STRENGTHENING NATIONAL RESPONSES TO CHILDREN AFFECTED BY HIV/AIDS: WHAT IS THE ROLE OF THE STATE AND SOCIAL WELFARE IN AFRICA?

BACKGROUND PAPER FOR WILTON PARK CONFERENCE NOV 14TH -16TH 2005

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Acknowledgements

Many people assisted in the organisation of the Conference and the production of this paper. Special thanks are due to the Wilton Park Steering Group comprising Stephen Devereux, Francie Lund, David Hulme, Mandy Heslop, Mark Gorman and Jane Falkingham who helped to set the agenda for the meeting. Various others provided help and advice at various stages, including Ros Eyben, Malcolm Ridout, Arjan De Haan, John Gledhill, Jocelyn De Jong, Sarah Atkinson, Tony German, Claire Shakya, Karen Moore, John Lonsdale, Keith Hart, Wenzel Geissler, Valerie Leach, Hamish Young, Winfrida Koroso, Rozanne Chorlton, Robin Milton, Stephen Kidd, Joe Lugalla, Egen Chalala, Samson Tandike, Ben Mganga and Donald Chawe.

The paper was produced under contract to UNICEF as background to the meeting. The views presented in the paper are solely those of the author and do not represent the views of UNICEF or any other agency or individual. I am grateful to Peter McDermott, Miriam Temin, Ting Shen and Megan Cornwell for their insights and assistance.

OVERVIEW

Introduction

HIV and AIDS have been a feature of global society for less than one generation. The social and economic impacts of the virus and the disease it causes have been unprecedented in intensity and scale. The majority of people infected with HIV live in low-income countries. HIV and AIDS are strongly associated with poverty and inequality (Farmer 1999; Baylies & Bujra 2000). Rates of infection are rising fast in India and China, along with economic growth. More than 60% of all people living with HIV globally, some 25.4 million, reside in sub- Saharan Africa. In 2004, an estimated 3.1 million people in the region became newly infected, while 2.3 million died of AIDS.

While recent developments in medical treatment in the context of well resourced health systems and in countries where infection levels are low have to some extent changed the prognosis for those who have developed AIDS, the situation in resource poor settings is less promising. Overstretched health systems, limited access to the supplementary treatments and improved nutrition which can extend the life of those infected and the currently restricted availability of Anti-retroviral (ARVs) means that HIV remains a threat to the lives and livelihoods of millions of people.

The social epidemiology of the disease in many countries means that young adults and parents in their prime have the highest risk of contracting the disease. Recent evidence suggests that women's risk of contracting the virus exceeds that of men. Although patterns of infection vary between countries and social groups, and according to the stage of the epidemic in particular places, HIV in Africa has disproportionately affected young people and, increasingly, women and girls. Six thousand young people aged between fifteen and twenty-four are newly infected each day. [1]

Social and Economic Impacts of HIV and AIDS

HIV and AIDS do not merely threaten those infected by the virus. The epidemic attacks economies and societies, incapacitating the generation on whom the productive sectors depend and reducing the numbers of skilled personnel in key public services such as education and health. In some of the highly impacted countries of southern Africa high rates of HIV prevalence may have contributed to rising food insecurity, as the ability of affected households to meet their food needs through agriculture declines (de Waal & Whiteside 2003; Baylies 2002; USAID 2004: 14).

In the absence of public safety nets for incapacitated workers the rural families who may once have depended on remittances from urban kin now bear additional burdens as those afflicted by illness return to their home areas (Nyangara 2004: 5). As well as the costs of illness, loss of earnings and reduced productive capacity, HIV and AIDS imposes long term obligations on many families who must assume responsibility for the care and support of children whose parents have succumbed to the disease.

In high mortality environments where up to 12% of children have already lost at least one parent to all causes (UNICEF 2004: 8), where around one third of children under five are undernourished and where some 320 million people live in extreme poverty, the social and economic consequences of HIV and AIDS are devastating.[2] Economic pressures intensified by

[1] UNAIDS AIDS Epidemic Update December 2004.

[2] These figures are taken from the World Bank's World Development Indicators 2005, although they are based on 2001 data. One quarter of the world's poorest population live in sub Saharan Africa (http//davdata.worldbank.org/wdi2005).

globalisation, falling producer prices, the decline in public sector employment and increased charges for basic services, including health and education, pose tough challenges for citizens of African countries which are accentuated by the cumulative impacts of the AIDS pandemic. Reversing previous gains in life expectancy, imposing unsustainable costs on the health sector and depleting human capital HIV/AIDS contributes to long-term poverty traps, jeopardizing the futures of individuals households and communities (Chronic Poverty Research Centre 2004; de Waal 2003; 2004).

