Weaving a tighter safety net:

Supporting children and families amidst the AIDS pandemic

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Executive Summary

Families play central roles in the current HIV/AIDS pandemic, taking up both the care of orphaned children and the care of children and adults suffering AIDS-related illness. This extra caregiving burden, however, depletes two family resources essential for supporting the healthy development of children: time and money. We use recent data from countries in sub-Saharan Africa to illustrate these deficits and to show how communities are currently responding. In our survey in Botswana, parents caring for the chronically ill had far less time for their preschool children (74 versus 96 hours per month) [1] and were almost twice as likely to leave children left home alone (53% versus 27%) [2]; not surprisingly, these children experienced greater health and academic problems [1]. Furthermore, caregiving often prevented adults from being able to work full time or earn their previous level of income; approximately half (47%) of the orphan caregivers and 64% of the HIV/AIDS caregivers reported financial difficulties due to this extra caregiving [2, 3]. Communities can play an important role in helping families earn enough to support children, and still be around to provide adequate childcare. Unfortunately, our evidence suggests that while communities commonly offer informal assistance, the value of such support is not adequate to match the magnitude of need. For example, 75% of children's families in Malawi received assistance from their social network, but this assistance averaged only US$81 annually [4]. We conclude by examining what this body of evidence tells us about how community support can strengthen the capacity of families to deliver care to children affected by HIV/AIDS. In

particular, we address the importance of implementing affordable quality childcare for 0-6 year olds, after-school programming for older children and youth, supportive care for ill children and caregivers, microlending to enhance earnings, training to increase access to quality jobs, establishment of decent working conditions that make it possible to provide care while earning a living in the formal sector, social insurance for the informal sector, and income and food transfers when families are unable to make ends meet.

Introduction

The HIV/AIDS pandemic has created a massive humanitarian crisis and left millions of children without adequate care and support. In sub-Saharan Africa alone, an estimated 12 million children now find themselves orphaned due to AIDS; another two million children are infected with HIV [5]. Many more children are made vulnerable when AIDS affects their families, including children living with chronically ill parents, those who must now share scarce resources with foster children, and those living in extreme poverty exacerbated by the epidemic. All of these children are at higher risk for malnutrition, poor health, psychological problems, educational difficulties, child labour and sexual exploitation.

Families are best placed to support these vulnerable children and have made tremendous efforts in the current crisis, taking up both the care of orphaned children and the care of children and adults suffering from AIDS-related illness. Extended families not only care for over 90% of double orphans, but they bear this responsibility largely on their own: only 5-20% of children affected by HIV/AIDS have access to external assistance [6-8]. Similarly, families provide up to 90% of the care for AIDS-related illness [9].

Importantly, this extra caregiving burden depletes two family resources essential for supporting the healthy development of children: time and money. After providing care to sick relatives and friends, and after caring for orphaned children left behind, parents have less time for their own children. HIV/AIDS-related caregiving also carries a financial

cost: medical expenses divert resources and exhaust savings; orphans increase dependency ratios and lower per capita income; and care giving disrupts work and competes with income-generation. These deficits are even more pronounced when a parent is HIV-positive, as related illnesses can interfere with the ability to earn a living as well as limit the nature and amount of time with children. As a combined result of time poverty and economic impoverishment, families are increasingly unable to provide the basic necessities children need for healthy development.

Communities can play an important role in helping families fill these deficits. Communities have a long tradition of providing private donations of money, food, or labour to vulnerable families [10-12]; but this safety net is beginning to disintegrate under the strain of the current crisis [13-15]. In its place, communities have organized new responses to the pandemic [10, 16]. Community-based organizations now provide material support to orphans and their families, care for people living with HIV/AIDS, and run day care centres that enable parents to better balance work and caregiving needs. Unfortunately, our research suggests that these initiatives are still far too limited in scope and scale.

In the following sections, we use recent data from two of the hardest hit countries, Botswana and Malawi, to provide initial insights into both the resource needs of caregiving families and how communities are currently responding to these needs. We conclude by tackling a critical question: what does this evidence tell us about how

communities can strengthen the capacity of *families* to deliver care to children affected by HIV/AIDS?

Methods

We use large-scale quantitative studies from two countries at the epicentre of the HIV/AIDS pandemic - Botswana and Malawi - to illustrate the availability of family resources and the extent of community support. Botswana, previously a successful example of economical prosperity and rising life expectancy on the African continent, has been hard hit by the epidemic and has seen its gains all but swept away. As a result of a staggeringly high rate of infection (24%), Botswana is now home to 95,000 orphans [5]. Data from this country are drawn from the Botswana Family Health Needs Study our research group conducted in 2002 [1-3, 17]. This study sampled working adults with caregiving responsibilities who used government outpatient health centres. Questionnaires focused on issues surrounding family health needs, care-giving and working. Of the 1033 adults in our sample, 379 (37%) reported caring for at least one orphan (i.e., any child age 0-17 years who had lost at least one parent) and 177 (17%) reported caring for someone who was HIV-positive.

