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**Under the Radar –
Community Safety Nets for Children Affected by
HIV/AIDS in Poor Households in Sub-Saharan Africa**

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Acronyms

AHH	adolescent-headed household
AIDS	acquired immunodeficiency syndrome
CHH	child-headed household
CSG	child support grant
FBO	faith-based organisation
GGLS	guaranteed group lending scheme
HIV	human immunodeficiency virus
NGO	non-governmental organization
ROSCA	rotating savings and credit association
SAT	Southern African AIDS Training Program
SHDF	Self-Help Development Foundation
UNDP	United Nations Development Programme
UNICEF.	United Nations Children's Fund

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“New associations based on common emotional bonds of caring beyond kinship ties will be necessary to support some vulnerable members. However, for such to prove durable in the troubled socio-economic context of sub-Saharan Africa, these will need strong links to or derive their legitimacy from the resilient, traditional social network, the African kinship system... AIDS portends more, rather than a less central role for the family and clan.” (Ankrah 1993).

“ Many years from now, when the history of the global HIV epidemic is written, self-help and community support initiatives will receive their proper recognition as the unique contribution of the African continent” (SAT 1999)

Research is required to better understand the structure, conduct, and performance of informal safety net institutions so as to help identify the type of formal safety net system that could build upon and complement existing informal systems (Haddad and Zeller 1996)

Executive Summary

Safety nets are formal or informal mechanisms that mitigate the effects of poverty and other risks on vulnerable households during times of severe stress. In sub-Saharan Africa, the extended family, assisted by the community at large, is by far the most effective response for people facing household crises. Since state-administered support is non-existent throughout most of Africa, social insurance for most people is provided through kinship ties that enable household members to access economic, social, psychological and emotional support from their relatives in times of need.

Many more households are now being affected by social and economic crises as a result of HIV/AIDS and extended family support systems are being increasingly stressed. Many of those affected rely upon community members, including neighbours, friends and community associations, to cope with the impacts of AIDS on their households. Yet though frequently alluded to, community safety nets are poorly understood, especially in relation to HIV/AIDS and have been inadequately described. This paper provides a review of published literature concerning community safety nets and assesses previously documented examples of their functioning, especially in relation to households and children affected by HIV/AIDS in sub-Saharan Africa.

Section 2 outlines organized and formal private systems and those that operate at household, family and civil society levels. Formal and informal safety nets provide support to households facing social and economic crises:

- Non-governmental organizations (NGOs) and governments provide formal and public sector safety nets using mechanisms such as price subsidies, public works, food or micro-credit programmes and cash transfers to targeted households through pensions and allowances.
- Informal systems involve transfers or exchange of cash, food, clothing, informal loans, assistance with work or child-care and the provision of accommodation. These informal and private safety net mechanisms may be provided by:
 - Relatives belonging to extended families
 - Community members, either individually or corporately

The section discusses the limitations of public safety nets and describes the relationship between activities designed to build the economic resources of households and those that act as safety nets to households facing destitution. The inter-relationship between extended family and community safety nets is depicted.

Section 3 describes the impact of HIV/AIDS on households and children at three different stages:

- following the onset of illness;
- death;
- long-term consequences for orphans.

The section outlines the direct and indirect economic costs to households and the consequences of these impacts including migration and household disintegration.

Section 4 describes the ways in which households coping with the impact of HIV/AIDS seek to improve their food security and maintain their household expenditure patterns by raising or maintaining their income, by adopting three main strategies:

- Drawing down savings or selling assets
- Altering household composition:
- Utilizing assistance from other households

Section 5 considers the ways in which households affected by HIV/AIDS cope. The section considers both formal and informal support mechanisms and summarises evidence concerning the nature and timing of informal transfers and the relative value of transfers from relatives and community members.

Section 6 considers the dimensions, mechanisms, strengths and deficiencies of community safety nets. The components of community safety nets are considered by examining the roles of social support groups, informal associations, self-help groups, community-based and faith-based organizations, as well as the roles played by individuals and local businesses in providing support and economic services within communities. Six broad components of community safety nets may be considered in relation to the support of households affected by HIV/AIDS:

- (1) savings associations to which households in crisis belong
- (2) business and agricultural cooperatives to which households in crisis belong
- (3) loan providers and savings collectors providing services to households in crisis
- (4) philanthropic groups providing support to households in crisis
- (5) philanthropic individuals providing support to households in crisis
- (6) community groups providing support to people affected by HIV/AIDS

Section 7 analyses the functioning of community safety nets by considering the extent and effectiveness of community safety nets, the types of households that access them, and the occasions for and methods of accessing community safety nets. The section summarises changes in community safety net mechanisms that have taken place as a result of HIV/AIDS and considers the resilience of community coping mechanisms.

Section 8 considers the role of governments, NGOs and the World Bank in strengthening or undermining community safety nets whilst section 9 outlines some of the research questions that could give more focus to what is needed to build virtuous cycles of support between households, community safety nets, and state or NGOs responses.

Following this review, a separately-funded study will be conducted in Zimbabwe to measure the amount and type of support provided by community members to needy households affected by HIV/AIDS containing children so that the dimensions of the community safety net in relation to HIV/AIDS-affected households can be better defined.

Definitions Of Key Terms

Household: One or more persons who usually live and eat together, whether or not they are related by blood, marriage or adoption; and, the individuals recognize each other as members of the same household (Barnes 2002).

Extended family: Family members are individuals who by birth, adoption, marriage, or declared commitment share deep personal connections and are mutually entitled to receive and obligated to provide support of various kinds to the extent possible, especially in times of need (Levine 1990).

Community: Persons in social interaction within a geographic area and having one or more additional common ties (Hillery 1955). It is important not to idealise the notion of “community” or use the term as a “metaphor for an imaginary safety net of supportive social networks, a form of social capital, a “warm glow” of social interdependence and exchange” (Veale 2000). The term “neighbourhood” is used synonymously with “community”.

Civil society: Over the past two decades, civil society has emerged as a vibrant new social and economic sector of activity alongside the public sector and the private for-profit sector. New elements of civil society have emerged with unparalleled rapidity and energy... (and) build upon and add to the already present political parties, labor unions, workers cooperatives, business associations, membership serving organizations, and religious bodies that have formed the traditional core of civil society. They include hundreds of thousands of informally organized local citizen's groups - membership groups, community associations, citizen's movements, social service centers, savings clubs and advocacy networks - along with scores of thousands of formally chartered voluntary groups (so-called non-government organizations or NGOs) addressing a wide range of social development problems, and additional thousands of supportive intermediary-level non-profit institutions concerned with networking, financing, servicing, and advocating on behalf of various parts of civil society (Shearer 1995).

Poverty: This is said to exist within a household when it fails to afford the basic needs of life (food, shelter and health). Poverty is directly associated with the household's purchasing power and the latter constitutes a key determinant underlying the household's inability to access life's basic needs (Mutangadura and Makaudze 2000).

1. Introduction

In sub-Saharan Africa, the extended family, assisted by the community at large, is by far the most effective response for people facing household crisesⁱ. Since state-administered support is non-existent throughout most of Africa, social insurance for most people is provided through kinship ties that enable household members to access economic, social, psychological and emotional support from their relatives in times of need. Community members, including neighbours, friends and community associations, also contribute to household support systems. Though many articles allude to community coping mechanisms, community safety nets remain inadequately described and poorly understood. Few studies have identified the components, defined the mechanisms or evaluated the effectiveness of non-formal safety nets (Haddad and Zeller 1996; Mutangadura et al. 1999; Barnett and Whiteside 2002b).

Traditional family and community coping mechanisms are under stress because of the HIV/AIDS epidemic and a concomitant proliferation in the number of households facing social and economic crises. Many communities throughout Africa have developed innovative mutual support initiatives as responses to the epidemic, utilizing a range of complex strategies. Since community safety nets are not new, an important question is how much have they been used as a response to HIV/AIDS, how much have these mechanisms been affected by HIV/AIDS, and how much have they been supported by state and NGO responses to HIV/AIDS?

There has been considerable interest in the past decade in building the economic resources of poor households through micro-enterprise services. Less attention has been given to analysing and developing strategies to strengthen community safety nets. There is need to develop a state-of-the-art understanding of community safety net mechanisms and the ways in which these are being adapted to respond to the challenges of HIV/AIDS. This study will review the historic dimensions of informal social security in sub-Saharan Africa and analyse changes taking place as a result of the impact of HIV/AIDS, particularly in relation to the impacts upon children. It will assess the role of communities in assisting extremely poor households facing or experiencing destitution and in addition, consider the role of external agencies in strengthening community safety nets.

2. The role of safety nets

Safety nets are formal and informal measures that protect people from the worst effects of low income and povertyⁱⁱ. Table 1 outlines the main dimensions of social security services and characterizes these in terms of their main objective (insurance or assistance) and the nature of the institutions providing them (public or private). Public includes government, NGOs and (in this classification) community-based organizations, whilst private refers mainly to individuals, households and markets.

ⁱ A study in urban areas of Zimbabwe found the following income shocks in order of prevalence: inflation, devaluation, unemployment, death in the family, long illness, retrenchment, taxes, drought and divorce (Mutangadura and Makaudze, 2000).

ⁱⁱ This section draws largely on Haddad and Zeller, 1996.

Table 1: Dimensions of social security

	Public provision	Private provision
Insurance function	Pensions Health care and health insurance Unemployment insurance Disability and death benefits	Pensions Health care Unemployment insurance Disability and death benefits Inter- and intra-family transfers: <ul style="list-style-type: none"> • gifts, remittances • (reciprocal) informal consumption credit
Assistance (Safety net) function	Child allowance General consumer subsidies Public works Credit schemes Cash transfers Social funds Relief programmes Funeral benefits	Inter-family transfers Intra-family transfers Voluntary contributions Funeral benefits

Social insurance programs, such as contributory pensions or unemployment insurance, are largely related to earnings and need not include any transfers. In general, “insurance” provides protection against specified risks; it does not aim to uplift people out of poverty but to maintain their status quo. Social insurance programs help households manage risk, but before the fact. Safety nets take up the load where households cannot participate in social insurance schemes or when the benefits from those are exhausted. “Assistance” aims to improve the living conditions of the poor. Safety nets mostly transfer income in one way or another to needy people. The distinctions between insurance and assistance functions of social security systems are sometimes blurred, such as the provision of pensions.

This paper focuses on assistance functions of safety nets that mitigate the effects of poverty and other risks on vulnerable households during times of stress by redistributing income and resources to the needy in society. When hard times hit, safety nets reduce the need for households to make hasty decisions to sell off productive assets and increase their likelihood of escaping destitution. A second benefit of safety nets is to enable households to manage risk by increasing their available options. The knowledge that safety nets exist enables households to take economic steps that incur greater risks but that bring potentially higher returns, such as: growing high yield varieties of crops; using modern farming methods; concentrating household labor on high return activities rather than working in many separate informal activities and holding assets in more productive, but less liquid ways than cash “under the mattress” (World Bank undated).

2.1 Different safety nets

Formal and informal safety nets provide support to households facing social and economic crises:

- NGOs and governments provide formal and public sector safety nets using mechanisms such as price subsidies, public works, food or micro-credit programmes and cash transfers to targeted households through pensions and allowances.

- Informal transfers involve transfers or exchange of cash, food, clothing, informal loans, assistance with work or child-care and the provision of accommodation. These informal and private safety net mechanisms may be provided in two ways, by:
 - Relatives belonging to extended families
 - Community members, either individually or corporately

2.2 Limitations of public safety nets

A World Bank study in Tanzania of households that lost breadwinners through AIDS found that 90 per cent of their material and other assistance came from relatives and community groups such as savings clubs and burial societies. Only 10 per cent of assistance was supplied by NGOs and other agencies. (Mutangadura et al. 1999). Public safety nets in developing countries often do not reach extremely poor people and those affected by HIV/AIDS (Kadiyala and Gillespie 2002). Many reasons account for failure of formal safety nets to reach those most in need, for example:

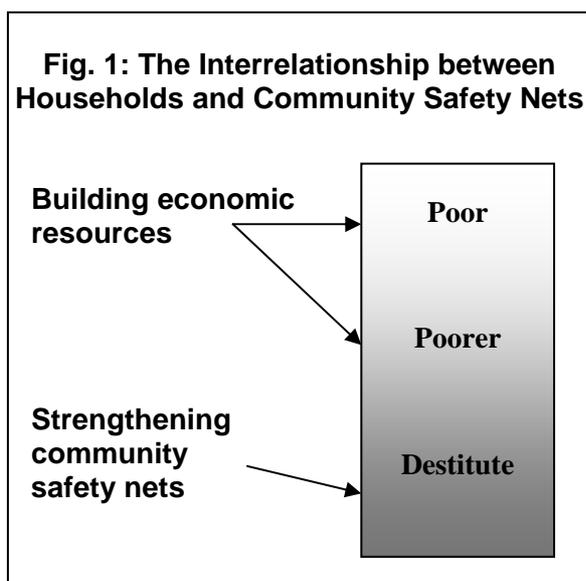
- food-for-work schemes may not be accessed by the chronically ill, those caring for sick relatives, the elderly and child heads-of-households (SADC 2003)
- school feeding programmes maintain children in school but do not benefit extremely vulnerable children who do not attend formal schools and do not target early childhood malnutrition (Grosh 2002).
- children living outside households with adults such as child-headed households and street children are unable too access social welfare grants they would otherwise be entitled to if living in households headed by adults (Barrientos and DeJong 2004).
- micro-finance services rarely act as safety nets and micro-credit interventions work best in areas which are well served by markets rather than remote rural communities (Grosh 2002). Services often do not reach the ultra poor and repayment is often constrained by the sickness and death of the participants or their family members.

2.3 Community safety nets and household resources

When designing projects to mitigate the socio-economic consequences of HIV/AIDS on communities, planners should consider two complimentary aspects:

- Building the economic resources of households
- Strengthening community safety nets.

Household economic resources and community safety nets are inter-related (Fig. 1). Building the economic resources of less poor households prior to times of stress helps them to remain economically productive and enables them to become net contributors to extended family and community safety nets rather than recipients. Economic strengthening activities are more effective when directed towards those somewhat better off in the community rather than the destituteⁱⁱⁱ.



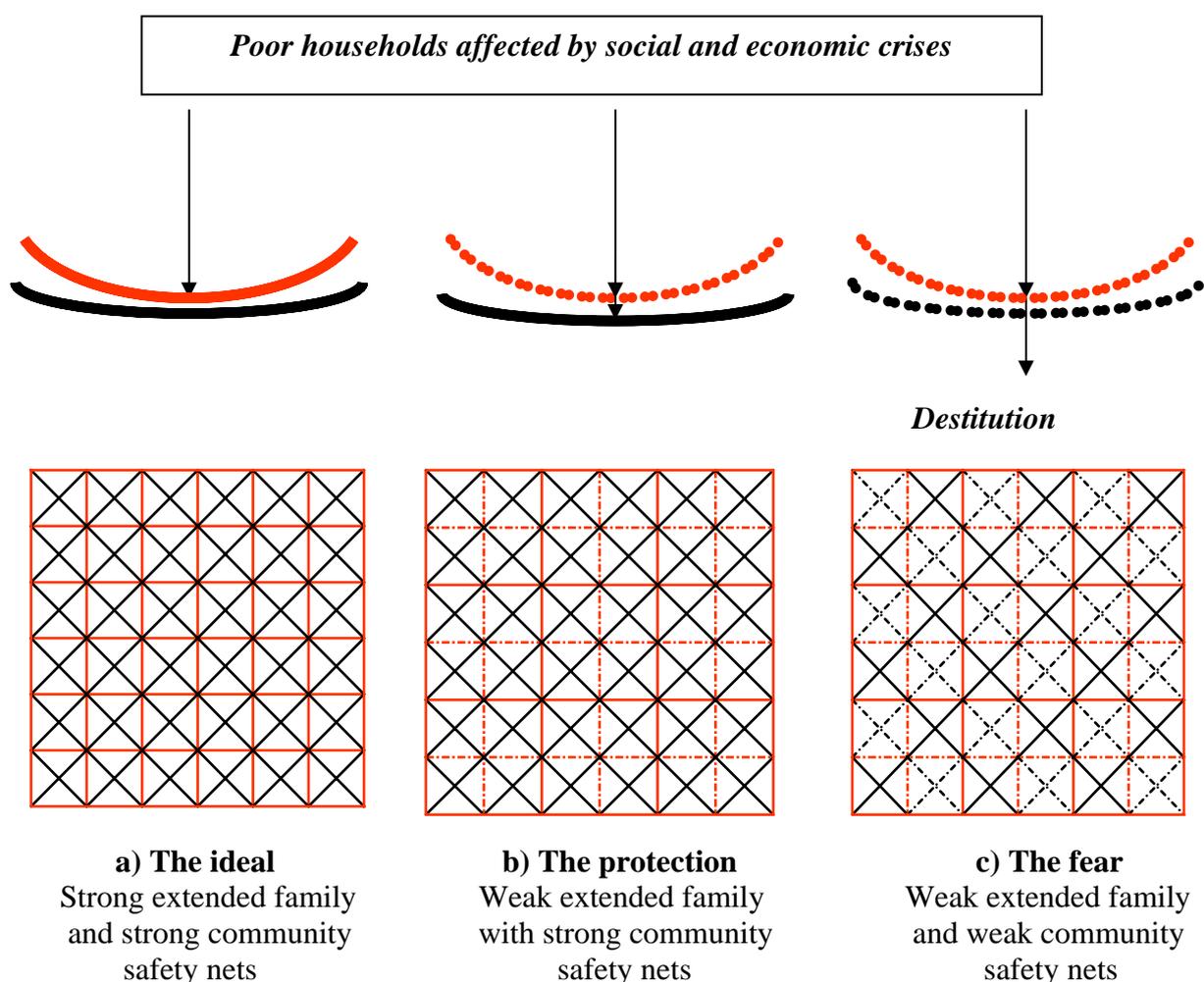
ⁱⁱⁱ This paragraph and figure 1 are based on Donahue, 1998. Micro-credit can still benefit households affected by HIV/AIDS or those that are extremely poor. In a survey of 338 loan-recipients of a micro-finance institution in Zimbabwe, 34 per cent were extremely poor, 33 per cent moderately poor and 33 per cent non-poor; 85 per cent were women and 40 per cent were possibly HIV-infected. (Barnes 2002); in a review of group guaranteed

The main concern of destitute households is to meet their basic needs and this involves accessing assistance from safety nets^{iv}. The contributions of better-off households are vital to the functioning of community safety nets and the economic well being of rural communities. In Tanzania, the wealthiest 25 per cent of households were more likely to give transfers to other households in the village and the amounts given were far greater than those given by the poorest households (Lundberg and Over 2000). Chronic illnesses in better-off households lead to reduced income for poorer households as a result of the latter's diminished employment opportunities in better-off household enterprises (Narayan 2002).