The economic and social consequences of the increased mortality and mobility associated with HIV/AIDS are both serious and diverse. HIV/AIDS adversely affects the accumulation of human capital, eroding people's skills, knowledge and experience. It debilitates welfare programmes and impacts on governance, finance and public services. Economic growth slows in countries affected by the epidemic.[3]

AIDS and Children

The epidemic is particularly damaging for children, the group most vulnerable to the effects of poverty (Harper & Marcus 2000; 2003). HIV and AIDS also affects children directly, with some 640,000 children annually infected by the virus as a result of mother to child transmission. Children under fifteen account for one in six global AIDS-related deaths and one in seven new infections. (UNICEF 2005). By 2004 an estimated 12.3 million children under the age of eighteen in Africa had lost one or both parents to the disease (UNICEF 2004: 1). Depending on what kinds of prevention, care and treatment policies are adopted and on the outcomes of efforts to halt the epidemic, a worst case scenario estimates that as many as 27 million children in Africa could be orphaned by AIDS between now and 2025 (UNAIDS 2003: 27).

In highly impacted communities where more than one fifth of households has experienced an AIDS related death or taken in additional members due to orphaning, community capacity to deal with the knock on effects of AIDS may have reached breaking point (Deininger et al 2003; 1201; Rugalema 2000; Baylies 2002: 613-617). In the absence of radical change in the kind of support available to AIDS affected communities there is no doubt that HIV and AIDS represents the biggest threat to achieving economic and social development in the region (Africa Commission 2005).

Policy Challenges

The challenge posed by the pandemic is as much social as epidemiological. AIDS is devastating for poor communities because it takes out the economically active adults on whom others depend and increases the dependency burden on those remaining to unsustainable levels. Yet international policy responses to the pandemic to date have focused largely on managing the epidemiological dimensions of the disease. (Jones 2004: 385; Devereux & Sabates-Wheeler 2005:1).

Interventions have prioritised the management and coordination of national responses focused on prevention mainly within the health sector (Allen 2004: 124; Baylies 2000: 486; Seckinelgin 2004; 292). Institutional innovations have helped facilitate a coherent response in some countries. Uganda's AIDS Commission has lead the assault on HIV/AIDS with some success in substantially reducing prevalence rates in that highly impacted country. Botswana's similarly joined up response has made some headway in confronting the epidemic (Allen & Heald 2004; Putzel 2004; Osei-Hwedie 2001; Parkhurst 2001).

[3] World Bank/UNAIDS press release, December 1st 2004.

The institutional response to HIV and AIDS, and subsequent capacity investments in policy formulation and implementation, has been restricted in practice to the health sector. Empirical research on the social, economic and political impacts of the epidemic has been limited, with the exception of intensive research in a few high prevalence situations (de Waal 2003: 3; Allen 2004).[4] Where social sectors have been engaged in the battle to tackle the impacts of the epidemic, emphasis has been on mainstreaming prevention messages, for example through the education sector (eg UNAIDS 2005), rather than on the development of a strategic social policy response.

Indeed, international development thinking has downplayed social policy in general through the twin track pursuit of policies oriented towards economic growth on the one hand and a narrow definition of social sectors on the other (Elson & Cagatay 2000; Mkandawire 2001: 11). This orientation has been pronounced in many countries in Africa where structural adjustment policies pursued since the 1980s have prioritised rolling back the state and effecting savings in the costs of government (Baylies & Bujra 2000: 483; Bujra 2004: 634; Putzel 2005; Young 2004). Promotion of the civil society sector as a response to a range of development problems, including HIV/AIDS, combined with the impacts of decentralisation policies has further relegated social welfare functions to lower or 'community' tiers of local government systems (Parkhurst 2001: 81; De Waal; 2003: 18). The ways in which states are resourced and organised has serious implications for their capacity to conceive and implement a broader social policy response to the enormous difficulties presented by HIV/AIDS. This problem is intensified in situations where social welfare as a policy sector is fragmented across other sectors, including food security and public works.

Political leadership of the fight against HIV/AIDS is growing. Global funding for HIV/AIDS has almost trebled between 2002 and 2004. Funding for HIV/AIDS programmes in low and middle-income countries increased from $300 million in 1996 to an estimated $6.1 billion in 2004.[5] Substantial increases in resources available for children affected by HIV and AIDS are anticipated as this trend continues.

The epidemic poses enormous challenges. Can these can be met through simply scaling up the current portfolio of responses? Or does the urgency of the epidemic prompt an innovative reappraisal of the social policy options which could help reduce its damaging impact? Are the kinds of responses currently proposed contributing to the structural incapacity to adequately address the negative social and economic outcomes of the epidemic? Does AIDS, in all its dimensions, present `a challenge which cannot be addressed without rebuilding the role of the state'? (Baylies & Bujra 2000: 485).