Malawi, which has long been one of the poorest countries globally (over half of its population lives below the poverty line), now faces a 14% HIV infection rate [5]. As a result, an estimated 560,000 children now find themselves orphaned due to AIDS and another 91,000 children are infected with HIV/AIDS [5]. To represent the situation in

Malawi, we use data from the 2004-5 Malawi Integrated Household Survey, a nationally-representative household survey administered by the National Statistical Office of Malawi with technical assistance from the World Bank [18, 19]. Household questionnaires collected detailed information on each member, including 27,495 children in 9,331 households in 564 communities; community questionnaires were also administered to residents knowledgeable about their community and a consensus response was recorded [19]. In the sample restricted to families, 17% of households contained at least one orphan, and 19% of households had an adult member age 18-59 years who was chronically ill.

In addition, our paper is informed by case studies of community-programs that serve children affected by HIV/AIDS. Between 2005 and 2008, our team conducted interviews with directors, staff, volunteers, caregivers, and community leaders at a range of programs in Botswana, Malawi, and South Africa [e.g., 20].

HIV/AIDS and declining family resources

Families are the first line of protection for children. They continue to form the core safety net for orphans, as they have done successfully for many generations in sub-Saharan Africa [21-26]. However, this safety net is beginning to disintegrate in the context of the HIV/AIDS [15, 26-29]. In places with severe epidemics, households are losing working adults at the same time as orphans swell dependency ratios [30]. Furthermore, families now face multiple caregiving responsibilities – for their own children, for orphans they

foster, and for chronically ill family members. HIV-infected parents, once the primary source of care for their children, often need to become the primary recipient. These additional responsibilities severely deplete both the time adults can spend with each child and the financial resources available to meet their essential needs. As a result, families' ability to protect orphans and other children in their care has been severely compromised [15, 27, 28]. This section examines the pathways by which HIV/AIDS contributes to adult time poverty and economic impoverishment, thus comprising families' ability to care for and protect children.

Adult time poverty

The AIDS pandemic has left millions of children without the essential time they need with adults. While the loss of parents places orphans particularly at risk, they are not the only children deeply affected. When parents are critically ill, their health limits the amount and quality of care they can provide for their children. Parents caring for orphaned children or for chronically ill family members also have far less time for their own children. Markedly under recognized, this time poverty is of enormous consequence for children's daily lives, their health and their education. The following data from Botswana illustrate the pandemic's contribution to time poverty.

After providing care to ill relatives, friends, and neighbours, we found that parents had less time for their own children. On average, these parents were able to spend only 66 hours per month with their children, significantly less than the 75 hours that other parents

were able to dedicate to childcare [1]. This deficit was most pronounced for children under six years: parents with additional HIV/AIDS caregiving responsibilities spent only 74 versus 96 hours per month with their young children – a deficit of 22 hours [2].

To fill this gap, older siblings were often recruited to provide childcare. This simultaneously lowered the quality of care that young children received and jeopardized the welfare of older children. Promoted to a position beyond their years, older siblings (6-14 years) often had to forgo school or other age-appropriate activities in order to provide childcare. Again, this situation was far more common in families caring for people living with AIDS (15% versus 9%; figure 1) [2]. When older children were not available to take their place in the home, we found parents often had no choice but to leave children home alone. This was particularly true of parents who had to provide essential care to sick relatives. Over half (53%) of HIV/AIDS caregivers reported that they left children under five years old home alone; 27% of parents who were not HIV/AIDS caregivers reported leaving children in this hazardous situation (figure 1) [2]. Parental care is even more critical when a child is sick, yet over a quarter of caregiver left children home alone during this time [2].

