

A Paper to Contribute to a Debate for the Joint Learning Initiative on Children and AIDS

**“Can a Developing Country Support the Welfare Needs of Children Affected by
AIDS?”**

August, 2007

Paper submitted to the Joint Learning Initiative on Children and AIDS
Learning Group 4: Social and Economic Policies

Chris Desmond
Human Sciences Research Council
South Africa



Introduction

Families, communities, faith-based organisations and non-governmental organisations do support the welfare needs of children affected by HIV and AIDS whether they can afford to or not. Families in particular carry the bulk of the costs associated with this support (Foster, 2005). Is this provision adequate? If not, can developing countries' governments afford to support those families caring for children so that the care provided is at least adequate? And what constitutes adequate?

Children are affected by HIV and AIDS in a number of ways. Children are themselves infected: they live with ill caregivers and in households that lose income and support as a result of illness, and many suffer the loss of parents and providers. If they are unable to stay in their homes, the bulk of dislocated children including orphans are then taken in by other households. This can affect the welfare of children already present in these households as resources are then more thinly spread (Monasch and Boerma, 2004). In highly-affected regions, arguably almost all children are affected as illness and death increase and children experience the loss of community members, teachers, health care providers and others who play a role in their care and communities.

The concentration of HIV infections in poor communities means that the impacts are also similarly concentrated. The families that take on the major share of the response are therefore typically poorer and have the least access to resources with which to provide care (Foster, 2005). Given their situation, these families are likely to struggle and support is needed. The literature examining the impacts of HIV and AIDS at the household level provides many examples of the hardship through which households go during adult illness and eventual death (UNAIDS, 1999). The literature further documents how, as a result of the impact or unequal treatment by their new carers many fostered children suffer and have poorer outcomes than other children (Arnab and Serumango-Zake, 2006; Beegle et al, 2005; Gregson et al, 2005). The problem is not, however, limited to those directly affected by illness in the household and parental and care giver loss; children in households that take in dislocated children have also been found to suffer materially (Ainsworth et al, 2005; Monasch and Boerma, 2004). In some instances the situation of children in general is so poor that it is indistinguishable from the situation faced by orphans (Richter and Foster, 2006).

From both practical and moral standpoints there would appear to be an argument for the need to



support those caring for children affected by HIV and AIDS. They are often not able to provide care even to the same low standard provided to other poor children and they are taking on the cost of what is a national problem. For the poor to do this without support is difficult to justify.

The providing for access to water, sanitation, and freely accessible health and education services are obvious means of support that governments can provide. The importance of investing in the delivery of such services has long been identified and is broader than HIV and AIDS and so will not be the focus here. The focus here will be on the provision of support specifically for the care of children. Alternatives to family care are expensive and damaging and, except as a last resort or as a temporary measure have no place in a large-scale response. Families are the only institution capable of providing direct care to children on the required scale to respond to those children affected by HIV in high-prevalence settings. The role of government in such conditions is to support families in the provision of care to children.

The purpose of this paper is to discuss the affordability of providing such support. Of course, an argument could be made that governments cannot afford not to support the care of children, as the long-term impacts on their health, education and development will be too great in terms of future economic losses. This argument, however, still frames the problem in cost-benefit analysis terms. 'Can' or 'cannot' afford suggests a trade off between economic growth and child welfare. Can a country afford the costs of providing adequate care to children in terms of the impact on economic growth? Surely a country pursues development and not growth alone and child welfare is a major part of that development. A country can hardly argue to be developing when the situation of her children is deteriorating, regardless of the economic growth that it may achieve. In such a formulation, child well-being is part of the goal of development and any thought of sacrificing child well-being for growth can only be justified if the benefits of future growth are directed to realise the goal to a greater degree at a later stage. Without economic growth, development is difficult, if not impossible, so it is necessary to consider if there is a trade off between development today and development in the future and, if there is, to ask where the sacrifice should be made. The question from this perspective is then: to what extent can developing countries' governments afford to support families in caring for children affected by HIV and AIDS today without making too great a sacrifice of future development? This question is only relevant if you assume that responding to children today will have a negative impact on economic growth and the prospect of providing for



children in the future.