As background to the Wilton Park discussion, this paper:

- Provides an overview of the situation of children affected by AIDS, with special emphasis on sub Saharan Africa.
- Outlines the strengths and weaknesses of current policy responses to children affected by HIV and AIDS and the role of different institutions in implementation.
- Explores some of the opportunities for children affected by HIV and AIDS presented by recent innovations in social welfare programming in low income settings.

[4] This is not to say that the epidemic has not resulted in large volumes of social research. It has. Most of the research to date has been concerned with the sociology of transmission and prevention, in line with the dominant epidemiological models and policy responses driving approaches to the disease. Consequently, the bulk of social research on HIV and AIDS in Africa, and elsewhere, has focused on the social categories constituted as high risk of infection and their cultural, social and sexual practices.
[5] UNAIDS and WHO AIDS epidemic update 2004.

CHILDREN AFFECTED BY HIV AND AIDS

Scale

Current data on the numbers of children affected by HIV and AIDS is complicated by the fact that definitions of affected children are variable and evolving, as agencies move towards a recognition that *all* children in highly impacted communities are affected by HIV and AIDS whether they are orphaned or not (Richter & Mangold 2004: 3). Estimating the proportion of children who are affected by HIV and AIDS within and between countries is further complicated by variable definitions of orphan status. These vary from country to country and even across international agencies (UNICEF 2005: 17). The definition adopted by UNICEF includes children under the age of eighteen who have lost one or both parents (UNICEF 2004: 1).

Governments and development agencies generally differentiate between those who have lost a father (paternal orphan) those who have lost a mother, and those (double orphans) who have lost both parents. As well as the definitional ambiguity, which renders cross country comparisons problematic, data on orphan numbers is based on estimated projections based on Demographic and Health Surveys (DHS) and informed by data on HIV prevalence derived from maternal blood testing (Bicego et al 2003: 1235).

The estimates suggest that there is considerable variation in the number and proportion of children who have lost one or both parents, to all causes, within and between countries. Estimates of double orphanhood range from between 10-17% in high impact regions of highly impacted countries (Bicego et al 2003: 1237). There is substantial divergence in the proportion of children orphaned by AIDS as opposed to other causes of parental death, ranging from 48% in highly impacted South Africa to a mere 4% in Senegal (UNICEF 2004: 26).

Half of all orphans are over twelve years old and 90% are above age six (UNICEF 2004: 12). The bulk of double orphans are older children. Their number has risen dramatically as the epidemic matures. Tanzania experienced a two fold rise in the number of double orphans during the 1990's (Bicego et al 2003:1239).

Most children who have lost a parent live with the surviving parent (Nyangara 2004; 22). And, as paternal orphans are more numerous than maternal orphans, children who have lost fathers usually reside with their mother (Ainsworth & Filmer 2002:6; Bicego et al 2003: 1237). If the mother dies, children are absorbed into related households, with some 40% residing with grandparents (Ainsworth & Filmer 2002:13). Child headed households are exceptional, accounting for between 1% and 2% of all households, even in high impact countries (Nyangara 2004:21; Gibson et al 2001: 7).

Phases of Impact

Orphan numbers increase only several years after the epidemic becomes established in a community. Initially better off households take in more children. As more families are affected poorer households gradually assume responsibility for greater proportions of children who have lost parents to the disease (Bicego et al 2003: 1243).

Data from Zimbabwe and Uganda clearly demonstrates the sequential impoverishment of households, which care for orphans as the epidemic progresses. By 1999 there were more orphans concentrated at the lowest end of the wealth index, a contrast to the situation at the start of the decade when poor households did not typically take in orphans (Bicego et al 2003: 1244). Recent research in Uganda demonstrates the long term costs to poor households of

fostering children, equivalent to 25% reduction in household investment relative to the average for each child absorbed (Deininger et al 2003: 1217).

Poverty limits the capacities of families and individuals to care for household members. Differentials between orphan children and other children are less significant than those between poor and non poor households (Ainsworth & Filmer 2002: 19). Where kinship bonds are strong and '*where families had adequate resources'* orphan children do not necessarily fare worse than non-orphans (Madhavan 2004: 1445, my emphasis), nor are their development outcomes very different (Ainsworth & Filmer 2003: 19). The poverty of the household in which a child resides had greater impact on educational participation than orphan status (Ainsworth & Filmer 2002: 19), but double orphans fare worse than other children, across all households (Case 2004: 500).

Who Cares?

