

**Economic strengthening and Children Affected by
HIV/AIDS in Asia: Role of Communities**

**Learning Group 2
JLICA**

by

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Abbreviations:

AIRD	Association for Integrated Rural Development
AMK	Angkor Mikroheranhvatho Kampuchea
BRAC	Bangladesh Rural Advancement Committee
CAAB	Creating Access to Alternative Life Choices for Children and Women of Daulatdia Brothel
CBO	Community Based Organisation
CCV:	Community Care Volunteer
CPN:	Child Protection Network
CRC	United Nations Convention on the Rights of the Child
DRDA	District Rural Development Agency
ECD	Early Childhood Development
ES	Economic Strengthening
GK	Gonoshasthya Kendra [People's Health Centre]
IGA	Income Generating Activities
KKS	Karmojibi Kallayan Sangstha (Working People's Welfare Association)
MMS	Mukti Mohila Samity
NGO	Non Governmental Organisation
PE	Peer Educator
PK:	Ponleur Kumar (local partner)
PWDS	Palmyrah Workers Development Society
PWN	Positive Women's Network
SCA	Save the Children Australia
SEWA	Self Employed Women's Association
SHG	Self Help Group
SRDPE	Society for Rural Development and Protection of Environment

1. INTRODUCTION

1.1 Rationale for the Study

Why we need to address Economic Issues

Communities in Asia¹ (as elsewhere) are faced with increasing numbers of children who are orphaned, affected with HIV and AIDS, burdened with the care of parents living with HIV and are witness to changing family structures as orphaned children struggle to cope economically whether they live alone in child headed homes, with single parents, with elderly caregivers or in foster homes (often members of extended families). The feminization² of HIV is starkly evident in these households³. The parent who survives (but may be living with HIV) is the mother, economically vulnerable and burdened with the care of her children. It is also true that many more HIV + children (and their parents) are surviving because of the free access to ART. As more and more children live and survive, communities are challenged as to what is the best⁴ way to respond to the economic needs of the children and their caregivers⁵.

Poverty has always been a challenge⁶ in these countries and HIV exacerbates the condition.⁷ There are many reasons why families slide deeper into poverty – most have spent large amounts of money in health care and medicines in order to be ‘cured’ of HIV, HIV+ parents may not be able to work at the same level; assets may have been sold.⁸ If orphaned the child has to work to support the family or ailing caregivers (a surviving parent or grandparent) or contribute economically to the foster family⁹. Lack of nutrition, food insecurity,¹⁰ and difficulties in accessing health services affect health, ability to work and contribute further to economic distress.

Poverty increases vulnerability, encouraging risk behavior, sex work and migration. Economic compulsions may drive children out of school, compel them to undertake exploitative work, accept poor wages, and forgo opportunities to build marketable skills - creating a new spiral of economic distress in communities.¹¹

Why we need to address children

Economic strengthening is critical for the well being of children – it affects all aspects of their life, health (physical, emotional and social), education, nutrition and shelter and has a direct relation to the vulnerability of children.^{12 13} The poorer children are, the more vulnerable they become. Children living with and affected by HIV belong to a very wide pool of ‘vulnerable’ children¹⁴ but they also bear the additional burden of stigma being children of the “drivers” of the epidemic, sex workers, people having multi-partner sex who are already stigmatized. Country policies¹⁵ recognize the need to address economic issues and suggest some social protection measures (cash transfers, food security, inheritance and property rights)¹⁶. The emphasis is on prevention and care and support, and less on economic strengthening. Discussion on community owned sustainable strategies by different stakeholders to address economic strengthening is limited.

Yet in acknowledging the need to address the economic issues of children affected by HIV, communities are forced to review their response to children who have been traditionally ‘vulnerable’ – children of the very poor, migrant workers, marginalized groups (such as low caste groups) and of female headed households; children of sex workers; street children and child laborers. In the past, countries in South Asia have addressed the needs of these ‘vulnerable’ children through other sectors – poverty alleviation, child rights, child protection including cross-sectoral services from social welfare, food programs, health and education.

With a growing body of evidence linking HIV infection with various risk factors, we can state with considerable certainty that each of these groups of 'vulnerable' children are at risk of HIV, some perhaps more than others, thus begging the question which children to include as children affected by HIV/AIDS and how to prioritize.

Why we need to look at communities

At the frontline, as the first response it is well known and well documented that families and communities do respond to the economic crisis that HIV brings.¹⁷ It is equally true that the all-prevailing endemic poverty pushes children out of families and communities often with their tacit support.

Stigma and discrimination as a result of HIV further complicates the problem. Families have been neglected, widows have been abandoned, and children have been dispossessed of their rightful inheritance. Female-headed households face a triple burden – stigmatized with HIV, traditionally discriminated against because of gender and economically the most weak. To cope, children and their families try to become 'invisible' in the community by not disclosing that they are affected by HIV.¹⁸ But in doing so it becomes difficult to reach out to these families. Families cannot claim for and access services for those living with and affected by HIV. In spite of these problems, the most sustainable and best way for children to be nurtured continues to be with their caregivers, in families and within communities.

Cash transfers, with or without conditions attached (food for education, incentives to delay early marriage, vocational training) are one way of supporting families and communities – these are however, external (not community resourced) and donor dependent.¹⁹ The economic burden of HIV is prolonged and heavy for individuals and families and it is being increasingly understood that the immediate as well as the wider community (civil society, government), building on the natural foundations of a sense of belonging and ownership, have a vital role to play in providing long-term, cost effective solutions. Evidence from Zambia and Malawi suggest a number of activities that can be implemented by communities such as community childcare, providing school supplies, providing agricultural produce to children, raffles and fund raising.²⁰ However, we know little of the **processes** within communities that *are* being implemented and *can* contribute towards the economic well being of children and their families. This paper will explore economic strengthening activities in greater depth.

High and Low Prevalence Countries: Is there a difference in program rollout?

The relatively low HIV prevalence^{21 22} region of South Asia faces a dilemma - child poverty is endemic, populations are large and the number of children who are vulnerable is considerably larger than the number who is affected by HIV²³. It is argued that with limited funds available for HIV/AIDS should one include 'vulnerable' children as well? Should there be different strategies to identify children in low prevalence and high prevalence settings?

Targeting vulnerable children in high prevalence areas such as, sub Saharan Africa is an effective strategy to reach out to children who are affected by HIV, as they represent a *large proportion* of the vulnerable children population. This strategy ensures services are available to children affected by HIV without stigma and discrimination. Other vulnerable children also access these services, making it an equitable strategy.

In low prevalence high poverty situations, the same strategy of targeting all vulnerable children would greatly dilute the limited resources available for children affected by HIV. On

the other hand, the targeting of children affected by HIV would ensure the most efficient use of limited resources but would also contribute to stigma.

In high prevalence countries, where numbers of children affected by HIV are large, the program responses for children affected by HIV/AIDS are clearly towards impact mitigation. There is a rich body of evidence (mostly from Africa) documenting how communities have responded to the challenge of economic support. In the different context of low HIV prevalence countries, communities need to address the economic factors that are increasing children's vulnerability to HIV. Community led economic efforts are towards HIV risk reduction rather than HIV impact mitigation. This differential response because of low HIV prevalence suggests different models of economic strengthening by communities.

Many of these low prevalence countries have a comparative advantage with a long history and rich experience through numerous non- HIV sectors in addressing economic strengthening issues of 'vulnerable' children, families and communities. Many of these programs in recent years have *added on* HIV related issues in the communities they work, effectively addressing the economic needs (among others) of children affected by HIV/AIDS and their caregivers. There is much to learn from these examples.^{24 25} This paper, using a case study method will analyze these strategies and make program and policy recommendations, filling an important gap in our understanding of programming for children affected by HIV/AIDS in South Asia and by inference, in other regions of low prevalence.

1.2 Hypothesis and Methodology

The study's hypothesis is that

- a) Economic strengthening (ES) of children affected by HIV/AIDS and families **is more effective if it is community based** (rather than just household or individual based)
- b) That examples of ES with children affected by HIV/AIDS in low prevalence countries may be different to those found in high prevalence countries
- c) That examples of ES in Asia involving communities are many, home grown and not necessarily in the HIV portfolio, with many lessons learned from the poverty alleviation sector
- d) Whatever the examples and interventions, ES is critical as it directly affects children's access to services – education, health, nutrition and psycho-social

To test this hypothesis, the study using a case study method identified four programs of ES and children affected by HIV/AIDS in three countries of Asia – India, Bangladesh and Cambodia. The projects are representative of the diversity and scope of the study and were selected using a child lens – which projects address children who are most affected and vulnerable to HIV?

The two India studies relate to HIV affected children, the Bangladesh study relates to the highly vulnerable children of sex workers whereas the Cambodian study along with children affected by HIV includes children vulnerable to HIV in the context of poverty and migration. It may be mentioned that donors (in the HIV/AIDS sector) in these three countries support numerous prevention, care and support programs, but few programs relate to economic strengthening of children affected by HIV/AIDS.

The table below provides information about the organizations selected for the case study, the children they address and the context in which they work.

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Economic Strengthening and Children Affected by HIV/AIDS in Asia

Organization	Country	Country prevalence and vulnerability	Community	Children addressed	Type of programs	Description
St. Paul's Trust <i>(multiple technical support including FHI India)</i>	India	PLHIV 2.0 –3.1 million, prevalence 0.36%, with 70% from six states including Andhra Pradesh and Tamil Nadu. **HIV transmission primarily through sex workers and clients.	Rural in East Godavari District of Andhra Pradesh state. Works with 9000 PLHIV; ANC prevalence 2-5%	HIV+, children of PLHIV, sex workers, leprosy affected. Orphans (HIV and Non-HIV), disabled children.	Community based care and support; vocational training, nutrition support, savings, loan and credit, educational support, IGA, Life Skills	CRS partner, worked with leprosy relief
PWDS Palmyhra Workers Development Society <i>(multiple technical support including India HIV/AIDS Alliance)</i>	India		Rural, rurban and urban in high prevalence districts of Tamil Nadu state	HIV+, children of PLHIV, orphans (HIV and non-HIV), other vulnerabilities depending on local context.	Empowering communities to build people's organizations and linking with mainstream; self help groups and federation; community banking; IGA, child support groups, life skills, vocational training; community food banks; community based care and support	Initiated to support Palm Growers; In HIV/AIDS as a Nodal NGO supporting a consortium of 20 local implementing partners
KKS/ MMS Kormojibi Kallyan Sangstha and Mukti Mohila Samity <i>(technical support from SC Australia)</i>	Bangladesh	<less than 1% but high vulnerability factors; concentrated epidemic and many interventions target sex workers.	Daulatia Brothel, Goalundo	Children of 1532 sex workers; 50 in safe home; In Daulatia, 25 Child Councils with 610 children All SCA projects: 80,000 children in 2,200 child councils	Primary school, Child Councils, Life Skills Program, ECD centers, Girls Safe Home, Safe Home – Future Fund; savings program, vocational training and alternative income generation opportunities	Local NGO in partnership with sex worker collective
PK Ponleur Kumar <i>(multiple technical support including CARE Cambodia)</i>	Cambodia	0.9 Prevalence down from 3%; 2006 estimates indicate 65,000 adults and 6000 children living with HIV; transmission generally through sex workers, clients, MSM and recently IDUs	Rural in 3 Districts of Banteay Meanchey and Pursat Province,	Positive children (9), 2299 children affected by HIV/AIDS including orphans, children of PLHIV, risk of sexual abuse, domestic violence, trafficking, child labor, disabled, poorest, addicted, scavenger and from female headed households	Grant for income generation, educational scholarship, nutrition support, vocational training, youth clubs, Life Skills program, community led savings, rice banks, transportation cost for health services	Rural development and livelihoods

The findings are based on site visits to each of the organizations, review of grey and published literature and interviews. Discussions were also held with SEWA (Self Employed Women's Association) in Ahmedabad, India – one of the pioneers in economic strengthening with marginalized women. A number of key researchers and practitioners have contributed their views as well.