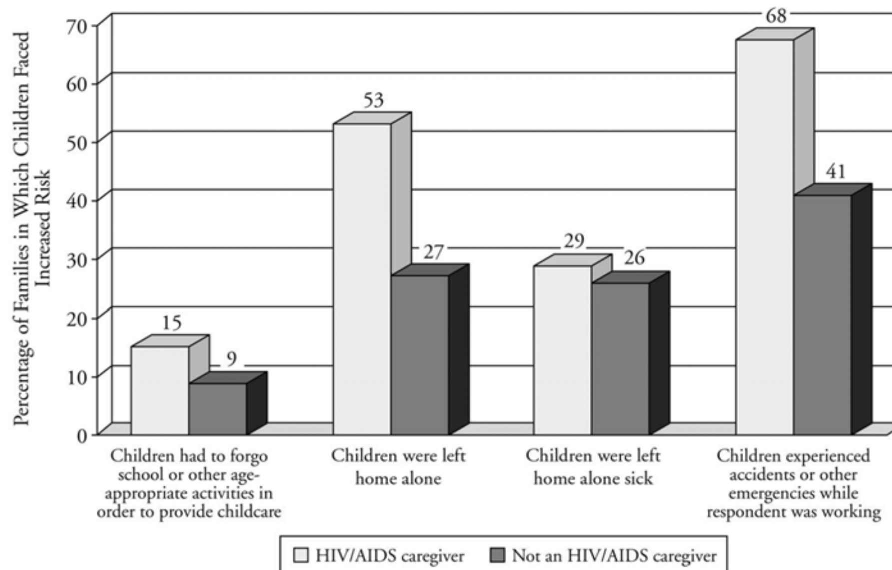

Figure 1. Children of HIV/AIDS caregivers face heightened risks; figure reproduced from Heymann, J., 2006 [2].

Not surprisingly, parents expressed deep concern about the welfare of their children when they were not able to provide care. HIV/AIDS caregivers, orphan caregivers, and HIV-infected parents all expressed concern about the quality of childcare while they were at work (36%, 41%, and 48% respectively) [1, 2, 17]. Concern intensified when the child in question was HIV-infected: 72% of caregivers for an HIV-infected child worried about the quality of childcare; this rose to 89% when the child was ill [2]. In the absence of quality childcare, parents and other guardians worried that their children were not receiving adequate educational or educational support. Specifically, orphan caregivers were more likely than parents without this additional responsibility to worry that their children were not receiving adequate educational and developmental support (32% versus 21%), and emotional support (35% versus 23%) while they were at work [17]. Similarly, HIV-infected parents were more likely than non-infected parents to report worrying that

their children were not receiving adequate educational and developmental support (39% versus 25%) or adequate emotional support (39% versus 27%) [2].

Parents concerns were well founded. The risk was heightened for children of HIV/AIDS caregivers because they both had less time to spend with their children and were more likely to leave their children home alone. In our sample, 68% of children whose parents were HIV/AIDS caregivers experienced accidents and emergencies while their parents were working away from the home, compared to 41% of other children (figure 1) [2]. The long-term impact of diminished time and financial resources was also evident in our sample. The children of HIV/AIDS caregivers were more likely to suffer from poor health (43% versus 28%); experience emotional/ behavioural difficulties (19% versus 14%); drop out of school (18% versus 11%); and have academic problems (18% versus 13%) [1].

Economic impoverishment

Caregiving related to the AIDS pandemic is exacerbating child poverty through three important mechanisms. First, HIV/AIDS-related medical costs divert resources and exhaust savings. Second, fostering the growing number of HIV/AIDS orphans increases dependency ratios and lower per capita income within the family. Third, HIV/AIDS-related care (both for orphans and for the chronically ill) disrupts work and competes with income-generation. Within this context, families that were already economically marginalized prior to AIDS-related crisis have the greatest risk of not being able to

provide basic necessities for children. However, many families who were previously able to meet basic needs also fall below a crucial line. The combined result is a marked increase in the number of children in families who can not meet even basic needs, afford to send children to school, or purchase the health care children need.

When parents fall ill with AIDS-related conditions, children are deprived of more then adult time; they are also deprived of financial resources essential for their welfare. Greater medical costs, combined with an inability to work, drain resources away from these families and are detrimental to child welfare. In our sample, almost half (48%) of HIV-positive adults experienced financial difficulties because of their health condition. Almost a quarter (23%) reported profound difficulties obtaining food, water, fuel, transportation [2].

When families take on additional HIV/AIDS or orphan caregiving responsibilities without additional income, financial difficulties also mount. Approximately half (47%) of the orphan caregivers and 64% of the HIV/IDS caregivers we surveyed in Botswana reported financial difficulties due to this extra caregiving [2, 3]. For at least one in five, these difficulties were severe enough to lead to shortages in paying for such basic needs as food, shelter, water, fuel, and transportation [2, 3]. These hardships were greatest among caregivers with only a primary-school education (figure 2) [2].