Women headed households are far more likely than male headed ones to absorb the children of relatives, just as women are more likely than men to assume the burden of care (UNICEF 2004: 10; Osei-Hwedie 2001). Around 40% of orphaned children are cared for by grandmothers (Ainsworth & Filmer 2002: 13).

Where grandmothers are carers of fostered children, they are not necessarily elderly. In South Africa where a means tested pension exists for women over 60 and men over 65 one study found that over half of the grandmothers caring for orphans could not use pension money to supplement their household costs because they were too young to claim it (Legido Quigley 2003:17). Similarly, in Western Kenya a mere 18% of carers who were household heads were over the age of 55 (Nyambedha et al 2004: 306).

Where older people have difficulty in caring for fostered children this is more likely due to low household incomes than age per se. Inadequate income, rather than meeting practical childcare needs, is the main difficulty for foster parents. Most fostered children are between the ages of seven and fourteen (Ainsworth & Filmer 2002:10). Older children commonly assist with the immediate care needs of younger children.

Foster parents have problems raising the cash to ensure that children have access to education, to basic health services and to better life chances, as well as ensuring that their households have adequate food. It is not surprising that families taking on children cited material support as their priority need (Gilborn et al 2001).

Despite the claims of grandparents to the status of carer in their capacity as household head, the day to day labour of care of both the sick and of children falls disproportionately on young adults and predominantly on women. Gendered patterns of care for children and for the sick contribute to the impoverishment of female carers. Not only was caring for adults and children time consuming and expensive, both in terms of inputs and opportunity costs, it curtailed the time women could spend on other income generating opportunities (Marcus 2004).

Cultural practices which place the main burden of care on the mother and which encourage remarriage or multiple partnerships though which a man may have children with several women increase the dependence of children on maternal care. Consequently, maternal orphans may be more vulnerable and at risk than paternal orphans (Nyamukapa & Gregson 2005: 11), and double orphans the most vulnerable of all.

Crisis Fostering and the Quality of Care

Although child headed households and resort to institutional care are rare in African countries, where the majority of children are absorbed into other households, recent evidence points to the differentials in the quality of care between orphans and other children, even within better off households (Nyambedha et al 2003: 304; Case 2004).

In poorer households additional members may simply increase the economic burden on household heads who lack the resources to make necessary investments in education and health for any members, irrespective of orphan status. This situation is highly likely where, as in Free State Province in South Africa, over one quarter of households affected by HIV and AIDS sheltered additional children (Booysen & Arntz 2002: 180).

The key determinant of quality of care for fostered children is the closeness of relationship between the child and carer. Paternal orphans looked after by their mothers had a better chance of attending school in Zimbabwe, despite a drop in income, than maternal orphans whose fathers survived and who therefore lived in better off households. (Nyamukapa & Gregson 2005: 34)

The less closely related the child and carer, the more uncertain the quality of care (Nyambedha et al 2003; Case 2004). Such situations are likely to be the consequence of crisis fostering, where no other options are available for the child. Fostering, both long and short term, is an established social practise in the region, which culturally places greater value on social parenting than on the biology of kinship relationships. Generally, fostering occurs with close relatives, children being brought up, for longer or shorter periods with parent's siblings, elder siblings or grandparents. This kind of fostering is purposive and may be associated with higher quality care.

Crisis fostering, in contrast, usually in response to a shock, characterises the new kind of fostering associated with AIDS and puts greater economic pressure on recipient families (Madhavan 2004). Fostering of unrelated children seems to become more common as the epidemic progresses (Nyangara 2004: 6; 24). Such practices may imply the employment of children as domestic servants, with attendant risks of abuse, particularly for girls (Nyambedha et al 2003).

Given the impoverishment of many families in rural Africa, and the increasing pressure on community caring mechanisms accentuated by AIDS, fewer households have adequate resources to provide adequate care, even for their own children (Harper & Marcus 2000). A study in Zimbabwe found that as the economy worsened, families affected by HIV and AIDS could no longer rely on support from relatives who simply could not afford to help them (Mutangadura 2003: 160).

Sources of Support

Virtually all children absorbed into other households and or cared for in their own household by older siblings or grandparents are reliant on informal support in the form of private transfers received through kin and neighbours. It is estimated that less than 5% of children who have lost one or both parents through all causes currently receive material or other support, from public agencies, civil society and faith based organisations.

Even in South Africa, where low income foster parents can legally claim the child support grant only between 33% and 42% of those entitled actually access the grant because of registration difficulties and problems with documentation (Charles & Matthias 2003: 365). Uptake is also constrained in a context where informal fostering is the norm by the fact that children have to be legally fostered to qualify (Legido Quigley 2003; Marcus 2004). Difficulties in accessing the grant may be compounded by the fact that it is not unusual for fostered children to move between carers and shift residence frequently (Booysen & Arntz 2002: 185; Bray 2003:47; Young & Agnell 2003: 338).

