Social capital is stressed as an important asset in disaster response and recovery processes. Closely linked with community resilience, social capital provides informal ‘safety nets’ that help to fill gaps in government responses. The Gendered Impact of COVID-19 in Pakistan (GIC) explored people’s sources of social capital and whether – and how – these changed due to COVID-19. Findings provide important insights into social capital and highlight significant gender-differentials – a still understudied aspect of social capital during and in the aftermath of disasters.

Social capital describes social connections and networks interlinking people and institutions, and is considered to have three dimensions: structural capital, meaning networks of access to people and resources; relational, denoting mutual trust within a particular social grouping; and cognitive, consisting of subjective interpretations of shared understandings. In disaster response and recovery processes the focus is on structural social capital that operates in three forms:

1. Bonding social capital – built on strong ties between members of a group such as families, friends and allies or cultural, religious, ethnic and other affiliations and community-based organisations (CBOs) – is evident in the provision of immediate emergency assistance and support: food, shelter and other necessities. A next level is bridging capital that derives from connections enabling access to support beyond social bonding circles by mobilising resources from within the community. By diversifying the network, bridging capital strengthens coping capacity as expanded connections allow an exchange of knowledge, experience, and resources that can facilitate community revitalisation and resilience. Finally, linking social capital describes the connections communities are able to leverage to bring non-local resources into the community such as the response
and recovery efforts of government, private and
civil society initiatives. Linking capital also connects
those impacted with relevant governmental
officials, and can be activated through the internet
and social media – a prominent feature in the
COVID-9 context. All such linkages facilitate and
accelerate recovery. Community resilience, denoting
the process and ability to survive major disruptions,
is abetted by social capital that enhances access to
information, resources, capital, and expertise as
well as emotional support to cope and recover.

The Impact of COVID-19

The study confirms social capital as a vital tool
for mobilising resources from within and beyond
the community, complementing as well as
linking to government efforts and officials. The
GIC research evidences that women in Pakistan
start off with far less structural social capital
than men. Social capital is built and nurtured
over time. This is more difficult for women with
restricted mobility that limits their socialising,
constricting social capital, especially bridging
and bonding capital. Across all districts studied,
men enjoy greater and more diverse social capital
than women and a difference was apparent in
the social networks of women and men. Because
women’s socialising is limited, their bonding
capital rarely extends beyond immediate
family circles. Only exceptionally can women
count on friends, usually if they are studying
or working in collective settings outside their
homes – meaning not domestic work, door-to-
door sales or individualised home-based work.
Both women and men differentiate between
who they approach for moral and emotional
support (relational-cognitive social capital)
and who they rely on for material support
(structural capital). Mothers and sisters –
and less frequently husbands and relatives –
provide women emotional and moral support,
but ever-married women look to brothers for
practical and material help. Women’s access to
social capital for financial support is commonly
limited to immediate male relatives (who are
often abusive, thereby leaving no avenue of
support for women) compared to that of men.

A unique form of social capital amongst
women is in the provision of emergency
shelter to women fleeing abusive situations,
few however have the linking capital to
connect such women with appropriate
support services.

While most women share problems with and look
to their husbands for support, few men turn to
wives. Easily accessible female health workers,
especially those based in the neighbourhood or village and/or who regularly visit communities, emerged as a source of outside support for some women – no men mentioned health workers. A degree of social cohesion was evident across most districts in the study but communities experienced a weakening or breakdown of such cohesion. In part, this relates to significant differences between the COVID-19 created upheaval and other disasters such as hurricanes, floods, cyclones, etc. that impact particular communities or locations. COVID-19 impacted everyone everywhere and was accompanied by quarantine and social distancing. Consequently, people experienced the disastrous impact not as a community but as atomised families – and even as individuals within families as some lost their jobs and others did not. The sense of community considered pivotal in enhancing coping capacity, was undermined: lockdown, social distancing protocols, and the fear of contracting the virus, impeded gatherings of socially bonded communities and obstructed community decision-making. Rather than communities collectively addressing a common problem, the calamity became individualised with everyone struggling to survive. In some cases, this led to a loosening of social bonds that depend on constant engagement. In some communities people hesitated to meet relatives for fear this might be misconstrued as a request for help or expose them to such demands – and help when asked for was not given. And yet, attesting to community resilience, all three forms of social capital – bonding, bridging and linking – were clearly evident in which CSOs, CBOs and informal groups played an important role.

Solidarity not only stemmed from existing normative structures, it was also generated through the acts of bridging and linking social capital. Linking capital was leveraged independently of bonding and bridging capital by, for example, using the internet or media programmes to facilitate people’s access to government relief programmes and officials. Mental stress, depression and anxiety were widespread; social distancing rules and pandemic-induced changes in attitude within families and others resulted in extreme loneliness and feelings of isolation with few – if any – means of relief. Mental health support to improve community coping capacity is important in upheavals. The Sindh Government launched a mental health helpline accessible nationwide, but there is no data on usage – whether women approached it at all – and effectiveness. Health resilience policies that can deliver immediate health benefits are also essential for building community resilience and contribute to reduced vulnerability in future disasters.