The paper has been informed by a wide review of literature related to economic strengthening, although in Asia, there is very little that directly informs on communities' role and their impact on children affected by HIV/AIDS. For this reason, literature in related areas has been explored. At the end of the paper, a bibliography lists these sources, with footnotes directly relating to specific points.

2. UNDERSTANDING THE CONTEXT

Of the 33.2 million living with HIV in 2007, 4 million live in South and South-east Asia. In the three countries of the case study, children under 15 years constituted less than 10% of those living with HIV²⁶. There are many more children however who are affected by HIV. Endemic poverty, large-scale migration and relatively large populations, indicate large numbers of vulnerable children as well.²⁷

In India, according to the 2007 NACO (National AIDS Control Organization) estimates, 70,000 children below the age of 15 are living with HIV in India and 21,000 children are infected every year through mother to child transmission. One of the largest child labour force is in India estimated unofficially between 60-100 million²⁸, 4-18 million are street children²⁹ and 26% of the entire population (260 million) lives below the poverty line.

In Cambodia, 9% of all children are orphans and 1690,000 children affected by HIV/AIDS, 'most in need' made vulnerable by HIV/AIDS and other causes and living below the poverty line.³⁰ It is estimated that there are 65,000 adults and 6000 children living with HIV and 136715 children affected by HIV³¹ and 35% of all families lived in poverty (0.63\$ a day).

Bangladesh has a low prevalence <1% but numerous vulnerability factors. Bangladesh is geographically vulnerable, sharing borders with a concentrated epidemic in Nepal (among IDUs), generalized one in India and Myanmar. Trafficking, migration and a male dominated society, make girls and women particularly vulnerable to HIV. Sexual exploitation at work in the garment factories, trafficking of adolescents into sex work both internally and to other countries, children growing up in brothels and transition into sex work are some of the vulnerabilities children face³²

Identifying children who are affected by HIV/AIDS has constituted a major challenge defying easy answers.

The case studies have indicated that a clear understanding of *who* the children affected by HIV/AIDS are is critical as it clearly influences the *role* of communities and the *nature* of the economic strengthening activities undertaken.

2.1 Defining children affected by HIV/AIDS

Although India's adult HIV prevalence is 0.39, surveillance data has identified districts with relatively higher ANC prevalence of >2%. Both NGOs in India³³, St. Paul's and PWD work in such districts. They use a two tier approach – identifying districts with high prevalence and then within these districts, identifying children who are living with HIV and the many more

affected by HIV. For example, at St. Paul's Trust, 275 children were HIV+ but HIV affected children were much more, about 4500³⁴. The definition of orphans was also extended to include children who had been orphaned for reasons other than HIV, such as children of farmers who had committed suicide due to indebtedness. Typically, most children came from female-headed households. Some vulnerable children were also included – disabled, very poor, children of sex workers, children affected by leprosy – this not only helped to have adequate numbers for children's programs and clubs in villages but to garner wider community support.

With a prevalence of 0.9 and a scattered rural population, the Cambodian NGO was able to identify fewer children who were living with HIV, affected or orphaned because of HIV in its geographical area. (See NGO table, Section 1.2)

Definitions of HIV vulnerability varied – from the obviously vulnerable, the children of sex workers in the case study from Bangladesh to the wider definition adopted by the NGO from Cambodia which included children abandoned by their parents, children from the poorest of poor families, children who were migrant workers, children from female headed households. In part, these decisions are made to avoid HIV 'targeting' of children, (and therefore offsetting stigma and discrimination).

Therefore in all three countries, identification criteria for children affected by HIV/AIDS was influenced by prevalence + socio- economic context and **perceived** vulnerability of children to HIV. Other children are included in programs by widening the definition of vulnerability³⁵ and risk to HIV. This strategy ensured that a skewed 'stigma of privilege'³⁶ in favor of children living with or affected by HIV was not artificially created.

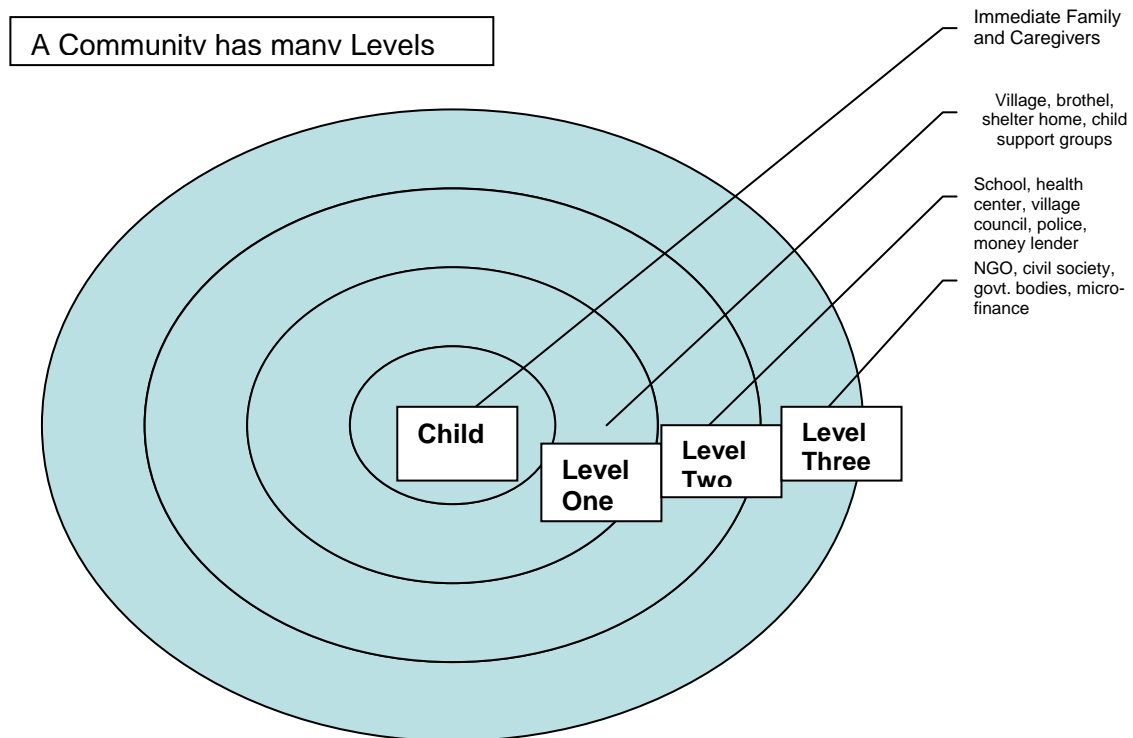
2.2 Defining Communities:

To understand the role of communities in economic strengthening, it is important first to understand *who* the community is. A generic understanding of community is commonly accepted, with the underlying assumption that it is the natural and best environment in which children and their families reside.³⁷ Strategies such as mobilizing, influencing and strengthening communities is based on this uniform, unilateral definition of community and captured in global frameworks, research and discussions in HIV related literature. The case studies however have identified various layers of communities, which were mobilized for economic strengthening. In addition, the case studies have identified that communities can lie anywhere on a continuum between empowering and disempowering, *if a child lens is used that places the child at the center of programming.*

A working definition of community is proposed that goes beyond the conventional definition of community.

a) A community has many levels:

A community is not a uniform mass. It can be differentiated by several criteria: first, by its proximity to the child and his or her family, second by the frequency of interaction and third by the ability to influence. Based on these criteria (and not in order of importance), one may identify different levels in the community – first, second and third.



- The First Level community is the one that children and their caregivers have direct links to and belong to. First Level community members are either geographically closer or determined by a common interest. In the first instance, the community has been in existence for some time and in the second, the community has been 'created'. Examples of the former are places where the child lives (the village, brothel, slum). Examples of the latter are common interest groups such as street children, sex workers collectives, self help groups, child support groups, shelter homes. Children and their caregivers may belong to several First Level groups. For example, children of sex workers belong to two such communities such as brothel and shelter home.
- The Second Level community though linked with the children and caregivers, has a less direct relationship. We may call it part of the *wider* community – the school, the health center, the workplace, the village council, the minority/ethnic/religious group they belong to, pagoda committee, the community that lives just outside the brothel area, the local police, the moneylenders.
- The Third Level community would refer to NGOs, government bodies, civil society, networks, banks, micro-finance institutions.

Typically, economic strengthening activities have been directed at the First Level community, generally the poorest and least resourceful. By defining various levels of what we mean by community, the case studies are able to demonstrate how the First Level communities are able to access and link with the wider communities (and vice versa) and be strengthened, demonstrating powerful models of community economic strengthening.

St. Paul's and PWDS promote local village level savings solidarity group or Self Help Group (First Level community), mostly women. They are able to connect to the wider community (Second and Third Level) such as village councils, access food programs, banks and through larger SHG clusters to form a federation (network) that is now in a position to provide crisis funds (among other support) to families affected by HIV in different SHGs at the village level, thus providing a synergy across the community levels.

b) The Empowering – Disempowering Continuum

Each of these community levels can range along a **continuum from empowering to disempowering**. Thus communities may make children more vulnerable, exploit, stigmatize, ignore or may provide an environment that empowers children and their caregivers. Since levels are interrelated, it is also possible that these different levels in the community (and even within each level) may pull and push in different directions. For example, the First Level community of a 12 year old daughter of a sex worker in Daulatia Brothel Bangladesh was empowering and protective (a shelter home) as well as exploitative (family and brothel), pushing her into sex work.

The empowering-disempowering continuum for communities is important from an economic perspective as well. Many communities are in transition – affected by globalization, feminization of HIV, migration, changing labor markets. In the search for cheap labour, there is increasing *commoditization* of children and communities – First Level and Second Level communities often push children affected by HIV/AIDS towards it when children become laborers, sex workers – poorly paid and widely exploited.