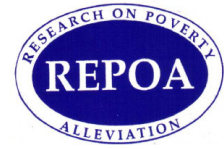
This paper will argue that responses to children today can actually positively affect economic growth and increase the potential for future development. The argument will be made that, for countries without the tax base to finance such responses, international aid will be required, but that the amounts involved are a small fraction of current pledges and that their use for this purpose will not have negative impacts on the macroeconomic stability of recipient countries. Finally, it will be argued that, while aid is a viable short-term option, it is not an appropriate long-term solution and that the call for a fairer global economic system should be directly linked to debates such as this.

The arguments presented in this paper are based on the generic situation in highly-affected regions. There will of course be variations in country context that cannot be dealt with here.

The response to children affected by HIV/AIDS

Any response to HIV and AIDS is at some level a response to the impacts on children. Treatment keeps caregivers and parents alive; prevention aims to stop them becoming infected in the first place and mitigation efforts seek to reduce the economic and social impacts in the societies in which children live. While treatment and prevention have direct implications for children, there has already been considerable debate on the costs and affordability of these interventions (UNAIDS, 2005). This paper is interested in the affordability of responses specifically directed at the welfare of children, particularly those directed at strengthening families. The returns on investments in education and health services is an old debate and will not be revisited here.

Stover et al examine the costs associated with supporting the needs of orphans and vulnerable children (2007). The authors recognise the role of the family and the context of poverty and the resultant need for support. They estimate the unit cost of supporting education, nutrition, health care economic stability, community support and organisational costs. They then examine the costs of providing these services depending on the coverage envisaged. Their focus is on the number of orphans, maternal or double and those near to being orphaned and what covering the different groups would cost. The results suggest a total cost of between US\$1.1 and US\$4.4 billion per annum by 2010 depending on who is covered. The largest cost component is associated with food,

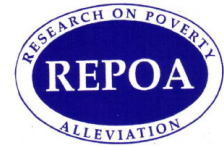


followed closely by education. It is important to note that the costing considered the costs to providers and not households and also assumed the increasing use of volunteers.

The costing provides a useful benchmark of the scale of resources required and raises the difficult issue of targeting in the context of widespread poverty. As mentioned, HIV and AIDS have a range of impacts on children. These impacts can be placed on a continuum from HIV specific to non-specific. At the one end are impacts such as HIV infection, which only occur for children directly affected by the epidemic. At the other end are impacts related to living in poverty. There are also impacts that fall in-between and are semi-specific, such as living with an ill caregiver or experiencing disproportionate impacts of household poverty as a result of being orphaned or separated from parents because of migration. Impacts at the specific end of the continuum require specialised targeted responses, those in-between require general responses that are HIV and AIDS sensitive; the non-specific impacts should be addressed as part of measure to address these impacts more generally.

Most HIV-specific impacts require health system responses, such as prevention of mother to child transmission and child treatment. As the paper seeks to examine the affordability of welfare interventions and focuses on efforts to strengthen family capacity, the semi-specific and non-specific impacts are of central importance as they relate to the interaction between poverty and the epidemic. The negative implications of poverty for children are well established and are not specific to children impoverished as a result of HIV and AIDS. The psychological impact of dealing with adult illness and losing caregivers and parents, the discrimination against children whose parents have died and the stigma of family illness are not HIV- specific problems, but children affected by HIV are more likely to experience these problems, possibly to a greater extent than children affected by the same problems but for different reasons (Cluver and Gardner, 2006). In the case of both the non-specific and semi-specific impacts, responding only to those experiencing these impacts as a result of the epidemic is difficult to justify. It is important to know that children are more at risk as a result of the epidemic and to consider this in the design of interventions and the selection of areas to target responses, but to consider only the cause of problem at the delivery stage of an intervention is inappropriate, as the seriousness of the problem should surely be the primary concern.

Arguably then, the appropriate response in terms of strengthening families is to target those families

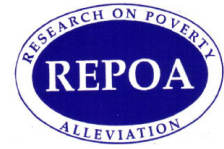


whose children's welfare is most at risk, regardless of the cause, but in a way that is sensitive to the more specific impacts of the HIV and AIDS epidemic.