Elsewhere children and the families who care for them do not have clear entitlements to designated levels of material support. Households in difficult circumstances may benefit on occasion from broader social protection interventions, such as food for work programmes, public employment schemes and emergency food aid. Such interventions are not systematic in most countries in sub Saharan Africa and are implemented periodically as part of emergency response (Gough & Wood 2004).

There are exceptions to this general picture. These include, in addition to South Africa, Namibia which has recently extended its non contributory old age pension scheme and Botswana which has universal old age pensions, a system of transfers for the destitute and provision of support for fostered children in poor families (Devereux 2001; Seekings 2002; Triegaardt 2002). The recent institutionalisation of the Food Security Programme in Ethiopia as an annual food or cash transfer to vulnerable households and individuals in certain regions of the country can also be interpreted as a transition to a more predictable system of welfare support, although entitlements are variable.

Where support specifically for the care of children who have lost parents exists it is fragmented and arbitrary, often a result of localised externally supported programmes implemented by local authorities, civil society and faith based organisations. Fewer than 5% of Uganda's 1.7 million orphans received any support at all, from all sources, including state, civil society and faith based organisations (Deininger et al 2003: 1214).

Much of the support which is available for this category of beneficiaries is not directed at household income. What has come to be categorised across agencies as programming for Orphans and Vulnerable Children (OVCs) has encompassed interventions aimed at protecting the legal and emotional status of the individual orphan. Such measures have included initiatives directed towards psycho social support, birth registration and succession planning. While these kinds of activities are invaluable for the individuals affected they do not address the immediate difficulties faced by households who have assumed responsibility for children and who may also be bearing the substantial livelihoods and health costs associated with AIDS (Devereux & Sabates- Wheeler 2005: 2).

Within community settings the inputs of faith based organisations (FBO's) are valuable in terms of local acceptability and reach. This reach is not extensive. Around half the FBO initiatives dealing with children surveyed in a recent cross country study are situated in urban areas. Levels of support are low, with one off grants, occasional assistance with food, school expenses and the like being the most usual interventions aimed specifically at supporting children (Foster 2005: 8-10).

POLICY ISSUES

The Framework

Current policy and programming interventions directed at supporting children affected by HIV and AIDS are guided by the principles set out in the 2004 *Framework for the Protection, Care and Support for Orphans and Vulnerable Children Living in a World With HIV and AIDS* . The Framework is intended to inform the development of national action plans and the lower tier initiatives which comprise them.

The Framework consist of five main strategies to address the needs of children made vulnerable by HIV and AIDS. These are:

- Strengthening capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support.
- Mobilizing and supporting community based responses to provide both immediate and long term assistance to vulnerable households
- Ensuring access for orphans and vulnerable children to essential services
- Ensuring that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to communities.
- Raising awareness at all levels through advocacy and social mobilisation to create a supportive environment for children affected by HIV and AIDS.

Although the strategies set out in the Framework inform the national plans of affected countries and the strategies of donor agencies its adoption has yet to transform the direction of policy around children affected by HIV and AIDS. There are various reasons for this, perhaps the most important being the fact that in many countries responsibility for children affected by HIV and AIDS, and indeed vulnerable children more generally, is dispersed across agencies.

Lack of co-ordination between responsible agencies limits the effectiveness of planning and implementation processes. Often, where national AIDS Commissions assume responsibility for children affected by HIV and AIDS their policy networks remain confined to the health sector and fail to adequately engage with social sector ministries, including departments with responsibility for social welfare.

Programming and policy development around children affected by HIV and AIDS, and indeed vulnerable children more generally, remains marginalised in many countries. Children and AIDS issues are not effectively addressed in Poverty Reduction Strategy Papers; may be confined to AIDS programming institutions which are weak at cross sectoral co-ordination; and do not adequately address the cross cutting issues of poverty and gender which require an integrated social policy response (de Waal 2004: 6; Bonnel et al 2004) .

The Framework is intended to provide guidance for implementers about how best to address the multiple difficulties faced by children living in a world with HIV and AIDS. It does not specify the means by which its various components could be operationalised. Consequently, the Framework is silent on the institutional means through which families and communities should be supported and on who is ultimately responsible for providing support. It is also silent on the policy modalities through which interventions in support of children affected by HIV and AIDS could be integrated into national strategies.

The situation is further complicated by the fact that the most effective responses to children affected by HIV and AIDS, including fostered children, are arguably interventions targeted not specifically at certain categories of children, but at child poverty more generally. However, funding structures and the policies of certain donor organisations create a funding stream around a specific category of children, with subsequent requirements around monitoring, evaluation and accountability.