For example, in India PWDS/Blossoms works in an area that is infamous for its child labor market. Children were employed in Sivakasi factories making firecrackers and matches. Media exposure and community outrage resulted in the ban on child labor. Blossoms had worked with these children, mapped their vulnerability to HIV and included them in the HIV/AIDS project. A situational assessment indicated that child labor had not been eradicated – contractors came to the homes and delivered firecrackers' raw material. Children were still engaged in this activity except that they were doing it from home.

In Bangladesh, SCA has worked with the sex worker collective and the local NGO, to establish a shelter home and a high quality community school till Std. V. After completion of Std. V, access to secondary school though available, is less attractive (fees have to be paid, teachers are not child-friendly, additional coaching is not available) and although 100% enroll into Std VI, within a year 90% children from the brothel drop out. The girls, now in puberty have become attractive commodities for the now ageing mothers and the nexus of brothel keepers, agents and paramours. Girls are emotionally blackmailed, some are given growth hormones, and most are pushed and pulled towards sex work as early as age 12.

Difficulties in agriculture – lack of water, lands riddled with land mines, inaccessibility to markets push Cambodian families cross the border to Thailand in search of work. Taking their children with them, children add to the family income but do so in exploitative conditions and at the cost of their education. On return, many children and adolescents are unwilling to return to education or focus on building marketable skills, the influence of peers often quite overwhelming.

The case studies demonstrate why and how a '**child lens**' is necessary at different levels of communities. Economic resources may be mobilized in communities but they may be at the cost of or neglect the needs of children and in the long run are disempowering.

3. ECONOMIC INITIATIVES FOR CHILDREN AND CAREGIVERS

The case studies indicated a variety of economic initiatives being implemented. These initiatives are not new, are available in projects in other countries and/or implemented by other sectors such as rural development, poverty alleviation, livelihoods and sustainable development. What is different is how they have been adapted to address HIV related issues in working with children, families and communities³⁸. For the purpose of the paper and based on discussions with the NGOs, a triangular typology for the economic strengthening activities is suggested. This typology will be used to discuss what **role** communities have played in each of these and what **strategies** were successful.

3.1 Economic Rescue and Assistance:

This refers to programs that are required for relief and emergency – cash transfer (pensions, grants and subsidies, direct support), food security (feeding programs, food banks, government ration cards), emergency funds. All the NGOs had a few programs in this section supported by government, as well as community.

- a) Cash transfer: Cash transfers can be direct (cash) or indirect (pension, subsidy, grant) provided by the community, donor or government. In India, linkages are preferred through the government. Families with children who are living with or affected by HIV are fast tracked for various government schemes. If grandparents are the caregivers, they are given priority for old age pension. Female headed homes receive widow pension and/or one time grant on the death of the husband under the National Family Benefit Scheme. Some widows also receive part subsidies on loans for buying a milch cow. PWDS has clear policies regarding providing direct support – it is only to kick start the other economic activities of protection and creation (see below). St. Paul's reviews case by case to determine who will get direct support and for how long. The Positive Women's Network India provides (through donors) money for food, rent and education but for only 6 months to a year.

In Cambodia, through the project, \$25 grants were given for small income generating activities and schools supplies for children to go to school.

- b) Food security: There were direct feeding programs by community, donors and government. In India the government provides free mid-day meals at all ECD centers and primary schools. Food Ration Cards are provided to those who are poor and are called BPL (Below Poverty Line) cards. The rice and oil obtained on these cards (called the Arunodaya and the Antodaya Cards) are at a fraction of the market cost. These BPL cards are available only on the recommendation of the Second Level (village council) and the Third Level (sensitization by NGO, sanction by district officials) communities. A protein mix called Hyderabad Mix developed by the National Institute of Nutrition, Hyderabad will be provided by the government to every HIV/AIDS patient with tuberculosis on DOTS. In the state of Andhra Pradesh, the government provides 1 KG nutritional powder to every PLHIV on ART. Many of these schemes are available in other states, but its implementation is widespread in Southern India especially Andhra Pradesh, Tamil Nadu where NGOs have made a tremendous effort to sensitize the Second and Third Level communities.

In Cambodia, the World Food Program provided food to schools in the project area. Limited resources have led to targeting, and as a result only one out of two shifts of primary school children are able to access it in Bantey Meanchey province.

In Bangladesh, the NGO run shelter provided food to the children who stayed there.

Communities have played an important role in food security³⁹. In India, the very successful 'Fistful of Rice' program encouraged each family to donate small quantities of rice each day. The wider community donates large quantities of food as well. At St. Paul's and PWDS, bags of rice and oil, are donated by civil society groups (Rotary, Lions, hotel owners) or by individuals (usually to commemorate births, deaths of loved ones). St. Paul's distributes these food supplies when children and caregivers come to the center to collect their monthly supply of ARTs, ensuring that children on ART have food security. In Cambodia, community rice banks ensured that there was food to tide over the gap months before harvest – usually 4 or 5 months when there was no food. With contribution from the NGO and labour from the community a 'rice shed' was constructed – a ledger is kept of all the bags of rice available and who it has been 'loaned' to. This was developed under a farmer based poverty alleviation program but is now available for children affected by HIV/AIDS.

- c) Emergency Funds: Typically, emergency funds are mobilized through appeals to the First Level and wider community – for food supplements, medicine (not provided by the project), clothes, education, and transport costs. Community (usually First Level) contribution towards funerals was quite common in the case studies.

St. Paul's works with 9000 families, of whom 5000 get nutritional support and many willingly contributes Rs. 5 (12 cents) every month (monthly collection is usually \$1000 – 1200) to the Risk Fund, used for emergencies – this is an example of a systematic economic rescue activity by the First Level community itself. PWDS encourages its partner NGOs to develop a Philanthropist List for quick responses during emergency needs. In Cambodia, AMK a micro-finance institution provides emergency funds – for death and accidents – if the person is a client of their micro-credit scheme for more than six months. Monies are received within four days.

3.2 Economic Protection:

This refers to programs that are savings (including internal lending), life and health insurance, will-writing and property rights.

Savings: In India, micro-savings is well institutionalized and linked with the banking sector. This may be through an established NGO, such as the SEWA bank or through the SHG or Self Help Groups (see Pg. 25 for details). In either case, being a member of the bank or the SHG opens many doors of opportunity for benefits and schemes. For example, a member of the SEWA bank can opt for both life and health insurance, a SHG member can apply for the government subsidized health insurance scheme and educational scholarships for children in secondary schools.

In Cambodia, where linking to the banking sector is less robust, the savings is less formal and community based where everyone contributes a certain amount every month and one of the members is eligible for an internal loan of the collected amount every month. PK supports this activity by providing capacity building to community groups on book accounting. Some micro finance institutions provide savings facilities as well.

In Bangladesh, the sex workers collective with the local NGO initiated a savings program. Though initially community members treated the scheme with suspicion, it is well accepted now. About 838 women have a shared corpus of \$ 3000. For those who are regular savers, it has made a remarkable difference – some have brought land, built a house, educated their children. Overall they were better able to budget and avoid debt.

⁴⁰ Though programs for loans and credit are available (Grameen Bank and BRAC are well known for this activity), sex workers because of their mobility and other factors are not eligible.⁴¹

There are also examples where *children* have been involved in savings. India HIV/AIDS Alliance partner NGOs, recognizing that many children are earning money but have no safe place to keep it have started pilot programs in savings where the NGO works as the guarantor, since children are not allowed to open bank accounts till 18 years. Advocacy to address this anomaly is currently underway with the banking sector⁴².

Insurance: The India case study provides various micro-insurance group models involving the government, NGO and private players. The government provides family health insurance to those who have BPL ration cards, and to members of SHG. SEWA an NGO that works exclusively with marginalized women towards economic empowerment has over the years developed numerous robust health and life micro-insurance products, tailor made to respond to the different needs of women in various communities. Initially, risk coverage was from SEWA but as the numbers multiplied dramatically, it has advocated with and works with private insurance players to devise appropriate micro insurance schemes.

SEWA and VIMO (insurance)

Vimo or insurance products (life and non-life) were started and tailor made to the needs of the women. Currently out of 2, 00,500 members, 30,000 children are beneficiaries.

Though reluctant initially, private insurance companies now provide coverage – a family health insurance scheme has become cashless, which means that medical costs incurred by a *VIMO* member are paid directly to the hospital by the insurance company. The member does not have to pay and then seek reimbursement. The cashless scheme is very convenient. Since 2007 a health insurance scheme has been launched for sex workers, their partners (not husband as is the norm) and children. With a premium of Rs. 285 (\$7) coverage of Rs. 10,000 (\$2500) is obtained. Part of the premium is spent by SEWA on training sex workers on the use of the various *VIMO* and banking products.

Another innovative scheme was developed for women in Rajasthan, a desert state where there are high transportation costs to the health center. By paying a premium of Rs. 30, conveyance up to Rs. 200 can be claimed.

Will- writing and property rights:

Protection of assets was a problem particularly for widows and orphans. PK has a set of activities under succession planning which includes a memory book, a will endorsed by the local authorities and caretaker arrangements. Challenges have been many as supporting documents are needed for the will especially in case of land. Some families had moved to another province and needed signatures from local authorities in the province where they had land.

In a study by Positive Women's Network (PWN) in a high prevalence district of Namakkal in Tamil Nadu India, 75% of the PLHIV were women and 65% of these had property disputes. Most of the widows were between the ages of 18-24 with two or three children. In most cases, their in-laws often in collusion with the local bodies tried to dispossess them of their rightful inheritance. Legal literacy and free legal aid has been an emerging area of work of PWN. Orphan children face a similar problem especially if their property is in custody of relatives. To safeguard the property, the NGO (such as PWN) becomes the custodian – this has created additional responsibilities. PWN is advocating with the

government to take a more active role in safeguarding the property and assets of children perhaps through setting up a Children's Trust.⁴³

3.3 Economic Creation:

This refers to programs related to livelihood, vocational training, microfinance, IGA and various other business development activities (introduction to new technology and training on it). Such activities have been well documented by numerous HIV and non-HIV programs.^{44 45} These require one time or periodic financial inputs rather than lifelong subsidies.

St. Paul's has successfully started 996 micro-credit units ranging from petty shops, goat rearing, milch cows, auto repair, sewing, agriculture, textiles, cigar rolling, mini hotels and others. Most beneficiaries are women. The amount advanced is Rs. 60 lacs (\$1.5 million) with a monthly recovery of Rs. 3 lacs (\$7500). This is a collaboration of St. Paul's Trust with the Dewan Trust, a UK based philanthropy.

Some programs have encouraged employment for caregivers as well. In Bangladesh, MMS managed ECD centers include ECD facilitators who are sex workers (who have received ECD training). NGOs have recruited PLHIV and caregivers as staff, outreach workers and peer educators. Other employment sources have been the PLHIV network in India, The Positive Speakers' Bureau and some PLHIV have received mainstream jobs (of *anganwadi worker* or ECD worker in the state run Integrated Child Development Scheme ICDS) as a result of advocacy with district officials who have 'pledged' these jobs.

