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Institutions and instruments for tackling chronic poverty: the case of special protection and HIV/AIDS

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What is Chronic Poverty?

The distinguishing feature of chronic poverty is extended duration in absolute poverty.

Therefore, chronically poor people always, or usually, live below a poverty line, which is normally defined in terms of a money indicator (e.g. consumption, income, etc.), but could also be defined in terms of wider or subjective aspects of deprivation.

This is different from the transitorily poor, who move in and out of poverty, or only occasionally fall below the poverty line.

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Abstract

HIV/AIDS is both a cause and a symptom of chronic poverty and requires new and innovative policy instruments and institutional structures to address its impacts. Focusing specifically on orphans, vulnerable children and the elderly, this paper explores the appropriateness of different social protection mechanisms for supporting households living with HIV/AIDS and suggests what roles are appropriate for different institutions – from households and communities to governments and donors – for tackling chronic poverty among people living with HIV/AIDS.

Keywords: HIV/AIDS, social protection, OVCs, policy instruments

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1 Introduction: the impacts of HIV/AIDS on chronic poverty

HIV/AIDS is both a cause and a symptom of chronic poverty in the developing world. The onset of AIDS in a household frequently triggers the slide into poverty or, for those already poor, the slide into destitution. The cost of treating the disease and caring for the sick diverts household resources away from productive activities that might provide the means by which households can make positive exits from poverty. HIV/AIDS also contributes to the intergenerational transmission of poverty. It strikes down the economically active population and leaves the young with little hope of equipping themselves with the skills and capacity to find their own way out of poverty. The impacts of HIV/AIDS at micro and macro level, in the short and long term and in different sectors, are increasingly well documented.

At the micro level: Households that are affected by HIV/AIDS face decreasing asset status over time and become less productive. In agriculture, for example, declining capacity to produce crops results from a number of factors: labour shortages resulting from sickness or the displacement of labour as household members become carers rather than working in their fields; falling agricultural productivity owing to lack of investment as money that would otherwise be spent on fertilisers and other inputs is allocated towards paying for medicines and funerals; the demise of intergenerational transmission of local knowledge and skills that are crucial for successful agricultural production; and a weakening of social networks through which people trade goods, access credit and find work (Barnett and Blaikie, 1992; Barnett *et al.*, 1995; Gillespie and Loevinsohn, 2003; Slater and Wiggins, 2005).

HIV/AIDS also has implications for food security. Urban households where people are sick and unable to work have reduced entitlements to food. Rural households oriented towards subsistence production struggle to produce enough food and have no surplus labour to supply larger commercial farms or to move into off-farm labour markets. Thus, the 'New Variant Famine' thesis posits that a different type of famine is emerging, driven not by drought or conflict but by the effects of HIV/AIDS as it increases the vulnerability of households to shocks and risk (de Waal, 2003; FANTA, 2001; WHO, 2003).

There is evidence, albeit incomplete, of implications for nutrition. HIV-negative people with poor diets are more susceptible to infection, HIV-positive people with poor diets develop AIDS more quickly and people with AIDS have increased nutritional requirements (Gillespie and Haddad, 2002). Antiretrovirals (ARVs) must be combined with a good diet in order to be most effective and to avoid side-effects (de Waal, 2003).

The impacts of HIV/AIDS reflect inequitable gender relations (Baylies, 2002). Women are more likely to be infected (both because of physiology and because they are less able to protect themselves through abstinence or condom use), and they take on greater burdens of



caring for the chronically ill. Men tend to die before women, increasing the number of female-headed households. There are also many references to the susceptibility of widows to property grabbing by in-laws (Baylies, 2002; FAO, 2003; 2004a).

At the macro-level our knowledge about the impacts of HIV/AIDS is patchy and, in general, qualitative. Quantitative data about the prevalence of HIV and of AIDS, and effects on life expectancy and death rates, tend to be unreliable. There are millions of people in the developing world who do not know their HIV status. Similarly, it is very difficult to aggregate up the impacts on households and individuals to understand how HIV/AIDS affects economic growth at national or regional level (Anderson *et al.*, 2004). Modelling by Robalino *et al.* (2002) estimates that, in the Middle East and North Africa, a region with relatively low HIV prevalence rates, average gross domestic product (GDP) losses resulting from HIV/AIDS for the period 2000-2025 could approximate 35% of current GDP. In different economic sectors, the impacts are different; they are in general greater in sectors where male workers live away from their families (for example, transportation, construction and power generation) (Bollinger and Stover, 1999). The UN Secretariat demonstrates the varied findings of research, arguing that, while in some cases estimates of the economic impact of HIV/AIDS have been 'small', elsewhere annual reductions of 2–4 percentage points of GDP per annum have been found (UN Secretariat, 2003: xiv–xv). The actual impact may be worse than estimated because calculations of the impact on GDP do not take into account the damage caused by lower investments in human capital, particularly children's education.

In spite of the difficulties associated with understanding the macro level, particularly macroeconomic effects of HIV/AIDS, an important outcome of research into the impacts of HIV/AIDS is the increasing acknowledgement by governments, donors and civil society that HIV/AIDS is eroding the hard-won development progress of the past few decades. Global life expectancy through the 1990s is now threatened by falls in Thailand, Botswana, Malawi, South Africa, Zimbabwe and Zambia (UNDP, 1996; 1997; 2000). Child mortality is on the increase too. It is estimated that under-five child mortality rates will more than double in countries such as Botswana, Kenya and Zimbabwe by the year 2010.¹ The initial denial that met the identification of the first AIDS cases in many countries has been replaced in most countries by recognition of the increasingly vulnerable livelihoods of those living with HIV/AIDS and of the fragile state of the broader economies in which they live.