Poverty plays a major role in the realisation of risks for children associated with HIV. Families are better able to support children through the impacts of the epidemic if they are not poor. For this reason the economic strengthening of affected families should arguably be the central aspect of the welfare response. This paper focuses on the affordability of cash transfers to poor households as a means of mitigating the impacts of poverty on children, while at the same time being sensitive to and including those affected by the epidemic. Cash transfers are discussed as they are a possible core aspect of a response. It is not suggested that other programmes and supportive services are not required, particularly those to deal with specific impacts. That said, the vast bulk of the costs identified in the Stover et al (2006) analysis relate to the provision of material goods and health care. As mentioned previously, the provision of health care and education are obviously important but are dealt with elsewhere. This paper argues that a more efficient approach to providing material support is through cash transfers to household and, as noted in the Stover paper, these are the major costs.

A number of middle-income countries have shown that cash transfer interventions can be affordable. Mexico, Brazil, South Africa and Botswana, among many others, have some type of scheme. The problem is, however, more difficult in low-income settings. While countries such as Lesotho have shown that cash transfers, in their case pensions, can be considered from their own budgets, at least at a low level, in the short term any meaningful expansion of family support of this type would need to be supported by international aid.

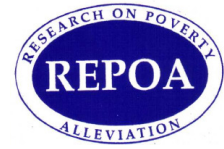
The ILO conducted a modelling exercise that examined the costs not only of a cash transfer but also a social protection package in low-income African countries. This included a universal old age pension, universal primary education, primary health care and a child benefit. The modelling exercise estimated that a child benefit of US\$0.25 a day for each child up to the age of 14 years would cost 1.5 – 4.5 percent of GDP, depending on the setting. The package as a whole was costly, and includes more general components than are being discussed here, with the major cost driver being the provision of health care (48 – 60% of total). Including health care, the total cost in most countries examined was estimated to be between 5 and 15% of GDP. (Pal et al, 2005)



The amounts involved in providing cash transfers are low relative to total foreign aid. If a recent Zambian pilot, involving \$15 per month per household to the poorest 10% of households, was implemented in all low-income countries in Sub-Saharan Africa it would cost only 3% of the aid to Africa agreed at Gleneagles (ILO modelling reported in DfID, 2005a). It is not suggested that this pilot, the existing programmes in middle-income countries, or the ILO example above are the appropriate designs to follow, but what they highlight is the possibility of such types of programmes in both middle and low-income countries and it is this type of programme which is argued to be appropriate. In middle-income countries they could be financed through tax, while in low-income countries there would likely be need for donor support. The question in both settings is whether the additional government expenditure will result in negative consequences that reduce economic growth to the point that the benefits are outweighed by the costs.

There are established links between child survival, school enrolment and future economic growth, although the evidence of the links between government expenditure and child outcomes in terms of health and education are mixed (Anderson and Hague, 2007). This, however, is a particular type of government expenditure and the evidence that cash transfer programmes have a positive influence on nutrition, school enrolment and utilisation of health services is strong (DFID, 2005b). Such investments in the future productivity of children take time to be realised and so it is important to also consider the short-term macroeconomic responses.

It is useful to begin with the more controversial aid-financed scenario, as the fear of Dutch disease is a recurrent issue. Dutch disease refers to the theory that inflows of foreign aid will have destabilising macroeconomic impacts. Foreign aid is received by governments who exchange it for local currency with the central bank. If this money is then spent it increases domestic demand, typically the demand for non-tradables. This increase in demand is then suggested to increase prices and wages in the non-tradable sector, leading to increased inflation. It is further hypothesised that this increase in the prices of non-tradables shifts the allocation of productive assets into the sector and away from the production of tradables. If there are 'learning by doing' factors at work in the tradables sector this will reduce the competitiveness of the sector, harming exports. The central bank then sells the foreign currency, which increases its availability relative to the domestic currency, leading to an appreciation of the local currency, further harming exports.