2.4 Extended families, community safety nets and destitution

Figures 2 and 3 provide a conceptual basis for understanding the functioning of, and relationship between, extended family and community safety nets.

Fig. 2: Conceptual model of extended family and community safety nets functioning



Extended family safety net is shown in **red**; community safety net is shown in **black**

lending schemes implemented as part of a project in Malawi targeting orphan households, 66 per cent of loan recipients were families keeping orphans or with chronically ill adults (Donahue 1998)

^{iv} In this paper, households are referred to in broad categories of “destitute”, “extremely poor” (abbreviated in places to “poorer”), “poor” and “not so poor”. Destitute households may be defined as those having no productive capacity and forced to rely on charitable donations. Extremely poor households are those forced to curtail spending on essential items, dispose of assets and at risk of destitution.

In developing countries, extended family safety nets are the first line of defense for households facing income shocks. The most significant support for households suffering a crisis such as an adult death normally comes from relatives through financial and material transfers and labour assistance (Fig. 2a).

Households in distress that receive inadequate support from relatives are extremely vulnerable and at risk of destitution (Fig. 2b). These households may receive support from the community safety net that acts as a survival mechanism particularly for extremely poor households that receive insufficient support from their relatives. Community members enable families in crisis to cope through transfers of money, material assistance and labour^v. In relation to HIV/AIDS, these transfers help low-income households suffering illness or death of a breadwinner to weather the storm of increased expenditure and acute income decline and assist in their economic recovery so that they can become self-sufficient after the crisis. Such support can enable extremely poor households avoid destitution.

But where extended family and community safety nets are both weakened, poor households facing income shocks are in danger of slipping through both safety nets, ending up destitute (2c). As a result, households may be forced to withdraw their children from schools and sell their productive assets such as land, implements and livestock. They are at risk of starvation and losing their shelter, and may become reliant on begging or scavenging for food. Though community safety nets act as the last resort for households struggling to survive, if the household disintegrates, members of the extended family may feel obliged to provide support by taking in destitute household members (Foster et al. 1997; Walker 2002). Consequently, even though households faced by income shocks may disintegrate, relatively few people end up as beggars or living on the streets of cities in sub-Saharan Africa.

Fig. 3: Transfers from communities and families to households by level of wealth of recipient

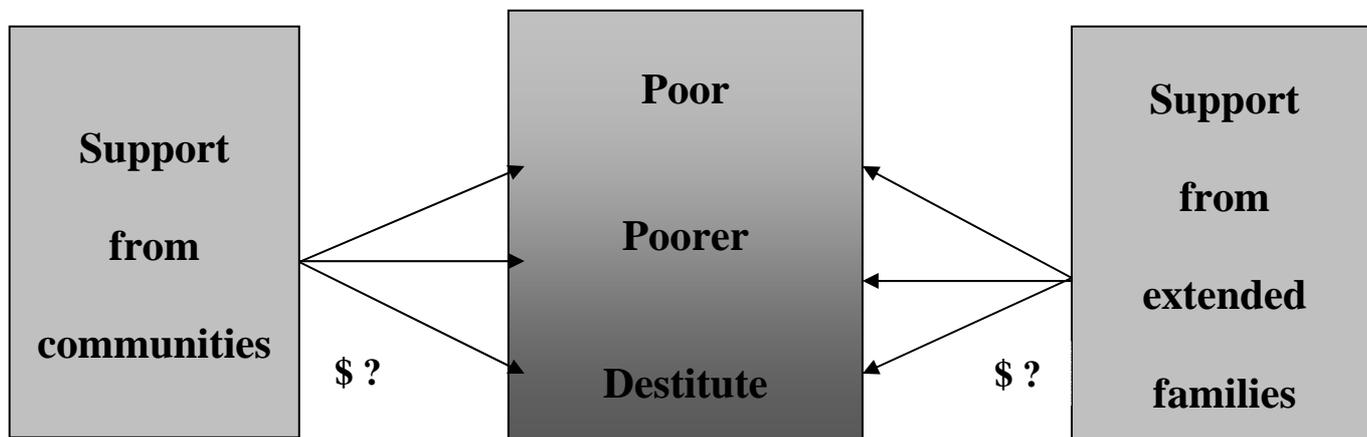


Figure 3 illustrates the fact that extended family and community safety nets function to different extents to assist poor households affected by social and economic crises. The illustration draws attention to the limited data that exists concerning the relative values of transfers from communities and families to households with differing degrees of poverty. Few studies have measured the value of informal transfers in relation to the level of wealth of recipients and assessed these transfers according to their source. In Tanzania, private

^v “Coping” is the act of making adjustments (typically short-term) in response to crises; the term is not synonymous with successfully overcoming a crisis. “Coping strategies” may also be termed “survival strategies”.

assistance received was proportionate to total income of recipient households; wealthier households facing income shocks received considerably more private transfers than poorer households, whilst the poor were more likely than the better off to receive support in the form of loans (Lundberg and Over 2000)^{vi}. The extended families of chronically poor people are more likely to be chronically poor (Bird and Shepherd 2003). Data is lacking to confirm the theory that a major reason why households become destitute is that they have weaker extended family safety nets and therefore receive less support from relatives compared to other equally poor households.

Communities target those households about which they are most concerned with philanthropic assistance, which tend to be those most vulnerable (Donahue 1998). Orphan households with fewer assets were more likely to be supported by a community group in Zimbabwe than better-off orphan households (Foster et al. 1996). It is unclear whether, and under what circumstances, the monetary value of community assistance to extremely poor households exceeds the value of assistance provided by relatives. It is also unclear whether households that receive little support from their extended families also receive little support from community safety nets for similar reasons. In Uganda, a poor person is said to be one who, among other things, lacks social support. The presence or absence of support networks (“social capital”) was one of the dimensions used by villagers in ranking households in terms of their well-being; they associated poverty with reduced cooperation in the family, increased social isolation and a process of “every one caring for oneself”(De La Rocha undated).

The components of community safety nets consist of different groups and individuals providing support through a variety of mechanisms. The challenge for external agencies wishing to mitigate the impact of HIV/AIDS on households and children is to identify which “strands” of community safety nets (such as churches, savings clubs or individual contributions) are most important in various settings (including informal settlements, rural communities and commercial estates)^{vii}; further work is needed to identify those factors that weaken community safety nets (such as urbanization, migration, government policies and external agency involvement in mitigation activities) and to understand the reasons why certain types of household (including female-headed, child-headed, elderly-headed and migrant households) slip through safety nets in certain settings. This information will assist agencies to develop strategies to toughen the major strands that take most of the strain imposed on community safety nets and enable the most vulnerable households to be supported. Section 5 reviews data on the value of support provided by community and family safety nets to households affected by HIV/AIDS.

3. The impact of AIDS on households and children

The impact of HIV/AIDS on households and children may be considered in three stages: following the onset of illness; around the time of death; and the long-term effects on orphan households. This and subsequent sections will discuss the economic consequences of HIV/AIDS to households and children and consider family and community responses. Direct costs are the medical costs prior to death and the costs of the funeral. Indirect costs relate to income lost due to death of the adult, and the impact on other welfare measures such as household food security status, child schooling, and loss of assets.

^{vi} Lundberg and Over suggest that this is because the better off are likely to reciprocate whilst the poor are not trusted, so support is provided as a loan with an explicit contract to ensure that if reciprocation does not take place, the likelihood of the loan being repaid will be increased.

^{vii} . Components of safety nets are described and discussed in sections 6 and 7. In relation to safety nets, the terms “strands”, “mechanisms” and “components” are used interchangeably throughout this paper.

3.1 Direct costs – Medical and funeral expenses

The direct economic impact of an adult household death includes treatment and funeral costs. Treatment costs include payments to doctors, hospitals and traditional healers, drugs and transportation expenses and costs of special foods. Funeral costs include the provision of food and lodging for mourners, expenses to transport the deceased, cost of the coffin, and sometimes transportation costs for mourners. For deaths from any cause, Tanzanian rural households spent nearly 50 per cent more on funeral costs than on medical costs; for deaths from AIDS, funeral costs were \$65 and medical costs \$59 (World Bank 1997). In Zimbabwe, the average cost of a funeral in urban and rural areas was Z\$5,716 (US\$ 140) and Z\$3,561 (US\$90) respectively (Mutangadura 2000). In typical rural households in Kenya, the cost of AIDS in the household represented 78 per cent of household income in the first year and 167 per cent in the second year.

The burden of medical and related expenses induces changes in family spending patterns. In Côte d'Ivoire in the mid-1990s, households affected by HIV/AIDS spent nearly twice the proportion of their budgets on medical care, as did households not affected by HIV/AIDS. In Rwanda, a household survey found expenses on health care to be over twenty times higher in HIV/AIDS affected, as compared to non-affected, households. Further, health care expenses by men were 2.6 times greater than for women, illustrating deep biases in accessing and using health care. Expenditures at this level became a major burden on family budgets (Nandakumar et al. 2000). Among households affected by HIV/AIDS in the Kagera region of Tanzania, almost all cash income was used to pay medical bills relating to HIV/AIDS (Tibaijuka 1997).

3.2 Indirect costs – Loss of earnings through illness and caregiving responsibilities

Direct costs due to medical and funeral expenses are only part of the costs incurred by households affected by HIV/AIDS. Indirect costs are also substantial as a result of loss of earnings of both those with AIDS-related illness and their caregivers. Late-stage HIV disease is characterized by prolonged periods of ill health with shortening periods of remission as the disease progresses. In a household study in Tanzania, the average length of illness was 18 months with remissions averaging two months at the onset of illness but shortening as the disease progressed^{viii}. Patients were bed-bound for around two-thirds of this time. The majority of caregivers for chronically ill individuals are close female relatives. Friends and neighbours represented less than 3 per cent of caregivers for people affected by HIV/AIDS in Uganda (Ntozi 1997b). In order to provide care for household members affected by HIV/AIDS, relatives employed the following care strategies:

- *Reduced time in agricultural production:* women provided care to sick household members and consequently spent 45 per cent less time in agriculture
- *Reduced time in social activities:* female caregivers reduced their involvement in leisure and village social activities by around half to provide care and carry out other responsibilities
- *Altering household composition:* extra-household labour for the provision of care occurred, especially in households where the husband was well and the wife was sick. Traditionally, a husband is not expected to take care of his wife as this would mean taking on domestic labour responsibilities. Consequently, female relatives are called upon to move into the household to provide care. The provision of extra-household labour for care, as well as divestment of time spent in labour or social activities, is thus defined by

^{viii} This section draws extensively on Rugalema, 1999.

the gender of the sick person in the household. The social support available to a man whose wife is sick is greater than that available to a wife whose husband is sick, and this gender differential continues after the death of the sick person.

- *Utilisation of child labour:* children are recruited to carry out tasks that would otherwise be the responsibility of a parent who is sick or who is preoccupied with care activities. Children as young as five collected water and firewood. Others were sent to harvest crops, mind livestock, prepare food, buy foodstuffs or beg for financial or material assistance from friends. The need for household labour during and after chronic illness may involve withdrawing children from school or postponing their enrolment, especially after the death of a mother (Lundberg and Over 2000).

3.3 Indirect costs - Asset removal and depletion

A further cause of economic stress to households affected by HIV/AIDS involves asset depletion. Savings are cashed in and household assets are sold to cover costs associated with illness. The assets of households affected by adult death are further depleted by the removal of property by relatives of the deceased (“property grabbing”), or the dispossession of land. This practice is widespread in some countries and less common in others. In Zimbabwe, in 76 per cent of cases, property was reportedly inherited by children after parental death whilst 15 per cent reported that property was taken by relatives (Drew et al. 1996a).

The economic impact of HIV/AIDS is significant and often dramatic in terms of changes in income, asset wealth and longer term prospects for economic security. A study in KwaZulu-Natal, South Africa, found that households that had experienced a death in the previous 12 months (not only from HIV/AIDS, it needs to be pointed out), had a mean monthly income equal to only 64 percent of households that had not experienced a death (Desmond and Gow 2002). Another South Africa study in Free State Province found that HIV/AIDS affected households tended to have monthly incomes one-third less than non-affected households (Booyesen and Bachmann 2002). In the Côte d’Ivoire, income of affected families was half that of total average household income (Desmond and Gow 2002).

A study in Zimbabwe compared 27 child-headed households (CHHs) and 16 adolescent-headed households (AHHs) and compared these with neighbouring control households; CHHs and AHHs had significantly fewer assets including livestock, blankets and other household items; household income of CHHs and AHHs was US\$8 per month compared to \$21 per month of controls (Foster 1998). Asset depletion follows a predictable pattern based on liquidation initially of non-productive assets (Table 2).

Table 2 Sequence of asset liquidation (after Donahue et al. 2001)

Protective assets	Most quickly liquidated	<ul style="list-style-type: none"> • Cash savings • In-kind savings that are quickly liquidated (chickens, goats, sheep, stored harvests)
	Less easily transformed into cash	<ul style="list-style-type: none"> • Furniture, kitchen utensils, radio, TV • Jewelry • Social capital (goodwill from relatives, friends and neighbors)
Productive assets	Selling has negative impact on income flows to household	<ul style="list-style-type: none"> • Business capital and equipment (e.g. plough) • Draft / dairy animals • Rental property
	Will sell only after having exhausted all other avenues	<ul style="list-style-type: none"> • Land

3.4 Migration, household disintegration and community safety nets

Migration plays a central role in the coping strategies of families affected by HIV/AIDS. With the onset of serious illness, many urban residents return to their rural villages, fulfilling a wish to go home to die. This decision is based on hard economic reality as much as cultural preference. It is considerably cheaper to be buried in rural areas and the costs of transporting the deceased can be fifty times higher than a bus fare and five times higher than private vehicle hire for a living person. On the other hand, rural to urban migration occurs when widows and orphans migrate to cities in search of work, partners or support.

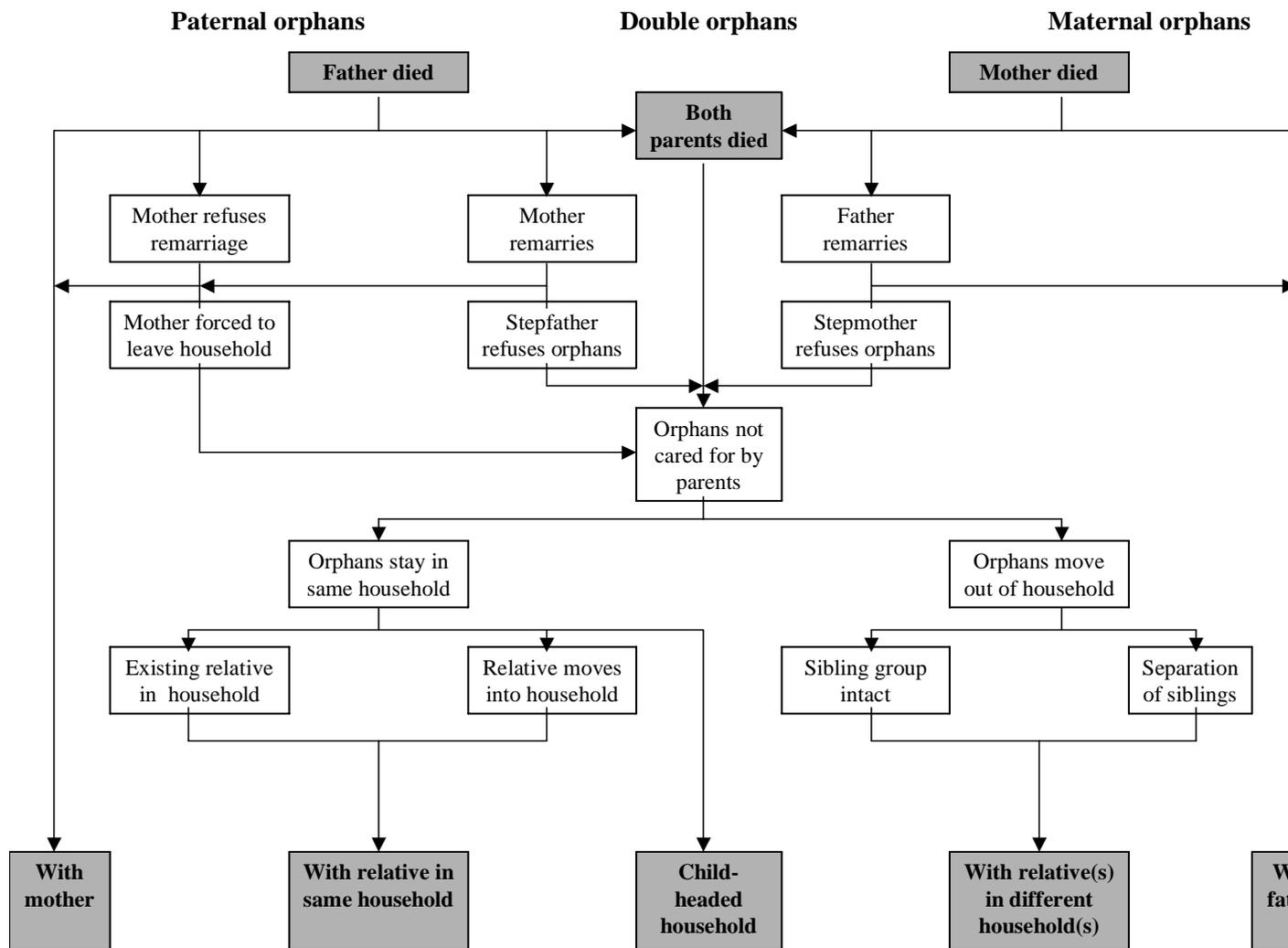
In Zambia, the majority of urban HIV/AIDS-affected families moved from their original home (which was provided by the deceased parents' employers) to cheaper housing on the outskirts of Lusaka (Nampanya-Serpell 2000). Selective migration of orphans from rural to urban areas can lead to clustering of orphan households in poor slum areas (McKerrow 1996). Mobility is common among adolescents affected by HIV/AIDS (Foster et al. 1997). Households experiencing income stress due to HIV/AIDS, frequently send their children to live with relatives who become responsible for meeting the children's food and education requirements^{ix}. Reversal of the normal urban-rural support networks is occurring, with communal lands increasingly acting as safety nets for urban households in distress (Marongwe, 1999). Rural-urban and urban-rural migration occur to varying degrees in different countries. Comparison of national household surveys found that in high HIV prevalence countries, the prevalence of orphans has shifted significantly from cities to rural areas in Kenya, Namibia and Zimbabwe, and from rural areas to cities in Central African Republic, Malawi and Zambia (Monasch and Boerma 2004).