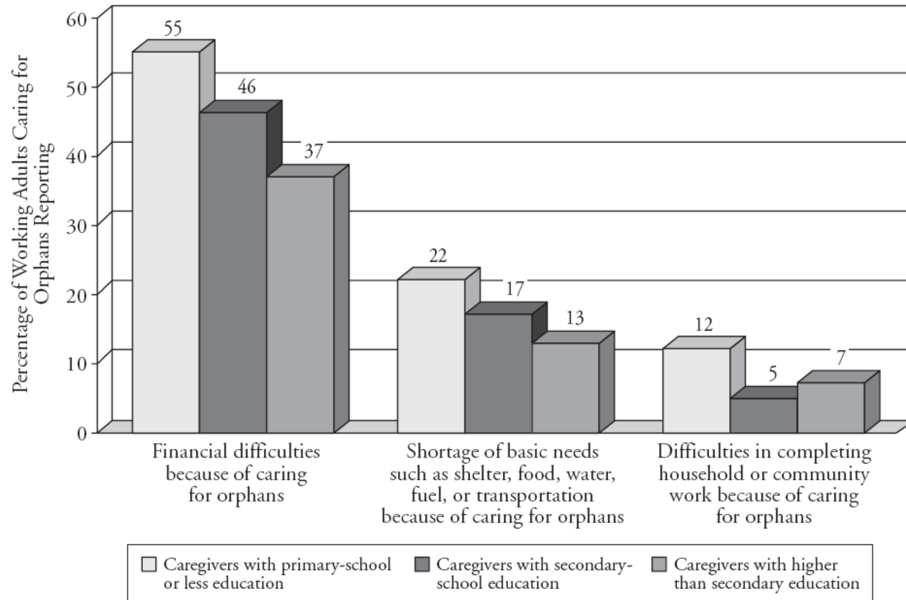

Figure 2. Orphan caregivers face greater financial problems due to caregiving; figure reproduced from Heymann, J., 2006 [2].

In the context of the maturing epidemic, families are likely to experience repeated HIV/AIDS-related crisis. It is not unusual for them to take up the burden of fostering orphans from multiple families, nor for them to simultaneously be caring for people living with AIDS. Unfortunately, each additional caregiving responsibility increases the likelihood that the family will experience financial difficulties. Compared to families fostering just one orphan, those fostering three or more orphans were twice as likely to experience financial difficulties. Adding HIV/AIDS caregiving to the mix doubles the likelihood of financial difficulties once again [3].

The relationship between the number of orphans fostered and the likelihood of financial difficulties is illustrated in figure 3. Low income families rarely escaped financial problems, even when caring for only one orphan. High-income families were more

resilient at this level of caregiving, but were plunged into financial difficulties at alarming rates as they absorb more and more orphans [3]. This pattern held true even when families were receiving external assistance to help care for the additional orphans [3].

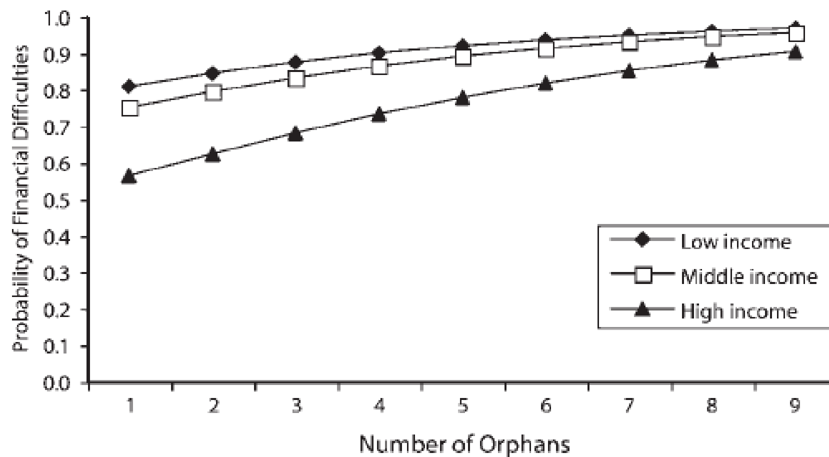

Figure 3. Fitted probability that a household will have financial difficulties because of orphan care based on the number of orphans cared for in low-, middle-, and high-income households without assistance; figure reproduced from Miller, C., et al., 2006 [3].

Furthermore, all of this additional caregiving often prevented adults from being able to work full time or earn their previous level of income. In our study, HIV/AIDS caregivers were more likely to take leave from work to provide essential care to sick adults and children (53 versus 39%), and this leave was more likely to be unpaid (54 versus 38%) [1]. Similarly, orphan caregivers were more likely to take unpaid leave and thus lose pay in order to care for sick children [17]. With greater demands on their time, orphan caregivers also had less flexibility to make up this income through overtime work. As a result, only 18% of orphan caregivers versus 26% of other working adults worked

overtime at least once a week [17]. Finally, we found that in addition to jeopardizing income, conflicts between caregiving and work also jeopardized child welfare: 47% of orphan caregivers said their work got in the way of meeting children's needs compared to only 30% who were not caring for orphans [17].

What communities are doing to support families

The HIV/AIDS epidemic is clearly weakening family capacity by depleting two critical resources: time and money. In the past, African communities traditionally provided valuable assistance in times of need. In the wake of the AIDS pandemic, it has been unclear the extent to which communities continue to voluntarily play this crucial role, or whether they are now too overburdened by the epidemic to work alone to strengthen families. To begin shedding light on this debate, this section presents a snapshot of what support has been provided by communities to families in Botswana and Malawi.