Vocational training for older children and caregivers is critical but it needs to be *the right one with the right quality for the right person and a clear roadmap* towards an economic activity. Many types of vocational training are well known. In the rural area, vegetable growing, chicken and pig raising and in the urban areas tailoring, carpentry, masonry. PWDS while working with palmyra workers found that the product from the sap had poor market value but converting it to 'palm candy' not only added value but created a niche market for the product. The technology was introduced and today is a hugely successful business and the banks have added 'palm candy' to the list of businesses eligible for loans.

Vocational training for children and adolescents must be reviewed carefully. After leaving school, the links towards vocational training and employment need to be better thought out.⁴⁶ Children from the brothel could be absorbed as NGO staff but require a minimum education, which is often not available. KKS/MMS had learned through a failed attempt towards carpentry training (quality was poor and there was no clear path to employment) for boys from the brothel and had introduced driving as an alternative. Beautician training was given to the girls but has had moderate success. In India, children are encouraged to remain in school, continue their education and *add on* vocational skills. Most NGOs train children in these skills using the available government schemes as they provide a stipend as well as a certificate.

3.4 Need based and integrated

None of these categories are mutually exclusive and all three – economic rescue, protection and creation are necessary to ensure that vulnerable families and communities are economically secure and do not slide into poverty.⁴⁷ Which economic activity is the most effective, will depend on the vulnerability of families – the more vulnerable they are, the more will be the need for economic rescue and assistance

activities.⁴⁸ Having said that, the NGOs in the case study were clear about the role of cash transfers in communities:

- a) PWDS includes economic rescue activities only at initiation (when they have just started working with a new community) and for the short-term, with clear plans to move into economic protection and creation categories.
- b) PWN (Positive Women's Network) has a policy of providing women PLHIV direct support for food, education and rent only for six months to a year during which the women must enroll in available skill building courses. PWN was very clear that cash transfer though necessary in the short term, is actually disempowering – women would give the cash to the family and so it was not used for nutrition. Also, it made the women less willing to try other economic initiatives and lastly, it was not sustainable. PWN has observed the transformation in women who have started earning (rather than receiving cash) – they are more confident, articulate, more careful with their money and present themselves better (cleaner, better communicators).⁴⁹
- c) MMS Bangladesh does not advocate cash transfer as women are able to earn through sex work. Even for older women, cash transfers were likely to lead to spendthrift utilization or seizure by brothel keepers and lovers.
- d) In Cambodia, cash transfers are dependent on external sources and have a very limited reach, as the need is so high. Consequently, the community council carefully reviews the criteria for receiving cash transfers and then selects children.

The case studies have illustrated that an integrated approach works best. For example, at St. Paul's a widow with small children would typically benefit from a one time widow grant of Rs. 10,000 (generally used to pay off debts), widow monthly pension, loan as a member of SHG group, a BPL ration card, free primary education (with midday meal), free ART services + protein mix, micro credit from microfinance institution. Some have also been able to access subsidized housing schemes. In the case of Bangladesh, economic creation is a problem only with older sex workers – most require long-term economic protection measures but currently have access to only savings. In Cambodia, an integrated approach is available and although institutional and government support is in comparison less, there are indications of greater support. For example, a Child Protection Network has been initiated at Pursat Province, bringing in all development agencies, NGOs and donors, on a common platform. At the community level, PK has over the years (through a food security program) mobilized groups for savings, social welfare committee, rice banks, and parents groups to mobilize various types of needed economic activities.

What is important to understand is that all three types of economic activities are needed – rescue, protection and creation – although its implementation will depend on the need, time and these decisions are best made by a sensitized community.

3.5 Economic Strengthening: Non Economic Activities

A number of non-economic initiatives, *by proxy*, contribute to long-term economic strengthening. They do so in two ways – one, service provision frees money for other expenditures and second, these services increase the economic potential either by enhanced skills, education or being in good health. These primarily refer to access to services – health, education, life skills and shelter.

- If children and their caregivers have access to good health care, ART services (usually free) plus the means to access them (transport costs) – children are more likely to remain in school for a longer time and caregivers are more likely to continue to be able to work. Since ART is free, NGOs in India and Cambodia ensured that transport costs were available. In addition, in India PWDS through its community care guides and youth groups ensures through regular home visits that children on ART take their medicines regularly and timely. The NGOs in India provide health supplements to children on ART – they have been specially devised (and some SHGs make it as an income generating enterprise) to fill the gaps in nutrition. Various subsidies – government, donors and private sector provide support. In Bangladesh, a NGO called Ganoshasthya Kendra (People's Health Center) has started a clinic just outside the brothel to provide good quality care at reasonable rates. SEWA through a study found that loan defaulters were because of excessive expenditure on health – this was the impetus to start a cadre of community health guides and low cost *Aarogya* (Health) Clinics.
- Similarly, if children have access to good schools (supplemented by home teaching) and the means to access them (cost of uniforms, books), children are more likely to continue their education to secondary school and beyond and acquire marketable skills. NGOs usually provide educational support at primary schooling.

In India, Cambodia and Bangladesh primary education is free and so, scholarships (for fees and transport as most secondary schools are in neighboring villages) are required at secondary level. Additional costs of notebooks, uniforms and school supplies need support however at both primary and secondary level. Some supplemental teaching is also required as most teachers do not teach – costs towards this were available with Bangladesh and through volunteer community teachers in some places in India. PK Cambodia did not have an activity related to this although it is well known that teachers often take additional money to teach subjects after school hours.

Unique examples of community contribution are the SHGs supported by PWDS Catherine Booth Hospital. By mobilizing the Third Level community (a civil society group – in this case a faith based organization - raised funds through a musical program) the SHGs created a corpus fund for all orphans and children living with HIV to look after the future educational needs of the children. They included not only their children but also those from the community whose parents had died for reasons other than HIV. An Educational Plan with expected monies required in which future year has been meticulously developed for each child.

Except for Bangladesh where considerable emphasis was placed on teacher training and improvements of school standards (but only up to Std V), the other case studies have not addressed the problem. Certain problems are common – children are not 'attracted' to go to schools, teachers are not present, or if present do not teach or use corporal punishment. In Bangladesh, the primary school was excellent and provided a strong foundation for the children. Unfortunately, the poor and less empowering secondary school resulted in children dropping out – the pull of the brothel was generally too difficult to resist and with no other marketable skills, girls as young as 10-12 years have become sex workers and boys have resorted to crime and pimping.

Problems in either of these – health and education services - are likely to impact the economic initiatives of rescue, creation and generation adversely and in fact,

increase vulnerability of children and families. Looking through a child lens, donors supporting non-economic programs will need to review their policies and ask the question – is the support provided sufficient, empowering and does it lead to and provide opportunities for economic stability?

- If children have access to life skills programs and are supported to develop child support or solidarity groups, children are more likely to be able to make wise choices, withstand peer pressure, perceive risk and develop long-term goals for healthy, positive economic choices and lifestyles. St. Paul's, PWDS, Bangladesh and Cambodia actively promote this and have realized that children are excellent agents of change.

LIFE is the Life Skills Intervention for Empowerment program of SCA where children are trained to be peer leaders who then conduct life skills sessions with their peers in their own communities. An evaluation of the program indicated that there were many changes including better ability to save money, greater determination to continue with education and vocational training, to raise their voice against trafficking, and overall higher self esteem.

St. Paul's follows the FHI India Life Skills Toolkit and an evaluation in 2007 indicated that with greater decision-making skills, children were able to withstand peer and community pressure and were able to continue their studies. Some who had dropped out of school rejoined non-formal school, others indicated better inter –personal skills and were able to continue with their jobs/work and did not shirk off. Most were able to discern risk behavior and consequences and set long-term goals for their education and work.

*Zaveri, S, LSE Review – Lessons Learned, FHI India (unpublished) 2007
Evaluation of Creating Access to Alternative Life Choices for the Women and Children of Daulatia Brothel, SCA 2007*

- In emergencies, children may need support for shelter and shelter related services, either temporary or long-term.⁵⁰ In Bangladesh, without the safe home, girls would not have been able to complete their education and the vocational training for boys as drivers was successful because it was residential. In fact, boys from the brothel area are asking for a safe home for themselves as well – currently many sleep in the office.

Related activities can make an impact on children's health and lives.

MMS, Bangladesh has set up and been running a very successful sanitation project in the brothel over the last 3 years. At the end of the last phase of the project, SCA gave MMS a small grant [Taka 50,000/US\$730] to be used for priority project activities of its own choosing. MMS used the funds to start a sanitation project that has increased latrine coverage in the brothel area from 20% in late 2003 to 80% at the end of 2006. MMS produces and provides the slabs/rings to women at just above cost price, thereby generating a small income for MMS. This project has not only provided improved sanitation facilities for families and had a positive impact on the environment in the brothel, but further demonstrates the capacity of MMS to initiate and manage program activities in response to community need.

Evaluation Report, Creating Access to Alternative life Choices for Women and Children of Daulatdia Brothel (CAAB), Feb 2007

4. COMMUNITY LED STRATEGIES IN ECONOMIC SUPPORT: LESSONS LEARNED

This section discusses community-based strategies that worked particularly well and had a comparative advantage over individual and family support. Overall, the strategies consciously addressed different levels of the community – First Level, Second and Third and the empowering continuum, with a special focus on children. All the strategies contributed to sustainability and ownership and were most cost effective as they were community endorsed and led across all the community levels.

The case studies identified three crosscutting and five core strategies that were used for economic strengthening in communities.

Cross-cutting Strategies	Core Strategies
1. Addressing Stigma and Discrimination	1. Economic Literacy
2. Promoting a Development Perspective	2. Collectivization
3. Using a Child Lens	3. Mainstreaming
	4. Public-Private Collaborations
	5. Volunteerism

4.1 Cross-cutting strategies

These strategies were fundamental for communities who were engaged in economic strengthening activities. Without these cross-cutting strategies, none of the core economic strategies utilized at the community level would have worked.

4.1.1 Addressing stigma and discrimination (S&D)

Stigma makes children and families 'invisible' and prevents them from accessing available services^{51 52}. The countries were not new to stigma and social exclusion – a girl child, low caste, disability are the visible faces of stigma unlike HIV affected and vulnerable children (including sex workers' children). Unless children affected by HIV/AIDS become visible and the supportive environment sensitized, policy makers cannot allocate resources.