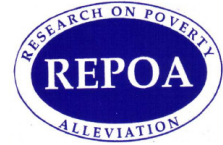


There are a number of problems with applying the above theory to developing country settings. The argument effectively assumes that the economy of the recipient country is operating at full employment on their production possibility frontier (McKinley, 2005). Many developing countries' economies suffer from an under-utilisation of productive resources characterised by high levels of involuntary unemployment resulting from deficient aggregate demand. The supply side may well be able to respond to the increased demand thereby reducing the inflationary impact (McKinley, 2005). In addition to this, fiscal expansions can be directed toward productivity enhancing expenditures that offset the negative impacts on competitiveness, although the nature of such expenditures also has distributional implications (Adam and Bevan, 2006). Linked to this is the possibility that, particularly in low-income settings, public expenditures can crowd in private investment, again increasing supply and productivity and limiting impact (McKinley, 2005). On the monetary side, the increase in the availability of foreign exchange allows for accumulation of reserves or financing of imports. Some central banks retain foreign exchange in reserves, avoiding the appreciation of the exchange rate but effectively negating the transfer of resources (Chowdhury and McKinley, 2006). If the increased availability of exchange is directed towards the purchase of productivity enhancing capital goods, the impact on competitiveness could even be positive.

The evidence that Dutch disease occurs is mixed, particularly in recent years as understandings of how to manage the inflow have improved (Chowdhury and McKinley, 2006). In general, the short-term negative macroeconomic implications, if they do occur, can be reversed if productivity is enhanced, which requires that aid results in delivery (Lewis, 2005).

It is important therefore that increases in aid lead to delivery and that this delivery results in productivity enhancement and/or a supply-side response to increased demand. Cash transfers have the potential to increase productivity and result in increased demand for goods produced in responsive and labour intensive sectors, supporting employment creation, growth and reducing the impact on inflation.

In addition to the long-run productivity outcomes resulting from investments in children, there is reason to believe, and evidence, that cash transfers have positive labour market outcomes via increased participation and productivity improvements. Starving is a full-time job, making

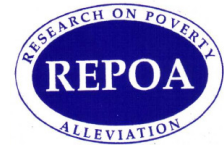


productive employment, employment search or self-employment difficult. The evidence that cash transfers have negative incentive impacts on employment is weak, particularly for poor households unless the amounts involved are substantial which is rarely the case (Samson et al, 2001). Recent evidence from South Africa, Brazil and Mexico has all suggested the opposite, with increased labour force participation in response to family grants (DFID, 2005b). Cash transfers may often increase individuals' capacity to search for work, in particular assisting in the pursuit of high risk – high return approaches to job search as well as assisting individuals to enter the informal sector (Samson et al, 2004) Grants may well be productivity enhancing, as a result of increased consumption by the poor (Samson et al, 2001).

The expenditure patterns of poor households tend to be directed towards food and other basic goods as well as to services in the informal sector. These sectors have high employment elasticities and, in the context of high unemployment, may well be responsive to increases in demand. There may well be a lag in some of these sectors but the increased availability of foreign exchange leaves open the possibility for short-term imports, particularly of basic food stuffs, so as to avoid inflationary pressure. Moreover, the high labour elasticities relate not only to the production of basic goods but their delivery, which is likely to be highly responsive to changes in demand.

For domestically-financed programmes, this demand pattern is more important. The redistribution associated with cash transfers shifts the composition of aggregate demand. Wealthier households are likely to have consumption patterns that support higher imports and economic sectors with low employment elasticities. The redistribution may well be employment generating and improve the current account balance of payments (Samson et al, 2001). That said, although wealthier households tend to borrow more, the net impact on savings is still likely to be negative (Samson et al, 2004), which requires context-specific consideration.

At the macro-level, cash transfers have the added benefit of directly reaching the poor. Adam and Bevan note that generally the non-poor are the immediate beneficiaries of expanded government expenditure, because as workers they benefit from the increased demand for goods and services (2006). As a result of directly providing to the poor, cash transfers have the potential to reduce inequality (Soares et al, 2006), rather than increase it through direct stimulation of the productive sector.