Figure 4 is a simplified diagram of events leading to orphaned children remaining in their existing households or in other cases moving into new household situations. The events illustrated above are those found commonly in patriarchal society settings. For most orphans, the care provider is the surviving parent or a relative. Because of the timing of HIV infection, paternal deaths often precede maternal deaths. In some cases, older siblings become caregivers, leading to adolescent- or child-headed households; these are sometimes established to avoid sibling separation or to maintain ownership of land and household assets (Foster et al. 1997); in Uganda, most were male-headed since older girl children are often taken into relatives' homes (Luzze 2002).

A study of 215 urban and rural households in Zimbabwe found that only 35 percent of the orphans were in their original dwellings where they were living with their mother before she died; relatives from other households fostered most orphans (Mutangadura, 2000). In rural Malawi, 73 per cent of households dissolved entirely after the death of the second parent with orphans moving to join new households (Floyd et al. 2003; Heuveline 2004). Women who refuse remarriage to one of the deceased father's brothers may be forced out of the village, leaving behind orphaned children that "belong" to the paternal family (Ntozi 1997a). Household disintegration may occur after paternal death when women return home to their parents. More than one half of young widows and one quarter of young widowers under 35 years in Uganda moved from the household of their late spouse to earn money or for remarriage; many left their children with relatives (Ntozi 1997a). Often when households disintegrate, orphaned children are separated from one another and taken into two or more relatives' households. Child-headed households are also prone to disintegration following social and economic crises (Foster et al. 1997; Walker 2002).

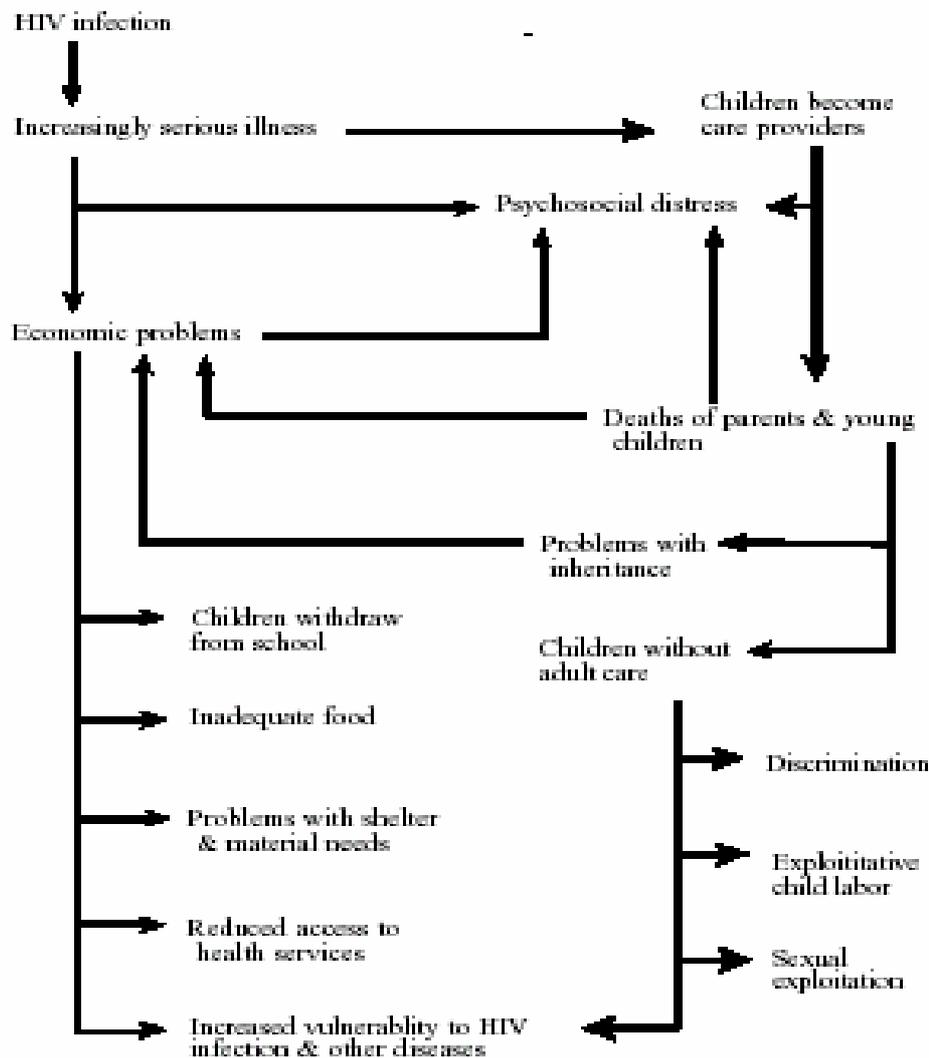
^{ix} Sauerborn et al. 1996; Barnett and Blaikie 1992; Lwihula 1999; Rugalema 1999; Drinkwater 1993; Mutangadura and Webb 1999.

Fig 4: Factors influencing final household status of children after parental death



Many households disintegrate after the death of parents because of the need to provide continuing care to dependants, remarriage, or because of conflicts over property. Migration in search of food is an extreme response to food insecurity and can also result in the break up of households. In southern Africa, households were more likely to migrate in search of food in households in which an adult member had died; there was a chronically ill adult; there were high dependency ratios; and in child- and elderly-headed households (SADC 2003). Though disintegration of households has been viewed as a failure of coping (Rugalema 2000), it is unclear whether this is in fact a coping response that enables relatives to inherit children and widows or widowers to remarry or the result of extreme poverty and lack of economic support from family and community safety nets.

Figure 5: Problems among children and families affected by HIV/AIDS



3.5 The impacts of HIV/AIDS on children

The social, economic and psychologic impacts of the HIV/AIDS epidemic combine to increase the vulnerability of African children. Figure 5 summarises the progression and relationship of problems among children and families affected by HIV/AIDS (Foster and Williamson 2000).

Though orphan households are assumed to be poorer than non-orphan households, this is not always the case. Orphaned children in Zimbabwe were more likely to be living in poorer households. This was unlikely to be because of higher HIV-associated mortality amongst poorer adults associated with poor nutrition and healthcare (Bicego et al. 2003). Many orphaned children living in better-off households are slipping down the socio-economic scale and moving into poorer households. But also, orphans may be taken in by relatives to live in better off households (Nyamukapa et al. 2003). Overall, there was no significant difference between orphan and non-orphan household wealth assessment in 20 countries of sub-Saharan Africa (Stover et al 2005).

Relatives go to considerable lengths to keep orphaned children in school, including borrowing money through informal networks and selling their own assets. For the most part, they treat these children the same way as they treat their biologic children. (UNICEF 2001; Makame et al. 2002). The likelihood of school drop out in Zimbabwe was found to be associated with the duration of maternal orphanhood (Nyamukapa et al. 2003).

4. Responses of households to the impact of HIV/AIDS

Households coping with the impact of HIV/AIDS seek to improve their food security and maintain their household expenditure patterns by raising or maintaining their income. Households adopt three main strategies to varying degrees to cope with the impact of the death of a prime-age adult relative within the household:

4.1 Drawing down savings or selling assets

Households accumulate savings and assets partly as a strategy to cushion unanticipated shocks. In rural societies, cattle are preferred as a form of saving because they can easily be converted into money in the event of crisis. Cattle are also useful as a status symbol of accumulated wealth and to pay bride price for espoused sons. Few rural people save money with banks because of the complexity of banking procedures, large distances to banking facilities, low interest rates, prohibitively high minimum balances and unreliability of banks (Ntalasha 2002).

When a household suffers a crisis, assets that are economically non-productive are capitalized initially (Table 2). In a study in Zimbabwe of households affected by the death of an adult female, 24 per cent of the surveyed households sold an asset to cope, with the highest rates in rural areas. The most commonly sold items were cattle, goats, furniture, clothes, televisions, poultry and wardrobe. The dominant reasons for selling assets were to buy food, meet funeral costs and pay school fees (Mutangadura, 2001). Deaths of adults in Uganda and Tanzania led to decreasing ownership of radios and bicycles; households without adult deaths had increasing ownership of these items (World Bank, 1997).

4.2 Altering household composition

The economic shock of the death of a prime-age adult is cushioned by altering household composition. Dependant children may be sent to stay relatives, or an elderly relative or an unmarried uncle or aunt may be invited to join the household in exchange for assistance with farming or childcare. Household composition in sub-Saharan Africa is extremely fluid. Among 759 households in Kagera, Tanzania, 130 household members of all ages died but around nine times as many people left the households and seven times as many people joined the households over a two-year period. During the six months between any two interviews, economically active adults left or joined about 40 per cent of households suffering an adult death and about 20 per cent of households that did not have an adult death (World Bank, 1997).

4.3 Utilizing assistance from other households

An important feature of the social organization of communities in Africa is their interdependence. Traditional strong family ties have been the best social insurance against starvation in Zimbabwe. These ties include regular urban-rural inter-household income transfers. When the crops fail, family members in town bring cash and purchased food to

rural areas. When a family member in town loses a job, they are sent food from the rural areas or are received back on the rural homestead (Thompson, 1993).

Over three-quarters of households in Tanzania received cash or in-kind assistance from other households, especially if there had been a household death. The median amount received during the six months after death (\$53) was more than twice the amount received in the six months prior to death (\$20) or of non-bereaved households (\$21) (World Bank, 1997). In another analysis of the same data, households that had experienced a death received significantly more transfers – more than 36,000 Tsh per capita (\$144) – than those households without a death and continued to receive relatively more transfers in the wave following a death as well (Lundberg and Over 2000).

4.4 Coping responses of children to the impact of HIV/AIDS

In addition to these three household coping responses, children are also involved in coping. In Malawi, children deployed a range of coping strategies, including dropping out of school, seeking paid work to meet their basic needs, and seeking help and support from their own peer networks, neighbours and other families outside of their household for specific needs^x. When hungry, children wandered from house to house throughout the community in the hope that someone would take pity on them and give them food. Others shared tasks in the household with supportive or kind children in order to reduce their workload. Children in rural villages approached supportive family members who were living outside their immediate household. While they might sleep in one house, they would eat, get clothing or school fees and play in different places. This strategy of approaching specific people for specific needs was less apparent in the support networks of children in urban settings, where networks with relatives outside their immediate household were often weak or non-existent. This reflected both isolation from their extended families and closer networks of unrelated people. Many children in urban settings said that relatives did not visit them regularly and that they did not feel comfortable sharing their problems with them. As a result, children relied almost exclusively on family members with whom they lived on a day-to-day basis. When these relationships were difficult or unsupportive, young children turned to friends for assistance with their material requirements, for emotional support such as sympathy and consolation, and for advice and protection from the cruelty of others.

5. Support provided through safety net mechanisms

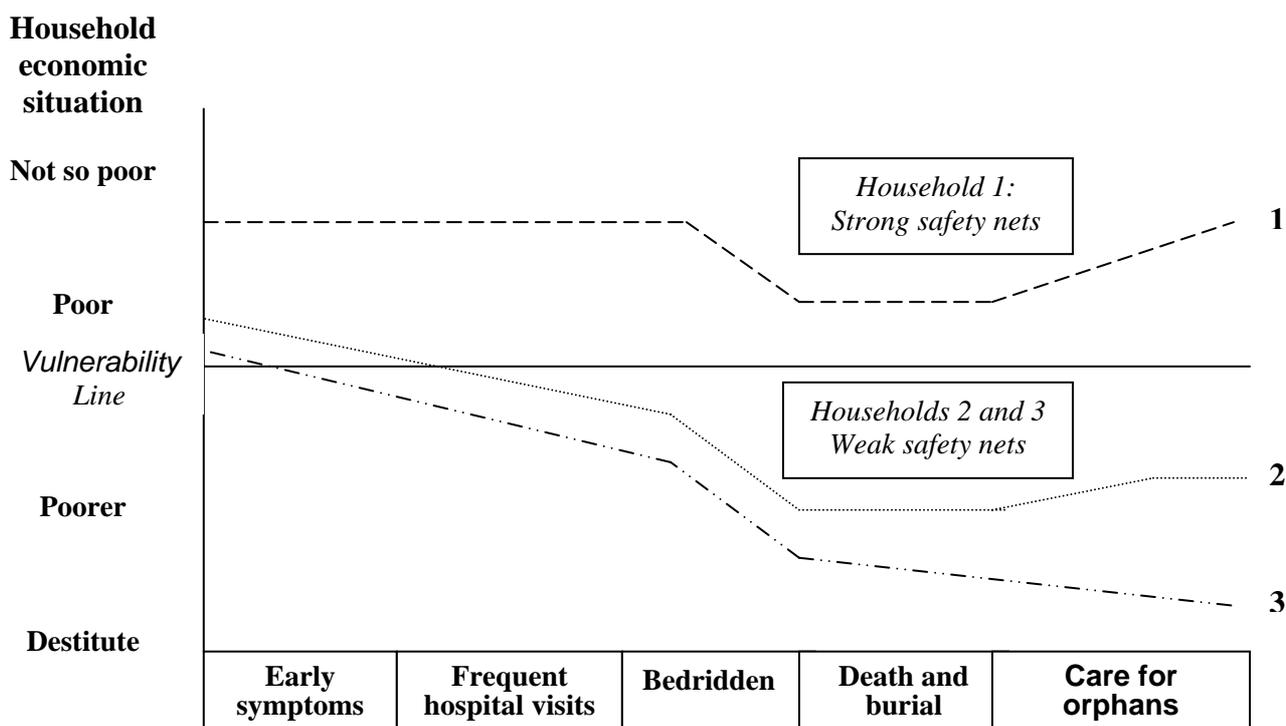
Households draw on their assets and savings to cushion the shock of an adult death. Households with lower levels of assets have greater difficulty coping with the death than households with more assets (Lundberg and Over, 2000). Safety nets help households recover from the impact of adult deaths from HIV/AIDS. Figure 6 illustrates the pattern of economic decline of households with a breadwinner affected by HIV/AIDS by comparing three households^{xi}.

^x This section draws extensively on Mann, 2002

^{xi} Representations one and two are based on descriptions by Ugandan focus group participants of the economic impacts resulting from HIV/AIDS-related illness (Donahue 2005). The representations are illustrative and not based on specific quantitative measurements. A Tanzanian study found that households were surprisingly resilient in terms of economic coping with the impact of premature adult death; expenditure fell by 30 per cent six months after an adult death and had partially recovered ten months after the death (World Bank 1997). These representations have been supplemented with descriptions of potential household situations. In addition, a

Household one has assets and accumulated savings and is able to access support from relatives and community members. As a result, the household economy is maintained until the terminal illness of the breadwinner. After death of the breadwinner, support received through family and community safety nets enables the household to recover from the economic impacts of HIV/AIDS.

Fig. 6: Household economies and HIV/AIDS-related income shocks (after Donahue, 2005)



Household two has fewer savings and assets and receives insufficient support from relatives and the community because of limited access to safety nets. These factors cause the household economy to deteriorate at an earlier stage of illness than household one. Economic decline accelerates during the terminal illness of the breadwinner. Following death of the breadwinner, the household receives inadequate support from relatives and community members and makes only a limited economic recovery. Household two was poor prior to the illness and became extremely poor as a result of the impact of HIV/AIDS. A further crisis might lead to household two sliding into destitution.

Household three has the fewest savings and assets. It follows a similar trajectory to household two initially and receives insufficient support from relatives and community members. Household three is affected by a “compound shock”, such as the combined impact of both HIV/AIDS and drought / famine (De Waal and Tumushabe 2003). The latter shock affects many households throughout the region, not just household three. This “covariate” shock inhibits the functioning of household three’s family and community safety nets. The household receives inadequate support and its economy fails to recover after the death of the breadwinner. It is forced to liquidate its productive assets and with its household members becoming destitute, its members rely on charitable donations. Should this situation persist,

third household scenario has been added, based on De Waal and Tumushabe’s 2003 description of the impact of a compound shock such as HIV/AIDS and drought/famine on livelihoods

the household may be forced to disintegrate with members dispersing to stay with relatives, work for other people or live on urban streets.

5.1 Formal safety net programmes

Governments attempt to alleviate poverty and provide support to households and children affected by HIV/AIDS through a variety of safety net mechanisms. These include employment creation, community development programmes, the provision of services such as free basic education and health care, and family support measures including direct benefits such as feeding schemes and grants. As part of poverty reduction programmes, some states implement social security interventions to protect people from falling into poverty.

State systems

During the past decade, many states have reduced their provision of social services and benefits, often as a result of structural adjustment policies (De La Rocha undated). In most of sub-Saharan Africa, government and NGO social protection mechanisms cover a minority of the population and rarely extend to households facing severe poverty. Formal social security systems in Kenya, Uganda, Malawi and Zambia are rudimentary (Amuyunzu and Ezeh. 2004; Haddad and Zeller, 1996; Kasente et al. 2002; Mukuka et al. 2002). In Tanzania, formal social security systems have declined in the past decade as a result of structural adjustment, so that social protection mechanisms cover only 6 per cent of the population and focus only on a few risks. (Mchomvu et al. 2002); In an urban household survey in Zimbabwe, 6 per cent reported receiving social dimensions fund assistance for health or education fees and none received public welfare assistance (Mutangadura and Makaudze, 2000).

Statutory agencies, such as social welfare departments, lack resources to reach remote rural areas where poverty is often most severe. In a study of 211 needy orphan families in a remote area of Zimbabwe, 83 percent failed to go to the welfare office because they either did not know of its existence or lacked the resources to travel the long distance to the district centre. Only 2 per cent of needy households actually received support (Drew et al. 1996b).

All formal social welfare systems have difficulty ensuring that resources reach those with greatest need, especially under-resourced welfare systems. Government and NGO programs in Tanzania did not target assistance based on households with deaths, nor to the poorest households and neither to households without alternative forms of assistance (World Bank 1997). Food-for-work and supplementary feeding schemes are some of the more effective formal safety net mechanisms and these work best following severe acute crises (Bird and Shepherd 2003).