In Botswana, the extended family far exceeded the community as a source of support. Forty-three percent of orphan caregivers received help from other household members, and 39% received help from relatives outside their home (figure 4). Among relatives outside the home, 67% assisted economically, 58% provided material help (e.g., food, clothing), 46% provided educational support, 28% provided emotional and spiritual support, and 21% assisted with childcare [17]. Other members of the community, including friends, neighbours, and community volunteers, rarely (2% or less) offered any support to orphan caregivers [17]. Organized responses by either a local traditional

council or the national government reached a third of all families fostering orphans (figure 4) [17].

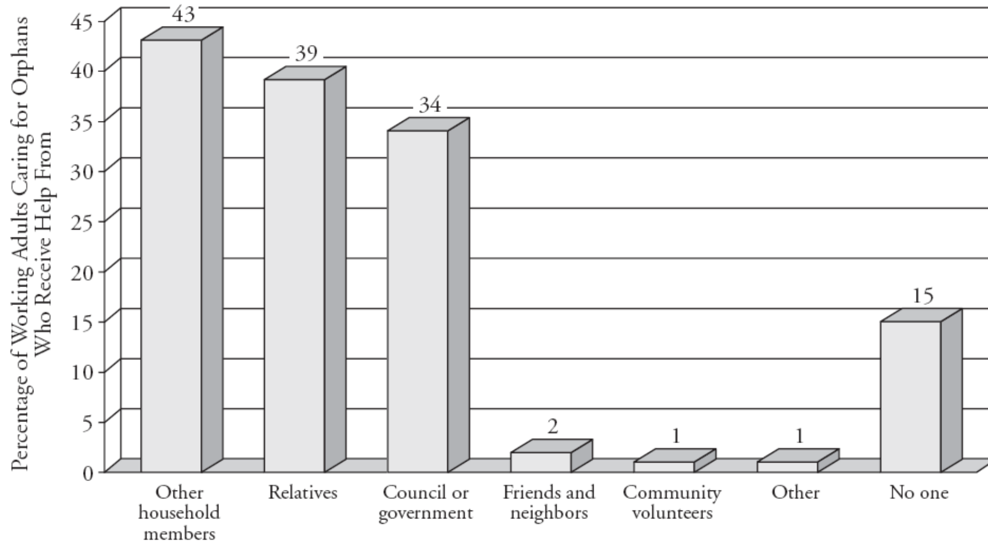

Figure 4. Working adults' sources of support in caring for orphans; figure reproduced from Heymann, J., 2006 [2].

In Malawi, vulnerable families commonly drew support from within their social network (i.e., relatives, friends, and neighbours). Seventy-five percent of children lived in households that had received food, cash or in-kind gifts in the past year, but the value of such support was relatively low (averaging US$81 annually) [4]. More specifically, 66% of children's households received food, 37% received cash, and 30% received in-kind donations. Families caring for double orphans were 42% more likely to receive private transfers of support, holding everything else constant [4]. Poor families with uneducated heads – in other words, those already least able to meet the essential needs of children in their care – received transfers of lesser value than other groups [4].

Furthermore, the data suggest that support comes from a broad section of the community, not just a few benefactors. Sixty-seven percent of households reported that they contributed to the welfare of another household through private donations of food, cash or in-kind gifts in the past year. Households below the poverty line were only slightly less likely to contribute than non-poor households (64 versus 70%). However, the value of their contributions was substantially lower than those made by non-poor households (US$121 versus US$33).

This assistance mattered to the family's welfare. We measured financial difficulties in working households caring for orphans in Botswana and found that external assistance lowered their likelihood of reporting financial difficulties by 70% overall [3]. For households with only orphan caregiving responsibilities, external assistance kept financial difficulties at bay for many families (figure 5a). For poor households with both orphan and HIV/AIDS caregiving burdens (figure 5b), however, the level of external

assistance was not high enough to protect them from financial difficulties [3].