Macroeconomic stability may, however, not be the most important consideration when considering expanded government spending (Lewis, 2005). Institutional weakness and lack of skilled personnel are concerns for both domestically and aid-financed responses. Reliance on uncertain aid flows and associated overexposure provide an additional worry for aid-financed programmes, as does the potential for heavy donor involvement and the establishment of vertical programmes with specific targets that fail to strengthen, and may even weaken, systems (Lewis, 2006).

Cash transfers are less labour intensive and require less administration than in kind transfers (Harvey, 2007), although the possibility of corruption and institutional strain do need to be given careful consideration. The success of existing programmes suggests that these issues can be dealt with. Cash transfers therefore avoid placing as heavy a demand on a countries stock of skilled professionals that would occur if a more service orientated response was implemented. Such services increase the demand for social workers and health professions when both categories of professional are typically in short supply. As a result, in the short term, the additional demand can lead to increased wages and loss of staff from other interventions.

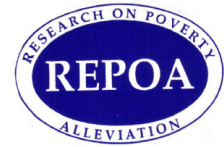
The uncertainty of aid flows and excessive donor involvement raise a more important issue. Responses to children living in difficult circumstances as a result of HIV and AIDS or other causes should be ongoing and stable. Aid provides important short-term support but also distracts attention from the bigger picture and the longer term.

Poverty, HIV and AIDS, compromised child well-being and many other social ills are the result of the failure to address local and international inequalities. The wealthy world gives aid while still protecting their advantaged position in international trade and making little effort to relieve the debt burden. In the poor world, wealthy elites continue to live lives of excess surrounded by poverty. In the long term what is needed is fairer trade, reduced debt, more efficient government, stronger democracies and reduced inequalities. They are all linked; separating problems out and discussing symptomatic responses diverts attention.

Linking the debate about development to aid, whether in general or specifically in response to children affected by HIV and AIDS, casts the wealthy as noble saviours. Considering the problems



within the context of poverty and its links with global power imbalances casts the wealthy, wherever they may live, as bullies. The truth, as is generally the case, lies somewhere in-between. Aid, although problematic at times, is an important source of support to developing countries and a meaningful expression of a belief in a shared humanity, but it is only part of the picture. Keeping the spotlight on programmatic responses and international aid to support them leaves the bigger picture, of the realisation of global power imbalances in unfair terms of trade and debilitating debt, in the dark. The global economic system has consequences for families and their ability to care and support children including those affected by HIV and AIDS. The conceptual distance between the debates needs to be narrowed so that important symptomatic responses supported by aid do not slow, or distract from, the development of long term solutions.



Conclusions

Countries do in fact afford the response to children affected by HIV and AIDS. The problem is that this response is typically borne by families and communities usually from the poorest segments of society.

There are ways in which governments can support these families, but the nature of the support must consider the general context of poverty in which children in many of the highly-affected regions are living. There are needs for specific programmes targeted at those affected, but more than that there is the need to address the detrimental impact of poverty on children and to strengthen families in their ability to help children through this crisis and others.

Cash transfers provide a means to support children that has been proven effective in a variety of settings. The design of such interventions, whether they carry conditions and what size of grant is appropriate, needs further consideration, but they cannot be discounted simply on the grounds of cost. The design of interventions in highly affected regions must be sensitive to the impact of the epidemic. For example, programmes based on family grants do not consider the impact on households that take children in, where as per child grants do. It is also essential to discuss further what constitutes adequate care, as interventions that have a positive impact on outcomes in not enough, the size of that impact is important. While there is need for more work in these areas the excuses relating to affordability are difficult to defend.

The amounts involved are low relative to total aid allocations and a number of middle-income countries have already demonstrated their affordability. What's more, far from being a drain on future growth they may well support it.

If families were not so poor the problems would not be so large and their ability to address them would be greater. Cash transfers go to the root of the problem. If this logic is carried further then the response, or at least the discussion of it, needs to be linked to the causes of poverty. This links this discussion to the broader debate on the continued exploitation of the poor by domestic elites and the wealthy world. The real question is how long are the wealthy of the world happy to maintain such high standards of living at the expense of everyone else? The answer unfortunately seems to be – a long time.