Of the countries most affected by HIV/AIDS, only three in sub-Saharan Africa (Botswana, Namibia and South Africa) have comprehensive social protection measures for older people, whilst Mozambique operates a cash transfer system targeting households headed by older, chronically sick or disabled persons. South Africa has made significant strides in developing a comprehensive social security system, particularly since the end of apartheid in 1994. Of the 17 million children in South Africa, between half and three-quarters may be considered to be living in poverty (Martin 2003). Family and child benefits in South Africa currently include the Child Support Grant (CSG) and State Old-Age Pension^{xii} (Box 1).

^{xii} In 2003, President Mbeki announced that the maximum age for the CSG would be raised to 9 years and the age would be raised progressively to 14 years by 2005.

Box 1: Pensions and Child Support Grants in South Africa

In South Africa, non-contributory pension programmes reach 1.9 million older people at relatively low cost (1.4 per cent of GDP). The R640 monthly pension (about US\$75) makes a vital contribution to household economies and reduces the poverty gap for pensioners by 94 per cent. Poor households that include pensioners are on average significantly less poor than households without pensioners. “Skip generation” households (comprising child and grandparent), on average, have their poverty gap closed by over 60 per cent. (Dekker 2003).

The main cash transfer supporting children living in poverty is the Child Support Grant (CSG), introduced in 1998. In 2003, it paid a monthly benefit of R160 (US\$20) to single carers with a monthly income below R1,410 (US\$235) for every registered child below the age of 13. The number of beneficiaries rose rapidly to 2.5 million by February 2003. It is estimated that 3.6 million children will eventually receive the grant, about half of all children in these age groups. The means test helps to target the grant to poorer households. In a poor district in KwaZulu-Natal, 36 per cent of children received the grant. The parents of grant beneficiaries were more likely to be unemployed and less educated and had less household assets than families and households of children not receiving the grant. (Barrientos and DeJong 2004).

In spite of increasing state provision, many of those who might qualify in terms of their age do not receive grants because they lack knowledge concerning their entitlement or have difficulty accessing social services. Applicants must present the child’s and parent’s bar-coded identification numbers to their provincial department of Social Development together with proof of guardianship and the child’s clinic card. Yet less than half of South African children have birth certificates. These factors combine with administrative delays in processing grant applications and poor attitudes of administrative personnel cause most families living in desperate poverty to be denied the grants to which they are entitled under South African law (Ewing 2002). The AIDS epidemic is making growing numbers of children eligible for support grants. Yet children affected by HIV/AIDS are less likely than other poor children to be able to access state support. Guardians often do not have appropriate certification concerning informally fostered children. Orphaned children are highly mobile, often moving several times before and after their parents’ deaths, further reducing their guardian’s chance of obtaining child support grants.

In addition, large numbers of the most vulnerable children are “invisible” to social service providers. These include street children, child labourers, illegal immigrants and children living in child-headed households. Though the CSG targets poor children regardless of household arrangements, it requires an adult carer to apply for and collect the grant; minors have no entitlement to receive child support grants on their own behalf. Children living and working on the streets, in domestic or agricultural employment and child-headed households currently receive little if any assistance through statutory child support systems. A study of 771 households affected by HIV/AIDS in South Africa and eligible for at least one kind of government grant found under 16 per cent of households doing so (Steinburg et al. 2002).

Non state systems

NGOs are also involved in supporting households and children affected by HIV/AIDS^{xiii}. In the Kagera region of Tanzania, 11 NGOs operated support programmes for households affected by AIDS. The amount of support provided to households by government and NGOs was less than one third the amount of private transfers and was less targeted towards the poorest households or those with adult deaths (Lundberg and Over 2000); costs of survivor assistance programmes varied from \$13 per child for educational support initiatives to \$217 per household for home care of people with AIDS (World Bank 1997).

NGO programs supporting vulnerable children are small in comparison to the scale of the problem. Civil society, private sector and local government assistance was estimated to reach under five percent of orphans in Uganda. Some programs run only for a year or two, and disappear when donor funding is discontinued. Few programs are sustainable in view of high costs: 61 international and national NGOs supported 61,155 orphans at an average annual cost per child of US\$215; programmes operated by 31 religious groups and 62 community-based organizations had lower costs (US\$121 and \$98 per child respectively) but reached smaller numbers of children (10,100 and 6,300 respectively) (Deininger et al. 2001). Local NGOs in Zimbabwe facilitate support to vulnerable children at lower costs through community mobilization strategies. The Bethany Project enabled 656 volunteers to support 8,004 vulnerable children at an annual cost of around \$2.50 per child. FACT's Families, Orphans and Children Under Stress (FOCUS) programme enabled 142 volunteers from seven faith-based partners to support 6,500 children at an annual cost of \$3-4 per child, with around half the programme expenditure being spent at community level (Lee et al. 2002; Phiri et al. 2001).

5.2 Informal safety nets: Support from relatives and communities

In the absence of large-scale social welfare programs in sub-Saharan countries, most households rely on their own resources and assistance from relatives and neighbors to cope with the effects of AIDS (Ainsworth and Over 1992). Extended family breakdown and increased demands for support as a result of HIV/AIDS have reduced the extent to which the better off can help their relatives. Migration and splintering of families and, in some cases, the establishment of formal safety nets in developing countries have led to weakening of non-formal inter-generational transfers, causing the elderly in particular to become extremely vulnerable (Morduch and Sharma 2001). In Botswana, a government grant of 100 pula (US\$23) for citizens over 65 years introduced in 1997 has upended the long-standing tradition of caring for one's elderly relatives; the elderly placed a higher value on the money and care provided by family than that provided by the state (Livingston 2003).

5.2.1 Nature and timing of informal transfers

Whilst informal transfers from families and community members occur on a continuous basis, family and community safety nets are of greatest value at times of crisis (World Bank 1997). In Zimbabwe, more than 60 per cent of sampled households resorted to seeking help from relatives, friends and neighbours, particularly during hard times. The help sought was mainly in the form of credit (27 per cent), food (25 per cent) and cash in kind (11 per cent). A small proportion of households sought help in the form of clothes (2 per cent) and child

^{xiii} Though NGOs have pioneered the development of programmes in Africa to support vulnerable children, their significance should not be overstated in relation to the considerable but largely undocumented contributions of community members, as in this quote: "It is a matter of growing concern that the vast majority of efforts to support children affected by HIV/AIDS in the southern African region are funded, managed and staffed through the assistance of international and national NGOs." (Richter et al. 2004)

fostering (2 per cent) (Mutangadura 2000). The largest increased costs associated with HIV/AIDS occur during the later stages of the disease and immediately following the death of a breadwinner

In Zimbabwe, extended family and community safety nets provided significant proportions of medical expenses (27-57 per cent of households) and funeral expenses (59 – 85 per cent of households) (Table 3)^{xiv}. For funeral expenses, the main source of payment was individual community members for 44 per cent and burial societies for 10 per cent of households (Jackson, 1994). In rural Tanzania, 45 per cent of funeral costs were provided by individual contributions (World Bank, 1997).

Table 3: Main source of payment for AIDS-related expenses in Zimbabwe

Main source of payment	Respondents stating main source of payment for AIDS-related expenses (per cent)			
	Study 1 (Jackson 1994)		Study 2 (Mutangadura 2000)	
	Medical expenses	Funeral expenses	Medical expenses	Funeral expenses
Affected household: wages, savings, sale of assets, medical or funeral insurance	72	41	43	15
Relatives or friends: gifts or loans	19	54	50	81
Church or government: welfare grants	8	5	7	4

Few studies have examined the sources of financial support for HIV/AIDS-affected households following the death of the breadwinner, or compared the value of support provided to orphan households to the value provided for medical and funeral expenses. In Tanzania, households with an adult death continued to receive increased informal transfers for some time after their bereavement (Lundberg and Over 2000). In Zimbabwe, households affected by HIV/AIDS were only able to access school fees, food and shelter support from their closest relatives since distant relatives no longer contributed (Mutangadura 2000). Amongst 43 mostly double orphan child- and adolescent-headed households in Zimbabwe, less than half received money, clothing, food or school fees from relatives in the preceding year (Foster et al. 1997). In Tanzania, 70 per cent of non-orphans who were in foster care with a relative received support from their parent, whilst 22 per cent of orphans who were fostered by a relative received support from the surviving parent. Less than 10 per cent of orphans and foster children received other support from outside their household. Support consisted of clothing, food, school support and money. No child received support from an organization (Urassa et al. 1997).

5.2.2 Comparison of value of informal transfers from relatives and communities

Many studies do not disaggregate data to determine the relative value of informal transfers from different sources to households affected by income shocks. It is therefore difficult to compare the value of support from family- and community-based sources. A study in Zimbabwe found that 46 per cent and 51 per cent of surveyed households in urban and rural

^{xiv} For the 1994 study, the sample included 15 rural and 26 urban / peri-urban households in which: father died (27); mother died (7); father and mother died (4); father ill (1); mother ill (2). For the 2000 study, the sample included 101 urban and 114 rural households containing orphans where the mother had died in the previous two years. Both samples were drawn predominantly from the same area around Mutare, Zimbabwe

areas respectively had asked for help from relatives, friends and neighbors within the last twelve months. The help sought was mainly in the form of food (maize meal, the staple food) and money. A few households asked for help in the form of clothes, credit and child fostering. Usually the community helps needy households by offering food and clothing and help in ploughing but rarely provides school fees, health fees and rent. Even though the extended family help with food and clothing, sometimes the help is not on a regular basis. Community help is less forthcoming because of inflation, lack of money, high unemployment, and too much commitment as everyone is being affected by the high morbidity and mortality being experienced due to the AIDS epidemic (Mutangadura 2000)

Amongst households affected by female deaths in rural and urban areas of Zimbabwe, the value of support was greater from extended families than from the community (Mutangadura 2000). In urban slums in Kenya, friends provide more support to help households with sick members than relatives (Amuyunzu and Ezeh 2004).

In the case of destitute households, the value of philanthropic support provided by the community may exceed that provided by extended families. In an area of Uganda where 45 child-headed households were heavily dependent on international NGO support, NGOs provided support in 85 per cent of the areas of need, compared with 38 per cent by neighbours and community, 30 per cent by relatives, 9 per cent by government and 3 per cent by local councils. Neighbours provided food relief, other basic necessities like soap and salt and enabled access to medical care. Most CHHs enjoyed a more cordial relationship with their neighbours than with their own kin with whom they had strained relationships, possibly because of property disputes since 29 per cent of CHHs decided to stay living together in their family home in order to protect their land and household property (Luzze 2002). Similar observations were made in Rwanda and this was thought to be as a result of adults and relatives trying to seize land left to children by their murdered parents (Netaid 2001).

6. Components of community safety nets

Community safety nets are vitally important to poor households affected by social or economic crises. Some articles and discussions about coping give the impression that the community safety net is a unified mechanism for which a clear definition and a common understanding exist. But few entities are so crucially important to development yet are so inadequately described or so poorly understood. Grassroots social security systems are diverse, widespread and well established - many mechanisms have been in existence for generations in African societies (Salole 1991). Yet there is in general a lack of studies to assess community safety nets or evaluate their effectiveness in fields as diverse as economic policy, community development, food security, poverty alleviation and HIV/AIDS.

This and the next section discuss the dimensions, mechanisms, strengths and deficiencies of community safety nets. The components of community safety nets will be considered by examining the roles of social support groups, informal associations and self-help groups, as well as community-based and faith-based organizations. The section will also consider the role played by individuals and local businesses in providing support and economic services within communities. The roles of government, non-governmental organizations and micro-financial institutions in relation to community safety nets will be outlined in section 8.

6.1 Community connectedness and cohesion

Poor households are poor not only in terms of income, savings and material assets, but also in terms of their social capital. They have smaller networks of friends, neighbours and relatives on whom they can depend in times of crisis, and are therefore less likely to receive assistance, and receive less assistance, than better-off households (Lundberg and Over 2000). Population surveys indicate the extent to which people have social connections with other members of their community. The significance of social network analysis is that, other things being equal, stronger community safety nets are likely to exist where community connectedness and community cohesion are higher.

Table 4 provides data from two studies detailing affiliation rates to community-level groups in South Africa. Since similar studies have not been conducted for most African countries, affiliation rates for specific community-level groups are included in the discussion below where these are available.

Table 4: Membership of South African grassroots organizations

Organisation	membership (1) (%)	membership (%)	
		urban	rural
Religious group / church organization	38	43	77
Burial society or savings club	23	13	11
Political party	13	NR	NR
Cultural organization	9	NR	NR
Youth organization	9	6	0.2
Women's organization	8	4	5
Trade union	8	NR	NR
Overall participation rate: no groups	40	46	14
1 group	30	30	50
2 groups or more	30	25	36

Notes: Membership rates are (1) average of annual surveys conducted during 1994 – 2000; (HSRC, undated). (2) Survey of 118 enumeration areas in 2003 in Kwa-Zulu, Natal, South Africa (University of Kwa-Zulu, Natal 2004). NR: not recorded.

The affiliation rate data in Table 4 provides an incomplete picture of community connectedness for three main reasons. Firstly, only groups with high affiliation rates and those most relevant to community safety nets that were identified have been listed below. The published studies provide more complete information. Not all groupings are equally likely to contribute to community safety nets. Thus, religious groups and savings associations contribute more support to households in times of crisis than sports clubs and dance groups.

Secondly, whilst it is possible to estimate population affiliation rates to better-established entities such as larger savings groups and visible religious organizations, it is difficult to assess affiliation rates to non-formal groups, especially in rural areas. Smaller informal groups not included in these two studies or in most other surveys include farmer's clubs, gardening clubs, labour sharing schemes, mutual assistance initiatives, agricultural cooperatives, communal grain loan schemes, village committees, independent churches and traditional structures. Many of these groups contribute to community safety nets yet little data on affiliation rates or their contributions to households in crisis is available.

Thirdly, even meticulous household surveys conducted by trained data collectors may fail to document affiliations to grassroots groups. The very intimacy and familiarity that ordinary people have with informal groupings that are so much a part of their social fabric and everyday existence leads to these associations often not being recognized or identified as an integral part of the development process, even by their own members (Foster, 2002a). Under reporting of affiliation rates to philanthropic organizations has been noted due to secondary gain (Luzze 2002).

Another important concept concerning safety nets is community cohesion^{xv}. Communities can be more or less cohesive. The level of cohesion, in this context, can be roughly equated to the level of social interaction and social control exerted among community members. The level of social cohesion in a society determines susceptibility to HIV infection (Barnett and Whiteside 2002a). Debate exists around the impact of the HIV/AIDS on community cohesion. If the epidemic destroys the social fabric, it undermines community cohesion and creates a positive feedback loop increasing its own propagation. If the epidemic generates greater cohesion by rallying people around the response to a common threat, the epidemic may soon reach a self-limiting threshold. Attempts to answer this question are associated with anecdotes and speculation, since it has never been considered important enough to become the subject of systematic enquiry.

6.2 Description of community safety net components

Six broad components of community safety nets may be considered in relation to the support of households affected by HIV/AIDS:

- (1) savings associations to which households in crisis belong
- (2) business and agricultural cooperatives to which households in crisis belong
- (3) loan providers and savings collectors providing services to households in crisis
- (4) philanthropic groups providing support to households in crisis
- (5) philanthropic individuals providing support to households in crisis
- (6) community groups providing support to people affected by HIV/AIDS

The initiatives described under each component are not mutually exclusive. For example, a community home care activity for people living with HIV/AIDS may also incorporate labour-sharing, income-generation activities, orphan care and philanthropic support.

6.2.1 Informal savings associations

There is considerable diversity in the functioning of informal associations associated with economic activities:

a. Savings associations

“Simple” rotating savings and credit associations Rotating savings and credit associations (ROSCAs) are a traditional means by which a group of people helps each other. These associations go by different names, including stokvels (South Africa), merry-go-rounds (Kenya), chilembas (Zambia) and tontines (Francophone African countries).

The basic principles underlying ROSCAs are simple. The group as a whole agrees an amount for each member to save on a regular basis. The cumulative savings of the group are then rotated to each member of the group on a regular basis. After everyone has had their turn in

^{xv} This paragraph draws largely on Decosas, 2003.

receiving the contributions, the group may disband or start another cycle. Operation of ROSCAs and other grassroots membership schemes is not governed by legislation but in accordance with rules agreed by members drawn from local communities.

Recent studies reveal exceptionally high participation rates in ROSCAs. Average adult membership rates ranged from 50 per cent to 95 per cent in the Republic of Congo, Cameroon, Gambia, and villages of Liberia, Ivory Coast, Togo, and Nigeria. Around 40-50 per cent of Tanzanians and 30 per cent of black South Africans are members of ROSCAs. The annual sums mobilized in ROSCAs have been estimated to equal 8-10 per cent of GDP in Ethiopia and half of national savings in Cameroon^{xvi}.

ROSCAs are frequently used to accumulate a lump sum in order to purchase capital items. They are used predominantly by the poor and most members are female. In South Africa, over three-quarters of ROSCA members were women and a quarter were old-age pensioners. The popularity of ROSCAs amongst women may be related to their limited ability to make financial decisions in societies dominated by men. Women use ROSCAs to ensure that money earned within the household is put to productive purposes such as purchasing agricultural products or paying school expenses. By contributing to a ROSCA instead of accumulating at home, wives render their savings illiquid, enabling them to withstand pressure from men to spend accumulated savings on items for personal consumption (Anderson and Baland 2002). Women generally prefer women-only ROSCAs because men are considered unwilling to forego spending available cash for future benefits. Men are not considered trustworthy since they are reluctant to confide details concerning their income to women and are susceptible to spending money on personal consumption items (Verkhoef 2002a).

ROSCAs are popular because they impose few transaction costs on members, build mutual trust, provide insurance and reciprocity that can be called upon in times of emergency, and give members access to a relatively large amount of money that would otherwise be difficult to accumulate. Rural people sometimes make equivalent contributions to ROSCAs in kind, such as food, agricultural inputs, kitchen utensils, etc. In Zimbabwe, savings clubs have been successful in rural areas. Many savings club members were able to keep their children in school and also start new investments more quickly after the rains had come, because of their prudence and the self-help orientation of their clubs. ROSCAs thus play a vital role, both directly and indirectly, in meeting the social security requirements of communal farmers (Madembo 1997).

