



**Weaving a tighter safety net:  
How communities can support families in the context of  
the AIDS pandemic**

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The AIDS pandemic has created a massive humanitarian crisis and left millions of children without adequate care and support, including:

- Children who have been orphaned – 12 million in sub-Saharan Africa alone [1];
- Children infected with HIV – almost 2 million in sub-Saharan Africa [1];
- Children living with and frequently caring for chronically ill parents;
- Children sharing scarce resources with foster children;
- Children living in extreme poverty exacerbated by the epidemic.

Families are best placed to support vulnerable children and have made tremendous efforts in the current crisis, taking up both the care of orphaned children and the care of children and adults suffering AIDS-related illness. This extra caregiving burden, however, depletes two family resources essential for supporting the healthy development of children: time and money.

Communities can play an important role in helping families fill these deficits. However, evidence suggests that in the context of the AIDS pandemic, far too little support is being provided relative to the magnitude of need.

In the following sections, we use recent data from two of the hardest hit countries, Botswana and Malawi, to provide initial insights into the resource needs of caregiving families and how communities are currently responding to these needs. We conclude by tackling a critical question: what does this evidence tell us about how *communities* can strengthen the capacity of *families* to deliver care to orphans and other vulnerable children in the context of the current crisis?

### **Adult time poverty**

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The AIDS pandemic has left millions of children without the essential time they need with adults. While the loss of parents places orphans particularly at risk, they are not the only children deeply affected. When parents are critically ill, their health limits the amount and quality of care they can provide for their children. Parents caring for the orphaned children or for chronically ill family members also have far less time for their own children. Markedly under recognized, this time poverty is of enormous consequence for children's daily lives, their health and their education. The following data from 1033 working caregivers in Botswana illustrates the pandemic's contribution to time poverty:

- HIV-infected parents were more likely than non-infected parents to report worrying that their children were not receiving adequate educational and developmental support (39% vs. 25%) or adequate educational support (39% vs. 27%) [2].

- Orphan caregivers were more likely to worry that their children were not receiving quality childcare (41% vs. 29%), adequate educational and developmental support (32% vs. 21%), and emotional support while they were at work (35% vs. 23%) [3].
- HIV/AIDS caregivers also had less time to spend with their children (66 vs. 75 hours per month) [4]; this deficit was most pronounced for children under 6 years (74 vs. 96 hours per month) [2].
- The children of HIV/AIDS caregivers were almost twice as likely to be left home alone (53% vs. 27%), and more than one and a half times as likely to have to forgo school or other age-appropriate activities in order to provide childcare (15% vs. 9%). As a result, these children experience substantially higher rates of accidents and emergencies (68% vs. 41%) (figure 1) [2].

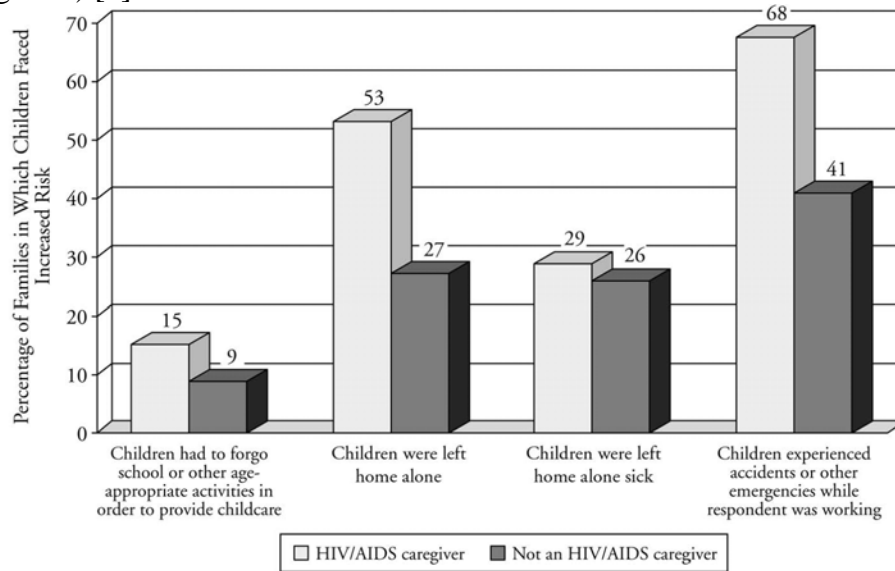


Figure 1. Children of HIV/AIDS caregivers face heightened risks; figure reproduced from Heymann, J., 2006 [2].

- The children of HIV/AIDS caregivers also experienced greater health and academic problems. They were more likely to drop out of school (18% vs. 11%); have academic problems (18% vs. 13%); experience emotional/ behavioral difficulties (19% vs. 14%); and suffer from poor health (43% vs. 28%) [4].

## Economic impoverishment

Caregiving related to the AIDS pandemic is exacerbating child poverty through three important mechanisms:

- 1) HIV/AIDS-related medical costs divert resources and exhaust savings;
- 2) HIV/AIDS orphans increase dependency ratios and lower per capita income;
- 3) HIV/AIDS-related care disrupts work and competes with income-generation.