In parallel with the growing literature on the impacts of HIV/AIDS is a growing concern with policy options for protecting vulnerable households through different social protection instruments.² Furthermore, in new thinking on social protection, rather than focusing solely

¹ <http://www.avert.org/children.htm>.

² Social protection is defined here as per Shepherd (2004), as a range of processes, policies and interventions to enable people to reduce, mitigate, cope with and recover from risk in order that they become less insecure and can participate in economic growth.



on safety nets (for coping), there has been a shift towards identifying potential linkages between the protection of people's livelihoods and the promotion of livelihoods through economic growth (Devereux, 2001; Farrington *et al.*, 2004). This new conceptual content in social protection focuses on 'how public actions designed to help people manage risk and adversity may contribute to larger policy objectives of economic growth and poverty reduction' (Conway and Norton, 2002: 533).

However, the scale and seriousness of HIV/AIDS in some countries, particularly in sub-Saharan Africa, poses a challenge to some of this new thinking on social protection. Vulnerability caused by HIV/AIDS has led to demands for social protection measures to assist HIV/AIDS-affected households but is combined with a recognition that people who are infected with or affected by HIV/AIDS may be unable to contribute to economic production. There is also a need to consider the benefits of social protection within a broader context, that of the social and long-term economic value in providing support for the children of those affected by HIV/AIDS, who might otherwise become destitute. There are good arguments for investments in young people, given the evidence that certain conditions of childhood poverty lead to the transmission of poverty over lifecourses and to future generations (Harper *et al.*, 2003).

1.1 Critical questions for policymakers

With increasing numbers of people infected with the virus, and spiralling morbidity and mortality effects, there is an urgent need to think about the ways in which different kinds of social protection interventions might be used to help people reduce, mitigate or cope with the impacts of HIV/AIDS. Two questions are particularly pertinent: Can existing forms of social protection absorb the impacts of the epidemic or are new instruments or a new social protection strategy required? What are the implications of HIV/AIDS for the roles of different institutions in tackling chronic poverty?

Thus, this paper seeks to identify:

- The most effective social protection instruments for addressing HIV/AIDS affected households, particularly given the rapidly changing and unpredictable nature of impacts;
- The most effective means of providing social protection to families and communities that support orphans, including particular measures that are likely to benefit the increasing number of elderly people looking after orphans;
- Which institutions (communities, non-governmental organisations (NGOs), governments, donors) are currently providing social protection for people affected by HIV/AIDS and which are the most effective channels for social protection provision.

2 Instruments for tackling chronically poor HIV/AIDS-affected households

Theoretically, social protection interventions can include a massive range of activities (from cash transfers to price support for consumer foods or producer staples to inflationary controls) and it is not possible to consider all of them here. The preoccupations of different agencies reflect this broad range of possible interventions and their particular sectoral priorities (Box 1).

Box 1: Selected agency activities in social protection and HIV/AIDS

Asian Development Bank (ADB): Social protection is not explicitly linked to HIV/AIDS but focuses on: 1) labour market policies and programmes designed to promote employment, the efficient operation of labour markets and the protection of workers; 2) social insurance programmes to cushion the risks associated with unemployment, ill health, disability, work-related injury and old age; 3) social assistance and welfare service programmes for the most vulnerable groups with no other means of adequate support; 4) micro and area-based schemes to address vulnerability at the community level, including micro-insurance, agricultural insurance, social funds and programmes to manage natural disasters; and 5) child protection to ensure the healthy and productive development of children.

Food and Agriculture Organization (FAO): Social protection activities include prevention and mitigation at a range of levels from: 1) grassroots (including voucher systems for improving access to farm inputs; improving nutrition; securing the asset base, especially land and other assets that improve agricultural productivity; and strengthening resilience through promotion of labour-saving technologies, introducing farmer life schools for OVC; creating field-level methodologies for recording and sharing indigenous and agro-biodiversity knowledge); 2) through national policy environments and institutions (including guidelines for incorporating HIV/AIDS considerations into food security and livelihood projects; developing new assessment indicators; research to better understand impacts); and 3) global level (international advocacy drawing attention to inter-linkages between HIV/AIDS, food security, nutrition and the role of the agricultural sector in mitigation).

International Fund for Agricultural Development (IFAD): IFAD's poverty alleviation strategy focuses on the economic empowerment and development of the rural poor through organisational and institutional development and through the facilitation of access to resources and their efficient use. Poverty is viewed as a driving force of HIV/AIDS and, simultaneously, HIV/AIDS increases the depth and extent of rural poverty. There are five main areas of IFAD's response to the HIV epidemic: 1) HIV/AIDS information, education and communication programmes for HIV prevention and AIDS mitigation among IFAD target groups; 2) poverty alleviation and livelihood security programmes adapted to the conditions created by HIV/AIDS, including income-generating programmes, microfinance projects and adult literacy programmes; 3) food security and nutrition-related innovations of adaptation of existing practices; 4) socioeconomic safety nets, with special emphasis on support to orphans and households fostering orphans; and 5) integrated HIV/AIDS workplace programmes for IFAD-supported projects.

International Labour Organization (ILO): HIV/AIDS is a workplace issue, given that most of the world's people who are infected with HIV are of working age. The focus of social protection activities in ILO is on basic worker rights (working against AIDS-related discrimination); establishing alternative workplace arrangements for workers with HIV/AIDS and for their carers (especially women); protecting OVC from child labour, especially sexual exploitation; provision of practical guidance to employers and workers' organisations for prevention of infection; and promotion of behaviour change. The emerging challenge for ILO is incorporating decentralised systems of social protection for informal workers.