The African concept of “*ubuntu*”, which means caring for each other’s well being in a spirit of mutual support, is an important underlying reason for membership of ROSCAs and other community associations (Dekker 2001). A South African study found the main incentive for participation in ROSCAs was to establish a social network of trusted acquaintances to assist people with adjustment to the urban environment and replace the kinship networks of traditional areas. It was only after joining savings clubs that many members came to appreciate the strong economic benefits that membership brought (Verkhoef 2002a).

“To me to belong to a stokvel, it is not only a question of saving money. It is also to be with friends and share ideas.”

Ronnie Shibe, Daveyton, South Africa (Verkhoef 2002a)

^{xvi} References are included in Bouman, 1995.

“Developed” ROSCAs Many economic support groups start off as ROSCAs but develop more sophisticated functions that contribute to economic development and social support of households and communities. Whilst continuing to provide savings contributions on a rotating basis to members, many groups incorporate one or several of the following additional roles:

- **Credit (“savings-and-loans”) associations:** These groups accumulate savings that are not paid out to members on a rotating basis; rather, the accumulated fund is utilized as a source of loans to both members and non-members. In the rural areas of Lesotho, there are no formal banking services. Credit associations act as informal banks. Even in urban areas where commercial banks exist, the poor lending practices of banks force people, women especially, to rely on informal credit associations (Green 2000). Interest rates for loans from credit associations vary and may be similar to commercial banks, minimal (as described in Lesotho) or extremely high, (as in “chimbado”, high interest loan clubs in Zimbabwe).
- **Guaranteed group lending schemes (GGLS):** For these groups, the ability to accumulate savings is used as a prerequisite for obtaining a loan from an external organization. The loan may be used by an individual or by the group as a whole, usually for a small business venture. The group guarantees the loan so that if an individual defaults on the loan, the whole group is liable for repayment. In recent years, there has been a gradual shift in policy focus by international organizations away from savings and into micro credit, leading to GGLS strategies being adopted by NGOs and government agencies and the establishment of micro-finance institutions to support GGLS groups (see Box 2).

Box 2: ROSCAs and micro-credit schemes in Zimbabwe (Raftopoulos and Lacoste 2002). Self-Help Development Foundation (SHDF), an NGO in Zimbabwe was established in 1963 to facilitate group savings and income generating activities for small farmers in particular women in rural areas. SHDF provided technical support and had 12,491 savings clubs with 355,000 members by 1998. Initially savings clubs did not depend on any external financial assistance. Their activities were totally based on the savings generated by club members and SHDF provided club members with technical training and savings materials. In 1996, the SHDF introduced a micro credit scheme to its members, enabling clubs to access loans. An assessment of the micro credit scheme noted that its major beneficiaries were better-off households; poor households did not benefit from the scheme

- **Business development groups:** Though not their primary purpose, some ROSCAs provide opportunities for development of business skills by members. As part of its strategy for HIV prevention, Project Support Group in Zimbabwe assisted partner NGOs to establish “single women’s associations”. The groups started as credit associations, developed into GGLS groups and incorporated processes by which members could learn marketing, financial management and specific skills related to established income generating projects from one another.
- **Investment groups:** These accumulate savings that are banked with the common goal of carrying out capital projects, purchasing an expensive large commodity, or investing in a business venture, property, or equity. Participation in investment groups has provided members with an opportunity to obtain “seed capital” to finance small businesses and facilitated long-term investments in capital goods, property, and financial instruments.
- **Insurance cooperatives:** In Cameroon and elsewhere, these provide life and health insurance to members by placing part of the contributions in a fund to be accessed as

grants or loans in the event of sickness or death of members or their dependants (Kaseke 1997).

b. Burial societies

Burial societies are distinguished from other forms of savings association and social insurance mechanisms because of their unique features. In African communities, caring for the dead by means of a funeral is of exceptional traditional and spiritual importance. Burial societies are established because people cannot afford formal funeral insurance schemes and realise that by themselves, they will be unable to meet the expense of a funeral for a relative, especially if the death occurs suddenly and unexpectedly. They are present in large numbers in urban areas but are less prevalent in rural areas and have more sophisticated economic functioning than simple ROSCAs. In some countries such as Lesotho, they are the most popular form of self-help association (Green 2000). A majority of members are women and people in informal employment (Dhemba 2002). In a study of urban households in Zimbabwe, burial societies were named as the dominant informal support mechanism (54 per cent), followed by savings clubs (17 per cent), church clubs (16 per cent), and women's groups (5 per cent) (Mutangadura and Makaudze 2000). A study of 205 people belonging to informal savings associations in informal settlements and middle class residential areas of South Africa found that 47 per cent belonged to burial societies, 27 per cent to pure savings groups, 15 per cent to savings and loan groups and 10 per cent to investment funds.

Societies can consist of a few households living together in a small town, to large organizations involving several thousands of people from different townships in large cities (Box 3). Members contribute both services to the society and money; in South Africa around R30 (US\$5) per month is common. Payments are very flexible, but it is essential that a member be always up to date with payments. Failure to do so may result in non-payment in case of bereavement. Resources are usually kept in bank accounts and are easily accessible. When the death of a family member arises, the member is entitled to claim money and services from the society. As part of the package, burial society members also devote part of their time to assisting the bereaved by cultivating their fields. Some burial societies have assets such as tents, furniture, cooking pots, gas stoves and other utensils needed for feasts and funerals which a member can use free of charge. These may be hired to non-members to generate money for the society. All members help with cooking and other duties (Green 2000)

Box 3: Burial societies in Botswana (Ngwenya 2003)

Three general types of burial societies have been identified: *work-based* burial societies draw members predominantly from workplaces in urban settings; *ethnically-oriented* burial societies also are predominant in urban settings; *communal* burial societies are the oldest and remain the most common type; membership cuts across social and physical boundaries of place (neighbourhood or village ward), occupation, educational level, religious orientation and ethnic affiliation.

On average, burial societies consisted of 55 subscribing members (range 10 – 400), mostly women. They are relatively self-reliant with a monthly subscription usually of P20 (US\$5) (range P5 – P30). Money is deposited in a commercial bank or post office. Each burial society decides how much support eligible recipients get. One society agreed that upon the death of a member or her child, the bereaved family would be entitled to P1500 (equivalent to US\$300), parents would receive P1000 (about US\$200) and a dependent relative would receive P800 (about US\$160).

Burial societies are popular with people living on low incomes because:

- Payments are flexible so that when members have cash flow problems, payments can be postponed to following months without any penalties. Members can choose between weekly or monthly payments;
- Contributions are reasonable as people agree amongst themselves how much to pay. As more members register with the scheme smaller amounts are usually contributed;
- They are not strict on household members to be covered, extended family members staying with paying breadwinner get covered too, and the schemes do not impose age restrictions;
- Money is released quickly whenever death is announced, no death certificate or affidavit is required;
- Bereaved families get more than financial support; they also receive emotional support, help with transport, preparation of food and in-kind donations.

Some burial societies invest contributions to generate more resources, thus they act as lending institutions, mostly to members charging interest. The interest rates charged vary from 5 per cent to 20 per cent of borrowed amount depending on burial society rules. Many societies operate without constitutions, resulting in suspicions of mismanagement or misappropriation of funds (Dhemba 2002). There are several reported cases where leaders steal the funds and flee, leading to lack of trust.

Burial societies are prevalent and are increasing in popularity as a result of the HIV/AIDS epidemic. High levels of adult death have led to many households realising the importance of belonging to a burial society. In a survey of 544 households in rural Zimbabwe, 40 per cent of households affected by AIDS were members of burial societies compared to 22 per cent of households without an AIDS death but with deaths from other causes (Kwaramba 1998). However, increasing numbers of burials has led to reduced payouts by burial societies (Madembo 1997; Rugalema 1999).

Relationship of savings associations and burial societies to community safety nets

The primary purpose of savings associations and burial associations is to enable members to build their economic resources and provide them with social insurance. Membership of informal savings associations appears to be growing (Verkhoef 2002a). A high proportion of the population of many communities in Africa belong to ROSCAs and burial societies, that consequently provide vital services to large numbers of people affected by socio-economic crises. However, socially excluded groups among the poor fare worse under systems of non-formal insurance (Morduch and Sharma 2001).

As organizations governed by constitutions, the role of savings associations in providing support to non-member households affected by socio-economic crisis is limited. Even for member households, responses are restricted to those stated in their rules and regulations. ROSCAs are therefore inflexible and may tie up money that might otherwise be used by households to address a crisis.

Households may proactively join savings clubs to enable access to a lump sum and provide access to loans in the event of likely future death. Membership of ROSCAs in Tanzania by households experiencing adult deaths decreased from 51 per cent to 36 per cent, more than the 41 per cent to 36 per cent decline by households without adult death (World Bank 1997). Following death, affected households probably withdrew from savings clubs and diverted potential savings into consumption to meet basic needs such as food and school fees. Households affected by severe adult illness or death in South Africa saved 36 per cent less than unaffected households (Oni et al. 2002). Households affected by AIDS may drop out of

informal credit organisations, as the impact of HIV/AIDS limits their ability to participate (Harvey 2004).

Nevertheless, though belonging to savings clubs may not provide direct financial benefit following a crisis, membership probably leads to indirect benefits that assist household coping. Membership of the group strengthens reciprocal obligations. Members in crisis are more likely to receive individual financial, material, emotional or labour contributions from other savings association members. These members may also solicit contributions from philanthropic individuals or groups or carry out fundraising activities on behalf of affected households. In addition to revolving credit, some ROSCAs have accumulated group savings that may be accessed by members in the form of loans. These savings may be loaned (or possibly, with the consent of the group, given) to a member facing extreme circumstances such as the death of a breadwinner (World Bank 1997). So joining a savings association may be a form of social insurance in order to qualify for a loan at short notice in the event of an emergency (Matin et al. 1999). Though in general, savings associations may not provide direct philanthropic contributions to affected households, they nevertheless contribute an important strand to the community safety net by strengthening community responses to help savings group members facing severe socio-economic crises.

6.2.2 Business and agricultural cooperatives

Cooperatives are member-owned, member-controlled businesses whose primary function is to enable member households generate an income^{xvii}. Cooperatives may consist of shared business ventures, or more commonly, of endeavours with shared components such as labour-sharing, joint purchasing in bulk or joint marketing of products. As with savings groups, cooperatives may provide safety net functions to members facing social and economic crises. The proportion of the population involved in business and agricultural cooperatives throughout sub-Saharan Africa is unknown, but affiliation rates are probably considerably less than ROSCAs or burial societies.

a. Agricultural cooperatives

According to the International Cooperative Alliance, there are 24,000 farmers' cooperative associations in Africa with 10.4 million members (Tafirenyika undated). Some rural cooperatives have become extremely lucrative; in Cameroon, the Common Initiative Group of Women Farmers promotes the cultivation of local crops, especially cassava. The group has been so successful in producing, processing and marketing cassava that it has been able to finance a school, a library, a processing plant to produce cassava flour and a communal kitchen, as well as to purchase medical supplies.

In savings cooperatives in Zimbabwe, members hold a pre-savings meeting to decide what they want to save for during a twelve-month period; they then decide on their requirements for seed, fertilizer and insecticides, which are ordered in bulk to benefit from quantity discounts (Madembo 1997).

Labour-sharing schemes in Zimbabwe have been in existence a long time. Similar schemes function in Tanzania where villagers assist by helping to cultivate one another's fields (Mukuyogo and Williams 1991). In Zimbabwe, the practice of loaning livestock, especially oxen, for draught power and of crop sharing whereby people without land are loaned land to cultivate for a given period of time are becoming less prevalent but are still practiced in

^{xvii} Independent cooperatives run by their members should be distinguished from state-supported rural enterprises that are established and controlled by government and para-government entities and are common throughout sub-Saharan Africa (Rouse, 1996; Tafirenyika undated).

isolated parts of the country as “society’s welfare policy” for the benefit of the poor (Marongwe 1999).

“Men are men. When one of the men’s beards sets alight, the others rush to extinguish it”
Zimbabwean proverb encouraging mutual assistance at times of crisis

In Tanzania, there is a long tradition of social support groups based on the wide-scale cooperative movement established in the 1950s and 1960s. These cooperatives provided economic and social protection to members so that poor peasants could sell their crops even in years of bad world market prices. The services provided by cooperatives, like education and trusteeship for peasants who took out loans, collapsed when the government abolished cooperatives in 1976. They were reintroduced in 1982 but, due to their abolition, they had lost capital, personnel and members. Current cooperatives are much weaker than the pre-1976 ones and cannot provide the same kind of protection they once did. Cooperatives still have a great potential for social and economic protection but change in government policy on cooperatives is needed to strengthen them. (Mchomvu et al. 2002).

In Zambia, traditional social security systems were destroyed by colonial and post-independence governments. Many of the poorest and most vulnerable people in urban and some rural areas are members of market associations and savings groups that provide non-formal social security (Mukuka et al. 2002).

Cooperatives assist households on a continuous basis but are especially valuable at times of crisis such as household illness when affected households are unable to carry out agricultural activities; members of the cooperative may provide labour to help in the affected person’s fields. The spontaneous pooling of community labour resources is a coping mechanism in response to HIV/AIDS by which farmers sustain the supply of labour and get their land farmed despite rising impact of HIV/AIDS within their families (Rugalema 1999; Cornia and Zagonari 2002).

b. Business cooperatives

Business cooperatives are primarily established as a means of income generation. These may in addition contribute to community safety nets by providing loans to affected households at times of crisis. Some business cooperatives have been established primarily as informal social security networks. In South Africa, a group of almost 200 pensioners meet in the local police station to do sewing, handcrafts and baking, which they sell in order to raise money. They have been running this scheme without financial support for four years. (Dekker, 2003).

6.2.3 Loan providers and savings collectors

People facing severe economic crises frequently obtain loans to enable them to cope. As well as credit associations (see 6.2.1) several other groups and individuals provide people with loans, or provide informal savings schemes. These constitute another important strand of the community safety net:

a Savings collectors

Savings collectors are individuals who act as financial intermediaries, collecting money from depositors' and keeping it safe for a small fee; they are particularly common in Africa (Matin et al. 1999). Savings collectors in KwaZulu-Natal do not pay interest to depositors whilst itinerant deposit collectors in Nigeria charge depositors who wish too withdraw part of their savings. Savings collectors may be more trusted than formal banks. This facility is used by people who are unable to open bank accounts because they do not meet the necessary

requirements. Many savers live in a cluster with the savings collector being a landlord, for example people living in a hostel. There is usually a very close and personal relationship between the collector and clients, hence communication between the two is easier and benefits both parties. (Moyo et al. 2002). They are popular because:

- Of convenience as collectors visit them at their premises;
- There is no need for complicated information as required by formal institutions
- Any amount can be deposited;
- Collectors can provide sources of credit to savers in emergencies

b Reciprocal lending arrangements

Obtaining a loan from friends or relatives is the oldest form of lending or source of credit. It is also one of the commonest financial transactions for many poor people. The principle of “reciprocal lending” is reinforced by regular, mutual lending of small amounts of money, foodstuffs or fuel (Matin and Sinha, 1998; Matin et al.1999).

Whenever people are in need of cash urgently, they usually first turn to people they are closest. There is an element of reciprocity in such borrowing - one would help a friend, neighbour or relative in time of need because they would be expected to return the favour in the future. Amounts lent are small - in South Africa, usually less than R500 (US\$80). Most people felt that this method of lending was losing popularity due to the frequency of failure to repay which led to quarrels and hence loss of trust (Moyo et al. 2002). Households affected by severe adult illness or death in South Africa were significantly more likely to borrow from relatives but were less likely to borrow from banks and burial service agencies than unaffected households (Oni et al. 2002). In a study in urban areas in Zimbabwe, informal borrowing was the commonest coping response to income shocks (21 per cent), higher than use of savings, informal activities or remittances from family members; 45 per cent of households with a chronically ill patient and 27 per cent with a household death stated informal borrowing as their main coping response to decreased income (Mutangadura and Makaudze 2000). Most loans in the informal sector in Malawi are free of an interest charge, even when given by socially distant lenders such as traders (Chipeta and Mkandawire 1991). Lending of implements and livestock is also practiced.

c Unregistered moneylenders

Unregistered moneylenders specialise in short term loans (usually 30 days) charging high interest rates. They are most prevalent in urban areas lending mostly to people whose ability to repay can be verified. Lending is relationship based, with clients gaining reputation as they build a clean repayment record. The largest proportion of clients consists of people who have jobs or are self-employed.

Pawnbrokers use durable goods as collateral against money that they advance to individuals in need of short-term funds to finance emergencies, or short term cash flow deficiencies. Interest rates are lower than moneylenders and advances are made against the pledged item. The borrower has up to three months to reclaim their item by paying off the advance, or else they forfeit the pledged item that is sold off. Registered and unregistered moneylenders and pawnbrokers are unlikely to be used by the extremely poor because of their lack of security and assets. .

When we are stranded and have no food we borrow money from Kaloba [a 100 per cent interest rate credit facility run by individuals]

(Mutangadura et al. 1999)

d Registered money lenders

Within South Africa, there are nearly 1,300 registered money lenders including banks, credit card providers and micro-finance institutions. Their operations are governed by legislation to protect borrowers from usurious interest rates. Small loans (under R10,000 or c. US\$1,600) are governed by special legislation. According to the Microfinance Regulatory Council the majority of micro lender loans are small (69 per cent between R1,000 and R6,000) and are utilised for emergency and consumption finance (Moyo et al. 2002)

6.2.4. Philanthropic group initiatives

a. Grain saving schemes or community gardens

Grain-saving schemes have a long history in Africa's rural areas, and for many years have been used to cater for the requirements of needy people in the community. In Zimbabwe, grain-saving schemes have been revitalized as an adapted form of a traditional practice called "the chief's field" in response to the orphan crisis (Madembo 1997; Ncube 1998). People in the community contribute labour in the field of the chief or headman, and store the produce that is donated to households in need when it is needed. These schemes form an important source of community support to affected households but suffer from lack of agricultural inputs and poor community mobilization (Dhemba et al. 2002; Mutangadura, 2001).

b. Traditional, benevolent and mutual assistance associations

Uganda has one of the most undeveloped formal security systems in Africa. In some districts, village residents' mutual assistance groups are compulsory for all adults. These groups are currently the most widespread and effective of all groups, though they are plagued with poor management and a low capital base (Kasente et al. 2002). Informal women's counselling groups and impromptu meetings have sprung up, where women assist each other in the plantations, caring for the sick and relieving the care giver. Neighbourhood women appear unannounced to weed and trim the banana gardens of a woman who is ill. The women have persuaded local Resistance Councils to solicit outside help for orphans and some have assumed the responsibility of caring for children in their homes. Informal counselling sessions enable women to share their experiences and concerns (Barnett and Blaikie 1992). "Munno Mukabi" refers to informal mutual self-help groups, a traditional practice that is seeing renewed popularity as a result of the impact of AIDS. One such group helped look after 102 orphans staying with very elderly relatives or on their own; the groups enable social and economic support activities as well as recreation (UNICEF, 1991). These associations are particularly useful in responding to periodic but unpredictable risks related to death, sickness, and celebrations that can impose significant financial pressure on households (Wright et al. 1999; Moyo et al. 2002).