In India, the emphasis is on full disclosure and inclusion. Sensitizing the community at all levels has been ongoing, intensive and emphasizes social responsibility. St. Paul's with its previous background of working with S&D among leprosy patients advocates that economic support is possible only if the community supports and cooperates. PWDS and its many partners have worked with marginalized groups – very poor, lower castes, child labour. Both NGOs felt that by its very nature, economic enterprises, access to loans and grants requires disclosure; the community is the first market for products and for these reasons believes strongly that communities must be sensitized before starting any economic program. A successful indicator of this approach is that in the districts that St. Paul works, many of the petty businesses of widows and PLHIV are related to food and the community buys and eats these products. Many symbolic events have also played an important role such as the District Collector having breakfast with 100 PLHIV women and their children.

In Bangladesh, a similar strategy was adopted although the context is very different. Sex workers children were not accepted in the regular school and so SCA with its partners - a local NGO (KKS) and the sex worker's collective (MMS) began a primary school *outside* the brothel area and opened admission to the community as well. Initially, the community

was wary but the high quality school began to attract community children. Parent meetings are well attended - sex workers have learned to assimilate and community mothers to accept. A local government official sends her child to this school.

In Cambodia, the emphasis on disclosure is less emphatic. PK generally adapts to the requests of the PLHIV for confidentiality or disclosure. It was mentioned that it is generally very difficult to keep the status a secret in a small village. PK has included various vulnerable groups of children and so broadened the targeting and selection of children, diffusing the issue of S&D. Communes and community groups are also involved in identifying and supporting children.

4.1.2 Promoting a development perspective

Improvement in economic conditions does not necessarily mean that the benefits will reach children, the marginalized and vulnerable. Sensitization and training on development Issues to all levels of communities is important⁵³.

PWDS and St. Paul's through the monthly meetings with all SHGs continuously emphasize the developmental perspective – this has ensured that children remain in school, members share and receive emotional support from each other and work to help their own members as well as others in the community. In one village, a SHG sensitized school authorities to give admission even though the sex worker was not able to provide the father's name. In another instance, an SHG could not be formed with sex workers because the norms of residence, etc were not available. By collectively advocating, an innovative solution was found – form a CBO of sex workers and then convert it into a SHG! For child-headed homes, SHGs provide a ready market for the retail goods they sell as a means of livelihood. SHGs have intervened for disputes related to inheritance of widows and children.

Every opportunity is taken to sensitize the Second and Third Level community as most of the services and schemes can be accessed only with their approval and influence. The continued feminization of HIV has demanded a wider response from the community. Some examples from St. Paul's Trust:

- The District Collector holds a grievance cell once a week and hundreds come for redressal of their problems. A system has been created wherein at the time of registration of the grievance; the persons are educated on HIV prevention, care and support. Over 1, 40,000 people have been sensitized.
- In Andhra Pradesh, there is a scheme called the Indiraamma Villages – where district officials recommend a village – the entire village benefits as a holistic development package is provided – electricity, water, pensions, grants, food security etc. St. Paul's works with the officials at local and district levels to ensure the inclusion of those villages with most children affected by HIV/AIDS. Currently, 16 out of 22 villages in one block have been covered under this scheme.

Both PWDS and St. Paul's have sensitized the government departments so that services and schemes are available for children affected by HIV/AIDS.

- Every government department has undergone a day's training on HIV. At the village level, local self-government bodies are informed about the problems of PLHIV and the children at the village gatherings. Most have discretionary funds at their disposal and by sensitizing them to the problems of children affected by HIV/AIDS, their caregivers and families, funds are allocated to these families.

SRDPE, one of the coalition partners of PWDS, mobilizes VDC (Village Development Committee) to allocate some of its budget for children affected by HIV/AIDS. Previously spent on festivals, funds are diverted for education support, nutrition for these children. In addition, the VDC

identifies common spaces for different groups to meet. Some community members donate their first salary towards children related HIV/AIDS activities rather than giving to the church.

AIRD another coalition partner of PWDS mobilizes the community to support children affected by HIV/AIDS by collecting resources during Christmas, mobilizing volunteers, and promoting the Fistful of Rice program. It firmly believes that if income stabilizes, it has a beneficial impact on health and reduces psycho-social stress.

The continuing sensitization of MMS in Bangladesh has led to the initiation of new services such as ECD centers, vocational training for older boys and girls, anti-trafficking. MMS has contributed a mosque and cemetery (sex workers were denied burial rights). Similarly, in Cambodia the community groups are educated regarding domestic violence, migration, abuse and trafficking and their relation to HIV in the villages where PK works.

4.1.3 Using a child lens

In Cambodia, the program is relatively new and life skills sessions have been initiated. In Bangladesh and India, there has been a sharp focus on children's participation and rights. This has had many implications in programming.

In Bangladesh, the Shishu Parishads (Child Councils) receive training on child rights and life skills. Collectively, they have identified cases of child trafficking, early marriage and supported friends who do not want to return to the brothel. Many mothers and grandmothers lure the children towards sex work – by gifts, emotion (“I am old and cannot work and eat, whereas you are able to do so in the shelter”) or by taking the child away, so that regularity in school is lost. Shishu Parishads have regular meetings in the community and also network with other Shishu Parishads across the country – this has given them a larger voice and sense of purpose. It has also challenged the sex workers and brothels. The empowering and disempowering continuum along which communities lie is clear in this case study. The NGO and the collective are discussing ways to deal with the complexities of life for sex worker's children, issues of child protection, sex work and alternative livelihoods for children. This has direct implications for support for higher education, vocational training, employment and shelter. As more and more children reach adolescence, the issues have acquired considerable urgency.

In India, various types of child support groups exist – life skills groups, children's clubs – each provide opportunities for children to share, play and support each other. Child members of these clubs have mobilized resources (clothes, books) for the more vulnerable among themselves and participate in numerous sensitization and advocacy meetings. Using a child lens has led to a clear emphasis by both NGOs regarding keeping children in school for as long as possible, advocating against child marriage and child labor. This means providing all the support necessary – admission, fees, uniform and supplementary teaching. In St. Paul's not a single child has dropped out of school. To respond to the special needs of child-headed homes (orphans or looking after ailing caregivers), PWDS/Blossoms promotes a *supplemental* income-generating program. Along with the other support (under economic rescue and protection), children are also supported for economic creation activities. After school and studies, children do house-to-house retailing or piece work, thus obtaining the extra income needed for miscellaneous needs. The work is however monitored by the NGO so that the child does not drop out of school nor undertake any exploitative work.

4.2 Core Strategies

4.2.1 Providing economic literacy

Economic enterprise requires a set of skills to succeed.⁵⁴ Most NGOs working in HIV issues rarely have an economic background. Examples of HIV+ support groups coming together to do income generating activities such as basket weaving, candle making abound and have not worked well as the focus was primarily on vulnerability rather than economic and the need to make profits⁵⁵.

PWDS has developed an Enterprise Manual for its implementing partner NGOs that addresses assessment of skills, product identification, market linkages and profitability. All staff compulsorily undergoes an intensive training program before beginning work in the project area. With its long experience in economic activities, PWDS approach is proactive, ensuring that NGOs who facilitate communities must have the required economic skills that will work in the field. By doing so, they have been able to involve many PLHIV who were novices in business enterprises. PWDS evaluates case by case, some PLHIV may need training, some seed money, and others market linkages. A similar approach is followed by St. Paul's whose philosophy is that 'gaps' have to be filled for successful economic enterprise.

A novel approach

PWDS uses an approach called MEALS for community development interventions which ensures that economic enterprises are successful.

M= Motivating
E= Equipping
A= Accompanying
L= Linking
S= Sustaining

The approach has evolved from its earliest work with poor laborers – the palmyra workers (who climb the long coconut trees for the fruit). Their economic condition was deplorable and their risks to life enormous. A number of community support structures were also promoted – friends of children, barefoot counselors (volunteers), mothers' groups, and youth task force for disaster preparedness. Communities became sensitized to collectively sort out different problems. People's organizations were promoted as part of the community development process.

This was the foundation on which the HIV/AIDS program was later added. Because of the strong roots with community mobilization, the HIV/AIDS program was also community based. To systematically assess the needs of the community a PCA or Participatory Community Assessment Appraisal is done to determine the community's needs and strengths. Community groups such as the ones indicated above were also started in the HIV/AIDS project areas.

On the other hand, St. Paul's and PK prefer to provide business loans to those who have some enterprise experience. They may suggest IG options through informal market assessment. Some economic discipline is inherent to all three case studies, in that all enterprise development beneficiaries are already part of a savings scheme.

Srekhmere SK⁵⁶ works in two districts, Bakan and Sampovmeas in Cambodia. Farmers' groups are formed with 15 –30 members in each village. Most of them are poor women. Great emphasis is placed on skill building through the farmers' school with 21 half day sessions. Two or three among them are selected to become master trainers and sent for 21-day training to Phnom Penh. A stipend is provided and on their return, they are expected to train the others in the village regarding better agricultural techniques, market

linkages, as well as development issues such as need for children's education, migration and risk behavior.

4.2.2 Collectivization: Creation of Social and Economic Communities

This strategy was widely used in all the case studies. Each NGO had sensitized communities to form groups, each had been formed according to one's special interest or concern – Cambodia had farmer's collectives, Bangladesh had sex workers collectives, children's collectives, both the NGOs in India promoted Self Help Groups or SHGs and children's clubs. PWDS had begun with PLHIV support groups but it was difficult to sustain interest. Micro- credit was added to the agenda, and the support group converted into a SHG. These "economic or social communities" then became the vehicle for the promotion of different initiatives in HIV related programs. By forming their own organizations they were able to become civil society actors to claim entitlements and rights.

- PK in Cambodia had several farmers' committees in the village (from an earlier poverty alleviation program); each had been formed to address different economic issues. In identifying children affected by HIV/AIDS, the collectives played an important role – they divided the community into four categories – rich, middle, poor and poorest. Within the poorest, other vulnerability factors were considered such as female-headed homes, orphans to identify children affected by HIV/AIDS so that the package of services could be offered. The collectives also provided oversight, were the IGA grants being used, were children who obtained scholarships attending schools, were children accessing feeding programs in the school? The collectives also made decisions regarding who would access the rice banks. The rice banks had been created to address the recurrent yearly food gaps and to tide over the 'no food' months. With the advent of the children affected by HIV/AIDS project, the collectives were sensitized on the needs of these families and the need to provide food security. In another project area, Banteay Meanchey, the commune council worked with the border police (Cambodia-Thailand border) to prevent families from illegally migrating with their children across the border for periodic manual labor. This had resulted in an increase in enrollment in schools.
- SCA in Bangladesh worked with a local NGO, KKS to mobilize and form a collective for social workers. The sex worker collective⁵⁷ has been key in mobilizing member sex workers to save, for community activities, for encouraging children to attend school and their future plans. Sex workers report spending more on their children as a result of the savings – for food, health and towards a future fund for the girls in the shelter. Those who save regularly are sending their children to private schools.
- Children's collectives need special mention. As mentioned in the earlier section, 'Using a Child Lens', SCA has promoted children councils or Shishu Parishads across Bangladesh. These children's collectives have prevented child marriage, trafficking and many of its child members have heightened risk perception and resisted recruitment by the brothel (and sometimes their mothers) into sex work.