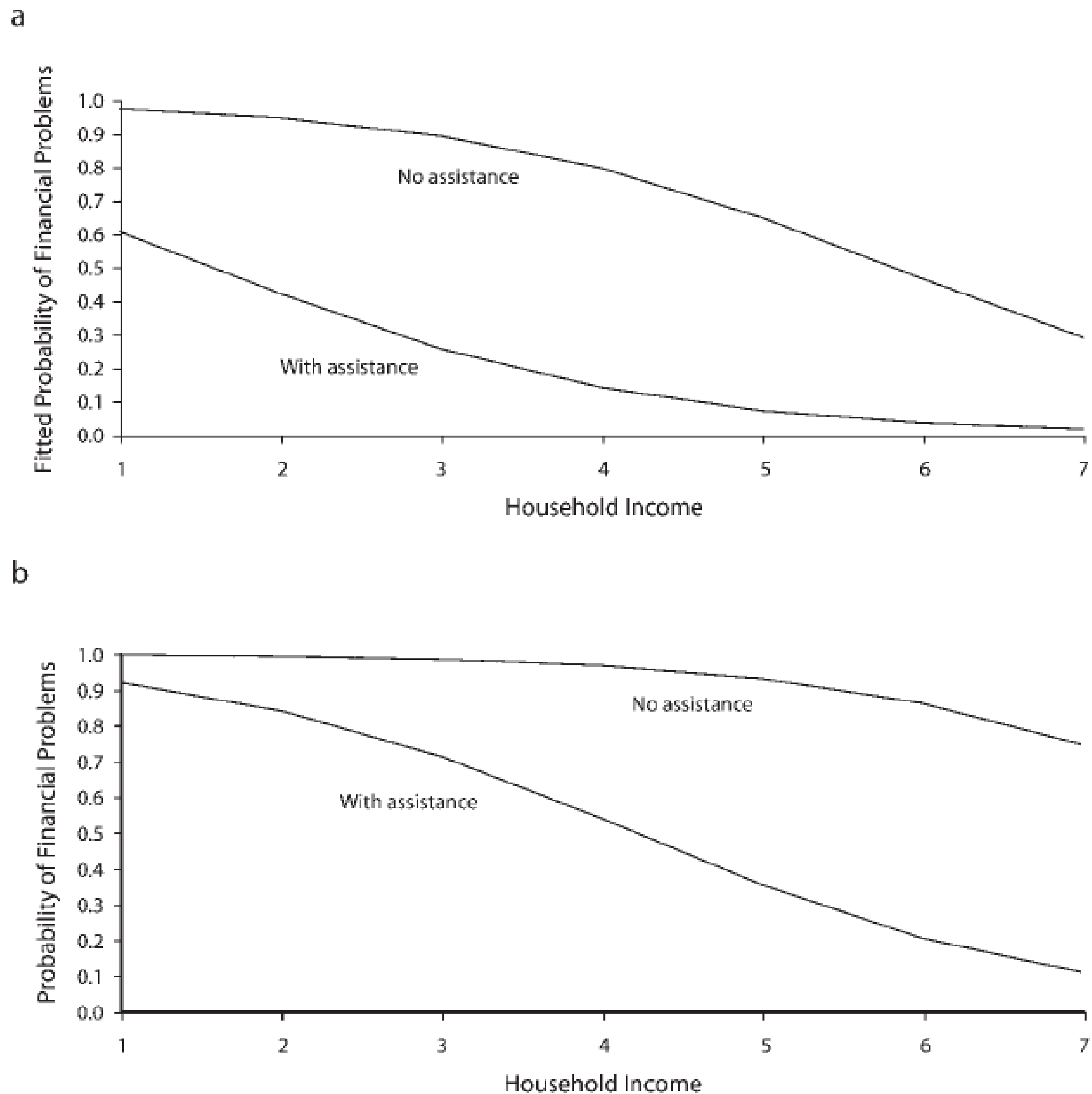

Figure 5. Fitted probability that a household will have financial difficulties because of orphan care based on income level and receiving orphan assistance in households not caring (a) and caring (b) for adults; figure reproduced from Miller, C., et al., 2006 [3].

As in Botswana, organized responses meant to ease the caregiving burden were less frequent in Malawi: only 40% of children lived in communities which had a community-

based support group for the chronically ill. These groups most commonly offered counselling (in 31% of communities), followed by support for orphaned and vulnerable children (in 25%), food or other in-kind gifts (in 24%), and medical care (in 20%). Cash grants were rarely offered (in 3% of all communities) [4].

Solutions within reach

Orphans and other children affected by the HIV/AIDS pandemic need to be assured of adequate adult care. For the vast majority of children, the best long term source of this care and support will be devoted family members. Yet, as the data makes clear, many families are currently too overburdened to adequately care for children affected by the pandemic. There is strong international consensus on the importance of providing families with the economic, psychosocial, and legal support and capacity building needed to provide this care, as reflected in the widely endorsed *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* [31]. Still, a great deal more needs to be done on the ground in most countries to implement solutions and strengthen families.

In this concluding section, we focus on those approaches that are most urgently needed to address families' economic and time burdens, and which could be effectively and feasibly implemented by communities. To alleviate time poverty, we suggest greater investment in affordable quality childcare for 0-6 year olds, after-school programming for older children and youth, and supportive care for disabled or ill children and caregivers.

To strengthen the economic security of the family, we stress the importance of microlending to enhance earnings by families, training to increase access to quality jobs, establishing decent working conditions that make it possible to provide care while earning a living in the formal sector, social insurance for the informal sector, and finally income and food transfers when families are unable to make ends meet.