In Tanzania, villagers often assist one another by helping to cultivate one another's fields. At times of special need such as sickness and funerals, or on occasions such as marriage ceremonies, they contribute labor, money or food to one another (Mukuyogo and Williams 1991). Residents of many villages have launched associations specifically to help families affected by an AIDS death. Most are operated by women and involve visiting orphans, widows and the sick and regular meetings at which members make contributions in cash or food. Some villagers provide labour to assist in the repair of dwellings and the rehabilitation of farms or equipment (Lwihula 1999). Mutual aid groups in rural areas cover almost every contingency, whilst those in urban areas cover specified risks (Mchomvu et al. 2002).

In Malawi, community groups concerned over the number of children not attending school responded in two ways. First, they visited surviving parents and/or guardians to impress upon

them the importance of education to the future of the children. Second, they discussed what they, as community members, could do to make it possible for more children to go to school. One solution they developed was to identify volunteers to take over children's tasks or assist their families with other household work. Often this was enough to allow the parent/guardian to manage their income needs without sacrificing education. In other cases, the community group supplied material help, such as school uniforms, which freed up household resources that could be used for schooling. (Donahue 1998). Village AIDS committees organised "big-walks" sponsored by businesses or individuals with proceeds being added to a community fund which was used for school fees and support of the destitute (Williamson and Donahue 2001).

In Zimbabwe, a program implemented by the Department of Social Welfare assisted 15 local chiefs in two districts to strengthen traditional support activities and income generating activities in response to the impact of AIDS on children. The chief in each area established a committee made up of traditional leaders who in turn mobilized community members through regular meetings and village committees headed by traditional heads of villages. Some of the areas had established one or more of the following activities (Matshalaga 1997):

- Grain-saving schemes
- Collections of maize meal and money from community members to purchase blankets and meet educational needs such as fees, uniforms and shoes, books and pens/pencils
- Labour assistance such as helping orphan households by ploughing fields, collecting firewood, thatching dilapidated shelters, moulding bricks, growing vegetables, cooking meals and caring for young children to allow child heads-of-households to attend school
- Mobilising financial and material assistance from church groups and NGOs for clothing, food and school fees
- Community-level income generating projects; these however were generally ineffective.

In Kenya, it was the responsibility of the community to ensure that children were supported by their relatives; if this did not happen, community feeding schemes provided food at central places to ensure that no one in the village, including orphans, went hungry; this centrality was also functional when it came to identifying desperate cases in the village for communal action; children who were forced to go looking for assistance outside their village were a source of embarrassment to their family and neighbours (Nyambedha et al. 2003).

Group businesses are considered to be risky endeavours that have enormous difficulties generating significant profits and that frequently require more management skills than a community can offer. In addition, the time and effort necessary to achieve the desired profits consumes members' time, which is then not available for the initial goal of helping vulnerable households (Donahue 1998).

c. Fundraising initiatives

Some community-based organisations fund their activities through one-time fund-raising projects that do not interfere with their livelihoods. These include (Donahue, 1998):

- Engaging in paid labor and donating the wages to those in need or to the organization
- Fundraising raffles, sponsored walks, entertainment shows, soccer matches, bake sales
- Soliciting contributions from community members (see 6.2.5c below)

d Community schools

In several countries in sub-Saharan Africa, local communities administer informal schools. They charge no fees, require no uniforms, provide almost all educational materials and use local teachers, often on a voluntary basis and mostly unqualified. Community schools are established because extremely poor households are unable to send their children to formal

schools because they cannot afford school fees, uniforms and equipment. Community schools are an important part of the safety net because they enable children from extremely poor households to receive a basic education with little financial outlay by their families. Their numbers have increased dramatically in some countries and the age of enrolment is decreasing, suggesting that poor families are using community schools as a parallel education system. In Zambia, there were 38 such schools catering for 6,600 children in 1996; by 2001, the number had mushroomed to 1,149 catering for over 140,000 children (Ministry of Education 2002). Community school students performed better than their counterparts at government schools in all sections of a competency test (Landis 2003).

e. Faith-based organizations

At community level, faith-based organisations (FBOs) are increasingly establishing support initiatives to assist households affected by HIV/AIDS and play a major role in supporting those who are extremely poor. Over 90 per cent of churches and mosques surveyed in a six-country study had activities to support orphans and vulnerable children and over one half of the initiatives were established in 1999-2002. Support was normally extended to community members "on the basis of need and not creed" (Foster 2004). Church organizations in urban areas of Zimbabwe provided clothes, counseling and spiritual support, mainly for AIDS-affected people, destitutes and children orphaned by AIDS (Mutangadura and Makaudze 2000). Surveys of households affected by HIV/AIDS frequently mention congregations as one of the few sources of ongoing community support.

In Namibia, a survey of 109 FBOs found that 26 per cent had fully-fledged HIV/AIDS programmes, 33 per cent a developing response, 28 per cent a minimal response and only 13 per cent had no response. Lack of trained persons was the main reason for limited responses. Amongst the 72 congregations with a response, spiritual support was provided by 76 per cent, counseling by 68 per cent, orphan support by 46 per cent, home-based care by 45 per cent, material assistance by 22 per cent and income-generating projects by 13 per cent. The main reason for involvement by volunteers was because of seeing sick neighbours and orphaned children (Yates 2003) (see also 6.2.6).

Box 4: Poverty and hopelessness in Zimbabwe

The Harare-based Samaritans organisation, which used to deal with hundreds of suicide emergency calls a month, has been hamstrung by the soaring cost of phone calls - phone boxes no longer work because hyperinflation has rendered coins worthless. A counsellor at the Samaritans said that many people are finding they cannot face the poverty - and are giving up altogether as money-related crises drive them to suicide. "Their spirits are broken by poverty," she said. "They give up and do not call us."

Many elderly people deliberately kill themselves by refusing to eat. Meanwhile children and teenagers are also driven by despair when their families are unable to pay fees that range from US\$0.60 a term at government primary schools to US\$12 at secondary schools. Some young girls buy anti-malarial tablets or steal pesticides, hoping for a swift end but die after suffering weeks of agony as their liver and kidneys are destroyed. "In the rural areas women hang themselves, or pour paraffin over themselves and their children and set themselves alight," says the counsellor. "In town they turn to poison. Families pretend it was an accident to try and avoid the stigma and the expense of rituals to propitiate the spirit."

(BBC News, 29/9/04, quoted by Hartnack, M, ZW News)

6.2.5. Individual philanthropic responses

Individually, community members make significant contributions to the welfare of households facing severe economic difficulties in sub-Saharan Africa. Many of these contributions are in-kind, consisting of labour, food or other material assistance. Contributions are often sporadic and spontaneous, in response to a particular need or as a result of a chance meeting. It is difficult to estimate the monetary value of individual responses.

Community safety nets are much more than economic coping mechanisms. Psychosocial and spiritual support provided by individuals and associations are as important as the provision of relief assistance and enabling households facing crises and poverty to cope (Box 4). Neighbours and friends spend time visiting households affected by HIV/AIDS and provide moral support and encouragement, advice on how to overcome problems and training in areas such as agriculture, household management and income generation.

a Funeral support

Throughout sub-Saharan Africa, funerals are events that bring members of families and communities together in solidarity. Households largely rely on contributions from friends and family. Bereavement is the crisis most likely to move the community safety net into action – more than major illness or lack of food. While contributions are generally voluntary, in some instances, a fixed amount is levied or expected from the immediate neighbors, those who live on the same plot or those who go to the same church with the deceased or from members of self-help groups (Amuyunzu and Ezeh 2004).

In rural Tanzania, 45 per cent of funeral costs were covered by gifts from other households (World Bank, 1997). In Zimbabwe, the single greatest source of financial support for funeral expenses was from contributions of individuals. Rural families relied most heavily on funeral contributions, often their only source of money. The amount collected was often small (US\$25 to \$30) and was used to buy food for mourners but was not sufficient to purchase a coffin. Family provided funeral support for around one third of rural respondents and burial societies around one fifth. Churches were also of assistance. Rural families provided more help with funeral expenses than better-off urban and peri-urban families that provided very little support (Jackson 1994; Chamlee-Wright 2002).

b. Provision of employment

Many households hire labour to assist with agricultural work; in rural Tanzania, roughly one-third of households reported hiring labor in the previous 6-12 months, mainly for strenuous tasks of clearing land (Beegle 2003). Sharecropping is a practice whereby the fields of someone else are cultivated; it allows the poor to access to seed, fertilizer, draught animals and skills of those that are better off. In Lesotho, it is a coping strategy of those that had average or below-average incomes, with land belonging to those who had above-average or average incomes (Green 2000). Working for others is an important coping strategy that people do when they have with little or no productive capacity on their own. In Burkina Faso extremely poor people sought informal paid employment after exhausting other coping strategies but before being forced to rely upon charity (Sauerborn et al. 1996). When households disintegrate, older children and young adults sometimes end up as low-paid domestic servants or agricultural labourers, receiving only shelter and food.

The importance of informal employment to rural economies is demonstrated in a Kenyan study. This found that for each better-off household affected by chronic HIV/AIDS-related illnesses, the food supply of five or more poor households diminished. As more of the better-

off household's resources are spent on medical care, fewer people are hired to help the affected household in agricultural and household enterprises (Narayan 2002). Informal employers may be more willing to employ those who are facing destitution, though the degree to which this decision is based on exploitation or involves philanthropy and subsidization is unknown.

c Provision of money or other assistance

Individuals frequently provide support to extremely poor households in the form of loans (see 6.2.3 above) and donations of money. The provision of financial support to those affected by crises is common in both rural and urban areas of Africa under certain circumstances. In informal settlements in Nairobi, Kenya, death of a neighbour or friend almost always led to a financial contribution being given; major illness often led to the provision of support, whilst shortage of food was seen as something that everyone suffers so led to little support being given, except for dire emergencies. Food support, unlike contributions to the bereaved or those suffering major illness, is provided by other community members as a charitable donation out of sympathy and is not obligatory (Amuyunzu and Ezeh 2004).

Individuals may become responsible for fund-raising on behalf of needy families. Those affected by crises are less likely to be successful in raising money on their own behalf. Community participation in fundraising for hospitalization increases when friends or neighbors take the initiative. In informal settlements in Kenya, friends were thought more likely to contribute than relatives. In order to obtain such support, it is important for those affected have good friends. Strategies often adopted for fundraising during funerals include going from door to door throughout the community and neighboring areas to ask for donations or playing music to attract people so that they could contribute towards the funeral. This general fund-raising strategy is known as "harambee" (pulling together).

6.2.6. Groups providing support to adults and children affected by HIV/AIDS

As well as modifying existing coping mechanisms, communities have also developed specific responses to cope with the impact of HIV/AIDS. These contribute another important strand in the community safety net by providing social, psychological, economic and spiritual support for people affected by HIV/AIDS:

a Support groups for people living with HIV/AIDS

A study from Zimbabwe provides an overview of what may be typical of support groups elsewhere in Africa. The study surveyed 150 support groups that had 2,509 members. Two-thirds of the groups were in rural areas and over a third were formed in the previous year. Two-thirds of the groups were small with 5-15 members and there was no difference in size between newly formed and older groups. Most groups were actively recruiting new members. Though membership was open to everyone in the community affected by HIV/AIDS most support groups consisted of women; nearly half required a membership fee. About one-third of the groups were hosted by an NGO or a hospital, mostly faith-based organizations; 90 per cent of the groups were affiliated, mostly with ZNNP+, the national network body for PLHA. The survey probably under-represented independent support groups.

The main source of revenue for support groups was membership fees; only five groups received external funding. Two-thirds of groups had an annual budget and this was under Z\$10,000 (US\$250) for all but four of the groups. All relied exclusively on volunteers and the main aim of the groups was to serve group members and help them live positively. The commonest reason for joining a group was participation in income generating activities, followed by access to counseling, participation in public education, access to material support

and access to home care. The failure rate of income generating projects was high, most commonly because of lack of access to capital (SAT 1999)

b Home care initiatives

It is difficult to estimate the number of home care initiatives established by communities and faith-based organizations in Africa but some writers describe the informal community home-based care movement as “an explosion”; community initiatives have emerged to fill the “care gap”, without external support, and in most cases, without systematic attempts by government structures to accelerate and support their development (Ogden et al. 2004). In Uganda, informal women’s counselling groups and impromptu meetings have sprung up, where women assist each other in the plantations, care for the sick and relieve the care giver (Barnett and Blaikie 1992). By 1993, there were at least 67 home care projects in Zimbabwe and by 1996 there were over 100 such initiatives in Zambia (Blinkhoff et al. 1999). These support chronically ill people in their homes and provide relatives, the main caregivers of the sick, with training and encouragement. Many initiatives provide spiritual support, food, clothing and money to help with rental payments.

Some initiatives are extensive, well-organised and cost-effective. In Zambia, the Ndola Catholic diocese helped churches and community members to mobilize over 500 volunteers. The area has 23 townships with a population of some 400,000 people. By 1998, over 10,000 patients received home care and coverage was estimated to be 78 per cent of chronically ill patients. The cost of the programme was around \$5 per patient with over half the money being spent on welfare support (food, clothing, blankets and bed sheets) or drugs and equipment. Other contributions by community members to households with chronically ill patients included practical help such as cleaning the house, washing clothes, fetching water, collecting firewood and cooking meals (Blinkhoff et al. 1999).

c Support initiatives for orphans and other vulnerable children

Community groups in Africa do not commonly establish children’s homes or institutions as responses to vulnerable children without external influence. In the past, it has been uncommon for community members to recognize the need for a specific response to vulnerable children. Instead, support has been provided to vulnerable households that care for such children through existing community safety net mechanisms. A completely new component of the community safety net developed during the 1990’s in response to the impact of HIV/AIDS on children. When key informants in Ugandan villagers were asked to state the problems affecting people in their community as a result of HIV, the three commonest problems identified were the large number of orphans, lack of child counseling and guidance available to parents, and reduced household income (Bolton and Wilk 2004).

In northern Tanzania, an early study found seven groups were established between 1987-91 to assist orphans and families affected by HIV/AIDS, providing home-based care, food and educational and health care assistance (World Bank 1993; Mutangadura et al. 1999). A study of 690 faith-based organizations in six countries found a proliferation of responses to orphans and vulnerable children (Box 5; Table 5). These were established largely in the absence of significant external facilitation or financial support, and though many community responses to-date are small scale and localized, many are expanding.

Box 5 : Proliferation of responses to orphans by religious groups

During 2002/3, research teams in Kenya, Malawi, Mozambique, Namibia, Swaziland and Uganda surveyed what religious groups are doing to meet the needs of orphans and vulnerable children (OVC). Interviews were conducted with 690 faith-based organizations, mostly churches, mosques and religious coordinating bodies. The scale of the response was staggering - over 90 per cent of surveyed FBOs engaged in activities to support OVC. Over 9,000 volunteers supported more than 157,000 OVC in 397 FBO initiatives. Most initiatives were established recently, and involved community-based activities such as spiritual, material, educational and psychosocial support. Responses were initiated after seeing growing numbers of children going hungry, lacking adequate clothing, out-of-school, lacking spiritual or parental guidance or exploited, abused, raped or pregnant. The organizational capacity of congregations in terms of governance and financial accountability was on a par with many larger NGOs. But few received significant external technical or financial support and of necessity were forced to rely on their own resources and skills. Many congregations indicated their only source of support was contributions by members of their congregations. This reflected the motivation of religious groups who commit their own time and resources to ensure the future well being of vulnerable children (Foster, 2004).

The cumulative impact of large numbers of local initiatives is significant. In the long run, affected communities are better placed to provide appropriate support and deal with complex social issues of children affected by AIDS than external agencies such as the State or NGOs.

Table 5: Community-based orphan support activities of faith-based organizations

Type of response	% FBOs	Description of responses
Religious education and spiritual support	90+%	spiritual support to families and children through scripture reading, religious instruction, prayers, singing and encouragement to attend worship.
School assistance	73%	school fees, levies, uniforms, equipment, books and boarding fees
Material support	62%	essential material support such as food and clothing to individual children from destitute households
HIV prevention	51%	increased awareness of HIV and moral guidance for children.
Visiting / home care	39%	volunteers identify needy households locally, regularly visit and provide parenting, advice, household supervision, meal preparation, dwelling maintenance, assistance in household agriculture or income generation, and home care supervision for HIV/AIDS patients
Psychosocial support	32%	counseling to children; psychosocial support group activities; experiential learning
Medical care	30%	enable children to access essential medical support through the provision of medical fees, medicines and transport costs.
Income support and generation	19%	income-generating projects to produce food and cash; preparation and distribution of school uniforms; agricultural projects at various levels to increase output; labour sharing; credit schemes for funeral benefits
Vocational training	15%	apprenticeship and training in marketable skills for orphaned adolescents; nutrition gardens, husbandry projects, manufacturing co-operatives, buying-and-selling initiatives, carpentry, dressmaking.
Day care centres	11%	care and food during the day for pre-school children, often whilst caregivers are working to enable women to work in or outside the home
Community schools	5%	non-formal education facilities for out-of-school children.
Fostering promotion.	3%	encourage fostering and adoption by non-relatives of orphans

7. Analysis of community safety nets

7.1 Do community safety nets really exist?

Community safety nets are indistinctly characterized and data on their extent, functioning and effectiveness is lacking. Some studies have found little evidence of significant assistance from community members and associations for extremely poor households affected by economic crises. It is therefore important to discuss whether community safety nets are as prevalent in sub-Saharan Africa as suggested in the preceding discussion.