World Bank: 1) Labour Market Interventions: helping governments' and individuals' skill enhancement programmes, improvements in the functioning of labour markets and the development of active and passive labour market programmes. 2) Pensions Helping: governments take care of their older and aging populations through the creation of or improvements in private pension provision, mandatory savings and public old-age income support schemes. 3) Social Safety Nets: programmes designed to provide targeted income support and access to basic social services to the poorest population groups, and/or those needing assistance after economic downturns, natural disasters or other events that pose major risks. 4) Social Funds Agencies: that channel grant funding to small-scale projects to help poor communities design and implement their own projects. 5) Lending to governments for social protection.

World Food Programme (WFP): Focus on food and nutrition in the fight against HIV/AIDS includes: food aid to prolong the lives of people suffering with HIV and AIDS; free WFP school lunches and take-home rations; food for healing; and HIV prevention and AIDS awareness campaigns.

UN Children's Fund (UNICEF): Programmes concentrate on: 1) preventing mother-to-child transmission of HIV; 2) providing education, vocational training and psycho-social counselling to children orphaned by HIV/AIDS; 3) ensuring that young people are informed about HIV/AIDS prevention; 4) working with governments to make HIV/AIDS education part of the standard school curriculum; 5) strengthening families and community capacity to protect children through health care services and farming assistance; and 6) organising communications programmes to prevent the spread of HIV/AIDS.

Sources: ADB (2003); FAO (2004b); ILO (2002); ILO (no date); IFAD (2001); UNICEF (2002); WFP (2004)

Much of the HIV/AIDS literature divides the response to HIV/AIDS into prevention, treatment/care and mitigation. Social protection instruments can contribute under each of these headings respectively by, for example, reducing the risk of infection through condom distribution or improved nutrition, through protection against deterioration in health using ART (antiretroviral therapy), or through the development of labour-saving technologies. In this paper, a different but overlapping approach from the Social Risk Management (SRM) framework (Holzmann and Jørgensen, 1999) is used, and instruments are assessed according to whether they reduce, mitigate or help people cope with risk. Interventions that are dealt with in depth in this paper are divided into transfers, public works, education and training, financial services and care and treatment.

Table 1 identifies the main advantages and disadvantages of a range of social protection instruments for tackling HIV/AIDS. Transfers probably have greatest potential because they can safeguard existing productive assets which, in HIV/AIDS-affected households, are typically drawn down to meet basic household needs, thereby trapping households in a vicious cycle of impoverishment. In some circumstances, food may be the most appropriate form of transfer, particularly in remote areas where there is limited supply of food and where an injection of cash might cause inflation. However, we should avoid the 'common assumption that, because HIV/AIDS exacerbates food insecurity, and because people with HIV/AIDS have additional nutritional requirements, food aid is needed' (Harvey, 2004: 33). Cash is an alternative transfer to food. In emergency contexts, it is more cost effective

because it has lower transaction costs, is easily convertible and gives more choice to beneficiaries can stimulate local markets (Peppiatt *et al.*, 2001).

Table 2: Impacts and appropriateness of various interventions

Types of intervention	Impact on and appropriateness for HIV/AIDS-infected and affected households
Transfers	
Cash	<ul style="list-style-type: none"> • Social pensions paid to the elderly can be particularly appropriate because of fungibility and the passing of benefits to other household members. Evidence shows that social pensions in South Africa are often used to pay for children's schooling and are not as expensive as is sometimes assumed • Enable households to buy medicines so that they are less likely to adopt coping strategies that are ultimately destructive (i.e. drawing down on productive household assets in an unsustainable way) • Require transparency, accountability and financial and administrative capacity on the part of governments, otherwise are subject to elite capture • Among donors there may be reluctance to commit resources to recurrent welfare budgets, though the HIV/AIDS pandemic is contributing to a rethink of perspectives • Child-headed households may not have the capacity to make good decisions about expenditure, though orphan allowances paid to households may encourage and strengthen community-based care of orphans
Food and nutrition	<ul style="list-style-type: none"> • Viable long-term safety net for households that are severely labour constrained and cannot participate in social protection programmes that have a labour constraint • Less viable for households that are not labour constrained because of danger of creating dependency • Donors, because of own grain surpluses, are willing to commit large quantities of food • Costly, particularly where there is poor transport infrastructure (for example, sub-Saharan Africa)
Inputs programmes	<ul style="list-style-type: none"> • Significantly cheaper than importing food aid • Provide seeds and fertilisers to households but are inappropriate for households that are severely labour constrained • Could be adapted to provide labour-saving technologies to households
School feeding	<ul style="list-style-type: none"> • School feeding can encourage enrolment and reduce dropouts but unlikely to present enough of an incentive to severely labour-constrained households, particularly child-headed households • Take-home rations can support OVC and their households
Public Works Programmes	
Cash for work and food for work	<ul style="list-style-type: none"> • Can be self-targeting, for example when inferior staple foods or lower wages are paid that richer households will not work for • Appropriate for HIV-positive but asymptomatic people, but only if they have a rich, healthy diet. Since this is unlikely, FFW and CFW can be counterproductive • Inappropriate for labour-constrained households, i.e. those containing people with AIDS and OVC