PWDS began with children's support groups to address S&D, but over the years they have evolved to form clusters and are represented at the state level as well. A state level working group advocates for the many problems children face.

- Women collectives' examples inform strategies for the increasing feminization of HIV. Many of these collectives formed to economically empower women have begun to address HIV related issues as well.

The SEWA Model: An example from India

SEWA's early roots as a trade union have evolved into a movement, espousing the philosophy of economic empowerment for women. With over one million members today, it started as a response to the economic exploitation of women in a variety of economic activities – home based enterprise, contract labor, small producers, and agricultural labor – all in the unorganized sector. It believes strongly in the cooperative movement and today works through 100 cooperatives. Services have grown organically in response to the women members and include health care, childcare and a host of financial services. In 1985-6, SEWA realized that maximum expenses were for health treatment. It started providing low cost generic medicine through a cadre of community health workers, established health clinics and raised health awareness. Health soon became the entry point to provide other SEWA services. A health insurance plan (VIMO) was also started.

In 2001, SEWA started its work with HIV. SEWA found it difficult to move from economic issues to sexual behavior. It started seven STD clinics at the workplace, identified key populations at higher risk, and provided medicines. Clinics were kept open at convenient timings so that there was no loss of daily wages. Because of SEWA's strong economic orientation, peer educators also discussed small savings, micro loans and insurance encouraging women to save, acquire credit and move up the wealth ladder. In the last two years, about 70 persons (40 women, 20 men and about 10 children) have been detected HIV+ in their project area in one city, Ahmedabad. The PLHIV receive a variety of services including OI medicines. In addition HIV + support groups were started and because SEWA supported them there was no stigma. Monthly meetings are held to sensitized the group on development issues; encouraged to save money in the SEWA Bank (it has 150,000 members). An analysis indicated that when women did not get 'full employment', they were tempted to indulge in high-risk behavior and children's needs of food and health were neglected. To maximize the economic skills a number of business development activities were introduced and to look after the needs of children, the *Balseva*, program was started that provided day care, nutrition, education support.

SEWA's vast experience indicates that *full* employment is necessary and possible through a package of social security – health services, child programs, insurance, housing and financial services (savings, credit). It does not believe in giving cash. It believes that every person has a skill that can be developed.

Information from Site visit and interviews

In India, both NGOs have made extensive and successful use of the SHG.

What are SHGs?

Groups of ten or twenty women come together to form a group called the Self Help Group or SHG. One of the requirements is that they must meet regularly generally, every month, each member contributes a small amount of money every month, generally less than a dollar (Rs. 30).

All the SHGs are technically supported by NGOs that provide inputs for account maintenance, various IGA projects, how to access loans etc. In six months, the SHG is eligible to receive a matching amount from the local bank as a loan. The monies thus accumulated are distributed among the members, depending on need and used for consumption or IGA. Typically, the groups start with internal lending but soon progress to various IGA activities. The SHGs are typically women, who have never stepped out of their homes but have been compelled to do business and earn money. The SHGs undergo consistent training on various economic and development issues every month and are highly sensitized. Petty businesses range from selling snacks to door to door retail, garment making, petty shops and raising livestock. Recovery rates are very high – above 95%.

Two models are available and both work depending on the need and context.

- Usually two PLHIV members are included in a SHG group – the group liability is spread if the PLHIV is unable to return the loan or contribute to the monthly petty saving. PWDS has through experience found this strategy most useful as it has helped to diffuse risk and enable group income generating projects.
- Exclusive PLHIV SHGs are formed – these are formed under a special category available for SHG (and also used with sex workers). They receive special privileges, for example a loan of Rs. 25000 needs repayment of only Rs. 15,000 (the other being written off, a type of ‘cash transfer’). Higher amounts are available on regular repayments. The other advantage is that being PLHIV the monthly mandatory savings amount is usually small as their earning capacity may be lower. In the integrated SHGs, the amounts are larger and it is easy to default.
- If a PLHIV dies, generally the caregiver or an older child is taken on as a member

St. Paul’s Trust has formed SHG with women living with or affected by HIV in Samalkot and Peddapuram Mandals of Andhra Pradesh, India. In the beginning it seemed doubtful that these women’s groups could be organized. The women gathered to understand and discuss what SHGs were before forming one. Each SHG had ten members – consisting of widows (some were living with HIV), older children, mothers, mothers in law and siblings of PLHIV. Since 2001, 200 SHGs have been formed and 2000 women in these SHGs revolve more than \$8700. They also have a Mahila (Women’s) Bank with \$3260 as working capital.

Within SHGs both types of income generation have worked – individual and group:

- St. Paul’s prefers to give loans to individuals who have some business sense and enterprise. If a new person wishes to start a small business, assistance is provided either for vocational training, which would then lead to a small business venture. Maximum use of available government training schemes are utilized as they also provide a stipend during training and hardware (such as a food mixer or sewing machine) once the training is over.
- Within the same SHG, some women may take individual loans for business, some may take for consumption and some may move into group income generation projects. PWN facilitated a textile shop with outreach activities in which 13 women are employed; PWDS has examples of napkin sewing where a group of women take contracts and each has a different task to do in the business – one cuts, one sews, one trims, one packs.

PWDS believing in promoting a people’s movement (thus taking collectivization to the next level of advocacy) and has facilitated the formation of clusters of SHGs and these into a district federation.

SHG Federations and Networks

Each SHG contributes a small yearly membership fee (\$2.50) to become a member of the federation. The federation is a powerful mechanism for advocacy. Training is provided on economic and development issues to its office bearers. They mobilize resources. They promote direct benefits for its members such as educational support and health costs and suggest various insurance schemes – health and life. They have advocated with local self governments for PLHIV to access schemes, negotiated with money lenders to waive interest of loans, challenged a cashew nut factory to raise the height of the chimney as it caused respiratory illnesses and campaigned against genetically modified seeds. Many of the members are now part of local self-government bodies.

These federations are forming networks, which will be able to advocate at state and national levels.

The creation of wealth has altered the status of the women and their children – their economic clout has enabled them to live independently, care for their children and are no longer considered a ‘burden’ by their families. When the SHG meet, there is a forum for them to discuss their problems and needs.

4.2.3 Mainstreaming

The overarching principle of mainstreaming is to encourage all development sectors to look at how HIV affects their work and make sure they are responding and supporting wider HIV responses through what they are doing.^{58 59}

The two main pillars of mainstreaming are referrals and linkages on the one hand and an intersectoral approach on the other. The case studies from India firmly believed that the principal role of NGOs in economic strengthening is that of **facilitation**.

Many different poverty alleviation schemes were being utilized by NGOs in India

1. National Family Benefit Scheme
2. Widow Pension
3. Anthodaya Cards (food ration)
4. Annapurna Cards (food ration)
5. Old Age Pension for older caregivers
6. SC Society (for low caste groups)
7. BC Corporation (for backward class groups)
8. DRDA – District Rural Development Agency
9. Rajiv Yuva Sakthi – business loans for young people
10. Indira Awas Yojana – Housing Scheme (subsidized)
11. Indiramma Adarsha Gramam – ideal village program
12. Jan Shree Bima Yojana – insurance scheme

PWDS and St. Paul’s in India had accessed, influenced and mobilized various government schemes for children and their caregivers by tapping into the wider pool of welfare schemes – for disability, old age, leprosy, and low caste groups – where monies are available. Both NGOs work with the government for **convergence** of programs available under poverty alleviation. As a result, many schemes under many departments belonging to different ministries are availed at the local level. By consistent, persistent sensitizing the Second and Third Level community - local village and district officials and bodies, St. Paul and PWDS are able to garner these government benefits for PLHIV, thus ensuring sustainable and long-term economic support. For example,

- Widows access Widow Pension schemes (monthly Rs200 or \$4.50 in Andhra Pradesh and Rs. 500 or \$10 in Tamil Nadu). Many also receive a one-time grant of Rs. 10,000 for the loss of their husbands under the Family Benefit Scheme. This scheme is available for older women but the district officials have relaxed the age limit to benefit the young widows living with or affected by HIV. PWN is advocating with the government to *officially* relax the age limit for HIV + widows and double the pension. Much of the grant is used to pay off debts incurred for medical expenses.
- St. Paul’s has very recently been able to obtain “child pension” for six orphans – a first in the district!
- Elderly caregivers are motivated to apply for Old Age Pension Schemes and the sensitized Second and Third Level communities complete the paperwork and endorsements.

- Life Insurance companies do not provide coverage for HIV but do provide group life and health insurance. When women form self help groups of ten or twenty members, they become eligible for health insurance (the Jan Shree Bima Scheme) where for Rs 100 paid yearly by the member, the government matches it. As PLHIV are members of the SHG, by *default* they too access the health and life insurance group schemes.
- For people Below the Poverty Line (BPL), the government provides ration cards (Antodaya and Arunodaya cards) to buy rice, oil, cooking fuel from certified government shops at a fraction of the market cost. These ration cards are available only with the recommendation of the village council and the District Officials. HIV affected families have accessed these schemes.
- All government early childhood centers and primary schools in India provide a mid-day meal – this is an incentive for children to go to school.
- Both NGOs exploit the local context. The prevailing caste system, which is so deeply rooted, is used to the advantage of those caste group members who are living with or affected by HIV. Thus, HIV affected women belonging to these caste groups became recipients of caste specific grants and interest free loans e.g. to buy milch cows and start a dairy business.
- St. Paul's has advocated with temple priests and government officials to '**pledge**' jobs for PLHIV such as Early Childhood Care worker (anganwadi worker) or as temple helpers.
- Vocational training is accessed through the DRDA (District Rural Development Agency), which provides training, a stipend during the training, a certificate and some hardware to start off the business. According to St. Paul's only if all these elements are in place does vocational training work.
- The District Collector where St. Paul's works has started Bridge Schools – to help children who had dropped out of school to get back through bridge courses.
- A job card under the National Rural Employment Scheme ensures 100 days of 4 hours of work for all unemployed.

These examples demonstrate how referrals and linkages to wider community economic resources provide sustainable solutions for economic empowerment. For such multi-sectoral approaches to work however, the local government officials need to be sensitized towards the needs of PLHIV. That is why the crosscutting strategies are important and the understanding of different levels of community to target necessary.

4.2.4 Public- Private Collaborations

NGOs are service providers whereas economic institutions must enforce fiscal discipline to be viable. This inherent conflict in roles is resolved through partnerships – NGOs with micro-finance institutions.^{60 61}

The Indian Association for Savings and Credit (IASC)

A new generation microfinance institution, it is promoted by HDFC (a commercial bank) and PWDS (a NGO). Established in 2000, its aim is to extend services such as micro credit, micro insurance and micro pension to the socio-economically deprived sections of society who would otherwise be excluded from the mainstream service providers. They also provide non-financial services such as housing, livelihood, education, environment and health. Over the years, it has continued to extend its services to more districts in Tamil Nadu. Although it gives individual loans, it also provides loans to Joint liability groups; livelihood groups, housing groups and self help groups. IASC intervention enables people to liberate themselves from informal moneylenders and mainstream their credit needs with the regulated formal market. It also aims to establish that poor are bankable, and demonstrate that financial services to the poor can be a self-sustaining business operation.