Moreover, the category at which interventions is directed is neither well defined nor agreed on between agencies and governments, as in the recent debates about the boundaries of the category OVC and its relation to HIV and AIDS. And, as we have seen, framing of categories in terms of orphan status is problematic where orphan status in itself (as currently defined) is not a good indicator of vulnerability. This difficulty is likely to be intensified with the availability of new funding directed specifically at AIDS affected children.

The Role of Families and Communities

There is another important reason why the Framework has yet to transform policy around children affected by HIV and AIDS. The Framework shares the normative assumptions concerning the obligations of states and the place of social policy in development programming. The Framework thus places great emphasis on the role of families and communities, the importance of advocacy and mobilisation, and on policy and legislation.

The main agent of implementation as set out in the Framework is the community, to which resources for the support of children and families should be channelled. This position is not simply consistent with a reality in many countries in which there are no other support mechanisms for the vulnerable, including children, the elderly and people living with HIV and AIDS. It perpetuates the notion of community as the locus of proper and effective institutional response to the problems both of HIV and AIDS and of social policy more generally.

The emphasis on community structures, community support and community based interventions is also predominant in the policy thinking around HIV and AIDS where it has been elevated to `an article of faith' (Campbell 2004: 1). Community is represented in policy documents and in policy research as the next level of social organisation up from the household which it encompasses . As well as evoking levels of local social organisation above the household, including kin and neighbours, the category of `community' is also used to refer to the more formal institutions of local governance, including villages and their institutional sub-components, through which rural societies are integrated into state structures in many countries.

`Traditional' Kinship Structures and Safety Nets

There are various empirical and conceptual difficulties with this construct of community and its assumed relationship to the household. Empirically, neither households or communities are discrete and bounded units of mutual support and obligation. Long and short term shifts in household composition are not unusual in many countries as both adults and children change residence frequently.

The informal entitlements to support which comprise what is often thought of as the `traditional' safety net cannot be assumed to be locally embedded. The kinship networks on whom individuals within households depend on for support are dispersed across and between countries. Access to support is arbitrary. There are no guarantees even where relationships are close and obligations strong. These kinds of support mechanisms benefit those best able to

reciprocate in the longer term or those with the resources to participate in building strong relationships of mutual obligation and hence entitlements to support. The destitute, the marginal and those with weak social capital are effectively excluded from such networks (Baylies 2002: 622).

Household poverty also challenges the sustainability and effectiveness of the community based care strategies promoted through the Framework. Individuals under pressure to secure their own fragile livelihoods have little spare capacity to assume responsibility for others (Marcus 2004). Incentivization of community based care schemes is often necessary to ensure the participation of `volunteers' (Lee et al 2002; Akintola 2004: 26).

Formal Community Structures

Where formal mechanisms, such as the Most Vulnerable Children (MVC) committees established through UNICEF in parts of Tanzania, are the basis of community disbursement and allocation schemes it must be remembered that such mechanisms are frequently established precisely for this purpose and that community participation in support activities is likely to be incentivised. These initiatives should be differentiated from the more usual informal private transfers which constitute `community' support, and which rely on the good will and personal generosity of numerous individuals, most of them women, across rural and urban Africa (Foster 2005: 48).

Informal private transfers and household support have become the de facto basis of responses to the social impacts of the epidemic in Africa because of assumptions around social policy and the limits of public responsibility for the welfare of citizens, which, with the partial exception of South Africa (Seekings 2002:1), has situated responsibility for welfare outcomes, including caring for children and people living with HIV and AIDS, within what is constituted as the private domain of the household (Chikwendu 2001: 246). This highly gendered allocation of responsibility has important implications for women and for female poverty (Bujra 2004: 633; Baylies & Bujra 2000: 485).

Finally, where community is understood as referring to lower tiers of local government and administrative systems, effective capacity to respond to the needs of vulnerable categories, including children affected by HIV and AIDS, may be limited in practice by the combination of inadequate resources and an underdeveloped infrastructure for the local implementation of policies and initiatives oriented towards social welfare outcomes. This is in turn a function of the way in which social policy has been viewed by many governments (including donor governments) as an unjustified expense when social outcomes should be achieved more cost effectively and for more people as a consequence of economic policy. South Africa, which regards social policy as a distinct but necessary complement to economic policy is a notable exception (Triegaardt 2002: 326; Seekings 2002).

The Basis of Social Welfare Policy in Africa

The view of social policy as residual is of course consistent with the adjustment and reform policies pursued in partnership with international donors since the 1980s. These policies emphasised the importance of the market and civil society as institutional mechanisms through which services could be delivered to citizens. But such policy visions have a far longer history. Current conceptions of social policy and the constitution of welfare in Africa are themselves legacies of previous welfare regimes, established initially by colonial administrations (Lewis 2000). This history created a distinct split between French and British administered territories in terms of social welfare policies.