Other instruments, including inputs programmes and work programmes, can help HIV/AIDS-affected households to maintain asset portfolios and retain incomes. However, for households that are severely labour constrained, agricultural inputs may be inappropriate, although options for adapting inputs programmes or work programmes to provide labour-saving technologies should be explored. Among donors and NGOs, there is no agreement about whether work programmes are appropriate for households affected by HIV/AIDS. One side of the argument is that both are inappropriate for people at risk of developing AIDS. Elsewhere, it is suggested that asymptomatic HIV-positive people can participate in food-for-work (FFW) or cash-for-work (CFW) schemes, and that perspectives (for example the Food and Agriculture Organization's (FAO) 'vulnerable but viable' classification) wrongly assume



that households with chronic illness are not viable. Harvey (2004: 35) argues that there is 'an urgent need for better and more explicit monitoring and evaluation of the labour constraints relating to HIV/AIDS to see whether they really are restricting effective participation in agricultural input programmes', and the same is true of participation in CFW and FFW. Furthermore, the Zimbabwe Red Cross argues that 'if it is assumed that people with HIV/AIDS are unable to benefit from input programmes without careful assessment, there is a clear risk that they could be further stigmatised' (in Harvey, 2004: 35).

Some donors and NGOs highlight the role that community-based financial services can play, particularly in *ex ante* risk mitigation for households affected by HIV/AIDS. Interventions can be divided into three main groups: savings, microcredit and insurance. In all cases, HIV/AIDS presents challenges to the sustainability of these activities and, while they may be appropriate for adults within the community, these types of activities have less direct relevance for orphans and vulnerable children (OVCs). Financial services may be more appropriate in Asia (where prevalence of HIV and AIDS is mostly lower) than in sub-Saharan Africa (which, on the whole, has high prevalence) because they are *ex ante* rather than *ex post* mechanisms.

For example, drawing down on savings is an important risk-mitigating strategy on the part of households affected by HIV/AIDS, and so encouraging savings *ex ante* is one way to help households prepare in advance for the effects of AIDS-related poverty. Informal savings clubs can be flexible and enable households to draw down small amounts of money to pay for medicines, though there is evidence from South Africa that certain kinds of social capital may contribute to, rather than reduce, HIV infection. 'Amongst members of *stokvels* (voluntary savings clubs accompanied by social festivities) however, young men were more likely to be HIV-positive, women of all ages were more likely to have a casual partner, and both young men and young women were more likely to drink alcohol than non-members' (Campbell *et al.*, 2002). Overall, it is important to remember that, for households that are already poor, *ex ante* savings are not possible.

The outlook for microcredit is similarly bleak. While HIV/AIDS-affected households may need access to a wider range of financial services (Parker, 2000), Baylies (2002) was critical of the implied assumption in work on microfinance and HIV/AIDS that the sustainability of HIV/AIDS-affected households will depend, in part, on their fuller integration into the market economy. She argued that 'micro-credit has clear limits where high levels of morbidity and mortality undermine the economic arena within which the logic of microfinance schemes is nested' (p.625). Microfinance programmes need to be more sensitive to the changing demography of rural poverty and the needs of old people and orphans if they are to be useful to HIV/AIDS-affected households.

In the case of insurance mechanisms, burial societies in South Africa are becoming less viable under the pressure of AIDS-related deaths and the failure of households to make



regular contributions. However, there are also arguments that community-based informal insurance mechanisms may be more adaptable and flexible, and thus able to accommodate the changing circumstances of households. In Ethiopia, members of community groups to which people pay subscriptions to meet mourning and funeral costs are being trained for HIV/AIDS-related work (UNOCHA, 2004). Barnett and Blaikie (1992) argue that modifications in customary practice regarding funerals are one community-based response to the HIV/AIDS epidemic. Holzmann and Jørgensen (1999) argue that traditional structures combine insurance functions with other activities and the insurance depends on the trust that arises from other functions. Thus 'while insurance mechanisms provide insurance, they are guided more by a principle of balanced reciprocity' (p.1015). In the context of stigma, discrimination and growing vulnerability among many households in the community, it is easy to see how informal insurance mechanisms and reciprocity can break down.

3 Instruments for orphans, vulnerable children and elderly people

Increasing numbers of OVC represent one of the gravest outcomes of the HIV/AIDS epidemic. In 2001, there were 13.4 million AIDS orphans and, without significant progress with anti-retroviral therapy, will reach 25 million by 2010 (UNICEF, 2002). Many OVC drop out of school because there is no money to pay for school fees, uniforms and books, and because the opportunity cost of lost labour in agriculture or in domestic work, including caring for the sick, is high. This applies particularly to girls. Orphans taken in by adults are at risk of exclusion, abuse, discrimination and stigma. (UNAIDS/UNICEF, 2002: 4). The most vulnerable are child-headed households, which are at greatest risk of destitution (Levine, 2001).

Various instruments are being developed to support OVC. Cornia and Zagonari (2002) explore experience in various countries. They find that cash and in-kind income transfers can be targeted directly or indirectly to AIDS-affected children (through orphan allowances, foster care allowances, basic pensions for the elderly – who often are in charge of a number of orphans – as well as to impoverished people sick with HIV and AIDS). Elements of such schemes are in existence in several AIDS-affected countries. In Botswana in 2000, the government introduced a 'package' of subsidies in kind for orphan children worth US\$60 per child/month. South Africa has instituted a child support grant, a foster care allowance and a care dependency grant for the most vulnerable children. Thailand has a mixed system in which temple and community-based transfers are increasingly accompanied by interventions targeted at children that originate from central government. Even financially stretched countries such as Zambia have considered a modest transfer system (worth half a million dollars a year) to offset school cost of AIDS orphans (personal communication of UNICEF Zambia).