In Cambodia, Angkor Mikroheranhvatho Kampuchea (AMK) provides a similar service.

AMK – A Micro finance Institution

AMK was initiated out of the savings and credit activities of Concern Worldwide Cambodia. AMK has a code of practice for client protection ensuring that the poor are selected, that microfinance products will not promote further indebtedness and other guidelines. It has a clientele of 68,000 persons and a portfolio of \$5.3 million. It follows a solidarity group methodology where village groups called Village Banks of 4-6 members come together and then in turn organizes into 4-12 groups (20-60 clients). The group members guarantee all loans. There are different loan schedules to suit the needs and various products to choose from including an emergency loan. AMK also promotes a savings program with ease of deposit and withdrawal.

Links with such institutions has improved access to long-term revolving credit and loans and enabled NGOs to concentrate on the work they know best – mobilizing communities.

Vocational training institutions tie-up have been done in SCA as well as St. Paul's – this has ensured the best quality training available.

Most businesses follow a corporate social responsibility model and the NGOs in India have taken full advantage of it. PWN collaborates with a large internet service provider firm *Satyam* to train and provide jobs for PLHIV women such as billing and managing internet cafes.

4.2.5 Volunteerism

Use of community volunteers was quite common across countries – they have been called different names, community care volunteers, health guides, home guides, peer educators, child-to-child. Those who were part of the project received an honorarium or stipend (not a salary) that covered their travel costs from village to village. Other volunteers included local philanthropists and in mature projects, the beneficiaries **themselves** became volunteers.

In both PWDS and St. Paul's, volunteerism is actively promoted – that 'this community is yours and that you have a social responsibility'. This sense of belonging had to be nurtured by the NGO. There are many examples of how the community has come forward to bear the funeral expenses and the funeral feast. Through the 'Fistful of Rice' program (a handful every day is set aside by each family and collected every month), every person in the village no matter how poor is able to contribute – this program initiated in one village has spread to many more villages and is now promoted as a national program. Some schools have reduced fees of children, others support the Red Ribbon Clubs (child support group meetings), some college lecturers support the education of a few children, a sub-inspector provides high protein mixes to children on ART, doctors provide sample medicine, a retired judge volunteers time, money and mobilizes resources from his social circle for PLHIV and their families – these are some of the numerous examples available. In one of the villages in St. Paul's area of work, the Peddapuram Municipality staff donated a day's salary for the PLHIV. A hotel owner feeds 40 children every month when they visit the ART center to collect their medicines. Twenty donation boxes have been set up in commercial establishments and government offices. In AP, movie stars promote Fan Clubs; they are usually youth groups who will mobilize resources on a simple request of their movie hero. This has been used to advantage by St. Paul's and the Chiranjeevi Foundation supports special nutritional supplements for seven HIV positive children.

The beneficiaries themselves become benefactors. In one program, heightened awareness among children affected by HIV/AIDS has led them to collectively mobilize money for food, books, clothes for 9 HIV + children and have encouraged teachers to voluntarily provide supplemental teaching and local politicians to support through government schemes.

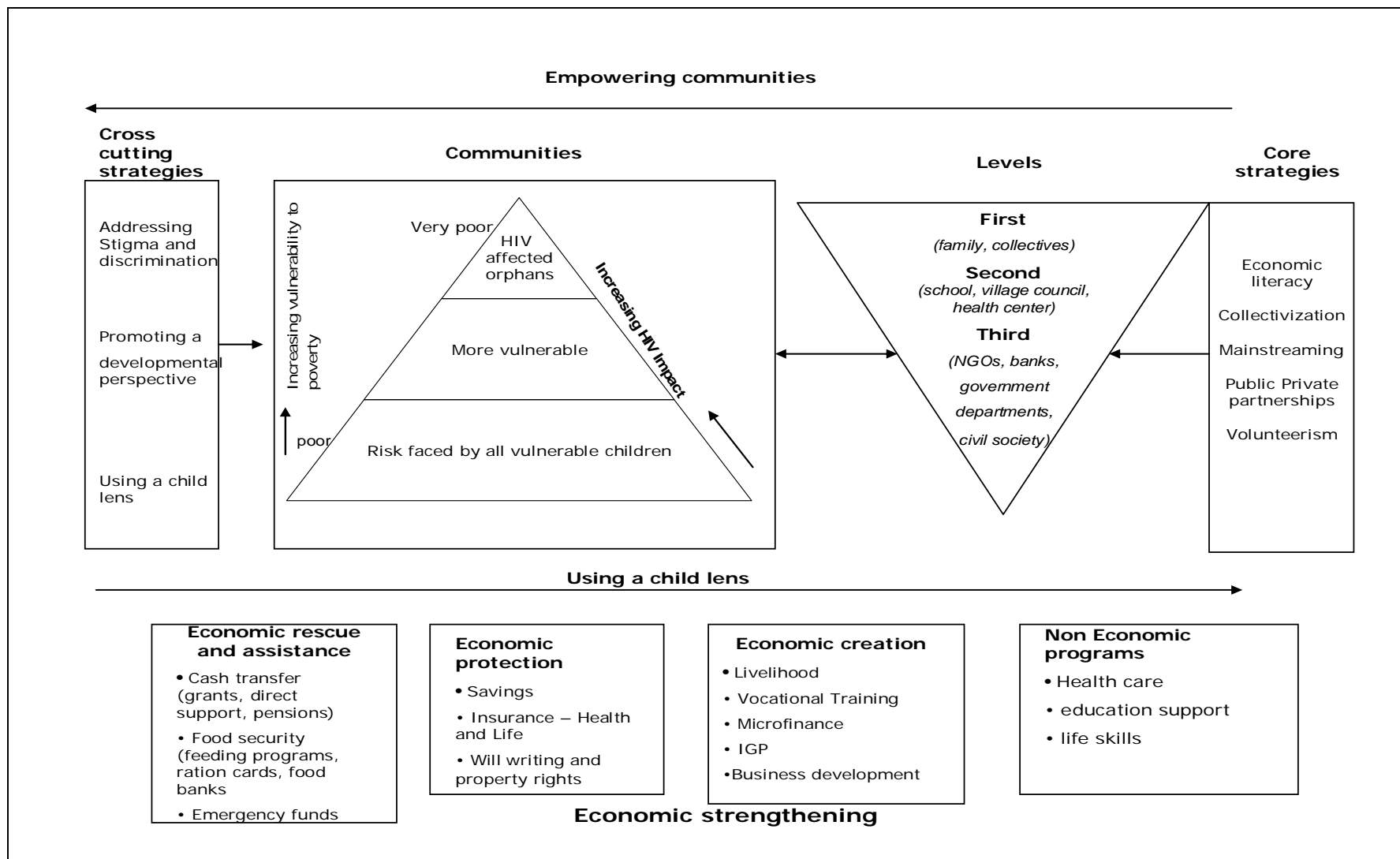
Salvation Army ISET: Catherine Booth Hospital

In 2001, the PLHIV support group decided to become a SHG as there were no economic activities. Today there are 3 SHG groups and 29 IGAs. Worried about their children's future, they approach the Helping Hearts Club to raise a corpus for their future education. Over two years through musical programs, Rs. 170,000 has been raised which has been placed in a separate account. One child is being sponsored for a hotel management course. For internal lending, the members voluntarily accept a higher rate of interest, the proceeds going towards this educational fund. For each child an educational assessment has been made – which year the child will leave school, expected educational expenses for higher studies, with whom the child is staying and what other needs he or she will have. On assessment they found that there were only 10-15 children who needed support, so they went out into the community and located other children – in all there are 51 on the roster. Because the money was lying idle in the bank, the group decided to lend it to the local shopkeepers – by doing so they are able to earn higher rates of interest.

Ref. HIV/AIDS Care and support program with PWDS and India HIV/AIDS Alliance

In Cambodia, PK in Pursat Province works with the monks in the pagodas to raise funds for children affected by HIV/AIDS through donation boxes. The rice bank stocks are being strengthened with support from those who have more. Those who are poor can take the rice and return with interest at the next harvest – creating a rice credit. The Social Welfare Committee consisting of the village chief, two community members and two beneficiaries decide who are eligible – earlier the poor had to pay back 3 to 4 bags of rice for each one borrowed. The Committee has ranked all the families from rich to poorest. Only the poorest get loans but they have to be part of a savings group in the village to be eligible for it.

Even in the most exploitative conditions, sex workers of MMS in Bangladesh have contributed to their communities – a sex worker has erected a mosque in the area.



Need for Economic Strengthening Activities: Voices from the field

Discussions with staff, beneficiaries, and members of various community groups indicated that economic strengthening activities had influenced the lives of children and their families in various ways.

Increased education: Where support was available, children were likely to be in school. The educational scholarships however can be a two edged sword – in Cambodia, where families are large, only one child gets the books, bag and uniform. PK found that the other children had dropped out of school (hence the need of a child lens). PK staff mentioned that although they had sensitized the Pursat community through Parents' Committee, school support through provision of school supplies or transport was necessary to ensure that parents sent their children to school.

In Bangladesh, the children completed primary school till Std. V because full educational support was provided and the schooling was of high quality. Once they had to leave for secondary school, 90% of the girls and boys dropped out, and returned to the brothel. *Thus the primary education was not enough to address long-term children's vulnerability.*

Children in all three countries have said that the access to schools and educational support has prevented child marriages, drop-outs, child labour and migration. For example, a child in India could earn up to Rs. 200 (\$4.50) a day and therefore without the educational support, would be pushed to work.

Better health: Increased income had led to more spending on food. For some it was increasing the quality of food, for others it was the quantity – families have reported that they now ate more than one meal a day. Food subsidies, food banks ensured that a continuous supply of food was available. Vegetable gardening promoted by SK Cambodia provided vegetables for the family meals and the surplus was sold to the market.

Access to ARV centers (where medicines were free) was made possible through provision of transport costs in both India and Cambodia available through grants or mobilized from the community.

Reducing debts: The savings schemes has helped caregivers to build capital. Where there was internal lending, the reliance on moneylenders and their extortionist interest rates (20 takas monthly interest to 100 takas in Bangladesh or 57% for ten months credit in Cambodia). There are reports from Cambodia and Bangladesh that moneylenders to remain competitive had voluntarily reduced their rates. Ability to access government grants helped to lessen previous debts in India. The combination of economic rescue, protection and creation activities ensured that caregivers were slowly getting out of the debt trap.

