore, this form of social capital was an obstacle for HIV prevention.

As this study illustrates, both age and gender are factors in the complicated relationship between social capital and HIV (Baum, 2000; Campbell et al., 2002), however these factors are rarely addressed in the literature. Likewise, it is possible to experience both positive and negative effects of social capital at the same time (Berkman et al., 2000). For example, having close physical contact with others increases the likelihood of high levels of social capital as well as increasing the likelihood of becoming infected (Berkman et al., 2000). It is important to emphasize that membership in different organizations has different effects since this is often overlooked in other studies that use associational indicators as measures of social capital (Putnam, 2000; Kawachi et al., 1999; 1997).

**Conclusion**

Although literature examining the relationship between social capital and HIV/AIDS is limited, it is apparent that the relationship between these two concepts is complex and in
need of further examination. While social capital can play a role in preventing infection through education and health-seeking behaviors, it can also increase vulnerability of the individual to infection depending on associational membership.

There are inconsistencies on the literature on the definitions of social capital. This is understandable, yet problematic if the term is not grounded theoretically (Baum, 2000; Hawe & Shiell, 2000). ‘Trust’, ‘participation’, ‘networks’ are very subjective terms and consequently how they are understood to affect health vary substantially (Baum, 1999). Furthermore, theoretical positions have underlying assumptions, which affect how social capital is defined, understood, and measured (Baum, 2000). A theoretical framework that outlines assumptions is necessary to develop effective indicators and to consider the political implications of social capital.

There are serious political implications to the work which links social capital and health. Often this research, which views social capital as strictly an asset for health, overlooks the policy implications of their findings. The most important of these policy implications is that linking social capital and health allows for a shift away from structurally inequalities to a focus on individual and community responsibility. Instead of focusing on research that demonstrates the relationship between social and economic inequalities and health, the shift to the focus on social capital results in individuals becoming responsible for their health and well-being. This new focus is “cheaper than that goal of reducing income inequalities” (Campbell, 2000: 184). van Kemenade (2003a) also warns that

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5 For an exploration of this shift to health as an individual’s responsibility see Greco (1993), Nettleton (1997)
privatization of health is a possible policy implication of using social capital as a health determinant. In other words, it allows for “a convenient justification for a retreat from expensive welfare spending” (Campbell, 2000: 183-4).

It is important to move beyond a conception of social capital based on individuals and move to an understanding of dynamic social capital(s) rooted in social contexts (Edmondson, 2003). This includes developing indicators of gender, age, class and ethnicity. These variables are excluded from much of the social capital and health literature (Muntaner & Lynch, 2002), and are fundamental when addressing HIV/AIDS in rural communities. It is also important to use a definition of social capital that allows for complex understandings of the relationships between HIV/AIDS (or health in general) and social capital. Such a definition must include different types of social capital and the potential for social capital to be negative (Baum, 1999).

This is a move away from Putnam’s (2000) understanding of social capital to a model of social capital such as Reimer (2002; Geepu Nau Tiepoh & Reimer, 2004). An understanding of social capital that emphasizes contexts, different types of social capital, uses diverse indicators, makes a distinction between the availability and use of social capital, and allows for social capital to be recognized as an obstacle as well as an asset. Such a multi-faceted understanding of social capital will encourage more effective HIV prevention in rural communities. HIV/AIDS is a complex issue, as it social capital. Both of which are embedded in social relations, therefore, “[k]nowledge of social forces is
critical for designing interventions to prevent STDs and evaluating their effects” (Thomas & Thomas, 1999: 1082).

To conclude, there is strong evidence that the distinct characteristics existing in rural Canadian communities can both benefit and hinder the fight against HIV/AIDS. People living in rural Canada are at risk of getting infected with HIV and social capital can be both an asset and an obstacle to HIV prevention and AIDS support. This does not mean that we should abandon work exploring the relationship between social capital and HIV/AIDS. Social capital remains an important concept in the field of health and we expect the literature to expand to include more specific work on the relationship between social capital and HIV/AIDS in rural Canada.

Bibliography