An alternative to child-focused transfers are those paid to the elderly. The elderly, who are without the resources and income-generating capacity to feed and clothe themselves, are often the primary carers of HIV/AIDS OVC. A growing body of evidence from countries with starkly contrasting HIV prevalence demonstrates the importance of social pensions paid to elderly people, particularly those who are supporting orphans (Box 2). Pension payments are often used to pay for education costs of grandchildren or to buy food for the rest of the household (IDPM and HelpAge International, 2003).

Box 2: Old-age allowances in South Africa and Nepal

With HIV infection rates of 24.5 percent in 2001, South Africa experiences some of the highest HIV prevalence levels in the world. In comparison, Nepal is in a much earlier stage of the pandemic, with adult prevalence in the 15-49 age group of 0.5 percent.³ However, evidence from both countries demonstrates the importance of transfers to old people.

In Nepal, all people above 75 years old have been entitled to a payment under the Old-age Allowance Program (OAP). Payments of 100 rupees (per month) were first made in 1995 and increased to 150 rupees in 1999. By 2002, there were nearly 200,000 beneficiaries in the programme, plus 227,000 receiving helpless widows assistance (for widows between 60 and 75 years) and nearly 4,000 receiving disabled pensions (Irudaya Rajan, 2003). While there has been research on the process through which people apply for pensions, much less is known about the ways in which allowances are utilised and the extent to which they support others in society. Accompanying investments to support old people (for example, the construction of old-age homes by NGOs) suggest that old-age allowances are intended directly to benefit the elderly and not their relatives or orphans.

Elsewhere, there has been more research on the utilisation of old-age pensions, particularly in middle-income countries in Southern Africa (for example IDPM/HelpAge International, 2003; Barrientos, 2003). In South Africa, it has been demonstrated that non-contributory (or social) pensions are shared within households and can have a substantial impact on poverty, both long and short term, for both the elderly and their dependents. Barrientos estimates that social pensions in South Africa reduce the poverty headcount by 2.8 percent (Barrientos, 2003). The burden on elderly people is growing rapidly as the number of AIDS deaths increases in South Africa. Ferreira *et al.* (2001) argue that older persons have to take on roles as carers for those who are terminally ill, and carers and providers for the dependents of the terminally ill or those who have already died, whereas Whiteside and Sunter (2000) estimate that, by 2005, there will be nearly one million AIDS orphans in the country. In this context, social pensions to the elderly will become increasingly important and their roles in supporting orphans and the chronically ill should be recognised (Legido-Quigley, 2003). However, it is also important to remember that not all elderly carers are of pensionable age (over 60 for women and over 65 for men in South Africa). Hunter and May demonstrate the

³ This figure is obtained from only eight sentinel surveillance sites and the national seroprevalence rate is expected to be underreported (<http://www.unaids.org/nationalresponse/result.asp>).



growing vulnerability of 50-59 year olds as old age is approached, highlighting the 'risk of unemployment or retrenchment, rising costs of living, the possibility of loss of assets or constraints to the effective use of assets, the possible reintroduction of reproductive work [especially caring]' (p.2). This highlights the need to explore orphan allowances for carers, in addition to expanding the role of old age pensions.

School-feeding schemes are also mooted as an appropriate response to dealing with HIV/AIDS-affected OVC. While the nutritional impact of school feeding has not been adequately proved, schemes can improve enrolment and reduce dropouts, particularly among girls (Devereux, 2002; Farrington *et al.*, 2004). It may, therefore, be appropriate, since HIV/AIDS threatens to undermine school enrolments, as children are taken out of school to work in the fields and generate income for the household. It is unclear whether school feeding is enough of an incentive to keep OVC in school, particularly in the case of child-headed households. As a result, school-feeding schemes that previously provided a lunchtime meal at school for children are also including take-home rations.

The main policy challenge in responding to HIV/AIDS-affected children relates to targeting. Targeting issues include whether payments should be direct or indirect (i.e. to orphans or to carers); whether the target population should be all children in AIDS-affected families, only AIDS orphans, all orphans or all OVC; and whether governments, NGOs and communities have the capacity to distribute the allowances. Incentive traps and stigma that result from transfers may be damaging to children (Cornia and Zagonari, 2002). HIV/AIDS exceptionalism – a danger that orphans from causes other than HIV/AIDS will be left out of programming – is significant.⁴ A focus on HIV/AIDS orphans could mask the problems of vulnerable children who are not directly affected by AIDS.

The question of affordability also requires consideration. There is a frequent assumption that social pensions for the elderly are unaffordable in all except middle-income countries such as Brazil, South Africa and India. While there are certainly large recurrent costs associated with pensions, these need to be balanced with the growing numbers of OVC, particularly in Africa. Devereux (2003) argues that the payment of social pensions in some countries is not necessarily unaffordable; rather, it represents a policy choice where politicians have prioritised (fixed-term) investments that are intended to alleviate poverty by driving economic growth. Similarly, Farrington *et al.* (2003) make strong arguments about the (in)efficiency of food distribution systems in India and suggest that, for every rupee of food delivered, there are administration, transportation and storage costs of one to two rupees. They argue that

⁴ A parallel concern is that, while undoubtedly important, a focus on orphans is, morally, an easier priority than, for example, focusing on transport workers or homosexual men. While orphans are undisputed victims of HIV/AIDS, 'there is often more resistance to working with marginalised social groups who may be subject to prejudiced views that they are somehow "morally responsible" for the epidemic' (DeJong, 2003).



'cash transfers paid through certain channels (e.g. the Post Office) for specific purposes such as pensions and allowances are less corruptible than many "in kind" transfers. They may help in reducing under-nutrition and stimulating the local economy by reducing "demand deficits" and merit increased funding' (p.1).