Decreasing migration and less vulnerability for women and children: In Cambodia, with better economic prospects, fewer women crossed the Thai border and were not subject to the rape and beatings at the border. According to one NGO SK that works with farmers' collectives, 80% families had stopped migrating to Thailand because of improved livelihood. Children were more likely to remain in the village, go to school.

Lessons from another sector: the SEWA Experience

Self Employed Women's Association (SEWA) is a trade union registered in 1972. With over one million members, it can only be characterized as a movement. Its strength is in its numbers and that its leadership is truly grassroots. Its members are very poor and belong to the unorganized sector. The SEWA experience has proved that they are both bankable and insurable. For SEWA economic security and social security go hand in hand.

Over the years, in response to needs it has developed a sisterhood of organizations:

1. SEWA Union – recruits and organizes the rural and urban membership – the flagship which gives access to other services
2. SEWA Bank – provides financial services
3. SEWA Cooperative Federation – a network of women's cooperatives
4. SEWA District Associations – village and self help groups that are linked together
5. SEWA Social Security – provides health care, child care and insurance
6. SEWA Academy – for training and education
7. SEWA Marketing – for reaching local, regional, national and international markets
8. SEWA Housing – provides housing and infrastructure activities.

Its strategy is built on networking and partnerships – with government, NGOs, institutions. Using this intersectoral approach, it has advocated for change in policies and laws.

Built on the two pillars of SEWA – full employment and self reliance: it has Eleven Points by which it measures how well it is doing:

1. Employment – have members obtained more employment?
2. Income – have they increased?
3. Ownership – do they have more assets in their name?
4. Nutrition – are they and their families better nourished?
5. Health Care – do they and their families have access to better health care?
6. Housing – do they have improved or more secure housing?
7. Child Care- do they have access to child care, if needed?
8. Organized strength – has the numbers of members increased?
9. Leadership – have more and more stronger leaders emerged?
10. Self reliance – have they become more self-reliant both individually and collectively
11. Education – has the education of members and their children improved?

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5. RECOMMENDATIONS FOR POLICY

5.1 Local self-mobilization

Local self-mobilization is key to community responses making them contextual and responsive to needs. It refers to the mobilization of people, resources and time into local support structures such as SHG, children's support groups, solidarity groups, collectives,

and faith-based groups. Communities may not be proactive and provide the empowering environment that is needed. Because communities are different and dynamic, it is important to **facilitate** the change processes and enable communities to determine their own responses. Economic strengthening activities are micro-enterprises dependent on numerous factors such as market linkages, skills, family structures and it would not be possible for donors and NGOs to centrally devise schemes and roll-out at community level. Hence, if emergency funds or cash transfers are required they need to be mobilized from the community itself.

First Level communities need to be mobilized to tap into the wider community for support and resources. Hence, the role of donors and NGOs must therefore be primarily be one of facilitators and mobilizers rather than providers of direct services; and resources (human and technical) should be available to mobilize these groups, prepare resource directories and learn strategies for advocacy and networking.

Groups and collectives have beyond doubt proved to be most effective in the management of economic activities. Both economic groups (self, help groups, savings group, micro-finance groups, group income generation) and solidarity groups have been useful to share both economic and daily living problems. By empowering communities to design their *own* development initiatives, they are able to get better control over livelihood resources. This experience suggests that there must be opportunity for sharing and learning. Programs should build in resources not only for creating and mobilizing groups but also for groups to meet and share, initiating a peer learning process and by doing so, encouraging creative responses to economic strengthening. In time, not only do responses begin to snowball but also beneficiaries themselves begin to contribute *back to the more vulnerable in the community*.

5.2 Capacity building

This is critical as most community organizations and NGOs that work in HIV/AIDS do not have economic understanding or 'economic literacy'. How to choose the appropriate enterprise, acquire related skills, use credit and manage a business are usually out of the realm of experience of community based or health NGOs. It is equally important that a developmental perspective be included so that communities understand how to best use the assets earned. Since most families fall into debt because of money spent on illnesses, it is important that capacity building on health related issues and how to access services is provided. A curriculum that builds capacities on economic enterprise with sensitization to developmental issues would also be recommended. Since, there is increasing feminization of HIV and many caregivers are women, a **gender perspective** to economic strengthening is suggested.

5.3 Partnerships and collaborations

These include the government, private sector and civil society. Linkages with the government are critical for sustainability and to creatively use existing programs for poverty alleviation, livelihoods to respond to the special needs of children affected by HIV/AIDS and their families.

Many of the skills required for profitable economic enterprises lie *outside* of the health sector. Utilizing institutions such as micro-finance, micro-insurance, vocational training institutions, agricultural colleges, marketing companies and other specialized services would ensure asset creation.

Since we are discussing children, it is important to consider non-economic partnerships and collaborations. Partnerships, and not just referrals and linkages, must be reviewed for education, vocational training and health. If neither of these services is of the desired quality, a referral and linkage has no meaning. If children are to go to school, it has to be attractive enough for children to stay there. If ART medicines are available, transport costs (with a caregiver) and high quality protein mixes are also necessary. Hence, partnerships and collaborations in the context of economic strengthening requires not only that the different sectors work together to ensure that economic strengthening becomes a sustainable reality but to understand that one sector has definitive impact on the other, that it can strengthen or undermine efforts of other sectors, in other words a **sybiotic relationship** is critical. A committee with representation from these sectors institutionalizes this approach. It is only then that economic strengthening activities can realize their full potential.

5.4 Multiple economic activities

Several economic activities are required for economic strengthening – economic rescue and assistance, protection and creation. Though the amounts allotted are small, together they add up and provide a composite set of services. Although efforts need to be directed to all of these, one may need to be emphasized over the other depending on the needs of the children and families. Whatever activity is to be implemented, it is critical that families and communities aspire for economic protection and creation activities although safety nets for economic rescue and assistance are in place. To implement any of these activities mobilization of the First, Second and Third Level communities are critical and wherever possible emphasis on strengthening *available* services rather than creating new (which are generally unsustainable) ones and to maximize the role of government and civil society is important.

5.5 Child focus

Rights based approaches that advocate for the best interest of the child areas are vital. Economic activities may harm the development of children if they are done at the cost of education or expose children to exploitation and abuse. The changing markets and increasing *commoditization* of children urgently requires that all economic strengthening activities place a child lens – what will be the impact of any economic activity on children and does it contribute to the overall health (mental, social, physical) and development of the children.

Using a child lens is also important for the selection of children. Children who are living with, affected by HIV, are orphans must and will be involved in the program. But it is important to include children who are at high risk and very vulnerable, *particularly so when families and communities themselves are not empowering.*

Finally we need to help children themselves – by providing life skills, children's rights and the supportive environment where children can gather, discuss and learn from each other. Facilitators need to be trained in child participatory methodologies, Convention on the Rights of the Child and global frameworks that have a child focus so that programs are tailored to ensure that children's' best interests are not compromised.

5.6 Continuity

Economic strengthening activities must be adequate, have a long term vision and available on a continuous basis. Grants need to be realistic and substantial e.g. grants for income generation need to be adequate. If too small, it is meaningless. Economic activities must result in asset creation and not be a liability. Providing relief and rescue measures is only an entry point to motivate the community so that they are more willing to access available services. Availability of a risk fund is important as PLHIV can suddenly get into a crisis and may need medical and nutrition support. For policy this means that the donor project cycles must have longer durations with a planned handing over that is sustainable for communities. Short fund cycles may actually create more harm as expectations are raised, children and communities are mobilized only to be confronted with a pull out of resources, leaving them in greater economic danger than before. Ensuring children have economic security is a moral and social responsibility and cannot be terminated without ensuring that alternative resources are in place.

In conclusion:

The case studies have clearly demonstrated that economic strengthening had many benefits – women (the most marginalized) had access to services for themselves and their children; children were in school and likely to remain there, had better nutrition, were able to access ART (as they were able to bear the transportation costs), there was movement from debt clearance to asset creation, increased social status within their families and communities as they were able to contribute economically as well and had become advocates – political and public – influencing policy and programs. This had direct impact – not just for social inclusion but social acceptance.

The role of communities has been multiple - as a source of support, by tackling stigma and discrimination and by advocating for the PLHIV and the children. The community – at all levels was able to support and therefore provide a host of services. The First Level community fulfilled many functions – provided emotional support, provided a base for many asset creation products, responded at times of crisis and galvanized the Second and Third Level, wider community to support, and synergize with them for maximum benefit.

Communities' responses need to be mobilized and supported. NGOs play a critical role in this process. Donors need to review their orientation to design programs that place communities at the center of the response and provide them with the capacity and support to design their own responses. The donor's role therefore would need to be transformed from a provider to a facilitator – understanding that responses from the communities would be diverse but responsive to the context. Only then can one ensure that communities will be able to respond to the economic needs of children and families, today and tomorrow.

Annexure

Site Visits:

In India

1. PWDS Coalition, Tamil Nadu including visits to head office in Madurai, to coalition NGO members – Blossom, AIRD, SRDPE and IASC in different parts of Tamil Nadu.
2. St. Paul's, Samalkot Andhra Pradesh
3. SEWA, Ahmedabad, Gujerat

In Cambodia

1. Ponleu Kumar PK in Pursat and Banteay Meanchey provinces
2. SK Srekhmere in Banteay Meanchey Province
3. AMK Microfinance Institution, Phnom Penh
4. CARE Australia Office, Phnom Penh
5. KHANA, Phnom Penh

In Bangladesh

1. SCA Save the Children Australia, Dhaka
2. Daulatia Brothel. Rajbari District
3. MMK – Sex workers Collective, Rajbari District
4. KKS – Local NGO, Rajbari District

Interviews:

1. Staff at above 12 site visits
2. John Williamson, USA (telephone)
3. Rachel Odede, UNICEF (in person)
4. Linda Sussman, USA (telephone)
5. P. Kausalya , Positive Women's Network India (telephone)

Endnotes

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¹² Children and AIDS: A Stocktaking Report UNICEF 2007

¹³ Children and AIDS: Second Stocktaking Report UNICEF 2008

¹⁴ Joint United Nations Programme on HIV/AIDS, 2006 Report on the Global AIDS Epidemic, UNAIDS, Geneva, p. 509. The terms 'children affected by AIDS' and 'affected children' are used to refer to children and adolescents under 18 years old who are living with HIV, have lost one or both parents due to AIDS, are vulnerable, i.e., whose survival, well-being or development is threatened or altered by HIV.

¹⁵ The Policy Framework for children and AIDS, National AIDS Control Organization and Ministry of Women and Child Development, India July 2007; National Plan of Action for Orphans, children affected by HIV and other vulnerable children 2008-10, Cambodia draft July 2007, National Strategic Plan 2004-10 Bangladesh.

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- ³³ The Policy Framework for Children and AIDS, National AIDS Control Organization and Ministry of Women and Child Development, India, July 2007 suggests addressing all children facing social exclusion (gender, caste, economic status, and disability), distress and abuse including children affected by HIV.
- ³⁴ August 2008 data
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