For many women – and men – the GIC research itself became an important source of alleviating stress through the mutual sharing of experiences – often for the first time, whether it was of their troubles or accomplishments during difficult times. Described as a “platform”, “group” and “family” it provided at least temporarily the social bonding that women in particular craved, leading to the desire to continue the process somehow. Several women spoke of their anxiety when research questions were delayed or when they lost their connectivity to the group because of technical problems. All of this underscores the vitality of – and need for – women’s social gatherings and groups; and it shows the transformative potential of the SALT approach designed to stimulate reflection, help self-confidence through people’s realisation of their own individual and collective strengths that paves the way for envisioning and taking collective actions for their own future well-being. Social capital facilitates coping and recovery enormously but is insufficient on its own to cope with and recover from disasters, and more generally. It complements but cannot replace responsive and accessible government institutions. Both are essential for building sustainable resilience for the future.
There is a need to study how social capital can be operationalised for community well-being, adaptive capacity and recovery for disasters. By bringing together neighbours around a common goal, social capital stimulates reflection on main challenges and existing resources, how to access essential information and mobilise resources through networks and act upon their pressing needs. The GIC study shows this can be done usefully with a bottom-up approach by deploying the SALT approach – an approach that helps people become aware of their own capacities, stimulates community members to reflect and generate ideas for their own future well-being and what they can do towards achieving this.

Regular gatherings of community women can help to foster and strengthen a collective identity that can underpin collective action for their common wellbeing and expand women’s bridging and linking social capital – not just in times of dire need but for all times and purposes. Bonding provides the basis for forming local organisations that can become help to expand bridging and linking capital by establishing tie and partnerships with community and external resources, support groups, and government schemes. Encouraging and supporting community-based organisations of women and local communities is closely linked to and can help to promote community resilience. Social media was used by numerous research participants – albeit more men than women – to promote to spread accurate information and facilitate coordination. This promotes mutual trust and recognition, helping to build social capital.

Effective resilience and social cohesion policies require that communities trust local officials and believe they are capable of helping them. Local government can play a crucial role in response and recovery and will be helped by partnering with CBOs and CSOs.
RECOMMENDATIONS

I. Strengthening Women’s Social Capital
   i. Encourage, provide opportunities and **support women to engage with each other and with people outside** their immediate family on a regular basis to help them expand existing social capital;
      a. Hold focus group discussions and community events,
      b. Task local government with facilitating spaces for women to hold conversations on community wellbeing amongst themselves and with local officials and community events for women,
      c. Consider how best to engage female health outreach workers in such activities;
   ii. Encourage and **support women to form local organisations and arrange trainings for leadership, self-expression, networking, know-how for gathering information, communicating with authorities, and proposal writing**;
   iii. Link **local women’s groups with external resources**; facilitate their engagement, networking and partnerships;
   iv. Widely **publicise information about CSOs amongst community women as potential support systems**
   v. Adopt measures to promote the **safe and effective use of social media** by women;

II. Health Resilience
   i. Integrate mental health resilience into all disaster management policies and plans to enhance the coping capacity of individuals, families and communities during and in the recovery process of the pandemic and other crisis situations;
   ii. Promote health self-care amongst women; and
   iii. Adopt robust legislation and policy frameworks for tele-health and telemedicine that is being promoted as a way of coping with the pandemic conditions.

III. Accessible Women-Responsive Government Institutions and Officials
   i. Re-envision safety nets: replace the traditional command and control model to one that enables communities to take charge of the problem, cope with and address their disaster concerns adequately. This requires formulating and implementing policies that include and maximize social capital, nurture community connectedness and help people access resources;
      a. Pilot community engagements based on the SALT approach developed in 2000 by people’s learning of working in UNAIDS
   ii. Establish a mechanism to formally engage all CSOs and CBOs responding to the disaster and recovery work and remove administrative obstacles for their operations;
   iii. Ensure opportunities for women and other marginalised groups to engage with government officials and elected representatives.
The Gendered Impact of COVID-19 in Pakistan study – supported by UN Women Pakistan, and undertaken by Shirkat Gah–Women’s Resource Centre (SG) and the Community Engagement Centre (CEC) – assessed gender-specific implications of pandemic-induced lockdown in 10 districts of Sindh, Punjab, and Khyber Pakhtunkhwa. The research provides evidence for effective inclusive response interventions and sustainable strategies for recovery around (1) livelihood and economic resilience, (2) intra-family gender relations and diverse facets of gender-based violence (GBV), (3) experiences of persons living with disabilities (PWD), and (4) social capital/cohesion and resilience.

The bulk of the data was collected from July to August 2020 by engaging 347 women, 180 men, and 9 transpersons. Inadequate data on women and girls living with disabilities led to another round of data collecting in November-December 2020 through in-depth interviews of 9 women and 1 man living with disabilities, and six organisations.


7 S: stimulate, A: appreciate, L: listen and learn; R: transfer. See https://vhai.org/our-work/salt-stimulate-appreciate-learn-transfer/