4 Institutions for tackling HIV/AIDS and chronic poverty

There are complex organisational issues associated with social protection programmes and HIV/AIDS. Putzel (2003) lays out the issues according to a set of tensions:

- Fast emergency response versus sustainable development intervention;
- Centralised versus decentralised organisation and resource mobilisation;
- Authoritarian and coercive measure of control versus participatory involvement of grassroots organisations;
- The imperative of public health (the good of the community) versus respect for individual rights; and
- Pressures to allocate resources to immediate killer diseases versus the imperative to head off an epidemic whose deadliness is not immediately evident.

Each of these tensions is evident in each type of institution discussed here:.

4.1 Household and community responses

The Joint UN Programme on HIV/AIDS (UNAIDS) concludes that family and community groups account for 90% of support provided for people living with HIV (PLWH) in Southern Africa (Mutangadura *et al.*, 1999). When someone becomes ill or dies, households respond first by making changes within their household (for example, buying cheaper food and commodities, reducing consumption and sending children to stay elsewhere). The second port of call is members of the extended family for support. At community level, the main responses are support and mitigation, treatment and care and cultural responses (protection of property rights, changing traditional practices, such as funerals, mourning, sexual behaviour, etc.). The same is true of South Asia, particularly India (de Haan, 2004).

HIV/AIDS does, however, place heavy strain on household and community mitigation and coping mechanisms. However large or small the impact, Seeley *et al.* (1993) point out that there are limits to community assistance, kinship networks and levels of reciprocity such that community-based systems should be seen as 'safety nets with holes'. Households go unsupported because of AIDS-related stigma and discrimination, whereas other households have very weak kin relations, particularly if other members of their extended families have already died or have AIDS-related illnesses. Furthermore, 'community safety nets necessarily reflect the entitlements embedded in prevailing power structures within a given



community, and whilst those most in need may not be overlooked, neither may they receive the assistance they require' (Baylies, 2002: 624).

However, there are arguments for exploring how mechanisms that work at the community level in specific contexts and locations might be appropriately scaled up without creating a 'crowding out' process where formal government and donor interventions replicate and undermine informal community mechanisms (Farrington *et al.*, 2003; Devereux, 2002). The NGO sector has significant experience here, although not always in dealing specifically with HIV/AIDS.

4.2 NGO responses

While households and communities contribute the most in the response to HIV/AIDS, NGO responses have also been disproportionately large. The reasons for this are twofold. First, NGOs have different operational structures to governments, so they can respond quickly on a small scale and are close to their constituents and understand power relations and influences at local level. Second, many governments were reluctant and slow in responding to the epidemic in its early stages, partly through denial, but also because the problem is strongly associated with sex and death (areas that are seen as private rather than public concerns) and with socially unacceptable or illegal behaviours that governments do not wish to condone. In comparison, NGOs are well placed to support stigmatised groups and can find paths to reach marginalised groups (DeJong, 2003).

Core competencies in terms of activities include providing education for behaviour change and providing care and treatment. However, many NGOs operate projects and programmes on a relatively small scale. Levine (2001) argues that 'while small-scale, community-based projects can be more efficient and easier to administer, scaling up these projects sufficiently requires widespread collaboration, including government participation, and careful assessments of standards, outcomes and evaluation mechanisms.' The need to move slowly in order to get scaling-up 'right' is juxtaposed against the rapid and devastating spread of the pandemic (DeJong, 2003). There is also a danger that, when NGOs seek to scale up, they lose their comparative advantage compared with other actors, particularly their close links to communities (Edwards and Hulme, 1992).

4.3 Government responses

Moving on to government level, there are various constraints and policy dilemmas associated with mechanisms that are implemented via ministries of social welfare, agriculture, health and education.



The impact of HIV/AIDS on the human resource capacity of governments is explored in Box 3. But serious financial resource constraints also limit the capacity of governments to provide welfare. This is what Devereux (2003) calls the 'Catch 22' of social protection: countries most in need of social protection are those least able to afford and implement it. This is particularly pertinent in the context of HIV/AIDS, which further reinforces the need for long-term protection while further undermining the capacity of government to provide it. One of the main policy dilemmas that governments face is whether to direct resources towards long-term welfare payments or towards projectised spending on activities that will drive economic growth. In the face of globalisation, an increasingly monetarised economy and liberalisation, it is no surprise that governments opt for expenditure with a prescribed end date, rather than a recurrent expenditure item.

Box 3: How HIV/AIDS affects capacity to deliver social protection

HIV/AIDS affects the capacity of governments and civil society to deliver appropriate social protection to poor people in two main ways.

It reduces the financial capacity of the state itself as HIV/AIDS reduces economic growth and, by extension, government revenue through different forms of taxation. Thus, the funds available through public expenditure for any sort of social protection (insurance, transfers, microcredit) decrease just as the need for them arises with the rise of HIV/AIDS-exacerbated poverty and vulnerability.

At the same time, HIV/AIDS reduces the human resource capacity of government itself. Public sector workers are not immune to HIV infection. Loss of working days to illness and the costs of training new staff as others die from AIDS affect all public sectors, including health, education and agriculture. The FAO cites a study showing that as much as 50 percent of agricultural extension staff time was lost owing to HIV/AIDS in sub-Saharan Africa. 'Highly qualified civil servants and technocrats are increasingly dying of AIDS and are not being replaced. In some districts [in East Africa] agricultural programmes cannot be implemented as a result of HIV/AIDS: extension staff are frequently attending funerals.'