A situation analysis of orphaned children in Namibia commissioned by the Ministry of Health and Social Services concluded: “virtually none of the respondents reported receiving any material assistance from community organizations or community members outside their own extended families” (UNICEF 2001). A survey in Uganda studied assistance provided to 1,292 persons who had been sick, around one quarter of illnesses being AIDS-related. Of the primary caregivers interviewed, 91 per cent stated they received no help from others, 5 per cent received support from relatives or friends, 3 per cent from health units and 0.6 per cent from an AIDS service organization (Ntozi 1997b). In Tanzania, less than one quarter of orphans received support from the surviving parent and less than 10 per cent received support from other relatives or elsewhere; no child received support from an organisation (Urassa et al. 1997). If these were the only data sources, they might lead one to conclude that support provided by community members to households affected by HIV/AIDS and orphans is minimal or non-existent.

By contrast, some practitioners believe that, given the scale of the AIDS epidemic in Africa, it is remarkable that relatively few children appear to have slipped entirely through family and community safety nets; this and their observations of community support have led them to conclude that community safety net support to orphans is prevalent throughout sub-Saharan Africa (Foster, 2002a; Foster, 2002b). There is a clear discrepancy between studies that have documented extensive community support for vulnerable children and others that have found little evidence for such support. Some of the reasons why studies have failed to find evidence for community support to extremely poor households include:

- Community support in some studies is included as “private informal transfers” and is not differentiated from support provided by relatives.
- Studies may fail to ask appropriate, specific questions concerning community support.
- Support received from individual community members may be under-recorded if contributions consist of small loans or gifts.
- Respondents may fail to mention non-financial contributions from community members
- Support may have been provided some time previously or at particular times of crisis
- Respondents may misunderstand questions related to the meaning of community support, especially if studies fail to probe respondents’ answers.
- Respondents and researchers may be biased in OVC studies and situation analyses. Potential beneficiaries, relatives and community level respondents may fail to disclose details of informal transfers because of “secondary gain”, especially if interviewers are from outside the community and organizations conducting studies are seen as potential donors. In a survey of child-headed households in Uganda, most respondents claimed they had received very little assistance from the church. It was only after further probing that correct responses were obtained (Luzze 2002). Some external agencies have little interest in documenting community contributions as lack of existing support justifies their service delivery role.

In view of these inconsistencies in field studies, there is need to carefully design specific studies to document the value of financial, material and non-material transfers by community members to households suffering social and economic crises.

7.2 Extent and effectiveness of community safety nets

Safety net support appears to be more easily accessed in rural areas where traditional structures and customs are maintained and community connectedness is higher. But deprived inner-city areas do not necessarily suffer from a lack of social cohesion or a depleted store of social capital (Cattell 2001). Community safety nets in impoverished urban environments have been established more recently and have not been documented in as much detail. A Zambian study found orphan household prevalence rates in excess of 70 per cent, suggesting clustering of orphan households in extremely poor areas (McKerrow 1997); it is difficult to visualize how safety nets operate in such impoverished environments.

Box 6: Child-headed households on commercial farms in Zimbabwe (Walker 2002)

A survey found evidence of low-level support being provided to 17 destitute child-headed households by community members on commercial farms in Zimbabwe. All the families except one were double orphans and there were 47 children. All but one of the households had poor living conditions; eleven families, including three of mixed gender, lived in a single room. Eleven households were headed by a boy and six by a girl. Two households had no contact with or knowledge of living relatives.

Most children were able to complete primary school but then were often forced to drop out because of lack of school fees. Five children raised their own fees, five had fees paid by a government social fund, three by an NGO and two by the farmer; no children were given free places by the schools. All households suffered food shortages; ten relied on casual work to obtain food and seven on food given by neighbours and friends. Two families regularly went a whole day without eating. Most of the children had ragged clothing and five households had no blankets. Eleven families relied on clothing given by community members or others. Four children reported sexual abuse against them. Over two-thirds of the children said their births were not registered; 14 (30 per cent) had birth certificates, necessary for secondary school admission and claiming public welfare assistance, but some certificates were kept by relatives.

Farm health worker volunteers and community members were the main source of help for the children. Only six families felt they could ask community members for financial help. All the respondents stated that many in the community were worried about the children. Help from the community came mainly in the form of visits by neighbours and volunteers. One respondent gave the children work in return for food and clothing and another stated the children received financial help from the community. Several expressed the guilt they felt by visiting the homes of the children without being able to offer material help.

Despite their crippling poverty, community members in Kenyan slums extended support to others faced with serious problems that went well beyond what might be considered general or commonplace. The traditional norm of reciprocity together with the expectations and obligations of mutual aid which it engenders have to some extent survived even in the difficult environment of informal settlements (Amuyunzu and Ezeh 2004). In peri-urban informal settlements, commercial estates and resettlement areas where traditional leadership structures are weak or non-existent, newer forms of support have evolved as solidarity mechanisms for those facing social or income shocks (Box 6). In urban settings, people have joined ROSCAs, burial societies and churches, partly in an attempt to recreate traditional communities but also as forms of social insurance.

Community safety nets seem to be better developed in some countries like Uganda and Tanzania, and to be weaker in other countries such as South Africa and Rwanda that have been affected by social dislocation, civil strife and urbanization. Community connectedness

surveys serve as a proxy for community cohesion and the strength of safety nets but comparative data on connectedness is not available. Informal coping strategies often fail when problems arise abruptly or are extreme (Amuyunzu and Ezeh 2004). Where poverty is widespread informal systems struggle to cope. Safety nets seem to work best during harvest times when the better off can redistribute to less fortunate neighbours and relatives.

The poorer a household is, the more reliant it becomes on informal transfers for its survival. Some poor households in Uganda, especially if they were female-headed and lacked support from an estranged husband or his family, drew 70 per cent of their livelihood from relatives and friends (De La Rocha undated). Many studies do not differentiate the source of informal transfers, making it difficult to assess the value of transfers to poor households through community safety nets (Box 7).

Box 7: The magnitude of informal transfers and their effect on poverty reduction

For those countries where data exist, private transfers (both household and community) account for between 2 and 41 percent of income for net receivers and between 1 and 8 percent of income of net givers. The bulk of informal transfers flow from older to younger households. Poor and vulnerable households are more likely to receive private transfers, while non-poor households are more likely to give private transfers. Informal transfers are generally weak in facilitating risk management by households, particularly for covariate (widespread) risks. Indian transfers amounted to less than 10 percent of the size of income shocks in bad periods. Following the 1984 drought in the Sahel, transfers comprised less than 3 percent of losses for the poorest households. There was little evidence that transfers offset income shocks in the Burkina Faso droughts in the 1980's. But in more "normal" circumstances, informal insurance is more effective; 40 percent of South African households either give or receive private transfers; the level of transfers is relatively high for net recipients (37 percent of income) and the transfers tend to go from young to old individuals. Transfers largely address low-frequency shocks (like aging and chronic health problems), not the sorts of high-frequency shocks considered elsewhere. While the reported transfers are far from ubiquitous, they do appear to matter for a substantial minority of households.

(abridged from World Bank, undated: article refers to secondary sources)

Traditional informal transfers are most concentrated at those times when households affected by HIV/AIDS face the greatest acute income shocks such as terminal illness and around the time of the funeral. This is also the period when social and economic impacts of HIV/AIDS on children are most severe (Gilborn et al. 2001; Sengendo and Nambi 1997). Unlike formal safety net mechanisms, informal support can be mobilised rapidly and is targeted to needy households facing crises. Since the timing of informal safety net support is appropriate, it allows households to arrest their downward livelihood trajectory and avoid coping strategies that are detrimental to their long term survival (Fig. 6: Households one and two).

Some households (such as household three in Fig. 6) continue their downward trajectory, possibly as a result complex income shocks (De Waal and Tumushabe 2003). No household data is available on the value of transfers taking place to survivor households following the death and funeral of the breadwinner. But it seems likely that community members recognize that some extremely poor households are at risk of destitution during this chronic phase of household economic decline. The widespread and spontaneous emergence of community initiatives for vulnerable children, including children affected by HIV/AIDS, often involves large components of parenting, protection, psychosocial and spiritual support in addition to economic and material support and this mix of assistance appears to represent an appropriate blend of material and psychosocial response to the situation.

7.3 Important strands of community safety nets

It is hard to gauge the strength of informal safety nets (Haddad and Zeller 1996); it is consequently difficult to determine which strands contribute most to community safety nets. Analyses of the value of safety net assistance by different sources within communities are scanty, variable and inconclusive. In a survey of urban centres in Zimbabwe, 21 focus groups considered informal social support mechanisms. Churches, burial societies and rotating savings and credit associations were considered to be the most important groups (Table 6). In another study from Zimbabwe, friends and neighbours contributed more frequently to households affected by maternal deaths than churches, savings clubs or burial societies (Mutangadura, 2000). Many groups do not provide support to people on the basis of need, without regarding whether affected households are members of their own identity group. Churches are most frequently mentioned as providing support to non-members, though some congregations limit material support to members.

Table 6: Local social support mechanisms in Zimbabwe ranked by importance

Rank	Major urban areas (35-50% poor)	Small towns (43-46% poor)	Growth points (83 – 89% poor)
1	Burial Societies	ROSCAs	Churches
2	Churches	Churches	Burial Societies
3	ROSCAs	Burial Societies	ROSCAs
4	Women's clubs	Political party affiliations	Political party affiliations
5	Support from friends / relatives	Crime and prostitution networks	
6	Crime and prostitution networks		
7	Political party affiliations		

Recent articles have identified appropriate situations for specific interventions that might strengthen community safety nets (Table 7 after Donahue, 2005; De Waal and Tumushabe, 2003).

Table 7: Appropriate situations for interventions to strengthen community safety nets

Type of intervention	Areas for intervention	HIV/AIDS household situations	Economic situation
Micro-enterprise service provision	Well-served by markets	* orphan households, caregivers well * HIV-affected households, caregiver well	* with productive capacity * is somewhat vulnerable and vulnerable to poverty (not-so-poor, and poor)
Savings schemes or savings-led credit initiatives	Remote rural areas	* with chronically ill adult who is not head of household	* has some productive capacity but unwilling to absorb debt * is vulnerable or very vulnerable to poverty (poor and poorer)
Advice/ guidance and training, possibly with small grants		* orphan households with able-bodied members	* little or no productive capacity (extremely poor; destitute) * could be productive (may have sold off assets to cover expenses)
Philanthropic community groups / individuals (temporary or permanent)		* with chronically ill individual who is head of household * orphan household headed by child, elderly or disabled	* little or no productive capacity (extremely poor; destitute)

In view of their importance in supporting vulnerable households, there is a need for studies to measure the extent and strength of components of community safety nets, the degree to which they function in adverse social environments and an analysis of factors that strengthen them.

7.4 Access by households in need to community safety nets

Some groups have limited access to informal social support, putting them at higher risk of destitution. The following household types are more likely to be reliant on community support than others: households in which both the head and the spouse are chronically sick; households in which the head is chronically sick; and households headed by single elderly females (Haddad and Zeller 1996). Other groups that may be at heightened risk of destitution include:

The poorest

Many social insurance mechanisms such as burial societies and savings clubs have membership fees and monthly contributions that are out of reach of those who are extremely poor. Less than half the population are members of economic support groups and non-members are more likely to be poorer. Nevertheless, the poorest often establish mutual support systems or rely on informal borrowing at times of crisis as safety net mechanisms. It has been suggested that a point of economic crisis or hardship is reached beyond which reciprocity between households ceases (Gillies 1998). In view of the lack of ability of the poorest (such as the elderly, the disabled or child-headed households) to reciprocate, they may be excluded from informal support mechanisms. There is need for studies to assess access of those that are extremely poor to community safety nets (Amuyunzu and Ezech 2004).

“Outsiders” and female-headed households:

Within communities, there may be “insiders” and “outsiders” with different degrees of access to community safety nets. Insiders include those that are better established, having lived in their community many years, or having moved into their spouse’s community as a result of marriage. They have a developed network of relatives and friends and are well integrated into community structures and associations. Outsiders may have migrated into the community relatively recently in search of livelihood, been ostracized as a result of breach of local mores or stigmatized because of HIV/AIDS. Amongst Zimbabwean female-headed households, insiders were members of women’s cooperatives who were better off, middle-aged, widowed and married women who socialized with the influential and wealthier members of their community. Outsiders were younger women who were divorced, never married, widowed, migrants and refugees. Nevertheless, outsiders were able to establish social networks among themselves and turned to each other, or sometimes other neighbours or members of their churches, if they were in need of food or childcare (Juliusdottir 1994).

The poverty rate among South African households with a female head is 60 per cent, compared with 31 per cent for male-headed ones. Female-headed households are more common in rural areas. Households headed by married women are better off by virtue of remittances and income from their husbands. Households headed by divorced, never married, and, to a lesser extent, widowed women are particularly poor. They may also receive fewer informal transfers because of exclusion for cultural or social reasons (Juliusdottir 1994).

People stigmatized by HIV/AIDS or other causes

People that are blamed, ostracized or stigmatized by communities are at greater risk following social and economic crises as they may receive little support from community members. The following groups are at increased risk:

- *People affected by HIV/AIDS* may receive little support if their illness is deemed to be retributive, leading to judgmental rather than supportive responses. Stigmatisation leading to lack of support to households affected by HIV/AIDS may occur during chronic illness and persist after death. However, judgmental responses towards children affected by HIV/AIDS by religious groups were rare (Foster 2004). A UNAIDS study of community responses found that in spite of negative perceptions of people with HIV/AIDS, what was striking across all study contexts was the care and support provided for and by household members (Aggleton and Warwick 1999). Orphaned children of women sex workers are at particularly high risk of slipping through community safety nets (Njoroge et al. 1998). In Uganda, women with AIDS received less support from relatives and friends than women with other illnesses; for men, the reverse was true (Ntozi 1997b).
- *Households deemed to be “bewitched”*: if household members are deemed to be responsible for misfortunes within their community by traditional healers or community members, they may be ostracized by community members leading to lack of involvement in community activities and less support from community members.
- *Households headed by those who are alcohol-dependant* may receive less support if private donors consider their support might be used to purchase alcohol. In some households, informal transfers are limited during the illness of an alcohol-dependant person but increase following the death of the affected alcohol-dependant individual.

The elderly and disabled

HIV/AIDS is placing a great burden on the elderly who are caring for orphans and vulnerable children. This comes at a time when their capacity to earn an income is compromised by age and infirmity. The elderly are more vulnerable than younger populations, as demonstrated by the fact that most extended family transfers occur on an age basis from the younger to those older in many developing countries (World Bank, undated). It is unclear how easily households headed by the elderly and the disabled access support through community safety nets.

Children and youth

Youth, like the elderly and disabled, are less likely to participate in public safety net activities such as micro-credit programmes, or participate in ROSCAs and burial societies. Philanthropic strands of the community safety net target transfers to households with vulnerable children, increasing their income, but this often still remains extremely low.

Children in Kenyan slums and rural areas of Malawi that were hungry or out-of-school were particularly likely to receive support from community members (Amuyunzu and Ezeh 2004; Donahue, 1998). Christians in Zimbabwe started church-based orphan initiatives after seeing children going hungry, without school fees, lacking adequate clothing, exploited, abused, raped, pregnant, neglected or living alone (Foster et al. 2002). Child-headed households in Uganda had a more cordial relationship with neighbours than from relatives and also received more significant support from them (Luzze 2002). Community members that come in contact with children in difficult circumstances seem more likely to provide support than to adults in similar circumstances. Though reciprocity is an important factor underlying community safety net functioning, it may not be the most important principle; child-headed households often receive philanthropic support from community members but are unlikely ever to repay private donors. Simple humaneness, religion and philanthropy may be more important motivations than reciprocity when considering community safety net responses to the destitute. This runs counter to the theory that if contributions to those facing crisis seem

unlikely to be reciprocated, as with the extremely poor, private donors replace gifts with loans (Lundberg and Over 2000).

7.4 Occasions for and methods of accessing community safety nets

Few studies have considered the occasions that lead community members to provide support to orphan households and how such support is accessed.

Informal transfers are more likely to occur on occasions when households face serious social or economic crises^{xviii}. Death of a household member is the most important precipitating event leading to community contributions; traditional religion has in the past contributed to supportive responses towards the bereaved by reinforcing beliefs that ancestral spirits of the departed need to be appeased or else this might result in misfortune to unsupportive community members. Major illness is another occasion on which community support is provided to affected households. Neighbours in slums in Nairobi were not willing to assist households affected by minor illness but assisted households affected by major illness by providing contributions for hospital fees, transportation for patients and food. Food support was not normally provided by community members since so many people suffer hunger. But in cases of destitution, where people were incapacitated by extreme hunger, an exception was made and households were provided with food to prevent people starving to death. Unemployment and food shortages during widespread famines were not found to be associated with increased community contributions (Amuyunzu and Ezeh 2004).

Some other crises that have occasionally been noted to lead to philanthropic contributions include: children dropping out of school; health crises; collapse of dwellings; property grabbing or theft by relatives or burglars; and severe food shortages.

Methods of accessing community safety nets

Several mechanisms of accessing support have been described:

Asking or begging friends and neighbours

In a study of urban households in Zimbabwe, 69 per cent asked for help in the previous twelve months, from relatives (67 per cent of cases), friends (17 per cent) and neighbours (17 per cent). Help was requested in the form of credit (42 per cent), food (39 per cent), money (17 per cent), looking after children (3 per cent) and clothing (2 per cent) (Mutangadura and Makaudze 2000). Among those experiencing maternal deaths in Zimbabwe, households asked for support from relatives (33 per cent), neighbours (11 per cent) and friends (4 per cent), mainly in the form of food or money. Rural households asked for help from neighbours six times more often than from friends (Mutangadura 2000). Households in rural Burkina Faso affected by adult illness sought assistance from community members after sequentially exhausting other coping strategies (savings, asset sales, borrowing and wage labour) but prior to “doing nothing” and “being on the verge of calamity” (Sauerborn et al. 1996).

It is difficult to differentiate precisely between “asking” and “begging” as exact meanings are language-dependant. Begging food from friends was noted as a survival strategy for poor rural households in Lesotho faced by crop failure; this occurred at an earlier stage in their coping responses - after using up money from their agricultural activities but before selling off their livestock or becoming indebted - than for less poor households: (Green 2000). Orphaned children in Malawi begged food and clothing from their neighbours (Mann 2002).