Within this context, families that were already economically marginalized prior to AIDS-related crisis have the greatest risk of not being able to provide basic necessities for children. However, many families who were previously able to meet basic needs also fall below a crucial line when they take on additional HIV/AIDS or orphan caregiving responsibilities without additional income. Moreover, among working families, caregiving often prevents adults from being able to work full time or earn their previous level of income. The combined result is a marked increase in the number

of children in families who can not meet even basic needs, afford to send children to school, or purchase the health care children need.

- Approximately half of orphan caregivers we surveyed in Botswana reported financial difficulties due to this extra caregiving. For one in five, these difficulties were severe enough to impact their access to essentials as food, water, shelter, and transportation. These hardships were greatest among caregivers with only a primary-school education (figure 2) [2].

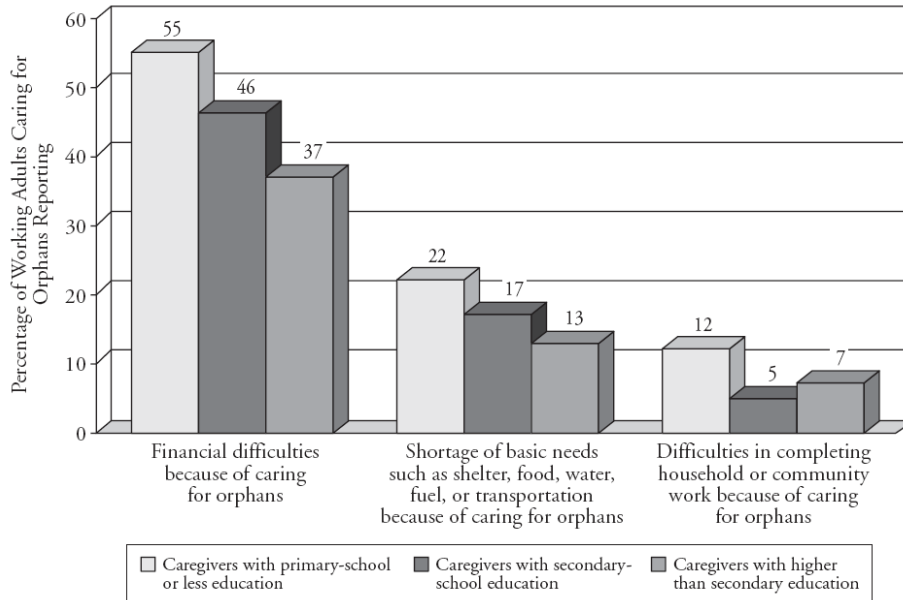


Figure 2. Orphan caregivers face greater financial problems due to caregiving; figure reproduced from Heymann, J., 2006 [2].

- The more orphans a family cares for, the more likely they are to report financial difficulties (figure 3). This pattern holds true even when the family is receiving external assistance to help care for the additional orphans [5].

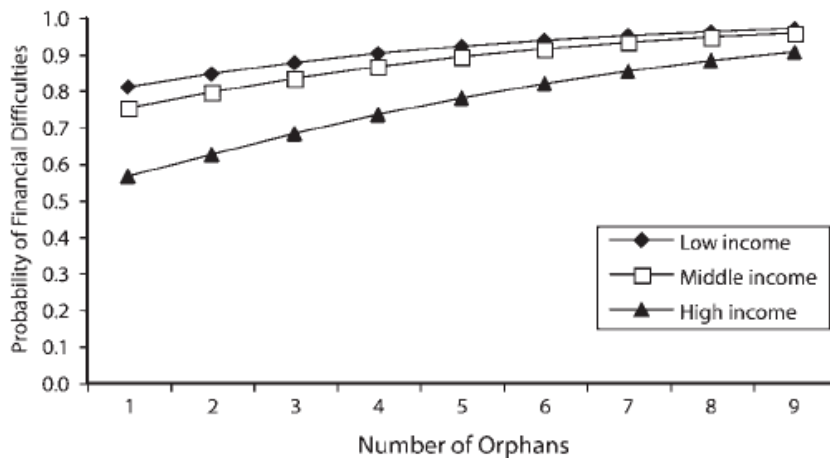


Figure 3. Probability that a household will have financial difficulties because of orphan care based on the number of orphans cared for in low-, middle-, and high-income households without assistance; figure reproduced from Miller, C., et al., 2006 [5].

- Sixty-four percent of HIV/AIDS caregivers reported financial difficulties. For 27% of HIV/AIDS caregivers, these financial difficulties were severe enough to lead to shortages in paying for such basic needs as food, shelter, water, fuel, and transportation [2].
- At the same time, conflicts between caregiving and work jeopardize child welfare: 47% of orphan caregivers said their work got in the way of meeting children’s needs compared to only 30% who were not caring for orphans [3].