Sources: *FAO Factsheet on HIV/AIDS, Food Security and Rural Livelihoods*

<http://www.fao.org/worldfoodsummit/english/fsheets/aids.pdf> and <http://www.fao.org/docrep/x0259e/x0259e08.htm>

It is well established that a multi-sectoral approach, rather than a focus solely on health, is required to tackle AIDS. However, achieving a multi-sectoral approach requires that AIDS is a political priority. In governments where this has been the case (Senegal and Uganda, and Thailand to some extent), significant progress has been made. Elsewhere, where government commitment to tackling AIDS has come later or not at all (India, South Africa, Zimbabwe), the impacts of the epidemic are likely to be much worse than those experienced in Uganda.

A large part of governments' multi-sectoral response thus far has come through social action funds, originally conceived to protect the poor and vulnerable from the harmful effects of



economic reform (Marc *et al.*, 1994). Success among social funds in tackling HIV/AIDS has been limited. While the funds effectively reflect the needs of poor people and poor communities, the extent to which social funds will adapt organically to suit the particular needs of communities affected by HIV/AIDS is limited; there is a need to find ways of encouraging innovative projects within communities. The activities of social action funds also highlight the problems in coordinating different social protection interventions and the danger that small-scale activities lead to fragmented and patchy interventions (Devereux, 2002: 4).

Where government funding is focused on HIV/AIDS, it tends to be focused around prevention and care, increasingly home-based care. While prevention and care are particularly important activities at certain stages of the epidemic, it is important also to be aware that households' experiences of HIV/AIDS vary and that there is no inevitable linear progression of household impact. Thus, governments need to adopt strategies that deal explicitly with the livelihoods/asset 'recovery' process. This may be more important in some places than others; for example, in western Uganda, Shepherd argues that strategies for recovery are what are required for thousands, if not millions of households. NGO and government efforts there were invested in training and credit activities for ameliorating the impact of HIV/AIDS, but welfare institutions for recovery were absent (Shepherd, 2003).

4.4 Donor responses

The role of donors in enabling people to reduce, mitigate and cope with the impacts of HIV/AIDS is varied and it is not always clear whether donors are treating HIV/AIDS as an emergency requiring a humanitarian response or a development issue requiring a longer-term response. While Barnett and Whiteside (2001) argue that HIV/AIDS is an emergency, Putzel argues, 'HIV/AIDS lies squarely at the intersection between "emergency response" and "development intervention" making it one of the most difficult policy and programme issues facing national and local governments and the international development community' (2003: iii). The confusion has implications for the coordination of activities and for partnerships with governments, NGOs and, through them, communities.

Donor agencies are often guilty of focusing on prevention and care at the expense of addressing threats to livelihoods and long-term development gains. While the responses of major agencies reflect their particular sectoral concerns (see Box 2), the majority of activity thus far has been linked to health care interventions. Food security and rural livelihoods interventions are emerging rapidly, although the direction of these is contested. As strategies are developed in different agencies, a significant challenge emerges for donors about the longevity of funding for HIV/AIDS activities. Like governments, donors shy away from commitments to long-term expenditure. However, the timeframe over which the impacts of HIV/AIDS will be felt extends long beyond the levelling-off of infection rates and AIDS prevalence rates. The challenge for donors is to move towards supporting long-term



interventions and to support governments as they try to build on rather than crowd out what is happening at community level.

There are particular challenges in donor attempts to support government departments where governments are particularly weak, and even more so where there is no pro-poor policy environment. Zimbabwe is a good example. There is little hope for the struggle against HIV/AIDS where governments are unaccountable, not transparent and undemocratic, but it is in these contexts that social protection is most important. In such situations, scaling up activities through partnerships between NGOs and donors is disproportionately important.

5 Conclusion: is HIV/AIDS a special case? Outstanding policy issues

General policy conclusions are highlighted in Box 4 but one question – ‘is HIV/AIDS a special case?’ – is worth discussing here. Much of the literature about HIV/AIDS highlights the pandemic as a special or unique type of crisis that requires a special and unique response. There are certainly aspects of the disease and its epidemiology that are fairly unique (for example, the fact that it affects mainly economically active members of the population, or the staging of the disease). For this reason, it is important to pay special attention to the different stages of HIV/AIDS and differentiate between interventions aimed at:

- Keeping HIV-negative people negative;
- Supporting people who are HIV positive but asymptomatic;
- Supporting people who are sick with AIDS;
- Supporting the orphans and other household members who are left behind when people die of HIV/AIDS.

Box 4: Policy conclusions and recommendations

Singling out the HIV/AIDS epidemic as a special and unique kind of crisis can be useful in order to direct resources and political attention towards dealing with the impacts of the epidemic. However, actual activities focusing on HIV/AIDS mitigation and coping should be part of larger programmes (for example those dealing with chronic illness or food security).



Except in very specific circumstances, targeting of social protection mechanisms should be towards vulnerable people to reduce risks, some of which are the result of HIV/AIDS and some of which have other sources, rather than targeting towards people affected by HIV/AIDS specifically/only.

Support should be targeted to households and not just individuals because of the problems that emerge when an AIDS patient dies and because, since it is generally orphans left behind, household recovery options are severely hampered.

Direct targeting of HIV/AIDS orphans, as opposed to other orphans, raises equity and social justice problems and is, in many cases, inappropriate. HIV/AIDS orphans should be supported alongside other orphans who have similar needs, for example, alternative curriculum and training at school to help them take on adult roles and responsibilities.

FFW and CFW programmes can be appropriate for HIV-positive but asymptomatic people, but these should be in parallel to other transfers, notably food and cash, for households that are labour constrained through morbidity or mortality effects. Running FFW and CFW programmes in parallel with food and cash transfers is important in preventing children, especially orphans, from being forced into labour markets.