Areas incorporated into the French system of governance adopted a social welfare system premised on individual entitlements to social support from the state. British administrations, reluctant to bear the costs of establishing a public system of social welfare, advocated the community development alternative, in which families and communities in rural areas were to assume responsibility for the support of the vulnerable (Maclean 2002: 70). Where formal social security systems were established they were restricted to formal sector employees or, as in South Africa, to particular categories of citizens.

Today, formal social security covers less than 10% of African workers (Bailey & Turner 2002: 107). Although the shrinking formal sector workforce in most countries has access to contributory pension schemes and provident fund benefits only Namibia , Botswana and South Africa have extensive non contributory pension schemes. These southern African countries also have a range of means tested citizen entitlements to social support, of which South Africa's system is the most extensive. However, notions of community self sufficiency and the capacity of rural dwellers to support themselves continue to inform South African welfare policy which is structured around support for the elderly and children (Seekings 2002).

The narrow conception of the South African welfare safety net is politically contested. In the absence of social support for the unemployed the old age pension in particular plays an important part in reducing poverty (Barrientos 2003; Mac Quene 2002). Campaigners are pressing for the introduction of a Basic Income Grant which would universalise entitlements and guarantee a basic income for all South Africans.

State Capacity and Social Funds

Community development models of social welfare combined with a limited definition of social sectors as comprising health and education have been reinforced by donor policy which has emphasised reductions in social spending and reducing the role of the state. Such policies have perpetuated a notion of welfare as the concern of vulnerable groups, rather than an entitlement of citizens. They have also perpetuated an association between social welfare provision and civil society organisations, consolidating not only a piecemeal approach but one which persistently dissociates the responsibility for social welfare from governments (Mkandawire 2001).

Where social sectors have been supported spending on what is classified as social infrastructure has been prioritised over social policy, as in the case of social funds (Reddy 1998; van Donge 2004). Social funds may have further contributed to an erosion of state capacity to develop and implement social policies and programmes, through the establishment of parallel systems for planning and project implementation (Carvalho et al 2002: 619; Platteau & Gaspart 2003: 1687) and in legitimating ongoing divestment in social policy capacity and social sector spending (cf Tendler 2000).

The emphasis on social infrastructure within ongoing sector programmes and the delegation of social welfare functions to community development has prohibited debate about the kinds of policies and institutions which would be required to impact on social outcomes. Social welfare and social policy more generally is underemphasised in poverty reduction strategy papers, is marginalised within under resourced ministries and, in being subsumed in economic policies, is effectively downgraded as a legitimate area of public investment.

Arguments about the limited capacity of Ministries with responsibility for social welfare are used to justify continued lack of investment in this area. Limited capacity and weak institutions become, as in the case of some South American countries, a self fulfilling prophecy (Kliksberg 2004: 659). Social welfare programming is not only fragmented through this process. It is effectively resituated to other departments dealing with, as in the case of Tanzania, community development, food security and emergency relief (REPOA 2005).

Time for Change?

In countries which rely on donor financing for large proportions of their budgets and where selectivity between different policy options has only recently become the basis of electoral competition there has been little political impetus to increase the responsiveness of government and, by extension, to broaden the social welfare agenda (Moore 2004). South Africa is once again the exception, responding to political demands to redefine welfare and with it the new social contract on which post apartheid citizenship is founded (Ardington & Lund 1995; Seekings 2002).

Several Latin American countries have also responded to changed political environments and new pressures of globalisation to enhance the reach of their social welfare programmes. Some, notably Brazil, Mexico and Nicaragua have introduced extensive new systems aimed at improving the income security and access to services of poor families. Such programming acknowledges the interconnectedness of social and economic policies, viewing social welfare programming as not merely a means of supporting those whose livelihoods are fragile or non viable in a global economy, but as a means of investing in the human and social capital necessary to have a chance of taking part in it.

Elsewhere, Bangladesh has expanded its system of old age pensions. India has extended its social safety nets programmes through guaranteed employment programmes. Social welfare is beginning to be reconsidered by some governments as a necessary investment in economic development, rather than as a cost (Barrientos 2004: 8).

EMERGING OPPORTUNITIES

A Shift in Development Thinking

The kinds of policies currently implemented in Latin America are a political response to changing citizen demands within democratic systems. Their design is also influenced by welfare reform thinking that emerged in the US and Western Europe during the 1990's. This places emphasis on the responsibilities of beneficiaries, on a range of conditionalities which are perceived to add value to transfers and on targeting (Kingfisher 2002:7). Programmes such as *Opportunidades* (previously *Progresa*) in Mexico aimed at families with children make payments to mothers for each eligible child conditional on school attendance and on uptake of basic health services.