### **What communities are doing to support caregiving families**

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

- In Botswana, while 43% of caregivers received help from other household members, and 39% received help from relatives outside their home, only 34% received help from the council or government, and 2% or fewer from friends, neighbors, and community volunteers (figure 4) [3].
- Among those relatives outside the home who helped, 67% assisted economically but only 21% assisted with childcare [3].

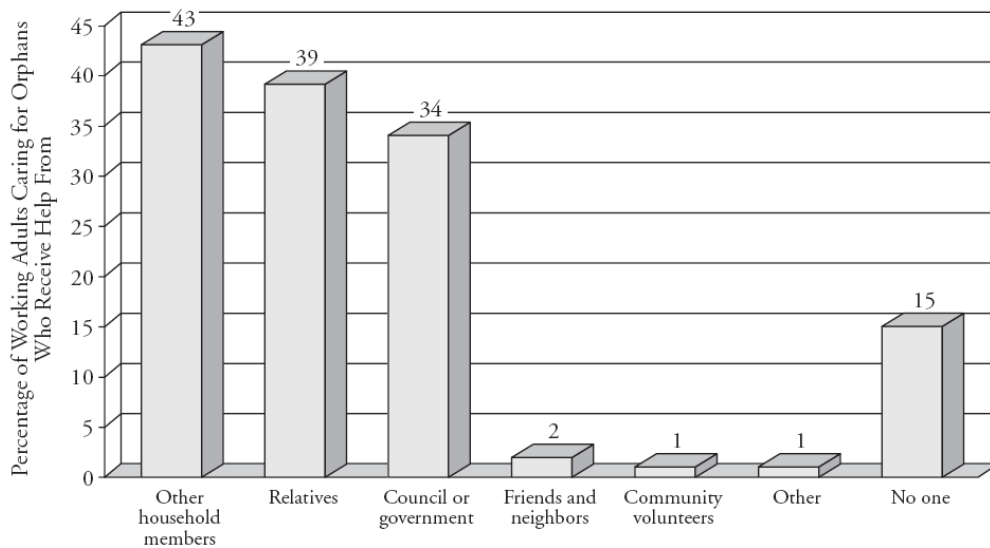


Figure 4. Working adults’ sources of support in caring for orphans; figure reproduced from Heymann, J., 2006 [2].

- Working households caring for orphans were 70% less likely to report financial difficulties if they received external economic assistance [5]. However, for poorer households with both high orphan and HIV caregiving burdens, the level of external assistance was often not high enough to protect them from financial difficulties [5].
- In Malawi, vulnerable families commonly drew support from within their social network (ie, relatives, friends, and neighbors). Seventy-five percent of children lived in households that

had received food, cash or in-kind gifts in the past year, but the value of such support was relatively low (averaging US\$81 annually) [6].

- Families with double orphans were 42% more likely to receive private transfers of support, holding everything else constant [6].
- The value of private transfers was lower to poor families with single, uneducated heads [6].
- As in Botswana, organized responses were less frequent: only 40% of children lived in communities which had a community-based support group for the chronically ill. These groups most commonly offered counseling (in 31% of all communities), followed by support for orphaned and vulnerable children (in 25%), food or other in-kind gifts (in 24%), and medical care (in 20%). Cash grants were rarely offered (in 3% of all communities) [6].

### **Solutions within reach**

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In communities hard hit by HIV/AIDS, families are increasingly unable to provide the basic financial necessities and caregiving time children need for healthy development. Communities are currently providing limited support to vulnerable families, but much more could be done at this level. The following programs could be effectively and feasibly implemented by communities and would greatly strengthen the family's ability to care for orphans and other vulnerable children:

- **Community-based day cares:** For children 0-5 years, community-based day cares could provide a safe, supervised environment and deliver high quality early childhood education. This alternative caregiving arrangement would also free up time for adults to engage in economically productive labor.
- **After school programs:** For school-age children, after school programs could provide important academic and emotional support. These programs should actively encourage the involvement of adolescents - a population often neglected in the global response but who need and want adults in their life to guide them through the transition to adulthood.
- **Home-based care:** For families nursing the chronically ill, home-based care programs would do much to relieve the caregiving burden. The extra time could be spent with children or in income-generating activities depending on the needs of the family.
- **Job skill training:** Job skills are a critical stepping stone to better paid jobs; communities could also initiate training programs and members could offer apprenticeships to help move families out of poverty.
- **Social insurance groups:** Once caregivers have paid work, communities can influence working conditions that affect their ability to care for children, such as paid leave to care for children. While formal employment is often governed by legal statutes, informal labor rarely is. Communities can help informal workers form social insurance groups to cover expenses if illness – their own or their children's – requires them to temporarily stop working.
- **Community gardens and grain banks:** While most people prefer to earn their way out of poverty, there will be times when stop gap measures are necessary (eg, non-earning periods while in training, when disability/illness prevents working, or when elderly caregivers are past working age). Governments will need to take responsibility for much of this support, likely in the form of cash transfers. At the same time, communities can generate extra resources for distribution to the most vulnerable families through community gardens and grain banks.

## References

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