Innovations in microfinance to support HIV/AIDS-affected and other vulnerable households should be encouraged, accompanied by a careful consideration of the embedded inequalities in communities that may result in exclusion of HIV/AIDS-affected households.

Various institutions have a role to play in contributing to or implementing safety nets. Outside HIV/AIDS-affected households and communities, other stakeholders, notably NGOs, governments and donors, should scale up community safety nets without generating a 'crowding out' effect. Partnerships between NGOs, governments and donors are crucial in this respect.

Better coordination is required between NGOs, governments and donors and could be provided through a national AIDS authority with a multi-sectoral mandate. However, actual programmes and projects should be mainstreamed into sectoral activities, in part to prevent HIV/AIDS exceptionalism.

Social protection interventions should be designed around impact rather than prevalence rates, and donors, governments and NGOs should ensure an appropriate balance between prevention, care and recovery activities, whatever the prevalence. Donors and governments should acknowledge the policy choices that are made between fixed-life projects that promote people's livelihoods through economic growth and recurrent expenditure on social protection for households that cannot contribute to, and are unlikely to benefit from, economic growth. They should recognise that the HIV/AIDS epidemic will create a long-term welfare bill and find ways of supporting this.

However, in conditions of widespread poverty, targeting interventions to HIV/AIDS-infected and affected people is not always helpful, and can have serious implications for equity and social justice. There are strong arguments for focusing not on people with HIV/AIDS *per se* but on vulnerability, which may or may not be HIV/AIDS induced. There are also good reasons for not targeting HIV/AIDS that are related to the practical implementation of programmes and projects. First, it is not possible accurately to identify who is HIV/AIDS



infected or affected; alternative ways of identifying HIV/AIDS, such as proxy indicators, are also indicators of other kinds of vulnerability (de Waal, 2003).

There are also reasons for simplifying rather than complicating social protection. Operating a large number of discrete social protection programmes is economically inefficient (Farrington *et al.*, 2003), so introducing a whole new set of programmes specifically for the HIV/AIDS infected and affected may be uneconomical and make it difficult for poor households to negotiate their way through a maze of programmes before finding one to which they are entitled. Keeping the range of mechanisms simple but flexible also enables interventions to respond to the changing needs of beneficiaries. This is important given that our understanding of the future impact of HIV/AIDS remains patchy (Anderson *et al.*, 2004).

One option for targeting that can be flexible to the changing impacts of HIV/AIDS-induced poverty and vulnerability is community-based targeting. While this is cost efficient, there is a danger that the notion of community is being romanticised (Levine, 2001). It is in communities that processes of stigmatisation, discrimination and denial are played out. Attempts to incorporate community-based targeting should be mindful of how patronage relationships and divisions within communities may lead to the exclusion of certain vulnerable people, and how the stigma of AIDS may exacerbate exclusion.

There are also broader social justice and equity arguments. In the case of orphans in China, for example, there are concerns about 'targeting scholarships to children who are out of school due to HIV when there are many other children out of school with rights to education who receive no support. Similar issues around equity emerge with exemption of taxes and fees for HIV-affected farmers, free medical treatment, etc.' (personal communication of DFID Social Development Advisor). In sub-Saharan Africa, many thousands of children are orphaned as a result of conflict; in many cases, their needs are not significantly different to HIV/AIDS orphans or other vulnerable children (Holmes, 2003).

On the whole, the recommendation is that, in conditions of widespread poverty, social protection for the HIV/AIDS affected should form part of broader social protection mechanisms that aim to reduce vulnerability and increase resilience. Exceptions to this include:

- (1) In areas of high prevalence, where there are already significant HIV/AIDS-targeted activities and where stigma or discrimination against people with HIV/AIDS has been overcome. One example of this is national school feeding in Uganda, which is supported at presidential level (Hickey, 2003).
- (2) Where ART is available and sustainable, it will be useful to tag additional forms of social protection onto it, including nutritional programmes to ensure that diets are sufficient for it to be effective.



(3) In the case of orphans, there is evidence that community-based targeting is likely to be less divisive and unjust than for other vulnerable groups and might lead to positive behavioural change through incentives to households that support orphans. 'Community targeting approaches, in which communities identify vulnerable children and choose program beneficiaries, can reduce stigma and enhance sustainability, though they can also introduce bias and leakage' (Levine, 2001). However, it is important to weigh benefits against the potential stigma attached to children whose parents have died of AIDS.

Mechanisms must be gender sensitive and seek to overcome the gender inequalities that are reinforced through HIV/AIDS. Incorporating labour-saving domestic technologies into programmes for labour-saving agricultural technologies can reduce the time that women spend on reproductive labour. Examples include provision of piped water closer to people's homes and distribution of more fuel-efficient stoves so that women have to spend less time collecting water and fuelwood (Barnett and Blaikie, 1992). However, given the additional burdens faced by women as a result of HIV/AIDS, programmes focusing around microcredit or transfers that target women should beware of increasing the financial, labour and budgetary responsibilities of women. Financial transfers and support aimed at empowering women can inadvertently have the effect of overburdening them with additional responsibilities. Training is one way to overcome these problems.

Ultimately, the challenge for governments and donors lies in going beyond the rhetorical commitment about doing something to reduce, mitigate and enable households to cope with the impacts of HIV/AIDS, and translating rhetoric into action. Achieving this will mean that institutions must acknowledge both the synergies and trade-offs between their fixed-term programme activities and alternative long-term commitments to recurrent spending on social protection.



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