The success of the Mexican programme and others like it is prompting a shift within development thinking. It is increasingly recognised that social and economic development can not occur in poor countries without significantly increased state involvement and massive social investment, much of it in social welfare (Chang 2003; Mkandawire 2001).

Some kind of expanded safety net is not only necessary to protect the vulnerable in poor countries. There is emerging consensus that this should be publicly provided. Innovations in programming which aim to transit from food aid to cash transfers, to experiment with predictable and ongoing sources of support for vulnerable individuals and households and to

reconsider conventional assumptions about the inappropriateness of `giving money to the poor' are part of this shift in policy thinking (Hanlon 2004; DFID 2005).

Opportunities for Children?

These shifts in the parameters of the possible in welfare programming create potential opportunities for children affected by HIV and AIDS in a range of African settings. Examples of successful programmes operating in resource constrained environments should at the very least prompt a rethinking of current approaches to supporting children affected by AIDS. Estimated costs of basic social transfer schemes demonstrate their potential affordability, even in low income settings (DFID 2004: 20).[6]

Larger scale national systems of entitlements would obviously be more expensive. However, even such extensive programmes as *Opportunidades* only costs around 0.32% of Mexico's GDP. In poorer countries social protection could be affordable with some transitional donor funding. A recent ILO study estimated that the implementation of a basic system of social protection benefits for Tanzania and Ethiopia, including old age and disability pensions, would cost respectively 0.94% and 1.0% of current GDP (Pal et al 2004: 16). Innovations in technology and communications make entitlements easier to track and facilitate payout. (Farrington et al 2003).

Lessons from the extension of social pensions in South Africa provide indications of the benefits for children of support to elderly householders. Child support grants also ease the burden on poor households, despite difficulties in uptake. Studies of the impacts of the extension of the South African social welfare system found that it actually enhanced the capacities of household and communities to assume burdens of care. Claims that extensions of social welfare to individuals would crowd out care and hence damage `traditional' safety nets have proved unfounded (Lund 2002: 664, 687).

Building Capacities for Social Welfare in Africa: What Future for Children?

Systems such as operate in Mexico or South Africa depend on an established government system for targeting of beneficiaries and disbursement of benefits, as well as, in the case of *Opportunidades,* complicated systems for monitoring and evaluation. These systems are central to national strategies for economic and social development, are prioritised in national budgets and are overseen by ministries with a central role in government.

The capacity of other states in Africa to implement such programmes is currently questionable, as is the commitment of development partners to facilitate a genuine rebuilding of the state in Africa (Eriksen 2001:305; Moore 2004: 306). As in the former socialist countries of Eastern Europe and Central Asia which have undergone an equivalent sequence of economic and political reforms (Stavrakis 2002: 278) , the emphasis of donor policy to date has been on state *dismantling* rather than state *building* (Grzymala-Busse & Jones Luong 2005: 530).

Capacity enhancement and investment, where it has occurred, has been oriented towards strengthening systems of governance, with an emphasis on systems for financial management, procurement and accountability. This orientation has resulted in enhanced capacities for planning and implementation at the centre, and in particular within Ministries of Finance now geared up to accommodate Direct Budgetary Support. It has also strengthened the systems side of service Ministries, for example Health and Education. Impacts on service quality,

[6] For example, scaling up the existing level of benefits to the poorest Zambian households to achieve national reach would cost around 3% of current government expenditure (DFID 2005:20).

sustainability and reach are less certain. We may question whether in fact it is the extent of state restructuring which has made AIDS in Africa a disaster (Bujra 2004: 634). We should certainly ask whether it has reached its limits.

The inability of civil society and the private sector to fill the gaps remaining is glaringly evident in relation to the social and economic impacts of HIV and AIDS. NGO response is important and provides useful services. But it is patchy, uncoordinated, overly reliant on unpredictable donor funding and works against a rights based approach to entitlements and access (Parkhurst 2001:81; Richter et al 2004; Seckinelgin 2004: 303).

Fifteen years ago Susan Hunter questioned whether the ` extension and support of traditional systems is optimal' as a means of containing the worst effects of the epidemic on children in Uganda (1990: 687). Experience from the intervening years suggests that it is not. Recent initiatives in social welfare from around the world show what may be better. Supporting children affected by HIV and AIDS in the longer term will not be best served by increasing the burden on already overburdened families and communities (Dixon-Fyle, K & Mulanga, C 2004: 16). It calls for an urgent reappraisal of approaches to social welfare and the state.

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