HIV/AIDS has intensified the need to find safe, affordable childcare alternatives. A primary concern for parents in our studies, especially those providing additional HIV/AIDS-related caregiving, was finding quality childcare while they were at work. As we saw, they were often forced to leave children home alone despite the extreme risk of accidents and injury, particularly for children under six. In too many instances, the education of older siblings was imperilled when they were recruited as surrogate caregivers. By delivering quality childcare, communities can free up time for adults to engage in economically productive labour and eliminate the need to withdraw older children from school in order to provide childcare. Moreover, quality early childhood interventions can ensure the healthy development of very young children. Studies in other settings have demonstrated higher levels of nutritional, health, cognitive and emotional well-being for participating children [32], as well as greater progression through school and ultimately better employment outcomes in adulthood [33-36].

A range of community-based programs have arisen that can be effectively employed to help families meet their caregiving needs for very young children (e.g., age 0-6 years). At one end of the spectrum, communities create their own safe, supervised daycare centres.

At the other end, communities help families provide childcare by improving access to and the quality of existing day care centres. We have reviewed models of both centralized care in Botswana and decentralized care in South Africa in a previous publication [20]. Many non-governmental organizations, and select national governments, are already supporting such programs. For example, Malawi has initiated a nationwide movement to mobilize and capacitate communities to provide community-based childcare [37, 38]. Within this program, members of the community serve as volunteer caregivers, and communities usually donate both materials and labour for the construction of the childcare centre. In turn, the Government of Malawi, with assistance from UNICEF, provides necessary technical training in early childhood development and psychosocial care for the caregivers.

Caregivers in our studies also expressed concern that their school-age children did not have access to adequate educational and emotional support while they spent long hours working away from the home. Communities can begin filling this crucial gap by organizing after-school and weekend programs. These programs should actively encourage the involvement of adolescents - a population often neglected in the global response but who need and want adults in their life to guide them through the transition to adulthood. A good example of after-school programming is provided through Consol Homes Orphan Care[1], an outstanding program we studied in Malawi which targets AIDS-affected children and youth. In addition to providing care for preschool children, they have developed a unique program for school-age children and youth that addresses their need for supervision and support in the after-school hours when working families

[1] For more information see www.consolhomes.org

are not always available. Their afternoon program includes homework and developmental activities integrated with programs designed to address physical and mental health needs and HIV prevention. The older orphans not only receive services tailored to their age-group, but are provided with leadership opportunities. Through Orphan Affairs Units, they have the opportunity to run their own council, provide counselling to their peers, and problem solve for their own communities – all under the guidance and support of adults. Having started in one community, Consol Homes has now expanded its services to 15,000 school-age children and youth in 50 communities. A similar expansion is underway throughout the country since the government of Malawi has simultaneously been working to capacitate community programs that reach school age children.

Our research has shown that caregiving for the chronically ill also deprives children of essential time with adults and interferes with the family's ability to generate income. This can happen in three situations: when HIV-positive parents are caring for their own illness this limits time with their children; when parents are caring for ill children this limits their time with healthy children; and when parents are caring for ill adults this also limits time with all children. One central way in which communities can alleviate this caregiving burden is through home-based care programs [39]. Our research showed that many communities already have a support group for those with chronic illnesses, though most offered only a limited range of assistance. Basic medical care, education on nutrition and healthy living, help with domestic chores, and emotional support to both the patient and the caregiver are all essential elements of comprehensive home-based care programs. For parents living with AIDS, this essential care can help them maintain their

physical and mental health, and greatly increase the amount and quality of time they have with their children. For families nursing the chronically ill, home-based care programs greatly relieve the caregiving burden and enable them to spend the extra time with children or in income-generating activities, depending on the needs of the family.

In addition to time poverty, our research has shown that families struggle with the economic impacts of the pandemic. Financial difficulties were particularly high among households caring for infected or affected individuals, despite often receiving support from individual relatives and friends. By working collectively, communities and policy makers could do much more to strengthen the economic security of the family. This could be achieved by organizing microcredit associations and social insurance schemes, by building vocational skills that will enable families to obtain higher paid employment, by adopting workplace practices that are sensitive to the needs of caregivers, and by providing food security through communal gardens and grain banks.

The majority of families affected by AIDS live in poverty. By providing access to credit and savings, communities can create economic opportunities for the poor. Village credit and savings associations save money through the purchase of shares; members are then eligible to borrow money from the communal savings pool in order to start small businesses. This enables families to realize higher returns for their labour, and this additional revenue can be invested in the health and education of their children. Furthermore, the overwhelming burden of care - both for children and people living with AIDS - is born by women. Credit and savings programs have attracted women in

unprecedented numbers [40]; studies in other regions have shown that women invest their savings in their children, leading to better nutrition and educational outcomes [41-46]. For example, the Village Savings and Loan Microfinance Program (part of the Livingstonia Synod AIDS Program in Ekwendani, Malawi) establishes and capacitates community-based credit associations open to the whole community; however, 83% of its participants are women. This and other forms of village microfinance (e.g., microlending by the Self-Employed Women's Association in India [47]) can play a crucial role in ensuring that families who are currently most negatively affected by the pandemic have a route to earn their way out of poverty.