^{xviii} This section draws extensively on the work of Amuyunzu and Ezeh, 2004, in informal settlements in Nairobi, Kenya,

Collections on behalf of needy households

In Kenyan slums, friends of the deceased raised money for bereaved households by setting up funeral committees and organizing dancing parties. These activities indicated social adaptation to cash-based urban environments. The suspicious nature of informal settlement dwellers called for members to be cautious in their dealings so that genuine need is not interpreted as extortion for funds. Fundraising is organized by friends, rather than family members, because then there is a greater likelihood that target households are genuinely in dire need (Amuyunzu and Ezeh 2004).

7.5 Changes in community safety nets as a result of HIV/AIDS

Existing social insurance and community safety net mechanisms to cope with poverty are being modified as a result of HIV/AIDS. In addition, new initiatives are proliferating. The following mechanisms and initiatives (described in section 6) have been noted:

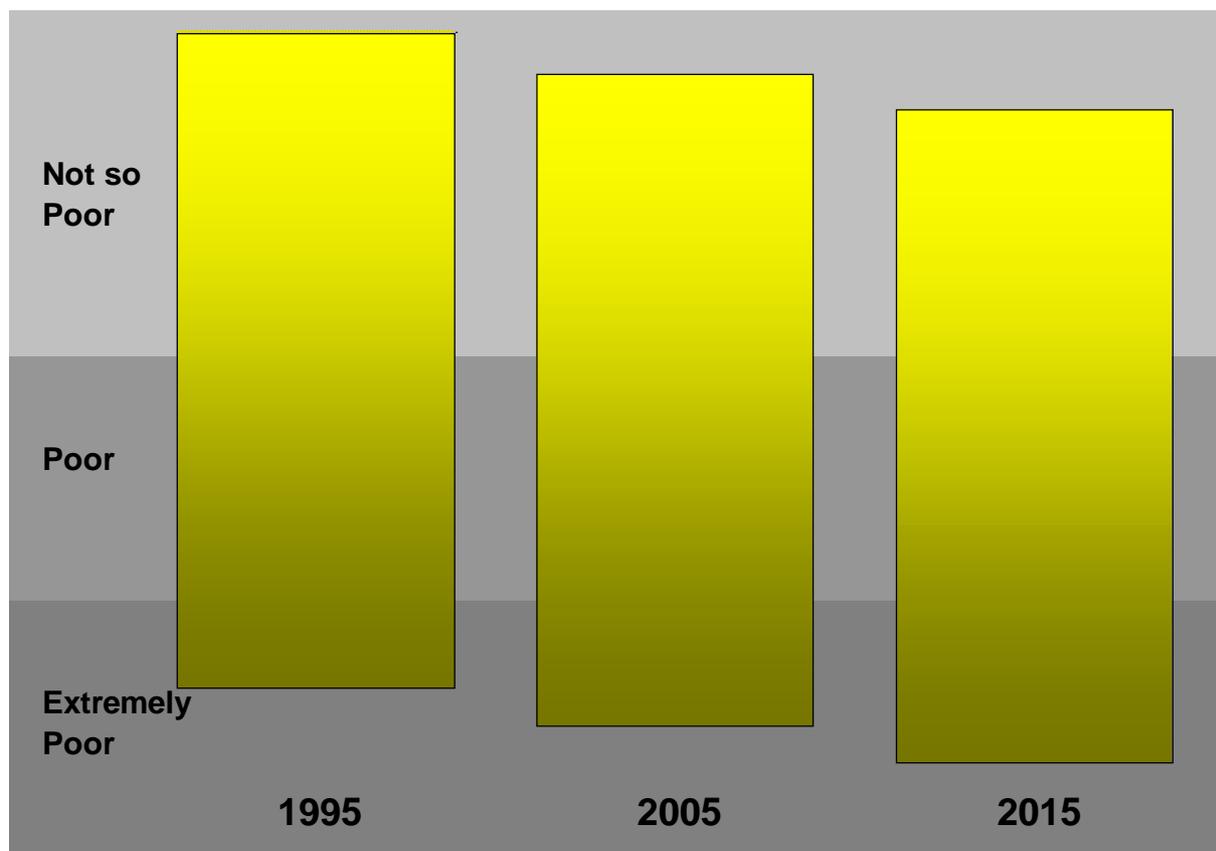
- Burial societies and saving associations are increasing in popularity. AIDS-affected households are especially likely to be members of burial societies
- Pooling of community labour to help prepare and plough fields is increasingly practiced
- Grain saving schemes have been revitalized by rural communities to assist the poor
- Mutual support organizations are being established to support households affected by HIV/AIDS
- Increasing involvement of faith-based organizations in establishing community-based responses for households affected by HIV/AIDS
- Increasing establishment of support groups for people living with HIV/AIDS

The myth of fragile coping mechanisms

The HIV/AIDS epidemic is imposing economic burdens on extended families and communities. Figure 7 is a notional representation of the deteriorating economic situation for a country with a severe HIV/AIDS epidemic. The number of households experiencing extreme poverty and destitution is likely to increase as a result of the impact of AIDS. At the same time, the number of better off households is likely to decline, weakening the capacity of community safety nets since fewer resources are available.

This raises the question of whether communities are likely to break down completely and community safety nets collapse as a result of the impact of AIDS. For over a decade now, experts have discussed the impact of HIV/AIDS on communities. For many, the discussion of community coping is framed purely in terms of their fragility. The collapse standpoint is frequently reinforced by situation analyses that fail to examine responses at family, household, village or community level. The predetermined viewpoint of external agencies assumes (and thereby reinforces) the belief that traditional coping mechanisms of poor communities are fragile. The quotations in Box 8 are representative of articles discussing community coping. None of these articles analyse trends that demonstrate community collapse and few present the valid alternative viewpoint that communities are resilient and are responding to the situation through modifying or establishing innovative coping mechanisms.

Fig. 7: Notional impact of AIDS on communities^{xix}



Little evidence has been adduced that convincingly demonstrates that community safety nets are breaking down or that communities are collapsing as a result of HIV/AIDS. School enrolment rates for orphans have remained robust in many countries in Africa with the worst HIV/AIDS epidemics. Southern African countries with the most severe HIV/AIDS epidemics have significantly fewer malnourished or working children than other regions of Africa (Monasch and Boerma 2004). A household study in Zimbabwe found similar rates of primary school enrolment and completion rates in orphans and non-orphans with orphans whose fathers died and double orphans having the highest completion rates (Nyamukapa et al. 2003). The proportion of children living and working on the streets varies enormously between different countries in sub-Saharan Africa but changes in their numbers bear little obvious relation to community safety net failure as a result of the impact of HIV/AIDS. A survey of all 300 street children and their guardians in Mutare and Bulawayo, Zimbabwe found the commonest reason for being on the streets was ill treatment by guardians (Mawoneke et al. 2001), an AIDS-related factor due to increased fostering but having no obvious direct bearing on failing community safety nets. Child-headed household prevalence is a poor indicator of community safety net failure since it may be positively associated with the degree of support provided within communities (Luzze 2002; Foster et al. 1997).

^{xix} “Not so poor” is in comparison to the poor and extremely poor. In Africa, four out of five people spend less than US\$2 a day, a level of consumption that suggests that even the “not so poor” are poor (Chen et al. 1994)

Box 8: Predictions of the collapse of communities and safety nets as a result of AIDS

“Because of the way that infection is clustered in families, occupations and geographical areas, the impact of multiple illness and death is much greater than the accumulated individual losses. Households and communities can quickly cease to be viable social or economic units.” (UNDP 1993):

“Community adjustment to economic crises depends on the material well being and coping ability of the community; communities have a certain threshold beyond which they break down.” (Moser 1996; Amuyunzu and Ezech. 2004).

“As the growing number of children losing parents to AIDS overwhelms fragile social safety nets...” (Henry, 2000).

“Institutional innovations such as “children’s villages” are recommended where orphans are numerous and community coping has reached its limits.” (Subbarao et al. 2001).

“Community capacity in coping with orphans is near braking point” (Desmond and Gow 2002).

“The growing pressure on kinship and neighborhood ties could lead to the erosion and eventual exhaustion of the relationships of mutual help, solidarity and social exchange that constitute a critical safety net for poor households” (De La Rocha undated).

“What we are seeing today in a number of countries of sub-Saharan Africa is an epidemic that is overwhelming the coping resources of entire communities...” (UNAIDS / WHO 2002)

“...over time, “community” is destroyed or dramatically altered. Although the government’s intervention programme attempts to address the physiological stress caused by the AIDS epidemic, it has not yet begun to address psychological and sociocultural stress on the scale needed to prevent cultural collapse” (Daniel, 2003; Richter 2004).

The HIV/AIDS-related community collapse scenario is based almost entirely on anecdotal evidence. Destitution that might be expected to follow in the wake of collapsing community safety nets would likely lead to migration and household disintegration. But political instability, war and urbanisation are more acute and potent factors causing weakening of safety nets than HIV/AIDS yet have received considerably less attention. Recent large inflows into informal peri-urban settlements (“slums”) have more to do with political and social crises such as the displacement of commercial farm workers in Zimbabwe and civil war in northern Uganda than community safety net collapse due to HIV/AIDS.

One of the problems associated with the notion of AIDS-related community safety net collapse concerns its conceptualization. The safety net illustration is drawn from a circus artiste slipping on a high wire. If the safety net is effective, the artiste’s fall is arrested. If the net is ineffective, the artiste’s descent is unchecked and he plunges into the ground. But the community safety net, unlike its physical equivalent, is not a unified mechanism with an all-or-nothing response to catastrophe. The community safety net does not collapse when it is over-stressed, leaving its strands shredded and the net ineffective. It accommodates increased demand by reducing benefits and rationing support, in just the same way as burial societies, one of its constituent parts, are adapting to the impact of HIV/AIDS. Safety nets are likely to continue to function, albeit at reduced levels of support per unit of demand, even when burdened by large numbers of households facing destitution.

But as well as being stressed by increased demand, communities are also responding to the HIV/AIDS crisis by adapting existing components of the safety net and developing new mechanisms. Using physical imagery, they are repairing damaged strands of the net and inserting new ones. Contrary to the notion of collapse, the evidence of past community coping and the present experience of grassroots responses has led some experts to conclude that the HIV/AIDS disaster may ultimately portend more, not less community cohesion (Ankrah, 1993; Decosas, 2003).

It should be added that the much-heralded “resilience of the poor” has its limits and we need to question analytical models based on the assumption that individuals that are poor can continually adapt to changing conditions and still survive. Such analyses frequently underlie oppressive economic policies and strategies of government and intergovernmental agencies. Recent evidence suggests that the economic burden of the HIV/AIDS epidemic is being shifted largely to the informal sector, with increasing social security, health and education provision by communities through safety nets, unlinked community care, traditional health care systems and community schools. There is need for increased government involvement in social service provision, especially through the provision of free basic health and education services for children, which could dramatically reduce demands on community safety nets. There is little evidence to date of African governments adapting to the HIV/AIDS epidemic through their recognition and support of community home care initiatives and the likelihood of governments supporting poorly characterized community safety nets appears less likely.

8. Strengthening community safety nets

Governments and NGOs have utilized considerable resources in establishing formal safety nets with only partial success in targeting those with greatest need. Yet the outstanding features of community safety nets are that they effectively target households in greatest need, respond rapidly to crises, are cost efficient, are based on local needs and available resources and involve the specialized knowledge of community members. Their main limitations are that they rely for the most part on women who already work long hours and they lack material resources. The few analyses that take into account the role of informal safety nets do so from the negative perspective of how to reduce their “crowding out” by public safety net mechanisms. Despite the fact that the informal sector is the lifeline for large numbers of extremely poor households, there is little evidence of systematic attempts by resource and policy organizations to strengthen community safety nets. Some reviews have concluded that institutional capacity strengthening is not critical for informal private safety net activities (Mathauer 2004). Governments, NGOs and international agencies could do much to strengthen community safety nets that provide poor households affected by HIV/AIDS with their most significant support. Limiting government social policy to government social security may cause other forms of social security to be undervalued and under-utilised.

8.1 The role of governments and the state

Government departments have an important role to play in establishing enabling environments in which community safety nets operate. Most African governments have done little to develop an understanding of community safety nets or put programmes in place to strengthen the provision of support by communities to the destitute. In some cases, governments have undermined community coping mechanisms. In 1976, the government of Tanzania abolished cooperatives that had previously been functioning effectively (Mchomvu et al. 2002). Governments have set up their own cooperatives but many are inefficient and unsuccessful. In the past decade in Zimbabwe, the government’s grain loan scheme failed to recover most of its loans, undermining the functioning of community-owned grain-loan

schemes. In Rwanda, government-run initiatives mobilize the population to engage in voluntary community action in monthly community-based work programmes; consequently, there are few spontaneous community initiatives and control of the population may have contributed to the genocide. In contrast with schemes operated by the private or not-for-profit sector, micro-credit programmes operated by governments frequently have low repayment rates, undermining private micro-credit schemes.

Governments have ultimate responsibility for ensuring the provision of basic needs to citizens that fail to access support from other sources. The principle of subsidiarity is based on a bottom-up model of concentric subsidiary groups (households, extended families, friends and neighbours, voluntary associations, NGOs, the private sector and the state). Each group should support sub-ordinate groups in fulfilling their tasks and only assume those tasks that none of the sub-ordinate groups are able to perform. Governments should play a complimentary role to subsidiary groups by:

1. establishing a sound framework for self-help initiatives (liberal regulation, rule of law, empowerment)
2. supporting traditional and self-help groups in their risk-management efforts wherever possible
3. directly engaging where group-based strategies fail

8.2 The role of donors, non government organisations and international agencies

International relief efforts to care for children affected by HIV/AIDS have unwittingly undermined families and communities, often because aid workers lack information about pre-crisis childcare networks and instead respond according to their own culturally based assumptions (Verkhoev 2002b) (Box 9). Donors and NGOs, along with governments, could play an important role in strengthening the functioning of community safety nets. To date, there have been few systematic attempts to do so other than the development of micro-financial initiatives. Even here, many initiatives have concentrated on better-off individual borrowers; few programmes have sought to build the capacity of existing burial societies and ROSCAs and strengthen the provision of their safety net functions to poor households facing income shocks.

The most sustainable and cost-effective efforts to protect, support, and assist households made vulnerable by AIDS are those initiated and carried out by grassroots community groups. Local people and communities have shown commitment by investing themselves and their resources to help those affected by AIDS. Many of these initiatives are now looking for external sources of support. They need access to greater amounts of capital than can be obtained through local fund-raising. Yet mechanisms to deliver small project grants combined with appropriate technical support to community groups are rudimentary or non-existent. Planners should design projects that develop the skills the community groups need to carry out these activities, mobilize community participation and ensure a sustainable source of funds rather than projects that implement the activities themselves.

Box 9: Community safety net undermined by external support (Luzze 2002)

In 1999, a disturbing case of a child-headed household (CHH) of ten children under the care of a twelve-year-old was reported. An elderly grandmother who could no longer cope with ten orphans had abandoned the family. The orphans were living in a very abject state and slept on a bare dusty floor, in a mud and wattle house that had collapsed on one side. Prior to the project's intervention, the orphans had struggled to survive, mainly by collecting firewood and growing sugarcane for sale. The NGO project's response to the family included providing relief food, beddings, medical care, counselling, planting materials and the construction of a new house. A survey was conducted and eleven other CHHs in the project area were identified. But after a few months of intervention in these families, assisted households tended to become dependant on the project for even the smallest of basic needs. Community members referred to orphans in CHHs as "*World Vision's children*". Over time, even sympathetic neighbours withdrew their support from CHHs.

The World Bank plays an important role in advising governments, inter-governmental organizations and international agencies on the design of public safety net mechanisms. Increasingly, international agencies are recognizing the need to support community-based social care services. World Bank lending for community-based social care grew cumulatively from US \$33.4 million in 1985 to over US \$1.6 billion by 2000 (World Bank undated). The emphasis of the World Bank in relation to informal safety nets has been on the extent to which formal programmes crowd out (displace) informal transfers. There have been no major studies to define community safety nets, examine their value to extremely poor households, or determine the extent to which public safety nets undermine existing informal systems of self-help and encourage a culture of dependency among the poor. There is need for studies to determine how community safety net mechanisms can be incorporated into public safety net programmes.

9. Research gaps

Whilst the effectiveness of many formal safety net initiatives has been evaluated, there have been no large-scale studies to assess how community safety nets assist the poor. Little empirical data has been collected concerning informal transfers at household and community level or how safety net functioning has changed as a result of the impact of HIV/AIDS. The significance of contributions by community groups and individuals to the survival of households has been overlooked, largely because conceptualization of HIV/AIDS programming has been from the perspective of industrialized countries. As a result, mitigation programmes established by external agencies not only fail to support community coping – some of them undermine informal social support. The following are some of the most pertinent areas for which research is needed so that programmes can be designed to strengthen community safety nets:

- i. What is the relative magnitude of support provided by families and communities to poor and destitute households during terminal illness, at the time of death and following the death of the breadwinner?
- ii. What are the comparative amounts of support provided by extended family members and by community members? Do these amounts differ according to the degree of poverty of affected households?
- iii. What are the most effective components of community safety nets in different contexts?

- iv. What is the relative importance of reciprocity and philanthropy as motivations underlying community safety nets? Is a point of economic crisis or hardship reached beyond which reciprocity between households ceases?
- v. What proportion of households that disintegrate following the death of the breadwinner do so as a result of lack of economic support from relatives and community members? What happens to members of households following disintegration?
- vi. Why do some households fail to receive support through informal transfers? In particular, how important are: stigma due to HIV/AIDS; cultural reasons relating to marriage and inheritance; and religious and moral value judgments?
- vii. Are some types of household in particular danger of not receiving support through informal transfers?

At the moment, the role played by community groups remains largely invisible to agencies supporting vulnerable children in sub-Saharan Africa, under the radar of donors, government departments, international NGOs, micro-finance organizations and local NGOs. Research could help external agencies recognize and understand the role played by community groups in supporting extremely poor households affected by HIV/AIDS. Toolkits need to be developed to assist external agencies to map community safety nets in different contexts depending on types of government, cultural environments, religious situations and urban, peri-urban and rural settings. It is imperative that model programmes become established to strengthen community safety nets through building the capacity of groups such as churches, women's groups, savings clubs and burial associations that are the most important strands of community safety nets.

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