References

Adam, C & Bevan, D. (2006). Aid and the supply side: Public investment, export performance, and the Dutch Disease in low-income countries. *The World Bank Economic Review*.

Ainsworth, M., Beegle, K. & Koda, G. (2005). The impact of adult mortality and parental deaths on primary schooling in North-Western Tanzania. *Journal of International Development*, 41, 412-439.

Anderson, E. & Hague, S. (2007). The impact of investing in children: assessing the cross-country econometric evidence. ODI and Save the Children. Working Paper 280.

Arnab, R. & Serumaga-Zake, A. (2006). Orphans and vulnerable children in Botswana: The impact of HIV/AIDS. *Vulnerable Children and Youth Studies*, 1, 221-229.

Beegle, K., De Weerd, J. & Dercon, S. (2005). Orphanhood and the long-run impact on children. Washington, DC: The World Bank.

Chowdhury, A. & McKinley, T. (2006). Gearing macroeconomic policies to manage large inflows of ODA: The implications for HIV/AIDS programmes. IPC Working Paper No. 17.

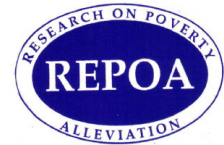
Cluver, L. & Gardner, F. (2006) Psychological well-being of children orphaned by AIDS in Cape Town, South Africa *Annals of General Psychiatry*. 5, 8. BioMed Press.

DFID. (2005a). Can low-income countries in Africa afford social transfers? Social Protection briefing Note Series, No. 2.

DFID. (2005b). Social Transfers and Chronic Poverty: Emerging Evidence and the Challenge Ahead. DFID, London.

Foster, G. (2005). *Bottlenecks and drip-feeds - Channelling resources to communities responding to orphans and vulnerable children in Southern Africa* London: Save the Children, UK.

Gregson, S., Nyamukapa, C., Garnett, G., Wambe, M. & Lewis, J. (2005). HIV infection and



reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe. *AIDS Care*, 17, 785-794.

Harvey, P. (2005). Cash and vouchers in emergencies, HPG Discussion Paper, ODI, London.

Lewis, M. (2005). Addressing the challenge of HIV/AIDS: Macroeconomic, fiscal and institutional issues. CGD Working Paper.

McKinley, T. (2005). Why is 'the Dutch Disease; always a disease? The macroeconomic consequences of scaling up ODA. IPC Working Paper No. 10.

Monasch, R. & Boerma, J. (2004). Orphanhood and childcare patterns in sub-Saharan Africa: An analysis of national surveys from 40 countries. *AIDS*, 18, S55-S65.

Pal, K., Behrendt, C., Leger, F., Cichon, M. & Hagemeyer, K. (2005). Can low income countries afford basic social protection? First results of a modelling exercise. Issues in Social Protection, Discussion paper 13, ILO, Geneva.

Richter, L. & Foster, G. (2006). *The role of the health sector in strengthening systems to support children's healthy development in communities affected by HIV/AIDS*. Geneva:

Samson, M., Babson, O., Haarmann, C., Haarmann, D., Khathi, G., MacQuene, K & Van Niekerk, I. (2001). The economic impact of a basic income grant in South Africa. EPRI Research Paper No. 21.

Samson, M., Lee, U., Ndlebe, A., MacQuene, K., van Niekerk, I., Gandhi, V. & Harigaya, T. (2004). The social and economic impact of South Africa's social security system. EPRI Research Paper No. 37.

Soares, F., Soares, S., Medeiros, M, and Osorio, R. (2006). Cash Transfer Programmes in Brazil: Impacts on Inequality and Poverty. IPC.

Stover, J., Bollinger, L., Walker, N. & Monasch, R.(2006). Resource needs to support orphans and vulnerable children in sun-Saharan Africa. *Health Policy and Planning*. 22: 21-27.



UNAIDS. (1999). A review of household and community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa. UNAIDS, Geneva.

World Health Organization.

UNAIDS. (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries. UNAIDS, Geneva.