Another way that communities can help families achieve greater economic security is by helping them obtain better paid jobs. Job skills are a critical stepping stone to better paid jobs; communities could initiate training programs and members could offer apprenticeships to help move families out of poverty. Out-of-school youth could also benefit from these training programs and come away with the skills necessary to earn a productive living. While training programs are increasingly being developed for youth affected by HIV/AIDS, more needs to be done to increase opportunities for the current generation of caregivers. This may mean enabling them to complete their education if they didn't have this opportunity in their youth - whether basic numeracy and literacy skills or formal secondary school – or it may mean providing technical and vocational programming. Some excellent examples of this already exist for youth, including within the Malawi Children's Village[2]. Their educational program has two tracks; the first track ensures that students in their catchment communities can finish secondary school and go

[2] For more information see www.malawichildrensvillage.com

on to tertiary school by providing academic support and scholarships if needed. The second track provides technical and vocational training to ensure sustainable livelihoods for older youth or those not attending secondary school.

Once caregivers have paid work, communities can influence working conditions that affect their ability to care for children. Our research has shown that a quarter of all working families leave children home alone when they are ill. When they did stay home to care for sick children, they lost pay and put their jobs in jeopardy. Families should not have to choose between staying home with a sick child and providing for the family. The local business community has a role to play in enacting workplace policies that are sensitive to the health and caregiving needs of their workers. Local businesses, for example, can offer flexible schedules and paid leave to care for sick children and adults. This ensures that children receive the critical parental care they need when sick, without endangering the family's livelihood. For HIV-positive individuals, flexible hours would accommodate critical medical appointments and paid leave would enable them to take time off to recuperate when they do fall ill. Non-discrimination in hiring practices, which can be monitored and enforced by the community, would secure the job opportunities for HIV-positive individuals in a context where significant stigma still remains. For a full discussion on the ability of companies to do this while economically succeeding, please see Petrow, Simmons and Heymann, 2007 [48].

Community action is equally essential for those working in the informal sector. While formal employment is often governed by legal statutes, informal labour rarely is.

Furthermore, when informal workers are unable to work due to sickness or family crisis, their income often evaporates in the absence of a safety net. Communities can help informal workers form social insurance groups to cover expenses if serious illness – their own or their children's – requires them to temporarily stop working. This can be a separate program, or can be bundled with credit and savings associations. In the Village Savings and Loan Microfinance Program mentioned earlier, families contribute a set amount towards a social fund every month. Rather than deplete their meagre savings or sell productive assets in times of crisis, families can borrow from this fund (without interest) to ensure that their children's essential needs are met. The Self-Employed Women's Association[3] likewise operates a very effective voluntary self-insurance scheme, financed through minimum premiums, to protect against illness or other crises.

While most people prefer to earn their way out of poverty, there will be times when stop gap measures are necessary (e.g., non-earning periods while in training, when disability/illness prevents working, or when elderly caregivers are past working age). Governments will need to take responsibility for much of this support, likely in the form of cash transfers that would allow families to identify their own needs and purchase health care, education, childcare and other services. At the same time, rural communities can generate extra resources for distribution to the most vulnerable families through community gardens and grain banks.

It is clear that families bear the overwhelming responsibility for HIV/AIDS-related care. Further, our evidence shows that the vast majority of families bear the burden alone,

[3] For more information see www.sewa.org

without the benefit of meaningful support from their communities. That is not to say that friends, neighbours and communities are not willing to help – some areas have high levels of informal assistance – but the support given is not adequate to match the magnitude of need. Furthermore, though they hold great potential, community-based organizations are still far too limited in scale and scope. Only a fraction of communities have developed organized responses to the epidemic generally, and even fewer provide support for families raising children affected by HIV/AIDS.

But we can also look at the evidence from another perspective: despite the high levels of poverty, and despite frequently experiencing their own AIDS-related crisis, we know that community members willingly donate both time and resources. This implies that important aspects of the traditional support system are intact, if severely overwhelmed in these highly affected communities, and could be leveraged into more effective mechanisms to strengthen families' capacity to care for vulnerable children.

By implementing the above programs, communities and policy makers can help families earn enough to support children, and provide adequate care and support for children. The success of these programs will require volunteers and resources from within the community, but also that technical and financial support be made available to these communities. Communities are themselves overwhelmed and under resourced, and cannot be expected to act in isolation. States, non-governmental organizations and international donors have the human and financial resources to mobilize and capacitate community responses on the scale required. They can help communities develop their

own solutions, provide technical expertise and training, create networks of service providers to enhance learning and coordination, and provide long-term funding. Ultimately, building strong families will require the combined efforts of many small, local communities, large national, and one very large international community.

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